

CIRCE-JA

JA TRANSFER OF BEST PRACTICES IN PRIMARY CARE



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CIRCE-JA



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HEALTH CARE Estonia PRIMARY CARE
Andalusia Romania Lithuania
Austria Poland Spain
Portugal CIRCE-JA
Greece Italy Croatia Slovenia
Catalonia Belgium Sweden
Hungary BEST PRACTICES Galicia

INTRODUCTION

An important part of the European Commission's approach to preventing and managing noncommunicable diseases is to identify and transfer best practices. In December 2020, the European Commission launched a call for collecting good practices in Primary Health Care (PHC), agreed by the Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases (SGPP).

Practices selected based on evidence of impact, transferability and sustainability were presented to the Member States during an online Marketplace event (June 2021).

Those selected as the best by Member States are the **SIX THAT HAVE BEEN INCLUDED IN THE JOINT ACTION TRANSFER OF BEST PRACTICES IN PRIMARY CARE – CIRCE-JA.**



INTEGRATED HEALTH ASSOCIATION –REGION OF WALLONIA, BELGIUM



TELEA: HOME TELEMONTORING IN PRIMARY CARE FOR CHRONIC DISEASE AND COVID-19 – GALICIA, SPAIN



INTEGRATED CARE FOR COMPLEX CHRONIC PATIENTS IN ANDALUSIA (SPAIN): PERSONALISED CARE ACTION PLANS (PAPs) – ANDALUSIA, SPAIN



ESSENCIAL PROJECT: ADDING VALUE TO CLINICAL PRIMARY CARE PRACTICE – CATALONIA, SPAIN



'HEALTH ACTION FOR CHILDREN AND YOUTH AT RISK' & 'HEALTH ACTION FOR GENDER, VIOLENCE AND LIFECYCLE' – PORTUGAL



HEALTH PROMOTION CENTRES (HPCs) – SLOVENIA



AIMS

CIRCE-JA will effectively transfer and implement 6 selected best practices (BPs) in primary health care among European 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. Moreover, knowledge transfer and twinning actions will support the transferring and implementation process, including a wide range of activities, such as workshops, staff visits and secondments, policy dialogues, expert advice, mutual and peer learning programmes.

The transferring and implementation process will be monitored and assessed. Knowledge will be generated and shared addressing the main elements and recommendations for its success beyond the duration of the JA.

CIRCE-JA ambition looks forward to effectively transfer (implement, validate and sustain) the 6 BPs from 4 MS (Belgium, Portugal, Slovenia and Spain) in to 40 implementation sites from 12 MS with relevant structural, organizational and institutional differences in their health care systems. The common transversal interest is to **STRENGTHENING HEALTH CARE SYSTEMS THROUGH REINFORCING PRIMARY HEALTH CARE.**

14 EU MEMBER STATES ARE INVOLVED IN CIRCE-JA. BENEFICIARIES AND AFFILIATED ENTITIES (AE) REPRESENT EUROPEAN HEALTHCARE SYSTEMS AND SERVICES DIRECTLY CONNECTED TO THE OVERALL AIM OF THIS JA, **BEING BPs OWNERS OR IMPLEMENTERS.**





BEST PRACTICE 1

Integrated Health Association

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:

- 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.

BEST PRACTICE OWNER	IMPLEMENTERS
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Region of Wallonia, Belgium
Agence pour une Vie de Qualité



Italy

- **Regione Lazio ASL ROMA 1**,
Local level, 6 Municipalities of the city of Rome
- **Regione Lombardia ATS Bergamo**,
Sub-regional level, Bergamo and other near provinces
- **Regione Liguria ASL 4**,
Local level, Tigullio

Romania

- **Ministerul Sănătății România**,
National level



BEST PRACTICE 2

TELEA: Home telemonitoring in Primary Care for chronic disease and Covid-19

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.

BEST PRACTICE OWNER

Galicia, Spain
Servizo Galego de Saúde

IMPLEMENTERS

Sweden

- Region Norrbotten, Regional level

Italy

- Regione Piemonte ASL AL, Local level, Alessandria province
- Regione Emilia-Romagna USL Modena, Local level-Modena province, Health district Pavullo and Mirandola





BEST PRACTICE 3

Integrated care for complex chronic patients in Andalusia (Spain): Personalised care action plans (PAPs)

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 is 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.

BEST PRACTICE OWNER	IMPLEMENTERS
<p>Andalusia, Spain Servicio Andaluz de Salud</p> 	<p>Estonia</p> <ul style="list-style-type: none"> • Sotsiaalministeerium, Local level <p>Greece</p> <ul style="list-style-type: none"> • Dioikhsh Ygeionomikhs Perifereias Krhths, Regional level 3 pilot sites <p>Italy</p> <ul style="list-style-type: none"> • Regione Liguria A.Li.Sa, Regional level • Regione Emilia - Romagna USL Bologna, Local level - Province of Bologna (excluding Imola) • Regione Emilia - Romagna USL Parma, Local level - Municipality of San Secondo Parmense • Regione Emilia - Romagna USL Romagna, Local level - Romagna Area <p>Poland</p> <ul style="list-style-type: none"> • Narodowy Fundusz Zdrowia, National level <p>Portugal</p> <ul style="list-style-type: none"> • Unidade Local de Saúde de Matosinhos, E.P.E., Regional level • Unidade Local de Saúde de Lisboa Central, Regional level • Unidade Local de Saúde de Lisboa Ocidental, Regional level <p>Slovenia</p> <ul style="list-style-type: none"> • Nacionalni inštitut za javno zdravje, National level



BEST PRACTICE 4

Essencial Project: Adding value to clinical primary care practice

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;
- 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 practice 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.

BEST PRACTICE OWNER	IMPLEMENTERS
Catalonia, Spain Agència de Qualitat i Avaluació Sanitàries de Catalunya	Greece <ul style="list-style-type: none">• Dioikhsh Ygeionomikhs Perifereias Krhths, Regional level, 3 pilot sites
	Poland <ul style="list-style-type: none">• Narodowy Fundusz Zdrowia, National level
	Croatia <ul style="list-style-type: none">• Croatian Institute of Public Health, Regional, several counties





BEST PRACTICE 5

‘Health Action for Children and Youth at Risk’ & ‘Health Action for Gender, Violence and Lifecycle’

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.

BEST PRACTICE OWNER	IMPLEMENTERS
<p>Portugal Ministerio da Saude/Directorate -General of Health</p>	<p>Spain</p> <ul style="list-style-type: none"> • Fundació Fisabio, Local level: Urban (2 neighbourhoods) Valencia and rural (2 deprived neighbourhoods) Alzira
	<p>Greece</p> <ul style="list-style-type: none"> • Dioikhsh Ygeionomikhs Perifereias Krhths, Regional level 4 pilot sites
	<p>Poland</p> <ul style="list-style-type: none"> • Narodowy Fundusz Zdrowia, National level
	<p>Romania</p> <ul style="list-style-type: none"> • Ministerul Sănătății România, National level



BEST PRACTICE 6

Health Promotion Centres (HPCs)

PHC centres are well established in Slovenia, representing the first point of contact for patients and providing access to curative and preventive services. 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-psycho-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. 25 Health Care Centres across Slovenia implemented the upgrade project from 2018–2019 led by the **National Institute of Public Health of Slovenia**. An important component of this project has been linking different stakeholders in local communities with health services, identifying 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 lifestyle habits due to increased risk for or early stage of chronic NCDs. In over 15 years of the NCD prevention programme and operation of 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 for reaching vulnerable groups.

BEST PRACTICE OWNER

Slovenia
Nacionalni inštitut za javno zdravje

IMPLEMENTERS

Spain

- **Servicio Cántabro de Salud**, Regional level, Cantabria
- **Fundació Fisabio**, Local level, Urban (2 neighbourhoods) Valencia and rural (2 deprived neighbourhoods) Alzira
- **Servicio Madrileño de Salud**, Regional level

Greece

- **Dioikhsh Ygeionomikhs Perifereias Krhths**, Regional level 7 pilot sites

Italy

- **Regione Piemonte ASL CN2**, Local level
- **Regione Lazio ASL ROMA 3**, Local level
- **Regione Liguria ASL 1**, Local level, Province of Imperia
- **ASL Ascoli Piceno**, Local level

Poland

- **Narodowy Fundusz Zdrowia**, National level

Romania

- **Ministerul Sănătății România**, National level

Estonia

- **Sotsiaalministeerium**, Local level

Hungary

- **Nemzeti Népegészségügyi és Gyógyszerészeti Központ**, Regional level Central Hungary

Lithuania

- **KVSB LT**, Local level
- **KLVS LB**, Local level



SPAIN



ITALY



GREECE



POLAND



SLOVENIA



BELGIUM



PORTUGAL



LITHUANIA



ROMANIA



ESTONIA



AUSTRIA



CROATIA

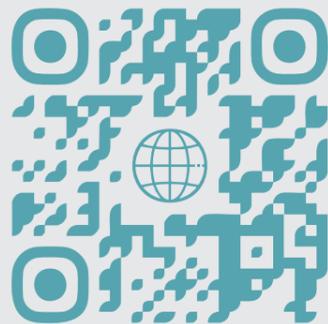


HUNGARY



SWEDEN

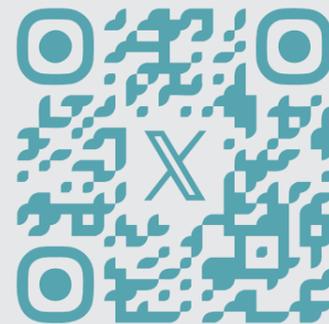




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