

Minutes – Clinical Design Group Online Meeting 10

Meeting Details	
Date	16 April 2025
Time	2:00-4:00pm
Location	<input type="checkbox"/> Virtual <input type="checkbox"/>

Meeting Overview	
Agenda Items	<ol style="list-style-type: none"> 1. TDG Update – AU Core, AU Patient Summary, AU eReq 2. AU CDI R2 Overall (content, feedback + backlog update) 3. Aged Care Report 4. PS and RFE/ER 5. CCM 6. Upcoming <ol style="list-style-type: none"> a. May Symposium b. July

Discussion Summary	
Welcome	<p>Welcome</p> <ul style="list-style-type: none"> • Acknowledgement of Country • Agenda presentation
Technical Design Group Updates	<p>AU Core TDG and AU Patient Summary FHIR IG Project Team</p> <ul style="list-style-type: none"> • Statistics update – see slide pack for full details • AU Core R2 is a maintenance release aimed at enhancing AU Core R1 and supporting key downstream projects. • AU Core R2 is scheduled to go to ballot as a working standard between August/September 2025 with a final publication expected January 2026 with an update cycle planned to occur every 15 months • The focus for AU Patient Summary is for the enabling, generating, viewing and sharing of summaries • AU PS R1 will go to ballot for comment in August/September 2025, followed by working standard ballot in February/March 2026 and final publication targeted for June 2026 • MedicationStatement which was added from AU CDI Medication Use Statement, RelatedPerson from R2 scoping workshops and HealthcareService have been added into R2 • The focus for AU Core R2 included: <ul style="list-style-type: none"> ○ supporting downstream projects like AU PS and AU eRequesting priorities ○ Incremental enhancement of AU CDI coverage and adding more structured data for wider use ○ Enhancing existing content in AU Core R1

- The highest priorities to come from the AU Core R2 Scoping workshops include:
 - New profiles – AU Core RelatedPerson and AU Core MedicationStatement
 - AUCDI coverage enhancement - alignment of medication statement from medication use and profile refinements
 - Enhancement of existing content and ongoing improvements based on proposals, feedback and testing
- Achievements for AU Core TDG Feb-Mar 2025
 - Confirmed inclusion of two new profiles - RelatedPerson and MedicationStatement and Dosage Must Support which focuses on the text elements
- Connectathon 19-20 March – AU Core
 - Focused on helping new implementers get started with AU Core testing and R2 profiles
 - 12 organisations participated in testing, with a focus on testing all profiles and particular focus on MedicationStatement and RelatedPerson, both of which reach AFMM 2 maturity (meaning they have been successfully tested across multiple independent systems against a majority of their key elements)
 - This Connectathon fostered the highest number of cross-organisation collaboration with Smart app launches, vendors connected across multiple systems and real-time sharing of AU Core Data
 - The testing event saw 28 implementers, and test results from 5 new products
 - There is an upcoming proposal for HealthcareService in AU Core R2 which is led by the ADHA. Its purpose is to describe services offered by organisations and to be use case agnostic and suitable for downstream IGs
 - The vote for this proposal will occur on 17 April 2025
- AU Patient Summary Workshops
 - The key priorities identified through workshopping include that it will be compliant with IPS and AU Core, technical dependencies were confirmed, and that key consumer journeys and use cases should guide AU PS R1
 - ‘Patient driven’ summaries were ranked highest followed closely by ‘clinician driven’ summaries when asked about “which use case fit your patient summary use case?”
- AU Patient Summary FHIR IG R1 Focus
 - AU PS R1 aims to support generating, viewing and sharing summaries and to align to IPS in AU Core. The focus is on key scenarios (e.g. GP visits, emergency admissions) and to be localised for the Australian context

- AU Patient Summary implements AU CDI, and complies with both AU Core and IPS, allowing it to be used both in Australia and internationally
- AU CDI R2 Patient Summary
 - See slide pack for full details on inclusions and future candidates for AU PS
- AU CDI PS R1 Scope
 - See slide pack for full details on the AU PS R1 Scope
 - R1 Resource profiles, including RelatedPerson and MedicationStatement are going to ballot for comment
 - Other content includes other IG elements which can be commented on
 - It's unlikely new resources will be added as this point unless they are raised through ballot for comment or feedback
- March Connectathon – AU PS
 - The March Connectathon saw the first end-to-end test of the PS, with vendors successfully generating and exchanging documents using Smart Health Links, QR codes or standard FHIR operations
 - Group discussions included My Health Record integration and secure exchange methods
 - The goal is to reach AFMM 1 maturity with patient summary
 - AU Patient Summary FHIR IG and AU Core R2 drafts are available for review

AU eRequesting TDG Update

- There is a draft IG which all changes and updates are updated within
- The main focus for R1 was supporting pathology and medical imaging requests in community-based care, with considerations for future use
- AU eRequesting R1 will go to ballot for working standard in August this year, which is followed by a resolution period to address feedback and comments, and a target publication of R1 in February 2026
- See slide pack for full information on AU eRequesting current R1 features and FHIR profile
- A number of systems actors have been modelled in AU eRequesting IG – concept of a place, a system, a file system, a patient access system and AU eRequesting server
- eRequesting TDG have recently worked through the management of groups of requests and grouping individual diagnostic requests for a complete order
- The diagnostic request coding guidance for both imaging and pathology use the RANZCR and RCPA value sets, respectively and the guidance details alternative code sets if required

	<ul style="list-style-type: none"> • Priorities identified by the TDG include clinical context, problem/diagnosis summary, tokens/barcodes/QR codes – see slide pack for full priority ranking
AUCDI R2 Update	<ul style="list-style-type: none"> • What is AU Core and AUCDI? <ul style="list-style-type: none"> ○ AUCDI specifies what clinical information (and corresponding data elements and terms) should be included for data entry, data use and sharing information supporting patient care – the CDG sits here ○ AU Core specifies how the core set of data (above) and information should be structured, accessed and shared between systems – TDG sits here • AUCDI R2 <ul style="list-style-type: none"> ○ AUCDI R1 focused on the ‘core of the core’ and R2 continues to build on that with patient summary, chronic condition management and encounter information ○ The patient summary public community review was published in November and was open for 6 weeks, with feedback received from 30 respondents and 116 feedback items. As a result, 7 data items have been updated, and 36 new items have been added to the backlog ○ The feedback was overall positive and included requests for additional data groups and questions around implementation ○ The chronic condition management feedback component was released in March and was open for 6 weeks, during which over 300 lines of feedback were received from 23 respondents ○ Aiming to publish AUCDI R2 in June, which will contain all of AUCDI R1 and content from patient summary and chronic condition management for AUCDI R2 ○ The document will include the data group library with minimal introductory information, with introductory and explanatory information being transitioned onto the Sparked website ○ Both patient summary and chronic condition management feedback from the draft for comment will be published with AUCDI R2 • Patient Summary Clinical Focus Group update <ul style="list-style-type: none"> ○ The AU PS CFG has collaborated to develop 5 patient summary consumer maps that are unbound by system limitations and illustrate the interactions and use of a patient summary during a consumers healthcare journey – these are being used by the AU Patient Summary FHIR IG Project • Chronic Condition Management Focus Group update

	<ul style="list-style-type: none"> ○ These meetings have just commenced and work has begun on developing a journey map, unbound by system limitations and with the aim to represent what a journey may look like ● Scope of AUCDI R2 <ul style="list-style-type: none"> ○ See slide pack for full detail on scope and backlog of AUCDI R2 ○ Due to be published June 2025
AUCDI Update	<p>AUCDI – maturing from Core to Clinical</p> <ul style="list-style-type: none"> ● As R1 has matured from use-case agnostic into R2, with specific use cases it is proposed that the name be updated from Australian Core Data for Interoperability to Australian Clinical Data for Interoperability ● Allows for ease of expansion into R3, which will include all of AUCDI R2 + additional use cases and content +AUeReqDI R1 ● Data groups and elements specific to particular use cases will be identified as such and may have multiple use cases identified (e.g. data group/data element sits in both patient summary and chronic condition management use cases) ● Benefits of the name update include: <ul style="list-style-type: none"> ○ Having all clinical use cases in one place ○ Simpler to find things ○ Demonstrate the reuse of data groups across use cases ○ Makes it clear that it builds on the clinical community of practice that has developed AUCDI beyond the technical core to specific use cases ○ Allows TDG to easily identify data groups and elements in scope for their use cases ○ Gives room to grow and add additional clinical use cases and data requirements beyond ‘core of the core’ <ul style="list-style-type: none"> ▪ Builds on clinical community of practise ▪ TDG can identify data groups in scope
The Australian aged care data landscape report	<p>Overview</p> <ul style="list-style-type: none"> ● The report was jointly commissioned between CSIRO and DHCRC and undertaken by Voronoi ● The report included consultations across government, clinicians, providers, industry and researchers ● It highlights: <ul style="list-style-type: none"> ○ The complexity and fragmentation across the aged care data landscape ○ The duplication of data requirements and the lack of standardisation of tools and data requirements meaning multiple assessment tools are in place ○ The challenges with differences in Aged Care and My Health Record legislation ○ The gaps in allied health digitisation and standards

- Work is happening with the Allied Health Professionals Association to look at how to improve terminology content, content through AUCDI etc.
- Further work is occurring around connectivity between the Aged Care System and MYHR – the current MYHR requirements are PDF however, there is a general desire for healthcare to move to FHIR

Considerations

- A key consideration is that we need additional data sets to incorporate aged care requirements, and that a whole of life-course and ecosystem approach is needed where the data follows the individual across the health, aged and social care ecosystem, and the approaches to assessment tools and scales need to be standardised
- Consider how to standardise the approach to data requirements across the health care ecosystem at the point of care, allowing for traceability and aggregation for population health
- The need to address gaps in the allied health professional (AHP) data standards and terminology
- Support digitisation of AHP
- Look at the use of AU Patient Summary could support transitions of care

Sparked

- AUCDI aims to include the whole of life-course and whole of ecosystem
- AUCDI roadmap includes Functional Status, activities of daily living (ADLs) based on feedback and community discussion
- AU Patient Summary roadmap includes Functional Status, Advanced Care Directives
- Sparked Roadmap to include standardised approach to assessments and scale observations
- Work is happening between CSIRO and ADHA around Smart Forms
- ADHA is leading work around allied health and aged care – allied health CIS to MyHR, and CSIRO is jointly working with ADHA around allied health terminology (NCTS)
- Key focus of the next year of Sparked is continuing the work around the approach to care plans and team care arrangements (TCA's) using smart forms and leveraging AUCDI

Group Feedback/Questions

- Services Australia have been in attendance and participating in some of the CDG meetings and there is discussion across government about how this works together
- Heavily liaising with DOHAC and peak bodies such as Aging Australia

	<ul style="list-style-type: none"> Reach out to sparked@csiro.au if you feel there are any other people/organisations/stakeholders who are not yet at the table that should be
Menti	<p>“What’s one word to describe the achievements of the CDG over the last 2 years?”</p> <ul style="list-style-type: none"> Collaboration, cult doing good, aucdi, agreement, team, progress, shared, supportive, incremental, cross pollination, at last, complex, clinician led, cool socks, awesome, hopeful, generosity, exciting, educational, phenomenal, the matrix of health data, discovery, work <p>“What do you want to see more of?”</p> <ul style="list-style-type: none"> Use cases, face-to-face, more clinician and interdisciplinary engagement, dedicated conversations with clinicians in smaller groups, examples of implementation, create patient data use cases, more engagement by states and territories, federal commitment – beyond ADHA, Services Australia, PBS & DOHAC should come to the party, even more clinicians from different areas involved, how FHIR will practically fit into the big picture of data flow and clinical workflows – e.g. interaction with LOINC, SNOMED, OMOP, eMRs, MHR, OpenEHR etc, direct engagement with medical colleges and specialty groups, implementation considerations, more engagement from leaders in some clinical craft groups, implementation considerations, specialty specific focus groups that do feed into the multidisciplinary meets, more access to events that permit practising clinicians to attend, facilitated patient feedback, funding of application of using the data layer in POC’s or trials in current systems, broader engagement across clinical and health care sectors, allied health participation, engage with more clinical quality registries – experts in clinical domain and data, adoption and implementation guidance, refresher learning modules to help reorient me to the terminology/lingo of the project – sometimes it takes time to do that cognitive plot, public health physicians, Open to having more CFG/breakout groups for discussion and working through things in more detail Potential for a weekend CDG to allow a wider community to attend if work-week commitments prevent them from doing so <p>“What can we improve on next year?”</p> <ul style="list-style-type: none"> More face-to-face – it’s really energising to meet and interact with industry, more chocolate, get the ACSQHC more involved, maintain momentum and your enthusiasm, short videos that provide snippet updates like you are providing here today – so we can share with others, name and congratulate software vendors who have implemented AUCDI, less presentations and more workshopping, invite new players – startups in health tech, nothing to improve specifically, just need to maintain and

sustain, more comms to share with clinicians to articulate value of participation and value of outcomes (consequences of inaction), keep up the amazing collabs, remembering that new participants to the design groups may need time to orient themselves to all the lingo and journey you have been on for the last 2 years – it's like learning a new language, summaries of outcomes that are relevant to clinicians, show how this integrates with AI, improving governance to make these standards mandatory, starter/refreshers kits for new or returning participants – how do I know what I need to know that has happened recently, release activities before in-person workshops so we can prepare/brainstorm in advance, promote program achievements more, keep the open and accepting culture, a lot of participants are giving their time for free so clearer timelines and maybe chunk up work into smaller pieces, analysis of legacy applications and whether there are approaches implement some aspects of the outputs, help me pitch to new players in digital health how vital this work is

“Where do we want to be in another 2 years?”

- Implementing, on FHIR, data flowing around the ecosystem, integrated – using less systems to manage a patient journey, entire industry adopting standards, utilisation of standards so that clinical communication can happen easily, in maintenance phase with limited updates as new requirements develop, blueprint which will be used by other countries, retired, anything that touches healthcare is interoperable, federal government – products are built FHIR first (IHI, PBS Auth, Proda etc), mandates on software, standard reporting for all, mandates to commercial providers, widespread implementation with clear and appropriate governance, I want to know that every child born will have an IPS AU, interoperable at a basic level, it's not what is AUCDI or what is FHIR or what is interoperability – we will be talking about required data for new use cases – FHIR and data standards will be an accepted norm, not needed, state health systems are integrated and utilising standards, higher level of data quality, share by default across all healthcare settings, be great to have PBS on board, working collaboratively with the patient as the centre using shared terminology with reduced costs to patients and better shared care with practitioners who are aware of each other, standard funding stream of this work – remove the political risk of not continuing, a much better more comprehensive and representative clinical terminology, healthier, patients have easy access to their health information, interoperability supporting linked data sets to inform health optimisation, I would like to feel we can move forward with confidence when new tech is built – it will work in the system

Sparked Adelaide Event Recap	<p>Overview</p> <ul style="list-style-type: none"> • Hosted by South Australia Health, this event was the largest yet with 220 people in attendance across the 3 days • Leadership evening and showcase <ul style="list-style-type: none"> ○ Vendors did a showcase of their implementation of AU Core, AU Patient Summary and AU eRequesting at the leadership evening event ○ Speakers from a range of organisations including DOHAC, ADHA, Healthdirect, SA Health discussed how they are leveraging the work of Sparked within their own work ○ Followed by a panel discussion with Jeremy Sullivan, Chris Moy, Angela Ryan, Marc Belej and Grahame Grieve • Design Group Meetings – CDG <ul style="list-style-type: none"> ○ Updates from DOHAC and ADHA ○ Showcase from SA Health around their initiatives, how they are implementing the Sparked outputs across their system, and their new ambulance patient care record project (amPHI) and how it is looking to implement AU Core and SNOMED CT-AU – allows ambulance records to be shared with the emergency department system ○ Workshops discussed a chronic condition management plan template, encounter summary/reason for encounter, and patient story
Content Recap and Overview – Patient Summary, Reason for Encounter, Chronic Condition Management	<p>Patient Summary</p> <ul style="list-style-type: none"> • See slide pack for full definition of the purpose of AU Patient Summary, workshopped by the AU PS CFG • AU Patient Summary is a standardised collection of an individual's health and healthcare information and is focusing around providing a consumer and their healthcare providers with timely and current access to relevant health information • The characteristics of AU Patient Summary include: <ul style="list-style-type: none"> ○ Be an interoperable set of clinical data ○ Will contain as up to date information as possible based on available sources at a point in time ○ May be either an asserted or non-asserted patient summary ○ May include asserted and non-asserted information ○ Will be portable and accessible to the individual and their healthcare providers ○ Will support individuals on their healthcare journey ○ Will support all transitions of care ○ Will be conformant to the International Patient Summary Standard • If a person is on their consumer journey through the health system, at various points they interact with the health system which needs the ability to access the AU PS information for that

patient and over time, this information would be kept up-to-date

Reason for Encounter

- See slide pack for full detail on key discussions and their interactions
- Clinical perspective, DOHAC perspective and AIHW perspective identified that they are looking to understand the complexity of care
- Common use cases that came out of the workshop can be divided into 3 categories:
 - Clinical reasons
 - Recording symptoms, diagnoses, and ongoing management.
 - Referrals, discharge summaries, clinical history, medication review, and care plans.
 - Relevant settings: GP, hospitals, clinics, aged care, and EMRs.
 - Consumer reasons
 - Routine check-ups, online appointments, mental health advice, and medication management.
 - Involves telehealth, GP EMRs, and real-time patient engagement
 - Administrative reasons
 - Handling forms, activities, routine scheduling, and financial matters.
 - Includes hospital PAS, administrative procedures, and managing patient information
- Value of Reason for Encounter
 - Research, population health, funding/billing, health administrators/management, clinical decision support – can be predictive of diagnosis, care delivery – aide memoire, understanding patient journey, quality improvement, interpretation at pathology imaging centre, accountability, clinical transfer of care, prioritisation/triage of care
- Additional Useful Information
 - Patient summary information – medical history, past history, medications
 - Encounter information – how many reasons for encounter?, reason for activity, modality, discharge details, presenting problems/symptoms, diagnosis (SNOMED CT, IC10, free text) – principal diagnosis and diagnosis in discharge, procedures
- There is value in encounter information, beyond just the reason for encounter
 - Consumer and clinician reason for encounter
 - Investigations

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- Provisional diagnosis
 - Relevant results
 - Recommended treatment plan
 - Follow-ups
 - This raises the question about whether we are after a record/summary of the things that happened within the encounter and whether each touchpoint the patient has with the health system is also accompanied with documentation
 - Could these be considered an encounter record?
 - Hospital discharge summaries (patient summary PLUS encounter information)
 - Event summary (MyHR)
 - Progress notes/Consultation notes (in local CIS, EMR)
 - Consult letter from specialist, allied health back to a usual healthcare provider or GP
 - Transition/transfer of care documentation
 - Etc
 - What is an encounter record?
 - Is an encounter record a structured encounter-focused record with specific details including encounter details, reasons for encounter, problem/diagnosis, investigations and interventions?
 - There is overlap between national guidelines for on-screen presentation of discharge summaries from ACSQHC and criterion-c7-1 content of patient health records from RACGP
 - Is there an overlap between a patient summary and an encounter record and can the information contained within the encounter record be used to provide up-to-date information for AU Patient Summary? See slide pack for extended summary and contents of both
 - Further determination is required around where the data is sourced from in the Australian Patient Summary information, where new up-to-date data comes from, and whether the patient encounters involve the creation of a structured encounter record which provide the up-to-date data
 - Adelaide Workshop – Encounter Record/Summary
 - Initially referred to as encounter summary however changing to encounter record as this resonated more clearly
 - Activity 1 – Encounter record and the consumer journey
 - Activity 2 – Prioritisation of data groups for an encounter record
 - See slide pack for detailed activity outputs
 - The top 5 priority data groups for an encounter record were identified as, in order, problem/diagnosis, reason
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for encounter, medication use, encounter details,
adverse reaction risk

Chronic Condition Management

- See slide pack for detailed scope for CCM
- Team Care Arrangement/Chronic Condition Management Plan
 - Considerations around TCA/GP management plan templates, AU CDI and AU Core, FHIR and Smart forms to determine whether a FHIR questionnaire template that supports team care arrangements be useful?
- Smart Form Principles
 - Forms based solution for health assessments
 - Capable of integrating into existing clinical systems
 - Data exchange and reuse
 - Data quality improvement – reducing duplication and permitting integration with terminology services
 - Improve efficiency for delivering clinical care
- Interface
 - See slide pack for interface diagram
 - Sparked and FHIR have created standards to help pre-populate data which can sit in the form which, once updated, could write back patient data, as the specification has been very clearly defined – the smart aspect allows for launch within context
- Smart Health Checks
 - Smart Health Checks is an Indigenous and Torres Strait Islander health check assessment which uses Smart Form software and is built out of the FHIR Implementation Guide (IG)
 - Work has been sponsored by First Nations Health Division, DOHAC
 - It is determining a repeatable national way of creating and using Smart Forms and FHIR IGs
 - Uses AU Core – this could be repeated in a chronic condition management template
- National SMART App Initiatives
 - First Nations Peoples Health Check
 - Smart Forms App
 - Comprehensive Health Assessment Program (CHAP) (ADHA)
 - Smart Forms App
 - Aus CVD Risk-i Calculator
 - SMART App
 - + more
- Chronic Condition Management Plan and Smart Forms
 - The Murrumbidgee PHN generic GPMP/TCA plan includes patient information and a management plan

	<ul style="list-style-type: none"> ○ Presented the GPMP/TCA plan and a diabetes management plan to the Adelaide CDG for discussion and to consider key usability principles for CCM template could look like, the workflow challenges, and what information should be recorded <ul style="list-style-type: none"> ▪ Key usability principles identified included: access, support team care contributions, traceability of information, visibility/presentation of information, inclusion of information (content), use of CDS tools, link to referrals <ul style="list-style-type: none"> • See slide pack for full summary of key usability principles as identified in the CDG workshop ▪ Workflow challenges identified included: need to form consensus, communication, care team, curation of patient information, patient, care management <ul style="list-style-type: none"> • See slide pack for full summary of workflow challenges as identified in the CDG workshop ▪ Additional information that should be recorded/additional features identified included: priority of conditions (when multiple), funding accessibility, outcomes, patients, goals, activities, care team details, follow up flags, referral recommendations, integration with, updated to the care plan from all involved providers, guidelines – easily retrieved or embedded, provenance of information, control of accessible data – make the clinically relevant information available to the right team member and the team when they are engaged with care, reports/monitoring metrics (patient’s POV as well) <ul style="list-style-type: none"> • See slide pack for full summary of additional information that should be recorded/additional features identified as identified in the CDG workshop
AUCDI R3 Next Steps	<p>Next Steps</p> <ul style="list-style-type: none"> • Further exploration of identified priority data groups for Encounter Record and Chronic Condition Management for AUCDI R3 <ul style="list-style-type: none"> ○ Functional Status ○ ADLs ○ SDOH ○ Advance Care Directives ○ Repeatable approach to assessment tool, scores, etc.

	<ul style="list-style-type: none"> • Continue developing the Chronic condition management plan as a Smart Form <ul style="list-style-type: none"> ○ Leverage AUCDI and AU Core ○ Build on the feedback provided by the CDG • Will be a focus for July 2025 CDG (face to face) <ul style="list-style-type: none"> ○ Prioritisation of data requirements for inclusion in AUCDI R3
Wrapping up 2 years of Sparked	<p>Wrap-up</p> <ul style="list-style-type: none"> • 6 F2F CDG meetings + 2 bonus (rural and remote and health equity sessions), across 6 cities • 10 online CDG meetings and 4 online CFG meetings • 25 workshop activities • 1 release of AUCDI R1 almost released
Upcoming Events	<p>May</p> <ul style="list-style-type: none"> • Sparked Symposium – 28 May <ul style="list-style-type: none"> ○ Virtual Sparked Partners Symposium, hosted by Peter Birch from Talking Health Tech ○ Register for tickets via the Eventbrite <p>July</p> <ul style="list-style-type: none"> • 29th and 30th in Sydney – Community Co-Design CDG & TDG F2F meeting <ul style="list-style-type: none"> ○ Further discuss SDOH, functional status, ADLs

Actions

ID	Description	Responsible	Due	Status
20250416-1	Register for the Sparked Symposium in May	Sparked CDG Members		
20250416-2	Reach out to sparked@csiro.au if you feel there are any other people/organisations/stakeholders who are not yet at the table that should be	Sparked CDG Members		

Attendees

1. Adrian Gilliland	2. Alvin Lai
3. Andrew Hugman	4. Averil Tam
5. Bojan Pjetlovic	6. Charlotte Howard
7. Charlotte Keane	8. Chris Moy
9. Christy Sieler	10. David Wiebe
11. David Willock	12. Dianne Brown
13. Jadumani Singh	14. Gautami Shetty
15. Heather Leslie	16. Isabelle Smith
17. Jackie O'Connor	18. Jai Dacey
19. James Griffin	20. James Wright
21. Jane Connolly	22. Jessica White
23. Jillian Kehoe	24. Joleen Rose

25. Kambiz Bahaadinbeigy	26. Kate Ebrill
27. Kath Feely	28. Kathleen Rogers
29. Kelly Knights	30. Kim Drever
31. Kimberley Hilton	32. Kylvynn Loi
33. Lana Briers	34. Landon Reilly
35. Lisa Kalman	36. Louise Jackson
37. Maxwell Holmes	38. Michael Hosking
39. Michael Osborne	40. Michael Wilson
41. Natasha Jane Radcliffe	42. Nyree Taylor
43. Olivia Carter	44. Owen Katalinic
45. Philip Loya	46. Richard Kwan
47. Rob Hosking	48. Rosemary Velardo
49. Sanjeed Quaiyumi	50. Shelley Behen
51. Stephen Chu	52. Steve Swinsburg
53. Steven Fullagar	54. Stuart Hanson
55. Susan Sheehan	56. Tim Blake
57. Tor Bendle	58. Vicki Bennett
59. Victoria Fitzgerald	60. Vincent McCauley