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BESZÉLGETÉSEK

Discussion about the integration of care - Benedetta Armocida and Heléna Safadi (transcript)

Beszélgetés az integrált ellátásról –Benedetta Armodica és Heléna Safadi (átirat)

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Abstract

This podcast explores integrated care approaches for diabetes and cardiovascular disease within the EU-funded JACARDI Joint Action. Through a structured dialogue between Dr. Benedetta Armocida and Dr. Heléna Safadi, the discussion highlights key dimensions of integrated care, including multidisciplinary collaboration, strengthening care pathways, digital tools, and person-centred approaches. Themes include the importance of equity, scalability of pilot projects, sustainability, and the active involvement of people with lived experience.

Absztrakt

Ez a podcast az Európai Unió által társfinanszírozott JACARDI Joint Action nemzetközi projekt keretében készült, és a cukorbetegség, valamint a szív- és érrendszeri betegségek integrált ellátási megközelítéseit mutatja be. Dr. Benedetta Armocida és Dr. Heléna Safadi párbeszéde az integrált betegellátás kulcsfontosságú dimenzióira világít rá, többek között a multidiszciplináris együttműködés szerepére, az ellátási útvonalak megerősítésére, a digitális eszközök alkalmazására és a személyre szabott ellátási modellek jelentőségére. A beszélgetés kitér az ellátáshoz való egyenlő hozzáférés fontosságára, a pilot projektek átültethetőségére és fenntarthatóságára, valamint a betegségben érintett személyek aktív bevonásának lehetőségeire is.

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This episode is structured as a dialogue between the two speakers, Dr. Benedetta Armocida and Dr. Heléna Safadi – without a separate host or moderator.

INTRODUCTION

Benedetta Armocida: Thank you very much for the invitation, I'm delighted to be here. My name is Benedetta Armocida, I am a physician and public/global health expert from Italy, with a background in global health, health policy and health systems strengthening. Over the past years, my work has focused on understanding and addressing the burden of noncommunicable diseases, particularly diabetes and cardiovascular diseases (CVDs), both in Europe and globally. I am currently a Senior researcher at the Italian National Institute of health, and I'm coordinating JACARDI – the Joint Action on Cardiovascular Diseases and Diabetes, which brings together 21 European countries to share best practices and pilot innovative approaches to prevention, care, and management of diabetes and CVDs. What really drives my interest is how we can make health systems more equitable, resilient, and responsive to the needs of people—with a specific focus on adolescents and young people—who are living with non-communicable diseases.

Over to you Helena.

Heléna Safadi: Hello, everyone, it is great to be here and let me also extend a warm welcome to all of you. I am Helena Safadi, a physician and an economist, with a primary focus on healthcare management, particularly quality management and patient safety. Over the past few years, I've been working on developing and implementing best practices in hospital settings, and I've also been exploring how big data could play a role in improving diabetes care in Hungary.

Currently, I work at the Gottsegen National Cardiovascular Center where I have the privilege of leading Work Package 9 of the JACARDI project alongside my wonderful colleagues. Work Package 9 on Integrated Care Pathways — which is a really exciting challenge. It gives us a unique perspective on where the care pathways could be improved across Europe and also lets us look into various possible solutions and the details of their implementation processes.

ABOUT JACARDI

Heléna to Benedetta: But before we dive deeper into integrated care, since our listeners might not be very familiar with JACARDI, can you give us the big picture? What is JACARDI trying to achieve and why?

Benedetta: Of course. JACARDI is a Joint Action co-funded by the European Commission, uniting 21 European countries with one shared ambition: to reduce the burden of cardiovascular diseases and diabetes. Running from 2023 to 2027, JACARDI brings together 81 partners from across Europe, reflecting a rich diversity of cultures, lifestyles, and health system structures.

The initiative is organised into several key areas of work – from knowledge sharing and policy alignment, to the design and implementation of pilot projects in real-world settings. The aim is not only to test innovative practices, but also to generate solid evidence and lessons that can be adapted and scaled across Europe.

What makes JACARDI unique is that it follows the entire patient journey: from healthy people, to those at risk of developing cardiovascular disease or diabetes, to individuals already living with the condition and at risk of progression or multiple illnesses. Along this journey, the focus is on health literacy and awareness, screening and early detection, integrated care pathways, self-management, and participation in the labour market for people living with these diseases. And all of this is carried out under two guiding principles: equity and better availability, quality and use of data – ensuring that no one is left behind, and that decisions are informed by high-quality, shared information. JACARDI engages a broad community such as ministries of health, public health institutes, universities, professional societies, patient organisations, and local health authorities.

The real engine of JACARDI is its 143 pilot projects. They test practical solutions on the ground – like strengthening primary care, improving self-management, or reducing inequalities – while generating lessons that can be scaled across Europe. Their purpose is twofold. First, to deliver tangible improvements locally and second, to generate models and lessons that can be scaled beyond the pilot sites.

In this way, the pilots act as “laboratories for innovation”: they show what works, reveal what doesn’t, and create a body of practical knowledge that can accelerate Europe’s shift towards more person-centred, sustainable, and resilient care.

> So in short, JACARDI is not only about improving care for people living with diabetes and cardiovascular disease today. It is also about shaping the future of how our health systems respond to non-communicable diseases – building approaches that are equitable, sustainable, and above all, centred on people’s real needs.

INTEGRATED CARE (SYSTEM PERSPECTIVE)

Heléna to Benedetta: Thanks for this great overview, Benedetta. In your opinion, how does WP9 – and the broader theme of integrated care – fit into the overall goals of JACARDI? Why do you think integrated, person-centred care is such a crucial element in improving outcomes for people living with chronic conditions like diabetes and cardiovascular disease?

Benedetta: Well, that's a very important question.

When we talk about conditions like diabetes and cardiovascular disease, we are talking about lifelong, complex conditions that often occur together and are influenced by a wide range of socio-economic determinants and biological factors. This is why focusing on integrated, person-centred care is so crucial. People don't experience their health in separate compartments – and yet too often, our systems deliver care in silos.

In my view, truly integrated care means that people living with these conditions experience their journey as continuous, coordinated, and supportive – whether they are in prevention, diagnosis, treatment, or long-term management.

Unfortunately, many of our health systems remain fragmented and oriented around acute care or single diseases. This has historical reasons – systems were designed to respond to infections and emergencies – not the reality of multimorbidity and ageing populations. The consequence is that people with multiple chronic conditions often face duplication of tests, conflicting advice, poor communication between providers, and ultimately inequalities in access and outcomes.

JACARDI
Joint action
cardiovascular diseases
and diabetes

This is precisely where JACARDI and Work Package 9 on Integrated care Pathways come in. Our goal is to help countries shift the paradigm – from fragmented, disease-centred models towards more holistic, person-centred, and resilient health systems. Through the pilot projects, we are testing practical ways to strengthen integrated care pathways, improve collaboration across providers, and empower people to better manage their conditions.

The idea is to show that integrated care is not just an aspiration – it is achievable, scalable, and essential. At the heart of this transformation is a simple but powerful idea: when we design care around people rather than diseases, we not only improve health outcomes, but also reaffirm dignity, trust, and solidarity as the foundations of our health systems.

INTERGRATED CARE WITHIN WORK PACKAGE 9

Benedetta to Heléna: Now, Helena, let's zoom into WP9. Can you walk us through the work of WP9? What is its overall goal? Where are the pilot sites? What kind of challenges related to integrated care are they trying to address? Could you share a few examples of the approaches they are testing?

Heléna: Of course. The main goal of our Work Package is to improve the diagnosis, treatment, and management of diabetes and cardiovascular diseases through pilot projects that develop integrated care pathways across Europe.

We start each pilot project with a thorough situation analysis and patient pathway mapping at each site. This helps us identify the key areas in the care process that need improvement, understand the local context, and pinpoint the relevant stakeholders.

Then, to develop tailored solutions, we also look at the available evidence — that includes existing best practices, relevant programs, and scientific literature that could guide our interventions. Based on this evidence, each pilot site designs its own intervention package, adapting these insights to fit their specific context and resources.

Once the activities are implemented the pilot interventions are implemented and evaluated across multiple dimensions. The idea is that, if these pilots prove successful, they can be scaled up — to other sites, institutions, regions, or even countries — and potentially extended to support the care of other chronic conditions as well.

All of this is being done through the implementation of 29 pilot projects across 11 European countries including Italy, Spain, Slovenia, France, Finland, Latvia, Belgium, Romania, Hungary, Iceland and Poland. These projects are incredibly diverse. Several pilots focus on improving the transition period after hospital discharge, other projects are centered around patient education or digital tools to support lifestyle interventions. Many strengthen the role of general practitioners in diabetes care or improve coordination and information sharing between different levels of care and among health care professionals, often using digital solutions. And finally, some are working on standardized documentation, and indicator sets to make care more evidence-based.

ADAPTATION AND TRANSFERABILITY

Benedetta to Heléna: That looks like a massive work to manage and coordinate. And tell us Helena, are the problems addressed by the various pilots specific to their regions and health systems? Or are there common challenges across countries? And what does this mean for the possibility of scaling up solutions or implementing them in different contexts?

Heléna: That is an interesting question, thank you, Benedetta for bringing it up. What we see is that, across countries, projects are working on the same core elements of integrated care such as multidisciplinary collaboration, patient involvement, decision-support tools, IT solutions, or community support. But the way these are implemented looks very different depending on the local characteristics, resources, or cultural context. Take post-discharge care: in one region, patient follow-up might be organized mainly through general practitioners. In another, specialist doctors take the lead, and the hospital provides the care coordination. Elsewhere, dedicated care coordinators are introduced.

> **The principle is always the same: do not let go of the patient’s hand – but the organization varies widely. That’s why we put so much emphasis on understanding local realities.**

The pilot sites analyzed their infrastructure, human, IT, and financial resources, existing care pathways, their stakeholders, and they identified barriers and enablers within and outside their organizations. In fact, the first year was devoted to this preparatory work. But, even though the solutions are highly tailored, we expect them to be valuable for others, because we are tracking and analyzing not just what works but why it works in a given setting. This way, future implementers will have a menu of tested options to choose from, making adaptation faster and easier. And our hope is that many of these pilot projects will ultimately become recognized European best practices.

COMPONENTS OF INTEGRATED CARE

Benedetta to Heléna: From your experience leading Work Package 9, what are the key components that make integrated care effective and meaningful? What must be present for a care model to be truly "integrated" and enable personalisation? And how do digital tools help make this possible?

Heléna: For me, integrated care means the coordinated operation of the different components, levels, and actors of care across time and space — tailored to the individual characteristics, preferences, and capacities of each patient.

We know that chronic diseases, like diabetes, require complex care and lifelong management. No single profession can handle that alone. Dietitians and endocrinologists to GPs, nurses, physiotherapists, psychologists, podiatrists, diabetes educators, and the related specialists like ophthalmologists, neurologists, cardiologists, they all have a role. It's easy to see how patients can get lost between all these points of care, important steps or interventions can be missed if roles and responsibilities aren't clearly defined. On the other hand, duplication can also become a problem if the same assessments or tests are repeated across different providers because existing information is not accessible, shared, or validated. This can also lead to significant delays in care.

> That's why clearly defined roles, well-structured pathways, and information sharing are all essential elements. Still, even the best designed care will fail if a patient does not, or cannot, follow through.

To earn a patient's cooperation, we have to equip them with the right information and skills. This is a resource-intensive process, and one that does not traditionally fall within the scope of classic medical practice. But patient education needs to be a constant, ongoing part of care — delivered in a way that always matches the patient's current needs and situation. But I would even go one step further. Truly involving patients in their care also means we need to understand what they want and can commit to. People have different preferences — and in some cases, they might be willing to trade off a certain amount of health benefit for something else that brings them more happiness or quality of life. In other cases, people simply do not have the capacity to fully follow the recommended therapy, due to their life situation, socio-economic factors, or biological limitations. That is why it is so important that care plans are developed together with the patient — based on a thorough understanding of their personal characteristics and context, and with full respect for their reality.

Digital solutions can really help here. They connect patients and providers, support decision-making, and make information available in real time. They enable closer monitoring and earlier interventions, while also saving time. And they offer new ways to support patient education. So I believe that, beyond a certain point, modern integrated care simply isn't possible without strong digital support.

LESSONS LEARNED

Benedetta to Heléna: Have any promising lessons or early results emerged already from the pilots? What are some barriers you've encountered in implementing these new care models? What advice would you give to others trying to improve integrated care in their regions?

Heléna: That is an exciting question. It's still a bit early to talk about concrete successes, as most of the pilot projects have only been running for less than a year, but we already see some important lessons.

One key factor is how implementation is managed. Some pilots are led by clinicians, others build on earlier project experience, some are led by public health institutes or care coordination bodies. I believe that by now, all of our pilot projects have recognized the importance of implementation. For example, we placed special emphasis on ensuring that stakeholders were involved as early and as fully as possible. Thanks to that, in some pilots where there were initial concerns that it might be difficult to recruit GPs or patients to participate voluntarily, they actually found that interest was much higher than expected.

Another factor is leadership support. Without real support from senior management or goverment bodies, projects can work locally but remain hard to scale. This is a particularly critical issue because changes at these higher levels are typically beyond the control of the project teams — and often unpredictable. What we have already seen is that the more significant delays and disruptions have often been linked to changes in leadership or institutional restructuring.

Digital solutions also need to fit with broader systems. Even the best tool won't last if it doesn't connect with local and national infrastructure.

At the same time, some outputs will be easier to transfer like patient education materials, training for healthcare professionals, and research projects using existing databases and algorithm-based methods to detect risks earlier.

> So I would definitely encourage people to follow the activities and final outputs of JACARDI and our work package, and we are hopeful that in about two years, we will be able to share the concrete results of 29 successfully implemented pilot projects.

MEANINGFUL ENGAGEMENT

Heléna to Benedetta: But what I would like to ask is that as we mentioned before, integrated care should be person-centred, which cannot happen without involving people with lived experience. I think it would be interesting to know how JACARDI is working to involve people living with diabetes or CVDs in shaping soltions – could you walk us through this?

Benedetta: I believe this is one of the most important dimensions of JACARDI.

If we want care to be truly person-centred, then we must start by listening to and working with people who live with diabetes and cardiovascular disease every day. They know better than anyone what it means to manage these conditions – not just in medical terms, but in the realities of daily life: balancing treatment with work or school, navigating fragmented services, and coping with the emotional and social impact of chronic illness. Involving them is not just the right thing to do ethically – it is essential if we want care models to actually work in practice.

Health systems are getting better at listening, but too often engagement with people with lived experience remains tokenistic — more of a box-ticking exercise than a genuine partnership.

And listening alone is not enough. Equity matters. People's needs are shaped by age, gender, socio-economic background, ethnicity, or religion. Without an equity lens, we risk designing care models that serve only the "average" patient, while leaving the most vulnerable behind.

That is why in JACARDI we are going further: ensuring that people living with these conditions are not only heard, but actively shaping decisions, and that voices from diverse communities are represented. Our Equity Framework is built on the 4Cs — Critical reflection, Context and data, Co-design, and inclusive Communication.

What we see is that when patients and communities are meaningfully engaged in co-design, the solutions they propose are not only more relevant and acceptable – they are often more cost-effective. They tend to focus on what really matters in practice, avoiding unnecessary complexity. As Dr Warner Slack wrote: "patient is the largest and least utilised resource in healthcare" – and I think JACARDI is proving that when we genuinely tap into this resource, we can design care that is both better and more sustainable.

In JACARDI, these principles are embedded in the methodology. Every pilot project should include an equity lens and begins with the establishment of a stakeholder board, which includes patients' associations, healthcare professionals, and other skey actors. These boards are not symbolic—they are a formal mechanism to ensure people with lived experience are actively shaping priorities, co-designing interventions, and helping evaluate their impact. This ensures that engagement is not symbolic, but built into the structure from the very beginning.

Of course, meaningful engagement is not without challenges. It requires time, resources, willingness to share power and a genuine cultural shift in how we think about "expertise." But when we listen deeply and act on what we hear, we end up with solutions that are more sustainable, equitable, and impactful.

> Integrated care will only succeed if it is co-designed with the people it serves, in all their diversity.

OVERCOMING FRAGMENTATION

Heléna to Benedetta: And still, there's always a risk that good pilots stay isolated. Why do you think integrated care solutions often remain fragmented? How can we ensure that what's being developed now (like in JACARDI) becomes practice and not just a solution for few?

Benedetta: That's a crucial question. Too often, promising integrated care models remain isolated pilots because they are not designed with sustainability, scalability, and system integration in mind from the start. Pilots conceived as short-term projects, without mechanisms for transferability, financing, and policy uptake, risk becoming "islands of excellence" that fail to transform or influence the wider system.

To overcome this, three elements are essential: stakeholder engagement, evidence, and transferability.

1) Stakeholder engagement comes from engaging policymakers, health authorities, and local stakeholders from day one, ensuring alignment with priorities and resources.
2) Evidence requires rigorous assessment across multiple dimensions.
3) Transferability demands structured platforms for sharing lessons, adapting solutions to different contexts, and avoiding duplication.

This is exactly the approach JACARDI takes. Our methodology embeds sustainability as a transversal principle: pilots are designed from day one with long-term viability in mind, thinking about how innovations can be integrated, maintained, and scaled within health systems.

In addition, JACARDI implements a structured pilot assessment framework that evaluates different key outcome dimensions such as clinical effectiveness, patient experience, economic efficiency, distributional equity, sustainability, implementation and process outcomes.

These assessments generate robust evidence that validates pilots locally and supports their transfer and scale-up across countries, creating practical, integrated models that can inspire system-wide change.

In JACARDI, we strongly believe the success of the project will not only be measured by the number of pilots implemented, but by the lasting change it enables in how care is delivered across Europe.

CONCLUSION

Benedetta to Heléna and vice versa: Before we close, Heléna, when you think about the future, what does real success in integrated care across Europe mean to you?

Heléna: Let me get a little sentimental here, especially because I'm quite sure, Benedetta, as a public health expert, you'll be able to give a much more solid professional take on it. So, my vision is that even with all the technological advancements and tools the future will bring, I believe that at the heart of it all, there will be — and should be — true human care. Not just healthcare professionals doing their jobs because that is their duty and what they are trained to do, but people who are truly driven by the desire to care, who want to find the best solutions for each patient, their families, and their communities. And on the other side, I hope we will see patients who do not place all responsibility for their physical and mental health on professionals, but who feel a personal duty to take care of themselves, to nurture and protect their health with intention and accountability. If we can get there, then humanity itself becomes embedded in the system and that's what I believe should be the true integrating element.

Of course, that kind of change goes far beyond any individual care pathway improvement project. It is not just a question of systems or processes — it is a cultural change, and that always takes time. But let's turn to you now, Benedetta, what is your more pragmatic and global public health perspective on this?

Benedetta: After your sentimental answer it is quite difficult to reply. Well, looking to the future, success in integrated care across Europe for me would mean that every person living with diabetes, cardiovascular disease, or any non-communicable diseases experiences care that is seamless, coordinated, and truly tailored to their needs, regardless of where they live, their background, or their circumstances. Integrated care should not be the exception—it should be the standard approach, embedded across primary, secondary, and community health services.

In this ideal future, health systems would be truly person-centred, with patients and communities actively shaping how care is designed and delivered. Decisions would be guided by evidence, but also by lived experience, ensuring equity, inclusion, and respect for cultural, social, and personal diversity at every step. Systems would anticipate risks, support prevention, and enable early detection and self-management, rather than reacting only when illness occurs. Health systems flourish when the voices of those they serve are at the heart of every decision.

To achieve this vision, three fundamental shifts are needed:

1) Policy and governance that prioritise integration and incentivise collaboration across services and sectors.
2) Health workforce and professional culture that embrace transdisciplinary work, shared responsibility for patient outcomes, and cultural humility—the ability to understand, respect, and adapt to the diverse needs, values, and experiences of the people they serve, which is one of the value embedded in JACARDI's Equity framework.
3) Data, measurement, and learning systems that track outcomes beyond clinical indicators—capturing patient experience, equity, and long-term sustainability—so that innovation can be tested, adapted, and scaled across contexts.

> For JACARDI, this vision guides everything we do. We are working to build practical, scalable models, based on evidence and co-designed with patients and communities, that can inspire real system-wide change.

Success will not be a single intervention, but a transformation in how Europe thinks about and delivers care: equitable, coordinated, sustainable, and centred on the person, not the disease.

If we achieve this, the impact will be profound. This is the ideal future I see for integrated care in Europe—and it starts with putting people at the centre, respecting and embracing their diversity, and designing care with them, not for them.

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INFORMÁCIÓK A SZERZŐKRŐL

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