Heart Failure Support Services in Queensland

Queensland Health (Statewide) Guideline

QH-GDL-517

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Contents

1. Purpose and Scope

This guideline provides a clinical framework for Heart Failure Support Services (HFSS) to support the implementation of best practice for patients with symptomatic heart failure in order to improve clinical outcomes, reduce avoidable hospitalisations, and ensure consistent, high-quality care across hospital and community settings.

Heart failure (HF) is a clinical syndrome caused by structural or functional cardiac abnormalities resulting in impaired cardiac output and/or elevated filling pressures (1).

Phenotypes include:

- HFrEF (heart failure with reduced ejection fraction ≤40%)
- HFmrEF (heart failure with a mildly reduced ejection fraction 41-49%)
- HFpEF (heart failure with preserved ejection fraction > 50%)
- HF related to valvular heart disease
- HF manifesting as isolated right heart failure
- HF related to pericardial disease

The aims are to:

- Improve outcomes for patients with symptomatic heart failure
- Optimise guideline-directed medical therapy (GDMT)
- Reduce avoidable hospitalisations
- Standardise service delivery of HFSS care across hospital and community settings

2. Heart Failure Support Service (HFSS) model of care

Multidisciplinary HFSS care reduces mortality and hospital readmissions, particularly in patients at high risk of decompensation (2). In Queensland Health there are 22 multidisciplinary HFSS that provide individually tailored programs which support patients at any phase in care.

Core Components of HFSS

- Early and structured post-discharge follow-up
- Medication review and optimisation and up titration of GDMT
- Individualised education and counselling
- Promotion of self-care (including flexible diuretic plans where appropriate)
- Rapid up-titration of GDMT
- Exercise rehabilitation
- Psychosocial assessment and support
- Advance care planning
- Escalation pathways to avoid ED presentations

Care may be delivered via face-to-face clinics, home visits, telephone, telehealth, and group rehabilitation programs. Services operate primarily weekday business hours, with escalation pathways also operating after hours.

Transitions of care

The key steps in the transitional care process following heart failure (HF) hospitalisation are in the figure below.

Figure 1: Key steps in transitional care following a heart failure hospitalisation in Australia (adapted from Sidone et al [3])

3. Referral and Eligibility for HFSS

Referral Sources

- Inpatient units
- Outpatient clinics
- GPs (following cardiology review)
- Other Queensland Heart Failure, Cardiac Rehabilitation or chronic disease services

Medical governance arrangements need to be clear and in keeping with local policies. This is particularly relevant for referrals from private cardiologists and other HFSS where the medical governance is at another site. Where no local medical mentor is available service governance pathways need to be developed with tertiary centres for virtual case conferencing.

Eligibility

All patients >16 years with confirmed symptomatic heart failure, regardless of aetiology.

4. Risk Stratification and Follow-Up

Follow-up intensity is determined by risk of decompensation. For all symptomatic patients HFSS should conduct:

- Initial comprehensive review within 2 weeks of hospitalisation or 4 weeks for outpatient referrals
- Regular medication optimisation reviews
- A six-month comprehensive review for stable patients with handover of care to GP
- Weekly or fortnightly MDT meetings for complex cases

Risk stratification and management are outlined in Table 1. Services should deliver patient-centred care and utilise existing models (e.g. HITH, virtual wards) to support diuresis, medication management, and infusion therapies (IV diuretics, IV iron). Coordination with GPs is required to ensure continuity of care.

Table 1: Managing the risk of decompensated heart failure

Risk level[1]	Factors determining risk	Management of risk
Intermediate	• NYHA II[1] • Adequate self-management and social support • Regular contact with GP	• Inpatient referrals: review by HFSS within 14 days • Outpatient referrals: review by HFSS within 30 days • Medication review and titration • Exercise referral • Ongoing education- individual or group • Specialist review if required
High	• NYHA III–IV[1] • Frailty, comorbidities, polypharmacy • Cognitive or social vulnerability • Two or more admission in last 12 months	• Review within 7 days (or sooner if unstable) • Access to rapid access HF clinic within 72 hours • Intensive medication titration • Structured exercise • Education re symptoms and self-management • GP communication • Consider palliative care referral • Completion of Heart Failure medication optimisation plan[3] as appropriate NB. Risk status may change rapidly and requires reassessment.

1. New York Heart Association (NYHA) Classification of heart failure places patients in one of four categories based on how much they are limited during physical activity.
2. Heart Failure Medication Optimisation plan available from: https://www.health.qld.gov.au/heart_failure/asp/med_titration

4.1 Medication Optimisation Pathway for Heart Failure

Early and intensive GDMT titration reduces mortality and readmissions. The STRONG HF trial, demonstrated intense intervention (at least 4 visits in 6 weeks post discharge) is required to implement new medical therapies that lead to reduction in heart failure hospitalisations and death within 6 months of hospital discharge (5). Appendix 3 details the recommended timelines for medication titration.

The aims are to:

- Initiate Guideline directed medical therapy (GDMT) at discharge and up-titrate to maximum tolerated doses within 6-12 weeks of discharge. (While best evidence suggests a 6-week time frame, this may be longer for some patients as clinical judgement should consider age, comorbidities, falls risk, living situation, and benefit versus risk.)
- Prescribe patients with Heart Failure with a reduced ejection fraction (HFrEF) all four pillars of medications (see table 2 below).
- Prescribe patients with Heart Failure with preserved ejection fraction (HFpEF) a SGLT2 inhibitor and MRA (finerenone preferred, spironolactone or eplerenone) (6).

Table 2: GDMT for Heart Failure with reduced ejection fraction (HFrEF)

Pillar	Medications
I.	Angiotensin Receptor-Neprilysin Inhibitors (ARNi) or Angiotensin Converting Enzyme inhibitors (ACEi) if intolerant to ARNi; or Angiotensin II Receptor Blocker (ARB) if intolerant to both ACEi and ARNi.* NB. Check PBS prescription limitations for ARNI initiation*
II.	Beta-blockers (Evidence-based): Metoprolol succinate, carvedilol, bisoprolol or nebivolol.
III.	Mineralocorticoid Receptor Antagonist (MRA): Spironolactone or eplerenone.
IV.	SGLT2 Inhibitors: Dapagliflozin or empagliflozin.

4.2 Multidisciplinary Reviews and Case Conferencing

Structured multidisciplinary reviews ensure comprehensive assessment and coordinated care planning for heart failure patients and improve outcomes.(5, 7)

Components of Multidisciplinary Review

- Clinical Assessment: Medical and nursing review of symptoms, examination findings, and functional status, health literacy and other potential barriers to management.
- Medication Optimisation: Pharmacist review of GDMT, comprehensive medication reconciliation to manage co-morbidities and rationalise polypharmacy, and adherence strategies
- Functional Assessment: Physiotherapy/exercise physiology evaluation of exercise capacity and physical function and occupational therapy assessment of functioning in daily life
- Nutritional Assessment: Dietitian evaluation of fluid and sodium intake, nutritional status, and weight management
- Psychosocial Assessment: Social work and psychology input for mood, coping, social support, and practical needs
- Advance Care Planning: Discussion of goals of care, prognosis, and treatment preferences +/- referral to Advance Care Planning service within HHS (as available) for completion of ACP documents.

Multi-disciplinary team (MDT) conferencing

Heart Failure multi-disciplinary team (MDT) meetings should be weekly or fortnightly depending on service size and patient volume and attended by heart failure cardiologist/physician, nurses, pharmacist, physiotherapist/ exercise physiologist, dietitian, occupational therapist, social worker, palliative care (as needed). The focus should be for new and complex patients, for example, those not responding to therapy, complex comorbidities, requiring advanced heart failure therapies or end-of-life planning.

4.3 Support of Regional HFSS

Where local medical support is not available, formal links should be established with tertiary centres for remote case conferencing. This is particularly important for:

- Regional and rural services without local cardiologist support
- Complex cases requiring advanced heart failure expertise
- Patients being considered for transplant or LVAD assessment
- Device management queries (ICD, CRT, pulmonary artery monitors)
- Education and mentorship for developing services

4.4 Rapid Access Review and ED Avoidance

Rapid access review is recommended where funding is available as it can prevent emergency department presentations and subsequent hospitalisations.

Rapid Access Heart Failure Treatment Services (RAHFTS) provide management for patients with worsening heart failure symptoms within 72 hours, aiming to prevent emergency department presentations and hospitalisations.

Service Model:

- **Access:** Patients known to the HFSS can self-refer or be referred by their GP/treating team for urgent review within 24-48 hours
- **Assessment:** Clinical examination, point-of-care testing (NT-proBNP, BNP, renal function), ECG, and imaging as required
- **Intervention:** IV diuretic administration, medication adjustment, fluid management planning
- **Follow-up:** Same-day or next-day review as needed until stabilised

Staffing and resources for heart failure rapid access:

- Nurse Practitioner or Clinical Nurse Consultant with prescribing authority
- Medical specialist oversight (cardiologist or physician with heart failure expertise)
- Access to treatment space and IV infusion capability
- On site or point-of-care pathology testing
- Dedicated appointment slots held for urgent presentations

5. Discharge from a HFSS and referrals

Discharge requires confirmation that:

- The patient can recognise deterioration
- Patient can manage symptoms and is aware of physical activity recommendations
- An action plan is in place
- GDMT is optimised or maximally tolerated
- GP and specialist follow-up appointments are in place
- LV function has been reviewed

Following optimisation of GDMT, some patients may require consideration for advanced therapies or specialist review.

HFSS should facilitate timely referral for:

- Electrophysiology review when deemed appropriate by treating cardiologist where EF ≤35% despite optimal therapy
- Advanced medical HF services (if persistent NYHA III–IV, two or more admission in 12 months, haemodynamic intolerance to therapy, ejection fraction less than 25%, repeated ICD therapy, persistent fluid overload, second organ failure, need for inotropes)
- Left ventricular assistive device or transplant assessment (selected patients)
- Early palliative care integration when appropriate

Referral to subspecialties (sleep medicine, thoracic medicine, endocrinology, nephrology, geriatrics, haematology) should occur as clinically indicated.

6. Optimal Workforce and Caseload Recommendations for HFSS

HFSS require a dedicated, multidisciplinary workforce managing a sufficient patient volume to deliver safe, high-quality and cost-effective care.

Workforce recommendations below are based on:

- Consensus across 22 Queensland HF services (Delphi methodology)
- Analysis of direct clinical care time
- Evidence from heart failure, rehabilitation, and chronic disease workforce literature

Adequate staffing is linked to reduced mortality, fewer readmissions, shorter length of stay, and quality of life.

6.1 Core Workforce

Staffing per 50–100 Active Patients

Table 3: Recommended workloads for Heart Failure Support Services

Role	Recommended FTE
Medical sponsor	Governance role (no dedicated FTE)
HF Nurses (CNC/NP/CN)	1.0–2.0
Physiotherapist/Exercise Physiologist	0.8–1.0
Clinical Pharmacist	0.8–1.0
Dietitian	0.4–0.6
Social Worker/Psychology/OT (as required)	0.4–0.6
Administration	0.4–0.6

6.2 Caseload Definitions (Critical for Workforce Planning)

Heart failure caseloads should be differentiated (active / deactivated) to guide appropriate staffing.

1. Active Caseload

Patients requiring regular clinical contact (weekly to monthly), typically:

- First 3–6 months post diagnosis
- Post hospitalisation
- During medication optimisation and stabilisation

These patients consume the majority of clinical time.

2. Deactivated Caseload

Clinically stable patients who:

- Have achieved optimal medical therapy
- Demonstrate self-management capability

Patients are discharged from active management but may be reactivated if clinically indicated.

3. Rural and Remote Services

Require additional FTE to account for increased travel time, telehealth coordination, building local clinical capability and reduced access to onsite specialist services.

4. Rapid Access Clinics

Services managing acute decompensation require:

- Dedicated clinical staffing
- Protected appointment capacity
- Additional administrative support

Rapid access capacity cannot be absorbed into standard outpatient staffing without impacting routine care.

6.3 Workforce Planning Assumptions

Service modelling assumes:

- HFSS care spans inpatient education, discharge planning, early follow-up, and longitudinal outpatient management.
- Typical duration of HFSS involvement: 6–12 months per patient.
- Senior HF nurses provide continuity and deliver the strongest outcomes.
- High reliance on rotational or short-term staff reduces continuity, increases training burden, and weakens outcomes.
- Services operate primarily on weekdays; after-hours support is via referral pathways.
- Workforce planning must include leave backfill and protected professional development time.
- Rapid access models require additional capacity beyond baseline FTE.

6.4 Evidence for Investment in HFSS

Structured, multidisciplinary HF care produces measurable clinical and economic returns.

Documented Outcomes

Intervention	Demonstrated effect
Inpatient nurse staffing	Higher nurse staffing is associated with reduced mortality and 30-day readmissions. Each additional patient per nurse is associated with a 7% increase in HF readmission risk; higher nurse staffing levels per inpatient are associated with lower excess readmissions (9-13).
Queensland nurse-to-patient ratio legislation	Associated with reduced mortality, fewer preventable readmissions, and shorter length of stay (14) (*Lancet*, 2021).
HF specialist nurses (outpatient)	~35% reduction in all-cause admissions, improved medication titration, quality of life and psychosocial outcomes; substantial cost savings per 1,000 patients. Typical active caseload: 50–60 patients per nurse Improved patient outcomes, quality of life, medication titration, psychosocial support (15-18).
Pharmacist integration	Reduced HF hospitalisations by 28%, all-cause hospitalisations by 24%; improved medication optimisation and adherence(19, 20).
Exercise-based cardiac rehabilitation	Reduced HF hospitalisations by 18%, all-cause hospitalisations by 18%(4); may improve exercise capacity and quality of life. .

6.5 Clinical Roles and Accountability

Medical Sponsor

- Cardiologist or physician providing clinical governance and oversight
- Rural/remote services require formalised tertiary links with telehealth support and case conferencing

Nursing Workforce (Core Service Delivery)

Nurses are the central coordinators of HFSS care.

- **Clinical Nurse Consultant (CNC):**
    - Clinical leadership
    - Post-discharge follow-up
    - Education and service evaluation
- **Clinical Nurse (CN):**
    - Direct patient care
    - Monitoring and coordination under CNC/NP supervision

- **Nurse Practitioner (NP):**
    - Advanced assessment and investigation
    - Medication prescribing and titration
    - Rapid access clinic management
    - Case coordination

For service sustainability, more than one NP is recommended where prescribing models are implemented.

Allied Health (Integrated or Referral-Based)

Specialist heart failure allied health service provision across the continuum and transitions of care and multidisciplinary collaboration and patient education specific to discipline expertise:

- **Pharmacist**: medicines management (GDMT optimisation, medication safety, collaborative prescribing models where supported within the health service).
- **Physiotherapy / Exercise Physiology**: Exercise Rehabilitation
- **Dietitian**: Nutritional and malnutrition management
- **Social Work / Psychology**: Psychosocial support
- **Occupational Therapy**: Functional optimisation

Administration

Essential for appointment coordination, data collection and reporting, registry submission, and performance monitoring.

7. Quality Indicators

All services should register new referrals into the Heart Failure module of the Queensland Cardiac Outcome Registry (QCOR) (24). Indicators currently collected by the Queensland Cardiac Outcome Registry are in appendix 2.

Key process clinical indicators include:

- Timely follow-up of referrals (≤14 days post discharge and 30 days for outpatients)
- LV function assessment within 2 years
- GDMT prescription and target dose achievement
- Quadruple therapy rates (HFrEF)
- SGLT2 inhibitor use (all patients)
- Exercise referral and uptake

Services should benchmark outcomes and participate in statewide quality improvement initiatives. Outcomes reported include readmission rates, average length of stay, mortality rates, and hospital utilisation.

Indicators sensitive to staffing capacity

- Time from referral to first contact (<14 days for post-discharge, <28 days for outpatient referrals) *
- Proportion of eligible patients achieving target doses of beta blockers
- Proportion of eligible patients prescribed all 4 pillars of guideline-directed medical therapy*
- 30-day and 90-day heart failure readmission rates
- Staff wellbeing metrics including satisfaction and burnout indicators
- Patients experience measures and satisfaction scores
- Waiting list length and time to follow-up appointment

**Reported to sites by QCOR*

8. Statewide Governance

Queensland has a Statewide Heart Failure Steering Committee that reports to the Queensland Cardiac Clinical network.

A statewide HFSS coordinator and administration support are recommended to:

- Support benchmarking
- Facilitate education, workforce development, and quality improvement
- Coordinate service improvement
- Maintain registry data quality
- Maintain and support and the Lived Experience Advisors Committee

9. Definitions

Term	Definition / Explanation
HF	Heart Failure, a clinical syndrome characterised by structural or functional cardiac abnormalities resulting in impaired cardiac output and/or elevated filling pressures.
HFSS	Heart Failure Support Service, a multidisciplinary service providing coordinated care for patients with heart failure.
HFrEF	Heart failure with reduced ejection fraction (≤40%).
HFmrEF	Heart failure with mildly reduced ejection fraction (41-49%)
HFpEF	Heart failure with preserved ejection fraction (>50%).
GDMT	Guideline-Directed Medical Therapy, evidence-based pharmacological treatment for heart failure.
MDT	Multidisciplinary Team, a group of healthcare professionals involved in coordinated patient care.
NYHA	New York Heart Association classification system used to categorise heart failure severity based on functional limitation.
HFSS active caseload	Patients requiring regular clinical contact, typically during early post-diagnosis, post-hospitalisation, or medication optimisation.

Term	Definition / Explanation
HFSS deactivated caseload	Clinically stable patients who have achieved optimal therapy and self-management capability and no longer require active HFSS follow-up.
Advanced heart failure	Persistent severe symptoms despite optimal therapy, often requiring specialised interventions such as device therapy, inotropes, or transplant assessment.
RAHFTS	Rapid Access Heart Failure Treatment Services, providing urgent outpatient management of worsening heart failure to avoid hospitalisation.
QCOR	Queensland Cardiac Outcomes Registry, a statewide registry for monitoring cardiac outcomes and quality indicators.
HHS	Hospital and Health Service.

10. Aboriginal and Torres Strait Islander considerations

Heart Failure Support Services must be planned, delivered and evaluated in partnership with Aboriginal and Torres Strait Islander peoples to ensure care is culturally safe, accessible, and responsive to community needs.

Services will:

a) Recognise and respect the rights of Aboriginal and Torres Strait Islander peoples to self-determination.

b) Ensure culturally safe and responsive care that acknowledges the impact of colonisation, intergenerational trauma, and social determinants of health.

c) Support equitable access to evidence-based heart failure care and reduce disparities in outcomes.

d) Promote shared decision-making that incorporates cultural, spiritual, and community contexts.

11. Human Rights

All Heart Failure Support Services must act and make decisions in a way that is compatible with the *Human Rights Act 2019* and give proper consideration to human rights in the delivery of care.

A HFSS should:

a) Integrate human rights considerations into clinical decision-making and service design.

b) Support informed consent and respect patient autonomy.

c) Provide reasonable and necessary adjustments to support vulnerable or disadvantaged individuals.

d) Ensure accessibility of services, including for rural and remote populations.

12. Legislation

Queensland Legislation

- *Hospital and Health Boards Act 2011*
- *Hospital and Health Boards Regulation 2023*
- *Public Health Act 2005*
- *Human Rights Act 2019*

Information and Decision-Making

- *Information Privacy Act 2009*
- *Guardianship and Administration Act 2000*
- *Powers of Attorney Act 1998*

Aboriginal and Torres Strait Islander Context

- *Path to Treaty Act 2023*

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14. Approval details

Custodian	Contact Details	Approval Date	Approval
Healthcare Improvement Unit, Clinical Excellence Queensland	Queensland Cardiac Clinical Network, Department of Health, GPO Box 48, Brisbane QLD 4001, HIU@health.qld.gov.au.	23 June 2026	Endorsed by the Statewide Heart Failure Steering Committee of the Queensland Cardiac Clinical Network.

15. Version control

Version	Date	Prepared by	Comments
1.0	23 June 2026	Statewide Heart Failure Services, Metro North Hospital and Health Service	This document has been reviewed by the Queensland Health Statewide Heart Failure Steering consisting of expert cardiologists, general physicians, senior nurses, pharmacists and physiotherapists and member of the Queensland Clinical Cardiac Network.

Appendix 1: Tools for assessment and management

National Heart Foundation of Australia

The Heart Foundation has many online educational tools and short videos for people with heart failure. A good introduction for all patients is the Living well with heart failure (overview of self-management).

Queensland Heart Failure Services

https://www.health.qld.gov.au/clinical-practice/referrals/statewide-specialist-services/heart-failure-services

This site contains a range of practical resources:

For clinicians:

End stage heart failure

Heart Failure: End-stage management guideline

Heart failure medication optimisation plan

https://www.health.qld.gov.au/__data/assets/pdf_file/0018/428121/Medn_Titration.pdf

For Patients and carers:

Weight and symptom diary

Fluid action plan

Sodium-glucose co-transporter-2 (SGLT2) inhibitors for heart failure - patient information sheet

Booklets:

Physical activity, exercise, and heart failure

Medications to manage heart failure

Heart failure a guide for families and carers booklet (PDF 550 kB)

Useful websites for patients

National Prescribing Service MedicineWise Information for consumers

Heart Failure Matters: Comprehensive site for patients with heart failure in several languages

Appendix 2: Clinical Indicators

Below are the clinical indicators in the Heart Failure Module of the Queensland Cardiac Outcomes Registry (QCOR)

Follow up times and assessment

1. **Timely follow-up by a HF support service for:**
a) Inpatient referral (within 14 days post hospital discharge)
b) Outpatient referrals (within 4 weeks)

2. **Assessment of left ventricular function within the last 2 years (all types of HF)**
a) Within the last 2 years at time of first clinical review
b) Repeat assessment at time of 6-month review (or deactivation – whichever is sooner)

Status at first clinical review

3. **Medication prescription for HFrEF at first clinical review:**
a) ACEI or ARB or ARNI
b) Guideline recommended beta blockers (Bisoprolol, Carvedilol, Metoprolol sustained release, or Nebivolol)
c) Mineralocorticoid receptor antagonist (MRA)
d) SGLT2 inhibitors
e) Quadruple therapy (ARNI/ACEI/ARB + Betablocker + MRA + SGLT2 inhibitor)

4. **Medication prescription for HFpEF at first clinical review:**
a) Sodium-Glucose Co-Transport (SGLT2) inhibitors

Status at 6 months from the first clinical review/referral or deactivation from service

5. **Patients reviewed at 6 months or on deactivation %**

6. **Medication prescription for HFrEF at 6 months or on deactivation**
a) ACEI or ARB or ARNI
b) Guideline recommended beta blockers (Bisoprolol, Carvedilol, Metoprolol sustained release, or Nebivolol)
c) Mineralocorticoid receptor antagonist (MRA)
d) SGLT2 inhibitors
e) Quadruple therapy (ARNI/ACEI/ARB + Betablocker + MRA + SGLT2 inhibitor)

7. **Medication prescription for HFpEF at 6 months or on deactivation**

8. **Beta blocker (HF specific) target dose or maximum tolerated dose (HFrEF only)**

9. **Exercise status (HFrEF and HFpEF)**
a) Patients referred to an exercise program
b) Patients referred to an exercise program who have commenced a group, individual or home exercise program

Key

HFrEF = Heart failure with reduced ejection fraction

HFpEF = Heart failure with preserved ejection fraction

ACEI =Angiotensin converting enzyme inhibitor

ARB = Angiotensin II receptor blocker

ARNI = Angiotensin receptor-neprilysin inhibitor

MRA = Mineralocorticoid receptor antagonists

SGLT2 = Sodium-glucose cotransporter-2 inhibitors

Appendix 3: Medication Optimisation Timelines

The following timeline and actions reflect the 2025 consensus statement on medication optimisation (6). Evidence from the STRONG-HF trial (5) demonstrates that early (within 2 weeks of discharge) up-titration of guideline-directed medical therapy with close follow-up over a two-month period significantly reduces the risk of death or heart failure readmission at 180 days.

Table 4: Timeline for medication optimisation

Period	Actions
Pre-discharge	• Initiate all GDMT therapy where appropriate • Refer to HFSS • Arrange review within 14 days
Weeks 1–2	• Phone contact within 48–72 hours • Review and titrate medications
Weeks 3–12	• Continue up-titration • Monitor renal function and NT-proBNP • Address comorbidities • Commence exercise rehabilitation
Beyond 2 months	• Maintain target doses • Repeat echocardiography at 6 months • Consider device or advanced therapy referral • Transition to shared GP care where appropriate

Phase 1: Pre-Discharge (During Index Hospitalisation)

- Initiate each pillar of GDMT prior to discharge unless contraindicated: ARNi (preferred over ACEi/ARB), beta blocker (once decongested), MRA, and SGLT2 inhibitors.
- For HFpEF: SGLT2 inhibitors and MRA (finerenone preferred); consider GLP-1 based therapies if BMI ≥30 kg/m² (25, 26) noting List of Approved Medicine [LAM] restrictions.
- Target at least 50% of recommended doses of GDMT.
- Refer to HFSS for heart failure education including fluid monitoring and management.
- Complete Heart Failure Medication Optimisation Plan and send to GP for services without access to titration clinics.
- Ensure adequate iron stores
- Arrange follow-up appointment with HFSS within 14 days

Phase 2: Post-Discharge (Week 1-2)

- Phone contact within 48-72 hours to assess symptoms, medication adherence, and daily weights.
- Review within 7-14 days (ideally face to face) to assess fluid status, blood pressure, heart rate, and renal function.
- Target up-titration to 100% of recommended doses if tolerated and adjust diuretics as needed.
- Exercise caution with up-titration when: systolic BP <95 mmHg; heart rate <55 bpm; serum potassium >5.0 mmol/L; or eGFR <20 mL/min/1.73m². An increase in serum creatinine up to 25–30% from start of titration may be tolerated. Consider potassium binders (e.g. patiromer) for recurrent hyperkalaemia to facilitate ongoing RAAS inhibitor use.
- Reinforce self-management strategies.

Phase 3: Optimisation (Week 3-8)

- Follow-up visits to monitor progress.
- Monitor NT-proBNP levels to guide therapy optimisation. If NT-proBNP is >10% higher than pre-discharge, consider increased diuretics and slower beta blocker up-titration.
- Continue medication up-titration towards target doses.
- Address comorbidities (diabetes, renal function, anaemia, iron deficiency).
- Refer patient to exercise rehabilitation.
- Review psychosocial needs and provide support.

Phase 4: Management (2 Months +)

- Maintain target doses or maximum tolerated doses of GDMT.
- Review echocardiography at 6-months to assess for LV recovery.
- Consider device therapy (ICD/CRT) for eligible patients with persistent reduced LVEF.
- Assess need for advanced therapies referral.
- Transition to GP-shared care with ongoing HFSS support as required.
- Plan for long-term disease management and self-care sustainability