

CIRCE-JA

JA TRANSFER OF BEST PRACTICES IN PRIMARY CARE

Co-funded by
the European Union

CIRCE-JA

Title: JA Transfer of Best Practices in Primary Care
Acronym: CIRCE-JA
Grant Agreement Number: 101082572
Website: www.circeja.eu

ABOUT THE PROJECT

What is CIRCE-JA?

CIRCE-JA transferred and implemented **6 selected Best Practices (BPs)** in primary health care across European Member States. The process was supported by a scientific, evidence-based methodology, which contributed to strengthening the capacity of participating countries to implement innovative care models and to supporting health system transformation at the primary care level.

Knowledge transfer and twinning actions supported the implementation process through **a wide range of activities, including workshops, staff exchanges and secondments, policy dialogues, expert support, study visits, and mutual and peer learning programmes.** The transfer and implementation process was monitored and evaluated. As a result, knowledge was generated and shared, providing insights and recommendations to support the sustainability and potential scaling of the implemented solutions beyond the duration of the Joint Action.

CIRCE-JA enabled the transfer, implementation, and validation of 6 Best Practices originating from **4 Member States (Belgium, Portugal, Slovenia, and Spain)**. These practices were implemented in **40 pilot sites across 12 Member States,** representing diverse structural, organisational, and institutional healthcare contexts. Despite these differences, all participating countries shared a common objective: strengthening healthcare systems through the reinforcement of primary health care.

In total, **14 EU Member States were involved in CIRCE-JA.** Beneficiaries and affiliated entities represented a wide range of European healthcare systems and services aligned with the project's objectives, acting either as Best Practice Owners or implementers.



> What makes CIRCE work is a shared commitment to improving primary health care across Europe. Our partners bring different perspectives, backgrounds and experiences, but we all work towards the same goal. Open communication, trust and a willingness to learn from one another turn that diversity into one of our greatest strengths.
>
> ***– Ana M. Carriazo, Project Co-Coordinator***

STRUCTURE

Work Package 1 | Coordination and Management

Servicio Andaluz de Salud, Spain
Fundación Pública Andaluza Progreso y Salud, Spain

WP1 ensures the overall coordination, governance, and smooth implementation of the Joint Action by providing scientific, administrative, financial, legal, and technical management support. It establishes and maintains the project's management structure and ensures compliance with contractual obligations. WP1 is responsible for strategic and operational oversight of all Work Packages, including monitoring progress against objectives, milestones, deliverables, timelines, and budget. It provides quality assurance, risk management, and supports decision-making and conflict resolution within the consortium. It ensures effective internal communication and collaboration across partners, organises consortium meetings, and maintains liaison with the European Commission and relevant agencies. WP1 oversees reporting activities and guarantees adherence to ethical and legal requirements, including Grant Agreement and Consortium Agreement obligations.

Work Package 2 | Dissemination

Narodowy Fundusz Zdrowia, Poland

WP2 ensures effective dissemination and communication of the Joint Action's objectives, activities, and results to relevant stakeholders at European, national, and regional levels. It develops and implements the dissemination strategy, manages communication tools (including the project website and materials), and promotes visibility of project outputs. WP2 actively engages stakeholders throughout the project to raise awareness, support knowledge sharing, and validate results. It also supports capacity building through a Knowledge Transfer and Capacity Building Hub, including training activities and online resources. Finally, WP2 coordinates dissemination activities across partners.

Work Package 3 | Evaluation

7th Healthcare Region of Crete, Greece
Universitatea de Medicină și Farmacie „Carol Davila", Romania

WP3 assesses the implementation, progress, and overall success of the Joint Action, ensuring it is delivered as planned and achieves its objectives. It defines the evaluation methodology, including formative and summative assessment approaches, and develops indicators to measure progress, outcomes, and impact. WP3 conducts continuous monitoring of project activities, collects and analyses qualitative and quantitative data from implementation sites, and evaluates stakeholder and practitioner satisfaction. In addition, WP3 explores the broader impact of the Joint Action on primary health care systems in Europe and formulates key lessons learned through expert consultations, supporting EU-wide knowledge transfer and future improvements.

Work Package 4 | Sustainability

Agenzia Nazionale per i Servizi Sanitari Regionali, Italy
7th Healthcare Region of Crete, Greece

WP4 ensures the long-term sustainability and transferability of Best Practices by identifying contextual, organisational, and socio-economic factors affecting implementation and adaptation. It supports partners in maintaining and scaling achieved results, strengthening their integration into primary health care systems and national policies. WP4 also develops recommendations based on implementation experience and works on the establishment of a European Primary Health Care Observatory.

Work Package 5 | Methodology for transferring process and needs assessment

7th Healthcare Region of Crete, Greece

WP5 develops the methodological framework for the effective transfer of Best Practices by assessing needs in implementation sites and defining common standards, tools, and processes for adaptation and implementation. It identifies priorities, barriers, and capacity gaps through collaborative assessments and ensures that transfer processes are tailored to local contexts. WP5 also supports the design and operationalisation of the transfer methodology in each site, enabling structured learning and successful implementation of Best Practices.

Work Package 6 | Transferring process and Pilot implementation

Servicio Andaluz de Salud, Spain
Fundación Pública Andaluza Progreso y Salud, Spain

WP6 supports the practical transfer and implementation of Best Practices in pilot sites by developing tailored implementation plans and guiding their execution. It facilitates the adaptation of selected interventions to local contexts and provides structured support through study visits, secondments, mentoring, workshops, and policy dialogue. WP6 oversees the implementation phase, including monitoring progress, defining KPIs, and ensuring continuous adaptation of activities based on local needs. It also coordinates training for end users and supports the reporting and validation of results in collaboration with other WPs.

Work Package 7 | Capacity building

Nacionalni inštitut za javno zdravje, Slovenia

WP7 strengthens capacities in Member States for the development, implementation, and evaluation of Best Practices by supporting policy development, sustainable financing mechanisms, and health system readiness. It facilitates stakeholder engagement to create enabling regulatory and financial frameworks for long-term implementation. WP7 also develops and delivers structured training programmes, including training of trainers and support for end-user education in collaboration with implementation sites.

BEST PRACTICES



BP1 | Integrated Health Association
Region of Wallonia, Belgium

A multidisciplinary primary care model was implemented across multiple regions in Belgium, operating through 101 centres in 52 municipalities and providing integrated medical, nursing, physiotherapy and psycho-social services. More than half of these centres are located in urban areas. Care is delivered by coordinated teams that regularly assess patient needs, maintain effective communication between healthcare professionals, and collaborate on both individual care and community health initiatives. Evaluations indicate improved patient outcomes and cost-effectiveness, showing that coordinated, multidisciplinary approaches support higher quality, patient-centred care and enable delivery of appropriate care by the right professional.



BP2 | TELEA: Home telemonitoring in Primary Care
Galicia, Spain

A telemedicine and home telemonitoring solution integrated with electronic health records enables patients to submit health data remotely while allowing healthcare professionals real-time access across the care network. The platform supports chronic disease management through functionalities such as videoconferencing, personal health records, custom notifications and adaptable clinical protocols, covering a wide range of patient profiles. In Galicia, TELEA has been used to monitor over 64,000 patients, including those with chronic diseases and COVID-19. Its use has been associated with improved health outcomes, reduced demand for healthcare services and high user satisfaction, while highlighting the importance of well-designed technology in overcoming initial resistance and supporting effective chronic care management.



BP3 | Personalised Care Action Plans
Andalusia, Spain

Personalised care plans are used to deliver holistic, patient-centred care based on comprehensive assessments of health status, including symptoms, functionality, quality of life and individual goals. They are developed and regularly updated by multidisciplinary teams in collaboration with patients and caregivers, and integrated into electronic health records to support coordination across levels of care. The plans involve a wide range of professionals, including family physicians, nurses, pharmacists and social workers. Their use has been associated with improved patient-perceived health status and reduced healthcare utilisation and costs, highlighting the importance of training, digital systems, organisational adaptation and leadership support for effective implementation.



BP4 | Essencial Project
Catalonia, Spain

An initiative focused on reducing low-value clinical practices supports evidence-based decision-making in primary care. It identifies and implements recommendations to reduce unnecessary tests, treatments and other interventions, helping prevent overdiagnosis and overtreatment. The approach engages professionals throughout the process, supported by e-health record data and targeted communication to clinicians and patients. In Catalonia, 169 teams participated in the initiative, achieving reductions in prostate-specific antigen screening (33%) and statin prescriptions for cardiovascular disease prevention (44%). Its implementation has led to measurable reductions in selected low-value practices, highlighting the importance of local context, training, clinical leadership and multidisciplinary engagement.



BP5 | 'Health Action for Children and Youth at Risk' & 'Health Action for Gender, Violence and Lifecycle'
Portugal

This model was established to promote children's rights and prevent abuse by integrating primary care and hospital services within a coordinated support network, guided by standardised guidelines and multidisciplinary teams. These teams raise awareness, train professionals, assess risk factors, and collaborate with social, educational and judicial services, enabling the early identification of and intervention in situations of vulnerability. This approach has supported children without the need for judicial intervention, highlighting the importance of early detection, cross-sectoral collaboration and adequate resources for effective prevention. Building on this model, the approach was extended to adults (18 and over), with new guidelines and an intervention network to prevent and address violence across the entire life course.



BP6 | Health Promotion Centres
Slovenia

Health promotion units integrated within primary health centres provide structured, free-of-charge programmes focused on lifestyle change (healthy nutrition, physical activity, mental health support, and reduction of harmful behaviours such as smoking and excessive alcohol use). These units combine preventive counselling, education, skills training and follow-up. They support early identification of risk factors for chronic diseases through close integration with primary care services. In Slovenia, these centres have contributed to screening over half of the adult population for lifestyle risk factors.
Their work is strengthened by multidisciplinary teams and community outreach, enabling targeted support for vulnerable groups and contributing to improved population health and prevention of non-communicable diseases.



PARTICIPANTS

14 EU Member States were involved in CIRCE-JA. Beneficiaries and affiliated entities represented European healthcare systems and services directly connected to the objectives of the Joint Action, acting as Best Practice Owners or implementers. These included **Austria, Belgium, Croatia, Estonia, Greece, Hungary, Italy, Lithuania, Poland, Portugal, Romania, Slovenia, Spain and Sweden.**

SPAIN

Servicio Andaluz de Salud
Consejería de Presidencia, Sanidad y Emergencias

Fundación Pública Andaluza Progreso y Salud
Consejería de Presidencia, Sanidad y Emergencias

Junta de Andalucía
Consejería de Presidencia, Sanidad y Emergencias

Agència de Qualitat i Avaluació Sanitàries de Catalunya

GENERALITAT VALENCIANA

Fundació Fisabio

SERVIZO GALEGO DE SAÚDE

AXENCIA GALEGA DE COÑECEMENTO EN SAÚDE

Valdecilla Instituto de Investigación Sanitaria IDIVAL

SCS Servicio Cántabro de Salud

SaludMadrid Gerencia Asistencial de Atención Primaria

SaludMadrid FIIBAP FUNDACIÓN PARA LA INVESTIGACIÓN E INNOVACIÓN BIOSANITARIA DE ATENCIÓN PRIMARIA
Servicio Madrileño de Salud

GREECE

7th HEALTHCARE REGION I CRETE

POLAND

NFZ Narodowy Fundusz Zdrowia

SLOVENIA

NIJZ Nacionalni inštitut za javno zdravje

BELGIUM

AVIQ

ROMANIA

Institutul Național de Sănătate Publică

ESTONIA

SOTSIAALMINISTEERIUM

UNIVERSITY OF TARTU 1632

AUSTRIA

Gesundheit Österreich GmbH

ITALY

AGENZIA NAZIONALE PER I SERVIZI SANITARI REGIONALI

ATS LIGURIA
AZIENDA TUTELA DELLA SALUTE LIGURIA

SISTEMA SANITARIO REGIONALE
ASL ROMA 1

SISTEMA SANITARIO REGIONALE
ASL ROMA 3

ast ASCOLI PICENO MARCHE

Sistema Socio Sanitario
Regione Lombardia
ATS Bergamo

BRA ALBA
ASL CN2

ASL AL
REGIONE PIEMONTE

SERVIZIO SANITARIO REGIONALE EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Bologna

SERVIZIO SANITARIO REGIONALE EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Modena

SERVIZIO SANITARIO REGIONALE EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Parma

SERVIZIO SANITARIO REGIONALE EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale della Romagna

PORTUGAL

ACSS ADMINISTRAÇÃO CENTRAL DO SISTEMA DE SAÚDE, IP

DGS Direção-Geral da Saúde

ULSM Unidade Local de Saúde de Matosinhos, EPE

UNIDADE LOCAL DE SAÚDE LISBOA OCIDENTAL

UNIDADE LOCAL DE SAÚDE SÃO JOSÉ

LITHUANIA

Lietuvos Respublikos sveikatos apsaugos ministerija

KAUNO MIESTO SAVIVALDYBĖS VISUOMENĖS SVEIKATOS BIURAS

KLAIPĖDOS MIESTO VISUOMENĖS SVEIKATOS BIURAS

CROATIA

HRVATSKI ZAVOD ZA JAVNO ZDRAVSTVO

HUNGARY

NNGYK NEMZETI NÉPEGÉSZSÉGÜGYI ÉS GYÓGYSZERÉSZETI KÖZPONT

SWEDEN

Socialstyrelsen
THE NATIONAL BOARD OF HEALTH AND WELFARE

REGION NORRBOTTEN

IMPLEMENTING SITES

Country	Partner	BP1	BP2	BP3	BP4	BP5	BP6
Spain	Servicio Cántabro de Salud	○	○	○	○	○	●
Spain	Fundació Fisabio	○	○	○	○	●	●
Spain	Servicio Madrileño de Salud	○	○	○	○	○	●
Greece	7th Healthcare Region of Crete	○	○	●	●	●	●
Italy	Regione Piemonte ASL CN2	○	○	○	○	○	●
Italy	Regione Piemonte ASL AL	○	●	○	○	○	○
Italy	Regione Lazio ASL ROMA 1	●	○	○	○	○	○
Italy	Regione Lazio ASL ROMA 3	○	○	○	○	○	●
Italy	Regione Lombardia ATS Bergamo	●	○	○	○	○	○
Italy	ATS Liguria	●	○	●	○	○	●
Italy	Regione Emilia-Romagna AUSL Bologna	○	○	●	○	○	○
Italy	Regione Emilia-Romagna AUSL Modena	○	●	○	○	○	○
Italy	Regione Emilia-Romagna AUSL Parma	○	○	●	○	○	○
Italy	Regione Emilia-Romagna AUSL Romagna	○	○	●	○	○	○
Italy	AST Ascoli Piceno	○	○	○	○	○	●
Poland	Narodowy Fundusz Zdrowia	○	○	●	●	●	●
Slovenia	Nacionalni inštitut za javno zdravje	○	○	●	○	○	○
Romania	Ministerul Sănătății România	●	○	○	○	●	●
Portugal	Administração Central do Sistema de Saúde	○	○	●	○	○	○
Portugal	Unidade Local de Saúde de Matosinhos, E.P.E.	○	○	●	○	○	○
Portugal	Unidade Local de Saúde de São José, E.P.E.	○	○	●	○	○	○
Portugal	Unidade Local de Saúde de Lisboa Ocidental, E.P.E.	○	○	●	○	○	○
Croatia	Croatian Institute of Public Health	○	○	○	●	○	○
Estonia	Sotsiaalministeerium	○	○	●	○	○	●
Hungary	Nemzeti Népegészségügyi és Gyógyszerészeti Központ	○	○	○	○	○	●
Lithuania	Kauno miesto savivaldybės visuomenės sveikatos biuras	○	○	○	○	○	●
Lithuania	Klaipėdos miesto savivaldybės visuomenės sveikatos biuras	○	○	○	○	○	●
Sweden	Region Norrbotten	○	●	○	○	○	○

BP1 – Integrated Health Association

BP2 – TELEA: Home telemonitoring in Primary Care for chronic disease and COVID-19

BP3 – Integrated care for complex chronic patients: Personalised care action plans (PAPs)

BP4 – Essencial Project: Adding value to clinical primary care practice

BP5 – 'Health Action for Children and Youth at Risk' & 'Health Action for Gender, Violence and Lifecycle'

BP6 – Health Promotion Centres (HPCs)

TRANSFER METHODOLOGY

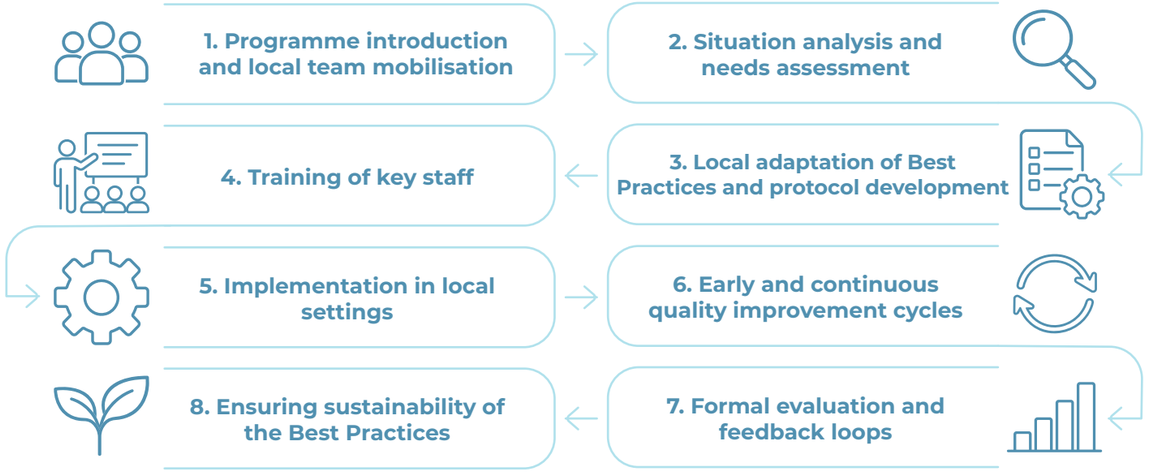
A structured and adaptable pathway

Transferring a Best Practice from one healthcare setting to another requires more than simply replicating an existing model. Differences in healthcare organisation, resources, professional roles and local priorities mean that each intervention needs to be adapted to the receiving context while preserving its essential components. The CIRCE-JA **Transfer Methodology** was developed as a **common, evidence-based framework** to guide this process across different European primary health care settings.

The methodology was developed based on international transferability frameworks, the **TO-REACH conceptual framework, a scoping review and the needs identified by CIRCE-JA implementation teams.** It highlights key factors for successful transfer, including a clear understanding of the Best Practice, identification of barriers and facilitators, local adaptation, stakeholder involvement, strong leadership, appropriate training and continuous quality improvement.

Based on this evidence and a consortium-wide consensus process, CIRCE-JA established a structured methodology covering **8 interconnected phases.** The process begins by creating a local implementation team, identifying key champions and developing a shared understanding of the Best Practice and the transfer process. This is followed by a situational analysis and needs assessment, which examines whether the Best Practice responds to local priorities and identifies relevant stakeholders, organisational conditions, barriers, facilitators and possible mitigation strategies. These findings provide the basis for adapting the intervention and developing **a local implementation plan while maintaining the essential components that make the Best Practice effective.**

The next stages move **from preparation into practice:** responsibilities and workflows are defined, key staff are trained, and implementation begins according to the locally adapted protocol. Importantly, implementation is treated as an ongoing process, not a one-time activity. Early and ongoing quality-improvement cycles are used to assess if activities are being delivered as intended, identify emerging barriers and introduce necessary adjustments. Formal evaluation and feedback provide evidence on implementation progress and results. The final phase focuses on **integrating the Best Practice into routine care and supporting its continuation beyond the project period.**



Throughout the process, CIRCE-JA also applied **Normalization Process Theory** to better understand how new practices become embedded in everyday healthcare. The framework considers 4 dimensions: whether professionals understand and see value in the intervention **(coherence)**, whether they engage and commit to it **(cognitive participation)**, whether they are able to put it into practice collectively **(collective action)**, and whether they assess its effects and use this experience to improve implementation **(reflective monitoring)**. This perspective, supported by the adapted NoMAD questionnaire and feedback meetings, enabled implementation teams to identify emerging difficulties and learning needs throughout the transfer.

Overall, the methodology combines a shared structure with flexibility for local adaptation, allowing implementation sites to **respond to their own organisational and healthcare context while maintaining the core functions of the original Best Practice.**

IMPLEMENTATION

Insights from pilots

In the implementation phase, 6 Best Practices were piloted across 40 implementation sites in 12 EU countries, each operating within different structural, organisational, and institutional contexts of their respective healthcare systems. This diversity allowed for testing the transferability and adaptability of the selected practices under real-world conditions. The following pages present a short summary of the main assumptions and key elements of each implementation.



> In the background of the implementation of BP1, a climate of trust is gradually being built between partners, healthcare professionals, care recipients and caregivers. This trust, embedded at every level of the model, serves as the indispensable glue underpinning its functioning and development.
>
> *– Gretel Dumont, BP1 Owner*



Best Practice 1

Integrated Health Association

Agence pour une Vie de Qualité, Belgium

Within CIRCE-JA, the **Integrated Health Association (IHA)** Best Practice was transferred through pilot projects adapted to local contexts, available resources and the implementing partners' roles within their health systems. The transfer began with a webinar presenting the Walloon model, followed by a visit to 2 Integrated Health Associations.

As it already had a coordinated multidisciplinary team, **ASL Roma 1** identified the activities to be developed to align more closely with the IHA model. Its pilot therefore involved **mapping all the social and health services available locally and analysing the needs and risk factors of the population cared for by GPs.** Community health projects were then set up based on the results of this analysis. Given the success of this pilot scheme, it will be continued and **scaled up to all medical centres in the district.**

The pilot led by **ATS Bergamo** drew on the IHA model to improve **support for people with Parkinson's disease.** The main innovations involved strengthening coordination between health and social services and building and expanding networks between public and accredited private professionals, and between hospital specialists and community services. They also included caregiver support and training and an IT tool for real-time monitoring and coordination. 3 multidisciplinary teams tested this more patient-centred approach in demographically diverse areas.

Within **ASL4 Liguria (now part of ATS Liguria),** a **Territorial Assessment Unit** was set up with a GP, a family and community nurse, and a social worker. The scheme aims to provide an **integrated and coordinated response to complex needs** by improving access to health and social services. Targeting older people with complex needs, the pilot was tested in 2 distinct areas, 1 coastal and 1 mountainous. Following positive results, the scheme was made permanent and reinforced with additional professionals, becoming a Multidisciplinary Territorial Assessment Unit. **It was then scaled up across all of ASL4 Liguria.**

In Romania, the BP1 pilot aimed to improve access for older people with chronic conditions to integrated medical and social services. It emphasised prevention, home-based care and referral to GPs and specialist services. Functional collaboration has been established between GPs, community nurses and social services through patient referrals and informal coordination. Initially planned for a limited number of sites, the pilot was **rolled out across 12 intervention areas.** Home visits remained central, maintaining direct contact with beneficiaries and supporting proactive monitoring of their needs. This approach has great potential for **wider national roll-out,** drawing on the existing community nursing network.

Despite differences between the pilots, their results were equivalent to those of the Walloon integrated health associations in terms of **improved care, professionals' well-being and the integration of primary care services into the community.**

> The experience with TELEA has shown that successful telemonitoring goes beyond technology. Integrating it into clinical pathways, adapting workflows and engaging healthcare professionals and patients are key to making telemonitoring a sustainable part of care.
>
> *– Alicia Piñeiro Redondo, BP2 Co-Owner*







> The CIRCE-JA experience has shown that transferring is not about replicating a solution, but about adapting its core principles to different healthcare contexts. The exchange of knowledge and experience has been essential to support sustainable telemonitoring approaches tailored to local needs.
>
> *– José María Romero Fidalgo, BP2 Co-Owner*

Best Practice 2

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

Servizo Galego de Saúde, Axencia Galega de Coñecemento en Saúde, Spain

TELEA was transferred to 3 implementation sites: ASL AL Piemonte and AUSL Modena in Italy, and Region Norrbotten in Sweden. They represented very different healthcare settings and target populations, from people with severe motor disabilities and complex neurological conditions to patients with chronic diseases and people living in remote and sparsely populated areas.

The transfer focused on **adapting the core elements of the TELEA model rather than replicating the Galician technological solution.** Each implementer integrated home telemonitoring into its own clinical pathways, organisational structures and digital environment, adapting patient eligibility criteria, professional roles, workflows, monitoring protocols and technological tools to local needs.
In Piemonte, telemonitoring was combined with remote consultations for patients with severe motor disabilities and neurological conditions; in Modena, it was embedded in primary care pathways for chronic diseases; and in Norrbotten, a predominantly nurse-led approach was developed for chronic patients across a large and sparsely populated territory.

As Best Practice Owners, **SERGAS and ACIS** supported the transfer by sharing the knowledge and experience gained from the development and use of TELEA. This included the development and sharing of guidance and supporting materials, on-site visits, webinars on the TELEA model, and regular online meetings to provide guidance and address implementation needs. This ongoing exchange helped implementation teams **adapt the core principles of the Galician model to their own healthcare contexts.**

The implementation experience showed both the potential and the challenges of transferring home telemonitoring across different healthcare systems.
Overall, the 3 sites developed **7 telemonitoring profiles and 172 healthcare professionals were trained.** The experience also highlighted challenges related to technological integration, usability, connectivity, professional adoption and the incorporation of telemonitoring into existing clinical workflows. Differences between sites confirmed the importance of adapting implementation to local organisational capacity, digital infrastructure, professional roles and patient needs.

A key lesson from CIRCE-JA is that **transferability does not mean replication.** Technology is only one part of the model: integration into clinical pathways, clear professional roles, appropriate training and engagement of patients, carers and healthcare professionals are equally important for implementation and sustainability. The experience gained has provided a basis for the participating regions to consider the continuation and further integration or scaling-up of their telemonitoring models beyond CIRCE-JA, according to their regional strategies and available resources.



> Our experience in CIRCE-JA showed that PAPs can be implemented in very different healthcare contexts while preserving their core elements. Local adaptation, multidisciplinary collaboration and continuous support were key to making the approach work in practice.
>
> *– Sebastián Tornero Patricio, BP3 Owner*



Best Practice 3

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

Servicio Andaluz de Salud, Spain

Within CIRCE-JA, the **Andalusian Personalised Care Action Plan (PAP) approach was transferred to 12 implementing organisations across 6 European countries: Estonia, Greece, Italy, Poland, Portugal and Slovenia.** 1 implementer had a distinct role, focusing on national coordination and support activities rather than on the direct delivery of PAPs.

Across sites, implementation centred on **comprehensive assessment, personalised care planning and structured multidisciplinary follow-up.** The core elements of the PAP approach were preserved, while target populations, professional roles, workflows, assessment and follow-up tools, and digital documentation were adapted to local healthcare contexts.

The BP Owner team provided continuous support throughout the transfer and implementation process. For BP3, **74 transfer-related activities and materials were documented by the BP Owner,** including 41 bilateral meetings, 6 online group meetings, 6 study visits to Andalusia, 4 on-site visits to implementing settings, 4 workshops and 2 webinars. In addition, **implementing sites developed or adapted 68 local documents and materials.** Study visits allowed implementers to observe the PAP approach in practice, while on-site visits helped address implementation challenges. The team also provided guidance, assessment scales, supporting materials and translations, including at least 9 documents or materials created and/or shared with implementers.

The **essential components of the PAP model were largely preserved** despite substantial differences between healthcare contexts. Among the 11 implementers directly assessed for fidelity, **10 met all BP3 validation requirements, resulting in an average validation score of 97%.**

Important facilitators included multidisciplinary collaboration, patient involvement, structured assessment tools, training and continuous implementation support. Key challenges included fragmented information systems, difficulties identifying eligible patients and accessing data, limited staff time and capacity, and coordinating GPs and other professionals.

10 of the 12 implementers intend to continue the approach, either fully or partially, while 2 reported that continuation would not be possible after CIRCE-JA. Longer-term continuation will depend on local organisational capacity, professional resources, digital infrastructure and institutional support.

CIRCE-JA showed that **the core elements of the PAP approach can be transferred to very different healthcare contexts** when local adaptation is treated as an essential part of implementation.

> In 3 different healthcare settings, Essencial supported teams to tackle inappropriate use of antibiotics and proton pump inhibitors through locally adapted de-implementation strategies, while strengthening clinical reflection and decision-making.
>
> *– Helena Bentué Jiménez, BP4 Owner*





Best Practice 4

Essencial Project: Adding value to clinical primary care practice

Agència de Qualitat i Avaluació Sanitàries de Catalunya, Spain

The **Essencial Project** was implemented by 3 organisations: **the Croatian Institute of Public Health (CIPH) in Croatia, the Narodowy Fundusz Zdrowia (NFZ) in Poland, and the Primary Health Care Centre of Tzermiadon in Crete, Greece.** Each implementer selected a low-value clinical practice from the Essencial repository according to local priorities and applied a structured, stepwise de-implementation process. CIPH focused on antibiotic use for bronchiolitis and bronchitis in children, NFZ on antibiotics for acute otitis media in children, and Greece on proton pump inhibitors in older people.

In **Croatia,** the pilot involved 2 health centres and paediatricians with whom the organisation already had collaborative relationships. In **Poland,** 2 centres were selected based on prescribing data and recruited through an open call. In **Greece,** the intervention took place in a rural primary care centre serving an ageing population. In Croatia, routine prescribing data were analysed and discussed with paediatricians through regular meetings, alongside Essencial recommendations and scientific evidence. In Poland, a questionnaire was developed to collect real-time clinical data and data on caregiver satisfaction. Educational materials, including posters and leaflets, were developed for professionals and patients, together with a train-the-trainer approach. In Greece, the intervention combined deprescribing of proton pump inhibitors with a questionnaire on reasons for treatment initiation. A plain-language leaflet supported patient communication. The team also attempted to involve local pharmacies and social services, although these collaborations were difficult to sustain.

The Essencial team provided practical training, study visits, evidence-based recommendations, educational resources and measurement indicators. Study visits supported understanding and practical application of the BP, while guidelines, videos and other resources were used by management teams and healthcare professionals. The BP Owner also provided ongoing personalised support through regular follow-up meetings and assistance when needed.

All planned milestones were achieved, although progress and outcomes varied across settings. Across the 3 pilots, implementation promoted a more cautious and reflective professional mindset regarding prescribing. The pilots also highlighted the importance of motivated local professionals and core teams, as well as management involvement and stronger structural support. **Data, practical tools and patient communication** were key to supporting implementation and clinical decision-making. Main challenges included limited established relationships with primary care, difficulties engaging professionals, workload constraints, fragmented systems, limited data availability and follow-up capacity, and deeply rooted beliefs around certain treatments.

Overall, the pilots show that the **Essencial approach is transferable when adapted to local circumstances.** The experience supported changes in clinical practice, professional engagement, data use, clinical reflection and patient communication.



> Promoting healthy family relationships is a form of protection. Through the proximity of primary health care, we can identify risks, prevent adverse experiences, support children and young people, and address violence at every stage of life, promoting health, safety and well-being for all.
>
> *– Marta Chaves da Silva, BP5 Owner*



Best Practice 5

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

Ministério da Saúde/Direção-Geral da Saúde, Portugal

Within CIRCE-JA, **Best Practice 5 (BP5) was implemented in Spain, Greece, Poland and Romania,** testing its transferability across different health systems and organisational contexts. Implementation reflected local priorities. **Spain and Greece** focused on children and young people aged 0–18, in line with Health Action for Children and Youth at Risk. **Romania** addressed domestic violence against adults through Health Action for Gender, Violence and Lifecycle, while **Poland** adopted a life-course approach aligned with both components.

Sites strengthened **early identification and risk assessment, professional training, awareness-raising, health literacy, and practical materials and guidance.** These activities covered responses to violence from prevention through identification, assessment, intervention and referral. Sites also improved interprofessional and intersectoral collaboration, referral, follow-up and continuity of care, involving the health, justice, law enforcement, social protection and academic sectors.

As the Best Practice Owner, **the team coordinating the National Programme for the Prevention of Violence in Lifecycle at the Direção-Geral da Saúde** provided consultancy, technical resources, training, implementation follow-up and opportunities to exchange experience.

The programme included 2 study visits to Portugal and 1 technical visit to Greece, with implementation reviews and meetings with national stakeholders. In Portugal, the first part of the visit took place at a **primary care unit,** where participants attended an on-site meeting with multidisciplinary teams from both primary care and hospital services. At the Direção-Geral da Saúde, participants met with representatives of the **Public Prosecution Service, Public Security Police, National Institute of Legal Medicine and Forensic Sciences, National Commission for the Promotion of the Rights and Protection of Children and Young People, and Commission for Citizenship and Gender Equality.** The meetings provided insight into national approaches to prevention, protection and intervention, and coordination with health services.

Implementation showed that BP5's **core principles and components can be transferred across different contexts, strengthening professional competencies, risk identification and assessment, and intersectoral collaboration.** Challenges included differences in governance, organisational structures and resources; adapting and translating materials; and varying prior experience in addressing violence. A key lesson was to **preserve the core components while adapting implementation locally** to ensure quality, relevance and feasibility. The experience also highlighted the importance of an organisational approach to violence prevention, with capacity building, intersectoral collaboration and knowledge transfer supporting sustainability and replication.

> The main challenge and achievement of transferring Best Practice on Health Promotion Centres was to identify and then implement key elements of Best Practice, which would efficiently address the needs of implementation sites in various EU countries.
>
> *– Radivoje Pribaković, BP6 Owner*





Best Practice 6

Health Promotion Centres (HPCs)

Nacionalni inštitut za javno zdravje, Slovenia

Health Promotion Centres were transferred with support from the **National Institute of Public Health (NIJZ)** across **14 implementation sites in 8 European countries.** Due to differing local contexts of each implementation site, **implementation approaches were highly diverse.** These ranged from establishing new Health Promotion Centres as independent units in primary health care to – most commonly – integrating selected Health Promotion Centre elements into existing primary care and community frameworks. The common foundation across all sites was the implementation of **lifestyle interventions featuring a more integrated and structured approach to chronic disease prevention, focusing on health literacy, patient empowerment, and long-term behavioural change.**

The comprehensive Health Promotion Centres model relies on **3 interconnected structural and functional pillars:** (1) population-based screening during preventive check-ups, (2) preventive interventions in Centres delivered by a multidisciplinary team, and (3) health promotion in local communities. Sites adapted the model and developed their local Best Practices by transferring:

- **Diverse target populations and entry points:** Recruitment via professional referrals, community outreach, combination of both. As most sites prioritised building the intervention framework, simultaneously establishing a population screening structure proved challenging.
- **Lifestyle interventions:** Most commonly addressing healthy lifestyle, nutrition and physical activity in the form of (1) structured group workshops fostering social inclusion and peer support, (2) individual counselling – commonly incorporating motivational interviewing to support self-management, and (3) a hybrid model combining both.
- **Multidisciplinary teams:** Enhancing professional competencies with prepared materials and training programmes in health promotion. Interventions were delivered by multidisciplinary teams, with team composition adapted to available professional profiles, including GPs, nurses, dietitians, psychologists, and physiotherapists.
- **Health promotion in local communities:** In all sites, healthcare professionals actively guided patients to external community support programmes. Some sites had strong community action and some activities were held in local community spaces.

NIJZ provided continuous support with: (1) implementation guidance and monitoring of implementation plans, local execution, evaluation strategies, and technical on-site visits, (2) translation of HPC materials (manuals, questionnaires, training programme), and (3) study visits to Slovenian Health Promotion Centres tailored to both managers and healthcare professionals, offering collaborative discussions with local teams and practical workshop simulations. **Challenges** included maintaining a balance between high clinical workload and dedicated time for preventive activities, workforce shortages, infrastructure constraints, post-project financing, and long-term behavioural change data collection. **Common key enablers** were institutional support and alignment, existing infrastructure and resources, professional commitment, established partnerships and networks, and structured management.

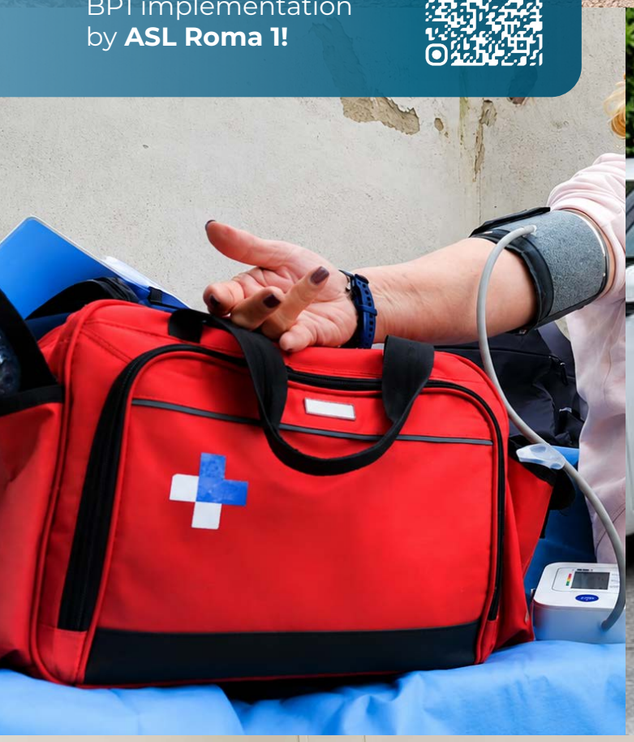
The pilots demonstrated that Best Practice 6 **is highly transferable as a modular set of interconnected – yet effective as standalone – practices,** whereas transferring the full organisational structure is more demanding. Nevertheless, the long-term objective should remain **full-scale implementation** to secure the full impact of the Health Promotion Centres model.



Watch a video on BP1 implementation by **ASL Roma 1!**



Watch a video on BP4 implementation by **Narodowy Fundusz Zdrowia (NFZ)!**





Watch a video on BP3 implementation by **ATS Liguria!**





Watch a video on BP6 implementation by **Nemzeti Népegészségügyi Központ (NNGYK)!**





LESSONS LEARNED

Successful transfer requires more than replication

The **CIRCE-JA** experience showed that successful transfer means more than simply copying an intervention. Best Practices need to be adapted to local healthcare systems while keeping their essential components. **Organisational readiness, stakeholder involvement and ongoing support were important** for implementation in different settings.

The experience gained through CIRCE-JA **provides practical guidance for future implementation of Best Practices across Europe.** Building flexible implementation models, investing in workforce capacity, strengthening digital infrastructure, and embedding innovations into routine primary care will support sustainable scale-up beyond the lifetime of the Joint Action.

Successful implementation is not about copying a Best Practice. It is about adapting it to local needs while preserving the evidence that makes it effective.

What makes the transfer more effective?



Context matters

Implementation should be adapted to local organisational, regulatory and healthcare contexts.

Clinical leadership

Local champions and multidisciplinary teams are essential to drive change and reduce professional resistance.





Integrated digital solutions

Interoperable IT systems and user-friendly digital tools facilitate implementation and reduce administrative burden.

Stakeholder engagement

Early involvement of healthcare professionals, patients and decision-makers strengthens ownership and long-term commitment.





Capacity building

Continuous training and protected time enable professionals to integrate new practices into routine care.

Policy support

Long-term sustainability depends on organisational commitment and alignment with regional and national health strategies.



RESULTS OF THE JA

CIRCE-JA examined whether evidence-based primary health care practices could be transferred and implemented in different European health systems. Its main shared result was the successful completion of a large and diverse implementation process.

From planning to completed implementation

All **40** **pilots moved beyond preparation and completed their planned implementation activities.** Across different organisational and healthcare settings, implementers established new care models, multidisciplinary teams, operational tools, training activities and structured care pathways. This shows that a common but flexible transfer methodology can support the implementation of complex primary health care practices in different local contexts.

Local objectives were put into practice

The objectives reflected the different needs of participating healthcare systems. The most common priorities included **better coordination of care, greater patient engagement and self-management, prevention and healthier lifestyles, and stronger professional competencies.** Of the **38** implementers that assessed their overall achievement, **25** reported full achievement and **13** reported partial achievement. These results reflect implementers' assessment of operational progress and should not be treated as a common measure of clinical effectiveness.

Adaptation largely preserved core functions

Fidelity was assessed for 39 implementers using checklists tailored to each Best Practice. The **average validation score was 93%**, with most implementers classified as high fidelity. The results suggest that local adaptation and fidelity were generally compatible. Most pilots changed how the practice was delivered while preserving its essential functions. Transferability should therefore be understood as preserving the core function of a practice, rather than reproducing its original form.

Progress and remaining challenges

Across the 40 pilots, **132** **implementation needs were assessed as relevant.** Of these, **45 (34.1%)** were fully addressed, **74 (56.1%)** were partially addressed and **9 (6.8%)** were not addressed. For **4** needs, no clear assessment was provided.

Continuation plans also varied. Of the 40 pilots, **23 (57.5%)** reported plans for full continuation, **15 (37.5%)** for partial continuation and **2 (5%)** for no continuation after CIRCE-JA.

These figures describe plans reported at the end of the pilot implementation period, not confirmed long-term sustainability. Moving from pilot implementation to routine practice will depend on stable funding and staffing, suitable digital infrastructure, clear governance and institutional support.

A shared European result

By transferring 6 Best Practices across multiple countries and healthcare systems, **CIRCE-JA generated practical knowledge** that would have been difficult to develop through isolated national initiatives. **The Joint Action strengthened cross-country collaboration, supported mutual learning and created a shared body of implementation knowledge.** This experience can inform future European initiatives seeking to transfer, adapt and sustain innovation in primary health care.



40
pilot implementations completed



6
Best Practices transferred



14
EU Member States involved



1,085
professionals involved in implementation



17,237
participants recruited



13,649
participants completed the pilot period



194
active implementation centres



93%
average implementation fidelity

SUSTAINABILITY

CIRCE-JA aims to ensure the **long-term sustainability and transferability** of the Best Practices: it identifies the contextual, organisational and socio-economic factors affecting implementation and adaptation, supports partners in **maintaining and scaling achieved results,** and strengthens their integration into primary health care systems and national policies. Building on implementation experience, **WP4 develops recommendations** and contributes to the establishment of a **European Primary Health Care Observatory.**

Sustainability is not a destination, but an ongoing governance process that needs to be maintained and nurtured over time.

The **transition from the pilot phase to routine care** is the decisive moment: professional commitment and motivation are essential, but long-term continuity also requires **adequate workforce capacity, clear responsibilities and continuous training.** The most resilient implementations embedded innovation into existing workflows, engaged authorities and frontline professionals from the design stage, and used **routinely collected data to monitor results and guide decisions.**

The CIRCE-JA experience thus highlights 3 interconnected pillars for lasting sustainability:



Towards the European Primary Health Care Observatory

The European Primary Health Care Observatory is an integrated **digital environment designed to support the collection, assessment, analysis and sharing of knowledge and evidence on digital health and primary care.** It provides institutions, healthcare organisations and stakeholders with a common environment to share experiences and best practices, assess digital health initiatives, analyse results, compare approaches and foster collaboration and peer learning.

The Observatory provides a set of integrated tools:

Knowledge Hub
A shared knowledge base for resources, best practices, methodological assets and digital health evidence.

Assessment Hub
Structured tools to assess initiatives, maturity and readiness and identify areas for improvement.

Survey & Measurement
Configurable surveys and data collection to capture uptake, evidence, needs, barriers and feedback.

Benchmark & Analytics
Interactive dashboards and comparative analysis to support monitoring, benchmarking and evidence-based decisions.

Community Hub
Spaces for knowledge exchange, peer learning and collaboration among national and European stakeholders.

Intelligent Support
AI-enabled capabilities supporting knowledge discovery, semantic search and access to relevant information.

The European Primary Health Care Observatory supports the **dissemination, accessibility and long-term sustainability of the knowledge, resources and results developed within CIRCE-JA.**

Why contribute?

By contributing to the Observatory, organisations and professionals can:

- **Share and showcase** digital health initiatives, resources and best practices;
- Support the transfer and adaptation of successful experiences to other contexts;
- Contribute to a **shared evidence base** on what works, where and in which conditions;
- **Compare experiences and results** through assessment, indicators and benchmarking;
- **Learn from peers** and access knowledge generated by organisations and EU partners;
- **Connect with a community of stakeholders** for collaboration and peer learning;
- Support **evidence-based decisions** and the continuous improvement of digital health policies and services.

Contribute knowledge. Compare experiences. Learn from others. Improve together.
Visit the European Primary Health Care Observatory:

For more information:
Visit the CIRCE-JA website: www.circeja.eu

Or contact:

Project Coordinator
SAS – Servicio Andaluz de Salud
e-mail: circe.ja.fps@juntadeandalucia.es

WP2 Leader – Dissemination
NFZ – National Health Fund in Poland
e-mail: circe.ja.wp2@nfz.gov.pl

CIRCEJA.EU CIRCE-JA CIRCE_JA CIRCE_JA

This document contains information which is proprietary to the CIRCE-JA consortium. Neither this document nor the information contained herein shall be used, duplicated or communicated by any means to any third party, in whole or parts, except with the prior written consent of the CIRCE-JA consortium.

CIRCE-JA is funded by the European Union under the EU4HEALTH Programme 2021-2027 under Grant Agreement no. 101082572. Views and opinions expressed are, however, those of the author(s) only and do not necessarily reflect those of the European Union or HaDEA. Neither the European Union nor the granting authority can be held responsible for them.



CIRCE-JA

JA TRANSFER OF BEST PRACTICES IN PRIMARY CARE

Co-funded by
the European Union

CIRCE-JA