

Living Well, Your Way Year in Review

*A summary of Murrumbidgee Collaborative
Commissioning's second year of implementation.*

MURRUMBIDGEE
LOCAL HEALTH DISTRICT



phn
MURRUMBIDGEE
An Australian Government Initiative

firstHealth
LIMITED

What is Living Well, Your Way?

Living Well, Your Way (Living Well) is a Collaborative Commissioning initiative between the Murrumbidgee Local Health District and Primary Health Network, proudly funded by the NSW Government.

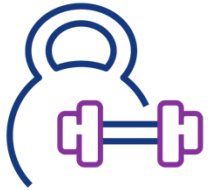
It aims to build a better way of delivering healthcare for people with chronic conditions including Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) and keep people healthier at home for longer.

The Living Well, Your Way model of care is an integrated approach includes acute and primary care, public and private providers in the Murrumbidgee.

It supports existing providers to enhance the services that are already available and fills gaps with innovative solutions where necessary.

Our vision

People with heart failure and/or COPD in our community – no matter where they live – have the best quality of life possible because they have access to the personal, professional, and community resources they need, when they need them, and in the way that they choose to use them



Our why



In 2017-18, Murrumbidgee had the third highest rates of potentially preventable hospitalisations for chronic conditions **in all of Australia.**

Access to diagnostics, specialist, and after hours care in our communities is

extremely limited.



Cost and travel

are significant barriers.

When patients with low acuity (triage 4 and 5) heart failure and COPD present to MLHD, they are up to

2.2x more likely to get admitted

(and transferred) as other patient cohorts.



In 2018-19, we spent more than **10 million dollars**

looking after patients with triage 4 and 5 heart failure and COPD.

At that time, the cost of caring for low acuity COPD patients who are admitted to our hospitals was

35% more than

the amount we're funded for (based on the national efficient cost).



Clinicians tell us about their frustrations with **lack of access, siloed care and an inability to work to top of scope.**



Patients tell us they want to look after themselves better, but

can't find someone to show them how.

Our guiding principles

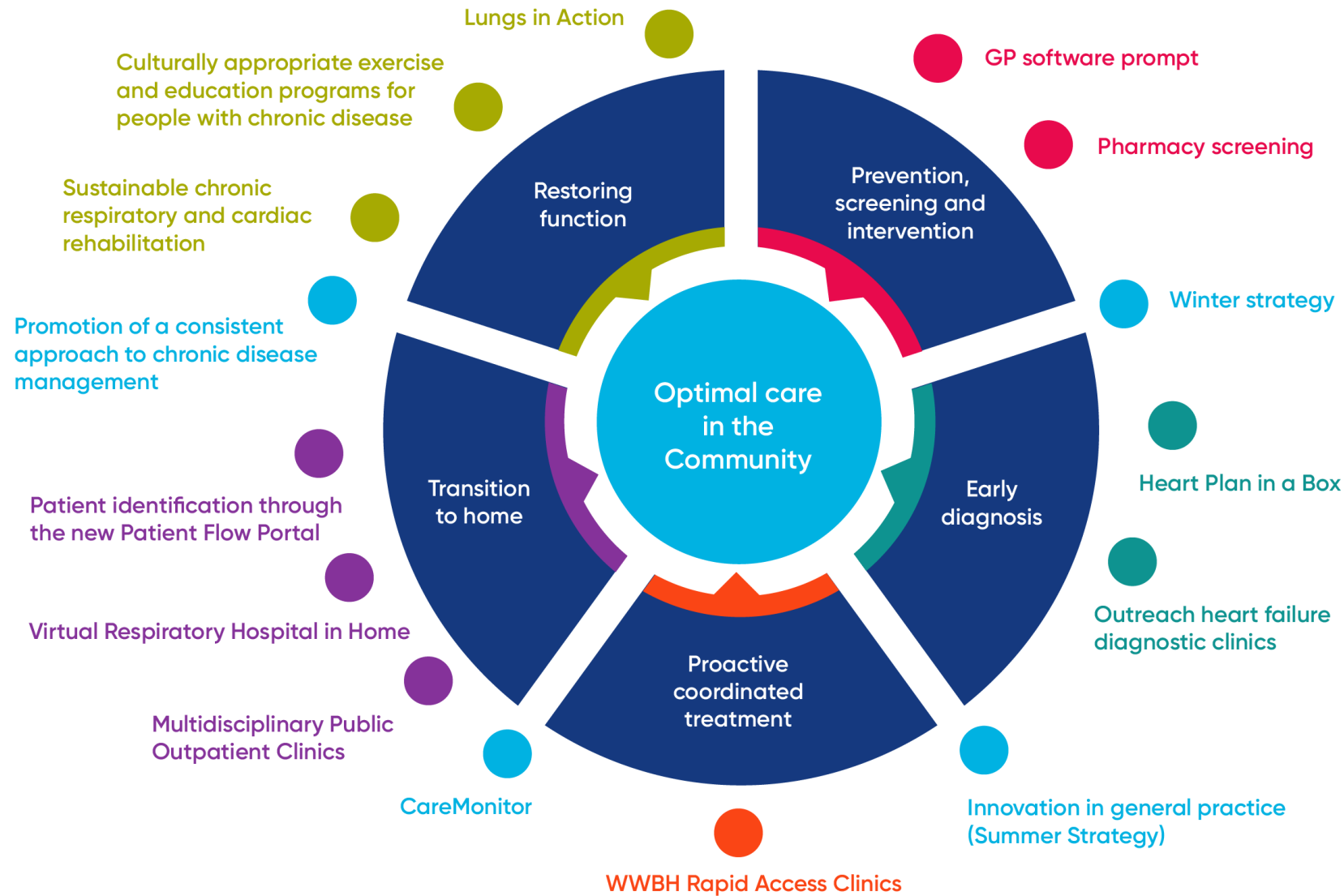
- No step in the pathway is finished until the next has started.
- Clinicians working to the top of their scope.
- Collaboration between providers.
- Alternatives to the emergency department.
- Patient focused; data driven.



Our goals

- To promote care in the community.
- To enhance individual's abilities to stay healthier at home for longer.
- To create a local culture of collaboration.
- To support the delivery of exceptional rural healthcare.
- To improve the efficiency and effectiveness of healthcare delivery for people with chronic disease in the Murrumbidgee.

Our initiatives





Achievements in Year Two



General Practice Software Prompt

From January to June 2024, a prompt appeared in general practice software, Medical Director, to assist general practitioners to identify patients who may have a missed diagnosis of COPD, in real time while patients are at the practice. The aim was to encourage follow up where appropriate.

The prompt had mixed success. It identified many patients who were on medication for COPD, but did not have a confirmed diagnosis. Compared to a control group, there was a small increase in patient diagnoses, spirometry testing and referral to a specialist.

A prompt for patients with suspected Heart Failure will appear from November 2024 – March 2025.

1128

Patient
prompts
displayed

142

Health care
professionals
reached

15

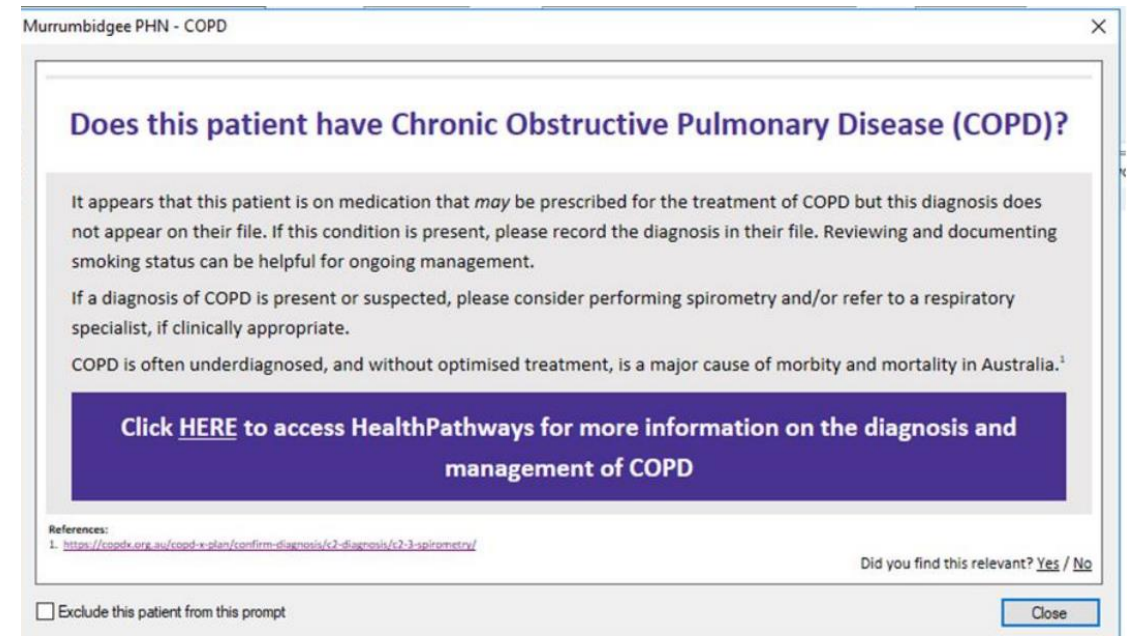
Patients diagnosed
following the
prompt

22

Spirometry tests
documented
following the
prompt

35

Patients referred to
a respiratory
specialist following
the prompt



Murrumbidgee PHN - COPD

Does this patient have Chronic Obstructive Pulmonary Disease (COPD)?

It appears that this patient is on medication that *may* be prescribed for the treatment of COPD but this diagnosis does not appear on their file. If this condition is present, please record the diagnosis in their file. Reviewing and documenting smoking status can be helpful for ongoing management.

If a diagnosis of COPD is present or suspected, please consider performing spirometry and/or refer to a respiratory specialist, if clinically appropriate.

COPD is often underdiagnosed, and without optimised treatment, is a major cause of morbidity and mortality in Australia.¹

Click [HERE](#) to access HealthPathways for more information on the diagnosis and management of COPD

References:
1. <https://copdx.org.au/copd-x-plan/confirm-diagnosis/c2-diagnosis/c2-3-spirometry/>

Did you find this relevant? [Yes](#) / [No](#)

☐ Exclude this patient from this prompt

[Close](#)

Prevention, Screening & Intervention

Pharmacy Screening Program

The Pharmacy Screening Program aims to identify patients at risk of COPD and CHF and link them with their general practitioner (GP) for assessment and early diagnosis.

The program also aims to:

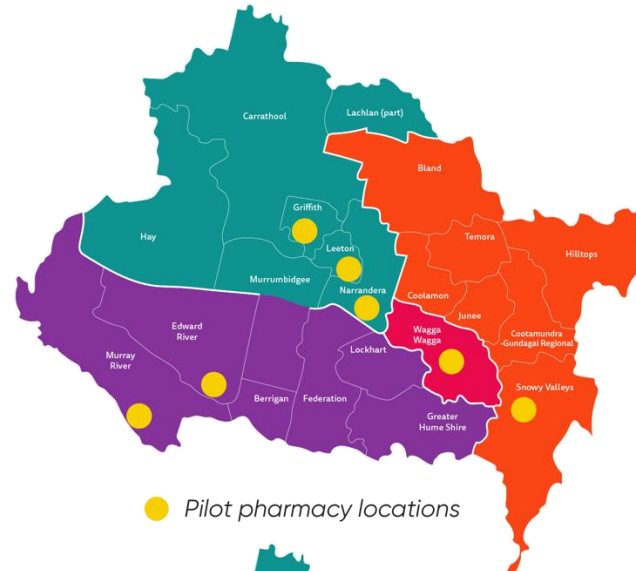
- Increase rural community pharmacist scope of practice in screening for chronic disease.
- Create a more formal link for referral from pharmacist to GP.
- Refer patients who may not have already seen their GP for symptoms of chronic disease.

Many patients visit pharmacies for symptom management before visiting their GP. This uniquely positions pharmacists to assist with identifying patients earlier with chronic disease symptoms.

GPs and pharmacists in Murrumbidgee collaborated to co-design the screening pilot.

11 pharmacies conducted screenings from November 2023 to April 2024.

Now, the program has been expanded into 27 pharmacies to conduct screening until June 2025.



● Pilot pharmacy locations



● Expansion pharmacy locations



Pilot results:

11

Participating
pharmacies

165

Total patients
screened

109

COPD patients
screened

56

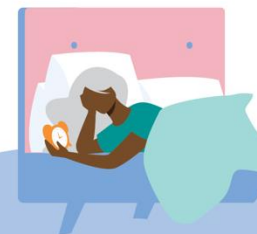
HF patients
screened

10

First Nations
patients screened

86

Patients
referred to GP
by pharmacist



Do you wake up
overnight with
difficulty breathing?



Do you **cough** several
times on most days?



Do you use
your **blue puffer**
every day?



Do you get **swollen**
ankles or feet?



Ask the Pharmacist as you may be eligible
for free chronic disease screening in the
Living Well, Your Way Pharmacy Screening program.



Early Diagnosis

Outreach Heart Failure Diagnostic Clinics

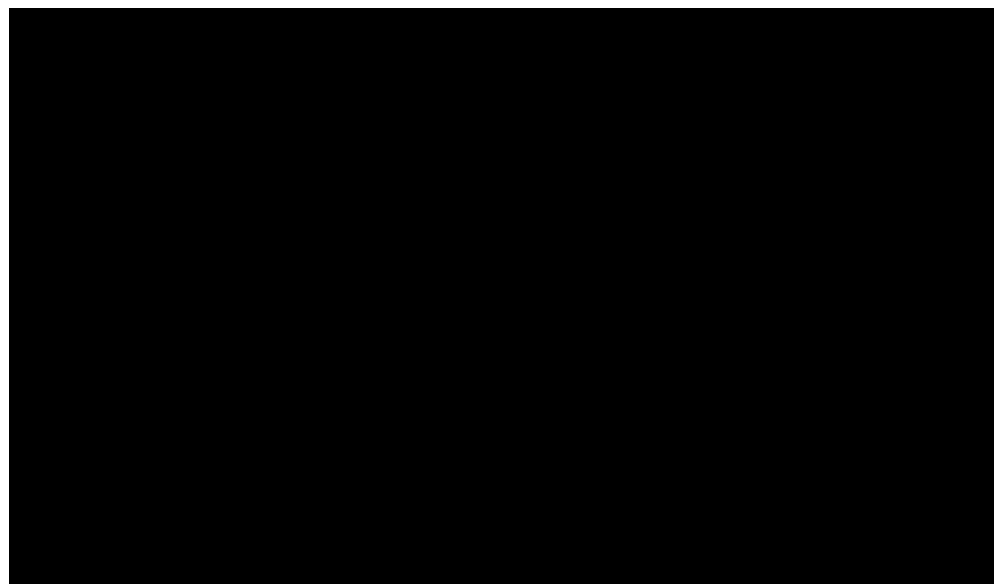
The Outreach Heart Failure Diagnostic Clinics aim to ensure patients at risk of heart failure have timely and affordable access to screening and diagnostic assessment including echocardiography in rural communities. There is a particular focus on Aboriginal people in the Murrumbidgee.

Clinics are funded by each community, using COAG19(2) Exemptions and delivered in rural and remote areas of the Murrumbidgee, at no cost to the patient.

Patients receive a comprehensive cardiac assessment, an echocardiogram, support for self-management and specialist follow up. Primary care providers also gain support through education and guidance to deliver optimal heart failure management.

Clinics are hosted at local general practices and Aboriginal Medical Services. Patients are identified and referred by their general practitioner. Visiting specialists include an MLHD Clinical Nurse Consultant, Sonographer, Cardiac Advanced Trainee and/or Cardiologist.

[Watch our Video](#)



Hay Clinic September 2024



● Clinic locations within the Murrumbidgee region

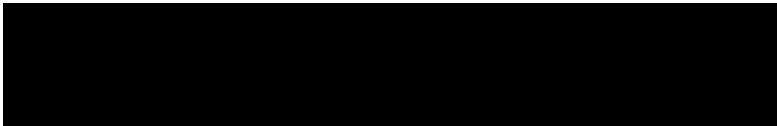
Early Diagnosis

Outreach Heart Failure Diagnostic Clinics

Service initiated
Dec 22

**Two
monthly
clinics**

"The formal recognition and profound appreciation from both the community and Hay Medical Centre are extended towards the Outreach Clinic for their invaluable contributions. We collectively express our deepest gratitude for the clinic's steadfast commitment, acknowledging the significant impact evidenced in the success stories that exemplify its positive influence on the healthcare landscape within our region."



Year 2: 13
Overall: 20
Clinics organised

12
Murrumbidgee
communities
visited

Year 2: 125
Overall: 177
Patient
consultations

Year 2: 21
Overall: 32
/new heart
failure diagnoses

Year 2: 27
Overall: 36
Predicted hospital/ED
presentation
avoidance



*Data: Year 2 / Overall until end of Sep 2024

W W B H

RAC

Rapid Access Clinic

Health Services Hub, Level 1

Monday to Friday
8:00am-7:00pm

Saturday and Sunday
8:00am-4:30pm

LOWER URINARY TRACT INFECTIONS AND UNCOMPLICATED PYELONEPHRITIS

CELLULITIS

PNEUMONIA

EXACERBATION OF COPD/CHF

SYMPTOMATIC DRAINAGE OF ASCITES

CATHETER / PEG CARE

WOUND CARE

URGENT & NON URGENT BLOOD TRANSFUSIONS

IRON INFUSION

ANTI-D INJECTION

REPLACEMENT OF GASTROSTOMY / JEJUNOSTOMY

Conditions appropriate for RAC referral can include

Criteria for referral

- ✓ Aged 1 year or older
- ✓ Clinically stable and can mobilise in their usual manner
- ✓ Patient demonstrates competency and capacity and consents to non-ED alternative to the RAC
- ✓ Requires rapid assessment, diagnosis or intervention
- ✓ Method of transport to the RAC unit may be via private transport or NSW Ambulance

Referral from GPs to include

- ① Patient details including contact details
- ② Clinical summary
- ③ Current medication list
- ④ Recent pathology results (Less than 6 weeks old for Iron Infusions – FBC, CMP, Vitamin D, Iron Studies)

NSW GOVERNMENT

Murrumbidgee Local Health District

RAC Medical Officer

Email: MLHD-Wagga-HITH@health.nsw.gov.au

Proactive Coordinated Treatment

Wagga Wagga Base Hospital Rapid Access Clinic

Seed funding from Living Well, Your Way has been used to expand the WWBH Rapid Access Clinic (RAC) to offer out of hours services on evenings and weekends.

The RAC provides an alternative place of assessment, treatment, and care coordination for triage category 4 and 5 patients with urgent and non-life threatening conditions.

The RAC is a referral only service. This includes transfer of care from the emergency department, as well as accepting referrals from general practice, NSW Ambulance, and residential aged care facilities. In 2025, referrals will be expanded to include community pharmacists.

Y2: 4,666
Overall: 7,023

Episodes of Care in RAC during normal hours

Y2: 899
Overall: 1,444

Episodes of Care in RAC after hours (evenings and weekends)

Y2: 182
Overall: 247

Referrals from General Practice

Y2: 88
Overall: 117

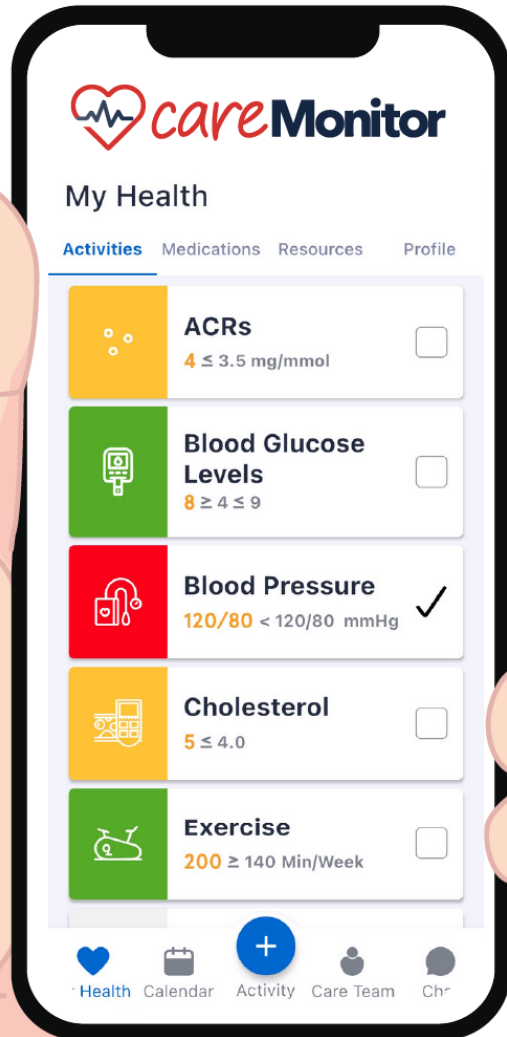
patients with known COPD or CHF*

* Only includes patients who have previously been admitted to an MLHD facility with a primary or secondary diagnosis of COPD or CHF.



Optimal Care in the Community

CareMonitor



CareMonitor is a patient driven self-monitoring tool available for mobile devices. The app enables patients to record their health metrics and access educational resources on how to better manage their chronic disease. It also includes a fully integrated dashboard for general practice and a web-based dashboard accessible by clinicians in the MLHD.

The dashboard allows the patients' allocated care team to access their self-collected metrics (blood pressure, weight, heart rate etc) and communicate with them directly. If the patients' self-recorded readings fall outside of their recommended values, an alert is shown on the clinician dashboard and the patient is provided with advice on how to manage their symptoms. Clinicians can also send health risk assessments and other questionnaires to patients on demand or at pre-determined intervals.

143

Patients using
CareMonitor

71

Clinicians
onboarded

14

General
practices using
CareMonitor

Optimal Care in the Community

Winter Strategy 2025

General Practices, the Living Well, You Way and MPHN Primary Care Engagement Teams went above and beyond during this year's Winter Strategy.

30 general practices worked with us to provide enhanced care for people with chronic disease over the winter period. Each practice engaged approximately 25 high risk patients, with a total reach of approximately 660 patients across the Murrumbidgee.

During the program, practice staff were offered education on a range of topics including chronic disease management, MBS Billing, Quality Improvement, Health Coaching, Advanced Care Planning, spirometry and triage for non-clinical staff, and more.

Overall feedback from participating general practices was that they enjoyed how the program helps them focus on their vulnerable chronic disease patients and assist them to improve their confidence and management over Winter. Practices primarily utilised Winter Strategy funding to employ more staff and to support patients with proactive interventions and education.

Practice staff felt supported to work at top of scope accessing the suite of professional development opportunities offered by our LWYW General Practice Nurse, [REDACTED]. Practices also stated that the program reporting and contractual requirements were more streamlined.



30
General practices
participated

727
Patients
participated

34
Practice nurses
certified in
spirometry

17
Education
sessions

222
Participants in
education
sessions

Winter Strategy: General Practice Spotlight

Vecare Holbrook and Walla

Vecare Health has truly made its mark in the vibrant communities of Holbrook and Walla Walla, earning a reputation for outstanding primary care over the years. Joining Living Well, Your Way Winter Strategy for a second consecutive year, Vecare are once again pulling out all stops to deliver the program aiming to make a difference for their patients and the wider community.

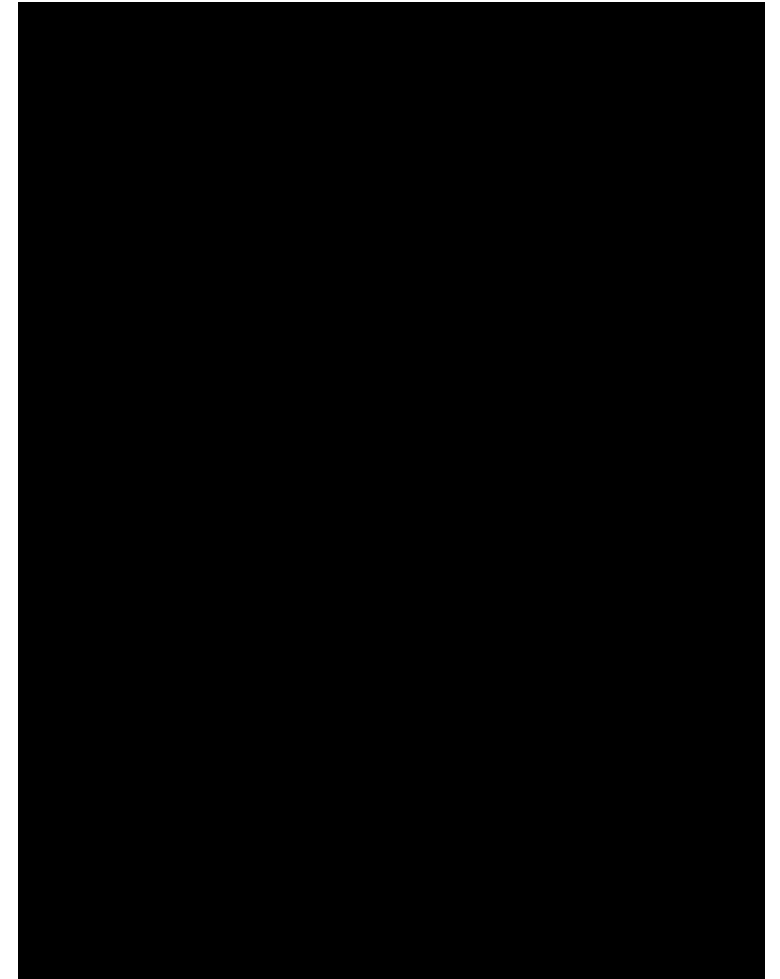
Their innovative “Winter Wellness Program” has become a local favourite, particularly for patients managing chronic obstructive pulmonary disease and chronic heart failure. The buzz around their Winter Wellness Program is palpable.

“We had patients from both Holbrook and Walla Walla asking when the Winter Wellness Program was going to start months before winter even began!” shares practice manager, [REDACTED]

What is the secret behind their success? A dedicated and cohesive practice team putting their patient’s wellbeing and needs at the centre of care. Practice nurses, [REDACTED] and [REDACTED], are at the heart of this initiative, providing exceptional patient-centred care through personalised care planning and goal setting. Their commitment to keeping patients well and out of the hospital shines through.

“Our patients, especially those most vulnerable during winter, have really benefited from these regular connections with their general practitioner and nurses,” [REDACTED] explains. “The program has been a fantastic success; patients love the additional check-ins and the extra time we spend together. They genuinely feel cared for.”

Harneet, [REDACTED] and their team of general practitioners are highly committed to supporting their rural communities during the winter months. They cherish being part of the Winter Strategy each year, seeing it as a chance to make a meaningful difference in their patients' lives. The Winter Wellness Program (Winter Strategy) has now become an integral and eagerly anticipated part of their annual care routine.





Optimal Care in the Community

Implementing HOPE in General Practice

MPHN contracts respiratory nurses in three general practices in the Murrumbidgee, and each uses the NSW Health HOPE platform to collect patient reported outcome measures as part of their routine care. This year, practices expanded their use of HOPE to collect more patient reported measures.

Staff report the benefits of collecting these measures include gaining a better understanding of the holistic needs of patients, and an ability to talk about their concerns in real time.

Y2: 111

Overall: 280

General Practice
patients
registered on
HOPE

Y2: 266

Overall: 483

Patient Reported
Outcome Measures
surveys completed
in primary care

Optimal Care in the Community

Heart Plan in a Box

Heart Plan in a Box was commissioned within general practice an add-on Quality Improvement (QI) initiative as part of Living Well, Your Way Winter Strategy.

The aim was to enhance the quality of care for patients with heart failure in general practice and support the patient's journey from diagnosis through to end-of-life care.

The initiative utilises the Plan-Do-Study-Act (PDSA) cycle to test and implement continuous improvements in the management of heart failure, with a focus on optimising patient outcomes.

Each practice conducted two PDSA cycles that addressed different stages of the heart failure patient journey.

Key activities in HeartPlan in a box include:

- 6 Data Quality Improvement Cycles, aimed at enhancing data collection and utilisation.
- 3 cycles focused on optimising the diagnosis of heart failure patients.
- 10 cycles focused on refining GP Management Plans.
- 2 cycles aimed at improving the processes for patient recalls and reminders.
- 1 cycle concentrated on optimising treatment strategies for heart failure patients.
- 2 cycles dedicated to enhancing patient education on managing heart failure.

12

General Practices
participated

24

Cycles
completed



HeartPlan in a box

A quality improvement toolkit
for heart failure management in
primary care

«

Heart Plan in a Box: General Practice Spotlight

Moama Health Clinic

At the heart of Moama Health Clinic is a commitment to exceptional patient care, embodied by the remarkable contributions of Nurse [REDACTED]. This year, [REDACTED] has demonstrated extraordinary dedication during the Winter Strategy, particularly through her involvement in the Living Well, Your Way Heart Plan in a Box quality improvement initiative. Her efforts have not only enhanced patient outcomes but have also showcased the profound impact that focused nursing practices can have on a community's health.

Heart Plan in a Box: A Collaborative Approach to Cardiac Care

Working closely with her registrar during Cycle Two of the Heart Plan in a Box initiative, [REDACTED] focused on cleansing patient data and optimising diagnosis pathways for those at risk of heart failure. By meticulously checking the last ECHO results of her patients, she ensured that appropriate steps were taken toward a formal diagnosis.

This approach not only streamlined patient care, but also fostered an environment where patients felt valued. [REDACTED] dedication to identifying potential heart failure cases demonstrated her commitment to early intervention and comprehensive care.

A Multidisciplinary Approach: Collaborating with Local Pharmacists

In Cycle Four of the Heart Plan in a Box initiative, [REDACTED] took collaboration to the next level by partnering with a local pharmacist to optimise treatment pathways for heart failure patients. Together, they tackled workflow inefficiencies related to Home Medication Review Referrals. Through this partnership, [REDACTED] and her pharmacist colleague identified a communication gap that affected patient care.

By improving procedures and enhancing the lines of communication between their respective practices, [REDACTED] was able to streamline referral processes, ultimately leading to better treatment outcomes for patients. This multidisciplinary approach is a testament to [REDACTED] belief that comprehensive care requires collaboration and shared expertise.

In celebrating [REDACTED] achievements, we are reminded that behind every successful healthcare initiative are dedicated individuals who strive to make a meaningful impact. With nurses like [REDACTED] leading the way, the future of patient care looks brighter than ever.

Y2: 437
Overall: 715

Patients identified by
the Murrumbidgee
Chronic Respiratory
and Heart Failure
Service using the New
Patient Flow Portal

Transition to Home

MLHD Chronic Respiratory and Heart Failure Service

The Murrumbidgee Chronic Respiratory and Heart Failure Service (part of the MLHD Community Care team) plays a vital role in supporting patients who have been to hospital, and those at risk of hospitalisation, to manage their chronic conditions at home.

Clinicians in this small team have been using the NSW Health New Patient Flow Portal to proactively identify people with COPD and CHF who present to hospital for two years now.

This 'pull' method of referral helps to ensure all patients are offered support in their transition home from hospital. Once identified, the team performs a comprehensive assessment, patient education and referral to rehabilitation and community-based services as required.



PFP



New PFP



Transition to Home

Public Outpatient Clinics

Three public outpatients clinics have been introduced as part of the Living Well, Your Way pathway. They include:

- Public Respiratory Clinic once a month in Wagga Wagga
- Public Respiratory Clinic once a month in Griffith (NEW in Year 2)
- Public Heart Failure Review Clinic once a month in Wagga Wgga (NEW in Year 2)

Clinics are focused on providing specialist multidisciplinary care to patients with complex respiratory and/or cardiac conditions.

Depending on the clinic, staff include an Advanced Trainee, Medical Specialist, Transitional Nurse Practitioner or Nurse Specialist, physiotherapist and/or pharmacist.



Patient feedback:
‘Fabulous’



Y2: 11
Overall: 19

Public respiratory
clinics at Wagga
Wagga Health
Service Hub

Y2: 6
Overall: 6

Public Heart Failure
Review Clinics at
Wagga Wagga
Health Service Hub

Y2: 5
Overall: 5

Public respiratory
clinics at Griffith
Ambulatory Care

Y2 : 110
Overall: 163

Patient interactions*
at the Wagga
Respiratory Clinic

Y2: 32
Overall: 32

Patient interactions*
at the Wagga Heart
Failure review clinc

Y2: 40
Overall: 40

Patient interactions* at
the Griffith Respiratory
Clinic

*Patient interactions include both initial appointments and follow ups in clinics

Restoring Function

Pulmonary and Heart Failure Rehabilitation

All patients with COPD and heart failure are encouraged to attend an 8-week pulmonary and heart failure rehabilitation program. The program provides supervised individualised exercise classes and education to participants. The aim is to:

- Promote healthy lifestyle and exercise.
- Promote health literacy within the chronic respiratory and heart failure population.
- Increase participant confidence with self-management of their chronic condition.
- Help reduce the risk of avoidable hospital admissions.

One of the challenges at the beginning of Living Well, Your Way was limited access to this exercise and education program across the region.

In partnership with MLHD, Marathon Health, Griffith AMS, RivMed and Kinetic Medicine, we have been able to significantly increase the number of rehabilitation programs throughout the region.

In year two, we also worked with the Lung Foundation Australia and In-Motion Fitness to commence a Lungs in Action program for people to continue exercise after they participate in rehabilitation in Wagga Wagga.

7

Newly established
chronic disease
rehab programs

2

Locally designed culturally
appropriate programs for
Aboriginal people in
partnership with AMS

2

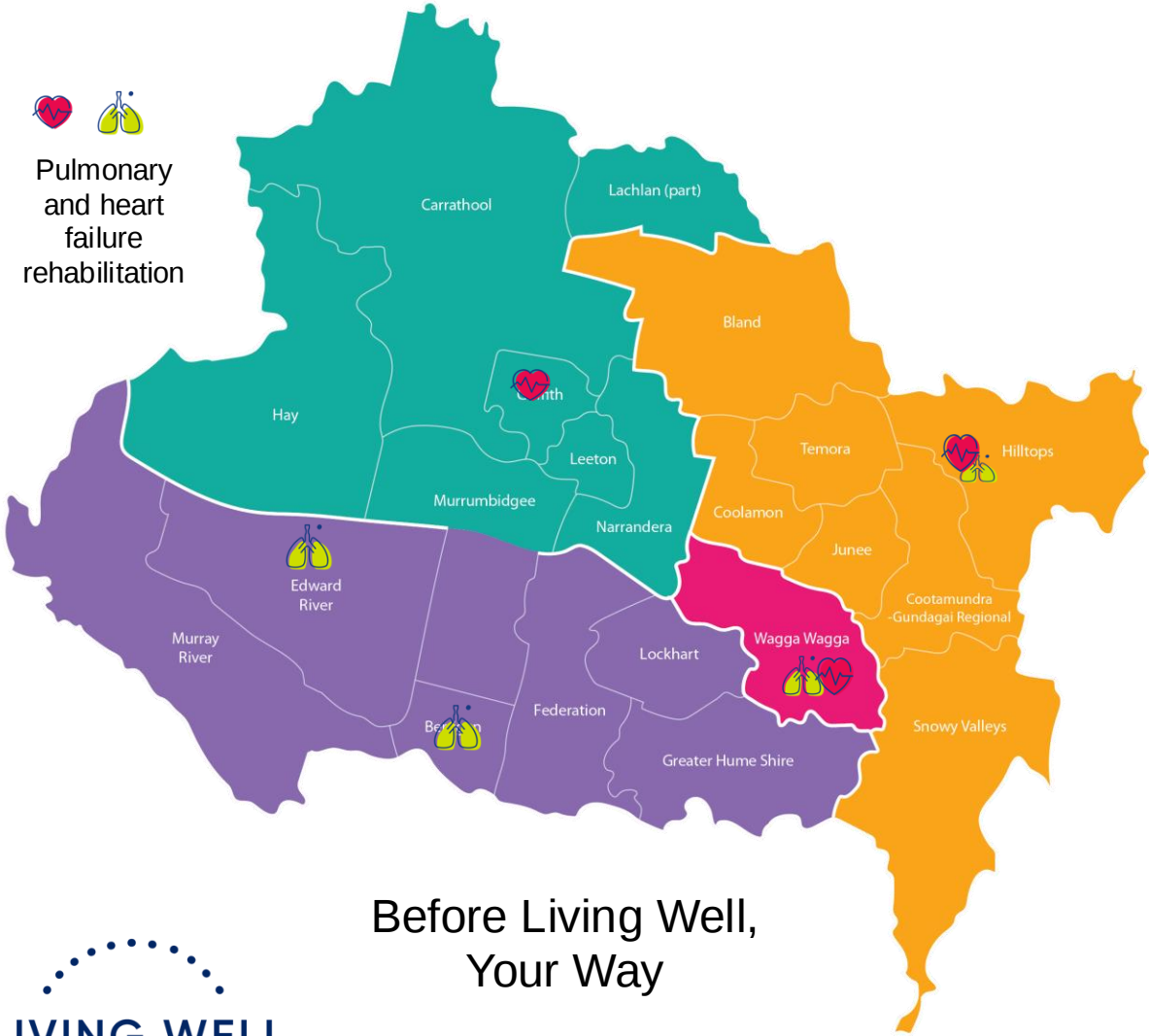
New Lungs in
Action programs



Access to pulmonary and heart failure rehabilitation



Pulmonary
and heart
failure
rehabilitation



Before Living Well,
Your Way



Existing pulmonary and
heart failure rehabilitation



Lungs in Action



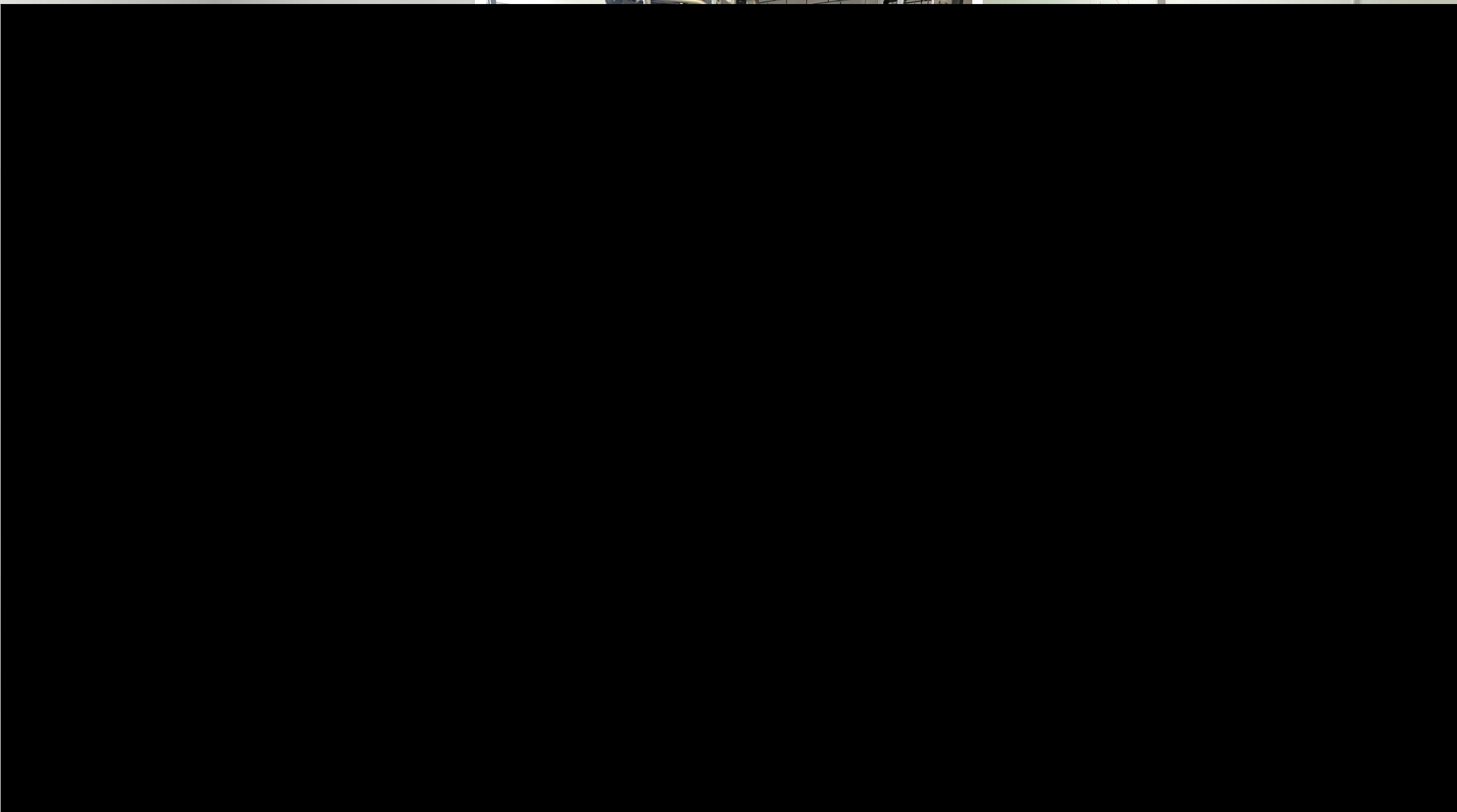
Murundhu



New pulmonary and heart
failure rehabilitation



By the end of
year two



Murundhu I Live, I Breathe: Griffith and Wagga Wagga

The Living Well, Your Way team partnered with clinicians in MLHD and Griffith Aboriginal Medical Service (GAMS) to co-design and trial a rehabilitation program specifically designed for Aboriginal participants, called “*Murundhu, I Live I Breathe*” in Griffith. The aim of the co design was to develop a program that fosters an environment that allows Aboriginal people to feel comfortable and welcome.

Since the co-design, the program has been run twice in Griffith and been expanded to Wagga Wagga in partnership with the RivMed.

Aboriginal and Torres Strait Islander peoples in the Murrumbidgee experience higher rates of heart and lung diseases, with greater risk of adverse outcomes associated with these diseases. Currently there are no pulmonary rehabilitation programs specifically designed inclusive of the cultural needs of Aboriginal peoples.

Participants are provided resources, tools, and knowledge to better self-manage their chronic illness.

Striving for a cultural approach to learning, yarning circles are ‘with’ and ‘led’ by the participants avoiding a traditional western didactive presentation which is typically delivered ‘to’ participants. From the outset this approach has been extremely successful in encouraging engagement, discussion, and promoting interest in health literacy.

Upon completion of the program participants will be linked with community exercise program options such as Aunty Jean’s (local generalised chronic health support group for aboriginal populations) for ongoing maintenance and provided a home exercise program.

The first cohort of participants have already spoken of and felt the physical health benefits of exercise. They recognise the significant positive impact on their social and emotional wellbeing through cultural connection and being ‘with mob.’

Participant Feedback

“More people need to do this - it is so good for the body and the mind.”

“I love yarning with my mob - we learn so much with each other.”

Team Feedback

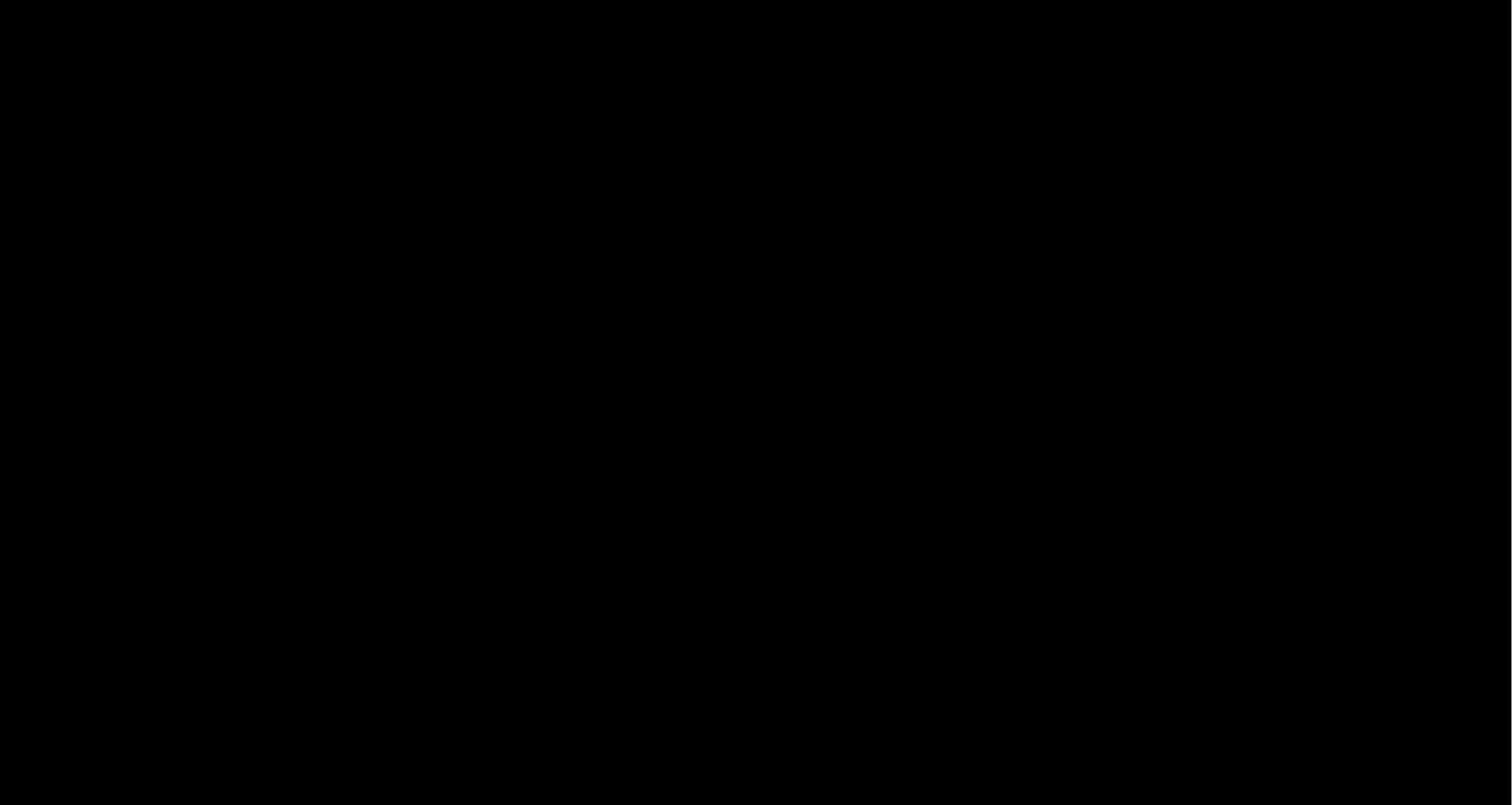
“The transformation in the group is amazing.”

“The social and cultural connection is so powerful.”

MLHD Excellence Awards Finalist: Keeping People Healthy Category

[Watch our video](#)





Clinician Education

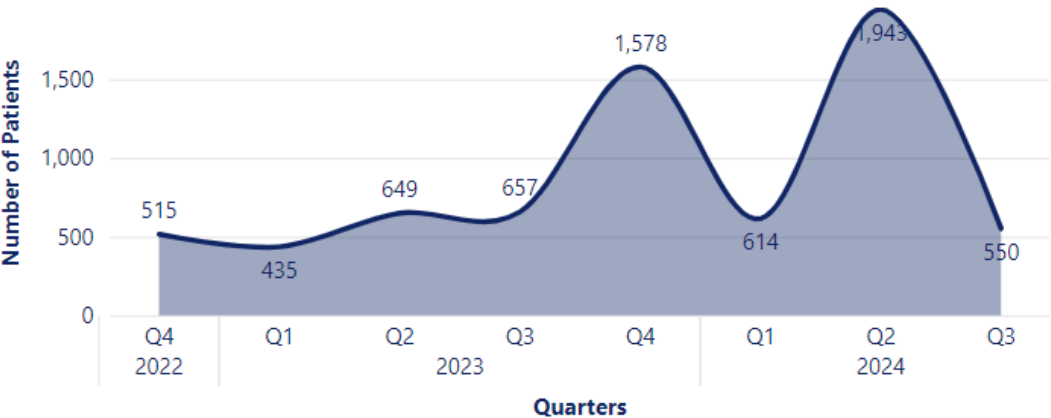
Living Well, Your Way is committed to clinical and non-clinical education to enhance care for people with chronic disease. Over the past year, the team has facilitated a number of training opportunities including:

- **Behaviour Change Skills Workshop Accredited Health Coaching** (June 2024 in Wagga) Attended by: 60+ clinicians.
- **Optimising the management of Heart Failure with [REDACTED]** (May 2024 in Griffith). Attended by 50+ clinicians.
- **Management of Complex Respiratory Conditions with [REDACTED]** (March 2024 - Wagga, Cootamundra & Tumut) Attended by: 57+ clinicians across three locations
- **Managing Heart Failure: From Hospital to Home** (May 2023 & 2024 Webinars) Attended by: 15 clinicians

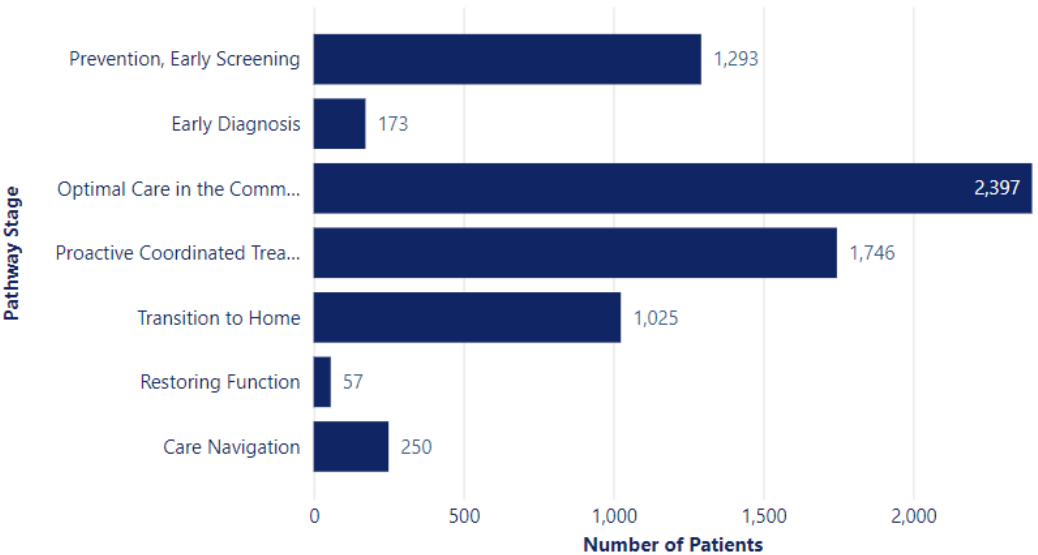
Living Well, Your Way Patient Enrolments

Number of patient encounters along the care pathway
Y2: 4,685
Overall: 6,941

Patient Enrolment/encounters by calendar quarters (Oct 2022-Sep 2024)



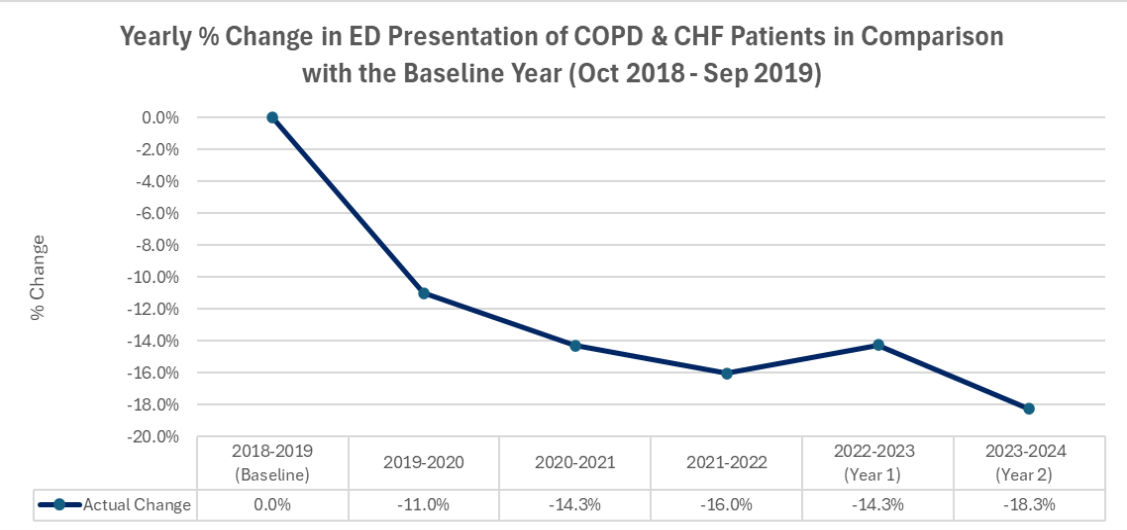
LWYW Patient Enrolment by Pathway Stages



*Data to the end of year two: proactive coordinated treatment includes all episodes of care in the RAC after hours, which is supported through funding from Collaborative Commissioning. Note: where the same patient is accessing multiple interventions, it is likely that patient has been double counted.



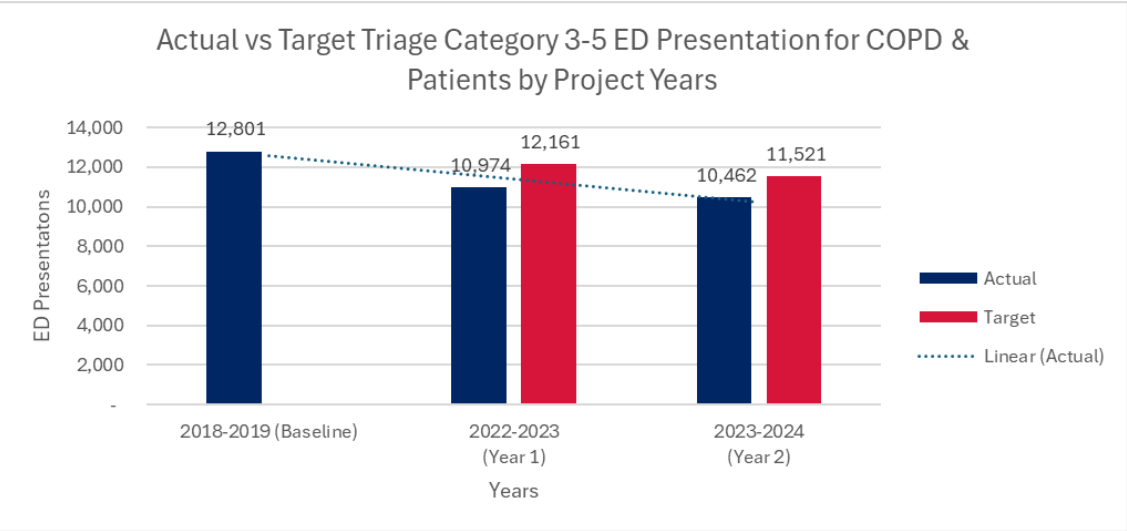
MLHD Triage 3-5 ED Presentations for people with COPD and Heart Failure



As part of our funding agreement with the NSW Ministry of Health, Living Well, Your Way has the goal of reducing Triage 3-5 ED presentations and hospital admissions for COPD and heart failure by 5% in Year One, 10% in Year Two and 15% in Year Three (compared to a baseline of 2018-19FY).

In the first year of LWYW, there was a 9.3% reduction in Triage 3-5 ED presentations, a great result.

This year, we continued to see a reduction in ED presentations but did not quite get to the 10% target, which suggests there is still more work to do!



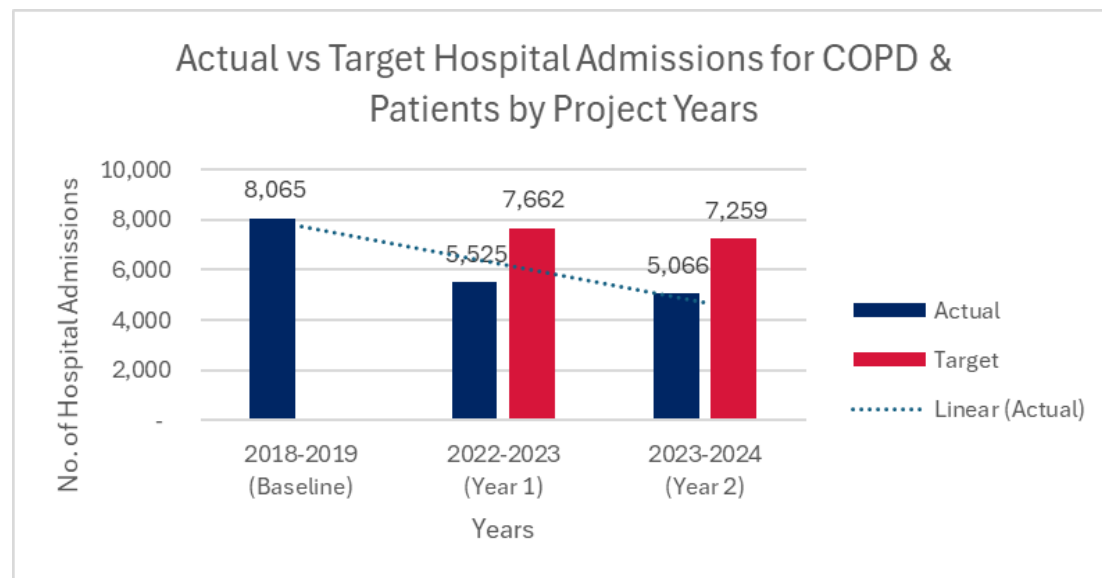
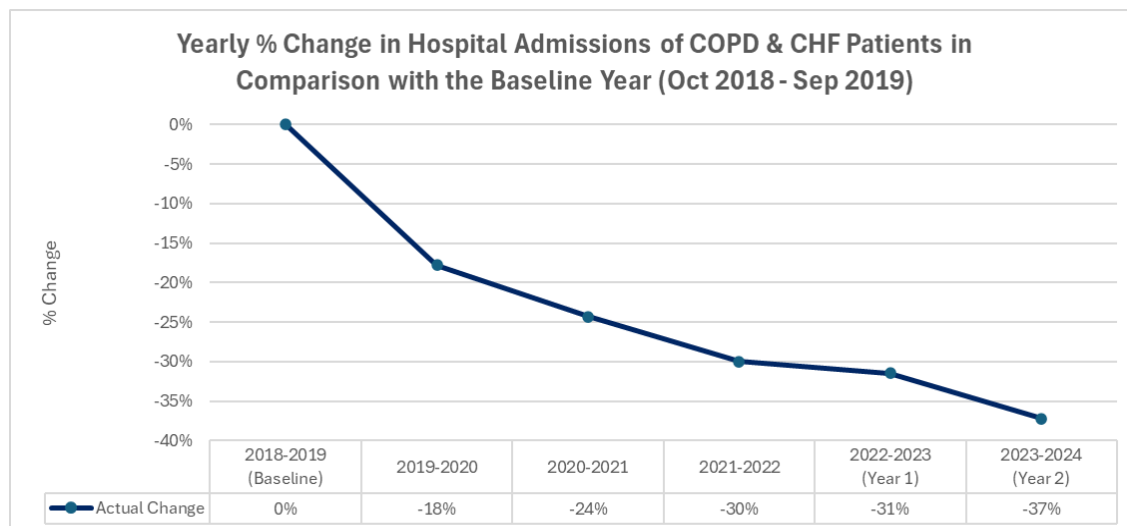
Project Year	Target Reduction	Actual Reduction
One (2022-23)	5%	9.3%
Two (2023-24)	10%	8.3%

✔
Almost there!

*Data Source: MLHD ED Dataset



MLHD Hospital Admissions for people with COPD and Heart Failure



There has been a steady decline in hospital admissions for people with COPD and heart failure in Murrumbidgee since 2018-19.

In Year One of Living Well, Your Way there was a 31% reduction in hospital admissions compared to baseline. This well exceeded the target 5% reduction.

This trend continued in Year 2, with a 37% reduction compared to baseline. A significant achievement by patients, primary and community care clinicians in the region.

Project Year	Target Reduction	Actual Reduction
One (2022-23)	5%	31%
Two (2023-24)	10%	37%



*Data Source: MLHD Inpatient Dataset

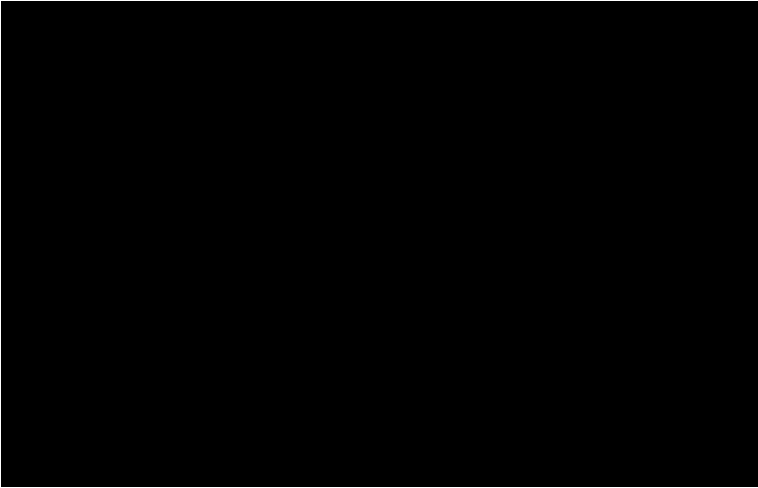
Awards & Nominations



MLHD 2024 Excellence Awards

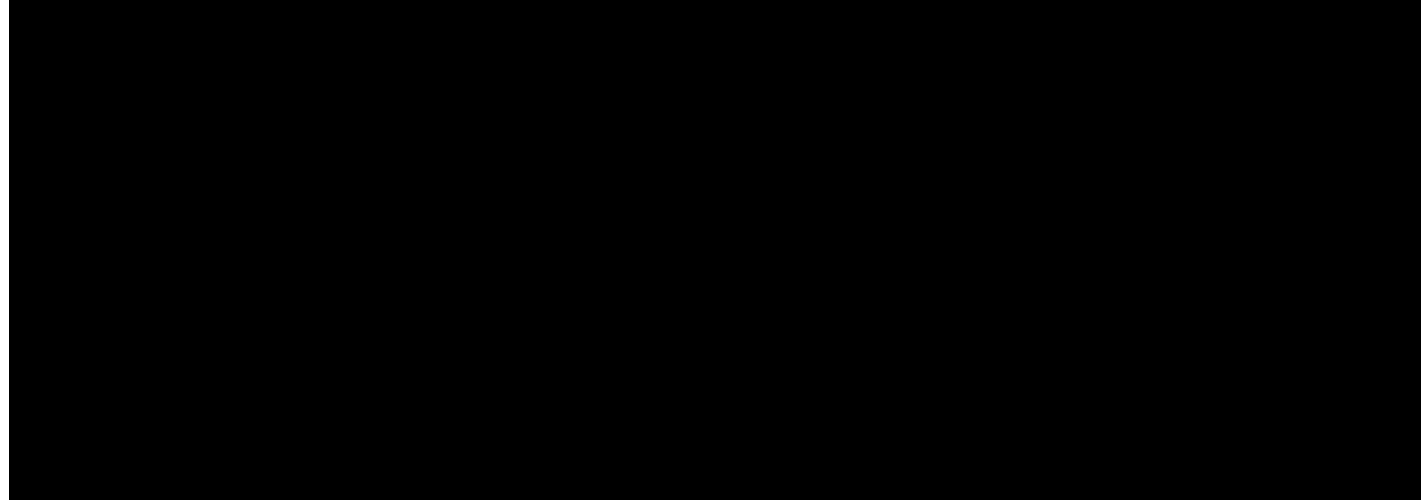
Outreach Heart Failure Diagnostic Clinic

- Winner of the Chief Executive Choice Award



Murundhu I live I breath

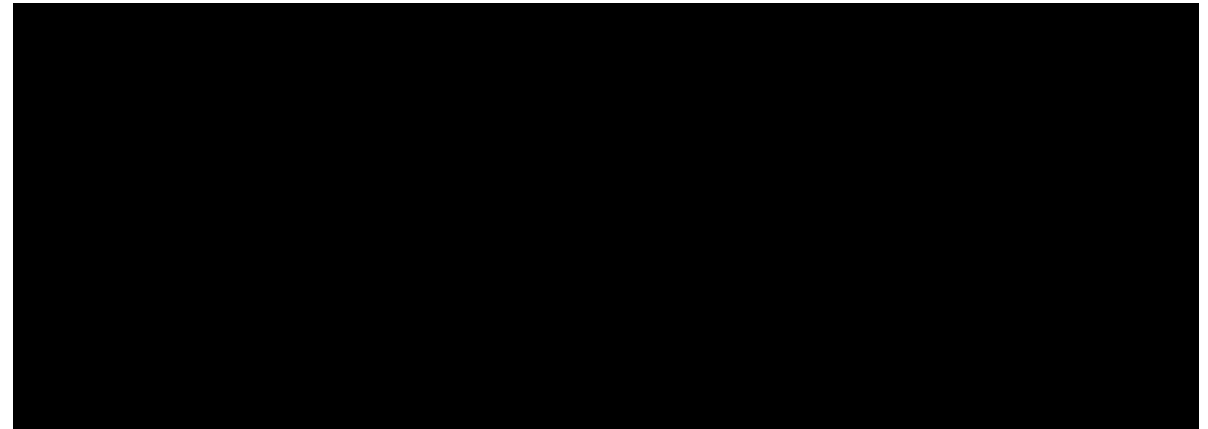
- Finalist: Excellence in Aboriginal Healthcare



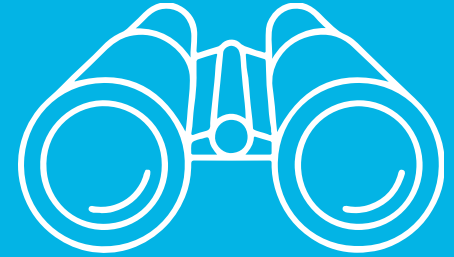
Pharmaceutical Society of Australia Conference (Aug 2024)

LWYW Pharmacy Screening Pilot

- Winner: Best poster presentation (from 44 entrants)



Moving into year three...



The Living Well, Your Way pathway demonstrates that it is possible to take a region wide approach to improve care in the community for people with chronic disease.

Thanks to our partners we have been able to deliver new and improved services, to people all across the Murrumbidgee, and shift our focus from treating people who are sick in hospital, to helping people stay well at home and in their communities.

In our third and final year, we have a few models of care left to implement. These include an outreach respiratory clinic model for people in rural areas, and nursing and pharmacy support to transition home from Wagga Wagga Base Hospital.

Beyond that, we are shifting our focus from implementation, to sustainability. Our aim is evaluate what we've done, and look for ways to do more of what's working, and stop what's not.

We look forward to working with you again in 2025.

Thank you to our partners



- Patients and carers with chronic disease in the Murrumbidgee
- MedicalDirector (Telstra Health)
- Commissioned pharmacies, general practices and rehabilitation providers
- Roy Cardiology
- Riverina Cardiology



- MLHD Respiratory and Heart Failure Service
- Wagga Wagga Base Hospital Respiratory and Cardiac Advanced Trainees
- MPH N commissioned respiratory nurses
- CareMonitor
- WWBH Rapid Access Clinic
- Griffith Base Hospital and Wagga Base Hospital Outpatients
- Griffith Aboriginal Medical Service
- Riverina Medical and Dental Aboriginal Medical Service
- Lung Foundation Australia
- Heart Foundation
- Marathon Health, Back on Track Physiotherapy
- Kinetic Medicine
- In Motion Fitness
- Novartis

