CSANZ 70 1952 - 2022

Heart Foundation

ACvA Australian Cardiovascular Alliance

Joint National Cardiovascular Implementation and Policy Roundtable Report

Draft **Report**

May 2022

Acknowledgements

The Cardiac Society of Australia and New Zealand (CSANZ), the National Heart Foundation of Australia (NHFA) and the Australian Cardiovascular Alliance (ACvA) acknowledge the Traditional Custodians of country throughout Australia where the participants of the roundtable work, live, and meet to improve cardiovascular and stroke outcomes for the community. We recognise the Traditional Custodians' continuing connection to land, waters and community and pay our respects to them and their cultures, and to Elders both past and present.

Introduction

Cardiovascular diseases (CVD) including stroke and blood vessel diseases remains the leading cause of death in Australia. It is the greatest healthcare expenditure cost, at around $11 billion annually. CVD is also a main contributor to the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

For these reasons the Australian Cardiovascular Alliance (ACvA), the National Heart Foundation of Australia (NHFA) and the Cardiac Society of Australian and New Zealand, (CSANZ) joined forces to bring the cardiovascular and stroke community together (State and Commonwealth Government representatives, peak bodies, clinicians, researchers, primary care, allied health, pharmacists, nurses, consumers, and industry), providing a unique opportunity to set a national CVD Implementation & Policy agenda and action plan. The aim being to lay new foundations that will shift the dial on cardiovascular health, by identifying new models and actions to accelerate the translation of evidence into policy and practice to directly benefit consumers, clinicians, health services and health budgets, and support delivery of the implementation goals of the MRFF and Mission for Cardiovascular Health. Links to these documents are available here: Roadmap and Implementation Plan.

In addition to the Roundtable, steps have been taken towards achieving an unprecedented level of collaboration between State/Territory and Commonwealth health jurisdictions and clinical and researchers leaders through a new initiative, known as Health Leadership Research Forums (HLRFs). This initiative will contribute to efforts to reduce the burden of CVD and stroke, by providing national and state/territory forums, where best available evidence is used to enable our health leaders to fully understand the unmet needs in relation to CVD and stroke and enable the whole research ecosystem to work collaboratively towards solutions that will make a measurable difference to cardiovascular health.

Joint National Cardiovascular Implementation Roundtable Objectives

The purpose of the Roundtable was to convene and document a whole-of-nation discussion with a wide-range of stakeholders to identify solutions for cardiovascular disease implementation and policy and to collectively agree on actions to be prioritised and implementation barriers and gaps for further implementation research. These outcomes will form the first steps in building the foundations for a national agenda and action plan.

In preparation for the roundtable a prelimary survey was circulated to the organisation committee to assist with setting the agenda for the day and with identifying appropriate speakers. The survey asked to identify top implementation priorities for primary prevention, acute care, and secondary prevention. And to consider priorities in regard to: high burden disease areas (coronary heart disease, heart failure and stroke), priority populations and in the context of public health, diagnostic tools, drug tools, device tools and service design and to consider existing global evidence and health economics and cost benefits. The results from this survey were diverse and widespread and were used to guide the setting the scene presentations in Session one on the day.

The Roundtable

The event was held in person at the Shine Dome in Canberra on the 10th March 2022 and attended by 65 participants from across Australia.

The roundtable focussed on the areas of prevention, acute treatment and secondary prevention, with discussions facilitated by Professor Don Nutbeam (Professor of Public Health, University of Sydney & Executive Director, Sydney Health Partners). Acknowledging the diversity of conditions that make up CVD, Roundtable participants examined examples such as implementation and policy gaps associated with hypertension, women and heart disease, cardiac rehabilitation, screening for cardiovascular risk and responses to and treatment of stroke.

Program

The day was divided into several sessions, in Session One, we set the scene with some short presentations of implementation in-flight. In Session Two, we held a broader discussion with breakout groups of 6 – 8 people with diverse expertise and geography to discuss implementation and policy priorities, bottlenecks, and gaps. In Session Three, group priorities were discussed and in Session Four, emerging and cross-cutting themes were identified.

Participants

Participants at the Roundtable were from a range of organisation from across Australia including: the National Heart Foundation of Australia, Cardiac Society of Australia and New Zealand, the Australia Cardiovascular Alliance, Federal Government, State & Territory Governments, the Australian Institute for Health and Welfare, the Australian Commission on Safety and Quality in Health Care, The Royal Australasian College of General Practitioners, NPS MedicineWise, the Australian Health Research Alliance/Advanced Health Research Translation Centres, the High Blood Pressure Research Council of Australia, the Australian Vascular Biology Society, the Stroke Foundation, the Australian Chronic Disease Prevention Alliance, the Australian Cardiovascular Health and Rehabilitation Association, the Australian Primary Health Care Nurses Association, the Pharmaceutical Society of Australia (PSA), Bioplatforms Australia, Phenomics Australia, the Queensland Cardiovascular Research Network, the NSW Cardiovascular Research Network, the Australian Stroke Alliance, the Medical Technology Association of Australia, Medtronic, Abbott Vascular, AstraZeneca, Bayer Australia, Consumers and Consumers Groups: including EndUCD, Hearts4hearts and the Australian Amyloidosis Network.

A full list of attendees can be found in Appendix 1.

Framing the Discussion

> ***" If the Minister for Health walked through the door now….. What is the one thing you would ask him to do? "***
>
> *- Professor Don Nutbeam*

In breakout groups, participants were asked to identify ambitious goals to be achieved and outline the necessary changes in service provision and policies that were required to achieve these goals. They were encouraged to explore how we could take knowledge and evidence and see it better implemented into clinical practice and public policy. Barriers to implementation and uptake were also considered, as well as the key stakeholders and partners that would need to be engaged if change was to occur.

The implementation and policy priorities put forward by participants have been grouped under the broad areas of primary prevention and screening, acute care and treatement, and secondary prevention and rehabiliation, and categorised further by whether:

- Intervention exists, but requires better implementation into practice
- Evidence is clear and needs to be implemented into the healthcare system
- More evidence and implementation research is required

Summary of top ten 'asks'

Funding and policy change that supports campaigns, incentives, mechnisms and strucutres that bridge the gaps.

1. Investment in national CVD and Stroke prevention program campaigns to raise awareness of CVD and Stroke and the associated risk factors – with strong input from behaviour change experts, consumers and evaluation of impact.
2. A more comprehensive and stratified approach to defining, communicating and screening of risk factors for CVD and Stroke.
3. Increase incentives and mechanisms to support and expand the key role of primary care and primary care providers in the delivery of primary and secondary prevention activities.
4. Government supported structures and co-funding models that incentivise and bridge the gap between hospital and primary care settings to promote continuity
5. Mechanism(s) that promote the translation of evidence and research through engagement with implementation experts.
6. Guidelines should be funded to include clear metrics, evaluation processes and reporting mechanisms for continual improvement in the health system.
7. Accurate and timely information on the burden of disease in Australia through nationally coordinated data collection and data access (driving towards a national data platform), by supporting and accelerating work that is already underway
8. Establish a clinical trials platform, including enabling pragmatic, data trials that can provide interventions or test interventions where evidence already exists
9. Implementation research that provides segmented information on priority populations and geographies and embed health economics and statistical expertise into all research programs and trials and prioritise increasing capacity and skills in this area.
10. Fund the innovative use of digital technology to leap-frog disparities in access and delivery of CVD and Stroke healthcare especially in regional, rural and remote areas.

Key messages

There was clear consensus for the need to set a national CVD and Stroke implemenation and Policy agenda, to propose an ambitous goal to be achieved, and to collectively spearhead action. There was also agreement on the need to capitalise on the use of data and innovative technologies, taking on board how COVID-19 has been a great mobiliser in our healthcare system, and the need for modelling and economic evaluations of the health impact of proposed health interventions. While there were many important topics discussed at the Roundtable we highlight below six key themes that emerged on the day, with the greatest potential to drive towards an ambitious target for improved health outcomes.

Set an ambitious goal to drive implementation and policy change:

" 30% reduction in CVD mortality, morbidity and inequalities by 2030
40% reduction in CVD mortality, morbidity, and inequalities by 2040
50% reduction in CVD mortality, morbidity, and inequalities by 2050 "

1. Earlier Identification of Australians at risk of future CVD and Stroke is needed now

- Significantly more effort should be directed towards detecting those at risk of CVD, especially for priority populations.
- There is a need to raise public awareness and increase education of CVD and Stroke risk

2. There is an urgent need to improve under-diagnosis and under-treatment of CVD & Stroke

- Under-management of those with disease remains an issue nationally. For example, we know that hypertension, which is a risk factor for both heart disease and stroke, is under-diagnosed and under-treated and that better treatment and management of people living with high blood pressure would save 83,000 lives and $91 Billion in GDP over their working lifetime, yet chronic undermanagement persists..
- Australians with atrial fibrillation have 5 times higher risk of having a stroke. This treatable disease often goes undiagnosed, with increased public awareness of the risks of atrial fibrilliation, implementation of screening programs and standardised treatment with oral anticoagulants there would be a significant reduction in the number of catastrophic strokes.
- We need to increase adherence to best practice clinical guidelines. To drive improvements the implemenation and evaluation of guidelines must be funded.
- The recommendations of the Women and CVD Roundtable, held in 2019, must be updated and implemented and we must engage the basic sciences in helping unravel missing or poorly understood biology if inequitable outcomes are to be addressed.

3. Ensure equitable access to CVD and Stroke healthcare for regional, rural and remote areas and for priority populations

- There are substantial and well documented inequities for access to care for Aboriginal and Torres Strait Islander Peoples, Australians living in rural and remote locations as well as gender disparities which continue to cause greater morbidity and mortality for these population groups. Implementation research to accelerate known solutions and find innovative new approaches must be supported.

- Continuity of care between primary and acute care, remains an issue. Integrated care must be a clear priority and addressed by systematised and funded collaborations between all State, Territory and the Commonwealth Governments working together with clinicians, researchers, data and health economics.

4. Consumer engagement is essential to drive implementation and uptake

- Consumer input and co-design of all implemenation initiatives and strategies are essential to ensure we do the things that people want/need and maximise uptake and impact by individuals and the health system.
- We must support a cross system approach (general practice, pharmacy, nursing) to provide consumers with accessible health education and tools/support to promote self-management and consumer-driven care e.g. home blood pressure monitoring and detection of abnormal heart rhythm by checking your pulse manually or using enabled smartwatch.

5. A national CVD data surveillance platform is critical infrastructure if evidence based change is to occur

- There is currently no national CVD monitoring system in Australia dedicated to collect CVD data that can be used to report timely and accurate information on the burden of disease, guide public health programs, identify inequities and areas for patient care improvements and for monitoring the outcomes of interventions.
- Nationally accessible, quality data that transcends primary, secondary, and tertiary care to inform action must be a government and health system priority, with integrated funding support provided and dedicated to driving development of a national platform.

6. New Digital and Imaging Technologies are opening exciting opportunities that need to be actioned

- Capitalise on existing and emerging technologies to support accessiblility to acute treatment, secondary prevenetion and service delivery e.g. increasing regional, rural and remote patient access to specialists using telehealth platforms e.g remote thrombectomies and to improve the uptake of cardiac rehabilitation programs.
- Promote the use of validated technology tools for home monitoring of risk factors e.g. wearables and home blood pressure monitoring
- Support trials that test/evaluate the use of innovative screening tools, such as Calcium Scoring Technologies and polygenic risk scores for efficacy and equity implications.

Primary Prevention and Screening

Goal 1: 90% of over 40 yr olds have been assessed and understand risk of CVD and Stroke

> ***" Economic modelling has been done that shows if we move from an individual risk to an absolute risk approach, we could save the Australian health system $5.4B "***

Aim 1: All Australians know and understand their absolute cardiovascular risk	
	• Improve uptake of the Heart Health Check Toolkit to help general practice embed Health Heart Checks into patient routine care e.g. PIPQI program

Exists but need better implementation	• Optimise the uptake of existing Medicare rebate for heart health checks through public health awareness campagins particularly in priority populations (work with communities to develop culturally-appropriate campaigns) and those who have had a COVID-19 infection • Increase general public awareness of cardiovascular disease and stroke through, public health education and improved health literacy • Work together as a sector to promote population-wide prevention initiatives e.g. Salt and sugar reduction, tobacco free generation, transport and public design to promote and encourage exercise • Reinvigorate and relaunch the campaign "Make the invisible, visible" to raise awareness of the risks and warning signs of cardiovascular disease in women.
Evidence exists but needs to be Implemented	• Increase incentives for GPs – through clinic accreditation (using models such as the National Association of Diabetes Centres Centre of Excellence Standards and Accreditation Program) • Undertake joint advocacy to increase the Medicare rebate to cover the full costs of service delivery for Heart Health Checks. • Reinvent health services delivery, for example, through allied health drawing on models such as the COVID-19 Vaccination in Community Pharmacy Program (CVCP), community nurse practitioners and primary health care nurses. • Provide funding incentives and appropriate remuneration for both practice level and individual staff level e.g. continuing professional development that could be provided by RACGP & Australian Primary Health Care Nurses Association
More research/evidence is required	• Collaboratively fund a cost-benefit analysis of Heart Health Checks • Collect and analyse data on screening program delivery to identify gaps, inequities and evaluate intervention (national data surveillance platform) • Develop, introduce and evaluate screening of CVD risk from childhood; develop childhood risk calculator • Establish a research priority that supports effective monitoring of the population for future COVID-19 related CVD clinical consequences • Advocate for more funding for vaccine development to prevent RHD in children in Aboriginal and Torres Strait Islander populations, ensuring strong governance and input from community • Provide supporting evidence and implementation plan for pilot projects for the introduction of new technologies and tools e.g. polygenic risk scores, coronary artery calcium scores; undertake cost-benefit analysis and health economic modelling

Aim 2: Double current blood pressure control rates to 70%	
Exists but need better implementation	• Support health professions to adhere to BP guidelines through existing quality improvement programs such as PIPQI • Improve health literacy in the community about the risk of high BP through evidence-based community education programs • Develop and launch campaigns to raise awareness in the community • Improve the accuracy of blood pressure measurement through clinical education and awareness campaigns (for example promoting greater awareness and use of ambulatory BP monitoring through uptake of Medicare number)

	• Increase the number of community-based blood pressure clinics (in regional, rural, and remote areas), encouraging and incentivising wider scale use of nurses and allied health, including pharmacists to measure blood pressure • Support consumers with accessible education on best-practice for blood pressure monitoring at home using validated devices
Evidence exists but needs to be Implemented	• Establish a National Hypertension Task Force with the remit to achieve the target of 70% blood pressure control rate • Raise awareness and promote screening for treatable hormonal causes of high blood pressure (e.g. primary aldosteronism) • Establish a national registry for blood pressure (starting with ambulatory BP and later linked to home monitoring devices) for population monitoring and evaluation
	• Collaboratively fund a cost-benefit analysis of doubling control rates to 70%

Aim 3: Australians with AF are identified

Exists but need better implementation	• There is no population-wide screening program for AF available in Australia.
Evidence exists but needs to be Implemented	• Raise awareness of the greater risk of stroke in AF patients and provide practical advice to the community for example, how to detect irregular heart beats by measuring your own pulse • Undertake research and evaluation of the role/efficacy of wearables as a monitoring and screening tool for AF • Promote and Implement population level screening for over 65yrs, given this is a treatable using preventative oral anticoagulants
More research/evidence is required	• Develop/coordinate the evidence-base to determine the cost and benefits of establishing a Medicare item number for AF assessment • Develop awareness campaigns and rollout nationally and monitor effectiveness and behaviour change outcomes • Investigate the role of telehealth in identification of AF in regional, rural and remote regions.

Aim 4: Establish a national CVD and Stroke data surveillance platform

Evidence exists but needs to be Implemented	• The sector recognises that data is central to understanding inequities and disparities in care and assessing and evaluating guideline driven approaches, yet no coordinated national approach (platform) exists. Such a platform should be a key advocacy priority as it will underpin best practice, drive greater equity and help deliver best value care. Data exists latent in primary, secondary and community service databases systems. Implementation research is required on how best to standardise, harmonise, and link data to be capture in a national CV and Stroke surveillance platform. The exemplar for such platforms would be the Cancer Surveillance Platform that exists across the world and is the backbone of cancer control planning and generation of quality cancer data that drives changes in health service and improves patient outcomes.

	• Support mechanisms that encourage and enable better sharing of data at all levels of health systems, governments and across jurisdictions. • CVDPrevent (UK GOV/NHS initiative) should be examined as a potential model for an Australian data monitoring platform

Acute Care and Treatment

"Women compared to men are:
more likely to present with 'atypical' symptoms
more likely to present late
less likely to get the necessary investigations & receive appropriate treatment"

Goal 2: Inequities and disparities in CVD outcomes are identified and addressed with enhanced access to appropriate treatment

Aim 5: No gender gaps in acute care	
Exists but need better implementation	• Include gender specific information in existing treatment guidelines for translation into clinical practice. • Introduce targets to identify and close gender gaps in health services e.g. hospital or rehabilitation services • Raise clinicians awareness on the risks of unconscious bias
Evidence exists but needs to be Implemented	• Australian national surveillance platform (UK GOV initiative) to include gender disparities • Further rollout of continued medical education (CME) systems for professional and clinical education on women and heart disease. • Add gender data element to hospital dashboards to monitor and evaluate outcomes for women • Develop and trial tailored treatment programs for women • Introduce reducing gender disparities into hospital KPIs.
More research/evidence is required	• Implementation and evaluation of tailored treatment programs for women • Need data to improve outcomes and identify gaps in treatment

Aim 6: All people should be treated to best-practice guidelines	
Exists but need better implementation	• Implement approaches that can drive behavioural change to improve adherence to guidelines using best practice examples from other clinical areas e.g. diabetes service standards and accreditation programs • Increase the specificity of guidelines in respect of priority populations and include benchmarks and/or evaluation measures
Evidence exists but needs to be Implemented	• Better implementation and evaluation of guidelines
More research/evidence is required	• Explore living guidelines as a model for maintaining currency and increasing the uptake of guidelines. • Undertake a cost-benefit analysis on maintaining living guidelines

	• Investigate the benefits of team-based care in delivering best practice

Goal 3: All Australians in all postcodes have access to acute stroke care

Aim 7: Co-ordinated national rollout of mobile stroke ambulances	
Exists but need better implementation	• Expand the use existing technologies that can assist with delivering remote access and treatment to regional, rural and remote communities e.g. ZEUS telehealth platform • Improve pre-hospital management of acute stroke patients including through thrombolysis
Implementation research is required	• Research is required to increase sensitivity and specificity around Stroke calls as 50% of ambulance calls for stroke are not actually stroke, with research needed to support more appropriate, efficient and cost effective use of scarce resources Support research with detailed, segmented population analysis and testing interventions • Research is required to support national rollout and improved accessibility of services through the use of emerging technologies e.g. CT scans in ambulances and telehealth • Health and economic evaluation to analyse the burden of catastrophic stroke and associated caregiver burden should be prioritised

Secondary prevention and rehabilitation

> ***"Only 10-30% of eligible patients attend traditional rehabilitation programs"***

Goal 4: Increase accessibility and uptake of rehabilitation programs

Aim 8: Expand implementation of effective digital solutions for cardiac rehabilitation	
Exists but need better implementation	• Support more extensive use of telehealth to deliver and support rehab patients
Evidence exists but needs to be Implemented	• Redesign rehabilitation programs to be more flexible and tailored to the individuals needs e.g. women-tailored and culturally appropriate programs
More research/evidence is required	• Need data to inform quality of care and identify gaps in delivery • Identify and prioritise effective interventions and disseminate those that would support women to overcome the gender gap in participation in and completion of cardiac rehabilition • Need expertise and infrastructure to support collection of relevant data across juristictions that supports centralised reporting to improve quality and reach of care (National CV surveillance platform)

Aim 9: Provide diversified and customised approaches to cardiac rehabilitation	
Exists but need better implementation	• Galvanise existing siloed programs with the aim of rolling out a national program

Evidence exists but needs to be Implemented	• Provide primary care and hospital-based care professionals with a 'menu' of programs and resources available for secondary prevention and management on discharge
Implementation research is required	• Apply feedback and guidance from patients obtained through nation-wide collection of standardised Patient reported outcome measure and Patient reported experience measures surveys

Next Steps

1. The work commenced at the Roundtable will be continued with the wider-sector, initially through a virtual briefing session that will be held in May 2022. This briefing will provide an opportunity for sector-wide input and feedback to help further prioritise areas for initial work.
2. The Roundtable report will also be provided to the National Cardiovascular Health Leadership Research Forum (CV HLRF) to support alignment of implementation and research priorities, with health system priorities (the National CV HLRF engages senior officials from health systems across the country, with clinical, data and researcher leaders, to bring data, evidence and expertise to bear on the identification of gaps and inequities in the health system and to prioritise the research and implementation required to address them).
3. Cross-sectoral working groups will be established to address the top priorities identified in the report, across prevention, acute care and rehabilitation/recovery, with key outcomes being to:
    a. Develop implementation research proposals and refer, as relevant, areas for further consideration by the ACvA's Flagships and/or the teams leading the development of the ACvA's Clinical Themes Initiative. For example, identifying and addressing data gaps or areas where pragmatic trials would provide additional evidence to drive implementation.
    b. Identify capacity and capability gaps, map existing programs that can address them and recommend new approaches and programs, where necessary.
    c. Refine the policy changes necessary to accelerate implementation.
    d. Refine and consolidate an advocacy agenda that will support this work.

Appendix 1. List of Roundtable Attendees

Name	Affiliation
Alicia Jenkins	Professor, Diabetes and Vascular Medicine, NHMRC Clinical Trials Centre, University of Sydney NHMRC Practitioner Fellow
Andrew Boyle	Professor of Cardiovascular Medicine and Head of Discipline, School of Medicine and Public Health, University of Newcastle
Andrew Dwyer	Co-Director, SA Node, National Imaging Facility Director, Clinical & Research Imaging Centre Head of Imaging, SAHMRI
Andrew Gilbert	CEO, Bioplatforms Australia
Andrew Goodman	Queensland Cardiovascular Research Network Manager
Caleb Ferguson	A/Professor Caleb Ferguson, NHMRC Emerging Leadership Fellow, University of Wollongong and Western Sydney Local Health District Deputy Director, Implementation Science, SPHERE
Carissa Bonner	Research Fellow, School of Public Health, University of Sydney
Carolyn Astley	Associate Professor, College of Nursing and Health Sciences, Flinders University Incoming president of Australian Cardiovascular & Rehabilitation Association
Catherine Kellick	Principal Policy Officer, Office for Health and Medical Research, NSW Government
Catherine Shang	Project Manager, Australian Cardiovascular Alliance
Chris Askew	Associate Professor, Clinical Exercise Physiology School of Health and Behavioural Sciences University of the Sunshine Coast
Chris Sobey	Professor in Physiology, Department of Physiology, Anatomy & Microbiology, La Trobe University Co-Director, Centre for Cardiovascular Biology and Disease Research Co-Head, Vascular Biology & Immunopharmacology Group, La Trobe University
Clare Weston	Interventions and Content Manager, Programs and Clinical Services, NPS Medicinewise
Clara Chow	Professor of Medicine, Academic Director Westmead Applied Research Centre, University of Sydney President, CSANZ
Don Nutbeam	Professor of Public Health, University of Sydney Executive Director, Sydney Health Partners
Eduardo Pimenta	Country Medical Director, Australia and New Zealand, Bayer
Elizabeth Halcomb	Professor of Primary Health Care Nursing & Head of Postgraduate Studies, School of Nursing, University of Wollongong
Firanah Korim Le Brun	International Renal Medical Lead Senior Medical Manager, CVRM Lead AstraZeneca
Garry Jennings	Chief Medical Advisor & Interim CEO, NHFA Senior Advisor, Sydney Health Partners Senior Director, Baker Heart and Diabetes Institute
Gemma Figtree	Professor, Faculty of Medicine and Health, University of Sydney

	Interventional Cardiologist, Royal North Shore Hospital
	Research Lead, Cardiothoracic and Vascular Health, Kolling Institute
	President, Australian Cardiovascular Alliance
Genevieve Gabb	Senior Consultant Physician, SA Health
	Membership Secretary, Executive Committee at High Blood Pressure Research Council of Australia
Geoffrey Donnan	Professor of Neurology, University of Melbourne
	Medicine – Royal Melbourne Hospital
	Co-Chair, Australian Stroke Alliance
Georgia Niutta	Policy Officer, Australian Primary Health Care Nurses Association
Grant Drummond	Head, Department of Physiology, Anatomy & Microbiology
	Co-Director, Centre for Cardiovascular Biology and Disease Research
	Co-Head, Vascular Biology & Immunopharmacology Group, La Trobe University
Jason Kovacic	Executive Director, Victor Chang Cardiac Research Institute
Jenny Doust	Clinical Professorial Research Fellow, Australian Women and Girls' Health Research Centre, School of Public Health, The University of Queensland
Jeroen Hendriks	Leo J. Mahar Cardiovascular Nursing Chair, College of Nursing and Health Sciences, Flinders University
	Department of Cardiology, Royal Adelaide Hospital
Jonathan Primmer	General Manager, Abbott Vascular, Australia and New Zealand
Julie-Anne Mitchell	Director Health Strategy, National Heart Foundation of Australia
Julie Redfern	Professor of Public Health, Research Academic Director (Researcher Development, Impact and Output), Faculty of Medicine and Health, University of Sydney
	Honorary Professorial Fellow, The George Institute for Global Health
Jun Yang	Consultant Endocrinologist, Monash Health
	Head, Endocrine Hypertension Group, Hudson Institute of Medical Research
	Research Fellow, School of Clinical Sciences, Monash University
	Adjunct Senior Lecturer, Department of Molecular Translational Science, Monash University
Lee Nedkoff	National Heart Foundation Future Leader Fellow
	Senior Research Fellow, Theme Leader, Linked Data Studies
	Cardiovascular Research Group, Population and Global Health, University of Western Australia
Louise Hickman	Pro Vice-Chancellor (Health), University of Wollongong
	Chair, CVD & Stroke Research Hub, Palliative Care Clinical Studies Collaborative
Karen Carey	Consumer Advisor
Kate King	Government Affairs and Policy, Medtronic, NSW
Kerry Doyle	Executive Director, Australian Cardiovascular Alliance
Kerry-Anne Rye	Professor, Head of the Lipid Research Group and Deputy Head (Research) in the School of Medical Sciences, UNSW
Kim Greaves	Director of Cardiac Research and Senior Staff Specialist, Sunshine Coast Hospital and Health Services
Kimberley Bardsley	Nurse Practitioner, Cardiology,
	Prince Charles Hospital and Queensland Health
Marcus Ilton	Director of Cardiology, Royal Darwin Hospital, Northern Territory
Mark Kinsela	CEO, Pharmaceutical Society of Australia

Mark Nelson	Professorial Research Fellow, Menzies Institute for Medical Research, University of Tasmania Chair of General Practice, School of Medicine, University of Tasmania
Markus Schlaich	Nephrologist & Hypertension Specialist President, High Blood Pressure Research Council of Australia Scientific Council Member, International Society of Hypertension Director, South Pacific Regional Office, World Hypertension League
Melody Ding	Associate Professor/NHMRC Emerging Leader Fellow Prevention Research Collaboration, Sydney School of Public Health, Faculty of Medicine and Health
Meng-Ping Hsu	Project Officer, Australian Cardiovascular Alliance
Miriam Lum On	Head, Cardiovascular, Diabetes and Kidney Unit, Health Group, Australian Institute of Health and Welfare
Niamh Chapman	Postdoctoral Researcher, Menzies Institute for Medical Research, University of Tasmania
Pat Neely	Consumer Advisor
Patricia Davidson	Vice-Chancellor, University of Wollongong
Paul Davies	Director for Government Affairs, Australia/New Zealand, Abbott MTAA Representative
Peter Meikle	Head, Systems Biology Domain, Baker Heart and Diabetes Institute Head, Department of Cardiometabolic Research Translation and Implementation, Baker Heart and Diabetes Institute Director, Platform Technologies, Baker Heart and Diabetes Institute
Ralph Audehm	Clinical Associate Professor, University of Melbourne General Practitioner, Carlton Family Medical
Rebecca Kozor	Cardiologist, Royal North Shore Hospital Senior Lecturer, Northern Clinical School, University of Sydney
Robyn Clark	Professor, College of Nursing and Health Sciences, Flinders University
Robyn Gallagher	Professor of Nursing, Faculty of Health & Medicine, University of Sydney
Rohan Poulter	Director of Cardiology, Sunshine Coast Hospital and Health Service
Sally Inglis	Heart Foundation Future Leader Fellow, University of Technology Sydney Chair, CSANZ Cardiovascular Nursing Council Deputy Chair, NSW Cardiovascular Research Network.
Seana Gall	Senior Research Fellow, Menzies Institute for Medical Research, University of Tasmania National Heart Foundation of Australia Future Leader Fellow, Menzies Institute for Medical Research, University of Tasmania
Sharon McGowan	CEO, National Stroke Foundation
Stephen Nicholls	Director of MonashHeart, Monash Health Director of Victorian Heart Institute
Susan Timbs	CEO, EndUCD
Tanya Hall	CEO, Hearts4Heart
Terence Dwyer	Nuffield Department of Women's and Reproductive Health, University of Oxford
Tony Blakely	Professorial Fellow in Epidemiology, Melbourne School of Population and Global Health