Marie McInerney reported on the Australian Primary Health Care Nurses Association (APNA) Conference – Nurseforce for the Future, held in Brisbane from 10–12 May, 2018, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. 
http://croakey.org
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May the #Nurseforce be with you: future of primary health care nursing on the agenda

The Australian Primary Health Care Nurses Association (APNA) had a novel approach to potential participants for Nurseforce for the Future, its 10th Annual National Conference for nurses working in primary health care, held in Brisbane from 10-12 May.

It offered tips on ‘pitching the conference to your boss’, including an email template explaining that attendance would enhance the would-be participant’s clinical expertise and showcase examples of service innovation, efficient models of care, quality and safety in practice, workforce recruitment and retention, embracing change and leadership in nursing.

These are some of the issues that journalist Marie McInerney reported on from the conference.

In the Q&A below, APNA President Karen Booth outlines some of the issues facing nurses, nursing and health systems, amid a projected shortfall of about 27,000 primary care nurses by 2025.

These include ongoing frustration in the profession that nurses are not able still to work to full scope of practice, particularly in primary health care, some hope in the potential of the Health Care Homes model (despite lagging enthusiasm elsewhere and nary a mention the recent Federal Budget) and heartening news elsewhere in the Budget.

Most common work settings for members of the Australian Primary Health Care Nurses Association (APNA)
Q&A with Karen Booth

Marie McInerney:
Your latest (2016) annual report commented that a Parliamentary Breakfast revealed that some MPs and key policy people knew very little about the work of primary care nurses, and the issues facing the profession. Where do primary health care nurses work and what would you like all health policy leaders to know about your work and issues?

Karen Booth:
Primary health care nurses work in an extremely wide range of settings. According to the APNA Workforce Survey 2017, the five most common areas of employment in primary health care include general practice, community health service, non-governmental organisation, and being self-employed (i.e. working as a consultant or contractor) (see feature image above).

We want health policy leaders to know that we represent the fastest growing area of nursing which makes up 12.5 percent of the 640,000 registered health professionals in Australia.

With four in five Australians having at least one chronic disease and an increasingly ageing population, Australia’s traditional approach to healthcare needs to change. Recognising the limitations of our current system, there has been an increased emphasis from governments on primary and community care. The Health Care Home model, for example, which the government is currently piloting, aims to keep people with multiple chronic diseases out of the hospital system by better coordinating their care in the community.

These shifts underline the increasing need for, and value of, primary health care nurses. But, as we know, Australia faces a projected shortfall of about 27,000 primary care nurses by 2025. For many, primary care nursing isn’t seen as a career of choice.

APNA supports primary health care nurses through increasing their visibility, recognition and influence in the industry. We do this by developing workshops and resources to improve the knowledge, skills and confidence of nurses.

Another key issue we advocate for is changes to models of care so that primary health care nurses can work to full scope of practice and are valued and optimised as part of an interdisciplinary team.

Marie McInerney:
What’s your reaction to the recent Federal Budget – what were you looking for from the Federal Government and what was the result?

Karen Booth:
We were very pleased to get the news of continued funding for our work, which the Health Department’s Budget statement said “will help nurses move into primary health care, test new ways for nurses to deliver care and better educate nurses about primary health care.”

It was important to have the government’s recognition of the contribution that our members make in primary health care and we welcomed its comments that the health system should make better use of the breadth of skills and experiences that the nursing workforce has in dealing with patients, particularly in multiple primary health care settings.

That funding commitment will support a number of key projects, including to expand the Enhanced Nurse Clinics program, and for our Transition to Practice program that supports new nursing graduates and those coming from the tertiary sector into primary health care. It will also support chronic disease education for nurses.
May the #Nurseforce be with you: future of primary health care nursing on the agenda

There was also great news in the Stronger Rural Health Strategy announcement of an additional 3,000 nurses – as well as the same number of more highly qualified doctors and hundreds of allied health professionals – in the regions over the next 10 years.

And we welcomed news in the ageing plan of health checks for people at ages 45 and 65 – nurses already do a majority of those sorts of health checks, like the aged health assessment and diabetes assessments, so they will have a key role in that.

However, like the Australian Nursing and Midwifery Federation (ANMF), we remain concerned about staffing levels and skills in the aged care sector. Nurses in the sector have a huge workload, huge responsibilities and their numbers are in many cases decreasing.

Marie McInerney:
What's behind the theme for this year's conference: 'Nurseforce of the future'?

Karen Booth:
The APNA national conference provides a platform to recognise and celebrate the achievements of primary health care nurses, and to further cultivate the expertise and collegiality of our nurse workforce—the Nurseforce for the Future.

APNA's vision is a healthy Australia through best practice primary health care nursing. Health care in the country cannot get better without investing in its Nurseforce. Australia's Nurseforce is a passionate, capable, scientific, diverse, progressive movement. There are nurses in primary health care Australia-wide trying to optimise their capacity to bring about sustainable, positive health outcomes for individuals, families, communities, and our nation.

Nurseforce for the Future conference is the opportunity to showcase nurses who are responding to their environment and employing innovative, evidence-based approaches to deliver safe, high quality, patient-centred care. We intend to harness the aspirations and expertise of the diverse delegation to pave the way for personal and professional growth.

Marie McInerney:
Your APNA Workforce Survey 2017 found that 29 percent of primary health care nurses felt they could do more in their roles, 11 percent felt they didn't get to use their knowledge and skills to the full extent, and of the 22.9 percent who spoke up to employers, half were not able to negotiate more complex tasks.

What sorts of tasks are they talking about? What are the benefits, risks and barriers to giving primary health care nurses these bigger, more complex roles? Are we seeing a shift?

Karen Booth:
Working on more “complex tasks” would simply mean to work to the full scope of practice. An individual nurse’s scope of practice may vary considerably from that of another nurse. The tasks themselves can vary depending on several factors including the nurse’s experience, qualifications, clinical specialisation and interests, not to mention the demographics and the need within the community or practice. A nurse can always build their clinical and professional capabilities to expand their scope of practice through education and training.

Complex tasks could be within a broad range of areas including immunisation, women’s health, family planning, health coaching, etc. With the growing number of chronic disease patients on the Australian health agenda, a good example of undertaking a more complex task would be working alongside a general practitioner to develop chronic disease management care plans and care coordination.
Primary health care nurses working to the breadth of their scope facilitate better outcomes by improving access and timeliness to care that the patients need when they need it. This enhances productivity for their teams, value for money for health services, and promotes an integrated care model.

It also helps to streamline care and allows health service to offer additional types of services as well as a reduction in waiting times, more timely assessments and referrals. This is particularly important given the increasing burden of chronic disease and the challenges associated with workforce shortages in Australia’s primary health care system.

Optimal use of the nursing skill-set as part of the interdisciplinary team enables other health professionals, such as general practitioners, to focus their time on higher level diagnostic activity, intervention and care decision making.

We have witnessed a growing interest in nurses wanting to better utilise their skill-set and work to their full scope of practice, especially through our Enhanced Nurse Clinics program, funded by the Australian Department of Health. Nurse clinics offer an alternative model of care delivery where the nurse is a key provider of care for the patient utilising a holistic, patient-centred and team-based approach to care

Marie McInerney:
APNA strongly endorsed the concept of the Health Care Homes model ahead of its (belated) 2017 rollout, saying nurses would play an “essential role”. Recently, as Croakey reported, former AMA head Dr Steve Hambleton, who led the expert advisory group on Health Care Homes, admitted that “implementation went wrong somewhere” and that the initial enthusiasm for what was promised has been lost.

What’s been the experience so far for primary health care nurses and what benefits and challenges are emerging?

Karen Booth:
In my opinion, the commencement of Health Care Homes trial in Australia has only just begun and changes within the system will require adequate time for implementation.

Anecdotal feedback so far suggests that under the Health Care Homes model, nurses have greater autonomy to provide coordinated team-based patient care within their scope of practice. That being said, some nurses will require greater support to take on roles in care coordination, health assessments and patient engagement to support a patient-centred approach to care delivery.

Marie McInerney:
Issues with recruitment and retention for nurses in Australia are also critical matters. The previous APNA survey found that 47 percent of respondents were actively looking for another job outside nursing and midwifery and only just over half intended to continue with their nursing/midwifery career in primary health care (including general practice) for the foreseeable future. Has that changed since? Why is that and what needs to be done for both retention, and initial recruitment?

Karen Booth:
In the APNA Workforce Survey 2017, where 1,703 primary health care nurses across Australia responded, 80 percent claimed they are satisfied and will continue to work in primary health care. That marks a 33 percent increase in job satisfaction since our 2016 survey.
From the survey we could credit that the most satisfying aspects of working in primary health care include: caring for patients and their families; collaboration and effective team-based care; creating positive health outcomes and being a value; and being a valued member of the team.

Nonetheless, recruitment and retention of nurses working in primary health care are still key issues. As mentioned above, primary care nursing isn’t seen as a career of first choice. If you look at it from an educational perspective, many academic courses have traditionally focused on preparing nurses for a career in hospitals, with limited opportunities for undergraduate nurses to experience primary health care. From a career development perspective, while the hospital setting offers obvious career progression opportunities, many primary health care nurses have found it hard to navigate and advance their career in a primary care setting. That view is now changing!

This lack of career structure can be a significant impediment to the development of primary health care roles in general practice and community nursing settings. This state of affairs has made it hard for general practices to recruit and retain nurses—and this is where APNA’s Career and Education Framework comes in.

With funding from the Department of Health, APNA was engaged to develop a framework involving extensive engagement across many consultation phases. Nursing in primary health care is a rewarding and attractive career option, and the project promotes clear pathways to support nurses to find suitable opportunities and a fulfilling career.

Marie McInerney: What conference speakers or issues would you like to highlight ahead of the event?

Karen Booth: Our event is packed with essential sessions that are particularly relevant for primary health care nurses. Key issues we would like to address through our sessions would be promoting nurses working to the full scope of practice and building a stronger nursing workforce through recruitment and retention. We would also like to focus on how nurse-led models of care could help nurses work to the top of their scope and make their work, their career opportunities and levels of satisfaction more exciting and rewarding.

Sessions to watch out for:

- Video address from The Hon. Greg Hunt MP, Minister for Health, Commonwealth Department of Health
- APNA 2018 Nurse Awards
- Health Promotion and Access with nurse practitioner Lesley Salem
- Leadership from the Frontline with Major Matina Jewell
- The Building Blocks for Nurse Clinics: Opportunities for Innovation in Primary Health Care with Linda Govan and a panel of nurses that run their own nurse-led clinics
- More to Mentoring with Melissa Richardson
- Models of Care: Heath Care Homes with Janet Quigley, Commonwealth Department of Health, with Nurse Champion Donna Datoon
May the #Nurseforce be with you: future of primary health care nursing on the agenda

- My Health Record Opt Out Update with Commonwealth Department of Health – Australian Digital Health Agency
- Grow your career in primary health care with Jacqui Richmond with Patrice Cafferky, Robbie Bedbrook and Lou Bromley
- A Multidisciplinary Team Performing to Top of Scope – Panel discussion with Kotara Family Practice
Lessons from the battlefield – a rousing presentation to #Nurseforce

Major Matina Jewell

Former Australian soldier and United Nations peacekeeper Major Matina Jewell received a spontaneous standing ovation at Nurseforce for the Future, the Australian Primary Health Care Nurses Association’s (APNA) 10th Annual National Conference in Brisbane.

While it may seem a long way from commanding a UN convoy under fire in Lebanon to daily practice in primary health care nurse settings across Australia, Jewell's lessons of resilience, strength and courage clearly resonated with the audience.

Journalist Marie McInerney reports below on Jewell's battles, including with her own government for health cover and recognition after a tragic ending to her UN tour.

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Marie McInerney writes:

Retired Australian soldier and UN peacekeeper Major Matina Jewell credits two important experiences with helping to her to survive when the 2006 Lebanon War broke out between Israel and Hezbollah and she had to lead a UN convoy to safety under fire.

The first lesson came when she was deployed by the Australian Army on operations in the Middle East after the September 11 attacks in New York and Washington.
You can track Croakey's coverage of the conference here.

Working with US Navy Seals, she was tasked to run operations with Kuwaiti special forces soldiers who, she said, “could not get their heads around” the idea of a woman being permitted to serve in the military, much less to command an all male team.

They had a very polarised response, she said. “Half of them would literally spit at the ground in front of me, turn their backs, not look at me, not speak to me, sure as hell not take orders from me. The other half, they wanted to marry me.”

It was, she said, the first time in her career where her culture and gender posed limitations for her leadership, and she ended up having to authorise one of her soldiers to pass on her decisions to the Kuwaiti soldiers.

Some years later, back in the Middle East with the UN, she decided she had to give herself new skills to have a better chance this time. So she learnt Arabic.

“That language skill made me a better peacekeeper and leader on a day to day basis,” she said. She was able to have critical face-to-face conversations with local mayors and muftas in Syria and Lebanon about minefield clearances and vital humanitarian aid distribution.

“It was vital I did have a voice I those conversations. But as a white woman, I would not have been invited in the room, let alone to sit at the table, without those language skills.”

**Importance of future proofing**

It was, she said, a lesson for her – and one that she says can apply to very different settings – about the need to identify what we might face in future “and to set about ‘future proofing’ ourselves and our organisations, to give us the best chance to be on the front foot”.

And she said her Arabic skills would later help save her life when she came under fire in Lebanon, allowing her to get directions for a safer route out from a local policeman.

The second lesson, she said, was when she learnt to ‘fast rope’ out of a helicopter – a skill she needed to take up the appointment as head of an assault team.

It was not just a huge physical challenge, of strength and endurance, but more importantly a mental challenge, she said. “Because I am absolutely terrified of heights.”

But she said it taught her to face fear, and not to place limitations on her capabilities.

“It is 100 percent normal for us to face fear, when we are looking in the face of a big challenge or going through big changes. For me, being able to continue operating in the face of fear was a vital skill I needed to survive in that war.”

It’s little wonder that Jewell, author of *Caught in the Crossfire: an Australian peacekeeper beyond the frontline*, is currently looking forward to a movie being made of her life.
It’s also little wonder that she’s in high demand as a public speaker, able to translate the experiences of being caught up, unarmed, in a full-scale war with tragic consequences into clear lessons on resilience and strength for other professions and organisations.

Jewell is also, she says, the epitome of why the most effective teams need to have leaders at every single layer of their organisation, not just those who have ‘leader’ in their job title.

This is because, she says, “in every career is a time when we’re called upon to step up, to lead, even when it is not our responsibility.”

In 2006, Jewell was the only Australian and only woman on the UN patrol base Khiam on the border between Israel and Lebanon when the 33-day war broke out.

Having already, with her UN colleagues, survived over 50 near misses from Israeli bombs and artillery and Hezbollah rockets, she had been due to go to Egypt on holiday, ahead of returning home from her tour.

Instead, she was called on to command a convoy of UN vehicles to safety on a road that normally took two hours to drive, but on this horrendous journey took two days, under heavy fire.

Against many odds, they made it to safety, but she was badly injured when a sudden evasive manoeuvre threw her into the bullet-proofed window of their armoured vehicle, breaking her back in five places and ending her career. Days later, her fellow peacekeepers at the Khiam base, whom she regarded more as brothers than colleagues, were killed in another assault.

There were, she said, many different lessons in those days and weeks to come.

There was the comfort, before the accident, of knowing that she had the full support of the UN command hierarchy in the choices she made to steer the convoy to safety.

That was the benefit, she said, of working in a culture that fully supported and empowered people in decision making processes rather than becoming, as so many organisations do, risk averse.

But she was also a casualty of many failures too, including having to lie for two days on her back, on a tiled floor, without pain relief, while the UN scrambled to evacuate her – its plans and backup plans having failed.

And she was devastated by the failure of any of her commanders to contact her about the deaths of her Khiam colleagues. “All the information I received via the media, on CNN.”

“Don’t ever forget your people,” she told delegates.

And there were more battles to come – with the Australian Government, over both her health cover and war service recognition, a “long, drawn out battle that took many years”, and also for her mental health, when she “hit absolute rock bottom”, fighting depression, survivor guilt, and post traumatic stress disorder.

“I had so much to be thankful for but I couldn’t see that. I was so focused on what I’d lost that I couldn’t see what I had to live for.”

Eventually, she found new purpose, including wanting to make sure that “no Aussie soldier had to endure what I had”.

Lessons from the battlefield – a rousing presentation to #Nurseforce
She was appointed to the Prime Ministerial Advisory Council on Ex-Service Matters (PMAC), advocated for injured soldiers, and was Ambassador of the Australian Peacekeepers and Peacemakers Veterans’ Association. Her book, she says, has helped lead to changes at the UN “which I know will save lives”.

Power of voice

What Jewell now has taken away from all those different experiences, she told the conference, is to “never underestimate the power of my own voice”.

“I think sometimes as individuals we think we’re not capable of effecting change on large industries or organisations but our voices can be a ripple that goes on to be a tidal wave of change,” she said.

“Even out of great adversity can come incredible opportunities, just so long as we have the courage to pursue them.”

Jewell asked the #Nurseforce delegates to consider: “What is your purpose? What is in your life, your team, your organisation, that is really worth fighting for?”

• Watch a two part Australian Story broadcast on Jewell’s battles here.

Tweet reports

Croakey team @CroakeyNews · 23h
First keynote at #Nurseforce: Leadership from the Frontline: Major Matina Jewell (retired), served with US Navy seals, peacekeeper with UN in Syria, Lebanon, advocate for injured war veterans, best selling author

Dr Ruth DeSouza @DeSouzaRN · 23h
Major Matina Jewell talking about her raced and gendered subject positions in a hypermasculinised context and the disruptions her embodied presence brought. She developed language skills to garner respect #culturalcompetence #Leadership #Nurseforce

Croakey team @CroakeyNews · 23h
Learning Arabic made me a better peacekeeper. Major Matina Jewell: Able to meet with mayors, muftis in Syria, Lebanon on minefield clearances, aid. “Vital I did have a voice in those conversations. As a white woman, not have been invited without that language skill.” #Nurseforce
You can track Croakey’s coverage of the conference [here](#).

Lessons from the battlefield – a rousing presentation to #Nurseforce

Dr Ruth DeSouza @DeSouzaRN · 23h
Major Matina Jewell challenging nurses to have a go #Nurseforce

APNA @APNA nurses · 22h
*See change as positive, something to embrace. Positive change takes time and persistent. And it takes great leaders to drive that change.*

@MatinaJewell’s inspiring keynote about Leadership on the Frontline was a crowd winner. Thank you Matina!
You can track Croakey’s coverage of the conference here.

Lessons from the battlefield – a rousing presentation to #Nurseforce

Big applause for inspirational talk on leadership, resilience at #Nurseforce from Major Matina Jewell (who suggested Chris Hemsworth to play her husband in the upcoming movie about her).

Standing ovation for Major Matina Jewell, amazing keynote, much to unpack. Her courage, leadership and capacity to create a new life while living with pain are amazing. #Nurseforce

An absolute privilege to share the stage today @APNAnurses #nurseforce conference with the talented & hilarious @jeankittson one of the best MC’s in the country #thankful #nurses @odermgmt
You can track Croakey's coverage of the conference here.

Lessons from the battlefield – a rousing presentation to #Nurseforce

#Nurseforce

Croakey

“Conference News Service”
Zap! Kapow! Meet the superheroes of #Nurseforce (and also some villains)

May the “Nurse 4s” be with you. Photo credit: Susan McInnes

Marie McLnerney reports:

Superheroes and villains alike were on full display during the Australian Primary Health Care Nurses Association (APNA) 10th Annual National Conference.

Clad in costumes and cloaks for the superhero-themed conference dinner, conference participants also demonstrated their virtual powers in having the conference hashtag #Nurseforce trending during much of the event.

The Nurseforce for the Future conference also had plenty of its own ‘everyday heroes’ to celebrate, to showcase the role of nurses and what they do in primary health care. See below for the winners and finalists of the Nurse of the Year and Emerging Nurse of the Year awards.
The final day of the conference fell on Saturday 12 May, International Nurses Day – held this year under the theme: Nurses: A voice to lead – Health is a Human Right, marked across the globe and on Twitter under a number of hashtags, including #IND2018.

The Australian Nursing and Midwifery Federation marked the day by launching a new campaign about a staffing crisis in aged care.

The day marks the birthday of Florence Nightingale, a traditional superhero of nursing, though one whose legend is now being scrutinised for the harms caused by health professionals and systems in the past through colonial views towards Indigenous people.

As this earlier Croakey story reports, the Australian Nursing and Midwifery Federation (ANMF) is considering a call from the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) for the profession to make a formal apology for its part in the harm inflicted by racist health policies and systems on Aboriginal and Torres Strait Islander people since colonisation.

Villains in the spotlight

Among the “villains” spotlighted during conference presentations and discussions were:

• The current fee-for-service payment model in the general practice – multiple sessions heard how it was not suited to true health care, particularly managing more complex conditions such as chronic disease, and inhibited what nurses can do.
• General practices that continue to downplay the role and capacity of primary health care nurses – one delegate told of the staff meeting where nurses were told their job was to “service the doctors”. Another said that practice nurses so often did the hard work with patients, which doctors were then able to claim from Medicare and then “drive off in the BMW”.

• Ongoing perceptions within the nursing profession itself that primary health care nursing represents “a soft option” versus acute hospital nursing – with most nursing courses still barely touching on practice nursing as a skill and opportunity.

And some medical ‘screen heroes’ also took a beating in a fantastic keynote from registered nurse Robbie Bedbrook, a nursing social media star known as Nurse Robbie through his Hot on Health YouTube channel.

**Representation matters**

He railed against the lack of representation of nursing in the media, particularly in hit medical dramas like Grey’s Anatomy.

“It is infuriating,” he said. “You’re likely not seeing a nurse on the screen or, if you are, they’re fuzzy in the background, drinking coffee and gossiping, having a great time.”

Of the 20 or so lead characters on Grey’s Anatomy, set in a hospital in Seattle, all were doctors and physicians, and there was not a single nurse. This was poor representation, he said, given that nurses make up the greatest number of people in the health workforce.

“The only nurse character I can remember gave everybody syphilis!” he said to much laughter, as he recounted the glorification of doctors and what they would do for their patients in the long-running drama.

“I didn’t realise my surgeon would answer my buzzer, I didn’t realise my surgeon would counsel me at the bedside and provide medication reviews and mobilise me to the bathroom and do my wound care!” he said.

Bedbrook said Australian medical drama All Saints, set in the fictional All Saints Western General Hospital, did at least have a lead character who was a nurse, he said, but she was “two dimensional – very matronly, no nonsense…”

And then when there was a show centred around a nurse, it was Nurse Jackie, a comedy series billed as: “Emergency room nurse Jackie Peyton does everything she can to provide her patients with the best care possible while navigating the waters of a crumbling health-care system. But she has a secret that is increasingly difficult to keep from people — she relies on Vicodin and Adderall to get her through high-stress shifts…”

“I don’t work with many Nurse Jackies,” Bedbrook said. “I pray I’m not Nurse Jackie!”

There was much laughter but he said there was a serious side for professions, as for other groups who are sidelined or invisible in the media.

“We’re not represented here, and the message is very clear: if you don’t see yourself represented, (the message is) you don’t matter. And that is rubbish because nurses do matter, we are fundamental to a health system that works.”
Zap! Kapow! Meet the superheroes of #Nurseforce (and also some villains)
You can track Croakey’s coverage of the conference here.

Zap! Kapow! Meet the superheroes of #Nurseforce (and also some villains)

#Nurseforce
Award-winning care

The 2018 Nurse of the Year award was won by Melbourne registered nurse Cathy Carrasco, who works at the Carnegie Medical Centre in Melbourne. APNA highlighted the comprehensive system she has developed for ensuring that care plans, care plan reviews and home health assessments are “carried out with clockwork regularity”.

The award also recognised her work to involve her clinic in two studies – Anxiety in Older Adults through Monash University and the Cancer Screening in General Practice facilitated by the Victorian Cancer Council.

Carrasco told Croakey that she was passionate about the in-home assessments she carried out, which were able to reveal far more about the health and wellbeing of elderly patients particularly than when they came into the practice for a consultation.

“People can present very well in the clinic...(but) going out into homes, you can have a look into the fridge and see if they have any food, see how clean their house is, see the relationship with neighbours, if they’re lonely,” she said. “There’s a lot more (understanding) that can come out from seeing them in their home.”

Carrasco said she was lucky that the GPs she works for give her a lot of autonomy. “They have said to take the job in the direction you want to take it,” she said.

Her colleague, Mary Reynolds, from the South East Melbourne Primary Health Network, said the benefits for such autonomy and respect for nursing practice cut many ways, with strong evidence that many patients disclose more to nurses than to their GPs.

“They feel they have the time to talk to nurses which means you can sort out that a lady can’t get to shopping centre which is why she is not eating, which is why she is not getting the blood results the doctors expect…,” she said.

“The nurses can take the time – usually – to help sort that out, and also to realise that’s the barrier, so to have the trust of your GPs as Cathy has got to be able to run with it, makes a huge difference on patient care,” she said.

Asked what message she would send to Health Minister Greg Hunt, who noted in a video presentation to the conference that both his mother and wife were nurses, Carrasco said – heralding a recurrent theme at the conference:

“It would be really nice if we could bill directly to Medicare ourselves, and just have a bit more recognition that way.”

Watch Carrasco and Reynolds
Other finalists for the awards were:

- **Caroline Gibson** for leading the creation of the Memory Health Support Service, a Nurse Clinic that looks to support patients to talk about cognitive issues sooner and be better prepared for the future.

- **Margaret Crowly**, whose leadership saw the Dubbo Sexual Health Clinic become the first in New South Wales to partner with the Gender Centre to provide support to transgender and gender-diverse clients, and led to another clinic in Orange earlier this year.

"Congratulations Cathy Carrasco (APNA Nurse of the Year), Shangying Tian (Recently Graduated Nurse of the Year), and Chris Helms (Rosemary Bryant Award winner).

And well done finalists Caroline Gibson, Margaret Crowley and Kerry-Lee McBride."
Heroic snaps

As the caped and costumed #Nurseforce participants made their entrances, one rallying cry was: “Who you gonna call? Wound busters…”
You can track Croakey’s coverage of the conference here.

Zap! Kapow! Meet the superheroes of #Nurseforce (and also some villains)

#Nurseforce #APNAconference

The FORCE behind #Nurseforce. APNA Board at Nurseforce Superheroes.

#APNAconference

#nurseforce #superheroes: @APNAurses #superboard: @KarenBooth43, Ken Griffiths, Maurice Wrightson

Croakey team @CroakeyNews · May 11
You can track Croakey's coverage of the conference here.

Zap! Kapow! Meet the superheroes of #Nurseforce (and also some villains)
You can track Croakey’s coverage of the conference here.

More selfies

Dr Ruth DeSouza @DeSouzaRN • May 10
Thanks for the support @nurse_robbie @CatMStephen @APNAnurses
#NurseForce

Catherine Stephen @CatMStephen • May 11
Day 2 wrap up with team Nurseforce @APNAnurses @sagelliana @jedda_cutten @nurse_robbie @ZacharyByfield #Nurseforce

Dr Ruth DeSouza @DeSouzaRN • May 11
Always great catching up with @CATSINaM buds @APNAnurses #NurseForce
You can track Croakey's coverage of the conference here.

Zap! Kapow! Meet the superheroes of #Nurseforce (and also some villains)
Profiling a nurse clinic working to improve the lives of people with dementia

The Australian Primary Health Care Nurses Association launched the Enhanced Nurse Clinics project in 2016, funded by the Commonwealth Department of Health under the Nursing in Primary Health Care Program.

The project has supported the establishment of 11 nurse clinics, Australia-wide – innovative models of care, led by nurses, based in a range of rural, regional and metropolitan primary health care settings, including prisons.

A number of these nurse clinics, dealing with very different health issues or patient cohorts, presented their work at Nurseforce for the Future, APNA’s 10th Annual National Conference for nurses working in primary health care.

In the first of two articles on these clinics, Marie McInerney reports on a new approach to dementia in general practice in the regional Victorian city of Ballarat.

Marie McInerney writes:

“Beware of making an assumption.”

That’s one of Caroline Gibson’s messages to fellow practice nurses, and others working in primary health care, when it comes to managing chronic diseases and dementia.
She says often when a patient with a chronic disease comes into a general practice for a care plan, “we get very focused on the disease”.

If they’re not doing so well, there’s often an assumption that they need to be told more about the condition or be scolded for not being ‘compliant’. If someone is frail or underweight, the tendency is to call in the dietician, but she said it may be that they can’t remember how to use the stove anymore.

Instead, she said, practice nurses and doctors at the Ballarat Community Health GP Clinic are being trained to “listen a little deeper”, so they can pick up on clues to cognitive impairment that can play a crucial role in overall health and chronic disease management.

Gibson was working as a dementia support nurse with district nursing and felt that people with dementia weren’t getting what they needed from primary care.

Her concern was backed by the statistics: 70 percent of Australians with dementia live in the community, and 50 percent of dementia cases in the community remain undiagnosed, delaying appropriate care planning.

She moved into primary health care and has led development of the Memory Health Support Service (MHSS) in the Ballarat Community Health GP Clinic, a nurse clinic focused on helping people living with dementia and their carers. It doesn’t operate as a separate clinic, but as an integrated service within all consultations.

At the conference, Gibson showed a series of slides illustrating what may contribute to issues for a person in the early stages of dementia when, for example, they become less able to differentiate colours clearly or their perception of depth diminishes.

Incontinence may be the presenting issue, she said, but they might not benefit from pelvic floor exercises. Instead their incontinence might be because they can’t remember where the bathroom is or they struggle to distinguish between the toilet and the basin.
Gibson said international research shows it takes nearly two years from the ‘first inkling’ by a patient or family that “something is not quite right” before it is mentioned as a concern to a doctor. It then takes another three years for a diagnosis.

“I don’t want anyone to rush a diagnosis, it’s a big deal to get that [dementia] label, “ she said. But she sees that two-year gap risks “a huge disservice to our patients, taking away the opportunity for them to plan their future”.

It also risks mismatched care planning, she said, given people with dementia on average have around four co-morbidities, and it means that their issues don’t get taken up in research and policy discussions, so their voices are further muted.

“If we’re not discussing cognition or considering the impact of it, we’re going to go in the wrong direction. If they have got a cognitive impairment, how can we expect them to manage those (chronic) conditions if we don’t take that into account?”

Gibson says it is difficult to open up those early conversations on cognition. Patients often won’t speak up about their concerns, fearful that it will be the beginning of a slippery slope, that “they’ll be put into a nursing home before they can blink”.

The hesitation for doctors, she says, is about utility, thinking ‘why open a can of worms’ when they don’t have resources to follow up.

That, she says, is where practice nurses come in, under the Memory Health model.

“We have the relationship with the patients. We spend a lot of time doing care planning. You start to notice when things are dropping off – suddenly (a patient is) not attending bowls twice a week (or) no longer going knitting for the premie (premature) babies. You start asking, why is this happening?”

That doesn’t mean nurses should be primed to ask ‘so do you think you have dementia?’ or to even mention the word. Nor, she says, does it mean that general practice clinics need to have a specialist dementia nurse or a separate dementia care plan pathway.

The Ballarat model has cognitive assessment inserted into all the chronic condition care plans, so it becomes integrated and reduces stigma, and is part of a holistic approach for patients to live to the best of their ability, independently at home.

“It’s really about what’s happening in their life, what’s the impact and therefore what can we do to support them?”
Gibson told the conference that there have been challenges to developing the service. She said it could be really difficult for practice nurses to be innovators and change artists, partly because of the hierarchy of general practice and conservatism of some doctors “but also because everything we do is supposed to be billed”.

She is interested to see what the Health Care Homes program might mean for that.

**For more information**

The Memory Health Support Service

Nurse Clinic Building Blocks resource

Watch this video interview

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**Tweet reports**

-Croakey team @CroakeyNews · May 10

The Memory Health Support Service in Ballarat called that because can be quite confronting to talk to people re dementia. The first thing that people worried about cognitive health talk about is memory: Caroline Gibson #NurseForce

The Memory Health Support Service

* Promotes having a conversation about cognition
* Recognising cognitive impairment
* Risk reduction
* Person-centred strength-based care planning (dyad)
* Connecting with community providers
* May include referral for diagnosis
You can track Croakey's coverage of the conference here.

Profiling a nurse clinic working to improve the lives of people with dementia

Caroline Gibson – Nurse of the Year Finalist, developed a framework, resources to provide other GP nurses with tools to address cognitive impairment within patient population. "No similar PN model of care identified in Australian or international primary care." #Nurseforce
The Teen Clinic: a friendly, innovative service seeking to meet “a massive need”

A still from the Bega Teen Clinic promotion video, of a mother and daughter talking about benefits of the service

The Nurseforce for the Future conference showcased a number of nurse clinics that the Australian Primary Health Care Nurses Association supports across Australia under the Enhanced Nurse Clinics project.

An earlier Croakey story reported on one of these clinics, a new approach to dementia in general practice in the regional Victorian city of Ballarat. The story below describes how a Teen Clinic was set up in the NSW coastal town of Bega following a spate of youth suicides.

Marie McInerney reports:

About three years ago a spate of suicides among young people in the NSW town of Bega rocked the small coastal community, including the staff at the local Bega Valley Medical Practice.

“We were sitting in the staff room going ‘what can we do?’, ‘why aren’t these kids coming and getting help?’, ‘what can we do to make the access easier for them to come and see health professionals?’,” registered nurse Meghan Campbell told the conference.

The staff realised that the pathways between local schools, young people and the health system were poor, and that the traditional ways of accessing care, such as making appointments with the family GP, were not options for many young people.
Campbell remembered that when she was a teenager and was ready to start going on her own to a doctor, her mother had helped her rehearse what to say in the consultation and how to manage payment and appointments.

She knew many young people did not have that support, or were worried about stigma and privacy, particularly related to sexual and mental health issues, given that the person next to you in a waiting room in a rural clinic might be your neighbour or relative.

So the practice set up a Teen Clinic, with a practice nurse available two afternoons a week for drop-in consults, offering STI screening, and advice on contraception, relationship concerns, mental health issues or general health and education.

A friendly entry

The nurse’s role, Campbell said, is to be a “soft entry point”, to triage the young people, provide initial screening and/or health education and to act as a facilitator to GPs and other providers as needed.

It’s a team-based model of care where, she says, the reception staff play a vital role – to be friendly, welcoming and discreet.

Beyond the practice, the clinic also aims to build community engagement and relationships with other services such as teachers and counsellors, mental health workers, family support services, and employment and housing support agencies.

A video promoting the Teen Clinic (you can watch it below) commends its approach. “It feels almost like a local solution to a global problem,” says a local teacher.

Bega Valley Medical Practice Principal Dr Duncan MacKinnon says the clinic takes seriously all the issues with which a young person might present.

“No problem, nothing that a teenager brings is unimportant...because it's important to them: acne or warts, concerns about contraception...as well as family and emotional problems, bullying, housing problems,” he says.

Campbell gave an example of the support the Teen Clinic was able to offer to a 16-year-old homeless girl who was pregnant and didn’t want to keep the baby.

She was told by a GP from another practice that the only way she could access a termination was a three-hour trip to Canberra where she would have to pay $500.
“That was out of her reach and incorrect information,” Campbell said. A friend of the girl’s recommended the Teen Clinic, which was able to help by referring her for a local procedure.

The APNA Enhanced Nurse Clinics website provides another example as part of its case studies, and a glimpse at issues for health care in rural and regional areas. It says:

“A mother phones the surgery saying she is worried about her son’s mental health. They are unable to get an appointment with their usual GP for two weeks. The son is seen immediately in the Teen Clinic by a nurse and reviewed by a GP that same day for a Mental Health Care Plan. It is determined that it is not an acute mental health presentation and he is booked with the onsite psychologist within the next three days. In Bega, a non-urgent psychology appointment can usually take 2–3 months to access.”

The important thing for young people, Campbell says, is that the Teen Clinic is not a ‘specialist’ sexual or mental health service, so as far as other patients know, they could be presenting with a “sore toe”.

“This is one of the things I love about this model, there’s no stigma,” she says.

Building relationships

The clinic also doesn’t try to be “everything to everyone” but has built relationships with other services in the region.

“We don’t want to replicate services that already exist, just improve access,” she said.

Campbell said it is difficult to measure outcomes for such an early intervention model – “we can’t measure how many pregnancies are prevented or mental health crises averted.”

But she said the clinic judges its success on the fact that young people keep coming, and that it has great community support.

The practice’s initial concerns – “that we’d either be overwhelmed or not cool enough for them to come” – were assuaged as the clinic built trust over time and became known as “a safe place to come with anything, big or little”.

It has also built trust with the local high school, and managed some early parental suspicion about their teen-aged children going to a clinic by themselves. “Now people stop us in the street and say how good it is what we’re doing.”

The cost of running the Teen Clinic was originally absorbed into the costs of the practice because MacKinnon “thought the potential benefit was so worthwhile”, she said. Since then it has won funding, not only through the APNA program and the local Primary Health Network but with grants from local groups like Rotary and Lions.

Wider potential

Four new Teen Clinics have now been opened up by other practices in the area and Campbell believes the model can and should be rolled out across rural and regional Australia.

“There’s a massive need in rural and regional areas around Australia for better access to youth friendly health services.”

She said the model makes efficient use of the Medicare dollar and utilises existing infrastructure and clinicians. If there are no patients on a Teen Clinic afternoon, the practice nurse just gets on with other work.
But she says all of the funding so far has been short-term and the model needs to have nurse training built in.

“It would be such a shame for a model like this to fall apart for an issue of ongoing funding,” she said. “It’s such an efficient model, there’s really minimal downtime if no-one is attending, and the potential benefits to the community are huge.

“We would love some policy change that supported Teen Clinics and Teen Clinic nurses in regional towns, so they are funded for training and to provide the service.”

“These might be really lofty ideas but what a time in primary care to put youth services to the fore and show what nurse led services can do when they’re given a bit more autonomy,” she said.

The Teen Clinic and the Memory Health Support Service profiled in the previous Croakey article showcase new, innovative ways to deliver health care. But they also face shared challenges around funding, and about how much autonomy primary health care nurses are given in general practice and whether they can give rein to their full scope of practice.

According to this review of Australian and international models of nurse clinics in primary health settings, commissioned by APNA, nurse-led clinics result in “improved health outcomes, shortened waiting times for patients and decreased rates of hospital admissions”.

It says they are a particularly exciting model for areas of health workforce shortages and rural and remote areas.

Watch this interview with Meghan Campbell

Watch the promo video for the Teen Clinic

• See a host of case studies and ‘building blocks’ for Nurse Clinics at the APNA website.
Tips from the front-line on how to move beyond paternalistic health promotion

Too many health professionals still act like they know what is best for all Aboriginal people, and health promotion can be unhealthy and unproductive when it is “top down”, according to Lesley Salem, a former Australian Nurse Practitioner of the Year.

Salem, who is based at a new primary health practice in the far north Queensland town of Doomadgee, delivered a keynote address at the Australian Primary Health Care Nurses Association (APNA) 10th Annual National Conference in Brisbane.

She raised concerns about health promotion and professional practices that can be counterproductive, particularly for Aboriginal and Torres Strait Islander people. (She also had some tough messages about how the health system and government funding make nurse practitioners like her “invisible” and unemployable within a business model – more on that in another article to come).

Marie McInerney reports on Salem’s speech below.
Marie McInerney writes:

Lesley Salem opened her keynote address at the #Nurseforce conference with a confession, joking that she had come over to primary health care nursing “from the dark side”, after working first for two decades in acute hospital nursing.

It was a nod to a recurring theme at the conference on the value of primary health care nursing – for example, nurses based in general practice and the community health sector – but also ongoing frustration that it is often still seen within the profession itself as a “soft option” in comparison with hospital nursing.

Moving from acute to primary care has been a serious conversion for Salem, an award-winning nurse practitioner and descendent of the Gringai-Wonnarua Nation in New South Wales who has worked extensively with Aboriginal medical services in her home state.

“I held very poor attitudes,” she said. “I was silo driven, felt that ‘we in renal and cardiology and diabetes, we know it all’."

But over time her approach shifted. She said:

“I got fed up with patients not receiving timely appropriate care. I got sick of being dragged in three or four times a week to do acute dialysis or something… I’d be sitting there thinking: ‘if only that patient had had their blood pressure medications reviewed, or had better heart failure management, if only that person had been put on a fluid tablet…if only… if only… if only’.

I was very saddened and tired of working downstream in chronic diseases, always with people with end stage renal failure, complex diabetes with complications, heart failure. I realised in hospitals you’re just a bandaid, it’s too late, they’re in end stage this and that.

I wanted to work upstream and do prevention, aiming for early recognition, remission, regression or improved chronic disease management.”

“Coming into the light now”

Salem now works for Gidgee Healing, an Aboriginal community controlled health organisation in Doomadgee, just south of the Gulf of Carpentaria (see map) which represents the health needs of around 11,000 Aboriginal people residing in the Mount Isa, North West and Lower Gulf regions of Queensland.

Salem told Croakey that Doomadgee has long had a small hospital, but health officials wanted a Primary Health Service there to help deal with many complex health issues and poor life expectancy (just 55 years).
“It’s meant to be doctor and nurse led, but it is sometimes difficult to recruit to remote areas, (so) at times, as a Nurse Practitioner, I take a lead.”

For her keynote, Salem said she wanted to talk to delegates about health promotion in Primary Health, to inspire them “to do a ‘bottom up’ approach”, to draw on lived experience, health promotion theory, and the data that can reveal the priorities of local communities.

“We’re not going to do this paternalistic hyperbolic thing that rams messages down their throat,” she said.

Below are some of her key messages, from a one-hour keynote and follow-up interview with Croakey (which you can watch below).

1. ‘Bottom up’ beats ‘top down’

Salem said many health promotion campaigns fail or have “very unanticipated effects” because those designing them don’t understand local communities.

Nor are they always designed for how local people will hear the health messages, not just due to speaking different languages, including “Aboriginal English”, but because of what the messages make people “feel”.

Salem said:

- **"When it’s a top down approach you don't always realise the social justice implications of what you're doing or the stigma that may be attached."**
- **"To flood an area with (promotions) about STIs (sexually transmitted infections), domestic violence or heart diseases...sometimes the community takes from that that they're ‘dirty’, or that no-one there is well."**
- **"There’s a stigma attached...some health promotion strategies leave patients feeling that the whole community is viewed with that lens."**

One woman had told her: “Everybody’s coming here and saying ‘we’ve all got this, everyone at Doomadgee has got STIs’. Other Aboriginal Medical Services have struggled in the past to get Aboriginal Health Workers to help with STI care “because it’s such a shame (issue).”

Echoing the concerns of many other Aboriginal and Torres Strait Islander communities, Salem said it can be the same with messages about alcohol and family violence: “Everyone is tarnished.”

2. Don’t be the new ‘great white masters who know what’s best’

Salem said some visiting specialists come with a retinue of registrars and trainees, excited to be “going to a real Aboriginal community!”.

“They’ll ask (the patient) if it’s okay that the whole group sits in on a consultation, but the patients are already nervous about their health and the consultation and don’t feel able to say no. Many people staring at them and they’re intimidated. They can’t understand a word. You’re swanning in...embarrassing and shaming those (patients)."
Later, she said, the specialist might comment that the patient had given permission, had said ‘it was okay’.

But the reality was: “He didn’t say it was okay. His body language was saying ‘I’m shamed here’.”

As well as causing indignity and embarrassment, such paternalism means that health promotion and health care messages “will get lost”, Salem said. She added:

“Often people come in, they’re taking the moral high ground: ‘I know what’s best for you’. (I think): ‘Well you would have been a really great white master in the days of the mission because they also knew what was best’.

Knowing what’s best for physical health does not mean you know what is best for past trauma or quality of life.”

3. Not everything will end badly or turn to gold

Another turn-off for patients and community members, she said, was the future orientation of many health promotion campaigns, with messages such as: ‘if you stay fat, you’ll die’.

That’s particularly so, she said, for communities that struggle from poverty and trauma where, by necessity, people are more focused on the past and the present, than on the future.

Salem said many Aboriginal people live in “a past and a present: the past was our richness and dignity, and the present is trying to navigate for survival”.

She said:

“I’m 57 and was not counted as an Australian till I was seven years old (after the 1967 referendum). It’s a very new wound…not being able to speak your language, practise your culture, practise your medicine…

Messages need to be geared to the now, what they can think and feel now.

All of us in health fail to remember that clients can be the architects of their own future: stuffing it down their throats does not make them hungry for the health choice.

Many threats have been around for so long that their messages have lost their force. It’s important you don’t kill your message with overkill.

People make decisions with what they can live with so you don’t know better than the patient….It’s for us to inform and leave the decision to the person. (When health professionals say) ‘I’m only doing this for you’, it’s in a tone that’s meant to guilt you into doing something.”

Salem quoted former US President Barrack Obama from an address to university graduates, warning that “we live in a culture that discourages empathy”.

That lack of empathy emerges in health care, she said, when patients don’t do as health care professionals say. It can be heard in comments like: “God, she never takes her tablets, she hasn’t even bathed for three days.”

She said: “A prejudice becomes evident and empathy goes out the door. It’s about paternalism, not about helping that person to be the best person they can.”
Two other tips:

- Don’t be paternalistic, blunt or accusatory – “It’s obvious you haven’t taken your medications again”.
- Don’t promise everything will turn from straw to gold – “If you take that tablet, you won’t have a heart attack”.

4. Involve everyone who can help

Salem warned that many public health and health policy decisions are made by “experts” whose life experience may share little with those of the clients whose interests they are serving.

Decisions may also be based traditional models of health that may be too narrow in their outlook and not what local communities want, she said.

She recommended two sources for ‘bottom up’ health promotion:

- Experience – Interactive knowledge, derived from lived experience with its focus on meanings and interpretations individuals provide to events.
- Critical reflective knowledge – Data, societal structures and power relations (not promoting inequalities and disenabling people).

In some areas, Salem said, the local priorities might be skin sores, or otitis media, a middle ear infection that causes hearing loss and is experienced more by Aboriginal people than any other people in the world.

Her practice did ear nose and throat checks at one school in the lead up to a swimming carnival. Of the 260-plus kids, 90 had otitis media.

Picking up these conditions is vital for the long-term health of each child or young person but the impact goes way beyond the clinical, she said.

Scabies or hearing problems might mean that children and young people are missing out on school (often for long periods of time, depending on the school’s rules and the access to treatment) and that parents have to miss work.

Thus it was important, when looking at what health promotions to plan and implement, to want to empower patients and the broader community.

Health seekers

Salem quoted her father, a Wonnarua Elder, as believing that “if you want change, start with the kids”.

She has seen that in action in areas she has worked where focused health education at schools is changing young people into “health seekers”, rather than being very reluctant to engage on health care, for many reasons including institutional racism, like their parents and grandparents.

Now, she said, the practice gets kids coming in saying, “Hey, I got one of them sores”. The practice rings for permission from a parent, then treats the child immediately.

She says it’s important to consult with the whole community on what might promote health. Ask the mums what time they need the practice to open. Ask the schools what health issues need to be addressed so kids can come to school.
But even then, she says, don’t assume that your clinical solution will get those kids back into school, if that’s your health promotion goal.

Salem says many families in communities like hers cannot respond to health issues because they don’t have the resources to deal with them.

For example, she says, if health professionals want to tackle health conditions like scabies in some Aboriginal communities, they may need to move the clinic to the school for an hour or so each morning, or involve organisations like Save the Children to provide industrial washing machines for the whole community to use as many households won’t have their own to keep linen clean when skin infections are being treated.

She said:

- “You can provide the treatment and advice but get others involved in helping to make soap...encourage regular showering with traditional medicine soaps and where washing can be done.
- Bottom up health promotion involves everyone in the community dealing with it.
- You’ve got to be guided by a concern for equity and social justice.”

Watch this interview

![Image of Lesley Salem](image-url)

Tweet and photo reports

- **Sage Watt** @sagelianna · May 11
  “Sorry, I got off track...” @LesleySalem on the right track if you ask me #Nurseforce

- **Croakey team** @CroakeyNews
  “In a system that values data so much, nurse practitioners are invisible, because they don’t want to know how hard and complex is the work we do.”
  @LesleySalem
  #Nurseforce
You can track Croakey’s coverage of the conference here.

Tips from the front-line on how to move beyond paternalistic health promotion

@LeahEast1 · May 11
Health promotion needs consideration to not cause harm @LesleySalem #Nurseforce @APNAurses

@CroakeyNews · May 11
Don’t be blunt & accusatory (‘you haven’t taken your tablets again, have you’), don’t promise to turn straw into gold & remember many patients are “anticipatory and afraid”: @lesleysalem #Nurseforce

@CroakeyNews · May 11
Lesley Salem: I’m 57, I was not counted as Australian until I was 7. It’s a very new wound. Not being able to speak your language, practice your culture, medicine. So a lot of people live in ‘now’. We have to stop saying ‘you’ll die if you don’t lose weight’ #Nurseforce

Issues delivering health promotion messages

- Not as easy as you think
- Hyperbolic messages
- Language
- Medium used
- Often seen as ‘stuffing’ messages down their throats
- Messages can take the thin air of the moral high ground
- One on one – come speak with a ‘practiced, patterned subservient tone’ to the message e.g. we are doing this for you...
Tips from the front-line on how to move beyond paternalistic health promotion

#Nurseforce

"Conference News Service"
Tips from the front-line on how to move beyond paternalistic health promotion

#Nurseforce
You can track Croakey's coverage of the conference here.

Tips from the front-line on how to move beyond paternalistic health promotion

#Nurseforce

Croakey team @CroakeyNews · May 11

"His body language says I am dying here." @LesleySalem talking about the 'shamejob' that happens when specialists come in force to Deemadgee community, reveal in opportunity to go close up on Aboriginal health but don’t understand impact on individuals #Nurseforce

Rebekah Cox @bcmzRN · May 11

‘don’t stuff it down their throats. Do your best, listen and understand what empathy is. Not Paternalistic. The patient should be in control. We are the bottom up not top down' @LesleySalem so many amazing, relevant and needed messages! #NurseForce #APNAconference @APNAurses
Check out these videos, vox pops and posters from Nurseforce

Watch this compilation of interviews by journalist Marie McInerney with presenters and delegates, discussing clinical and practice issues, and the ways ahead for better nursing, better patient-centred care, and better work environments.
VOX POP: Issues on the agenda at #Nurseforce

As the conference was set to open, Croakey asked four delegates to talk about who they were and why they were at #Nurseforce. They turned out to be a key group of presenters from the University of Wollongong: Sue McIness on mental health, Sharon James on lifestyle risk prevention, Dr Christine Ashley on the transition from acute to primary health care nursing, and Professor Liz Halcomb on workforce issues.

Stigma about blood borne viruses: when health care is unhealthy

Most cases of discrimination against people with hepatitis C occur in health care. That was the introductory message to a video featuring people with lived experience of blood borne viruses about the stigma and discrimination they experience in health care settings.

It was part of a presentation by Melinda Hassall and Shelley Kerr from the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine’s (ASHM) Nursing Program about a new online learning module. It’s being developed to help nurses gain a greater understanding of human immunodeficiency virus (HIV), hepatitis B (HBV) and hepatitis C (HCV) and embrace changes to practice and policy to reduce stigma and discrimination experienced by patients with these blood borne viruses.
On being 2018 Nurse of the Year

APNA’s 2018 Nurse of the Year award was won by registered nurse Cathy Carrasco, who works at the Carnegie Medical Centre in Melbourne. APNA highlighted the comprehensive system she has developed for ensuring that care plans, care plan reviews and home health assessments are “carried out with clockwork regularity” and her work to involve her clinic in two studies, on anxiety in older adults and cancer screening in general practice.

Carrasco talks here about her work and broader issues in nursing, with colleague Mary Reynolds, from the South East Melbourne Primary Health Network.

Read more here about the awards and some superhero action at the conference.

Why we need practice nurses looking for loose wedding rings

Adult malnutrition can often be missed in screening tools, and elderly patients are rarely in hospitals long enough to be treated, with the average stay of 4.7 days after an acute admission.

“We’re pretty good but can’t really do anything in less than five days for malnourished patients and it requires coordination back in the community,” says Dr Peter Collins, from the Queensland University of Technology and a research fellow at the Princess Alexandra Hospital in Brisbane.
He says that is why he’s passionate about the work clinicians do in the community, and sees practice nurses as playing a vital role in spotting the early, critical signs of malnutrition – ill-fitting dentures, a wedding band loose on the ring finger, clothes that no longer fit.

Collins told the conference the etiology of malnutrition is complex – sight, smell, taste, dental, functional capacity, budget, deprivation, isolation, and the strongest predictor of risk is postcode. And the toll is high. Patients identified as malnourished or at risk were three times more likely to be frail and had poorer survival rates.

Setting up a teen clinic in coastal NSW

A spate of suicides among young people in the NSW town of Bega about three years ago rocked the small coastal community and has led to the creation of a Teen Clinic in the town, now being replicated at four other local general practices. Registered nurse Meghan Campbell describes the challenges in setting up the clinic and how its success is being measured, as well as the need to establish a sustainable funding model for such innovative models of care – particularly in rural and regional Australia. Read our story here.

“Listen a little deeper” for memory loss

With 50 percent of dementia cases in the community remaining undiagnosed, delaying appropriate care planning, Caroline Gibson felt that people with dementia weren’t getting what they needed from primary care.
She has led the development of the Memory Health Support Service (MHSS) in the Ballarat Community Health GP Clinic, which operates as an integrated service within all consultations, rather than as a separate clinic.

It’s training practice nurses and doctors to “listen a little deeper”, so they can pick up on clues to cognitive impairment that can play a crucial role in overall health and chronic disease management, she says. Read our story here.

Tips from the frontline: ‘don’t be paternalistic’

Keynote speaker Lesley Salem is a nurse practitioner with Gidgee Healing in Doomadgee in far north Queensland.

She talked about health promotion, particularly in Aboriginal and Torres Strait Islander communities and the risks that it can be unhealthy and unproductive when it is “top down” rather than “bottom up”. Beware also of paternalism, overkill, promising to turn straw into gold and stereotyping, she said. Read our story here for her tips on what works and what doesn’t.

VOX POP: Some conference ‘takeaways’
“It’s been uplifting. Sometimes as a nurse, we don’t always feel uplifted so that’s been really pleasant.” That was one of the takeaways from the conference from Wagga Wagga nurse Alison Bradney. For her practice colleague Elizabeth Blucher, who celebrated 50 years as a registered nurse at the conference, one of the highlights was new insights into osteoporosis. More highlights from delegates in this quick vox pop before the final plenary at #Nurseforce.

Plus some posters from the conference
You can track Croakey’s coverage of the conference here.

Check out these videos, vox pops and posters from Nurseforce.
Doctors can’t hold the only keys to future of Health Care Homes

The Federal Government’s Health Care Homes program was hailed by the Prime Minister as one of the greatest health system reforms since the introduction of Medicare.

But in Senate Estimates in late May, Rural Health Minister Bridget McKenzie could not have been more equivocal about the new model of care for chronic disease which was only launched last year.

The program has lost a lot of its early support, particularly from medical groups, but others want to make sure its team-based care approach is not lost and that all stakeholders, including consumers and nurses, are at the table when it’s under review.

Marie McInerney reports below, in her final story of issues emerging from the Australian Primary Health Care Nurses Association’s (APNA) 10th Annual National Conference.

Marie McInerney writes:
Consumer and nursing groups are calling on the Federal Government to consult widely – and not only with doctors – on the future of the landmark Health Care Homes program that was promised to “revolutionise” chronic health care but now faces an uncertain future.

The Consumers Health Forum of Australia (CHF) and Australian Primary Health Care Nurses Association (APNA) also warned that any redesign of the Health Care Homes program, which has struggled to enrol patients and been roundly criticised by medical groups, should not shift away from the commitment to team based primary health care.

“It’s got to be all at the table in that discussion, because primary care is more than just about GPs,” CHF chief executive Leanne Wells told Croakey.

“Nurses, allied health groups, consumers and pharmacy all need to be at the table.”

It’s a timely warning, given that Health Minister Greg Hunt gave seven out of ten positions on his Ministerial Advisory Committee on Out-of-Pocket Costs to representatives of medical groups and specialties and only one to a representative of a consumer group.

In the wake of a Four Corners program on out of pocket costs, the Australian Health and Hospitals Association (AHA) said the government would benefit from including more consumer and patient organisations on its review committees if they want to know first-hand the impacts the current system is having on ordinary Australians.

“The current out-of-pocket costs review committee is totally dominated by doctor organisations, private health providers and private health insurers—the very people who benefit most from leaving the system as it currently is,” it said.

Health Care Homes was launched last year as a new model of care for people living with two or more chronic health conditions, to reduce preventable hospitalisations and fragmented care – many see up to five different GPs a year and also need services from specialists, nurses, pharmacists, physiotherapists, psychologists and dieticians.

Under the model, general practices develop a tailored care plan for each enrolled patient and coordinate all their treatment needs. Instead of traditional fee-for-service Medicare payments, practices receive a combination of upfront grants and so-called ‘bundled’ payments to cover care by teams that usually cannot be billed under Medicare.

It was enthusiastically embraced across the health sector when the concept was first developed, but support began to collapse, particularly among key doctors groups, when funding levels and other implementation details were announced.

As a result, the uptake by patients and practices has been disappointing.

The first staged rollout of Health Care Homes, which began late last year, was intended to involve up to 200 general practices, including Aboriginal community controlled health organisations (ACCHOs), and to enrol up to 65,000 patients by the end of 2019.

Senior Health Department executive Janet Quigley, chair of the Health Care Homes evaluation working group, told the recent APNA #Nurseforce conference that, as at May 8, only 1,679 patients had been enrolled, with 175 practices participating.
“Not a failure, but not biggest priority”

On Tuesday, 29 May, in Senate Estimates, Rural Health Minister Bridget McKenzie would not be drawn by Labor to declare the beleaguered program a failure, saying it was set up as a trial.

But she declined repeatedly to endorse Prime Minister Malcolm Turnbull’s early announcement of Health Care Homes as one of the biggest health system reforms since Medicare 30 years ago.

“I’m not sure the Prime Minister was expressing the government’s view, he was expressing his view and not prioritising this particular initiative over other reforms the government has undertaken across the health portfolio,” she said.

In a speech in May to doctors at the Australian Medical Association (AM) annual conference, Health Minister Greg Hunt gave a heads up that the program was under review, less than half way through its planned initial two year first rollout stage.

He said the government was in talks about it with the AMA and Royal Australian College of GPs (RACGP), as well as with Professor Bruce Robinson, who is heading the Medicare Benefits Schedule (MBS) Review Taskforce.

Hunt gave few details, but said discussions were on the “lessons” from Health Care Homes “and advancing that to have an additional focus on a quality structure, on an opt-in basis”.

Shift in concept be “incredibly disappointing”

Former AMA president Dr Steve Hambleton, lead architect of the Health Care Homes concept, recently admitted that “implementation went wrong somewhere” and that “the initial enthusiasm for what was promised has been lost”. See this excellent backgrounder from the Parliamentary Library.

Criticisms of the rollout include – as Professor Lesley Russell wrote for Croakey – that “it is underfunded, payment mechanisms are inappropriate, the time frames for evaluation are too short, essentially only one model is being trialled, there is a lack of consumer consultation, and many are nervous about the involvement of the private sector.”

Preliminary research was also presented to the APNA conference that Health Care Homes could better use the health workforce, particularly practice nurses, in more effective chronic care. It found that challenges to reform would include medical dominance of the health care system, lack of education/training for nurses, and the need for cultural and operational change in general practices. (See tweets at the bottom of this post).

APNA President Karen Booth said it would be wrong to give up so early on a model that has worked well in the US and New Zealand.

“It would be incredibly disappointing for all the people who have put so much time in to created a better, more cohesive, comprehensive model of care if it just went back now to a discussion about higher payments to GPs rather than better systems for managing complex conditions,” she said.

Booth said primary health care nurses would be “heartbroken” if preliminary problems produced a shift from a model that could allow them to work to their full scope of practice through “truly team-based, multidisciplinary care”.

Booth and Wells were both members of the Primary Health Care Advisory Group (PHCAG), headed by Hambleton, which developed the Health Care Homes model.
“Lessons to date”
At the APNA conference, Quigley outlined some “lessons to date” from the early days of Health Care Homes that included:

- “Practice transformation takes time”.
Quigley said the department had deliberately chosen general practices at varying points of capacity “so can see what the implications of this model are and what that might mean for us if we were to roll it out further”.

- “Challenges with the new model”.
The bundled payment for practices had raised “some interesting tax questions”, with concerns, that she said were later resolved, that it would change the relationship between the contractor and the employer.

There were also “teething problems” with a new risk stratification tool, used to work out which patients were eligible for the model and at what level of payment, she said. “Clearly that’s something we need to test and validate through the course of the trial and refine as we go,” she said.

Varying data quality in primary health care was also an issue, she said.

- “Patient recruitment”
Describing the target of 65,000 patients for the trial as “ambitious”, Quigley said it would “take time” to get there as “lots of time needs to be spent with patients” so they can understand the model, its benefits and what it means to be involved.

- “Need for engaged leadership”.
“This is incredibly important,” she said. “We’re seeing that the practices who have had that have been really able to take this model forward. Others are really trying to build that engagement within their practices...”

At Senate Estimates on Tuesday, Caroline Edwards, the Deputy Secretary of Health Systems Policy and Primary Care Group, conceded that patient takeup so far had been “lower than we hoped for” and needed to be lifted for the sake of robust evaluation.

But she defended the process, given its ambitions.

“This trial of Health Care Homes is trialling some really important new ideas about how we really stretch our thinking about primary care, how we do innovations in primary care, how we work with practices to do things differently,” she said.

“Making real changes and reforms in this space means we have to try new things and that’s what we’re doing and we’re learning from it as we go,” she said.

Pressed by Labor Senator Lisa Singh on whether Hunt’s comments indicated the government was “walking away” from Health Care Homes, Edwards said:

“I’m not aware of any change. We’re looking at ways we can help our support of practices to increase the patient numbers. As far as I’m aware, the trial is continuing, will be evaluated in due course and we’ll take learnings from it.”
Edwards and Quigley were also grilled by Greens Leader Richard Di Natale about why the evaluation would not measure whether patient outcomes improved.

“How will you know if it works?” he asked.

They said the trial period was short, did not have a control group, and was “disease agnostic” so it wasn’t possible to measure outcomes for patients. Instead it would focus on implementation – “what impact it will have on the type of care patients get”.

To date, they said, nearly $30 million has been spent on the rollout: $7.8 million in 2016-17 and $21.6 million in 2017-18, on a range of clinical services and infrastructure supports such as the risk stratification tool, education guidance, and funding to Primary Health Networks.

A Health Department spokeswoman told Croakey over $110 million has been provided for the two year implementation program.

**Different approaches needed**

Wells said it was clear with hindsight that the program design was “a bit too rigid”, with not enough flexibility for practices to implement a model that was “fit for purpose” and so they could sustainably employ allied health providers or bring in non-dispensing pharmacists.

As a result it had been a “disappointing implementation”.

“You could say that’s symptomatic of the change needed to get something like this embedded at a critical mass point but I think it’s more symptomatic that there could have been a different approach to implementation,” she said.

“I think it would have been better if there had been some broader national guidance: such as ‘these are the sorts of outcomes we are looking for, here are some KPIs and an accountability framework, here’s the sort of patient experience we’re looking for, here’s some money to invest in change management, here’s the funding model to support it.

“I’m not advocating necessarily for a ‘let a thousand flowers bloom’ approach but I do think a little more flexibility (to determine) what are the best features, the best enablers, the no go zones and then draw on those learnings.”

Wells said she was still hopeful the model would be retained and that the Minister was not set to ‘throw the baby out with the bathwater’, but she said it would be “retrograde” if he settled for just paying GPs a higher fee for service for complex cases.

She was not worried that he did not intend to wait for the evaluation, due in early 2019, before making changes, “as long as consumer advisors are at the table and part of that discussion early in the policy cycle”.

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Doctors can't hold the only keys to future of Health Care Homes

#Nurseforce
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"Conference News Service"
You can track Croakey’s coverage of the conference here.

Doctors can’t hold the only keys to future of Health Care Homes

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#Nurseforce
Thanks to all who helped share #Nurseforce news

According to Symplur analytics, during the period of Croakey’s coverage of the conference, there were almost 12 million Twitter impressions using the #Nurseforce hashtag, and 370 participants on Twitter using the hashtag. Read the Twitter transcript here.

The #nurseforce Influencers

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<th>Top 10 by Mentions</th>
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The Numbers

- 11.895M impressions
- 2,130 Tweets
- 370 Participants
- Avg Tweet/Min: 4
- Avg Retweet/Min: 6
- Avg Like/Min: 2

Twitter data from the #nurseforce hashtag from Wed, May 9th 2018, 10:00AM to Fri, June 1st 2018, 10:35AM (Australia/Sydney).

#nurseforce Participants

Data for #nurseforce can be up to 15 minutes delayed

Croakey Conference News Service

- Reporting by Marie McInerney
- Editing by Melissa Sweet
- Layout and design by Mitchell Ward

Doctors can’t hold the only keys to future of Health Care Homes

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