International Diabetes Federation Europe

EASD 2025 VIENNA

IDF Europe Symposium at EASD 2025

INTEGRATION OF CARE
THE WAY FORWARD

September 18, 2025

Air Liquide HEALTHCARE

Air Liquide Healthcare is a partner of this symposium

PROGRAMME

On September 18, IDF Europe held a symposium on 'Integration of Care' during the European Association for the Study of Diabetes (EASD) 61st Annual Meeting.

The event brought together people living with Type 1 (T1D) and Type 2 diabetes (T2D), healthcare professionals (HCPs) and public health experts to discuss why integrated care is essential to support people living with diabetes (PwD) in managing this complex condition, and how we can overcome fragmented health systems and scale integrated care solutions.

The symposium built on discussions garnered from last year's symposium on *'Personalisation of Care'*, leading to insightful conversations from our speakers, This report summarises the key discussion points and takeaways that will inform and strengthen our ongoing efforts to advocate for and drive the delivery of high-quality, personalised and integrated diabetes care across Europe.

SPEAKERS

Benedetta Armocida
JACARDI Coordinator, Istituto Superiore di Sanità-ISS, Italy

Cajsa Lindberg
T1D & Global Health Advocate, and IDF Europe Advisor, Sweden

Martin Clodi
Head, Internal Medicine Department, St. John's Hospital, Austria

Alexandre Lourenço
CEO & Chairman of Coimbra's Integrated Health Delivery System, Portugal

Scott Cunningham
Senior Lecturer, University of Dundee, Scotland

Ermal Nazifi
T2D Advocate, Member of the IDF Europe T2GETHER Platform, Albania

Tomás Griffin
Consultant Endocrinologist in the Galway City Hub, Ireland

João Raposo
Medical Director at APDP, President of the Portuguese Diabetes Society and IDF Europe Chair Elect

Symposium Chair and Moderator:

Tadej Battelino
IDF Europe Regional Chair

KEY TAKEAWAYS

INTEGRATED, PERSON-CENTRED CARE

- Diabetes is a complex condition requiring coordinated, multidisciplinary and timely access to a wide range of health services – particularly when people live with multiple chronic conditions.
- PwD should not bear the burden of navigating fragmented systems – coordination of care should be facilitated seamlessly by health systems.
- Integrated, personalised care means seeing the person behind the numbers – recognising their unique needs, circumstances and experiences.
- Health systems should deliver the right care at the right time, ensuring proximity to local communities and continuity across care levels.

SUPPORTING & EQUIPPING HCPs

- Integrated care relies on multidisciplinary collaboration and communication among HCPs.
- All HCPs – including those not specialised in diabetes – should be equipped with basic diabetes education to understand the needs of PwD.
- Continuous professional education and improved team-based collaboration are essential to break down silos and ensure coordinated care.

REDESIGNING HEALTH SYSTEMS

- Health systems should be redesigned to strengthen coordination between primary, community and specialist care, avoiding duplication and fragmentation.
- Context assessment is crucial before implementation – integrated care solutions should reflect local realities and population needs.
- Health systems should enable early detection, timely intervention and proactive prevention to reduce the risk of complications and improve health outcomes.
- Sustainability must be built into integrated care programmes from the outset, ensuring their evolution into lasting, system-wide change supported by stable funding, sufficient workforce capacity and integration into national frameworks.

EMPOWERING PwD & COMMUNITIES

- PwD must be active partners in co-designing integrated care solutions from the outset.
- Diabetes associations play a crucial bridging role – connecting communities, empowering people to have their voice represented and driving health system redesign.

DIGITALISATION OF HEALTH SYSTEMS

- Digitalisation is a cornerstone of integrated care – enabling data collection and sharing, interoperability and supporting management and decision-making for PwD and HCPs.
- Strong IT infrastructure and shared data systems are essential to coordinate care effectively, measure outcomes and improve care delivery.

WELCOME AND INTRODUCTION

IDF Europe Chair, **Prof. Tadej Battelino**, opened the symposium by welcoming participants and noting that the programme offers a valuable opportunity to learn about integrated care from diverse perspectives.. Following a recap of last year's key takeaways by Global Health Advocate, **Cajsa Lindberg**, the event featured testimonials from PwD, presentations showcasing country examples of integrated care in practice and a panel discussion on the main barriers and enablers to achieving integrated care.

The value of personalised and integrated care: a perspective from PwD

During this session, T2D and T1D Advocates, **Ermal Nazifi** and **Cajsa Lindberg**, shared their personal experiences and perspectives on **why integrated care is crucial to enable PwD to manage their condition effectively and live long, fulfilling lives**.

Ermal was diagnosed with T2D ten years ago, but his experience with the condition started earlier, with his father, who also lived with T2D: *"Sadly, we lost him to complications that were detected far too late. For two years, he was treated for a skin condition, but no one thought to test for diabetes."* Drawing from his story, Ermal stressed the **importance of early diagnosis and timely action**. According to him, this illustrates how **many cases of diabetes remain undiagnosed**, putting people at higher risk of developing life-threatening complications.

*"We often forget that **living with diabetes is not just about numbers**. People living with the condition have needs, a family, a story and specific situations they face every day. Numbers don't struggle, don't grieve, don't hope – people do."*

Ermal explained that for PwD, many important aspects of care need to be put in place as early as possible, from timely diagnosis to adapted and coordinated care: *"After the first consultation at diagnosis, people often end up with more questions than answers. We don't only need access to a diabetologist; **we need integrated care, with clear communication between multidisciplinary experts and a personalised care plan that reflects our specific needs**. Integrated care is not just a matter of healthcare but it's a human rights issue."*

Cajsa has been living with T1D for 23 years, alongside other chronic conditions resulting from having had brain cancer some years ago. She explained that *"Managing diabetes can be very complex – your day is filled with decisions and the constant need to be on top of everything."*

Living with multiple interacting conditions, she navigates the health system from different perspectives and has seen first-hand the need for better integrated care – not only for people living with diabetes and its complications, but also for those with other conditions that, while not caused by diabetes, interact with it and make managing their health more challenging. She explained how **fragmented health systems often force people to act as their own care coordinators**: *"It puts you in the position of being a project manager of your own medical care. This is not what we mean when we say we want the person living with diabetes at the centre."*

As an example, Cajsa illustrated her own experience, where the diabetes and endocrine clinics were separate – resulting in double the appointments, double the tests and no coordination between HCPs.

INTEGRATED CARE IN ACTION: COUNTRY EXAMPLES

This session featured three country presentations illustrating integrated care **programmes from Ireland, Portugal and Scotland** with the aim to provide practical examples of how health systems in Europe are developing integrated care for chronic conditions like diabetes, highlighting their successes, challenges and lessons learnt.

Ireland's Integrated Care Programme for Prevention and Management of Chronic Diseases

Dr. Tomás Griffin, Consultant Endocrinologist in the Galway City Hub, presented Ireland's National Framework for the Integrated Prevention & Management of Chronic Diseases introduced in 2020.

GOAL

Shifting Ireland's health system away from episodic, hospital-centred care towards integrated, person-centred care for people living with, or at risk of, chronic conditions.

Delivering proactive, preventative and coordinated health services in closer **proximity to local communities** and empowering individuals to prioritise their health, manage their risk factors and live well with chronic conditions.

APPROACH

The need for this new model of care stems from challenges common to many European countries, including a rapidly ageing population and a growing number of people living with diabetes and multiple long-term conditions.

A key feature is that **care is not delivered in isolation** – rather than managing diabetes, cardiovascular and respiratory diseases separately, services are designed to address these conditions together.

CHRONIC DISEASE CARE

1. **PRIMARY CARE LEVEL:** general practitioners (GPs) deliver structured disease reviews and proactive care.
2. **COMMUNITY SPECIALIST AMBULATORY CARE HUBS:** providing rapid access to multidisciplinary expertise, including diagnostics, rehabilitation and education, supporting GPs in managing multimorbidity locally and reducing hospital referrals.
3. **ACUTE AMBULATORY CARE:** offering alternatives to traditional outpatient services.
4. **SPECIALIST HOSPITAL CARE:** reserved for complex cases.

EARLY RESULTS

- **57%** of people at risk of chronic conditions **identified** at primary care level and **enrolled in prevention programmes**.
- **4%** received a new **diagnosis**.
- **Reductions** in mean **HbA1c**.
- **74% drop** in outpatient **waiting times**.
- PwD reporting **greater control** over their condition.

"The right care, at the right time, by the right team, at the right place"

CHALLENGES

Challenges include **workforce shortages and turnover**, the need for robust **IT systems** and **referral criteria**, and better **communication** across teams.

FUTURE PLANS

Future plans include expanding the **Virtual Ward for home monitoring** and the **Virtual Island initiative** to support people living in **remote areas**.

Portugal's Diabetes Population-based Care and Management Programme

Prof. Alexandre Lourenço, CEO & Chairman of Coimbra's Integrated Health Delivery System, presented the programme implemented in the Coimbra region since 2024, which aims to provide integrated care for various chronic conditions, including diabetes, by bringing together six hospitals, 69 primary care units and two maternity units.

GOAL

Improving coordination between primary and hospital care, as well as between specialists, to prevent PwD from feeling lost within the healthcare system, while **improving health outcomes, reducing A&E visits and hospitalisations**, and lessening the burden of diabetes-related complications such as retinopathy and amputations.

APPROACH

In response to regional challenges such as an ageing population, a higher mortality rate and long waiting times for hospital care, the programme has established **dedicated diabetes clinics and clearly defined digital clinical pathways bringing together all the services and specialties needed to provide adequate and coordinated diabetes care**.

CHRONIC DISEASE CARE

1. **SELF-MANAGEMENT:** support through tele-follow-up and remote monitoring including automatic detection of irregular situations triggering follow-ups.
2. **PRIMARY CARE UNITS:** implementing a structured care programme for PwD with monitoring for quality improvement.
3. **HOSPITAL-BASED DIABETES CLINICS:** gathering all specialties required for diabetes care.

KEY COMPONENTS

- **Tailored IT system** enabling digitalisation and integration of clinical pathways and providing HCPs with access to all relevant data.
- Measurement and use of Patient-Reported Experience & Outcome Measures (**PREMs and PROMs**).

EARLY RESULTS

- **2,000 PwD** currently following the **digital clinical pathway**.
- Over **11,000 communications** with PwD, with a **30% response rate**, **18%** of which (521) generated **clinically relevant alerts and follow-ups**.
- **Five proximity ophthalmology units** ensuring annual screening for all PwD.
- **Three proximity wound care units** providing timely care for diabetes-related foot complications.

"People have the feeling they are lost within the healthcare system. We started to implement the concept of a diabetes clinic – a space where PwD know where they are receiving care and where all specialties come together."

NEXT STEPS

Expanding the digital clinical pathway to reach an **additional 14,000 PwD** in the region.

'My Diabetes My Way': Scotland's interactive diabetes platform for integration & personalisation

Dr Scott Cunningham, Senior Lecturer, University of Dundee, presented the digital platform 'My Diabetes My Way' (MDMW) – a digital platform for PwD, their families and carers which collects data and information to support diabetes management.

GOAL

Empowering PwD across Scotland to better understand and manage their condition, while improving integration and coordination between healthcare teams through shared access to comprehensive health data.

APPROACH

The platform builds on the **diabetes management system** in Scotland (SCI-Diabetes) to bring together **information from various sources**, including primary and secondary care, laboratories, outpatient services and emergency care. The system provides both HCPs and PwD with access to their up-to-date health information to support more person-centred, data-driven care.

KEY COMPONENTS

- **Digital access to personal health records**, allowing PwD to view their clinical data and track test results.
- **Educational resources** on diabetes care and self-management, including interactive content and structured e-learning courses.
- **Personalised guidance and reminders**, such as alerts when appointments and/or screening are required, and goal-setting features linked to individual data.
- **Quality monitoring** with regular user surveys and content overseen by a multidisciplinary team and shaped by a patient advisory group.

RESULTS TO DATE

- **Improvements in HbA1c, blood pressure, weight and cholesterol** among users.
- **Reductions in emergency care** use and diabetes-related **complications**.
- **PwD** report feeling **more informed, motivated and engaged** in their care.
- Health-economic analysis shows that **for every euro invested in MDMW, the healthcare system saves approximately five euros**.

"MDMW came along when people began asking for access to their own data – it helps them understand and manage their diabetes, stay motivated and engage in more meaningful, focused conversations with their HCPs."

NEXT STEPS

Current priorities include **improving device connectivity** (e.g. insulin pumps and closed-loop systems), enabling **two-way communication between PwD and their clinical teams**, and incorporating **predictive risk modelling** to support personalised prevention. The team is also exploring **expansion to other conditions**, such as cardiovascular disease **as well as** to other **geographical areas**.

PANEL DISCUSSION

Overcoming fragmentation: enablers, barriers and the path forward to integrated care




During the panel discussion, **Cajsa Lindberg**, **Dr. Armocida**, **Dr. Clodi** and **Prof. Raposo** reflected on the main challenges health systems face in delivering integrated care and shared insights on enablers and practical solutions to overcome fragmentation, highlighting the importance of collaboration with all stakeholders, particularly PwD, in co-creating effective care solutions.

Speaking from the perspective of people living with diabetes and other chronic conditions, **Cajsa Lindberg** emphasised the importance of having a **point of contact or care coordinator within the health system**: *"someone who can help us navigate and coordinate the many tasks and services related to our care."* Such support could significantly reduce the burden of interacting with a fragmented system.

She also highlighted the need to **improve diabetes awareness across the healthcare sector**. Even HCPs who are not directly involved in diabetes care should be equipped to understand PwD's needs and challenges.

Cajsa noted that **digital solutions** – including home care programmes and systems form managing appointments, follow-ups and communication with healthcare teams – can further support the integration of care and make the experience with the health system more seamless.

Dr. Benedetta Armocida, from the Italian National Institute of Health, presented **JACARDI**, the **EU Joint Action on CVD and Diabetes**, which is conducting 142 pilot projects across Europe, including initiatives on integrated care pathways. She emphasised the importance of **assessing the context** before designing pilots, to identify gaps and limitations in health system organisation. *"The initial JACARDI assessment found that **fewer than half of the 21 countries examined have policies or strategic frameworks for integrated care**, with key barriers including project-based funding, insufficient inclusion of vulnerable populations and limited integration of digital tools and professional training."*

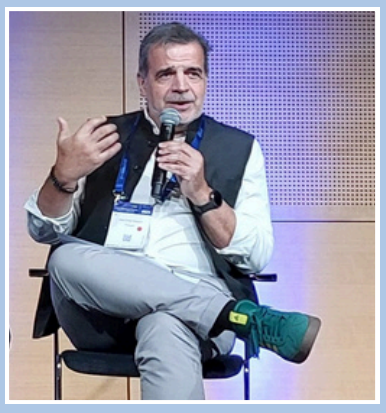
A central principle of JACARDI is **co-design and co-creation, actively involving people with lived experience and patient associations** in planning and implementation. Dr. Armocida stressed that *"sustainability from the outset is crucial to ensure pilots do not remain isolated but instead evolve into fully integrated models within the healthcare system."*

Dr. Martin Clodi, from the Austrian Diabetes Association, reflected on Austria's health system, where strong diabetes care and management programmes are already in place. A key gap, however, is the absence of a comprehensive **national diabetes registry** – particularly for people living with T2D who are primarily managed in primary care.

He highlighted the importance of **strengthening early detection and timely intervention**, noting that preventive check-ups from the age 18 are already available and that in the future metrics such as HbA1c could become part of routine screening. He stressed that recognising prediabetes early, and treating it as a serious, high-risk stage of the condition, is also key to enabling timely intervention.

He emphasised that ***"integrated care through outpatient diabetes clinics, where multidisciplinary teams work together can improve efficiency and reducing costs."***

Dr. Clodi also called for **better education and training for HCPs** – from GPs to internists and specialists – and for a more **value-based reimbursement system**, pointing out current imbalances where brief diagnostic procedures are rewarded far more than time spent in meaningful consultations with PwD.



Prof. João Raposo, Medical Director at APDP, President of the Portuguese Diabetes Society and IDF Europe Chair Elect, spoke about the key role of **diabetes associations** in facilitating **collaboration between PwD, HCPs and decision-makers** in designing and delivering integrated care solutions.

He stressed that, despite progress, **health systems still fall short of providing truly integrated person-centred care**. Drawing on the century-long history of the Portuguese Diabetes Association, APDP, he reflected on the role of local associations in addressing the **social determinants of health** and **empowering people** through **education** and **community engagement**.

Dr. Raposo emphasised that involving people with lived experience in improving care must happen form the outset if health systems are to achieve better outcomes. Associations, he said, have a unique responsibility to empower and equip PwD to participate as equal partners in shaping care and to challenge system design when it fails to reflect their realities. He explained that this approach helps turn community insights into meaningful, sustainable change.

"PwD are more than their condition – they live in families, they work, they might feel stigma and judgement. If we don't provide space for this, we can have the best-designed system but the results won't deliver results."

OPEN DISCUSSION WITH THE AUDIENCE

Following the panel discussion, interaction with the audience brought up interesting reflections on **universal health coverage** and the **meaningful engagement of lived experience**.

A remark from the audience highlighted the **challenges of coordinating and financing fully integrated, multidisciplinary care** across both public and private payer models. Achieving person-centred, integrated care also requires **rethinking how such services are funded and sustained**.

The observation prompted a reflection by **Prof. Lourenço** on what access to universal healthcare truly means. Even in countries where medicines and devices are fully reimbursed, barriers such as transport to consultations can still prevent some PwD from accessing the care they need. **Reducing inequalities** therefore **also means tackling issues of accessibility** – for example, by bringing services closer to communities.

Cajsa Lindberg welcomed the **growing recognition of the voices of PwD** within the broader community and the fact that their perspective is increasingly championed by others, including HCPs.

Building on this point, **Dr. Armocida** stressed that **collaboration must move beyond working *for* PwD to working *with* them**. She also underlined the importance of cultural humility among HCPs – the need to listen, respect, and adapt to the diverse needs and experiences of people living with chronic conditions.

Learn more about integration and personalisation of care

Interested in learning more about the theme of integrated care? Listen to our recent **podcast episode** where we explore what **integrated care** looks like in practice, why it is essential for people living with chronic conditions and the main challenges to scaling up innovation across health systems.

EP. 1
PERSONALISATION OF CARE

Last year, we also released a **podcast episode** aligned with the theme of our 2024 EASD Symposium, where our guests discussed what **personalisation of care** means for PwD and HCPs, what is needed to drive its implementation and how new technologies can support this process.

EP. 2
INTEGRATION OF CARE

The two symposia and podcast episodes are part of our ongoing work to advance personalised and integrated care across Europe. Building on these discussions, **we aim to drive progress towards more equitable, person-centred diabetes prevention, management and care for all people living with, or at risk of, diabetes.**

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IDF Europe wishes to thank all the speakers and attendees who joined the event and our partner, Air Liquide Healthcare, who helped make the symposium happen.

We look forward to continue collaborating with our community as we drive forward these essential conversations.

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