ENHANCING NUTRITION CARE IN RURAL PALLIATIVE SERVICES: A VIRTUAL MODEL FOR EQUITABLE DIETETIC SUPPORT

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KEYWORDS

Palliative Care, Dietitian Nutrition, Equity

EXECUTIVE SUMMARY

Access to specialised dietetic support in rural MM5 and remote MM6 palliative care settings is often limited by geography, workforce constraints, and service fragmentation. In response, a virtual model of care was developed to provide equitable access to palliative and end-of-life nutrition support across a large regional health district.

INTRODUCTION

Aim: To improve access to timely, specialist dietetic assessment and nutritional management for palliative care clients regardless of location.

HIGHLIGHTS

- Delivered equitable specialist dietetic support to 225 newly referred palliative care clients over 12 months
- Standardised nutritional care across rural and remote communities, including Modified Monash categories MM5–MM6
- Enabled early screening, proactive intervention, and telehealth delivery to improve access and timeliness of care

METHODOLOGY/ PROCESS

Within a 12 month calender period, a virtual service model was implemented, incorporating early identification of nutritional risk using an Allied Health screening tool.

Clients identified as at risk were scheduled for dietitian-led telehealth consultations, typically within a structured pathway as part of the Specialist Palliative Care Service. Prior to consultation, oral nutrition supplements and nutrition education resources were arranged to support immediate needs.

Dietitians conducted comprehensive telehealth assessments (30–40 minutes per client), addressing nutritional requirements, symptom management (including nausea, bowel issues and lack of appetite), medication impacts on intake, home enteral feeding if appropriate, and practical challenges to food consumption. A service delivery map was developed to illustrate the diverse, geographically responsive approach across the district.

RESULTS/ OUTCOMES

The model enabled consistent access to specialist dietetic input across a large rural footprint, reducing inequity in service delivery. Clients received timely, individualised nutrition advice and interventions, supporting symptom management and improved intake. Early initiation of nutrition support prior to formal consultation enhanced continuity of care and responsiveness to client needs.

CONCLUSION

This virtual dietetic model demonstrates a scalable and effective approach to delivering equitable nutrition care in rural palliative settings. By integrating early screening, proactive intervention, and telehealth delivery, the service supports improved client experience and clinical outcomes at end-of-life, regardless of geography.

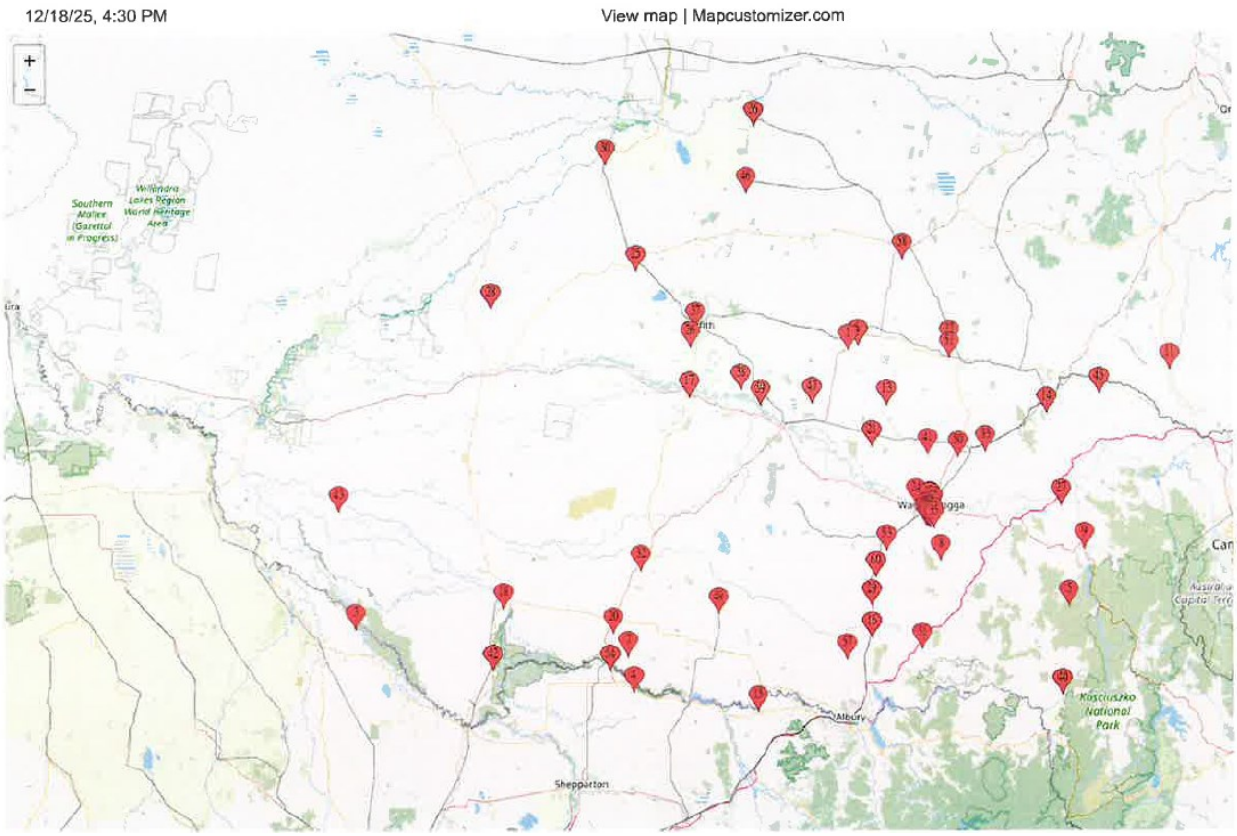

Figure 1. *MLHD Map of Dietetic service provision (Please note this will be improved for poster presentation)*