# JTC 2025 | The Call

*Third THCS Joint Transnational Call for R&I proposals · launched November 2024 · co-funded by the European Commission*

CALL TOPIC

## Better care closer to home: Enhancing primary and community care

Europe relies too heavily on costly hospital and institutional care. The Call funds collaborative transnational projects that develop scalable, people-centred care models, improve coordination across care settings and shift services towards primary and community care.

**1 Strengthening primary & community care**

Organisational, operational and workforce innovations moving care from institutions to integrated, community-based services.

**2 Systemic approaches to modernisation**

Practical, evidence-based knowledge that policy and decision makers can apply across European contexts.

**€ 36M**

**initial funding commitment** by the participating national/regional Funding Agencies, plus EC top-up

**34** Funding Agencies

**22** Countries

**Two-stage process**
Pre-proposals → Full proposals, with the new **widening measure**

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# JTC 2025 | Call Results

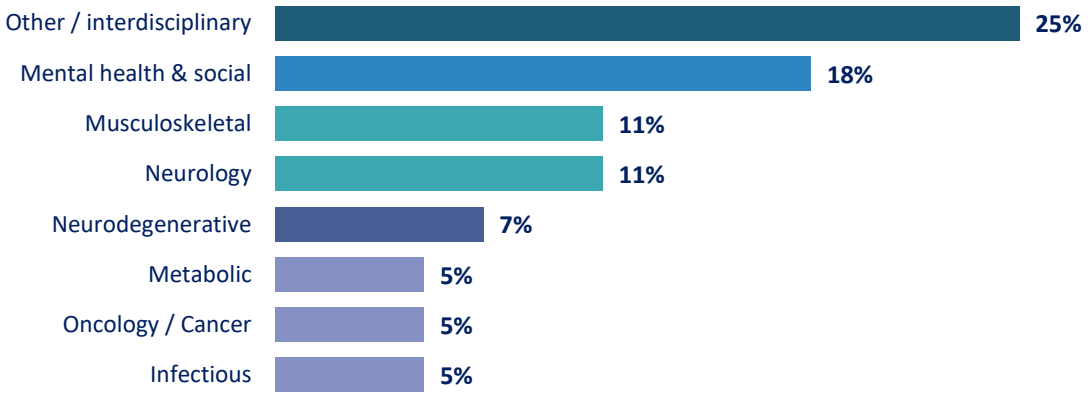
**28**
**projects selected for funding**
*from 149 eligible pre-proposals*

**€ 38.7M**
**total Call budget expenditure**
*incl. ≈ €6.9M EC top-up generated*

**179**
**research teams funded**
*22 countries · 34 Funding Agencies*

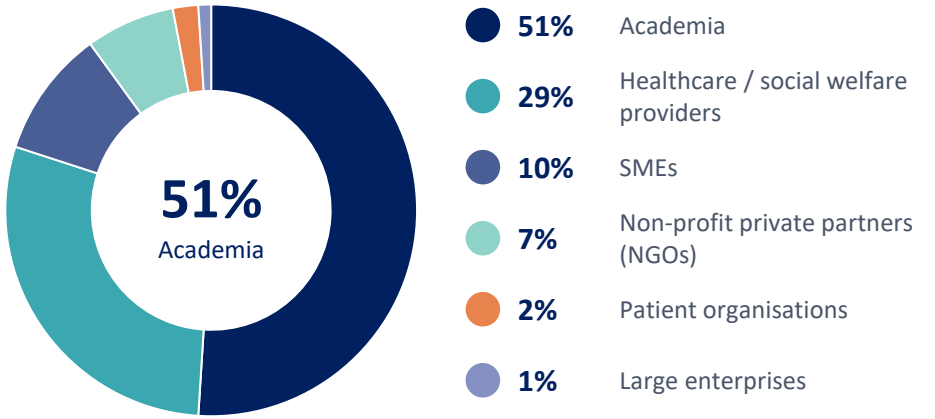
**19.5%**
**overall success rate**
*from pre-proposal to award*

## Medical domains of awarded projects




*Also 2% each: cardiovascular, paediatrics, rheumatology, gastro, dermatology, ENT · multiple domains allowed*

## Type of entities selected for award




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THCS
TRANSFORMING HEALTH AND CARE SYSTEMS

# JTC 2025 | Projects Selected for Award

*28 transnational consortia bringing care closer to home, from digital tools and AI to rehabilitation, mental health and chronic disease management*

**AT-HOME study**
Home antimicrobial therapy

**CARE@HOME**
AI for ageing at home

**CARE-CDS**
Nursing practice & decision support

**CARE-HOME**
Connected home-based recovery

**CARING-AI**
Social assistive robots

**CC4C**
Paediatric rehab closer to home

**CLARITY**
Health literacy for migrants

**CO-ACT**
Adaptive care for ageing communities

**CoCare**
Co-care learning ecosystems

**DISA-LNT**
AI-powered schizophrenia assessment

**ENABLED**
Near-home AMR diagnostics

**ENCOURAGE-ME**
Coaching & empowerment for ME/CFS

**ENHANCE-SVD**
Small vessel disease in primary care

**eRECOVER**
Digital care for mental disorders

**GlaukomaiCare**
Glaucoma care in the community

**GOAL-MM**
Multimorbidity management

**IBD-CARE**
Digital primary care for IBD

**INTEGRA**
Telerehab for persons with disabilities

**LIZZ-TRANSCARE**
Hospital-to-home rehab companion

**MOMENT**
Midwifery-led perinatal care

**MUSCLE**
Lean care for MSK disorders

**PRIME**
Community mental health pathways

**PRIME-OncoTBC**
Breast cancer care transition 65+

**SHIFT-EU**
Digital self-management

**SONETTO**
Sarcopenic obesity prevention

**SPACES**
Telerehab & telemonitoring

**STRIDE-COM**
Diabetic foot ulcer prevention

**WISH**
Hormonal health in breast cancer

**28 projects · 179 teams · 22 countries**

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# How can Successful Primary Healthcare Practices be Transferred and Adapted across Different European Health Systems? Lessons from CIRCE Joint Action

***Ana M Carriazo MD PhD***
*Regional Ministry of Presidency, Health and Emergencies of Andalusia*

***Oihane Abiega PhD***
*Andalusian Public Foundation Progress and Health*
*CIRCE-JA Coordination team*

1/10/2026

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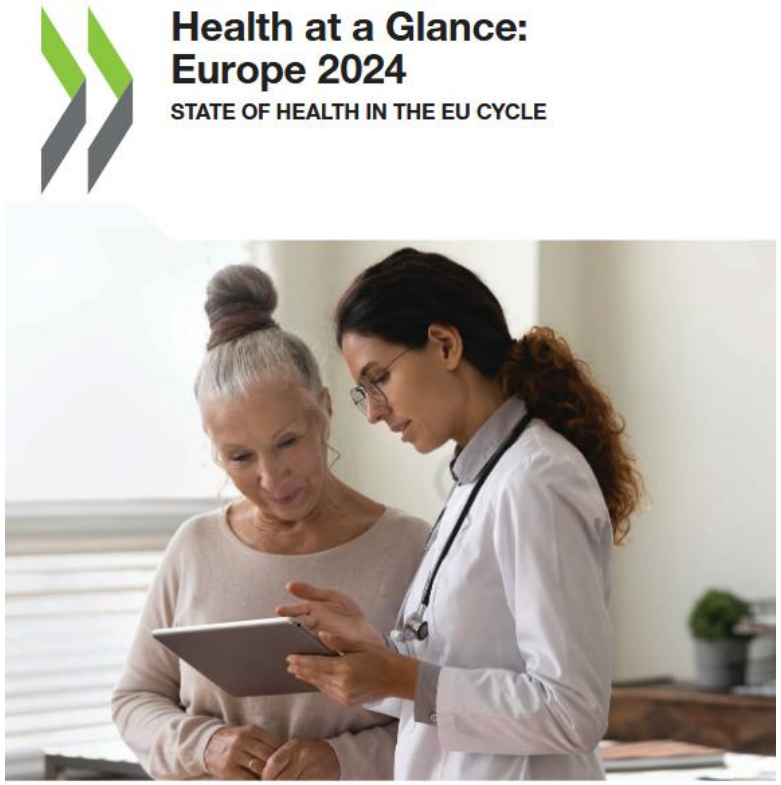
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8. SUSTAINABILITY
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CIRCE-JA

# The current European health challenges and the role of primary health care




- Urgent action is needed to address health workforce shortages in Europe
- **Promoting healthy longevity can reduce the burden on health and long-term care systems**
- **Significant life expectancy gaps persist across countries and the health of young people is an enduring concern**
- **Progress in addressing lifestyle risk factors** has stalled, with persistent socio-economic disparities
- EU countries have made gradual improvements in health crisis preparedness, but significant challenges remain in **building public trust and combatting AMR**

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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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# 3 Summary

- FULL NAME: Joint Action on Transfer of Best PraCtices In PRimary CarE
- ACRONYM: **CIRCE-JA**
- PROJECT NUMBER: 101082572
- FUNDING BODY: HaDEA
- BUDGET: 12.170.161,03 € [EU Grant (80%) 9.736.128,83 €]
- WEBSITE: www.circeja.eu
- DURATION: 1st February 2023 till 30th November 2026 (46 months)
- PROJECT COORDINATOR: **SERVICIO ANDALUZ DE SALUD (SAS)**

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# 4 CIRCE-JA Partnership




**46 entities (after last amendment)**

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CIRCE-JA

# 5 Objectives

Effectively **transfer and implement** (validate and sustain)
**6 selected best practices** (BPs) in primary health care from 4 MS (Belgium, Portugal, Slovenia and Spain) into
**40 implementation sites** from 12 EU Member States with relevant structural, organizational and institutional differences in their health care systems.

- 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

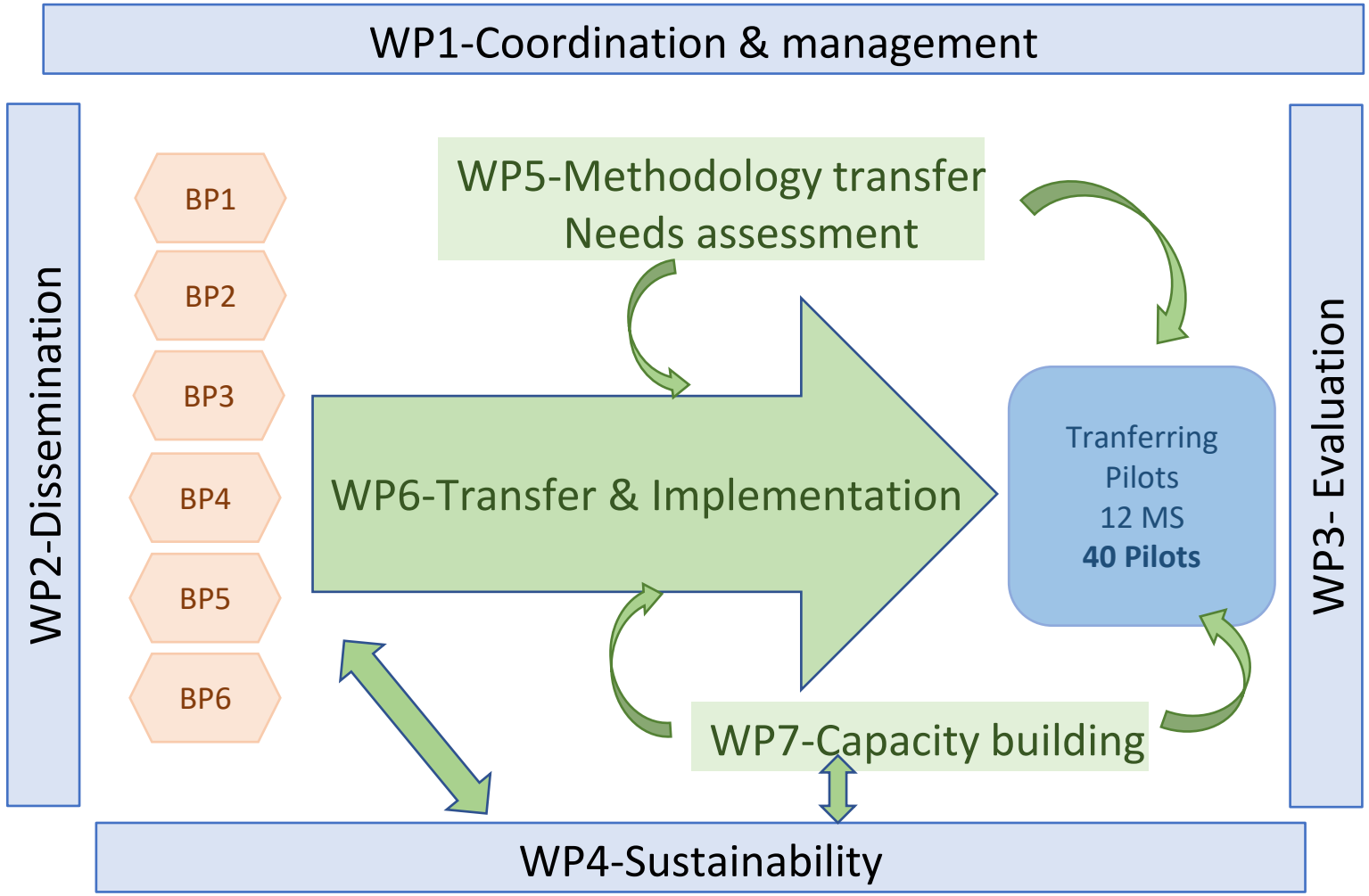



Strengthening healthcare systems by fostering primary healthcare

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# 6 Structure



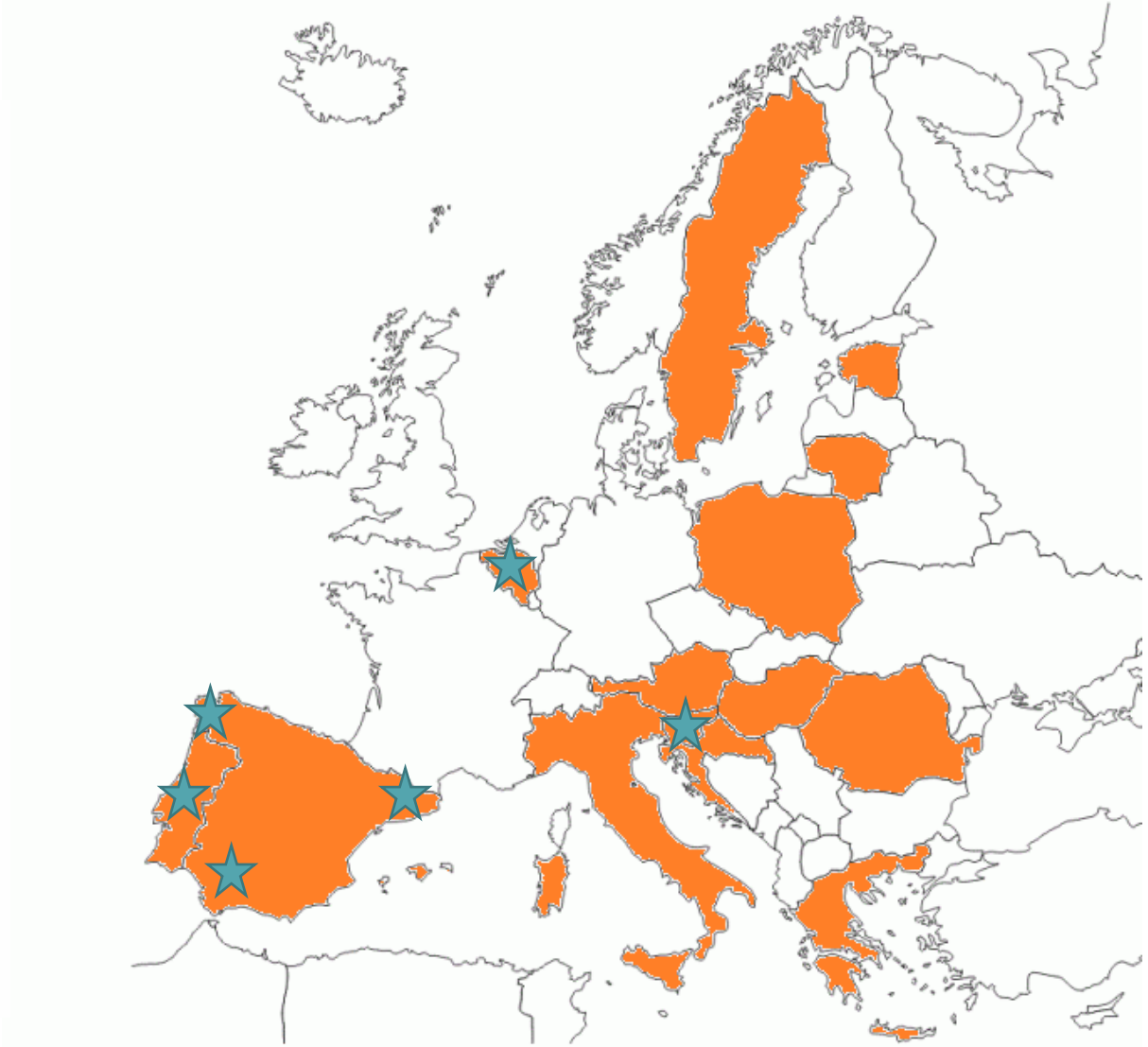




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CIRCE-JA

# 7 Best Practices

- Integrated Health Association –Region of Wallonia, Belgium
- TELEA: Home telemonitoring 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



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# Best Practice 1

## Integrated Health Association

BEST PRACTICE OWNER | IMPLEMENTERS



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

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# Best Practice 2

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



BEST PRACTICE OWNER | IMPLEMENTERS

Galicia, Spain
Servizo Galego de Saúde




Sweden

- Region Norbotten- Regional level

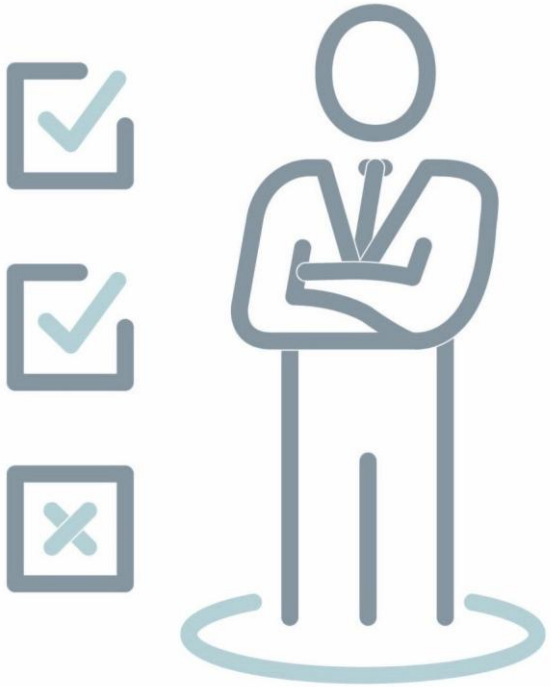
Italy

- Regione Piemonte ASL AL - Local level- Alessandria province
- Regione Abruzzo ASL 4 Teramo - Local level province of Teramo
- Regione Emilia-Romagna - USL Modena - Local level-Modena province, Health district Pavullo and Mirandola

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# Best Practice 3

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



| BEST PRACTICE OWNER | IMPLEMENTERS |
|---|---|
| Andalusia, Spain<br>Servicio Andaluz de Salud | Estonia<br>• Sotsiaalministeerium - Local level<br><br>Greece<br>• Dioikhsh Ygeionomikhs Perifereias Krhths - Regional level 3 pilot sites<br><br>Italy<br>• Regione Liguria A.Li.Sa - Regional level<br>• Regione Emilia - Romagna - USL Bologna - Local level - Province of Bologna (excluding Imola)<br>• Regione Emilia - Romagna - USL Parma - Local level - Municipality of San Secondo Parmense<br>• Regione Emilia - Romagna - USL Romagna - Local level - Romagna Area<br><br>Poland<br>• Narodowy Fundusz Zdrowia - National level<br><br>Portugal<br>• Ministerio da Saude/ Directorate-General of Health - National level<br>• Unidade Local de Saúde de Matosinhos, E.P.E. - Regional level<br>• Centro Hospitalar de Lisboa Central, EPE - Regional level<br>• Centro Hospitalar de Lisboa Ocidental, EPE - Regional level<br><br>Slovenia<br>• Nacionalni inštitut za javno zdravje - National level |




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# Best Practice 4

## Essencial Project: Adding value to clinical primary care practice

BEST PRACTICE OWNER | IMPLEMENTERS

Catalonia, Spain
Agència de Qualitat i Avaluació Sanitàries de Catalunya




Greece

- Dioikhsh Ygeionomikhs Perifereias Krhths - Regional level3 pilot sites

Poland

- Narodowy Fundusz Zdrowia - National level

Croatia

- Croatian Institute of Public Health - Regional, several counties

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# Best Practice 5

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



BEST PRACTICE OWNER | IMPLEMENTERS

Portugal
Ministerio da Saude/
Directorate-General of Health




Spain

- FISABIO - Local level: Urban (2 neighborhood) Valencia and rural 2 deprived neibourhoods) Alzira

Greece

- Dioikhsh Ygeionomikhs Perifereias Krhths - Regional level 4 pilot sites

Poland

- Narodowy Fundusz Zdrowia - National level

Romania

- Ministerul Sănătății România - National level

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# Best Practice 6

## Health Promotion Centres (HPCs)

| BEST PRACTICE OWNER | IMPLEMENTERS |
|---|---|
| Slovenia<br>Nacionalni inštitut za javno zdravje | Spain<br>• Servicio Cántabro de Salud - Regional level/ Cantabria<br>• FISABIO - Local level: Urban (2 neighborhood) Valencia and rural 2 deprived neibourhoods) Alzira<br>• Servicio Madrileño de Salud - Regional level<br><br>Greece<br>• Dioikhsh Ygeionomikhs Perifereias Krhths - Regional level 7 pilot sites<br><br>Italy<br>• Regione Piemonte ASL CN2 - Local level<br>• Regione Lazio ASL ROMA 3 - Local level<br>• Regione Liguria ASL 1 - Local level - Province of Imperia<br>• ASL Ascoli Piceno - Local level<br><br>Poland<br>• Narodowy Fundusz Zdrowia - National level<br><br>Romania<br>• Ministerul Sănătății România - National level<br><br>Estonia<br>• Sotsiaalministeerium - Local level<br><br>Hungary<br>• Nemzeti Népegészségügyyi Központ - Regional level Central Hungary<br><br>Lithuania<br>• KVSB LT - Local level<br>• KLVSB LT - Local level |




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# Best Practices

## BPs common aspects & specific challenges

**Multidisciplinary teams**

**Focus on health promotion and prevention**

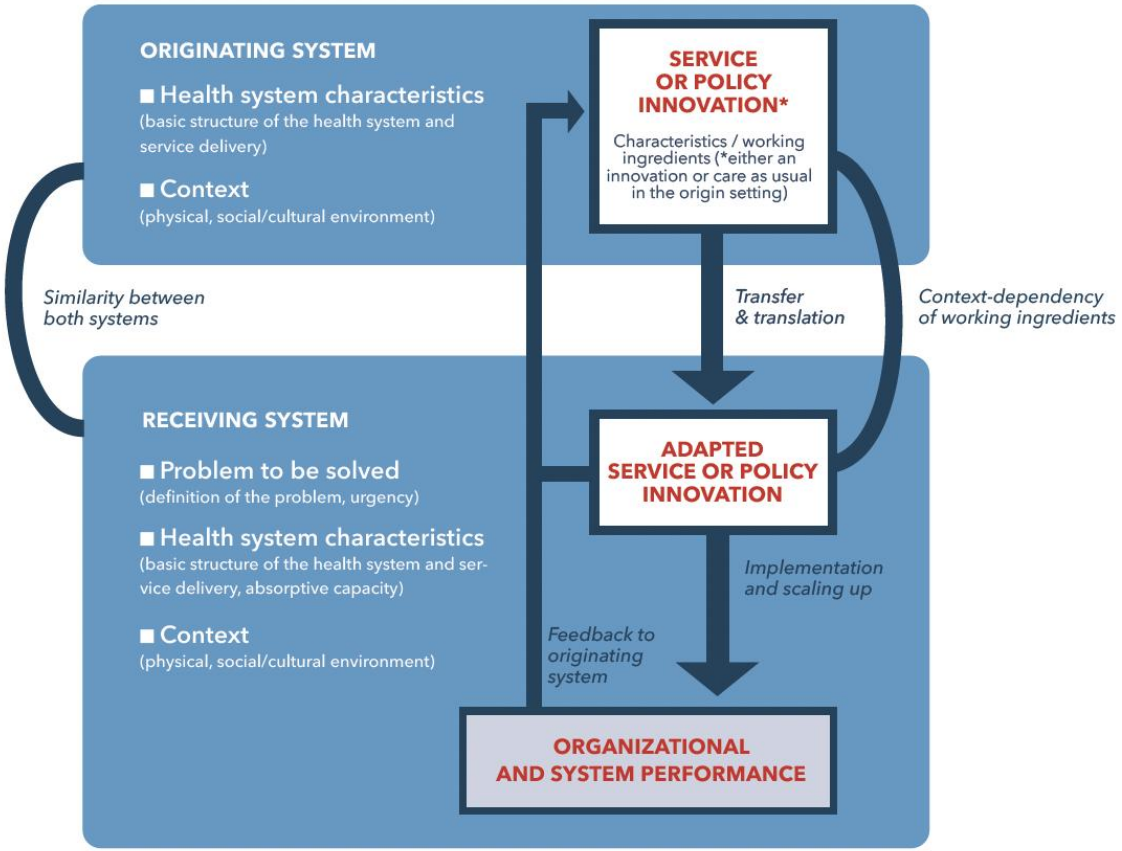
**Community based**

**Digital tools**

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# CIRCE-JA transfer methodology

**TO-REACH conceptual framework**
for the transfer of service and policy innovations between regions and countries



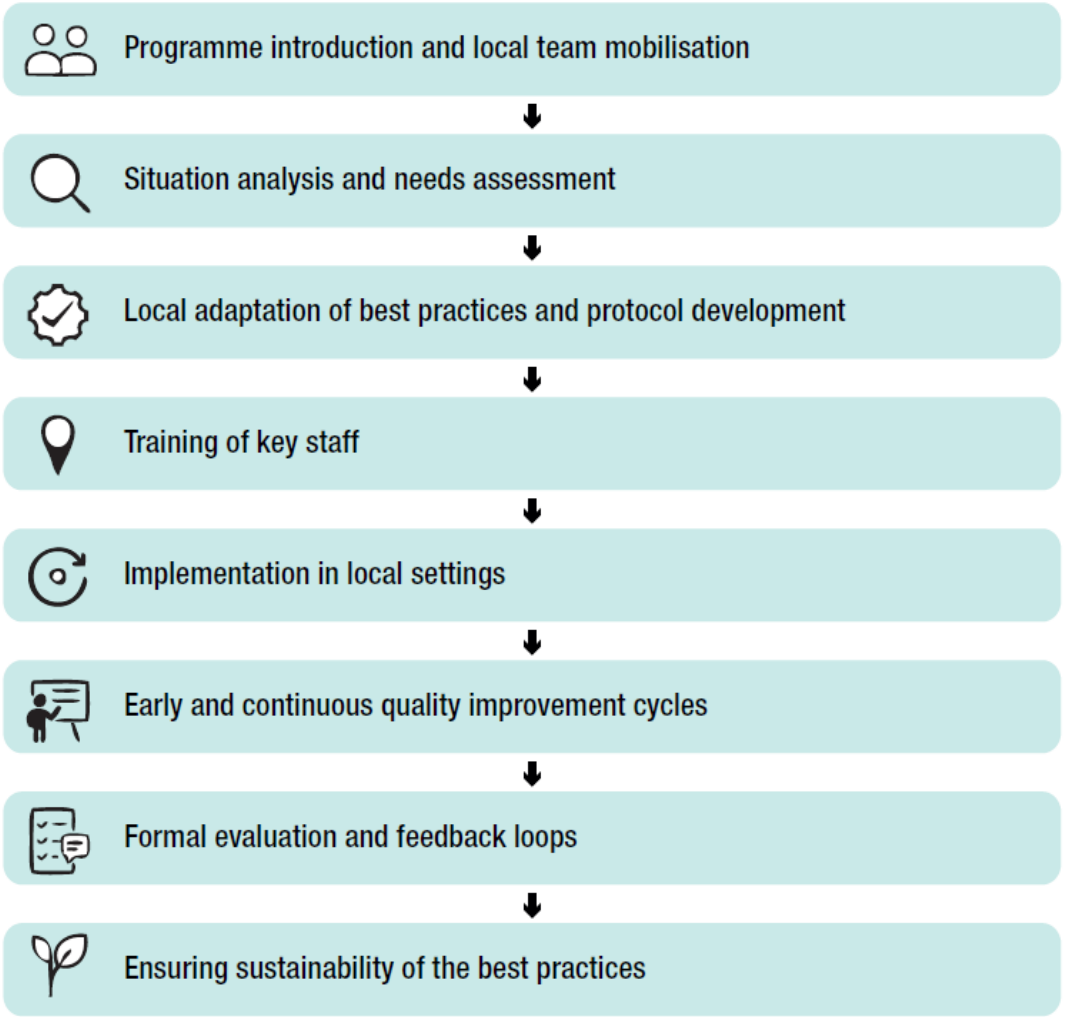

## Innovations are transferred more rapidly when….

- The best practice is well understood
- They are locally adapted (tailored to local context)
- There is sufficient and consistent leadership at all levels
- Co-created with end users
- There is adequate support with implementation process
- There is a relative advantage
- The barriers are well understood and mitigation strategies in place
- The necessary partnerships are cultivated
- Clear local protocols and processes, roles and responsibilities
- There is appropriate training for key staff
- There is appropriate funding
- Quality improvement cycles are used to refine

Source: METHODS FOR THE TRANSFERABILITY OF EVIDENCE-BASED HEALTH INTERVENTIONS (PRACTICES) IN PRIMARY HEALTH CARE:A SCOPING REVIEW. UNIVERSITY OF CRETE ON BEHALF OF CIRC JA PARTNERS; 2023.

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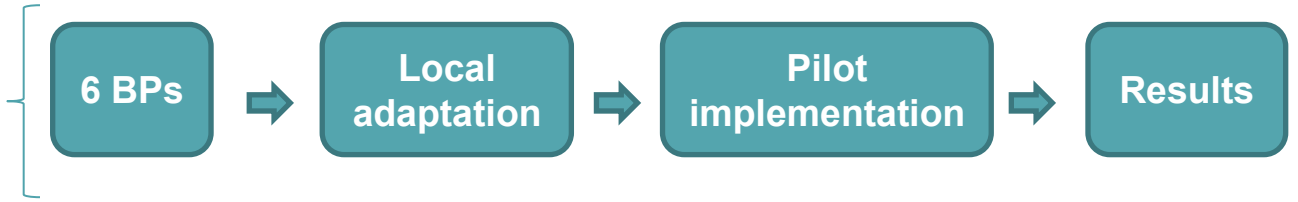
# CIRCE-JA transfer methodology




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# WP6: From transfer to local implementation

**WP6 coordinates and supports the transfer of six Best Practices(BPs), providing a common methodology, monitoring progress and facilitating their adaptation across 40 European pilots**




167 direct exchange and support activities

| Type of activity | BP1 | BP2 | BP3 | BP4 | BP5 | BP6 | Total |
|---|---|---|---|---|---|---|---|
| **Bilateral meeting** | 6 | 2 | 41 | 6 | 1 | 15 | **71** |
| **Online group meeting** | 7 | 5 | 6 | 6 | 8 | 5 | **37** |
| **Study Visit** | 4 | 2 | 6 | 5 | 2 | 7 | **26** |
| **On-site visit** | 2 | 0 | 4 | 2 | 2 | 7 | **17** |
| **Workshops** | 0 | 0 | 4 | 0 | 0 | 0 | **4** |
| **Webinars** | 3 | 0 | 2 | 0 | 0 | 1 | **6** |
| **Documents/materials** | 9 | 7 | 77 | 22 | 31 | 106 | **252*** |
| **Others** | 2 | 0 | 2 | 1 | 0 | 1 | **6** |
| **Total** | **33** | **16** | **142** | **42** | **44** | **142** | **419** |

**Material-related activities include resources developed or adapted by both BP Owners and implementers*

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# 10 Implementation at scale

**All 40 pilots moved from planning to implementation**

- **40 pilots**
  12 EU member states
- **194 active centres across diverse territorial settings**
  108 urban (55.7%) · 66 rural (34%) · 20 mixed (10.3%)
- **17,237 participants recruited** → 13,649 completed the pilots (79.2%)
- **12.4 months**
  Median pilot duration

- **1,085 professionals involved**

⬇

- **796 delivering core pilot activities**
  - 51.3% nurses
  - 18.1% GPs/family doctors
  - 9.9% administrative staff
  - 20.7% other professional profiles
    (*Professional profile distribution based on comparable data from 38 pilots (n = 618)*)
- **289 supporting or coordinating implementation**

| Achievement of implementation objectives | | |
|---|---|---|
| 66% fully achieved | 34% partially achieved | 0% non-achievement |
| *Achievement of implementation objectives (n = 38)* | | |

**Implementation was achieved at substantial scale across highly diverse healthcare contexts**

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CIRCE-JA

# Adaptation and fidelity

**Adaptation enabled implementation while generally preserving fidelity**

| BP | Average validation score | High fidelity | Moderate fidelity | Low fidelity |
|---|---|---|---|---|
| BP1 | 100% | 4 | 0 | 0 |
| BP2 | 80% | 2 | 0 | 1 |
| BP3 | 97% | 10 | 1 | 0 |
| BP4 | 95.8% | 3 | 0 | 0 |
| BP5 | 95.5% | 4 | 0 | 0 |
| BP6 | 89.3% | 10 | 3 | 1 |
| **Total** | **93%*** | **33** | **4** | **2** |

**39 implementers assessed*

**What was adapted?**

- **Population and recruitment**
  Target groups and inclusion criteria
  Recruitment approaches
- **Organisation and delivery**
  Professional roles, workflows, settings and intensity
- **Tools and systems**
  Materials, assessment tools, documentation and digital solutions
- **Governance and coordination**
  Responsibilities, institutional arrangements and coordination mechanisms

Most adaptations changed how the BP was delivered, not its essential purpose

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# Main outcomes across the six BPs

## BP1: Integrated Health Association

**Communication is key**

- 1,391 communications between team and GP (emails > phone calls > coordination meetings)

**Nurses and GPs constitute the operational backbone**

- 3,267 patient assessments were reported, carried out by: Nurses (46.6%) > GPs (37.3%)

**Quick access to core primary care services**

- Appointment waiting times were shortest for Nurses (1day) < GP (1.5 days) < Specialists (12.8 days)

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# Main outcomes across the six BPs

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

- **Training is key**
  - 172 professionals trained: Nurses (66%) > Specialists (16%) > GPs (15%)
- **84% of patients satisfied with telemonitoring**
- **67% of patients satisfied with accessibility to healthcare services**
- **39% of patients with improved quality of life**
- **40% of professionals satisfied with telemonitoring**
  - Similar to the original BP

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# Main outcomes across the six BPs

## BP3: Personalized Care Action Plans – PAPs

- **84% of patients' show positive perception of the self-management support provided by the health care organization**
- **81% of professionals show positive perception of chronic care model**
- **Patients remained stable or improved health status-related aspects**
  - Cognitive Function (92.3%) > Mental Health and Psychological Wellbeing (91.7%) > Frailty, Complexity and Vulnerability (91.6%) > Functional Status and Independence (89.8%)
- **Reduction in healthcare utilization**
  - 36.8% reduction in emergencies > 52,6% in hospitalizations

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# Main outcomes across the six BPs

## BP4: Essencial. Adding Value to Clinical Primary Care practice

- **Professionals show increased reflection on prescribing behaviour and greater awareness of low value care**
- **Professionals show stronger use of data, indicators, and educational materials to support practice change**
- **Organizational capacity building improved**

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# Main outcomes across the six BPs

## BP5: Health Action for Children-Youth-Gender-Violence

- ✓ 84% of professionals perceive the BP as appropriate and useful
- ✓ 100% of stakeholders perceive the BP as appropriate and useful

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# Main outcomes across the six BPs

## BP6: Health Promotion Centres – HPC

- **440 interventions carried out**
- **More than 60% of patients improved in 59% of the interventions**

| Rank | Intervention type / well-being parameter | % of patients improved |
|---|---|---|
| 1 | Physical / Nutrition / Mental Health activity workshop | 100% |
| 2 | Emotional well-being in women | 90% |
| 3 | Walking club | 86.1% |
| 4 | Physical activity | 82.3% |
| 5 | Stress management | 80.8% |
| 6 | Emotional load | 80% |
| 7 | Distress: lack of information | 80% |
| 8 | Distress: lack of will and capacity | 73.3% |
| 9 | Smoking dependency rate | 66.7% |

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# Main outcomes across the six BPs

## BP6: Health Promotion Centres – HPC

## TRANSFER OF HPC KEY ELEMENTS

**THE DEGREE OF INTEGRATION OF BP6 HEAVILY DEPENDS ON THE IMPLEMENTATION SITE LOCAL CONTEXT.**

| | HPC KEY ELEMENTS | 1.5 FISABIO | 1.7 SCS | 1.8 SERMAS | 2 7HRC | 3.3 ASL CN2 | 3.6 ASL Roma 3 | 3.10 ASL1 Liguria | 3.19 AST Ascoli Piceno | 4 NFZ | 6 Romania | 11 MSAE | 12 NNK | 13.1 KVSB | 13.2 KLVSB |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Screening at preventive check-up | PARTIALLY | YES | YES | YES | NO | YES | PARTIALLY | PARTIALLY | YES | PARTIALLY | PARTIALLY | PARTIALLY | PARTIALLY | PARTIALLY |
| 2 | Individual counselling | NO | YES | PARTIALLY | YES | YES | PARTIALLY | UNCLEAR | YES | YES | YES | UNCLEAR | YES | YES | YES |
| 3 | Structured group workshops | YES | YES | YES | YES | YES | YES | NO | NO | NO | NO | YES | YES | YES | YES |
| 4 | Multidisciplinary teams | YES | YES | YES | YES | YES | YES | YES | YES | YES | NO | UNCLEAR | YES | YES | YES |
| 5 | Local community programes | YES | YES | YES | YES | YES | YES | YES | YES | UNCLEAR | YES | YES | YES | UNCLEAR | UNCLEAR |

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# Key implementation impacts across CIRCE-JA

## Implementation generated value beyond delivery of the six Best Practices

| | |
|---|---|
| **Patients** | More person-centered care, stronger engagement and self-management, and better continuity of care |
| **Professionals** | New competencies, greater confidence and stronger multidisciplinary working |
| **Organisations** | Better coordination, more structured processes, organizational learning and improved governance |
| **Health systems** | New service models, stronger service integration, greater emphasis on prevention and increased capacity for future scale-up |

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# Main barriers encountered and mitigation strategies

| Barriers reported by implementers of all BPs | n | Mitigation Strategies |
|---|---|---|
| Lack of time and high workload | **25** | Flexible scheduling, task redistribution, integration into routine care and simplified procedures |
| Difficulty engaging professionals and resistance to change | **17** | Early involvement, training, clearer roles, feedback and local champions |
| Participant recruitment and retention | **16** | Personalised contact, flexible appointments, repeated follow-up and family or community support |
| Difficulty adapting organisation and routines | **15** | Gradual implementation, local coordinators and integration into existing structures |
| **Other frequently reported barriers** | **n** | **Mitigation Strategies** |
| Limited staff availability and team changes | **18** | Task redistribution, backup staff, additional profiles and adjustment of pilot scope |
| Problems with digital systems and technology | **15** | Interim tools, technical support and adaptation of platforms and data systems |
| Difficulties with data collection and reporting | **13** | Simplified forms, clearer guidance, standardised templates and data-quality checks |
| Coordination across professionals and organisations | **12** | Main contact persons, regular meetings, clear roles and shared working procedures |

**Facilitators:** Committed and motivated professionals, multidisciplinary collaboration, supportive leadership and regular communication helped maintain implementation despite local barriers

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# From implementation to continuation

**38 of 40 pilots (95%) plan to continue the BP fully or partially beyond CIRCE-JA**

| BP | Implementers | Full continuation | Partial continuation | No continuation |
|---|---|---|---|---|
| **BP1** | 4 | **3 (75%)** | 1 (25%) | 0 |
| **BP2** | 3 | **3 (100%)** | 0 | 0 |
| **BP3** | 12 | **4 (33.3%)** | **6 (50%)** | 2 (16.7%) |
| **BP4** | 3 | **3 (100%)** | 0 | 0 |
| **BP5** | 4 | **3 (75%)** | 1 (25%) | 0 |
| **BP6** | 14 | **7 (50%)** | **7 (50%)** | 0 |
| **Total** | **40** | **23 (57.5%)** | **15 (37.5%)** | **2 (5%)** |

Most pilots plan to continue, but in many cases, long-term continuation will depend on favourable organisational and institutional conditions

- Continuation was more advanced where the BP had been integrated into existing services, policies or organisational structures

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# Sustainability: Sustainability plans

## Sustainability plan METHODOLOGY

**Implementers assessed 7 sustainability dimensions**

- Likert scores, checklists and open questions.

## KEY FINDINGS

1. **Overall sustainability is moderate but variable: viable overall trajectory, presence of local implementation contexts where sustainability is at risk**
2. **Technology and economics are the weakest dimensions**
3. **Workforce is the main risk: staff training is top enabler and most exposed dimension**
4. **Transition from pilot to routine is the true critical step: Sustainability is won or lost in the transition**
5. **Sustainability requires a governance cycle, not a one-off plan**

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# Lessons Learned

## TRANSFER AND PILOT DELIVERY

1 **Adaptation is essential for transfer**

Local workflows, roles, tools and delivery models must fit the context while preserving core functions.

2 **Continuous support moves teams from planning to delivery**

Training, study visits, structured tools and regular feedback helped teams translate the BP into practice.

3 **Multidisciplinary involvement builds local ownership**

Early engagement improved coordination and helped teams address barriers during implementation.

## CONTINUATION AND SCALE-UP

4 **Professional commitment can bridge structural gaps only temporarily**

Motivated teams sustained implementation despite limited time, staff and digital infrastructure.

5 **Routine integration determines long-term continuation**

Protected time, workforce capacity, interoperable systems, stable funding and institutional support are needed.

**Pilot delivery relied on committed teams and flexible adaptation. Long-term impact requires structural and institutional integration**

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# THANK YOU!










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