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14-15 GIUGNO 2023 LOMBARDIA
FIERA DI BERGAMO

CIRCE-JA Joint Action on Transfer of Best PraCtices In PRimary CarE

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- FULL NAME: Joint Action on Transfer of Best PraCtices In PRimary CarE
- ACRONYM: **CIRCE-JA**
- PROJECT NUMBER: 101082572
- FUNDING BODY: HaDEA
- WEBSITE: -under construction-
- DURATION: 1st February 2023 TILL 31st January 2026 (36 months)
- PROJECT COORDINATOR: **SERVICIO ANDALUZ DE SALUD (SAS)**

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HS-g-14.3.1 **Transfer of best practices in primary care**

Policy context:

- Primary care has been part of Country Specific Recommendations (CSRs) in European Semester 2019 and 2020
  - ✓ strengthen the resilience of health systems and improve their accessibility
- COVID-19 pandemic highlighted the important role of primary care
  - ✓ Managing COVID-19 patients, track & tracing, reducing pressure on hospitals
  - ✓ *Opinion of the Expert Panel on Effective Ways of Investing in Health*: primary care forms the foundation of any emergency response
- An investment topic in Cohesion Policy funds and in National Recovery and Resilience Plans
- Importance of PHC internationally recognized since 1978, Declaration of Alma Ata, and its relevance continues, Declaration of Astana 2018, reinforced by documents on Vision, Transformation into Action and operational framework, a key component in SDG 2030 (SDG 3.8); as well as in the OECD report.

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JA SUMMARY

OVERALL OBJECTIVES

Effectively transfer and implement 6 selected best practices (BPs) in primary health care among Member States (MS)

- Supported by scientific evidence-based methodology
- Raising MS capacity in implementing innovative care models and addressing health system transformation at this level of care
- Strengthening health care systems through reinforcing primary health care
- Transferring and implementation process activities, monitored and assessed
- Knowledge generated and shared, with recommendations

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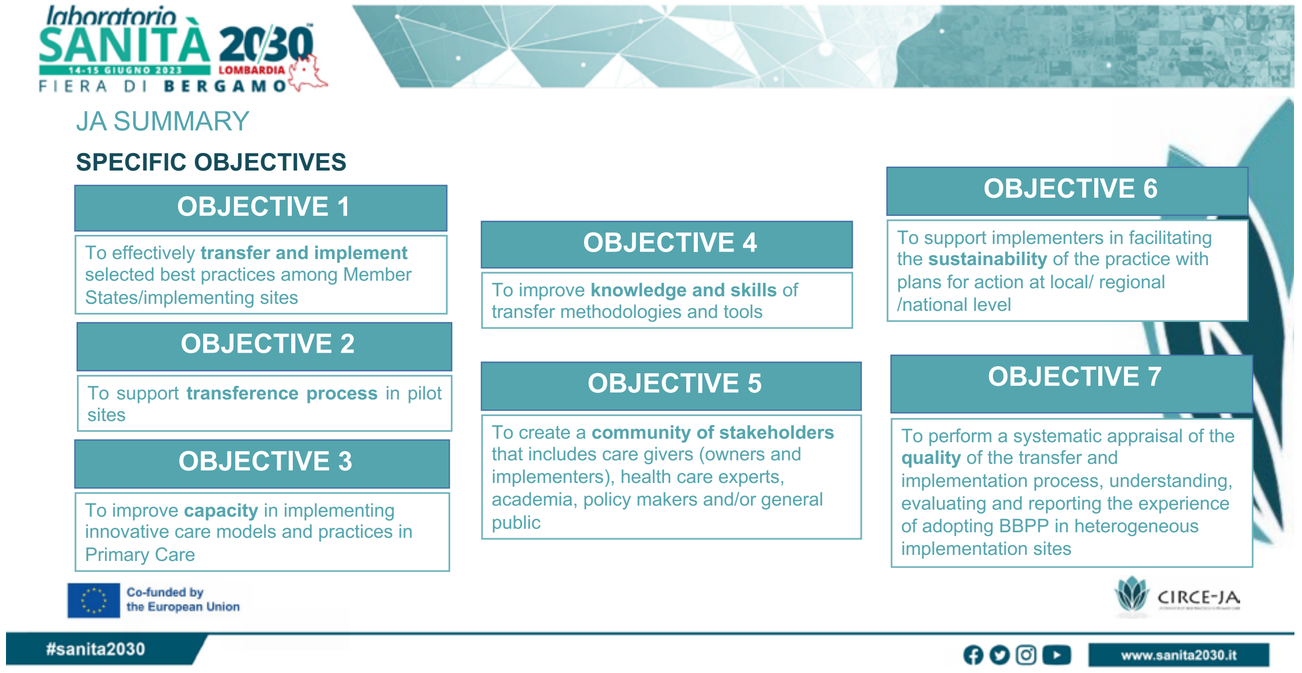

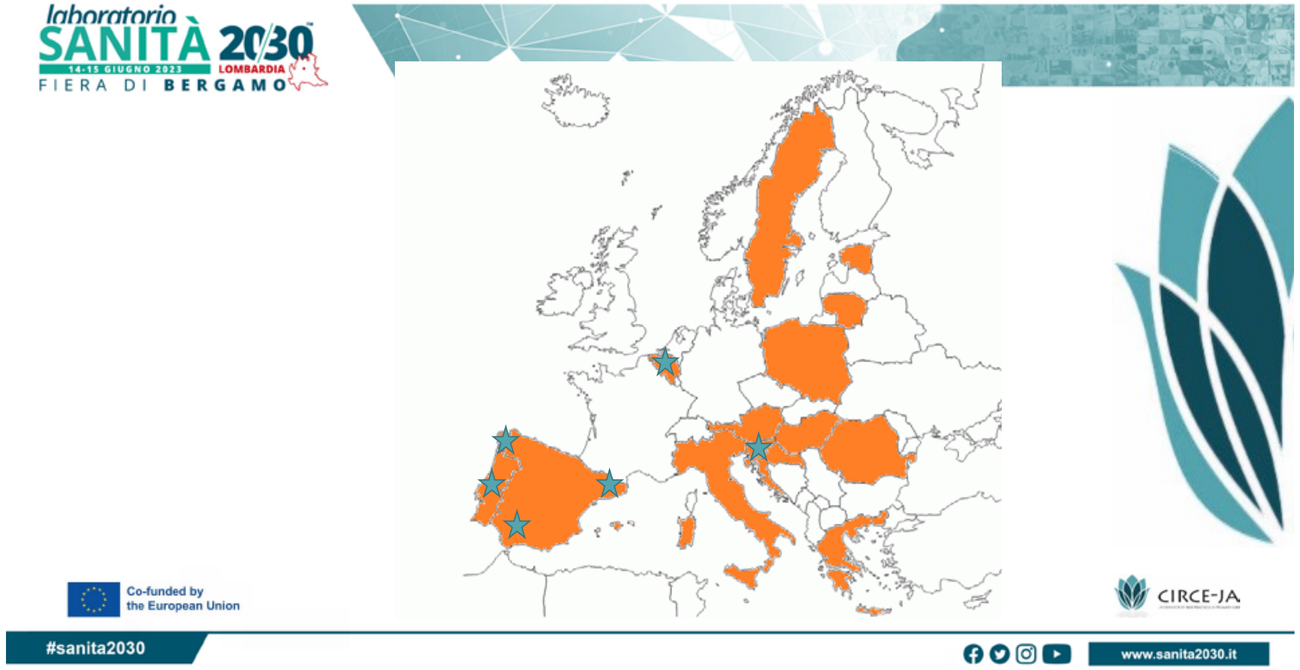

partner n	Partner (Designated authority)	Partner short name	COUNTRY	BP OWNER/ ADOPTER	AE
1	Servicio Andaluz de Salud	SAS	Spain	OWNER (3)	9
2	7th Health Authority	7HRC	Greece		
3	Austrian National Public Health Institute	GÖG	Austria		
4	Agence pour une Vie de Qualité	AVIQ	Belgium	OWNER	
5	Administração Central do Sistema de Saúde	ACSS	Portugal	OWNER	5
6	Croatian Institute of Public Health	CIPH	Croatia		
7	Ministry of Social Affairs	MSAE	Estonia		1
8	Ministry of Human Capacities	EMMI	Hungary		
9	Agenzia Nazionale per i Servizi Sanitari Regionali	AGENAS	Italy		16
10	Ministry of Health	SAM LT	Lithuania		
11	National Health Fund	NHF	Poland		
12	Ministerul Sănătății România	MS-MoH	Romania		2
13	Nacionalni inštitut za javno zdravje	NIJZ	Slovenia	OWNER	
14	The National board of health and welfare	Socialstyrelsen	Sweden		
					33

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BEST PRACTICES

1. *Integrated Health Association –Region of Wallonia,* ***Belgium***
2. *TELEA: Home telemonitoring in Primary Care for chronic disease and Covid-19 –Galicia,* ***Spain***
3. *Integrated care for complex chronic patients in Andalusia: Personalized care action plans (PAPs) –Andalusia,* ***Spain***
4. *Essencial Project: Adding value to clinical primary care practice - Catalonia,* ***Spain***
5. *'Health Action for Children and Youth at Risk' & 'Health Action for Gender, Violence and Lifecycle' –****Portugal***
6. *Health Promotion Centres (HPCs) –****Slovenia***

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Integrated Health Association –Region of Wallonia, ***Belgium***

The Integrated Health Association (ASI) is a practice originally deployed in the region of Wallonia, Belgium and owned by the AVIQ. Subsequently established the same system in the regions of Flanders and Brussels, currently there are 101 ASIs that are active in 52 municipalities, with just over half located in urban areas. These ASI centres are primary care practices incorporating a multidisciplinary team offering basic services, including medical care, nursing, physiotherapy and psycho-social assistance. The team members consult each other in coordination meetings, assessing the needs of the beneficiaries, including for implementation of /or to consider community health projects that could help them. Evaluation of these ASI centres has shown a positive impact on patient health and cost-effectiveness. The lessons learnt from this practice are that 1) the coordination of providers leads to better quality care in a patient centred way; 2) the multidisciplinary team coordination allows for the "right care by the right carer"; 3) the establishment of community health activities.

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TELEA: Home telemonitoring in Primary Care for chronic disease and Covid-19 –Galicia, ***Spain***

The Galician Health Service has developed the TELEA tool, integrated into the electronic clinical record, performing telemedicine and home telemonitoring. Any patient with specific access, can send information in a pre-established format to his own electronic record. It is accessible to healthcare personnel from any point of the Galician healthcare network in real time. TELEA is a home-care platform integrated with clinical information systems, improving management of chronic illnesses and balancing the cost of resources used. TELEA integrates several functionalities: Videoconferencing, Personal Health Record, Custom Notifications, and is ready to incorporate any clinical protocol, allowing customization. 3,809 patients with chronic diseases plus 60,607 patients with COVID-19 are being followed up by TELEA in primary care. Profiles include: arterial hypertension, heart failure, diabetes mellitus, chronic obstructive pulmonary disease (COPD), COVID-19, oral anticoagulation treatment, among others. Significant improvements in health outcomes and reductions in resources required by patients; 17.23% reduction of patients accessing hospital emergency and admissions, 90.75% reductions in care nursing visits and 31.46% reduction in primary care doctor visits, with a user satisfaction above 85%. The lessons learnt from this practice include 1) there has been resistance to change by professionals and users for new health technologies, which have been overcome with the use of the well-designed technology, 2) new telemonitoring technology does improve user satisfaction and the management of their chronic disease.

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Integrated care for complex chronic patients in Andalusia: Personalized care action plans (PAPs) – Andalusia, ***Spain***

Personalised Action Plans (PAPs) are a key element to provide the needed holistic care for comprehensive health plans designed to tackle the most relevant health problems in the region by the Andalusian Health Service (SAS-Servicio Andaluz de Salud). The PAPs are implemented in primary healthcare centres in collaboration with other levels of care, based on a comprehensive assessment of key aspects of patient status; including targeting symptoms, functionality and quality of life, and their preferred desired outcomes. These plans have been designed by multidisciplinary teams; family physicians, nurses, internists, case manager nurses, pharmacists, social workers, among others, with the consultation of each patient and/or caregivers. PAPs are regularly reviewed and revised depending on patient status and needs which are recorded and stored on the electronic health record facilitating coordination throughout the healthcare system. There was an overall reduction in the expected healthcare services utilisation compared to previous year, resulting in a 23.5% reduction in economic impact costs compared to expected trajectory. Moreover, there was improvement in health status perceived by patients. The lessons learnt from this practice include 1) Guidelines and online training course availability is key for HCPs 2) A corporate information system for electronic health records in important for PAPs implementation 3) HCPs' agendas need to be adapted for performing PAPs 4) the support of key leaders is vital for the practice's success

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Essencial Project: Adding value to clinical primary care practice -Catalonia, ***Spain***

The Essencial Project (EP) is a public policy initiative that was implemented in 2015, in primary care centres of Catalonia. The EP is based on knowledge transfer, evidence-based practices to avoid unnecessary care by the elaboration of recommendations to reduce low value clinical practices (LVCPs), such as overdiagnosis, overtreatment, overuse. EP includes four phases: 1) identification of LVCPs from HCPs, identification of clinical leaders in the primary care teams 2) prioritisation and elaboration of recommendations, 3) implementation of recommendations and impact assessment, feedback to monthly primary care teams using electronic health records and 4) communication of the products adapted to the citizens and patients. In total, 169 primary care teams participated. The impact of this practice demonstrated a reduction in LVCP, including a 33% reduction in prostate specific antigen screening and 44% reduction in statin prescriptions for cardiovascular disease prevention. Out of 86 recommendations for primary care, 25 were implemented. A survey identified that 69% of the HCPs believe that they are best positioned to deal with LVCPs. Also 64% of HCPs need to decide based on LVCP more than once per week. The lessons learnt from this project include: 1) the importance of considering local context for the de-adoption of strategies, 2) providing adequate training and communication material for patients and clinicians, 3) supporting key role of clinical leaders from providers 4) addressing barriers identified needs a multidisciplinary approach and broad stakeholder commitment.

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'Health Action for Children and Youth at Risk' & 'Health Action for Gender, Violence and Lifecycle' – ***Portugal***

The Health Action for Children and Youth at Risk was created in 2008, by order of no.31292/2008, and supported by the National Program for the prevention of violence in Lifecycle. Its main goal was the creation of a structured response for the promotion of children's rights and the prevention of abuse and maltreatment in the National Health Service. The practice incorporates both primary health care and hospital with paediatric care settings orchestrated through the "National Network of Support Centres for Children and Youth at Risk". The model was developed with specific guidelines from health professionals and disseminated using manuals, flowcharts, register systems, which allow the standardised working process throughout the NHS. 295 support teams are working in the NHS, including multidisciplinary teams of medical doctors, nurses, psychologists and social workers. These teams are responsible for raising awareness among community and health professionals, training HCPs and partners in addition to providing consulting for HCPs regarding child maltreatment. In very complex situations, these teams can directly intervene which leads to the situation being flagged in the health service. Families are assessed using risk indicators regarding the child, the family, and the socio-economic context. Additionally, there is close collaboration between health professionals, police, child protection services, educational, judicial and social protection systems. This network enables early intervention, appropriate tracking of violent situations and health surveillance of children and youths at risk to promote the well-being of children and their families. Between 2008 and 2019, 80,000 children have been monitored. 80% of these children did not need judicial intervention and were supported at the first level of intervention with their families allowing their best interests to be met. The lessons learnt from this practice include: 1) optimum results of intervention are obtained by connecting both primary care and hospitals, 2) early detection of risk factors by HCPs are key to success, 3) Intersectional communication and articulation to the community are important, 4) it is necessary to improve human resources and time allocation for HCPs to work on the intervention.

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*Health Promotion Centres (HPCs) –**Slovenia***

PHC centres are well established in Slovenia, representing the first point of contact for patients, providing access to curative and preventive services. Given their gatekeeping role, PHC centres have a wide range of practitioners including general practitioners (GPs), paediatricians, gynaecologists, community nurses, midwives, dentists for adults and children, pharmacists, physical therapists, psychologists and others. Every PHC centre in the country has a Health Promotion Centre (HPC) within its structure. These centres were introduced in 2002 alongside the National programme for prevention of cardiovascular diseases, theoretically and conceptually based on a bio-psyco-social model of care. HPCs provide fee-free lifestyle intervention programmes on healthy nutrition, physical activity, mental health, smoking and alcohol drinking. An upgrade to the HPCs was established in 2013 with interventions focused on vulnerable populations. Twenty-five Health Care Centres across Slovenia implemented the upgrade project from the period of 2018-2019 lead by the National Institute of Public Health of Slovenia. An important component of this project has been in linking different stakeholders in the local communities with the health services, identifying the needs and accessing vulnerable groups. New professionals, such as dieticians and kinesiologists, have been added to multidisciplinary teams previously composed of nurses, physiotherapists and psychologists. Nurses are recommended to lead the multidisciplinary teams as well as providing services and interventions. The HPCs are integrated with primary health services which provide preventive check-ups to detect individuals at risk of non-communicable diseases (NCDs). HPCs provide information, counselling, motivation, practical lessons, skills training and follow up of users to change life-style habits due to increased risk for or early stage of chronic NCDs. In over 15 years of NCDs preventive programme and operating HPCs, more than half of the adult population has been screened for lifestyle risk factors. There have been trends in reduced premature mortality due to cardiovascular disease by 19% between 2007 and 2015. However, disparities still exist between regions and income categories. The lessons learnt with this practice include: 1) multidisciplinary teams in HPCs have a broad spectrum of competencies and skills to provide health promotion and disease prevention programmes, 2) Primary health care services together with public health services reaching out to communities have proved to be a powerful vehicle to reaching vulnerable groups.

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Work Packages	WP Leader	Country
WP 1 Coordination and management	SAS	Spain
WP 2 Dissemination	NHF	Poland
WP 3 Evaluation	7HRC(L) MS-MoH (CL)	Greece Romania
WP 4 Sustainability	AGENAS (L) 7HRC (CL)	Italy Greece
WP 5 Methodology for the transferring process and analysis of needs and priorities	7HRC	Greece
WP 6 Transferring process and Pilot implementation	SAS	Spain
WP 7 Capacity building	NIJZ	Slovenia

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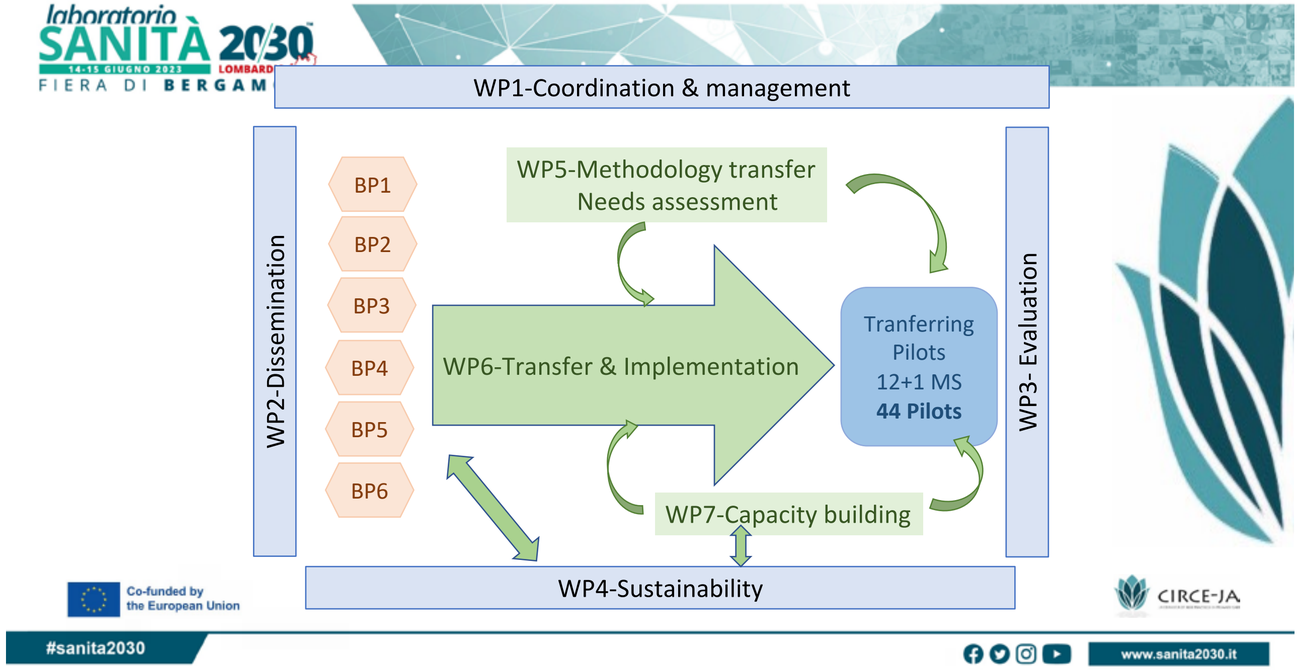

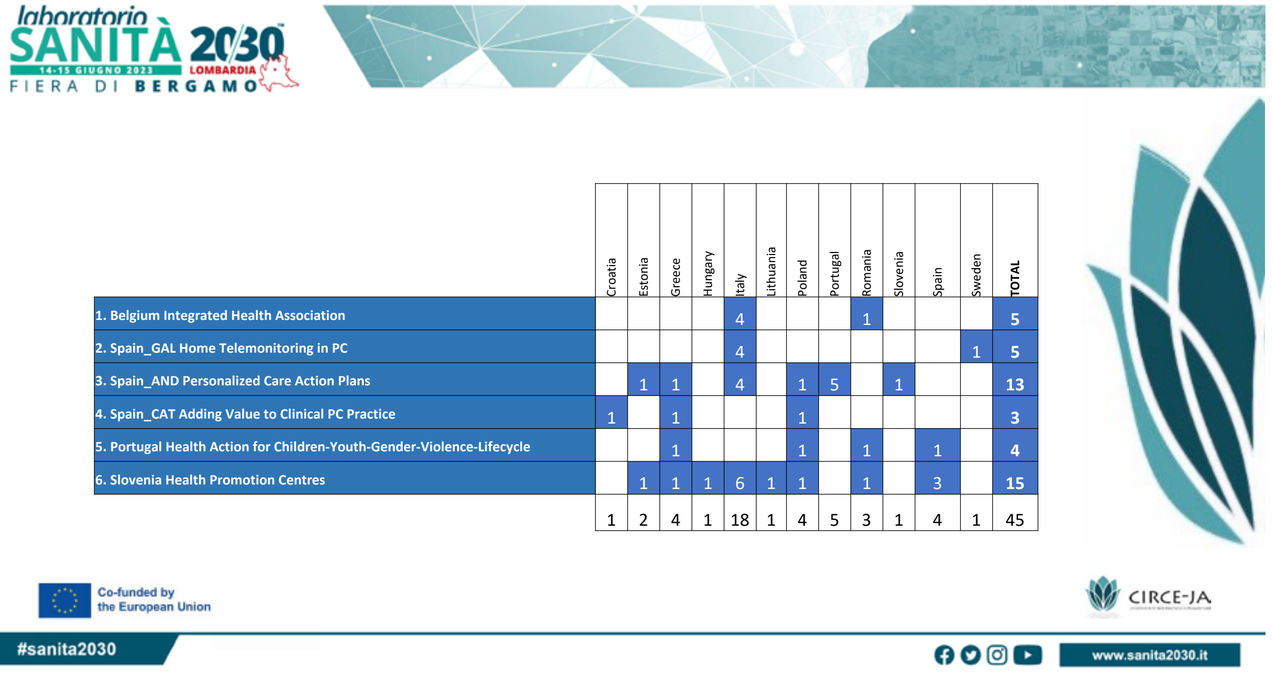

	Croatia	Estonia	Greece	Hungary	Italy	Lithuania	Poland	Portugal	Romania	Slovenia	Spain	Sweden	TOTAL
1. Belgium Integrated Health Association					4				1				5
2. Spain_GAL Home Telemonitoring in PC					4							1	5
3. Spain_AND Personalized Care Action Plans		1	1		4		1	5		1			13
4. Spain_CAT Adding Value to Clinical PC Practice	1		1				1						3
5. Portugal Health Action for Children-Youth-Gender-Violence-Lifecycle			1				1		1		1		4
6. Slovenia Health Promotion Centres		1	1	1	6	1	1		1		3		15
	1	2	4	1	18	1	4	5	3	1	4	1	45

WP/TASK CODE	WP/TASKS NAME	Start Month	End Month	Leader	YEAR 1				YEAR 2				YEAR 3			
					Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8	Q 9	Q10	Q11	Q 12
WP1	Coordination and Management	1	36	SAS												
T 1.1	Scientific coordination, quality assurance & risk management.	1	36	SAS												
T 1.2	Implementation of efficient management and support structures.	1	36	SAS												
T 1.3	Contractual, legal and ethical aspects	1	36	SAS												
T 1.4	Reporting and support of financial management & controlling.	1	36	SAS												
WP2	Dissemination	1	36	NFZ												
T2.1	Definition of the Dissemination Strategy and Action Plan	1	5	NFZ												
T2.2	Develop JA communication resources	1	36	NFZ												
T2.3	JA Communication	6	36	NFZ												
T2.4	Knowledge Transfer & Capacity building HUB	12	36	NFZ												
T2.5	Final conference	30	36	SAS												
WP3	Evaluation	1	36	7HRC												
T3.1	Definition of the processes and methodology of assessment	1	6	7HRC												
T3.2	Evaluation of project progress and outcomes	6	36	7HRC												
T3.3	Evaluation of project outcomes	6	36	7HRC												
T3.4	Assess the impact of the project implementation	25	36	7HRC												
WP4	Sustainability	3	36	AGENAS												
T4.1	Identification of principles and characteristics of BPs' successful implementation	3	14	AGENAS												
T4.2	Support implementers in ensuring the sustainability of BP in the future	13	33	AGENAS												
T4.3	Generate new knowledge and understanding	18	36	ASL ROMA 1												
T4.4	Development of a European Primary Health Care Observatory	25	36	AGENAS /7HRC												
WP5	Methodology for transferring process and needs assessment	1	24	7HRC												
T5.1	Analysis and definition of the methodological framework	1	4	7HRC												
T5.2	Definition of key priority areas for the implementation settings.	5	12	7HRC												
T5.3	Adapting and preparing the transferring process of the best practices in the implementation sites	10	24	7HRC												
WP6	Transferring process and Pilot implementation	4	36	SAS												
T6.1	Initial implementation plan	4	14	SAS												
T6.2	Transferring process support	10	24	SAS												
T6.3	Implementation and validation	13	36	SAS												
WP7	Capacity building	8	34	NIJZ												
T7.1	Policy developments & financial mechanisms; stakeholders involvement process	8	16	GOG												
T7.2	Development and provision of training programmes	10	22	NIJZ												
T7.3	Management capacities in transferring organisations	10	34	NIJZ												

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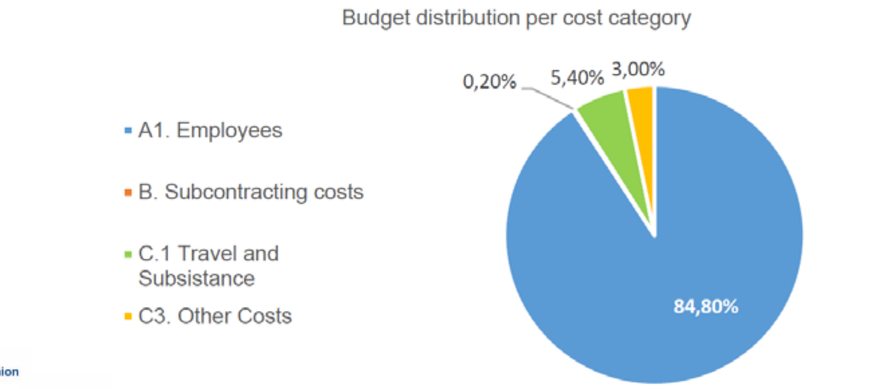
JA BUDGET

Total Cost 12.170.161,03 € / EU Grant (80%) 9.736.128,83 €



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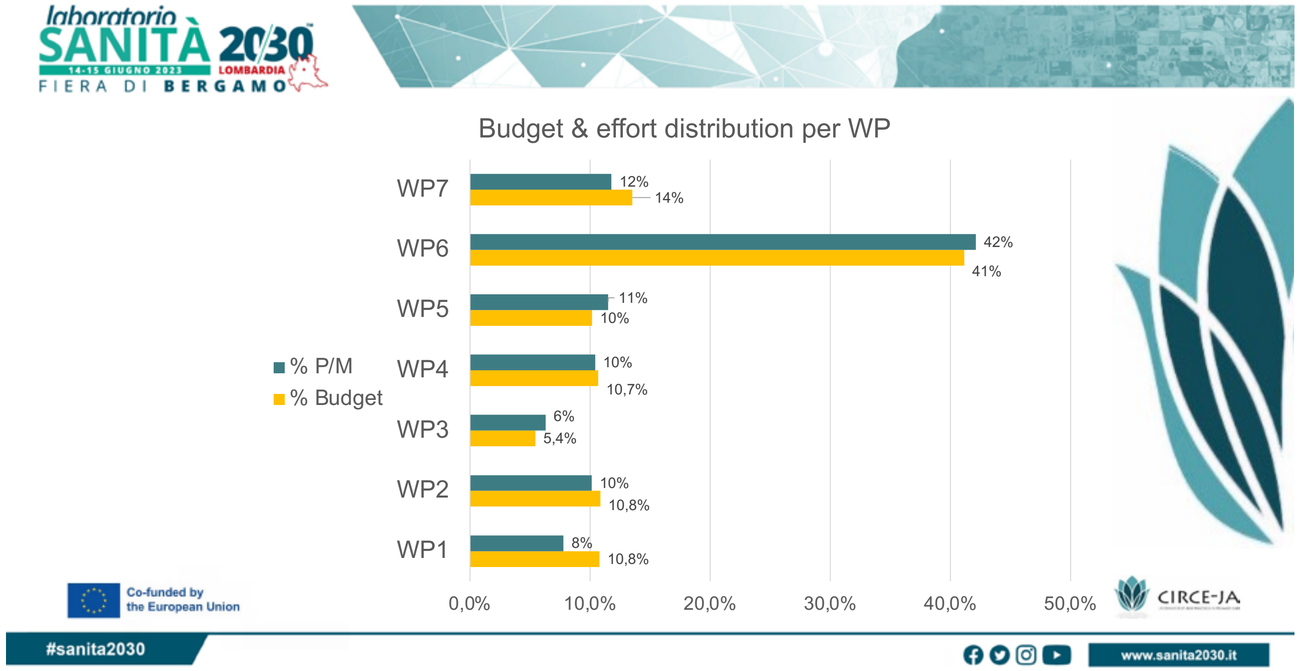

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4. CURRENT SITUATION

WP CODE	WP/TASK CODE	WP/TASKS NAME	Start Month	End Month	Leader	2023 Feb (1)	Mar (2)	Ap (3)	May (4)	Jun (5)	Jul (6)	Ag (7)	Sep (8)	Oct (9)	Nov (10)	Dec (11)	2024 Jan (12)
1	WP1	Coordination and Management	1	36	SAS		MS1				D1.1						
2	WP2	Dissemination	1	36	NFZ					D2.1	D2.2; MS2	D2.3					
3	WP3	Evaluation	1	36	7HRC						D3.1; MS4						
4	WP4	Sustainability	3	36	AGENAS									MS5			
5	WP5	Methodology for transferring process and needs assessment	1	24	7HRC				D5.1; MS8								D5.2; D5.5; MS9
6	WP6	Transferring process and Pilot implementation	4	36	SAS												MS10
7	WP7	Capacity building	8	34	NIJZ												D7.2

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Delitti in materia di violazione del diritto d'autore (Art. 25-novies, D.Lgs. n. 231/2001) [articolo aggiunto dalla L. n. 99/2009]

- Messa a disposizione del pubblico, in un sistema di reti telematiche, mediante connessioni di qualsiasi genere, di un'opera dell'ingegno protetta, o di parte di essa (art. 171, legge n.633/1941 comma 1 lett. a) bis)
- Reati di cui al punto precedente commessi su opere altrui non destinate alla pubblicazione qualora ne risulti offeso l'onore o la reputazione (art. 171, legge n.633/1941 comma 3)
- Abusiva duplicazione, per trarne profitto, di programmi per elaboratore; importazione, distribuzione, vendita o detenzione a scopo commerciale o imprenditoriale o concessione in locazione di programmi contenuti in supporti non contrassegnati dalla SIAE; predisposizione di mezzi per rimuovere o eludere i dispositivi di protezione di programmi per elaboratori (art. 171-bis legge n.633/1941 comma 1)
- Riproduzione, trasferimento su altro supporto, distribuzione, comunicazione, presentazione o dimostrazione in pubblico, del contenuto di una banca dati; estrazione o reimpiego della banca dati; distribuzione, vendita o concessione in locazione di banche di dati (art. 171-bis legge n.633/1941 comma 2)
- Abusiva duplicazione, riproduzione, trasmissione o diffusione in pubblico con qualsiasi procedimento, in tutto o in parte, di opere dell'ingegno destinate al circuito televisivo, cinematografico, della vendita o del noleggio di dischi, nastri o supporti analoghi o ogni altro supporto contenente fonogrammi o videogrammi di opere musicali, cinematografiche o audiovisive assimilate o sequenze di immagini in movimento; opere letterarie, drammatiche, scientifiche o didattiche, musicali o drammatico musicali, multimediali, anche se inserite in opere collettive o composite o banche dati; riproduzione, duplicazione, trasmissione o diffusione abusiva, vendita o commercio, cessione a qualsiasi titolo o importazione abusiva di oltre cinquanta copie o esemplari di opere tutelate dal diritto d'autore e da diritti connessi; immissione in un sistema di reti telematiche, mediante connessioni di qualsiasi genere, di un'opera dell'ingegno protetta dal diritto d'autore, o parte di essa (art. 171-ter legge n.633/1941)
- Mancata comunicazione alla SIAE dei dati di identificazione dei supporti non soggetti al contrassegno o falsa dichiarazione (art. 171-septies legge n.633/1941)
- Fraudolenta produzione, vendita, importazione, promozione, installazione, modifica, utilizzo per uso pubblico e privato di apparati o parti di apparati atti alla decodificazione di trasmissioni audiovisive ad accesso condizionato effettuate via etere, via satellite, via cavo, in forma sia analogica sia digitale (art. 171-octies legge n.633/1941).

Torna all'inizio