WORLD HEART FEDERATION

WORLD HEART FEDERATION ROADMAP SUMMARY

INTEGRATED CARE OF CARDIOVASCULAR DISEASE AND MULTIPLE LONG-TERM CONDITIONS

A FRAMEWORK FOR PEOPLE-CENTRED, COORDINATED CARE

WORLD HEART FEDERATION CARDIOVASCULAR DISEASE AND MULTIPLE LONG-TERM CONDITIONS:

A GROWING GLOBAL CHALLENGE

Cardiovascular disease (CVD) remains the leading cause of death worldwide, responsible for almost 20 million deaths each year, with a disproportionate burden in low- and middle-income countries.[1] At the same time, the number of people living with multiple long-term conditions (MLTC) is rising rapidly across all income settings, driven by ageing populations, social determinants of health, and changing disease patterns. Many people with CVD now live with several chronic conditions requiring ongoing, complex care.

A SYNDEMIC, NOT SEPARATE DISEASES

CVD rarely occurs in isolation. Conditions like obesity, type 2 diabetes, hypertension, and chronic kidney disease (CKD) share biological, behavioural, and social drivers that actively worsen cardiovascular outcomes.

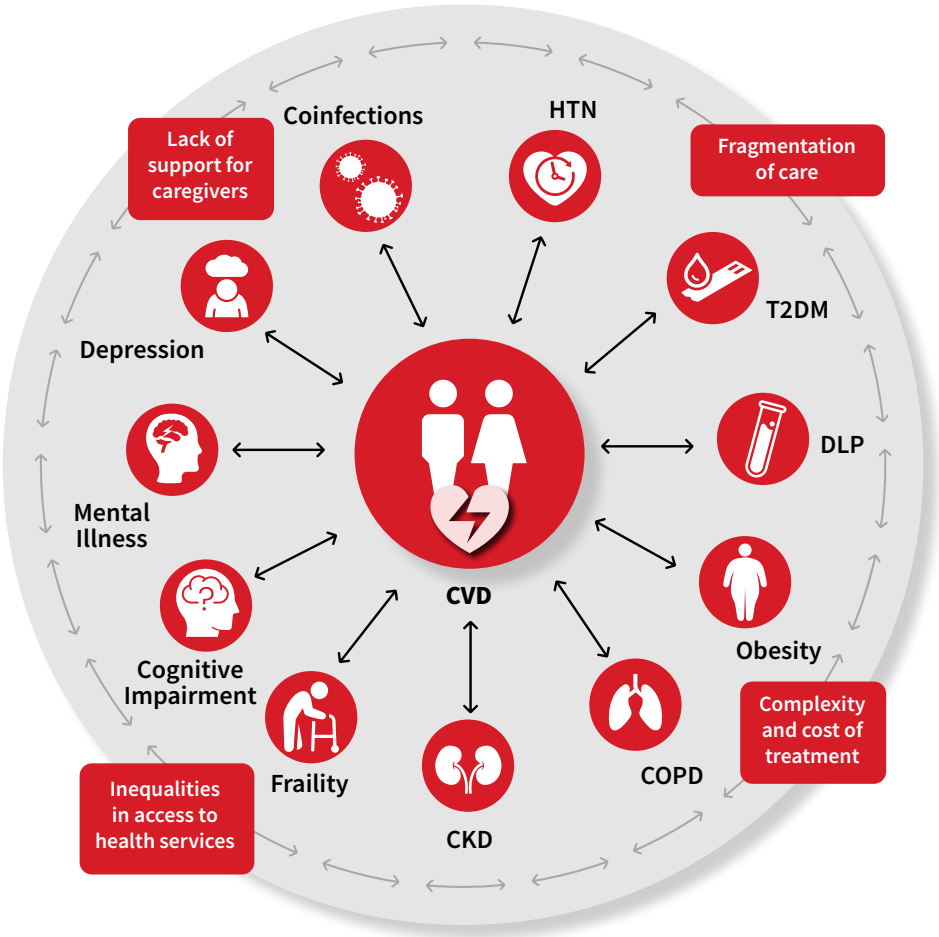
These shared biological, behavioural, and social drivers form a global syndemic that amplifies disease burden, treatment complexity, and health inequities.

CVD: cardiovascular disease; MLTC: multiple long-term conditions; HTN: hypertension; T2DM: type 2 diabetes mellitus; DLP: dyslipidemia; COPD: chronic obstructive pulmonary disease; CKD: chronic kidney disease.

This document is a summary of the World Heart Federation (WHF) Roadmap for integrated care in people living with – or at risk of – cardiovascular disease and multiple long-term conditions.[2]

The WHF Roadmap outlines a structure approach to advancing care integration. It identifies key barriers and provides practical, context-specific strategies to design, implement, and scale integrated care.

Designed for policymakers, health professionals, and communities, it demonstrates how integrated care can improve patient outcomes and strengthen health systems in response to the growing burden of multimorbidity.



[1]Global, Regional, and National Burden of Cardiovascular Diseases and Risk Factors in 204 Countries and Territories, 1990-2023. JACC. 2025 Dec, 86 (22) 2167–2243. https://doi.org/10.1016/j.jacc.2025.08.015
[2]Sperling L, Irazola V et al. WHF Roadmap for Integrated Care in People Living with – or at Risk of – Cardiovascular Disease and Multiple Long-Term Conditions. Global Heart. 2026. http://doi.org/10.5334/gh.1541

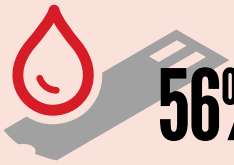
SHAREHOLDER INSIGHT

WHF Member and Network survey findings from clinicians and patients highlight widespread fragmentation of care for people living with CVD and multiple long-term conditions. Respondents consistently reported challenges related to coordination across specialties, treatment burden, and limited continuity of care, reinforcing the need for integrated, person-centred models.

HEALTHCARE PROFESSIONALS (N=78):

MAJORITY WERE CARDIOLOGISTS, WITH BROAD GEOGRAPHIC REPRESENTATION.

MOST COMMON COMORBIDITIES SEEN:



56%
Diabetes

20%
Obesity

13%
Chronic Kidney Disease (CKD)

BARRIERS:

74%
Insufficient Funding

64%
Fragmented Systems

64%
Lack of political prioritisation

SOLUTIONS: Patient awareness, training for healthcare professionals, national policies, accessible and affordable medicines, digital monitoring.

PATIENTS WITH CVD AND CARERS (N=58):

98% were patients living with CVD, often with multiple conditions.

50%

Hypertension

48%

Diabetes

28%

Mental Health

76%


Took five or more medications

57%

Reported poor coordination of care

55%

Long waits or distance to services

9%

Had access to integrated risk assessment tools

PRIORITIES: Better communication, financial support, access to multidisciplinary teams.

KEY TAKEAWAY: **Both groups strongly support integrated care, but systemic, financial, and organisational barriers continue to limit implementation. Their voices highlight the urgency of building sustainable models of care that bridge these gaps.**

WHY INTEGRATED CARE?

Integrated care organises health services around people rather than single diseases. For people living with CVD and MLTC, it enables coordinated, continuous, and person-centred care across providers and settings, reducing treatment burden, improving outcomes, and strengthening health system sustainability.

Fragmented care increases treatment burden and risk. Integrated care restores continuity, coordination, and person-centred outcomes.

INTEGRATED CARE IMPROVES OUTCOMES FOR PATIENTS AND SYSTEMS

EVIDENCE SHOWS THAT INTEGRATED CARE FOR PEOPLE WITH CVD AND MLTC CAN:[2]

- **Improve clinical outcomes and quality of life**
- **Reduce avoidable hospitalisations**
- **Lower treatment burden and duplication**
- **Strengthen health system efficiency and sustainability**

[2]Sperling L, Irazola V et al. WHF Roadmap for Integrated Care in People Living with - or at Risk of - Cardiovascular Disease and Multiple Long-Term Conditions. Global Heart. 2026. http://doi.org/10.5334/gh.1541

INTEGRATED CARE CAN TAKE MANY FORMS. THE EXAMPLE HERE ILLUSTRATES ONE WAY HEALTH SYSTEMS ARE REORGANISING CARE FOR PEOPLE WITH CVD AND MLTC.

CASE STUDY: NURSE-LED INTEGRATED CARE FOR PEOPLE WITH CVD AND MLTC[3]

SETTING
Since 2013, the Heart–Nephrology–Diabetes (HND) Centre at Danderyd University Hospital (Sweden) has delivered integrated, person-centred care for people living with cardiovascular disease (CVD), chronic kidney disease (CKD), and diabetes. Care is coordinated by trained nurses working across cardiology, nephrology, and diabetes teams.

WHAT CHANGED
Instead of attending separate specialist clinics, patients receive coordinated, multidisciplinary care focused on shared care planning, patient education, and continuity across conditions.

WHAT THIS SHOWS
A randomised trial comparing this model with usual siloed care found improved patient-reported quality of life, better communication, and fewer heart failure hospitalisations among people receiving integrated care. The model was feasible and cost-efficient, even in patients with advanced MLTC.

KEY LESSON
Integrated, nurse-led care can reduce fragmentation and improve patient experience for people living with CVD and MLTC, even in highly complex populations.

[3]Evén. G, Stenfors. T, Jacobson. S. H, et al Integrated, person-centred care for patients with complex cardiovascular disease, diabetes mellitus and chronic kidney disease: a randomized trial, Clinical Kidney Journal, Volume 17, Issue 11, November 2024, sfae331, https://doi.org/10.1093/ckj/sfae331

KEY COMPONENTS OF INTEGRATED CARE

Integrated care for people living with CVD and MLTCs requires coordinated action across nine interconnected system domains. At the centre is the person, whose needs and capacity should shape care design and delivery.

***The International Foundation for Integrated Care* identifies nine pillars that underpin effective integrated care systems.[4]**

1. SHARED VALUES AND VISION:
A successful integrated care system is built on a clearly articulated and collectively supported vision that prioritises person-centred care, equity, and sustainable improvement. This shared foundation allows diverse stakeholders to align their goals and collaborate effectively.

2. POPULATION HEALTH AND LOCAL CONTEXT:
Care models must be responsive to the specific demographic, cultural, and epidemiological characteristics of the population. Understanding the local disease burden, health behaviours, and service access issues is essential for designing relevant and targeted interventions.

3. PEOPLE AS PARTNERS IN HEALTH AND CARE:
Patients, families, and carers are recognised as equal partners in designing, delivering, and evaluating care. This principle supports shared decision-making, self-management, and the development of services that reflect the lived realities of service users.

4. RESILIENT COMMUNITIES AND NEW ALLIANCES:
Integrated care extends beyond the health sector, requiring collaboration with education, housing, social services, and civil society to address social determinants of health and build community capacity to support wellness and prevention.

5. WORKFORCE CAPACITY AND CAPABILITY:
Health and care professionals need the right mix of skills, training, and support to work collaboratively in multidisciplinary teams. Interprofessional education, new roles such as care coordinators, and team-based service delivery are fundamental enablers.

6. SYSTEM-WIDE GOVERNANCE AND LEADERSHIP:
Strong leadership is required to guide implementation, overcome institutional silos, and maintain accountability. Governance structures should enable strategic oversight and cross-sectoral alignment.

7. DIGITAL HEALTH:
Digital solutions, such as interoperable health records, telehealth, and patient apps, facilitate information-sharing and continuity. These are essential enablers of integrated care but also raise equity and governance challenges.

8. ALIGNED PAYMENT SYSTEMS:
Financial mechanisms should incentivise collaboration, prevention, and long-term outcomes rather than episodic or volume-based care. Models such as bundled payments and shared savings are examples of alignment.

9. TRANSPARENCY OF PROGRESS, RESULTS, AND IMPACT:
A culture of continuous improvement is driven by open reporting, robust evaluation frameworks, and the use of outcome and process indicators to measure and share results.

[4]https://integratedcarefoundation.org/nine-pillars-of-integrated-care

ROADBLOCKS AND ACCELERATORS TO INTEGRATED CARE FOR CVD AND MLTC

KEY ROADBLOCKS	KEY ACCELERATORS
Fragmented governance and siloed funding and outcomes	Aligned financing that rewards continuity
Episodic, volume-based payment models	Capitation, bundled payments, shared savings
Digital fragmentation and poor interoperability	Interoperable, government-enabled digital infrastructure
Workforce shortages and single-disease training	Team based care, task sharing, interprofessional training
Professional silos and resistance to role change	Supportive regulation, collaborative culture, trust
Limited patient engagement and weak feedback loops	Active patient, caregiver and community partnership

IMPLEMENTATION IN DIVERSE SETTINGS

While the principles of integrated care are globally applicable, implementation must be adapted to local health system realities, as high income countries (HICs) and low-middle-income countries (LMICs) face distinct challenges.[5]

In HICs, fragmentation across specialised services and siloed data systems limits coordination. Key solutions include shared digital platforms, multidisciplinary care, medication reviews, and patient reported outcome measures (PROMs), supported by advanced diagnostics and medical devices for early detection and tailored management.[6]

In LMICs, constraints in workforce, primary care, and access to diagnostics, medical devices, and specialist services are major barriers.[7]

Expanding access to essential diagnostics and technologies is important, alongside community-based care, task-shifting, mHealth tools, and simplified care pathways.

Across all settings, success depends on strong leadership, community engagement, adaptable models, and effective monitoring systems.

[5]Banerjee A, Hurst J, Fottrell E, Miranda JJ. Multimorbidity: Not Just for the West. Glob Heart. 2020 Jul 2;15(1):45. PMID: 32923339; PMCID: PMC7413145. DOI: https://doi.org/10.5334/gh.835
[6]OECD. Does healthcare deliver? Results from the Patient-Reported Indicator Surveys (PaRIS); 2025. PDF. https://www.oecd.org/en/publications/does-healthcare-deliver_c8af05a5-en.html
[7]Basto-Abreu A, Barrientos-Gutierrez T, Wade AN, et al. Multimorbidity matters in low and middle income countries. J Multimorb Comorb. 2022 Jun 16;12:26335565221106074. PMID: 35734547; PMCID: PMC9208045. DOI: https://doi.org/10.1177/26335565221106074

TOP 10 TAKE-HOME MESSAGES

WHAT EVERY STAKEHOLDER SHOULD KNOW ABOUT INTEGRATED CARE FOR CVD AND MLTC

1. INTEGRATED CARE IS ESSENTIAL

Cardiovascular disease rarely occurs alone. Most patients also live with multiple long-term conditions. Integrated care models are necessary to manage this complexity effectively, improve outcomes, and reduce the strain on health systems.

2. PEOPLE-CENTRED APPROACHES ARE VITAL

Integrated care puts individuals – not diseases – at the centre. Care must align with individual's needs, priorities, and capacity to manage their treatment burden. It must also include caregivers and acknowledge the support networks that contribute to health and wellbeing.

3. ONE SIZE DOES NOT FIT ALL

Integrated models must be tailored to each context and responsive to the diverse cultural, structural, and resource-related realities that exist across – and within – countries and regions. Strategies differ according to local needs and capacities, but share a common goal: accessible, coordinated, continuous, and person-centred care.

4. THE SELFIE FRAMEWORK PROVIDES STRUCTURE

The SELFIE framework (Sustainable integrated chronic care models for multi- morbidity: delivery, FInancing, and performance) outlines six components – service delivery, workforce, leadership, financing, technology, and monitoring – that support integrated care implementation. However, true patient-centredness requires a seventh component: partnership with patients, caregivers, and patient associations. Their co-leadership in designing and evaluating care ensures services are relevant and responsive.

5. MULTIDISCIPLINARY TEAMS ARE THE FOUNDATION

Effective collaboration among specialist physicians, primary care clinicians, nurses, community health workers (CHWs), social services, and caregivers is essential for delivering coordinated, person-centred care. Training and support for teams must foster shared responsibility and mutual respect.

6. DIGITAL HEALTH AND DATA-SHARING SUPPORT CONTINUITY OF CARE AND PERSONALISATION

Technology – including interoperable electronic health records (EHRs) and mobile health (mHealth) tools – enhances care coordination, enables tailored interventions, supports patient self-management, and facilitates real-time monitoring and learning.

7. ROADBLOCKS MUST BE ADDRESSED HEAD-ON

Legal, organisational, cultural, and financial constraints limit progress. Resistance to change among healthcare professionals and systems remains one of the most significant obstacles. Overcoming these barriers requires leadership, investment, supportive regulation (e.g. scope-of-practice laws), education, and alignment of incentives that reward collaborative, integrated care.

8. MONITORING AND EVALUATION (M&E) MUST FOCUS ON WHAT MATTERS MOST

Evaluation should go beyond service metrics to include what matters most to people, such as quality of life, care experience, and capacity to manage one's health. Tracking implementation, service performance, and patient-reported outcomes (PROs) ensures accountability and enables adaptation. Embedding these processes within a learning health system approach allows continuous feedback and improvement. Clear key performance indicators (KPIs) help systems learn and evolve.

9. COMMUNITY INVOLVEMENT ENHANCES SUSTAINABILITY

High-quality health systems are people centred. Engaging patients, caregivers, and communities in the co-design, delivery, and governance of care builds trust, ensures relevance, and strengthens long-term sustainability. This inclusive approach aligns with global frameworks for effective, resilient care systems.

10. THE TIME TO ACT IS NOW

The COVID-19 pandemic exposed critical global and health system vulnerabilities, emphasising the need for integrated, adaptable care. Integrated care is not only a reform strategy, but also the foundation for building resilient, equitable, and future-ready healthcare systems able to manage rising MLTC.

CALL TO ACTION:

Integrated care for people living with – or at risk of – CVD and MLTC must be implemented urgently through aligned policies, shared leadership, patient and community engagement, and targeted investment, especially in primary care, to build more equitable, resilient, and person-centred health systems

"Cardiovascular disease rarely exists in isolation. This roadmap makes clear that health systems designed around single conditions can no longer meet the needs of today's patients. Integrated, person-centred care is not optional, it is essential for improving outcomes and ensuring the sustainability of health systems worldwide."

PROFESSOR LAURENCE SPERLING
CO-CHAIR OF THE WHF ROADMAP FOR INTEGRATED CARE IN PEOPLE LIVING WITH – OR AT RISK OF – CARDIOVASCULAR DISEASE AND MULTIPLE LONG-TERM CONDITIONS

"There is no single model of integrated care that works everywhere. What matters is designing care around people's real lives, capacities, and contexts. This roadmap shows how countries can adapt integrated care for CVD and MLTC while keeping equity, continuity, and community at the centre."

PROFESSOR VILMA IRAZOLA
CO-CHAIR OF THE WHF ROADMAP FOR INTEGRATED CARE IN PEOPLE LIVING WITH – OR AT RISK OF – CARDIOVASCULAR DISEASE AND MULTIPLE LONG-TERM CONDITIONS

WORLD HEART FEDERATION ROADMAPS

CVDs and related conditions can often be prevented, or, through early detection, can be treated cost-effectively to prevent hospitalizations and death.

Successfully tackling CVDs requires coordinated national policy and health systems responses built around evidence-based strategies. Health resources are limited meaning cost-effective interventions for the prevention, detection and management of CVD must be prioritized to plan effective health systems responses.

WHAT ARE ROADMAPS?

WHF Roadmaps are a global framework that can be adapted and used at national or regional level. Their goal is to trigger effective action that can measurably reduce premature deaths and the associated global economic burden caused by CVD.

WHF ROADMAPS AIM TO SPUR ACTION THROUGH:

1. **Summarizing current recommendations that are proven, practical and cost effective to reduce the burden of CVD.**
2. **Highlighting obstacles to implementing these recommendations.**
3. **Proposing potential solutions for overcoming these obstacles.**
4. **Providing tools and strategies to adapt solutions to local needs.**

HOW DO THEY WORK?

WHF Roadmaps offer a global framework, tools and solutions that can then be used and adapted, through stakeholder collaboration, to meet the specific needs of individual regions and nations. *This requires:*

- A situation analysis of the current health system based on tools such as WHF CVD Scorecards
- Roundtables with multiple stakeholders to discuss obstacles, solutions and appropriate strategies
- A plan to implement and evaluate the proposed strategies.

WHO ARE THEY FOR?

Roadmaps empower WHF Members, including CVD foundations, societies and patient associations, to lead country-specific, action-oriented initiatives, including Roundtables.

These involve diverse stakeholders, such as:

- Governments and policy makers
- NGOs, health activists and advocates
- Healthcare professionals
- Corporate entities
- Academic and research institutions
- Patients and patient groups.

TO ACCESS ALL WHF ROADMAPS PLEASE VISIT – WORLD-HEART-FEDERATION.ORG/CVD-ROADMAPS

We recognise AstraZeneca and MSD for their support of the WHF Roadmap for integrated care in people living with – or at risk of – cardiovascular disease and multiple long-term conditions. We recognise Novo Nordisk and Roche for their support of this Roadmap Summary. The content of both documents is the sole remit of the co-authors.

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WORLD HEART FEDERATION

32, rue de Malatrex, 1201 Geneva, Switzerland
(+41) 22 807 03 20
info@worldheart.org
www.worldheart.org

worldheartfed
worldheartfederation
worldheartfederation
World Heart Federation
World Heart
World Heart Federation