THE PRIVILEGED NURSE

MAKING SURE THAT THE NURSE'S VOICE IS HEARD

MURFET G [1,2]

[1] TASMANIAN HEALTH SERVICE, BURNIE TASMANIA , AUSTRALIA

[2] DEAKIN UNIVERSITY , MELBOURNE VICTORIA , AUSTRALIA

INSPIRED FOR THE FUTURE ……..

With the title of the conference in mind – I ditched my usual abstracts with focus on clinics and health outcomes

Focus on nurses of the future, young nurses within the audience by story telling

With the hope to inspire

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AIM

To describe strategies taken to drive nursing-led models of care

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INTRODUCTION

- Nurses are positioned well to advocate for the patient group for whom they provide care.
- Helping them to make:
  - informed decisions regarding their health.
  - navigate a complex medical system.
  - ethical decisions.
- Simultaneously, nurses can advocate for the pivotal role of the nurse more broadly to healthcare.
- The abstract explores activities and strategies that have created my career in diabetes nursing.

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SO WHAT DO I MEAN BY THE PRIVILEGED NURSE

- A special right, advantage, or immunity granted or available only to a particular person or group
- Legally protected information

- Nurses and midwives ‘sit’ in a position of privilege every day
- We are granted an opportunity to understand individuals, their needs and their motives.
- Within this position of privilege there is an opportunity to use the information learnt to create meaningful change.

THE PRIVILEGED NURSE

But even more specifically:

- As ‘the privileged nurse’ I am put in a position of power from the beginning of every session.
- We automatically sit in the chair with privilege as we delineate the “rules” of therapy.
- The health professional is in the position of power as the care provider and is in a position of power and privilege in society.
- It is important to bring up issues of difference in the room so that the consumer can be free to explore, tell the truth, and be him/herself.

METHODS

- The quote, “Ask not what your country can do for you – ask what you can do for your country” lays the foundation for change.
  - 'Country' was substituted with community.
  - Community was:
    - People living with diabetes; and
    - The ADEA, the national peak body for diabetes educators.
- An accumulative identification of linkages and champions, setting sights on lifelong learning and mentoring, intuitive reflexivity, and embracing leadership roles.

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INSPIRED FOR THE FUTURE ……..

Clinician / Credentialed Diabetes Educator

Nurse Practitioner

Leadership roles in working parties and organisations

PhD Candidacy

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RESEARCH PROJECTS SUPPORTING IMPROVED HEALTH OUTCOMES

Paediatric project

- MoC to ensure evidence-base and screening
- Resulted in high consumer satisfaction and reduced A1c

Pregnancy project

- MoC to ensure timely evidenced-base care
- Resulted in higher screening rates, reduced adverse neonatal outcomes

AMOS

- MoC to promote self-maintenance strategies and weight sustained loss
- Resulted in mean 9% weight reduction – up to 55%. Reduced A1c by 1%

Capability Framework for Diabetes Care

- A framework to guide HCP training for delivering diabetes care
- Funding for rollout nationally as an online tool and engagement by many organisations for supporting a flexible agile workforce for diabetes care

INSPIRED FOR THE FUTURE

.....

Keep your eyes and ears open and embrace

Welcome what others see in you that you may not see

Consider how you can use these skills – your skills

DO NOT put up walls and barricades – you will be surprised how willing others may be to help

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JOURNEY OF A DIABETES EDUCATOR …..

- In 2003, I took on role of NUM of the Diabetes Centre
  - GPs were cross with us due to poor levels of communication
  - Paediatric population attendance was low
  - Simple CQI activities in paediatric consumer population (presented abstracts)
- In 2005, I was mentoring other CDEs
  - University supervisor suggests to take on a Masters
  - I realised this was an opportunity; I could strengthen the QCI activity and make it robust research that could created change
  - Pregnancy audit (presented abstract)

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IMPROVING PAEDIATRIC DIABETES SERVICES IN A RURAL REMOTE REGION

G. O. MURFET1, B. SHUGG2, M. C. SMITH1, L. A. TAYLOR1

1 DIABETES CENTRE, NORTH WEST REGIONAL HOSPITAL, BURNIE, TAS, AUSTRALIA

2 WOMEN'S & CHILDREN'S SERVICES, NORTH WEST AREA HEALTH SERVICE, BURNIE, TAS, AUSTRALIA

Aim: To ensure paediatric cases with diabetes residing in a rural, remote region receive regular evidenced-base care and the service meets consumer expectations.

Background: North west Tasmania has **three times** the national average of new cases of type 1 diabetes. Similar issues are faced as most rural remote areas; shortages in medical specialists, reoccurring changes to locum paediatricians and lack of allied health professionals. This lead to **inconsistencies** in care provision and a non person-focused service as evidenced by quality activities undertaken. Many paediatric cases are dealt with by GPs, there was a **low level of complication screening** and minimal self- management was encouraged. Access to diabetes education, as well as screening or treatment procedures for children with diabetes in the region were not consistent. Thus, activities were undertaken to evaluate screening and management procedures for children with diabetes.

Methodology: A **consumer forum** was held; followed by a **scoping** exercise involving local health professionals. These activities determined that an after hours services was required to ensure appropriate timely access to evidenced based guidelines and care. This was coordinated by a rotation of Diabetes Educators and to support this, an **endorsed protocol** was developed for stabilisation and sick day management to ensure consistent accurate information. In addition, a template was created to enable a planned approach to assessment of cases and to adequately review complication screening status; later developed into a **clinical software program** that captures clinical results, issues being dealt with and allowed for recall. Negotiations with Diabetes Tasmania freed a hospital dietitian to be involved in multidisciplinary team clinics.

Results: The proportion of paediatric diabetes cases seen at the Diabetes Centre on a minimum 3 monthly basis has **increased from 40% to 98%.** All paediatric diabetes clinics have a dietitian involved ensuring adequate carbohydrate intake for normal growth and development, and enabling the prompt adjustment of insulin accordingly. Mean glycated haemoglobin decreased from **8.9% to 8.0%.** The after hours 'on-call service' was utilised appropriately by patients during sick days and periods of hyperglycaemia. A change reflecting a shift to self management was also evident. There was a **decline in admissions rates** for diabetic ketoacidosis, with the majority of cases not being readmitted following their initial diagnosis. There was an improved multidisciplinary approach to care provision and consistency in advice given to patients.

Conclusion: Remote regions may be without many metropolitan services; however, strategies can be developed to increase screening for children with diabetes and the initiation of prompt evidence-based management protocols to **decrease the prevalence of negative acute health outcomes**.

Consumer perspectives of a paediatric interdisciplinary collaborative clinic

G. Murfet[1], H. Bridgman[1], L. Taylor[1], B. Shugg[2], N. Samra[1], M. Smith[1]

[1]Diabetes Centre, North West Area Health Service, Burnie, TAS, Australia

[2]Womens & Children's Services, North West Area Health Service, Burnie, TAS, Australia

Aim: To evaluate guardians' **experience** with an interdisciplinary collaborative diabetes paediatric service.

Background: A systematic approach to paediatric diabetes care was developed to deal with common issues impacting rural remote areas and to improve on previously identified feedback [inconsistencies in care provided and frequent long appointments]. In addition, the service enhanced the delivery of the paediatric program by offering an interdisciplinary collaborative model of care. It was felt that this would drive a consumer focused model that responded to the needs of chronic disease management. Whilst anecdotally consumers appeared satisfied, an evaluation was required.

Methodology: A survey was developed by the psychologist, a credentialled diabetes educator and a dietitian. It asked demographic questions and used ratings on a 5 point Likert scale with statements about aspects of the paediatric service; e.g. 'when I call the after hour's service, I have received consistent information'. After ethical approval the survey was disseminated during routine clinics, via phone survey and by mail out. Surveys responses were de-identified, collated and analysed by the psychologist.

Results: A **70.8% response rate was achieved**. The sample was representative of the population, gender, time since diagnosis and age [ranging 6 to 17 years]. At least **87% of guardians indicated high satisfaction with all aspects of the service** questioned. More that 81% of the sample indicated satisfaction with all aspects of the after hours on-call service and 81.4% believed they received consistent information. Additional qualitative comments followed four main themes including positive attitudes about the service e.g. 'diabetes educators are a God send …', appointment/service utilisation, health professional approach and transition concerns. Results were mixed regarding the need for a parent support group.

Conclusion: A **model of care supporting collaborative interdisciplinary practices** within a Diabetes Centre can provide evidence based care whilst remaining consumer focused. Future quality improvement projects will gain feedback from young people, particularly adolescents, about their experiences with the service to continue to improve their engagement as they transition into adult services.

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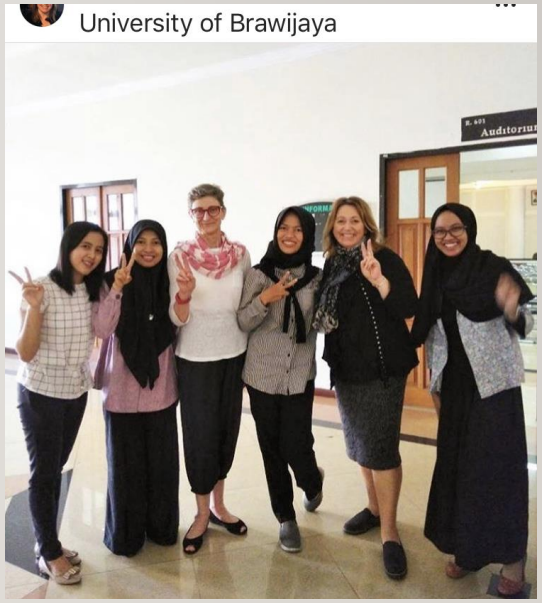
ADEA JOURNEY

- First approached early in my career as a National representative
- Editorial magazine committee
- Abstract writing training
- Frustrations → Board member (what can you do ….)
  - Asked for governance training
  - Opportunities e.g. Indonesian diabetes nursing curriculum
  - Many national working parties on obesity, management of type 2 diabetes, therapeutics
- President of the ADEA



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NURSE PRACTITIONER JOURNEY

- In 2007 I was approached by EDON re developing NP roles in NW
- Focus group: including allies and nemesis., established mentoring relationships
- Strengthened DIP research by evaluating model
- Ollie Nurse Practitioner award twice – 2014 and 2019
  - European diabetes conference in Berlin in 2015
  - ICN/ANPP conference in Halifax, Nova Scotia in 2020
- Sabbatical leave across the UK and US to obesity clinics and NP/Diabetes conference
- Approached colleagues to discuss funding opportunities with focus to create change
  - Wellness scholarship – PhD studies
  - NPA scholarship qualitative AMOS data

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Title:	**NURSE PRACTITIONER LED RESEARCH AND MODEL OF CARE CHANGING NEONATAL HEALTH OUTCOMES FOR PREGNANCIES AFFECTED BY GESTATIONAL DIABETES**
Author(s):	G. Murfet[1], P. Allen[2], T. Hingston[3]
Institute(s):	[1]Diabetes Centre, Tasmanian Health Organisation - North West, [2]Rural Clinical School, University of Tasmania, [3]Maternity Department, North West Private Hospital, Burnie, TAS, Australia
Text:	**Aim:** To describe nurse practitioner-led (NP) research into pregnancies complicated by gestational diabetes (GDM) and model in a rural/remote region; and to examine changes in neonatal health outcomes. Background: In the Tasmanian THO-NW, access to screening, education and treatment for women with GDM was not consistent. Anecdotal evidence suggested higher incidence of complicated pregnancies and/or adverse effects to the infants. **Methodology:** An audit of 2003 -2006 maternity data from two hospitals discovered a paucity of screening and inadequate care provision, both of which were inconsistent with national recommendations. The NP took on a leadership role, co-ordinating discussions with both public and private sector local health professionals to achieve consensus for action. A systematic, interdisciplinary, consumer-focused model of care was devised and implemented. After two years, maternity data was audited to evaluate the model. **Results:** A close interdisciplinary approach incorporating the obstetrician, dietician, Credentialed Diabetes Educator (nurse) and antenatal nurse saw referrals to medical physicians significantly reduced (47.8% vs. 15.2%, p< 0.0001). Screening for GDM became universal, compared to 33% of pregnancies pre-intervention. The proportion of women receiving diet/insulin treatment increased (9.8% vs. 52.7% p< 0.0001). There was a reduction in mean neonatal birth weight (3706.3g±620.7 to 3411.6g±559.2, p=< 0.0001) and a 40% decrease in the risk of adverse neonatal outcomes following implementation of the model (Relative Risk 0.60 [CI 95% CI 0.48-0.76]). **Conclusion:** The NP role can support and drive changes to health models that create positive health outcomes for infants born to women with GDM.
Author Keywords:	´gestational´ ´model of care´ ´nurse-led´ ´neonate´

No decrease in risk of adverse maternal outcomes

A close multidisciplinary approach

24% decrease in adverse neonatal outcome overall

40% decreased in adverse outcomes in GDM case

Mean birth weights decreased by a mean 300grams

Referrals to diabetes educators and dietitians increased while those to physicians decreased

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COST ANALYSIS OF THE CREDENTIALLED DIABETES EDUCATOR (CDE™) DIP CARE MODEL AS COMPARED WITH CONVENTIONAL CARE: AN EFFECTIVE AND EFFICIENT STRATEGY

Neil A[1], Weber H[2,3], Murfet G[3]
Menzies Institute for Medical Research, University of Tasmania, Hobart, Australia
Rural Clinical School, University of Tasmania Burnie, Australia
Tasmanian Health Organisation – North West, Burnie, Australia
Amanda Neil (Amanda.Neil@utas.edu.au, +61 3 6226 4640)

- **Aim:** Assess the **economic credentials of an evidence-based interdisciplinary screening and management protocol compared with standard antenatal diabetes care** in the identification and/or management of diabetes in pregnancy in a rural region of Australia.
- **Background:** Diabetes in pregnancy increases the risk of short and long-term adverse health outcomes in mothers and infants, with consequent resource implications. In rural/remote areas with significant resource and workforce constraints, reliance on conventional care including care initiation by an endocrinologist may compromise timely diagnosis and/or management. Innovative strategies may facilitate appropriate and timely diagnosis and care.
- **Design:** Simple trial-based modelled economic analysis of the CDE™ DIP Model of Care compared with standard antenatal diabetes care over a one-year period from a health care system perspective.
- **Methods:** Proportion of pregnancies screened for and identified with diabetes and number of adverse perinatal outcomes were estimated from data collected through audits pre- and post-implementation of the CDE™ DIP Model of Care. Assuming 1250 pregnancies per year, annual costs for screening and provision of diabetes care (endocrinologist, CDE, dietician, and obstetrician visits) and neonatal care were assessed using standard unit prices (2012 Australian dollars).
- **Results:** Universal screening (CDE™ Model) more than **doubled identification of women with gestational** diabetes from 31 to 67 per annum. Total number of pregnancies complicated by diabetes managed increased from 39 to 75. Management costs increased by $11,048: screening costs by $1,339 to $1,909 and care provision by $9,709 to $29,464. Average expenditure per patient managed reduced by $103 to $418 reflecting workforce changes (↓physician and ↑ AHPs visits). Five fewer babies were born with congenital abnormalities; and another five without severe metabolic impacts (macrosomia and hypoglycaemia +/- birth injuries), **generating annual savings of over $150,000.**
- **Conclusion:** The CDE™ DIP Model of Care is efficient and sustainable within a severely resource constrained rural context.

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‘NURSE PRACTITIONERS’ INNOVATIONS IN REDESIGN: THE IMPACT OF NP MODELS OF CARE

Giuliana Murfet1, Dr Michelle Woods2 3

1 Diabetes Centre, Tasmanian Health Organisation-North West, Burnie, Tasmania, 7320, Australia

2 Diabetes Centre, Royal Hobart Hospital, Tasmanian Health Organisation-South, Hobart, Tasmania, 7000, Australia

3 School of Health Sciences, University of Tasmania, Hobart, 7000, Australia

- **Background:** The NP role remains relative new in Australia; a role that encompasses assessment, diagnostics, management of pharmatherapeutics and research skills. Development of **specific NP roles established following identification of a service gap**. The model of care that ensues designed to specifically target the health care gap identified.
- **Methods:** Outcomes of NP led models of care evaluated through **clinical audits** were reviewed. These included the critical review of: 1) GLP-1 and insulin combination program for people with type 2 diabetes, 2) Combined Clozapine and diabetes and, 3) Diabetes in Pregnancy clinics.
- **Findings:** Within Model 1 approximately **70% of patients had a sustained reduction in HbA1c** over 12 months greater than 1% (28% ≥2%) and weight. Pre-intervention mean HbA1c was 9.7% (range 7.7-12.9%); post mean 7.7% (range 6.5 – 9.2%). Review of data showed benefits seen were contextual and reflective to complexity of each case including hypoglycaemia reduction and a diminished progression in other morbidities (eg chronic cellulitis). A 2-fold increase in screening tests performed was seen in Model 2 and there was a **marked decrease in admissions/presentations** to department of emergency medicine. In Model 3 all pregnancy cases over 5-years were included: 112 pre-intervention and 149 managed under the NP-led model. Referrals to dietitians and diabetes educators increased, while referrals to physicians decreased. There was a **24% decrease in adverse neonatal outcomes** overall (including congenital abnormalities, macrosomnia, hypoglycaemia, birth injury) and a 40% decrease among infants of women with gestational diabetes.
- **Conclusions:** **Innovative models of care by the NP resulted in a reduction in adverse health outcomes and/or increased specialist care access.** The NP role, as an entity, calls for redesign by virtue of the process of NP role development. Within Australia the NP is an Innovation within Clinical Redesign as essentially the role is developed for meeting of service gaps.

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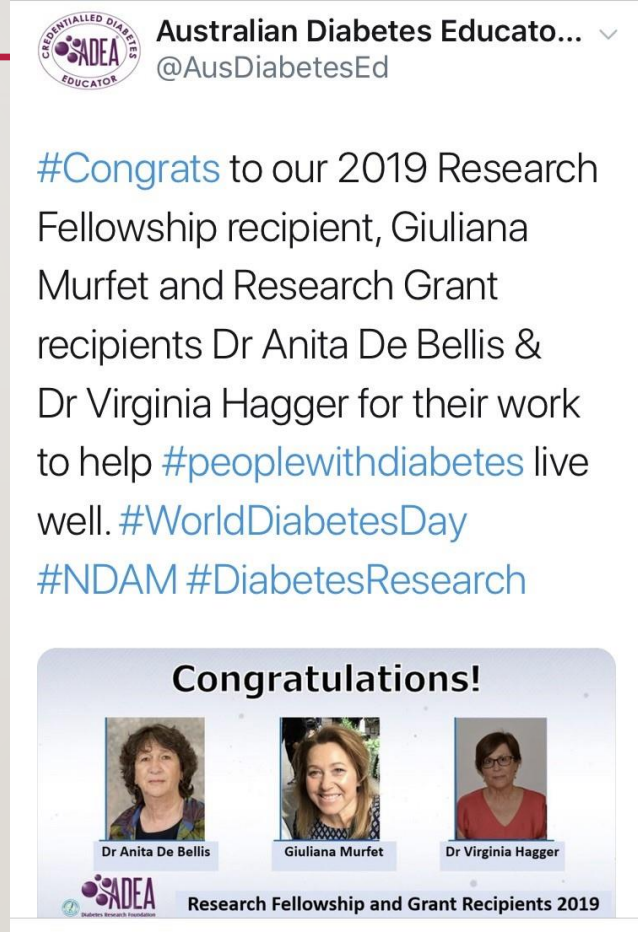
THE JOURNEY OF A PhD CANDIDATE 2016-2020

- Exposure - HCT
- Approached by Endocrinologist in 2014 who was interested in Obesity clinic
- Tasmanian Reform funding for obesity
- AMOS 2014-2020
- PhD Research Fellowship Grant for 2020
- **Capability Framework for Diabetes Care:** A guide for practice for nurses, allied health professionals, Aboriginal and Torres Strait Islander health practitioners, and health assistants



Targeting an obesity epidemic: outcomes of a nurse practitioner-led clinic focused on self-maintenance

MURFET G [1,2], KILPATRICK M [3], LUCCISANO S [1]

Background: Obesity is associated with increased cancer risk, e.g. pancreas, colon and rectum; type 2 diabetes, mental health, cardiovascular disease and arthritis. **BMIs of adults** attending Diabetes Clinics in regional Tasmania **are high; maximum BMI 69.5m2 and mean 44.5m2**. NPs enable prompt and specialised assessment and treatment in people living with obesity and diabetes. The role comprising skills in assessment, diagnostics, pharmacotherapy, care coordination and research.

Purpose: To describe the impact of an NP-led obesity clinic for people living with diabetes.

Method: Between 2015 and 2016, 130 adults were recruited to a 2-year program focused on self-maintenance. Personalised programs were devised in partnership derived from the results of psychometric scores, physiotherapy assessment, weight history, sleepiness scale, nutritional review and NP medical assessment. Individuals saw the NP and dietitian 3-monthly, with referral to others as required. Weight gaining endocrinopathies were eliminated. Glucose-lowering medicines altered to weight-neutral or weight-lowering medicines. Metabolic surgery offered to suitable program candidates after 12-months. Nutritional status and medicines management were managed pre and post-surgery.

Results: Mean age 60 years (23-74); 76.3% on disability allowance or unemployed. Indigenous Australians represented 11.4%. Eighty-six completed the whole 24-month program. Nineteen dropped-out following pre-clinic assessment. HbA1c reduced by 0.5% at 12-months and 0.9% at 24-months. Reduced insulin use. More than half sustained >10% body weight loss; 15% had metabolic surgery. **Mean weight loss** at 12-months was 4.9% (-10.5% to 36.2%); **24-months 9.8% (-9.6% to 49.7%)**. Weight gain associated with chronic pain or comorbidities, e.g. Charcot's joint. **Improvements seen in mean values for lipids, liver function, weight, BMI, systolic-BP, physical and mental component summaries.**

Conclusion: **Cardiovascular benefits were seen with 5% body weight loss or > 0.5% decrease in HbA1c, which is clinically significant.** The NP role supports quality healthcare in obesity and diabetes. Supporting healthcare integration and reducing cardiovascular risk through specialist care.

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THE CONTINUED JOURNEY

- LE4D – Living systematic reviews and living guidelines
- Have just submitted a Position Statement on Prediabetes awaiting publication

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DIABETES NURSING VOICE ON MULTIPLE PLATFORMS

- ADEA
  - DVA Health Consultative Forum
  - PBAC – Diabetes RV Reference Group
  - NHPA - Benchmarking
  - Magazine Editorial Committee
  - Board of Diabetes Australia
    - MESAC
- Cochrane LE4D
- Parliamentary National Diabetes Forums
- National and International conferences
- Health Council of Tasmania
- Ensured nurses role is considered as an alternative to care giving in areas of deficits
- Ensured the nurse is recognised in all fact sheets
- Ensured that the role of nurse in education is understood (all Fact sheet no longer written by medical officers)

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EMBRACING THE NURSES 'VOICE' AND MAKING SURE IT IS HEARD

LINKAGES AND CHAMPIONS

SETTING SIGHT ON LIFELONG LEARNING

MENTORING

INTUITIVE REFLEXIVITY

EMBRACING LEADERSHIP ROLES

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MENTORING AND LIFELONG LEARNING

- The practice of mentoring has occurred for thousands of years in varying forms; there is no single accepted definition of mentoring in the literature.
- Mentoring is defined as "…a reciprocal relationship between colleagues for the purposes of personal and professional development focused on support, guidance, advice, feedback and challenge"
  (Morton-Cooper & Palmer, 2000, cited in Browne, Thorpe, Tunny, Adams, & Palermo, 2013, pp. 457-458).
- Embrace learning – be open to learning from everyone
- Learn from your mentees

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REFLEXIVITY

- A reflexive relationship is bidirectional with both the cause and the effect affecting one another in a relationship in which neither can be assigned as causes or effects.
- The term reflexivity refers to 'the process of critical self-reflection on one's biases, theoretical predispositions, preferences and so forth'
- Reflexivity is self-reflection and the critique of practice on practice (Rolfe & Gardner, 2005).
- Reflexivity requires the researcher not only reflect on their practice but they moved beyond reflection to determine ways they influence and transform their practice because of the process
- It allows for the synthesis of knowledge through the recognition of bias that leads to change in practice

Woods, M. & Murfet, G. (2015) Australian Nurse Practitioner Practice:Value adding through clinical reflexivity. *Nursing Research Practice*; 2015, Jan.

LAY OUT YOUR PRIORITIES AND THE STRATEGIES TO GET THERE

- Sometimes there is no clear supportive evidence
- Collect the evidence
  - Only list what is important
  - Make it easy
  - Engage important stakeholders
  - Identify champions

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PLANS REQUIRE STRATEGY

Trump said he wasn't concerned about terrorists 7,000 miles away.

When Pelosi led a Democratic walkout, Liz Cheney, the third most senior House Republican told Trump the terrorists responsible for 9/11 came from '7,000 miles away.'

Art of the deal (Trump) / Art of the possible (Pelosi)

- White House scrapped a briefing for the full House and the Democrats said they were concerned Trump did not have a strategy in the region.
- "I asked the president what his plan was to contain ISIS. He didn't really have one," Schumer said.
- Democrat Schumer asked Trump: 'Is your plan to rely on the Syrians and the Turks?'
- Trump replied 'our plan is to keep the American people safe,' prompting Pelosi to tell him 'That's not a plan. That's a goal.'

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MARK TWAIN

"If it's your job to eat a frog, it's best to do it first thing in the morning. And If it's your job to eat two frogs, it's best to eat the biggest one first."

- He was referring to the big-ticket items on your to-do list, the ones that would provide the most benefit towards your long-term goals.
- Find a mentor
- Leverage daily goals to get to your main goal
- Welcome failure
- Seek inspiration
- Welcome criticism
- Track your progress

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DO NOT WAIVER FROM THE MESSAGE

Trump impeachment

- They constantly recited 4 facts and never moved from these even when other evidence came in:
  - No conditionality tied to the aid
  - Other president did not feel pressured
  - The aid was released and received
  - The investigation was not launched

- Used branding
- Consistency in messaging
- Helps get your message across
- Do not waiver

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EMBRACING THE NURSES 'VOICE' AND MAKING SURE IT IS HEARD

Nurses need to seat themselves at the table, they need to embrace the important information that they can bring and their nuanced understanding of health, to inform care.

As a nurse, one sits in a position of privilege, which can create worthwhile and meaningful change.

Set small goals

Focus on lifelong learning & plan

Create mutual & mentoring partnerships

Brand

Do not waiver from the message

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