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Murrumbidgee Primary Health Network
(ABN 15 111 520 168)

Legislative Assembly
Select Committee on Remote, Rural and Regional Health
Chair, Dr Joe McGirr, State Member for Wagga Wagga
NSW Parliament House
6 Macquarie Street
Sydney NSW 2000

Friday, 20 December 2024

Via email: remoteruralregionalhealth@parliament.nsw.gov.au

Dear Chair,

Thank you for you for allowing Murrumbidgee Primary Health Network the opportunity to participate in the *inquiry into the implementation of portfolio committee no. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities* as part of the Legislative Assembly Select Committee on Remote, Rural and Regional Health, on Thursday, 12 December 2024.

This correspondence serves to respond to two supplementary questions and information requests in relation to my evidence, specifically:

1. Results from our Collaborative Commissioning Living Well Your Way program
2. Joint funding arrangements for the Local Health Advisory Committees in the Murrumbidgee region

Please find following the relevant details to both of these items in the following pages.

If you require any more information, please contact our Strategic Initiatives and Engagement Advisor Monica McInnes via email [redacted]

Yours sincerely,

[redacted]

Narelle Mills
Executive, Integration and Partnerships

1. Results from our Collaborative Commissioning Living Well Your Way program

Refer attached PDF file.

2. Joint funding arrangements for the Local Health Advisory Committees in the Murrumbidgee region.

Murrumbidgee Primary Health Network (MPHN) and Murrumbidgee Local Health District (MLHD) jointly manage and support 33 Local Health Advisory Committees across the Murrumbidgee region.

Examples of our collaborative approach to managing and supporting LHACs:

- Joint twice yearly LHAC Forums (MPHN's contribution to funding these is between $10,000 - $15,000 per forum)
- Joint recruitment drive (In 2024 MPHN's financial contribution to this campaign was a resource to develop the campaign collateral and $1,000 as part of a social media campaign to promote being involved in the LHACs)
- Joint LHAC resources webpage, hosted on MPHN's website
- Joint priority planning sessions with each LHAC every two years
- Dedicated staff from MLHD and MPHN to support LHAC activities at the local level (MPHN's has around 20 staff members involved in supporting LHAC activities and meetings).

In addition to this joint work, it is our understanding MLHD provides nominal funding for each LHAC to implement local activities initiated by the LHAC. From time to time MPHN has community grant opportunities in which LHACs are eligible to apply. Over the past seven years, MPHN has provided over $100,000 in grant funding to LHAC committees through various grant initiatives including cancer screening, palliative care, drought, bushfire and flood recovery.

Living Well, Your Way Year in Review

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

MURRUMBIDGEE LOCAL HEALTH DISTRICT

NSW GOVERNMENT

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.

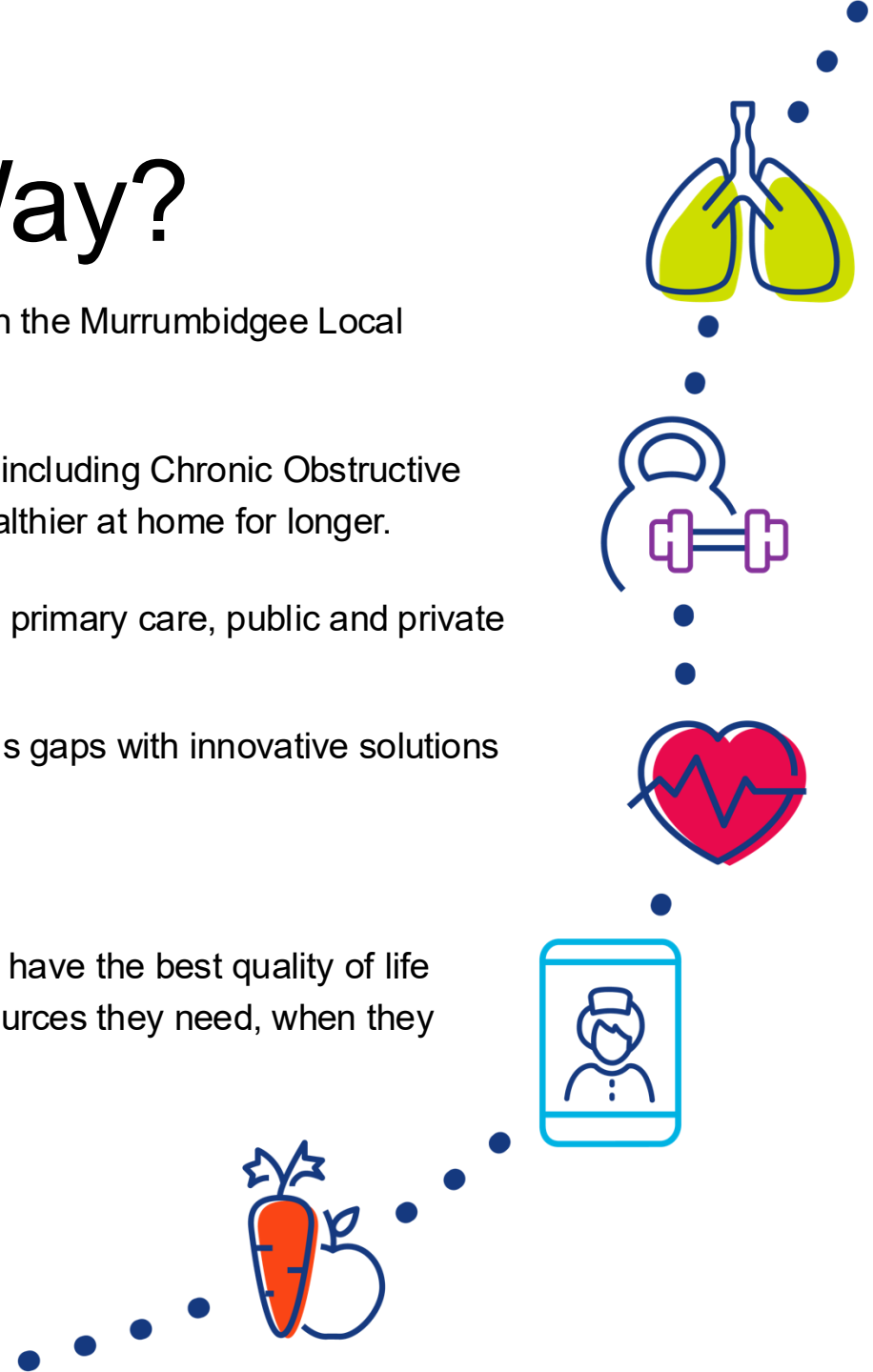
It aims to build a better way of delivering healthcare for people with chronic conditions including Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) and keep people healthier at home for longer.

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

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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.

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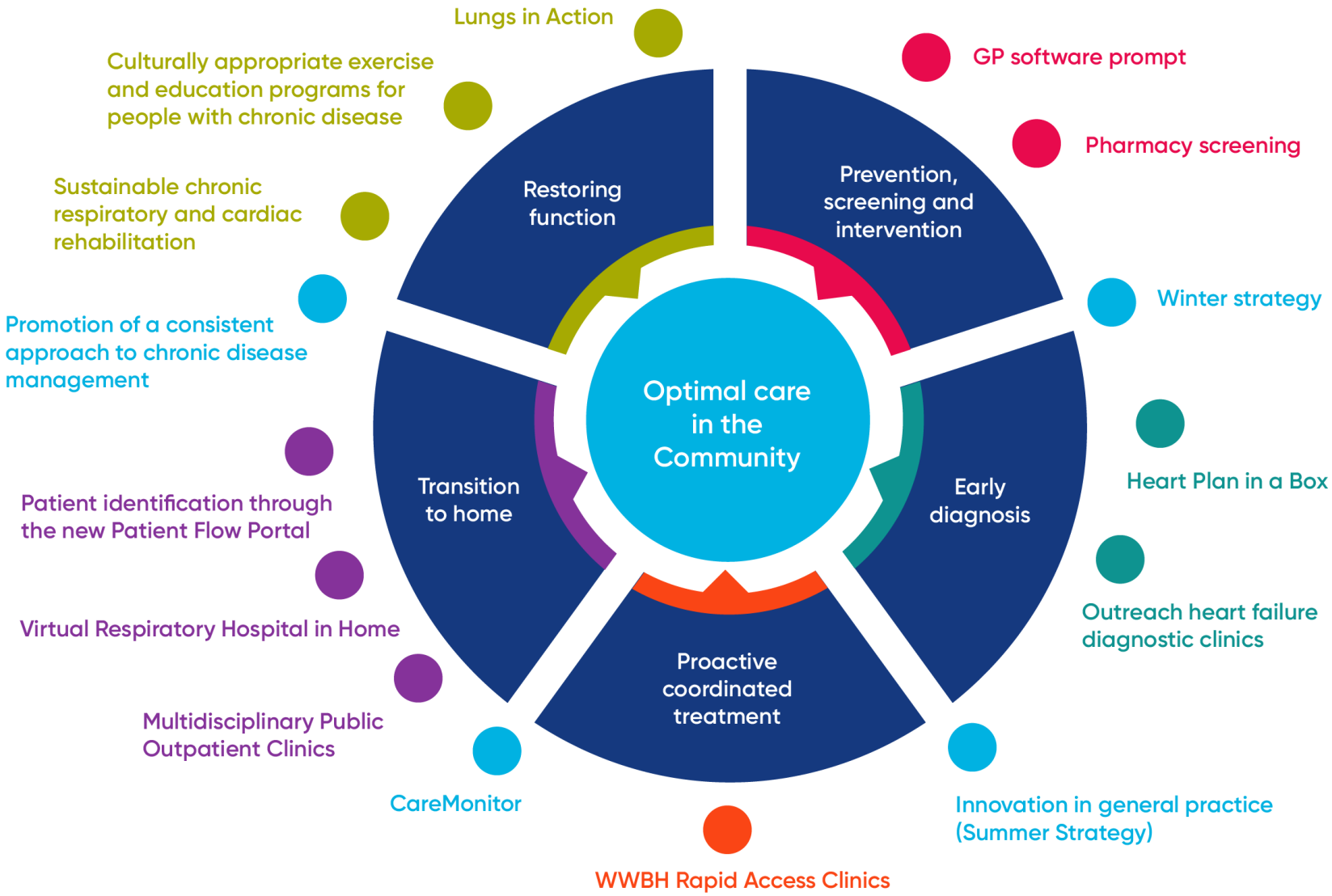
Our goals

- 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

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your way

Prevention, Screening & Intervention

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.

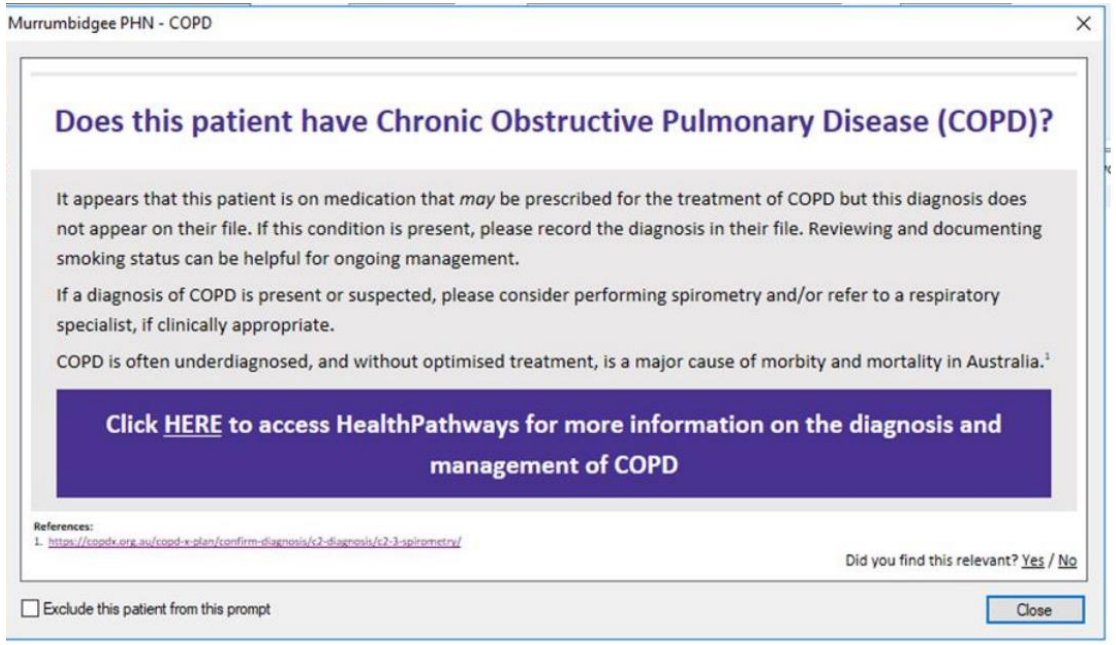
1128
Patient prompts displayed

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



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:

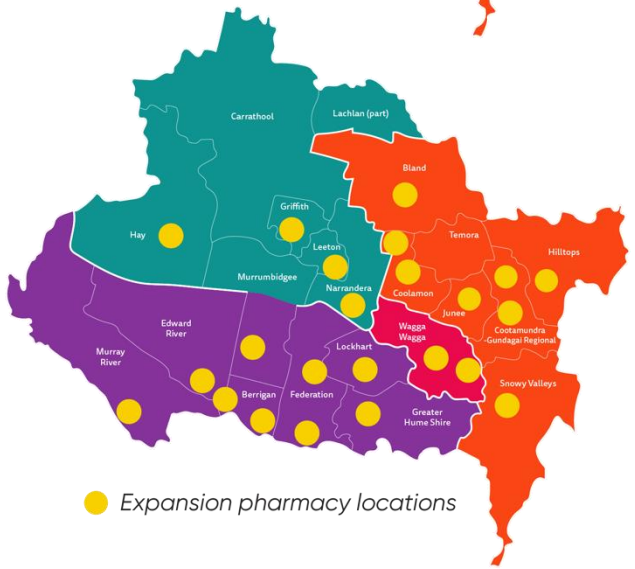
- Increase rural community pharmacist scope of practice in screening for chronic disease.
- Create a more formal link for referral from pharmacist to GP.
- Refer patients who may not have already seen their GP for symptoms of chronic disease.

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 codesign 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 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

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Early Diagnosis

Outreach Heart Failure Diagnostic Clinics

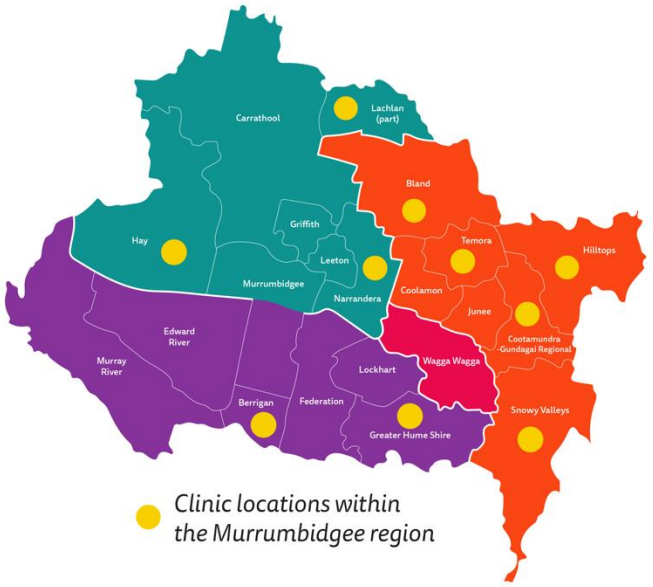
The Outreach Heart Failure Diagnostic Clinics aim to ensure patients at risk of heart failure have timely and affordable access to screening and diagnostic assessment including echocardiography in rural communities. There is a particular focus on Aboriginal people in the Murrumbidgee.

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



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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."

Dr Shahzad,
General Practitioner, Hay Medical Centre

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

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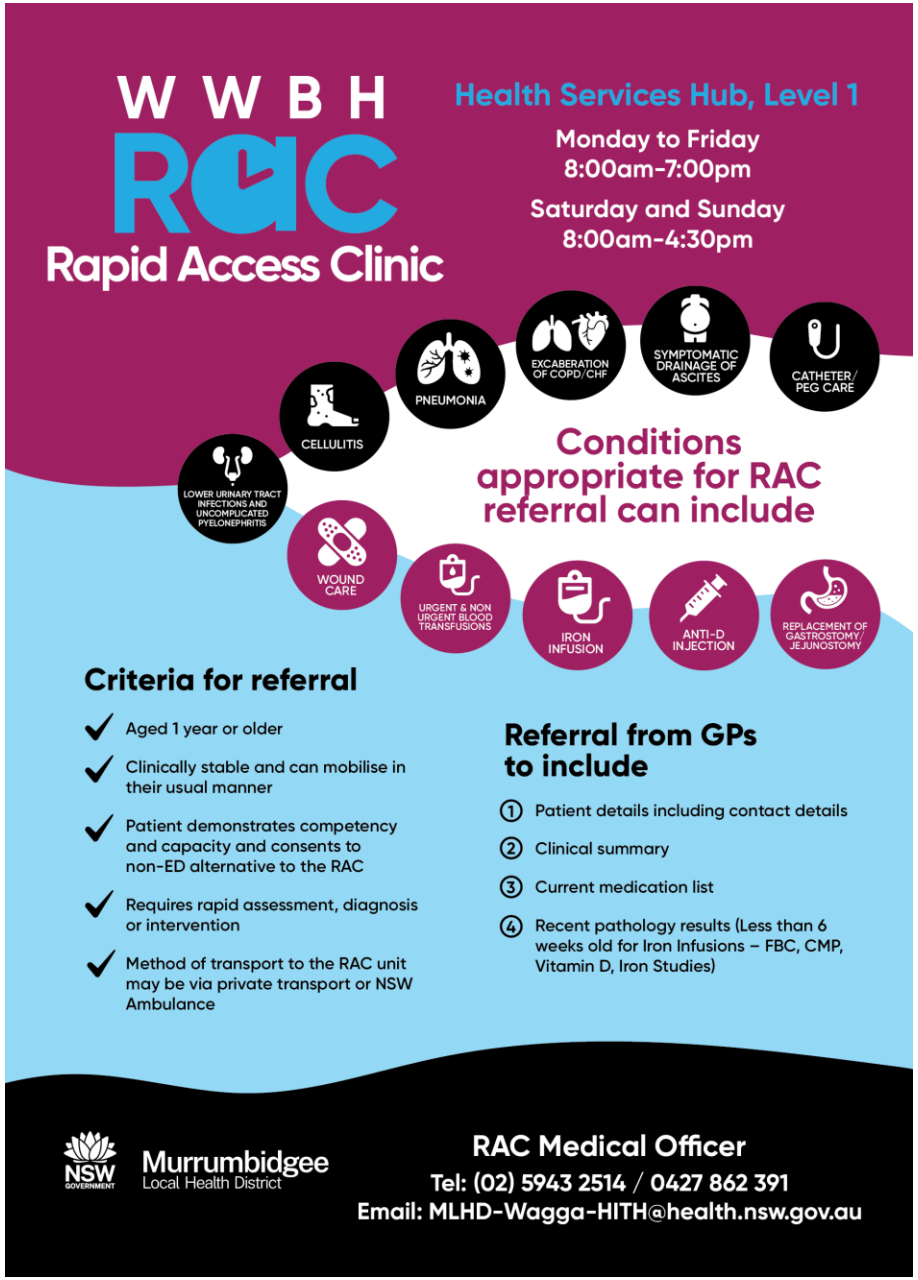
*Data: Year 2 / Overall until end of Sep 2024



*Data to the end of year 2: 30 September 2024

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

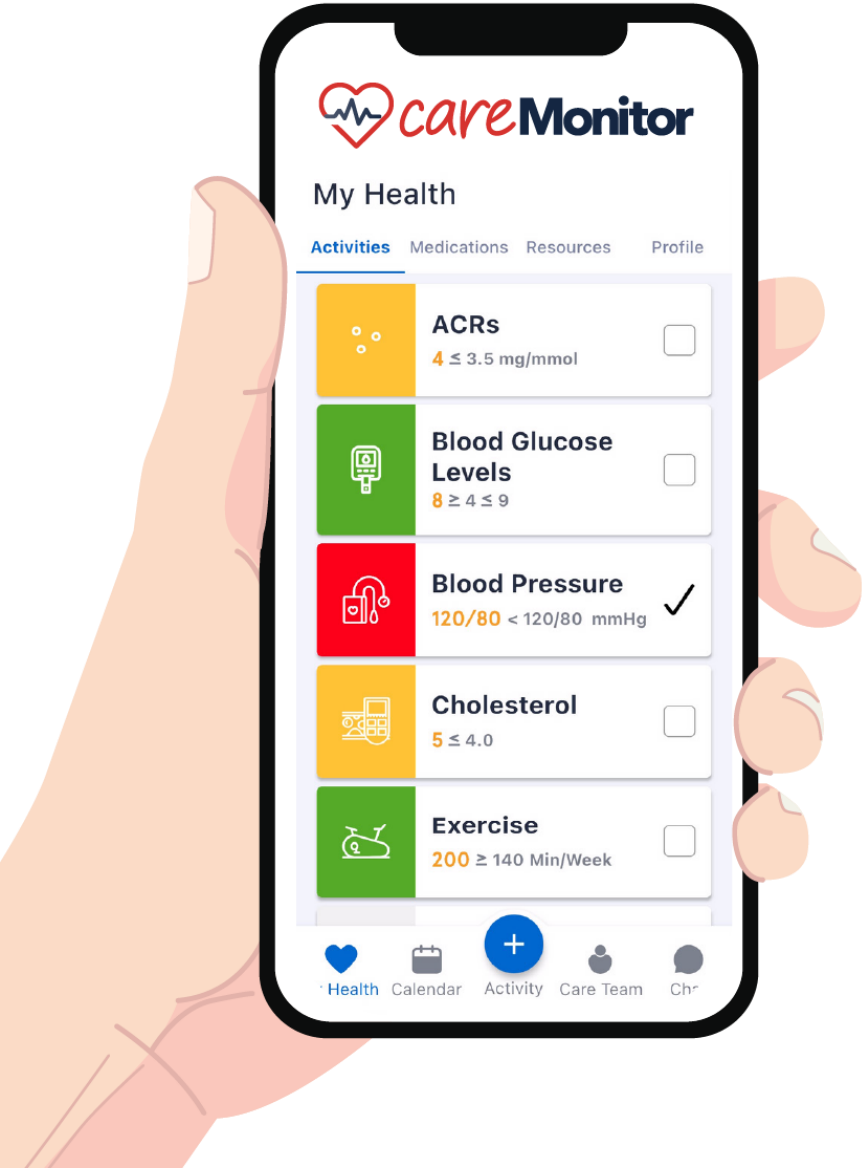
Y2: 899
Overall: 1,444
Episodes of Care in RAC after hours (evenings and weekends)

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.

careMonitor



Optimal Care in the Community

CareMonitor

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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, Elise Penton. 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.

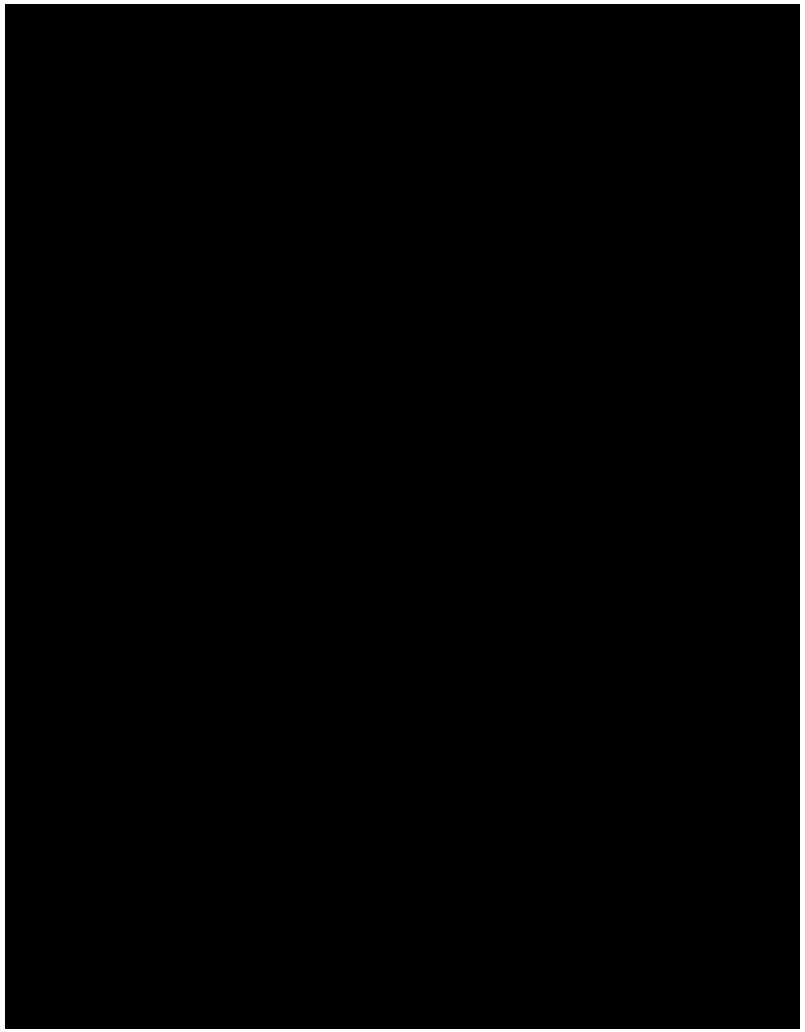
Their innovative “Winter Wellness Program” has become a local favourite, particularly for patients managing chronic obstructive pulmonary disease and chronic heart failure. The buzz around their Winter Wellness Program is palpable.

"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, Mr Harneet Gill.

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, Lauren and Miranda, 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,” Lauren 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, Lauren, Miranda 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.

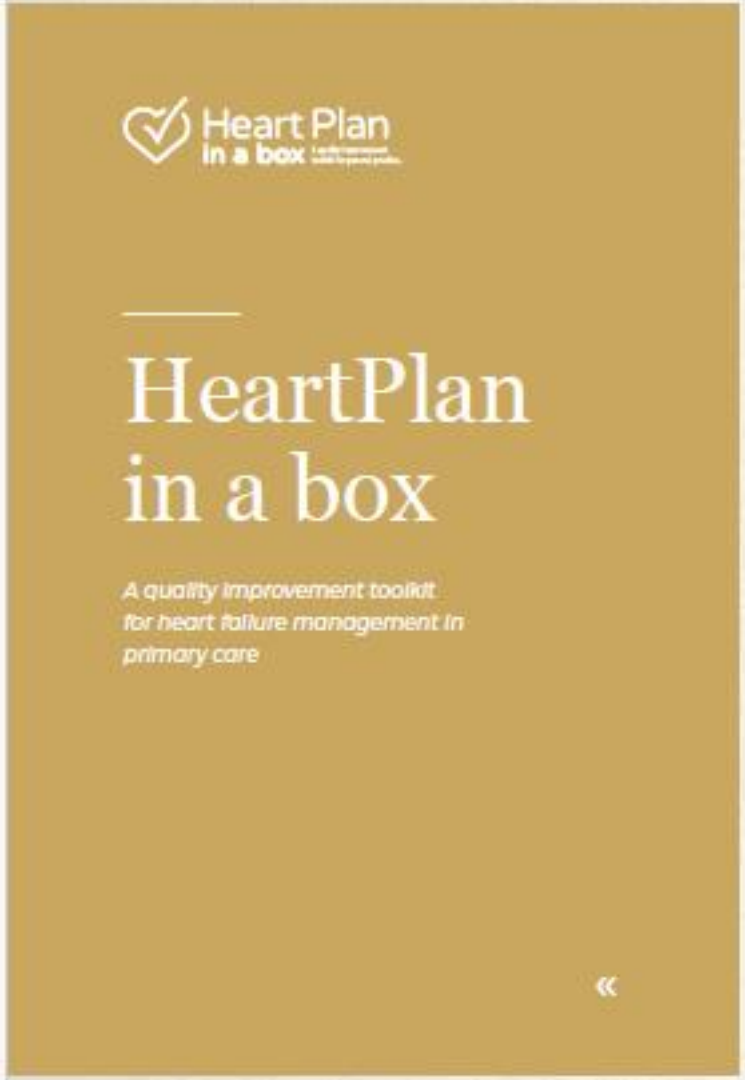
Staff report the benefits of collecting these measures include gaining a better understanding of the holistic needs of patients, and an ability to talk about their concerns in real time.

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

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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.

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.

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Patient feedback:

‘Fabulous’

Y2: 11
Overall: 19

Public respiratory clinics at Wagga Wagga Health Service Hub

Y2 : 110
Overall: 163

Patient interactions* at the Wagga Respiratory Clinic

Y2: 6
Overall: 6

Public Heart Failure Review Clinics at Wagga Wagga Health Service Hub

Y2: 32
Overall: 32

Patient interactions* at the Wagga Heart Failure review clinc

Y2: 5
Overall: 5

Public respiratory clinics at Griffith Ambulatory Care

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

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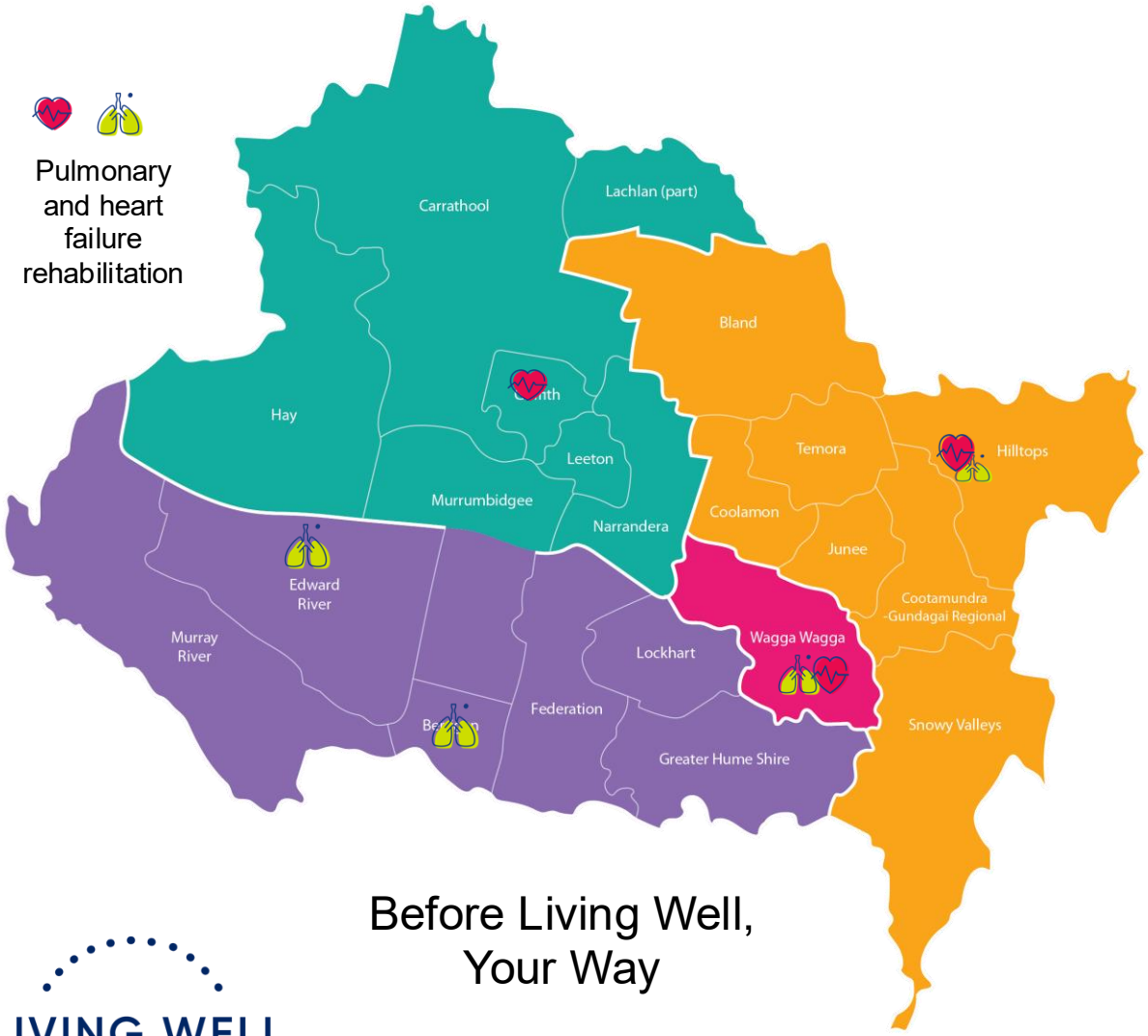
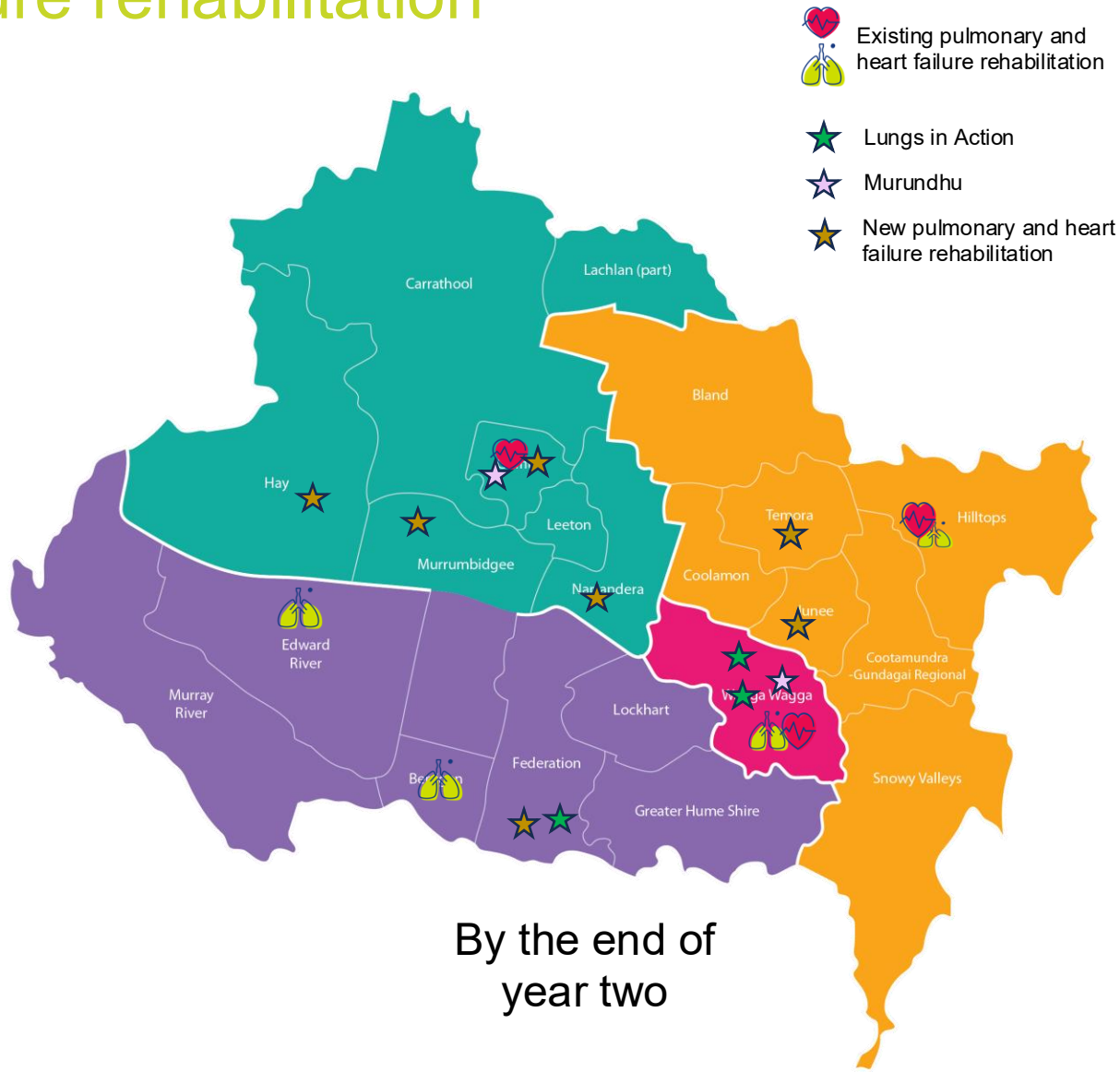
Access to pulmonary and heart failure rehabilitation



Before Living Well, Your Way



By the end of year two

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Restoring Function

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

LIVING WELL your way

*Thank you and acknowledgements to Amy Kilby at GAMs who designed the logos and artwork for the Murundhu program.

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 Dr Imran Kassam** (May 2024 in Griffith). Attended by 50+ clinicians.
- **Management of Complex Respiratory Conditions with A/P Adriaan Venter and Dr Timothy Gilbey** (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

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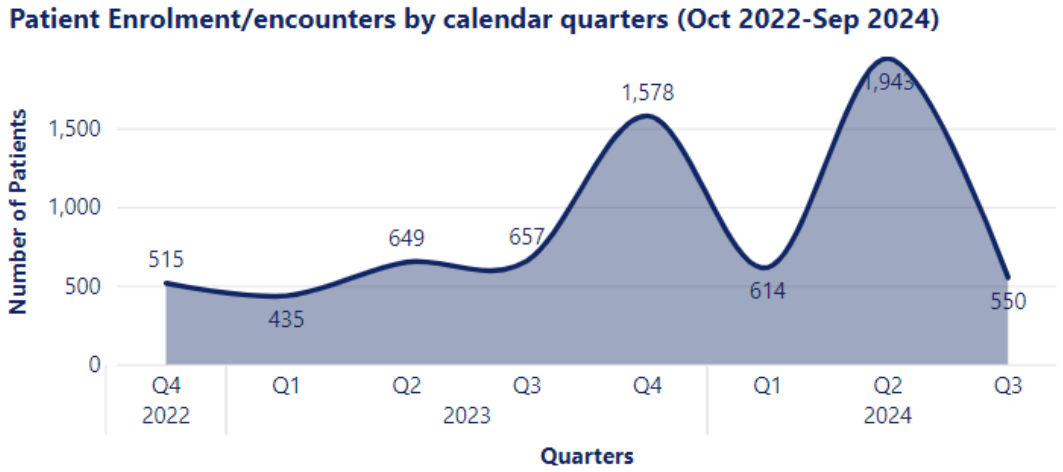
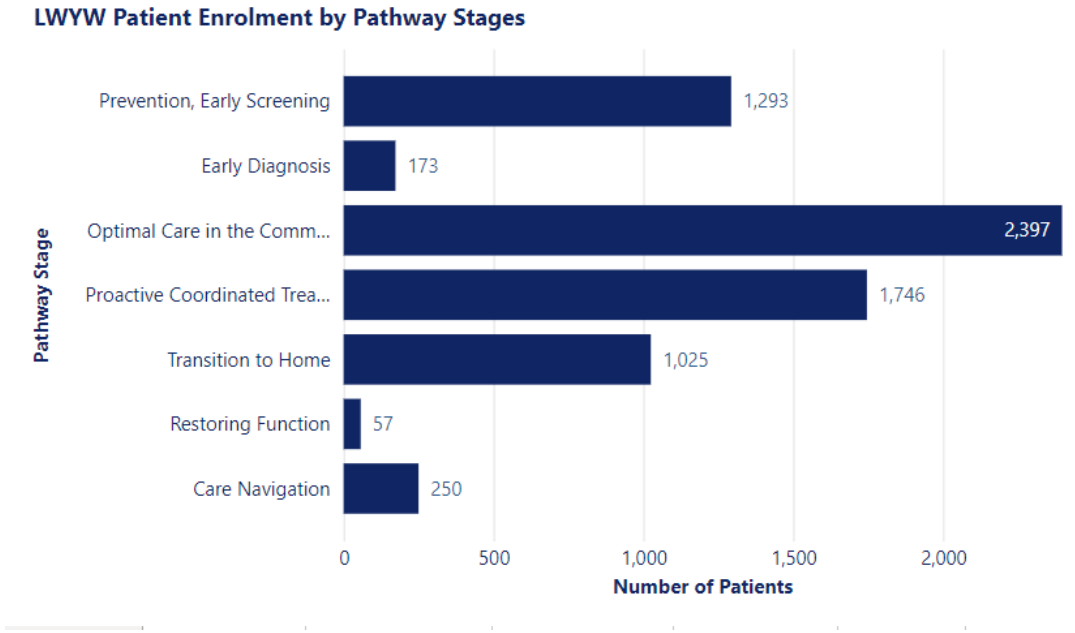
Living Well, Your Way Patient Enrolments

Number of patient encounters along the care pathway

Y2: 4,685

Overall: 6,941





*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.

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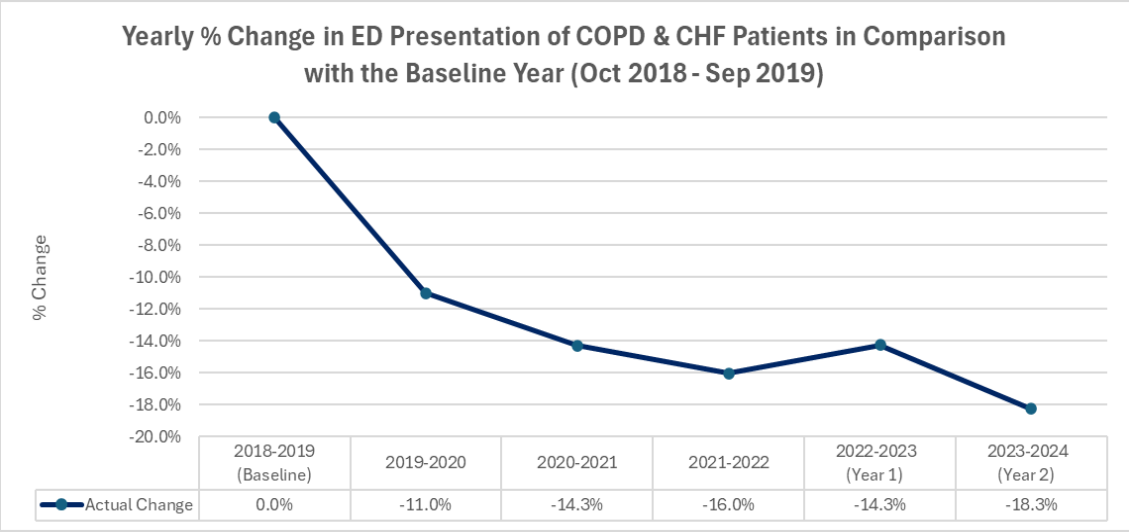
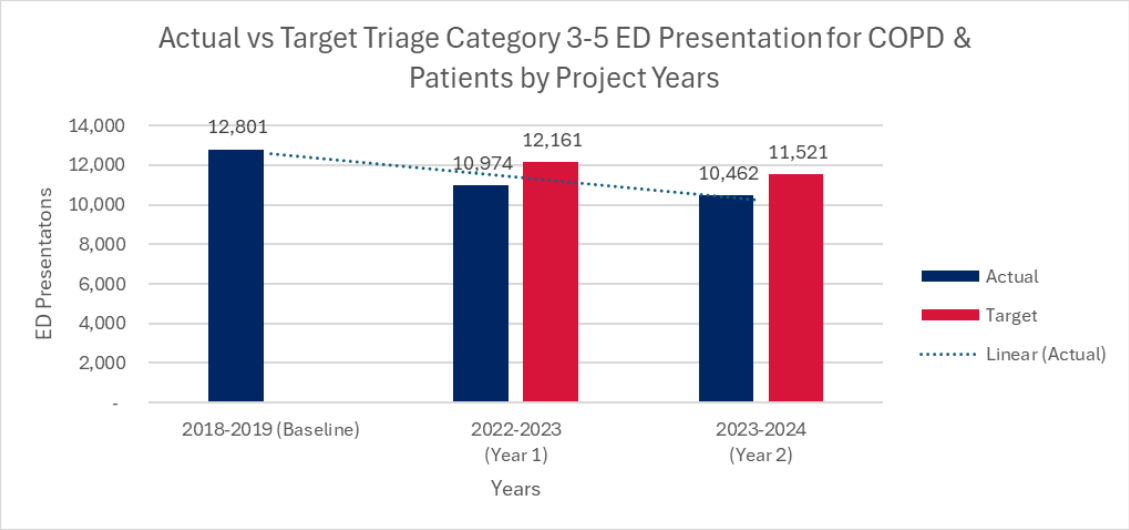
MLHD Triage 3-5 ED Presentations for people with COPD and Heart Failure





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 by 5% each year for three years (compared to a baseline year of 2018-19FY), for COPD and heart failure patients.

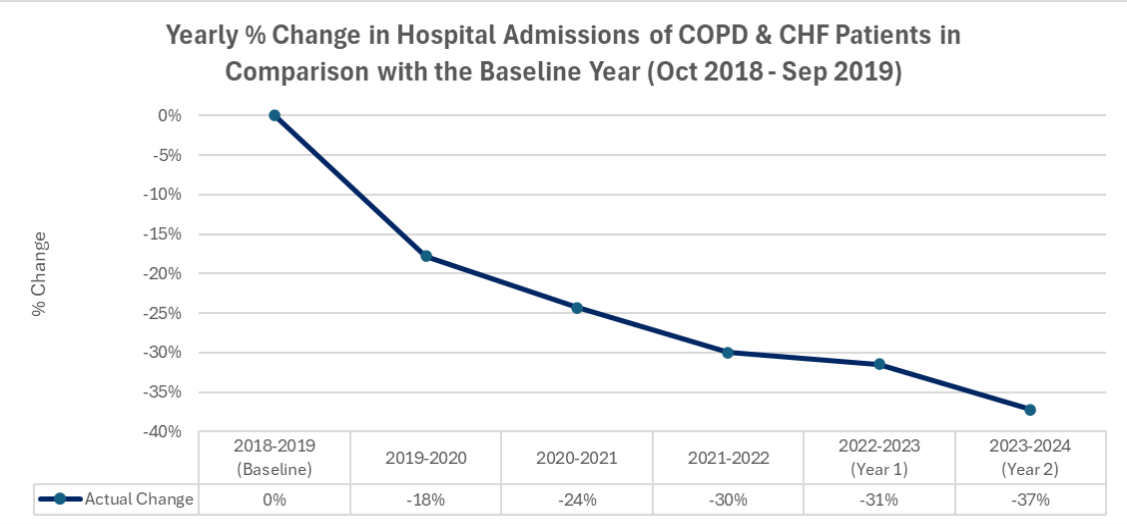
In the first year of LWYW, there was a 14.3% reduction in Triage 3-5 ED presentations compared to baseline, a great result.

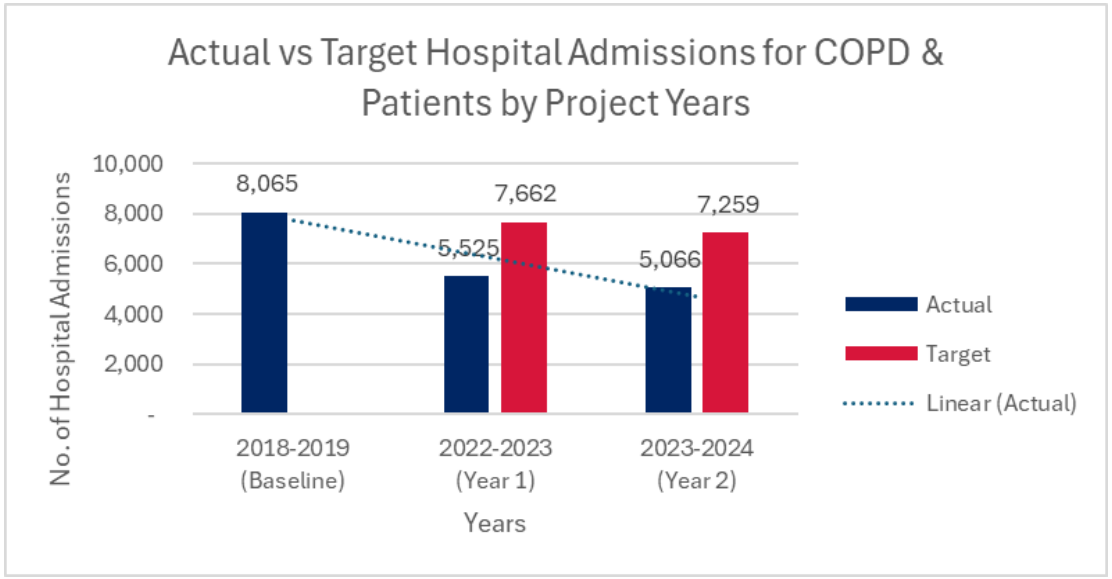
In year 2, we continued to see a reduction in ED presentations achieving an 18.3% reduction from 2018-19.

Project Year	Target Reduction	Actual Reduction	
One (2022-23)	5%	14.3%	✓
Two (2023-24)	10%	18.3%	✓

*Data Source: Internal monitoring data from MLHD for patients with any diagnosis code (ICD-10) for COPD and congestive cardiac failure.

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 compared to baseline (2018-19)

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: Internal monitoring data from MLHD for patients with any diagnosis code (ICD-10) for COPD and congestive cardiac failure.

Awards & Nominations

MLHD 2024 Excellence Awards

Outreach Heart Failure Diagnostic Clinic

- **Winner of the Chief Executive Choice Award**

[redacted]

Murundhu I live I breath

- **Finalist: Excellence in Aboriginal Healthcare**

[redacted]

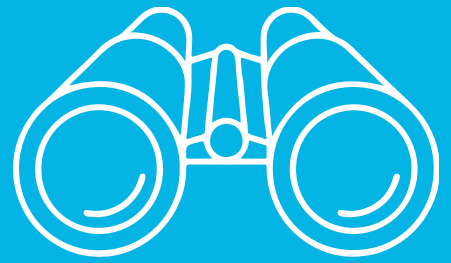
Pharmaceutical Society of Australia Conference (Aug 2024)

LWYW Pharmacy Screening Pilot

- **Winner: Best poster presentation (from 44 entrants)**

[redacted]

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
- A/Prof Adriaan Venter & Dr Timothy Gilbey
- Dr Alex Brennan
- MLHD Respiratory and Heart Failure Service
- Wagga Wagga Base Hospital Respiratory and Cardiac Advanced Trainees
- MPHN 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

LIVING WELL your way

MedicalDirector

marathon health
Better healthcare, closer to home

Heart Foundation

ROY CARDIOLOGY

Lung Foundation Australia

ST VINCENT'S PRIVATE COMMUNITY HOSPITAL GRIFFITH

careMonitor

RIVERINA CARDIOLOGY