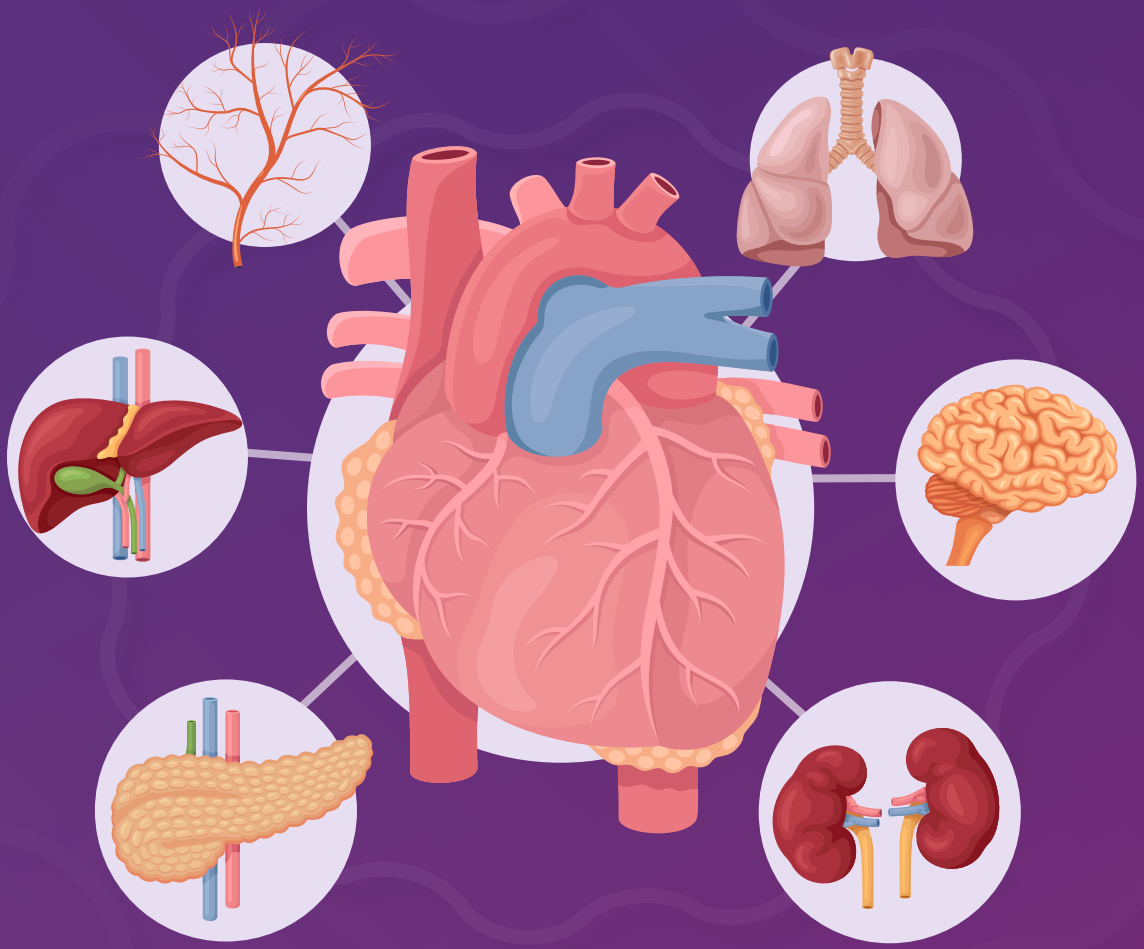
Unite
Annual Summit
2024

Global Heart Hub

# Unite for Change: Transforming Cardiovascular Care for People Living with Multiple Conditions



## A Policy Agenda Built on Five Key Joint Asks for Integrated, Equitable and People-Centred Care


Global
Heart Hub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# Foreword

Every year, millions of people worldwide navigate the immense challenge of living with **Multiple Interconnected Chronic Conditions (MICC)**. Yet, healthcare systems remain largely unequipped to provide them with the integrated, person-centred care they deserve. Too often, people with lived experience are forced to navigate fragmented pathways, where specialists work in silos, early diagnosis is missed and access to innovation remains out of reach. This must change.

The **2024 Global Heart Hub Unite Summit** was a defining moment, bringing together **people with lived experience, clinicians, policymakers and experts** to confront these challenges head-on. The conversations were not just about identifying problems - they were about shaping solutions.

> *"This was an unprecedented gathering of patient organisation leaders and advocates from across the heart, stroke, diabetes, obesity, kidney and liver disease communities. In the cardio-renal-metabolic landscape, the coexistence of multiple conditions is a feature that presents challenges for both the individual and healthcare systems. Regrettably, people with lived experience frequently fall through the cracks of siloed care systems. Those with lived experience are calling for change. People living with comorbidities are an increasing reality and there is an urgent need for a model of comprehensive integrated care."*

This report presents a **clear policy agenda**, outlining the urgent reforms needed to ensure that cardiovascular and multimorbidity care is prioritised at both national and global levels. At its core are **Five Key Joint Policy Asks**, designed to drive real change by improving **care coordination**, **early detection**, **access to innovation**, **equity and empowerment**.

These are more than just recommendations - they are a **call to action**. We now have the insights and the evidence; it is time to ensure that the right frameworks are in place to transform healthcare.

**Global Heart Hub** stands ready to work alongside **policymakers, patient organisations, healthcare providers and industry partners** to ensure that MICC is firmly embedded in health strategies worldwide.

The opportunity to transform cardiovascular care is within our grasp. By working together, we can build a healthcare system that is equitable, proactive and people-centred - one where no one is left behind.

**Now is the time to act.** Let's drive the change our communities need.

**Neil Johnson,**
Executive Director,
Global Heart Hub

## Collaborators

Global Heart Hub would like to acknowledge and extend our appreciation to our collaborating organisations across the connected disease areas.

## Supporters

This summit was made possible with support from:
***AstraZeneca, Boehringer Ingelheim, Daiichi Sankyo, Edwards Lifesciences, Fáilte Ireland, MSD, Novartis, Novo Nordisk, Roche and Servier***.

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# Executive Summary

**Global Heart Hub 4th Annual Unite Summit – Driving Change for Cardiovascular Disease & Connected Conditions**

3-5 November 2024, Dublin, Ireland

Cardiovascular disease (CVD) is no longer an isolated health challenge - it is part of a **growing crisis of Multiple Interconnected Chronic Conditions (MICC)**, including stroke, diabetes, chronic kidney disease, liver disease and obesity.

The Global Heart Hub 4th Annual Unite Summit convened lived experience communities from across these conditions, alongside policymakers, clinicians and researchers, to tackle the urgent need for integrated, people-centred cardiovascular care.

This international event was unprecedented, marking the first time that lived experience communities representing cardiovascular disease and its interconnected conditions came together with a **unified purpose**:

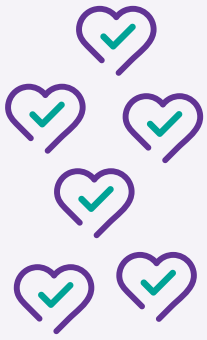
- **To explore and address the challenges faced by individuals living with cardiovascular disease and interconnected conditions.**
- **To identify opportunities for improved detection, diagnosis, treatment and overall health management.**

## In Numbers

**165**
**delegates**

**34**
**countries**

**20**
**speakers**



**65**
**patient organisations**

## Why This Matters

The Summit highlighted persistent **gaps in early detection, care coordination and access to innovation**. People with lived experience continue to experience **fragmented, disease-specific models of care**, while healthcare systems struggle to deliver **multidisciplinary, whole-person treatment approaches**. **Structural changes are essential** to break down silos and ensure every person receives timely, coordinated and equitable care.

## Key Insights from the Unite Summit & Live Survey

The Live Survey was open to all 165 Unite Summit delegates and was directly shaped by the real-time input, perspectives and lived experiences shared by those in the room.

- People experience **uncoordinated**, **siloed care models** that fail to address interconnected conditions.
- **Early detection and prevention remain inadequate**, with high-risk patients often diagnosed too late for optimal intervention.
- **Structural barriers in care coordination**, including the lack of patient navigators, shared records and integrated teams, hinder effective treatment.
- **Innovation and digital health adoption remains inconsistent**, limiting access to AI-driven diagnostics, telehealth and advanced therapies.
- **Equity gaps persist**, across **gender**, **ethnicity**, **geographic** and **socioeconomic** backgrounds.
- **Mental health needs greater recognition and integration** in cardiovascular and multimorbidity care.

## The Unite Action Agenda: Five Key Joint Policy Asks & Next Steps

To address these urgent challenges, the Unite Report outlines Five Key Joint Policy Asks that provide a clear, structured roadmap for policymakers:

1. MULTIDISCIPLINARY CARE & NAVIGATION FOR PEOPLE WITH LIVED EXPERIENCE
2. EARLY DETECTION & COMMUNITY SCREENING
3. INNOVATION & DIGITAL HEALTH ACCESS
4. EQUITY IN CARDIOVASCULAR & MULTIMORBIDITY CARE
5. PREVENTION, EMPOWERMENT & MENTAL HEALTH INTEGRATION FOR PEOPLE WITH LIVED EXPERIENCE

These Five Asks align with the forthcoming European **Cardiovascular Health Plan** and global policy efforts, ensuring a **structured**, **scalable** and **impactful approach to reform**.

# The Time to Act is Now

Global Heart Hub calls on policymakers, healthcare leaders and industry partners to **move from discussion to implementation**. These Five Key Joint Asks provide a clear, actionable roadmap to drive meaningful reform and improve outcomes for people living with cardiovascular and interconnected conditions.

The opportunity to **change the trajectory of cardiovascular health** is now.

The time to act is today.

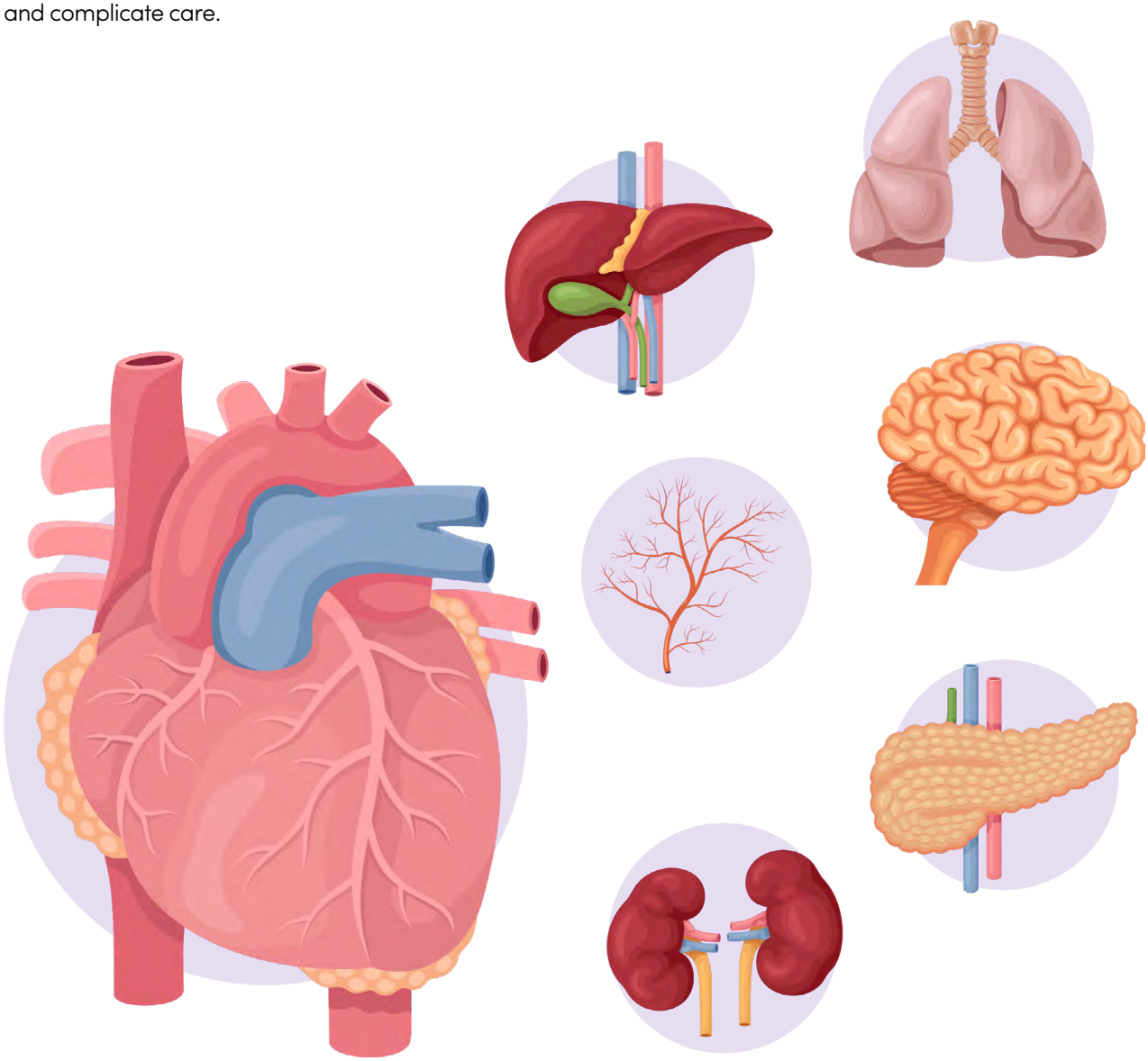
## INTRODUCTION

# Cardiovascular Disease in the Era of Multiple Interconnected Chronic Conditions

Cardiovascular disease (CVD) is no longer an isolated health challenge. It exists within a complex web of **Multiple Interconnected Chronic Conditions (MICC)**, including stroke, diabetes, chronic kidney disease, liver disease, obesity, hypertension, as well as amyloidosis and complications following organ transplants. Today, millions of people worldwide are not only managing CVD but also coping with these interconnected conditions, which are often the underlying cause and together amplify health risks and complicate care.

The burden of MICC is immense – **affecting individuals, families, healthcare systems and entire economies**. Yet, **most healthcare systems remain structured around single diseases**, leaving people with lived experience to navigate a fragmented and inefficient system that fails to meet their needs.

The **2024 Global Heart Hub 4th Annual Unite Summit** brought together, for the **first time, lived experience communities from across the heart, stroke, diabetes, obesity, kidney, and liver disease communities**, alongside policymakers, healthcare professionals and industry leaders. Together, they explored solutions to these pressing challenges and identified concrete actions to drive systemic change.



## Interconnected Chronic Conditions: A Growing Crisis

The **interconnectedness of chronic diseases** is a growing global crisis, driven not only by ageing populations but also by the increasing prevalence of obesity, diabetes and other risk factors. **Multimorbidity - the presence of two or more chronic conditions - significantly worsens health outcomes**, reduces quality of life and increases healthcare costs. For example, diabetes is not only a condition in itself but also a major risk factor for cardiovascular disease, stroke and kidney failure.

Yet, despite the scale of the challenge, **most research, policies and healthcare guidelines remain focused on individual diseases**, failing to address the **real-world complexity of people's lived experience**. This **single-disease focus leaves dangerous gaps in data, clinical care and policy**, undermining efforts to improve outcomes. **Expanding the evidence base on MICC and understanding their cumulative impact** is essential to informing better healthcare strategies and long-term planning.

This report calls for **systemic reform**, advocating for **integrated, people-centred approaches to care**, alongside better data and research frameworks that reflect the true burden of living with multiple conditions.

## Fundamental Facts

### DISEASE BURDEN

- **Leading Cause of Death**: CVD remains the leading cause of death globally, responsible for over 20 million deaths annually.[1]
- **Prevalence of Multiple Conditions**: Globally, **one in three adults** live with several chronic conditions. In developed countries, this number increases to nearly **three out of four** among older adults and is expected to grow significantly.[2]
- **Worse outcomes**: People with multiple conditions are more likely to have poorer health, poorer quality of life and a higher risk of dying.[3]
- **Metabolic Syndrome and risk of CVD**: According to current research, approximately 20-30% of the world's adult population is estimated to have metabolic syndrome, which is a cluster of risk factors including abdominal obesity, diabetes, hypertension and elevated cholesterol, significantly increasing the risk of developing CVD.[4]
- **CKD and risk of CVD**: Many conditions are intrinsically connected, for instance, people living with chronic kidney disease (CKD) exhibit an elevated cardiovascular risk manifesting as coronary artery disease, heart failure, arrhythmias and sudden cardiac death.[5]
- **Obesity/diabetes and risk of CVD**: Obesity increases CVD risk ≈2-fold, and diabetes with metabolic syndrome increases CVD risk ≈5-fold.[6]

## SOCIETAL BURDEN

- **Mental Health Impact**: Individuals with multiple chronic conditions are at a higher risk of **depression** and **anxiety**, leading to **diminished quality of life**.
- **Caregiver Strain**: Family members often bear significant caregiving responsibilities, leading to emotional, physical and financial stress.

## ECONOMIC BURDEN

- **Costs**: The cost of chronic disease worldwide is estimated to reach $47 trillion by 2030.[7]
- **Healthcare Costs**: Multimorbidity leads to increased healthcare expenditures due to more frequent hospitalisations, specialist consultations and extended treatment plans.
- **Lost Productivity**: Chronic conditions contribute to absenteeism and reduced productivity, impacting economic output.

## SURVEY RESPONSES

*What are the most important issues that need to be addressed to improve outcomes for people living with multiple interconnected conditions?*

The breakdown of responses is as follows:

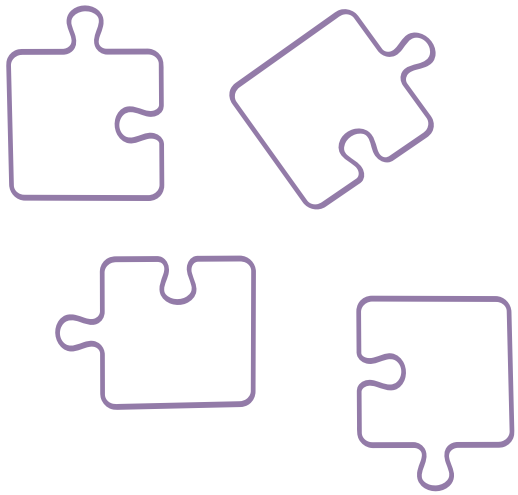

**75%** of participants identified **Access to Coordinated Care** as the most important issue to address.


**25%** identified both Improved Healthcare Policies and **Greater Patient Education** as priorities.

# Health Systems Are Failing People with Lived Experience

People with multimorbidity face many challenges because of the way health systems are organised. Most health systems are designed to cater for people with a single chronic condition.

- **Fragmented Care**: Health systems are often designed to address single diseases, making them ill-equipped to manage people living with multiple chronic conditions. This leads to poor coordination of medical care, challenges in managing multiple medications and increased healthcare costs. For instance, due to the complex interactions between the heart and kidneys, integrated screening and treatment are the only way to address the rising burden, but the two conditions continue to be treated separately in most healthcare systems.
- **Polypharmacy Risks**: Managing multiple conditions often leads to polypharmacy (the use of five or more medications), increasing the risk of adverse drug events and complicating treatment regimens.
- **Preventable Hospitalisations**: Many surgeries and medical procedures, particularly for chronic conditions such as CVD and diabetes, could be avoided with better preventive health measures.



## SURVEY RESPONSES

*Which type of policy change do you believe would most improve outcomes for people living with multiple interconnected conditions?*

The breakdown of responses is as follows:


**49%** suggested both a **Greater Emphasis on Preventive Care & Improved Training for Healthcare Providers**.


**51%** identified **Increased Funding** for **Integrated Care** and the need for greater **Patient Advocacy** as priorities.

## Integrated Care Models in Action: A Best Practice Example

A compelling example of how integrated care models can improve health outcomes for people with lived experience was shared by Dr Susan Connolly who highlighted an Irish innovative national framework for preventing and managing chronic diseases, including cardiovascular disease, chronic respiratory disease, and type 2 diabetes. This innovative model, which centres on community health hubs and collaborative care teams, is providing people with coordinated, comprehensive care that addresses their interconnected health needs.

In this approach, people with lived experience are seen in community specialist hubs, where multidisciplinary teams - including cardiologists, nephrologists, diabetes specialists, nurses, dietitians, and physiotherapists - work together to provide holistic care. This model has resulted in significant improvements in care delivery, including measurable reductions in hospital admissions and emergency readmissions, demonstrating the effectiveness of collaboration across specialities.

Dr Connolly emphasised the importance of empowering people with self-management tools and education, with digital tools playing a pivotal role in maintaining continuity of care, exemplified during the disruptions caused by the COVID-19 pandemic.

This integrated care model offers a concrete example of how coordinated, people-centred approaches can effectively address the challenges of managing multiple interconnected conditions.

Data indicates that individuals with multiple long-term conditions have a greater increase in the risk of death compared to those without, irrespective of socioeconomic status.[8]

*People with multiple long-term conditions have a higher usage of healthcare, face poorer quality of life and more impaired functioning, more hospital admissions and more adverse outcomes. We need to change this. And the way to change is to deliver an integrated care approach, but that requires quite a seismic change in the way we deliver healthcare because it's always been traditionally delivered in a silo or a disease-based approach*

**Dr. Susan Connolly,**
Consultant Cardiologist, Integrated Care,
Galway University Hospital, Ireland

# The Urgent Need for Policy Action

Addressing the challenges posed by multiple interconnected conditions requires comprehensive policy interventions to reform healthcare systems, focusing on integrated care models, preventive strategies and support for mental health services.

The time to act is today.

# The Burden & Complexities of Living with Multiple Interconnected Chronic Conditions: Insights and Themes

Living with Multiple Interconnected Chronic Conditions (MICC) presents significant challenges, not only in terms of medical management but also in its impact on **daily life**, **emotional wellbeing and access to care**. The discussions at the Unite Summit highlighted the **systemic barriers within healthcare systems** and the **urgent need for a holistic, people-centred approach to care**.

## LIVED EXPERIENCE: DAILY IMPACT AND MENTAL HEALTH STRAIN

### The Emotional and Psychological Burden

For many people, managing multiple conditions is an ongoing battle that extends far beyond their physical symptoms. The **emotional burden is profound**, with **depression** and anxiety frequently accompanying chronic illnesses. The psychological weight of these conditions is compounded by feelings of **guilt and loneliness**, as individuals struggle to balance the demands of their health with their personal and professional responsibilities. Many people with lived experience spoke of the **emotional exhaustion** that comes with navigating a fragmented healthcare system, attending multiple appointments and keeping track of various medications and treatment regimens.

### Uncertainty, Shame and Stigma

Uncertainty is a constant reality for those living with MICC. Many people live with the **fear of sudden health declines**, **complications or disease progression**, which significantly impacts their mental wellbeing. **Shame and stigma** further complicate the experience, particularly for those whose conditions are perceived to be linked to lifestyle choices. The social perception of diseases such as **obesity, diabetes and cardiovascular disease** often discourages individuals from seeking the care and support they need, reinforcing a cycle of **isolation and inadequate treatment**.

### The Practical Challenges of Managing MICC

Beyond the psychological toll, people with lived experience face **substantial practical challenges**. **Social isolation** is a common issue, as the burden of managing chronic illnesses can make it difficult to maintain social connections. The **financial strain** of multiple conditions is also significant. Many people experience **economic hardship** due to **missed work**, **high medication costs and frequent medical visits**, all of which place additional stress on individuals and their families. Often, people need permanent informal care, and the emotional (and accompanying economic) burden extends to their carers, too, as demonstrated by chronic kidney disease – a disease-risk multiplier that increases the potential for cardiovascular disease, heart failure and premature death.[9]

### Fragmented and Uncoordinated Care

The **logistical aspects of managing MICC can be overwhelming**. People with lived experience often spend an excessive amount of time **scheduling and attending appointments** with different specialists, only to find that their care is **not well-coordinated**. Many experience **frustration when their medical records are not shared between providers**, leading to **repeated tests**, **conflicting advice and a lack of continuity** in their treatment plans. This **fragmented approach to care places an unnecessary burden on people with lived experience**, forcing them to act as their own care coordinators in an already complex system.

## THE FOCUS ON SINGLE CONDITIONS: TREATMENT GAPS AND POOR OUTCOMES

People managing multiple interconnected chronic conditions frequently encounter a **healthcare system designed around single-disease treatment models**, leading to fragmented care and missed opportunities for better outcomes. Many describe their experience as a **constant struggle to navigate an uncoordinated system**, where specialists operate in isolation, medical records are incomplete, and treatments are often contradictory. This lack of care integration not only complicates treatment but also puts people's health and wellbeing at greater risk.

### Poor Communication and Lack of Care Coordination

One of the most common frustrations among people with lived experience is the **breakdown in communication between healthcare providers**. Many feel they must act as their own care coordinators, repeatedly explaining their medical history at each appointment. Without a **centralised care pathway**, people are left juggling multiple referrals, test results and specialist recommendations, often with little to no oversight from a coordinating physician. As a result, **critical information is lost** and the burden of managing care falls almost entirely on the person.

### Conflicting Treatment Plans and Missed Opportunities for Early Detection

People living with multiple conditions often follow **disconnected treatment plans**, as different specialists focus only on their specific area of expertise, without considering how treatments interact. This leads to **contradictory medical advice, overlapping medications and increased risks of drug interactions**. The absence of **comprehensive, shared medical records** further complicates matters, leaving healthcare providers without a full picture of the person's overall health.

Opportunities for **early detection and intervention are frequently missed**, as healthcare systems remain largely reactive. Instead of identifying conditions in their early stages through regular screening and prevention programmes, many people are diagnosed **only after complications arise**. Without systematic processes to screen for interconnected conditions, late diagnoses become the norm rather than the exception.

### Systemic Barriers to Quality Care

Several structural issues contribute to poor health outcomes for people with multiple conditions. **Polypharmacy**, or the use of multiple medications, is a particular concern, with many people experiencing **severe side effects or adverse drug interactions** due to a lack of coordinated prescribing. Additionally, **access to essential resources varies widely**, with some people struggling to obtain necessary treatments, rehabilitation services, or chronic disease management support.

Financial constraints present another significant challenge. **High costs for some diagnostic tests**, such as genetic screenings, can prevent early and precise diagnosis, while limited insurance coverage or out-of-pocket expenses create further barriers to timely care. **Health inequities persist across gender, ethnicity and socioeconomic background**, leaving many without the same level of access to specialist care or innovative treatments. Furthermore, people living in rural areas often experience more difficulties in accessing care.

### The Impact of Provider Shortages and Limited Consultation Times

Workforce shortages in healthcare systems globally mean that people **face long wait times** to see specialists, delaying essential interventions. When consultations do occur, they are often **too short to allow for comprehensive care discussions**, forcing both people with lived experience and clinicians to make rushed decisions about complex treatment plans. Many healthcare professionals also report feeling **under-equipped to manage multiple chronic conditions simultaneously**, due to a lack of training in **integrated care approaches**.

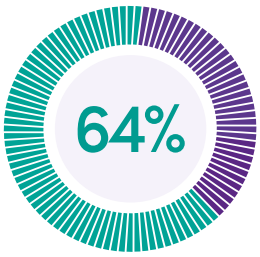
### The Need for a Paradigm Shift in Care Delivery

Without a shift toward **coordinated, people-centred care**, people will continue to experience **fragmented treatment, unnecessary hospitalisations and avoidable complications**. Addressing these systemic shortcomings will require **investment in integrated care models, improved data sharing and greater focus on prevention and early intervention**.

## SURVEY RESPONSES

*What do you believe is the biggest challenge faced by individuals living with multiple conditions?*

The breakdown of responses is as follows:




**64%** highlighted **Poor Coordination Between Specialists** as the biggest issue.


**14%** suggested **Lack of Awareness** among Healthcare Providers is the biggest challenge.


**14%** highlighted **Psychological Impacts** as the most important key issue.


**8%** reported **Limited Access to Care** as the most significant concern.

## SHARED DECISION-MAKING & INVOLVEMENT OF PEOPLE WITH LIVED EXPERIENCE

Shared decision-making is a fundamental aspect of people-centred care, ensuring that individuals are actively involved in decisions about their treatment and management plans. Research has consistently shown that when people are meaningfully engaged in their care, they experience **better health outcomes**, **improved adherence to treatments and greater satisfaction with their healthcare experiences**. However, discussions at the Unite Summit highlighted that **shared decision-making remains limited or entirely absent for many people with multiple interconnected chronic conditions (MICC)**, particularly in the **cardio-renal-metabolic landscape**.

### Exclusion from Treatment Decisions

Many people with lived experience described feeling excluded from critical discussions regarding their care. Instead of participating in **collaborative treatment planning**, they were often presented with medical decisions **as a directive rather than an open discussion**. This lack of engagement leaves people feeling **disempowered, disconnected from their own care and less likely to adhere to treatment recommendations**. The failure to involve people with lived experience in decision-making not only diminishes trust but also reduces the likelihood of achieving optimal health outcomes.

### Time Pressures and Clinician Barriers

A major obstacle to shared decision-making is the **time constraints within clinical settings**. Healthcare providers, working under intense pressure and with limited consultation times, often prioritise efficiency over engagement. **Clinician resistance to shared decision-making** was also noted as a significant challenge, with some healthcare professionals lacking training in **people-centred communication** or defaulting to **traditional**, **hierarchical models of care**. As a result, people with lived experience frequently report feeling dismissed when they seek to express concerns or ask about alternative treatment options.

### The Impact of Health Literacy Gaps

Another key barrier to effective shared decision-making is **limited health literacy**. Many people with lived experience **struggle to understand complex medical terminology, the interconnected nature of their conditions or the long-term implications of their treatment choices**. Without adequate explanations or accessible resources, people may feel overwhelmed and **unable to advocate for their needs or preferences**. This gap in knowledge prevents **truly informed decision-making**, leaving people reliant on clinician recommendations without a full understanding of the potential risks and benefits.

### The Urgent Need for a Cultural Shift

Without a significant shift towards **collaborative, people-centred care**, shared decision-making will remain a missing element in the management of MICC. The discussions at the Unite Summit reinforced the need for:

- **Stronger partnerships between people with lived experience and healthcare providers,** where treatment plans are co-developed rather than imposed.
- **Healthcare provider training in shared decision-making**, ensuring clinicians have the tools and time to engage people with lived experience effectively.
- **Easily accessible, clear health information**, empowering people to make informed choices about their care.

Embedding **shared decision-making** as **a standard practice across healthcare systems** will not only enhance the care experience for people with lived experience but also lead to better clinical outcomes and more effective management of multiple interconnected chronic conditions.

## SURVEY RESPONSES

*Which systemic gap do you feel contributes most to poor outcomes for people living with multiple interconnected conditions?*

The breakdown of responses is as follows:


**88%** suggested **Lack of Integrated Care & Ineffective Communication Between Providers**.


**12%** mentioned **Financial Barriers to Accessing Care**.

## BARRIERS WITHIN THE HEALTHCARE SYSTEM

People living with multiple interconnected chronic conditions (MICC) often face **significant structural and communication barriers within healthcare systems**, which compromise their ability to receive effective and coordinated care.

Discussions at the Unite Summit highlighted how **fragmented care pathways**, **siloed treatment approaches and a lack of integrated health records** contribute to disjointed care experiences and poorer outcomes for people living with multiple interconnected conditions. These barriers create **avoidable delays, inefficiencies and added burden** for people with lived experience—reinforcing the urgent need for systemic reform.

### Fragmented and Siloed Care

One of the most pressing challenges faced by people with lived experience is the **lack of coordination between different specialists and healthcare providers**. Rather than receiving holistic, people-centred care, many individuals are treated for separate conditions in isolation, often with **conflicting medical advice and unaligned treatment plans**. Without a designated care coordinator or an integrated approach, people with lived experience are left to navigate the system on their own, leading to frustration and inconsistent care.

A major consequence of this siloed approach is **missed opportunities for early intervention**. Many interconnected conditions share common risk factors, yet current healthcare models rarely screen for or manage them together. As a result, people with lived experience often receive a diagnosis only after complications have progressed, rather than benefiting from **proactive, preventive care** that could improve long-term outcomes.

### Data and Digital Barriers

Another significant barrier to effective care is the **absence of integrated health records**, preventing seamless information-sharing between healthcare providers. People with lived experience frequently experience **duplication of tests, inconsistent diagnosis and treatment delays** due to incomplete medical histories or inaccessible records.

Despite advances in digital health, many healthcare systems still lack **interoperable electronic health record (EHR) systems**, leaving providers with **fragmented, outdated or incomplete patient data**. This lack of digital integration also affects people with lived experience directly, as they often have **limited or no access to their own health records**, restricting their ability to track progress, make informed decisions or share critical medical information with new providers.

### When Communication Fails: Gaps Between Providers and People with Lived Experience

Beyond systemic barriers, **poor communication between people with lived experience and healthcare providers** further exacerbates challenges in care delivery. Many participants at the Summit reported feeling that their experiences and concerns were **not fully acknowledged or taken seriously** by healthcare professionals.

Some people with lived experience described instances of **provider scepticism**, where their symptoms were dismissed or minimised, delaying necessary interventions. Others highlighted **cultural differences** as a factor affecting their interactions with clinicians, particularly in cases where language barriers or differing health beliefs influenced treatment decisions.

A key frustration for many people with lived experience was the **repetitive need to recount their medical history at every appointment**, often due to the lack of shared health records across healthcare providers. This not only results in wasted time but also increases the risk of **miscommunication and medical errors**. Additionally, the **use of complex medical language** without sufficient explanation leaves many people with lived experience struggling to understand their condition, treatment options or the rationale behind medical decisions.

### The Impact on People with Lived Experience and the Urgent Need for Reform

These barriers collectively contribute to **disjointed, inefficient and inequitable care for people with MICC**. People with lived experience are left feeling **overwhelmed**, **unheard and unsupported**, with many disengaging from their own care due to persistent obstacles in the system. Without a fundamental shift towards better **care coordination, improved communication and greater data integration**, people will continue to experience avoidable harm, **delayed diagnosis and suboptimal health outcomes**.

*Language, education, and community engagement must be at the core of healthcare transformation. We need to move beyond labels that define individuals by their conditions and instead recognize the full experience of living with them. Empowering people through education and fostering care models that treat the whole person—not just an organ or a disease—is essential for a truly inclusive and effective healthcare system.*

**Lucas Xavier,**
International Diabetes Federation,
Brazil

# Strategic Approaches to Transforming Care for People Living with Multiple Interconnected Conditions

The discussions at the Unite Summit emphasised the **urgent need to transform healthcare systems** to better serve people living with multiple interconnected chronic conditions (MICC). Addressing the complexities of managing these conditions requires **a fundamental shift towards integration, collaboration and people-centred care**. Discussions focused on **improving detection, diagnosis and care coordination** to ensure more responsive systems and meaningful impact for people managing multiple conditions.

### Adapting Healthcare Systems for Integrated Care

Current healthcare models struggle to address the needs of people managing multiple conditions, often resulting in **fragmented care, limited access to diagnostics and inconsistent treatment approaches**. To overcome these challenges, several **opportunities for change** were identified:

- A more **person-guided care model** was seen as critical, with recommendations including the introduction of **nurse navigators** - registered nurses who coordinate care, assist with scheduling and ensure appropriate treatment. **Community health educators** could also play a key role by providing **localised health information**, raising awareness of disease interconnectivity, and encouraging preventive action.
- Healthcare professionals need **enhanced training** to equip them with the necessary skills to **manage complex and interconnected conditions effectively**. The **use of artificial intelligence (AI) and data analytics** was also highlighted as a transformative tool in healthcare, with potential to **improve diagnostic accuracy, identify disease patterns and personalise care plans**.
- Pharmacists were also identified as **critical members of the care team**, supporting **medication management** and reducing the burden on doctors by helping people with lived experience understand drug interactions and treatment regimens. Additionally, the introduction of **accessible electronic patient records** and **personalised digital health cards** could provide **people with lived experience and clinicians with full visibility into medical history and treatment plans**, ensuring continuity of care across providers.
- Increased **education and transparency** were seen as essential to empowering people with lived experience to make informed decisions about their health. Access to **clear**, **understandable information** would support individuals in navigating their conditions and engaging more confidently and actively in their care.

*Better coordination, earlier detection, and equitable access—these are not luxuries, but necessities for people managing multiple chronic conditions.*

**Anita Sabidi,**
Diabetes Initiative Indonesia

### Strengthening Collaboration in Care Delivery

Transforming care for people with MICC requires a **collaborative, multidisciplinary approach**. Establishing **team-based care models** - where a diverse group of clinicians, including primary care doctors, specialists, nurses, and pharmacists, work together - ensures that **all aspects of a person's health are considered in a coordinated way**.

To achieve this, **stronger collaboration between patient organisations, healthcare professionals and policymakers** is necessary. Establishing **structured mechanisms for stakeholder engagement** will help optimise care and ensure that healthcare systems take a unified approach to treating interconnected conditions.

Additionally, **care coordinators** could be introduced to streamline communication, ensuring that information is shared effectively across different healthcare settings, avoiding duplication, and improving efficiency in treatment delivery.

### Policy-Driven Strategies to Support Change

To drive large-scale change, policy interventions must support **more integrated and proactive approaches to care**. A major recommendation was the **statutory integration of interdisciplinary care protocols** into medical training, ensuring that healthcare professionals are equipped to manage people's health holistically rather than treating conditions in isolation.

Ongoing **professional development and awareness campaigns** were also seen as essential. **Education webinars, continuing medical education (CME) courses and conference presentations** can showcase successful collaborative care models, fostering a broader adoption of people-centred approaches.

**Integrated clinical guidelines** are essential for making care coordination a standard part of practice. They must centre on **shared decision-making and the perspectives of people with lived experience**, ensuring that care pathways are responsive to the realities of managing multiple, overlapping health conditions.

### Addressing Gaps in Healthcare Guidelines

Current healthcare guidelines are often disease-specific, failing to account for **symptom overlap and the complexities of managing multiple conditions**. Participants emphasised the need to develop **cross-disciplinary guidelines** that provide **holistic, consistent care approaches** for people living with MICC.

A key recommendation was to create **patient roadmaps**, offering **clear, actionable guidance on navigating the healthcare system beyond initial diagnosis**. These structured pathways would empower individuals with lived experience to better **understand their treatment options, anticipate what comes next, and take an active role in managing their care**.

### Improving Communication Between Healthcare Providers and People with Lived Experience

Improved communication between healthcare providers and people with lived experience is fundamental to ensuring **greater patient engagement, adherence to treatments and overall better outcomes**. However, this requires a cultural shift in medical education and practice.

Training for healthcare providers should include **people-centred communication techniques**, fostering greater **empathy, active listening and shared decision-making**. Clinicians should be encouraged to use **clear, straightforward language**, ensuring that people with lived experience fully understand their diagnosis, treatment plans and long-term health outlook.

Personalised communication strategies – tailored to **each individual's needs**, literacy **levels and cultural background** – were also recommended. Integrating **diverse communication methods**, including digital tools and in-person support, can help healthcare providers engage more effectively with people from a wide range of communities and lived experiences.

*When working with connected conditions, it's really important to listen to the perspective of the person with lived experience because they may talk about things that are not immediately evident to a clinician treating just one illness. For instance, symptoms may be related to another condition. Drug side effects may be related to drugs that the person is on for their other condition. It's really only the person with lived experience who can provide this type of information on drug interactions and their impact on the person.*

**Leigh Bell,**
President, Cardiomyopathy Australia New Zealand

*We say people-centred care and really bringing the people with lived experience and making them the central focus is key. But bringing people from the clinical aspect, people who write guidelines, people who are policy experts— and having everyone at the same table is actually changing the conversation. I think it's helping all of us understand each other's perspective, but also understanding how we get from point A to point B. Working together is ultimately the end goal to really change things.*

**Dr. Martha Gulati,**
Professor of Cardiology, Smidt Heart Institute,
Cedars-Sinai, Los Angeles

**Empowering People with Lived Experience Through Education and Support Systems**

Empowering people with lived experience of MICC is key to transforming care. Access to **education, tools and tailored support** enables individuals to manage their conditions more effectively and participate fully in their care journey.

A key strategy is the **generation of evidence through patient experience data**, identifying gaps in knowledge and care based on direct patient feedback. Establishing **patient support hubs** would also offer dedicated assistance, allowing individuals to access resources tailored to their needs.

Developing **educational tools such as mobile apps and digital platforms** would give people with lived experience **easy-to-access information about their conditions**, helping them understand their treatment plans and self-care options. Additionally, fostering **peer support networks** would enable people to share experiences, learn from one another, and build a sense of community.

Public education campaigns aimed at raising **awareness of cardiovascular disease, interconnected conditions and available healthcare resources** could further drive engagement and improve health outcomes. Upskilling people with lived experience in **telehealth usage** would also empower them to make the most of remote care options, ensuring continued access to healthcare professionals even in challenging circumstances.

**The Future of People-Centred, Integrated Care**

Transforming care for people with multiple interconnected chronic conditions requires a **system-wide shift** - one that prioritises **early detection, integrated care pathways, shared decision-making and multidisciplinary collaboration**. By implementing these strategies, **healthcare systems can move from a fragmented, reactive approach to a proactive, people-centred model of care**.

*Obesity is a visible disease and therefore may lead to stigmatisation within healthcare appointments, as people may assume a lot of bias about a person living in a larger body. Everyone's story is different, and we need to be assessed holistically.*
*One size does not fit all.*

**Maura Murphy,**
Irish Coalition for People Living with Obesity

## Key Challenges Hindering Progress

Despite advancements in healthcare, people living with Multiple Interconnected Chronic Conditions (MICC) continue to face **significant barriers to effective**, **coordinated and people-centred care**. Discussions at the Unite Summit underscored the **systemic failures that prevent early detection, integration and equitable access to treatment**. Addressing these critical challenges is essential to achieving lasting policy change.

### 1. A SYSTEM BUILT FOR SINGLE DISEASES, NOT PEOPLE

Healthcare remains structured around **individual diseases rather than interconnected conditions**, forcing people into **fragmented, specialist-driven pathways** that fail to treat them holistically. This outdated model results in **disjointed treatment plans, delayed diagnoses and missed opportunities for preventive care**.

### 2. GAPS IN EARLY DETECTION AND SCREENING

Too many people are diagnosed **only after complications arise** due to **inconsistent screening and risk assessment** across specialties. The lack of proactive, multidisciplinary screening **delays intervention and increases the burden on healthcare systems**, leading to worse outcomes.

### 3. LACK OF CARE COORDINATION AND NAVIGATION SUPPORT

People with lived experience must navigate **complex, disconnected healthcare systems alone**, with no clear **point of contact to guide them**. The absence of **care coordinators and structured patient pathways** leads to redundant testing, conflicting medical advice and poor continuity of care.

### 4. RESTRICTED ACCESS TO INNOVATION AND DIGITAL SOLUTIONS

Breakthroughs in **AI-driven diagnostics, telehealth and precision medicine** remain underutilised due to **regulatory hurdles, reimbursement gaps and digital exclusion**. Many people - especially those in underserved populations - **struggle to access innovations that could transform their care**.

### 5. HEALTH INEQUITIES AND STRUCTURAL BARRIERS

Access to high-quality care is **not universal**. **Women, low-income populations and minority groups** experience **delays in diagnosis, limited access to specialists and poorer health outcomes** due to systemic inequalities. Without targeted interventions, these disparities will continue to widen.

### 6. OVERBURDENED AND UNDERTRAINED HEALTHCARE WORKFORCE

Time constraints, **short consultation time**s and **limited training on managing multiple conditions** leave healthcare professionals ill-equipped to support people living with MICC. Many clinicians lack the tools or incentives to practice **truly integrated, multidisciplinary care**.

### 7. FAILURE TO EMBED PEOPLE-CENTRED DECISION-MAKING

Shared decision-making is **not yet standard practice**. People report feeling **excluded from treatment discussions**, struggling with **complex medical language**, and lacking access to the **clear, actionable health information** they need to advocate for themselves.

# A Call for Urgent Action

These challenges are not insurmountable, but they require structural, systemic reform.

The next section outlines the **Five Key Joint Policy Asks**, providing a clear roadmap for change.

The time to act is now.

# The Unite Action Agenda: Five Key Joint Policy Asks & Next Steps

The Unite Report presents a **structured roadmap for policymakers**, addressing the systemic barriers outlined in this report. At the core of this agenda are **Five Key Joint Policy Asks**, each reflecting the priorities identified at the Summit. These asks provide **clear, actionable solutions** to transform the management of Multiple Interconnected Chronic Conditions (MICC) and drive meaningful change.

1

## MULTIDISCIPLINARY CARE & NAVIGATION FOR PEOPLE WITH LIVED EXPERIENCE

Current healthcare systems are **fragmented**, forcing people with lived experience to navigate multiple specialists without structured support. Without coordination, people face **conflicting treatment plans, delays in care and higher risks of adverse outcomes**.

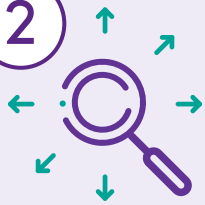
**What Needs to Change:**

- Establish **specialist-led, integrated care teams**, bringing together cardiology, endocrinology, nephrology and other specialities to deliver comprehensive, whole-person care.
- Implement **standardised clinical guidelines** that reflect the complexities of managing multiple conditions, ensuring a unified approach to multimorbidity management.
- Introduce **patient navigators, nurse coordinators and central care liaisons** to support people with lived experience in navigating the healthcare system, improving efficiency and reducing patient burden.

**NEXT STEP:**

Develop **national frameworks** for specialist care hubs and patient navigation models, embedding them into **existing healthcare structures** to ensure long-term sustainability.

2



## SCALE UP EARLY DETECTION & COMMUNITY-BASED SCREENING PROGRAMMES

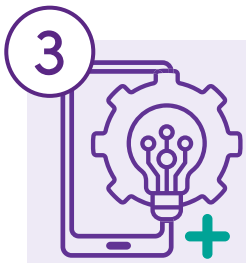
Too many people are diagnosed **only after complications arise**, leading to avoidable hospitalisations and poorer outcomes. **Inconsistent screening protocols and limited access to diagnostics** contribute to missed opportunities for prevention.

**What Needs to Change:**

- Expand **nationwide risk screening** for MICC, including **CVD, stroke, diabetes, chronic kidney disease, liver disease and related conditions**.
- Ensure **greater accessibility to point-of-care diagnostics** in primary and community settings, particularly for underserved populations.
- Integrate **mental health screening** as a routine component of cardiovascular and multimorbidity risk assessments, recognising the psychological burden of chronic illness.

**NEXT STEP:**

Launch **public health campaigns and national policy initiatives** that prioritise early detection, risk assessment and accessible screening programmes.




## ACCELERATE ACCESS TO INNOVATION & DIGITAL HEALTH SOLUTIONS

Healthcare is falling behind in **leveraging technology and innovation** to improve outcomes for people living with MICC. **Regulatory hurdles, fragmented data systems and lack of investment** prevent the widespread adoption of **AI, digital health and integrated patient records**.

**What Needs to Change:**

- Implement **AI-driven risk prediction models**, real-time data sharing and telehealth solutions into standard clinical practice.
- Reform **regulatory and reimbursement frameworks** to support the adoption of new technologies, ensuring that digital health solutions are accessible to all patients.
- Promote the **use of electronic health records (EHRs) across healthcare settings**, ensuring seamless care transitions and better-informed decision-making.

**NEXT STEP:**

Create **incentives and policy structures** to accelerate the adoption of **AI, digital health and patient data-sharing initiatives**, ensuring these tools are widely available and equitably distributed.


## GUARANTEE EQUITY IN CARDIOVASCULAR & MULTIMORBIDITY CARE ACROSS GENDER, GEOGRAPHY, ETHNIC AND SOCIOECONOMIC GROUPS

Access to high-quality care is not universal. Significant disparities persist across gender, ethnicity, income, and geography. Women, ethnic minorities, and lower-income populations are more likely to be **misdiagnosed, face longer wait times and have poorer outcomes**. These inequities are often compounded by where a person lives – access to care can vary dramatically between countries, within countries, and even within cities. People in rural or remote areas frequently struggle to access specialists, diagnostics or innovative treatments.

**What Needs to Change:**

- Embed **sex-specific research and gender-sensitive care protocols** into clinical guidelines to address disparities in cardiovascular and multimorbidity treatment.
- Expand healthcare access for **underserved communities** – particularly ethnic groups, rural populations and low-income groups – through targeted **policy-driven funding and infrastructure investment**.
- Strengthen the **representation of diverse communities** in research and policymaking to ensure that care guidelines reflect real-world lived experiences.
- Address **regional gaps** in care access by ensuring that national cardiovascular and multimorbidity strategies actively tackle urban-rural divides and health system fragmentation.

**NEXT STEP:**

Develop **national equity action plans** that eliminate disparities and drive equitable access to **specialist care, innovation and preventive health interventions**.

5

## PREVENTION, EMPOWERMENT & MENTAL HEALTH INTEGRATION FOR PEOPLE WITH LIVED EXPERIENCE

The current system is **reactive**, **not proactive**, focusing on managing disease progression rather than **prevention and empowerment**. People with lived experience often feel excluded from their own care decisions and mental health remains an overlooked aspect of chronic disease management.

**What Needs to Change:**

- Scale up **lifestyle-based prevention strategies** that promote cardiovascular health and multimorbidity risk reduction.
- Ensure **people with lived experience have a leading voice** in shaping cardiovascular health and other non-communicable disease (NCD) policies, fostering greater patient advocacy and involvement.
- Integrate **mental health support within cardiovascular and multimorbidity care pathways**, recognising the impact of psychological wellbeing on physical health.

**NEXT STEP:**

Launch person-led policy initiatives and embed mental health services into national CVD and multimorbidity care programmes.

**Aligning with Broader Policy Initiatives**

These Five Key Joint Asks are designed to **align with the forthcoming European Cardiovascular Health Plan, national cardiovascular plans** and global health strategies, ensuring a **structured, scalable approach to healthcare reform**.

**The Time to Act is Now**

Global Heart Hub calls on **policymakers, healthcare leaders and industry partners** to move from discussion to implementation. **These Five Key Joint Asks provide a clear, actionable roadmap to drive meaningful reform and improve outcomes for people living with cardiovascular and interconnected conditions**.

**The opportunity to change the trajectory of cardiovascular health is now. The time to act is today.**

# Conclusion

### The Path Forward: Turning Commitments into Action

The **Five Key Joint Policy Asks** are not just recommendations - they are **a blueprint for change**. They provide a **clear**, **actionable and urgent framework** for policymakers to address the systemic failures in managing Multiple Interconnected Chronic Conditions (MICC).

### From Policy Asks to Policy Action

The next step is to **launch the Five Key Joint Asks to policymakers** at both the **European and national levels**, advocating for their inclusion in the forthcoming **European Cardiovascular Health Plan** and broader healthcare reforms. These policy commitments must be embedded into **national cardiovascular plans**, ensuring that governments take responsibility for delivering integrated, people-centred care.

Importantly, this work is part of a **growing global movement** to tackle interconnected chronic conditions through structural reform. For example, the **American Heart Association's Cardiovascular-Kidney-Metabolic Health (CKMH) Initiative** is bringing together stakeholders across disciplines to break down silos between cardiovascular, kidney and metabolic care. Their goal – like ours – is to drive more **coordinated**, **equitable and outcome-driven care** for people living with multiple interconnected conditions.

This alignment of efforts across continents underscores a powerful message:

> **THE WORLD IS WAKING UP TO THE URGENT NEED FOR SYSTEMIC CHANGE.**

Global Heart Hub's Five Key Joint Policy Asks contribute directly to this international momentum and provide **clear policy actions** to shape the future of care for people living with cardiovascular and interconnected conditions.

### A Long-Term Vision: The Declaration of Needs in Cardiovascular and Interconnected Health

Beyond immediate policy change, we must establish a long-term vision for the future of cardiovascular and multimorbidity care. The development of a **Global Heart Hub Declaration of Needs in Cardiovascular and Interconnected Health** will lay the foundation for truly integrated, equitable, and high-quality care for all people with lived experience of cardiovascular and interconnected conditions.

This Declaration will serve as a guiding framework, outlining **core principles for integrated care, empowerment and equitable access**. Over the next **5–10 years**, it will evolve into a **structured roadmap for sustainable, systemic change** - a commitment to ensuring that no person is left behind.

*It's important to ensure that healthcare systems are better equipped to address the complex needs of patients with multiple conditions. It is also crucial that the root causes of health disparities are addressed, paving the way for systemic change.*

**Brenda Chitindi,**
Zambia Heart and Stroke Foundation

# The Call to Action: The Time to Act is Now

Transforming healthcare requires more than just dialogue; it demands **collective action** from policymakers, healthcare professionals, patient organisations, industry and academia. Each stakeholder has a vital role to play in bridging systemic gaps and ensuring that **people-centred solutions become a reality**.

By championing the **Five Key Joint Asks** today, we take the first critical step toward a **future where every person living with interconnected conditions receives the care they deserve**.

Global Heart Hub calls on all stakeholders to act now. The momentum for change is here – **we must seize it**.

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# Appendices

**Appendix A:** Summit Programme and Event Page

The Summit Programme is available here:

The Summit Event Page is available here:

**Appendix B:** Contributors

The summit programme included presentations and discussion panels where insights, experiences and perspectives were shared by a range of distinguished speakers whose contributions, together with those of the participants, played an important role in shaping this report.

### *SPEAKERS & DISCUSSANTS:*

- **Prof Roberto Bertollini**, Advisor to the Qatar Minister of Public Health, Qatar
- **Dr Susan Connolly**, Consultant Cardiologist, Integrated Care, University Hospital Galway, Ireland
- **Len Crispino**, Entrepreneur, Philanthropist, Heart Valve Patient, Canada
- **Dr John de Verteuil**, General Practitioner with Special Interest in Cardiology, UK
- **Dr Apoorva Gomber**, Associate Director of Advocacy, Center for Integration Science, Brigham and Women's Hospital, USA
- **Anu Gomanju**, Patient Advocate, Global Health Professional, CHEER Hearts, Nepal
- **Penilla Gunther**, Former Policymaker, Patient Advocate, FOKUS Patient, Sweden
- **Lynn Hedgecoe**, Patient Advocate, British Society for Heart Failure and Cardiomyopathy UK, UK
- **Prof Jeroen Hendriks**, Professor of Cardiovascular Nursing and Co-Chair of ESC ACNAP Science Committee, Australia
- **Dr Rani Khatib**, Consultant Cardiovascular Pharmacist, UK
- **Rhonda Monroe**, Patient Advocate, Women Heart Champion, USA
- **Maura Murphy**, Patient Advocate, Irish Coalition for People Living with Obesity, Ireland
- **Sarah Murray**, National PPI Group Chair, National Cardiac Surgery Clinical Trials Initiative, Leicester University and British Heart Foundation, UK
- **Diana Wong Ramos**, Patient Advocate, Portugal AVC (Union of Stroke Survivors), Portugal
- **Prof Raymond Vanholder**, President, European Kidney Health Alliance, Belgium
- **Prof Ariane Vieira Scarlatelli Macedo**, Chair of Cardio-oncology, Cardio-oncology Service, Americas Health Group, Brazil
- **Lucas Xavier**, Young Leader in Diabetes, International Diabetes Federation, Brazil
- **Beatriz Yáñez Jiménez**, Advocacy Manager, International Diabetes Federation, Spain

### *SUMMIT PARTICIPANTS INCLUDED REPRESENTATIVES OF THE FOLLOWING ORGANISATIONS:*

- Amyloidosis Ireland, Ireland
- Amyloidosis UK, United Kingdom
- Aortic Hope, United States
- APAC CVD Alliance, Singapore
- Asociación Española De Portadores De Válvulas Cardíacas, Anticoagulados Y Adultos Con Cardiopatías Congénitas (AEPOVAC), Spain
- Associação de Apoio aos Doentes com Insuficiência Cardíaca (AADIC), Portugal
- Association Vie Et Coeur (AVEC), France
- Associazione Italiana Cardiomiopatie (AICARM), Italy
- Astra Zeneca
- Boehringer Ingelheim International
- BOOST - Better Outcomes Optimal Scientific Therapies, United States
- Brigham and Women's Hospital, United States
- British Heart Foundation, United Kingdom
- Canadian Women with Medical Heart Issues, Canada
- Cardiomyopathy Association of Australia, Australia
- Cardiomyopathy UK, United Kingdom
- Cedars Sinai Smidt Heart Institute, United States
- Centre for Cardiovascular Prevention and Rehabilitation, Kenya
- CHEER Hearts - Connecting Hearts to End Heartbreak, Nepal
- Children's Cardiow myopathy Foundation, United States
- Croí, Ireland
- Cuore Nostro, Italy
- Daiichi Sankyo
- Dakshayani and Amaravati Health and Education, India
- Dutch Patient Association for People Living with Overweight & Obesity, Netherlands
- Edinburgh Napier University, United Kingdom
- Edwards Lifesciences
- European Association of Patients with Cardiovascular Diseases, Poland

- European Coalition of People Living Obesity (ECPO), Spain
- European Federation of Pharmaceutical Industries and Associations (EFPIA), Belgium
- European Kidney Health Alliance, Belgium
- European Kidney Patients Federation, Netherlands
- European Liver Patients' Association, Belgium
- European Patients Academy on Therapeutic Innovation (EUPATI), Belgium
- European Society of Cardiology (ESC), Belgium
- European Transplant and Dialysis Sports Federation, Ireland
- Federación Española de Diabetes, Spain
- Flinders University, Australia
- FOKUS Patient, Sweden
- Galway University Hospital, Ireland
- Global Alliance for Rheumatic and Congenital Hearts (Global ARCH), United States
- Global Patient Alliance for Kidney Health, Belgium
- Greek Carers' Network - EPIONI, Greece
- HCM Patients Foundation, Italy
- Health Service Executive (HSE), Ireland
- Heart & Stroke Voice Ireland, Ireland
- Heart Failure Patient Foundation, United States
- Heart Failure Warriors Northern Ireland, Northern Ireland
- Heart Health India Foundation, India
- Heart Support Australia, Australia
- Heart to Heart Foundation, Thailand
- Heart Valve Voice Canada, Canada
- Heart Valve Voice US, United States
- HeartCharged, United States
- HeartLife Foundation, Canada
- Hearts of Valor Inc, United States
- Hearts4heart, Australia
- Herzschwäche Deutschland e.V., Germany
- Initiative Herzklappe, Germany
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- International Consortium for Health Outcomes Measurement (ICHOM), Mexico
- International Diabetes Federation, Belgium
- International Diabetes Federation Europe, Belgium
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- Merck
- National Forum for Heart Disease & Stroke Prevention, United States
- National Health Service (NHS), United Kingdom
- National Institute for Prevention and Cardiovascular Health, Ireland
- National Stroke Aid, Zambia
- National University of Galway, Ireland
- NCD Alliance, United Kingdom
- Novartis
- Novo Nordisk
- Pacientes de Corazon, A.C., Mexico
- Pacientes Fundacion Española del Corazón, Spain
- Panhellenic Heart Disease Association, Greece
- Portugal AVC, Portugal
- Preventive Cardiovascular Nurses Association, United States
- Qatar Ministry of Public Health, Qatar
- Queen's University Belfast, United Kingdom
- Roche Diagnostics
- Royal Brompton Hospital, United Kingdom
- SADS UK, United Kingdom
- Salvando Latidos A.C., Mexico
- Santa Casa de São Paulo, Brazil
- Self-care group „Heartily Welcome", Germany
- Servier
- Stroke Action Rwanda, Rwanda
- SzivSN National Patient Organization, Hungary
- The British Society for Heart Failure, United Kingdom
- The George Institute for Global Health, India
- The Mended Hearts, Inc., United States
- Union of Heart Patients of Hellenic Navy Officers, Coast Guard & Friends, Greece
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- University of Florence, Italy
- University of Leeds & Leeds Teaching Hospitals, United Kingdom
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