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### **Proposal for investment in ongoing multidisciplinary heart failure care in the ACT**

The Heart Foundation ACT, in collaboration with ACT Medicare Local, would like to submit a proposal for inclusion in the 2012-13 Budget to support ongoing multidisciplinary chronic heart failure (CHF) care in the ACT.

CHF is a complex clinical syndrome that occurs when the heart fails to pump enough blood to satisfy the needs of the body. Each year approximately 30,000 Australians receive a diagnosis of CHF, costing the economy in excess of \$1 billion.

While traditionally CHF patients have had high rates of hospitalisation and readmission for acute exacerbations, it is estimated that up to two-thirds of these admissions could be avoided through improved adherence to therapy, adequate access to medical and social support for patients and carers, and appropriate responses to acute exacerbations or signs of deterioration. Access to multidisciplinary CHF care can significantly reduce the risk of hospitalisation, improve quality of life, reduce health care costs and prolong the survival of CHF patients.

The attached proposal seeks support to extend and expand the current ACT Multidisciplinary CHF Care Service Pilot. The proposed model will support best practice care for all patients with CHF, providing appropriate services for people experiencing varying severity of disease and across their continuum of care. The model is based on the Heart Foundation's evidence-based guidelines and has been developed locally by the ACT Divisions of the Heart Foundation and Medicare Local, in consultation with clinicians from both the Canberra and Calvary Hospitals, and representatives from ACT Community Care.

We appreciate the ACT Government's consideration of this joint funding proposal. Should you require further information on any aspect of the proposal, please do not hesitate to contact the Heart Foundation on telephone (02) 6282 5744.

Yours sincerely

Tony Stubbs  
Chief Executive Officer  
Heart Foundation – ACT

Steve Sant  
Chief Executive Officer  
ACT Medicare Local



## **Multidisciplinary chronic heart failure care for the ACT**

### **1. Introduction**

Chronic heart failure (CHF) costs our community lives, health and money. Every year an estimated 30,000 Australians receive a diagnosis of CHF<sup>1</sup>. The cost has been estimated at more than \$1 billion per year<sup>2</sup>.

CHF patients have high rates of hospitalisation and readmission for acute exacerbations, however, up to two-thirds of CHF related hospital admissions could be avoided by improved adherence to therapy, adequate access to medical and social support for patients and carers, and appropriate response to acute exacerbations or signs of deterioration<sup>3</sup>. Access to multidisciplinary CHF care can significantly reduce the risk of hospitalisation, improve quality of life, reduce health care costs and prolong survival<sup>4</sup>.

Recent improvements in the management of Acute Coronary Syndrome (ACS) in the ACT have resulted in the ACT having a best practice model in place. The cardiac rehabilitation services in the ACT consistently have significantly higher referral and completion rates than in any other jurisdiction.

The under resourcing of CHF services has, by contrast, meant that the management of CHF in the ACT has not been best practice for many patients and has failed to meet the needs of this complex patient group. The lack of a CHF multidisciplinary service has resulted in CHF patients being referred to the cardiac rehabilitation programs which are designed for patients post myocardial infarction. The structure of these programs do not directly address and care for the very specific needs of CHF patients who have different educational needs, require closer monitoring and have different multidisciplinary team requirements.

The Multidisciplinary CHF Care Service Pilot has gone some way to addressing these concerns. The Pilot, which commenced in July 2011, has seen the establishment at the Canberra Hospital of a dedicated outpatient heart failure service. Notwithstanding this, further work is required to deliver a model that complies with current best practice guidelines for the management of CHF and delivers coordinated care for CHF patients in the ACT.

A new approach to CHF services in the ACT would be consistent with the current health reform agenda and ensure that high quality, evidence based care is available for all Canberrans diagnosed with CHF.

The National Health and Hospital Reform Commission (NHHRC) identified the following areas for improvements to health care in Australia:

- tackling major access and equity issues affecting health outcomes

- redesigning the health system so that it is better positioned to respond to emerging challenges
- creating an agile and self-improving health system for long-term sustainability.

The Heart Foundation also has its position statement *Multidisciplinary care for people with chronic heart failure: principles and recommendations for best practice*<sup>5</sup> (August 2010). This document provides clear direction on how to improve CHF services and meet some of the challenges outlined in the NHHRC work.

## **2. What is Heart Failure?**

CHF is a complex clinical syndrome that is frequently, but not exclusively, characterised by objective evidence of an underlying structural abnormality or cardiac dysfunction that impairs the ability of the left ventricle (LV) to fill with or eject blood, particularly during physical activity. Symptoms of CHF (e.g. dyspnoea, fatigue) can occur at rest or during physical activity.

Systolic heart failure (the most common form of CHF) is characterised by weakened ability of the heart to contract.

Heart failure with preserved systolic function (HFPSF; also known as diastolic heart failure) is characterised by impaired relaxation and/or abnormal stiffness of the LV in response to exercise or a volume load, despite normal ventricular contraction.

## **3. Current burden of Chronic Heart Failure in Australia and the ACT**

The Heart Foundation position statement notes that an estimated 30,000 Australians receive a diagnosis of CHF each year<sup>4</sup> and the cost has been estimated at more than \$1 billion per year<sup>2</sup>.

According to the Australian Institute of Health and Welfare, over 49,000 Australians were hospitalised due to CHF in 2007–08<sup>6</sup>. Although admission rates for CHF appear to have stabilised, the contribution of CHF to total bed-days attributed to circulatory diseases appears to be increasing. Within the ACT, hospitalisations due to heart failure increased by 26% in 2008-09<sup>6</sup>.

The Heart Foundation position statement notes that CHF is 1.7 times more common among Indigenous Australians than non-Indigenous Australians, and occurs at a younger age<sup>4</sup>. Indigenous Australians are also significantly more likely to die from CHF than non-Indigenous Australians (standardised mortality ratio 2.1 for men and 2.4 for women).<sup>6</sup>

In the ACT hospital discharge data provides a record of hospital admissions and presentations with a primary or secondary diagnosis of CHF, however, this data is currently not in a format that is useful without significant additional analysis. In addition data is lacking on CHF prevalence in the wider ACT population and hospital usage by this population group.

The Canberra Hospital data indicate that there were 1013 admissions in 2008 and 985 admissions in 2009 where CHF was either a principal or secondary diagnosis. The total number of hospital days was 8985 days in 2008 and 9056 days in 2009. Additional analysis would be required to determine readmissions and ACT residency status.

#### **4. Purpose and Scope of this document**

This paper aims to outline a proposed new approach to multidisciplinary CHF care in the ACT, building on the Multidisciplinary CHF Care Service Pilot currently in train at The Canberra Hospital (TCH). The proposed model aims to support best practice care for all patients with CHF, providing appropriate services for people experiencing varying severity of disease and across their continuum of care. While this paper aims to provide clear direction for multidisciplinary CHF care in the ACT, more detailed service planning and costing would need to be completed as a next step.

#### **5. Consultation process**

The Heart Foundation has had a long term interest in the provision of services for people with CHF. Prompted by the opportunity to enhance services for people with CHF via the COAG funding for sub acute services, a small working group comprising Heart Foundation staff, Professor Leonard Arnolda representing TCH cardiology, Dr Peter French representing Calvary Hospital cardiology and Phil Lowen, Jessy McGowan and Dr Jenny Thomson representing ACT Division of General Practice (now ACT Medicare Local), was formed in 2010. The aim of the group was to discuss and progress the development of a new model of care for CHF in the ACT.

The working group met three times in developing the model of care presented in this document and played an instrumental role in securing support for the current Multidisciplinary CHF Care Service Pilot.

Discussions were also held with the following individuals to gain a full understanding of system parameters and opportunities for a new model of care.

- Ineke Bleeker, Cardiac Rehabilitation CNC, CHC
- Margaret Flaherty, Cardiac Rehabilitation CNC, TCH
- Denise Gibson, Heart Failure CNC, TCH
- ACT Community Care, Continuing Care program, Helen Mathews (Allied Health Manager), Kate O'Brien (Acting Nutrition Manager) and Maree Sullivan (Health Promotion Advisor).

#### **6. CHF management in Australia and the ACT**

CHF care is distinguished from generic chronic disease management programs by the special needs of patients with CHF (e.g. ongoing medication titration, symptom monitoring and management of devices). These needs require specialised services from a multidisciplinary team to achieve best outcomes for patients<sup>5</sup>. This type of service requirement is not unique to CHF, with specialist multidisciplinary services being the norm for conditions such as diabetes.

The benefits of multidisciplinary approaches to the management of chronic diseases are well established, with several successful models already operating in the ACT. The Community Services Directorate, for example, offers multidisciplinary therapy, support services and care plans for people identified as having characteristics consistent with Autism Spectrum Disorders. Following diagnosis, support is provided in several forms including family group workshops, information sessions and parent networking. Therapy services, including speech pathology, occupational therapy, psychology and social work, are provided to children from diagnosis to eight years of age.

There is convincing evidence that among people who have been hospitalised with CHF, those who receive multidisciplinary care have significantly reduced subsequent morbidity and mortality, while improving quality of life and providing large cost savings<sup>7</sup>.

The Heart Foundation position statement notes that while there has been a growth in structured multidisciplinary CHF management programs in Australia, not all patients who need them are able to access these services.

The composition of multidisciplinary teams is not consistent in Australia or across the world. Disciplines involved include, but are not limited to: Aboriginal health workers, cardiologists, dietitians, exercise physiologists, general physicians, general practitioners (GPs), nurses (including those with cardiology training, formally accredited CHF nurse practitioners, community nurses, palliative care specialist nurses and practice nurses), occupational therapists, palliative care physicians, pharmacists (including hospital pharmacists, community pharmacists and accredited pharmacists), physiotherapists, psychologists and social workers.

The multidisciplinary care described in the Heart Foundation position statement is designed primarily for patients with symptomatic CHF (NYHA class II–IV)<sup>5</sup> who have a history of hospitalisation for heart failure and are at high risk for further exacerbations and adverse clinical outcomes.

However, patients with NYHA class I (asymptomatic) CHF still require comprehensive care including pharmacological therapy, non-pharmacological management, education and support for self-care as appropriate, and management of other related conditions<sup>4</sup>. It is for this reason that any new model of care must consider the needs of the whole CHF population and ensure that required services are provided and coordinated.

Services for people with CHF in the ACT have traditionally been poorly coordinated and had limited accessibility. The Multidisciplinary CHF Care Service Pilot assisted in addressing these concerns and meeting the needs of CHF patients. The Pilot, in its current form, is coordinated by a part-time heart failure nurse and involves a 12 week heart failure-specific exercise and education program conducted at TCH. The combination of staffing limitations and the complex nature of heart failure patients have, however, seen only a limited number of outpatients enter the service. Referral pathways and linkages with allied health practitioners, GPs and Calvary are also yet to be fully resolved.

Current acute CHF services in the ACT are outlined below.

### **The Canberra Hospital**

ACT Health employs a CHF clinical nurse consultant (CNC) who is based at TCH and is part of the chronic care program (CCP). The CCP was introduced by ACT Health to target ACT residents with CHF and/or chronic obstructive pulmonary disease (COPD) who are frequent users of the acute care system to co-ordinate their care.

The CHF CNC operates a CHF clinic with cardiology support three times per week and there are currently approximately 120 active patients with 10-15 patients seen per week in the clinic and phone contact made with other active patients. Referral pathways into the service are complicated and uncoordinated with the majority of referrals coming via the cardiac rehabilitation CNC who also provides the in-hospital education for CHF patients. There are no allied health services allocated to the CHF clinic and due to limited capacity, no acute CHF specific exercise or education program exists. The cardiac rehabilitation CNC accepts CHF patients into a modified and extended CR program,

however, the structure of the program does not directly address and care for the very specific needs of CHF patients. Patients not considered suitable for CR are referred to the CHF CNC for clinic appointments and patients requiring additional social support may receive care coordination from the CCP care coordinators. The complex nature of the referral process and the three different potential pathways has resulted in a system with limited reach.

Best practice coordinated multidisciplinary care does not currently exist for patients with CHF in the ACT. While every effort is made to link patients with services required in the community, communication between the CHF CNC, general practitioners and community based allied health practitioners that patients are referred to is generally poor or non-existent making a multidisciplinary team care approach impossible.

### **Calvary Hospital**

Calvary hospital employs a single part time cardiac rehabilitation CNC who runs a 6 week program for CHD patients post cardiac event. A small number of CHF patients attend the program for an extended 12 week period but no specific CHF exercise or education program is available to these patients. No individual consultations by allied health professionals are available for either CHD or CHF patients on an individual basis and referral to community allied health providers does not routinely occur. Due to limited capacity CHF patients receive in-hospital education and information by the CR CNC on an ad hoc basis and are easily missed.

### **General Practice**

General Practitioners have a strong interest in the management of CHF, as demonstrated by a very high attendance at an ACTDGP (now ACT Medicare Local) professional development event on CHF. From discussions with the ACT Medicare Local it is clear that the two key issues for GPs with regards to the management of patients with CHF are poor communication between the acute and primary care sectors, including allied health professionals and community health services, and the lack of support that GPs receive in the timely diagnosis and community based management of CHF.

Access to echocardiograms within an appropriate time frame, particularly for patients who cannot afford a co-payment, is a key issue identified by general practice. Improved access to echocardiograms will assist better management of CHF patients in the community and contribute to reducing the risk of emergency department presentation or hospitalisation for an acute episode.

CHF patients managed in general practice are eligible to be placed on GP management plans (GPMP) and have team care arrangements (TCA) in place which entitles them to five allied health visits per year covered by Medicare rebate. (In some cases private allied health practitioners bulkbill but more commonly the patient has to pay some co-payment.) GPs commonly refer patients to private or community allied health services, however communication back from these providers to the GP is often poor resulting in GPs having to rely on patients to provide information on what advice or treatment other health professionals have provided.

A streamlined communication process for GPs into ACT Health services, ready access to specialist consultation, improved access to echocardiograms and a greater involvement of practice nurses in the coordination of CHF patients' care would assist GPs manage CHF patients more effectively in the community.

## **ACT Community Care**

ACT Community Health offers a wide range of community and at home support and treatment services to people with chronic conditions through the Continuing Care Program (CCP) and the Aged Care and Rehabilitations Service (ACRS). In addition a Chronic Disease Telephone Coaching Service (CDTCS) has been established by the Chronic Disease Management Unit and CHF patients are eligible for referral to this service.

Community nurses provide an extensive range of nursing services to people in their homes and also offer nursing services in their ambulatory clinics across Canberra. The CCP and ACRS also offers a range of other allied health services that are required by many patients with CHF such as dietetic services, occupational therapy, physiotherapy and social work. These services are available for all residents of the ACT and surrounding region and can be accessed via referral from a GP or self referral. The majority of these services are provided at no cost to the patient.

Poor communication back from these services to general practice and the CHF clinic about the care patients have received has been identified as an issue which impacts negatively on the ability of the GP and the CHF CNC to effectively monitor all aspects of the patients' ongoing care and self management needs and impedes a team approach to CHF care.

### **7. What is needed for people with CHF in the ACT?**

The Heart Foundation position paper indicates that the following issues should be considered when undertaking the planning of CHF services:

- the needs of the target population
- systems to coordinate health services and promote continuity of care
- workforce availability
- effective management of data and monitoring of the quality of care
- adequate resourcing for staffing, consumables and administrative costs
- efficient delivery of the core components of effective care as set out in the position statement.

The position statement also notes some broad elements identified from the literature that are common to the most effective programs.

These include:

- involvement of health professionals and other providers from a range of disciplines using a team approach across healthcare sectors
- implementation of evidence-based management guidelines, including systems for optimisation of pharmacological and non-pharmacological therapy
- monitoring of signs and symptoms to enable early identification of decompensation and/or deterioration, and effective protocols for symptom management
- inclusion of patients and their families in negotiating the aims and goals of care
- development and implementation of individualised management plans
- promotion of and support for self-care (e.g. taking medicines, following lifestyle management advice about smoking cessation, physical activity and exercise programs, nutrition and limiting alcohol use, and monitoring and interpreting symptoms) as appropriate to patients' needs, capacity and preferences

- the use of behavioural strategies to support patients in modifying risk factors and adhering to their management plans
- continuity of care across healthcare services, including acute care, primary care and community care
- monitoring of program outcomes and systems to ensure continuous quality improvement.

To develop a whole of ACT approach to CHF, the role of all sectors across the continuum of care should be identified. And the existing workforce within these sectors mobilised in a more coordinated and cooperative way to support an effective team approach to multidisciplinary care for all ACT CHF patients.

Policies and protocols will be needed to ensure continuity of care between health sectors and effective communication between all providers, including acute and primary care health professionals, allied health professionals, and the patient and their family.

### **8. The role of the acute sector**

The acute sector is central to the management of patients with CHF. People with CHF often have a strong history of hospitalisation and many regularly present to hospital due to acute exacerbations. For many people, their entry into a CHF program will commence upon hospitalisation.

The Heart Foundation position statement notes the roles of acute sector services in multidisciplinary CHF care as follows:

- developing and implementing protocols for identifying patients who require multidisciplinary CHF care
- multidisciplinary care meetings and case conferences during the hospital stay
- discharge planning processes that include identifying available multidisciplinary CHF care opportunities (noting that the person may be eligible to access both private and public health services, including Department of Veterans Affairs)
- coordinating with community-based services (e.g. general practice, community or accredited pharmacists, diabetes educators and cardiac rehabilitation programs, community and private nursing services, Home and Community Care Program) to provide care after discharge
- specifying a plan for managing the patient's medicines following discharge (e.g. referring the patient to their GP or a community pharmacist who has been contacted by inpatient care team to ensure continuity of care).

### **9. The role of general practice and primary care sector**

While it is acknowledged above that for many people with CHF care begins in hospital and continues after discharge, it is important to note that some people will be diagnosed with CHF outside the acute setting. Whilst these patients may be asymptomatic or have less severe symptoms, it is essential that the needs of this group are also considered within a comprehensive ACT wide CHF service.

The involvement of general practice and the primary care sector is central to optimum management of all people with CHF and in most instances GPs, with assistance from practice nurses in some cases, will take a central role in coordinating the long term multidisciplinary CHF care with input from cardiologists and/or the acute sector CHF services during periods of exacerbation, deterioration or following a hospital admission.

The Heart Foundation position statement notes that the roles of general practice in multidisciplinary CHF care can include:

- identifying and referring to services that are accessible to the patient
- coordinating a multidisciplinary team
- collaborating with a pharmacist to assess and adjust the medicine regimen (e.g. through Home Medicines Review) to reduce the risk of hospitalisation for heart failure exacerbations.

Practice nurses within general practice play an increasingly important role in the support and management of patients with chronic disease and have great potential to support improved care for people with CHF in Canberra.

The Heart Foundation position statement notes the role of practice nurses include:

- managing registers and recall systems
- identifying patients who would benefit from multidisciplinary CHF care
- targeting patients for the education, resources or support services from which they are most likely to benefit
- identifying patients eligible for structured care plans
- providing administrative and clinical support.

It is important to ensure that practice nurses receive support and mentorship from heart failure nurse specialists. This could be provided via improved linkages with specialist heart failure nurses and a heart failure clinic and by the delivery of ongoing professional development to increase their skills, knowledge and confidence in working with these patients.

As previously mentioned there is great interest from general practice in the area of CHF support. This is also demonstrated by the interest shown by the ACT Medicare Local in being involved in the working group that developed this proposal. This high level of interest and involvement is a very positive sign in relation to building capacity for better CHF care in this sector.

## **10. Suggested characteristics of a new model of CHF care for the ACT**

The proposed model of care is made up of a number of flexible components that can be tailored to individual needs. The components of the model of care that are accessed will be dependent on the patient's individual preferences, their clinical condition and their social and economic circumstances. Coordination of care, communication between health care providers and patient involvement in self-care are at the centre of the model.

The following characteristics are based on the recommendations noted in the Heart Foundation position statement combined with recommendations arising from consultation with ACT health professionals involved in CHF management.

- A CHF service based initially in the acute sector (either TCH with a mobile service to Calvary or a service at each facility) that includes an inpatient hospital education component provided by specialist heart failure nurses, an outpatient clinic and a CHF specific group exercise program would provide a service for patients post discharge from hospital following diagnosis or an acute exacerbation. The clinic would be staffed by a CHF CNC/nurse practitioner, a medical specialist with a particular interest in CHF and supported by appropriate allied health professionals. Patients will attend the clinic for 12 weeks and then be

discharged, when clinically appropriate, to their GP who will coordinate their ongoing care utilising existing community services as required. The clinic will commence an individualised management plan which will be communicated to the patient's GP.

- The service will have strong links with general practice and support GPs and PNs to manage their patients in the community both during their time attending the clinic and after discharge. GPs will be offered the opportunity to participate in the clinic as an educational activity and to improve links.
- Patients identified with complex social needs and with limited self management capacity, thus requiring additional support, would be referred to the existing chronic care program for care coordination and additional services.
- Improvements in access to timely diagnostic services in both the private and public sectors will be required to ensure that GPs are able to commence effective management as quickly as possible and reduce the likelihood of acute hospital admissions. The most important requirement would be access to early echocardiography and clinical review.
- Patients diagnosed with CHF outside the acute sector who do not require admission to hospital, patients who opt not to attend the clinic program and patients discharged from the clinic program will have their care coordinated in general practice with support from the CHF service if required. A variety of existing community providers such as ACT community health, private allied health providers and chronic disease telephone coaching can be utilised depending on the patient's preference and clinical condition. Communication will need to be strengthened between these services and general practice to ensure that care is undertaken in a coordinated way using a team approach.
- Within TCH, Calvary Hospital and NCPH in-hospital links with cardiology, general medicine, gerontology and palliative care should be strengthened to improve appropriate referral and comprehensive management.
- A Coordinated CHF model of care in the ACT would be greatly enhanced by e-health record capability. Patients with CHF often have very complex medical needs and best practice care requires a range of different health professionals to be involved in their care. There is an opportunity for this patient group to trial e-health initiatives, particularly given the major communication issues identified.
- A well coordinated CHF service will provide an opportunity to collect accurate data on CHF prevalence in the ACT and service usage by CHF patients as well as conduct research relevant to the management of CHF.
- Patients with CHF assessed as NYHA functional class II–III (at the time of discharge from hospital after an admission for heart failure) should commence contact with the structured multidisciplinary CHF program or commence multidisciplinary care within one week of hospital discharge. This group of patients should receive multidisciplinary care for at least 12 weeks.
- Patients at higher risk at the time of discharge from hospital (NYHA functional class IV or other characteristics indicating high risk<sup>1</sup>) should commence contact with a structured multidisciplinary CHF program or commence multidisciplinary care within 24 hours of discharge. This group of patients should receive multidisciplinary care for an indefinite period, based upon a comprehensive needs assessment and provided in consultation with their GP, specialist doctor/s and other health professionals involved in their care.

## 11. Budget

The costing template at Attachment A has been developed by TCH cardiac rehabilitation to estimate the costs required to implement and evaluate a Heart Failure Rehabilitation Program (exercise and group education). The cost to the acute sector, including the provision of cardiologist time and services, and funding for additional services at Calvary Hospital, are not included in the attached template and will need to be considered separately.

Additional funding would also be required for linking and working with general practice to improve flow processes and communication between the acute sector and the primary sector, as well as for interdisciplinary professional development and resource development. Estimates have been provided from ACT Medicare Local for a project officer, whose role has been outlined below. We acknowledge that these costs may be outside the scope of the sub-acute funding allocation and may need to be supported via other funding options. A breakdown of costs is provided at Attachment B.

The core duties and responsibilities of the proposed position of the ACT Medicare Local Project Officer would include:

- In consultation with the Project Team Leader and Program Director, developing program plans, outlines, reports and budgets with agreed outcomes and timeframes;
- Working with General Practice and Allied Health professionals in primary health care in the ACT to promote consistency in the delivery of the program;
- Managing process and procedure changes and disseminating the information to primary health care clinicians;
- Establishing and maintaining effective communication and working relationships with all stakeholders; act as a link between primary health care clinicians and the ACT Multidisciplinary CHF Care Service to act on issues to make the patient journey seamless and decrease hospitalisation;
- Liaising with primary health care clinicians and community organisations on relevant program issues where appropriate;
- Working to identify, respond to and rectify problems, issues and risks that arise;
- Working collaboratively with colleagues and relevant stakeholders to improve the delivery and effectiveness of patients with HF who have been discharged from hospital and keep them out of hospital ;
- Providing secretariat services to program specific committees, network groups or advisory forums where appropriate;
- Planning relevant education sessions for Clinicians in Primary Health care.

Consideration has also been given to providing more timely access to echocardiograms, with any additional costs expected to be modest. An extra 2 sessions per week from stenographers and an extra 3-4 hours reporting time from cardiologists would be required. This would enable an additional 8 echocardiograms per week to be performed.

A formal costing of the proposal is required as a next step.

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## References

- <sup>1</sup> Australian Institute of Health and Welfare. Australia's health 2008. Cat. No. AUS 99. Canberra:AIHW, 2008
- <sup>2</sup> Clark RA, McLennan S, Dawson A, et al. Uncovering a hidden epidemic: a study of the current burden of heart failure in Australia. *Heart Lung Circ* 2004; 13: 266-73.
- <sup>3</sup> Michalsen A, Konig G, Thimme W. Preventable causative factors leading to hospital admission with decompensated heart failure. *Heart* 1998;80:437-41.
- <sup>4</sup> National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand (Chronic Heart Failure Guidelines Expert Writing Panel). Guidelines for the prevention, detection and management of chronic heart failure in Australia, 2006. Melbourne: National Heart Foundation of Australia, 2006.
- <sup>5</sup> National Heart Foundation of Australia. Multidisciplinary care for people with chronic heart failure: principles and recommendations for best practice. August 2010.
- <sup>6</sup> Australian Institute of Health and Welfare. Australian hospital statistics 2009- 10. Canberra:AIHW, 2011.
- <sup>7</sup> McAlister FA, et al. A systematic review of randomized trials of disease management programs in heart failure. *Am J Med* 2001; 110:378-84.

**Attachment A: Costing Template**

**TCH costing Heart Failure Rehabilitation Program 2010-11 Budget Initiative**

Position Level	Salary	Superannuation	EPS	LSL/ LL	Allowances	Comcare	Salary Sub-Total excl. penalties	Admin On-Costs	Total Salary & Admin. On-Costs	Penalties	No. of Staff (FTE) including relief	2012-13 Total Costs \$	2013-14 Total Costs \$	2014-15 Total Costs \$	2015-16 Total Costs \$	
		<b>9.00%</b>	<b>3.00%</b>	<b>4.00%</b>		<b>3.67%</b>										
RN2	77,472	6,972	2,324	3,099	0	2,843	92,711	15,765	108,476	0	1.20	130,171	135,378	140,793	146,425	
HP3 Psychologist	80,436	7,239	2,413	3,217	0	2,952	96,258	15,765	112,023	0	1.20	134,427	139,804	145,397	151,212	
HP2 Exercise Physiologist	70,459	6,341	2,114	2,818	0	2,586	84,318	15,765	100,083	0	0.50	50,442	52,460	54,558	56,740	
HP2 Dietitian	70,459	6,341	2,114	2,818	0	2,586	84,318	15,765	100,083	0	0.50	50,442	52,460	54,558	56,740	
HP2 Pharmacist	70,459	6,341	2,114	2,818	0	2,586	84,318	15,765	100,083	0	0.50	50,442	52,460	54,558	56,740	
HP3 Physiotherapist	80,436	7,239	2,413	3,217	0	2,952	96,258	15,765	112,023	0	0.50	56,459	58,718	61,067	63,509	
HP3 Occ Therapist	80,436	7,239	2,413	3,217	0	2,952	96,258	15,765	112,023	0	0.50	56,459	58,718	61,067	63,509	
HP3 Social Worker	80,436	7,239	2,413	3,217	0	2,952	96,258	15,765	112,023	0	0.50	56,459	58,718	61,067	63,509	
ASO2	48,003	4,320	1,440	1,920	0	1,762	57,445	15,765	73,210	0	0.24	17,570	18,273	19,004	19,764	
Project evaluation												10,000	10,000	10,000	10,000	
Operating Expenses												24,000	24,960	25,958	26,997	
<b>Total Recurrent</b>												<b>5.66</b>	<b>636,873</b>	<b>661,948</b>	<b>688,026</b>	<b>715,147</b>

**Notes:**

- \*Rates for Superannuation are: CSS 20.6%, PSS 16%, PSSAP 12.4% and **Other 9%**. The Other rate has been used in the above calculations.
- \*Admin On-Cost based on ACT Department of Treasury Salary and On-Cost Model Dec 2006 \$15,765 per FTE.
- \*Operating Expenses include Training, Education Materials and Other Operating Expenses .
- \*Rates based on top of range salary as at October 2011
- \*All positions is Mon-Fri 9-5.
- \*Positions backfilled with relief for ADO/ARL/SL/PDL cover at M-F Relief factor of 0.20fte (4wks leave).
- \*Penalties based on TM1 Budget Model figures.

### Multidisciplinary chronic heart failure care for Year 1

Posteres/pamphlets	\$	2,000.00	
Invitations and Mail out	\$	1,000.00	
Health Professional Education events x 5	\$	18,000.00	
GP Advisor	\$	3,000.00	
Recruitment costs	\$	3,000.00	
Consumer Representation	\$	600.00	
Launch	\$	1,000.00	
Car	\$	8,000.00	
Meetings	\$	600.00	
Allied Health Professional representative costs x2	\$	2,000.00	
Wages	\$	84,678.46	
Administrative Costs	\$	60,121.54	
Total excluding GST	\$	<u>184,000.00</u>	(GST Excl)
GST	\$	<u>18,400.00</u>	
Total including GST	\$	<u><u>202,400.00</u></u>	(GST Incl)

**Multidisciplinary chronic heart failure care for the ACT****Year 2**

Posteres/pamphlets	\$	2,000.00
Invitations and Mail out	\$	1,000.00
Health Professional Education events x 5	\$	19,000.00
GP Advisor	\$	3,000.00
Consumer Representation	\$	600.00
Car	\$	8,000.00
Meetings	\$	600.00
Allied Health Professional Representative x2	\$	2,000.00
Wages	\$	87,811.56
Administrative Costs	\$	59,988.44
Total excluding GST	\$	<u>184,000.00</u> (GST Excl)
GST	\$	<u>18,400.00</u>
Total including GST	\$	<u><u>202,400.00</u></u> (GST Incl)

**Multidisciplinary chronic heart failure care for the ACT****Year 3**

Posters/pamphlets	\$	2,000.00	
Invitations and Mail out	\$	1,000.00	
Health Professional Education events x 5	\$	20,000.00	
GP Advisor	\$	3,000.00	
Consumer Representation	\$	600.00	
Car	\$	8,000.00	
Meetings	\$	600.00	
Allied Health Professional Representative x2	\$	2,000.00	
Wages	\$	91,060.65	
Administrative Costs	\$	63,739.35	
Total excluding GST	\$	<u>192,000.00</u>	(GST Excl)
GST	\$	<u>19,200.00</u>	
Total including GST	\$	<u><u>211,200.00</u></u>	(GST Incl)