European countries have achieved major improvements in public health over recent decades. Life expectancy at birth in the EU-27 countries has increased over the last 50 years by about 10 years. Europeans are also living to just over 60 years without poor health or disabilities affecting their lives. Whether longer life expectancy is accompanied by good health and functional status among ageing populations has important implications for health and social care systems. Healthcare systems are under financial and human resources pressures and facing the challenge of building prevention strategies while addressing the rapidly growing number of patients with chronic conditions and diseases who all need information, on-going self-management support and integrated person-centered care to stay healthy and productive and achieve optimal quality of life. However, the current European medical models are mainly oriented towards acute and short-terms treatments and often overlook the complex basis of chronic diseases, the possible active role of patients in treatment procedure and the need for coordination and cooperation between the different units of healthcare and social care systems organization.

The primary objective of the workshop is to address this growing need to support changes in current healthcare delivery systems which would lead to the provision of integrated, patient-centered care models that consider the realities of multi-morbidity and take into account the medical, socio-economic and technology dimensions in a holistic continuum of care. It intends to raise awareness about the current situation in the field of chronic conditions management (CCM) in Europe and highlight some good practice examples to showcase the value and importance of working with a CCM framework. The workshop also aims to outline key learning and policy recommendations to the practical implementation of CCM models in Europe.

After the first introductory presentation on a multi-stakeholder, consensus-driven Optimal European Chronic Care Framework, highlighting the key policy recommendations for
its practical implementation, three related topics will be presented. The second presentation illustrates the EU perspective on CCM, in particular how the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA) helps to support necessary changes in the present medical and financial healthcare delivery models. The third presentation gives a multi-national perspective and learning on patient-centered chronic illness care for people with diabetes, emphasizing patient’s perspectives on the value and need to implement worldwide patient-centered care models. The fourth presentation offers good practice example on the effectiveness of CCM models by illustrating a new care model for elderly people living in the community and its effectiveness concerning well-being and complexity of care needs of the elderly. An audience discussion concludes the workshop.

Key messages
- Common vision and framework for action to address the growing need of truly patient-centered CCM models.
- Awareness and sharing of good practice examples on the value of working with and for the patients to implement CCM models.

An Optimal European Chronic Care Framework and Key Policy Recommendations for its Implementation
Andrea Pavlickova
Epposi, Brussels, Belgium
Contact: Andrea.pavlickova@epposi.org

Background
The evidence suggests that the introduction of integrated care models can improve the chronic care process. Improvements in clinical care affect intermediate outcomes, disease control and adherence to evidence-based guidelines. The evidence in the role of self-management support and delivery system, particularly when combined with decision support, clinical information systems and community linkages, is also growing. This research was performed to: (1) validate the relevance of CCM framework in Europe (2) identify and raise awareness about the existing gaps in the CCM in Europe; (3) promote initiative to tackle the alarming situation and impacts of chronic diseases; (4) provide policy recommendations to the implementation of CCM models.

Methods
The research on an Optimal European Chronic Care framework started with mapping of the EU-27 countries in terms of prevalence of CCM national plans across 5 disease areas. Secondly, 10 EU countries were selected for the evaluation of their CCM national plans. The identification of commonalities across good practice examples as well as weakness in the current CCM resulted in the formulation of evidence-based policy recommendations, summarized in the form of White paper. Recently, “in-situ” testing of this CCM framework has been launched in order to assess the interoperability and scalability of such a framework across the EU member states.

Results
The components of Epposi Optimal European Chronic Care framework have proved to be closely linked and interconnected. The framework thus suggests that improving and integrating these components is the key towards improving the CCM in Europe. In addition, the formulation of key policy recommendations is an important tool to help to address the challenge of chronic conditions and areas of potential action and initiatives for its implementation at policy, community and individual levels.

Conclusions
Epposi’s research findings suggest that introduction of integrated chronic care models can improve the chronic disease care process. It is becoming increasingly clear that the focus of chronic care models should not be solely to manage diseases and treat the sick, but to improve the prognosis of chronic disorders and work to prevent illness.
drivers for provision of person-centred diabetes care. Through the exploration of results from this study, the relevance and usability of the person-centred chronic care model framework in individual conditions can be established.

**Results**
The DAWN2 study highlights significant gaps and better practices in relation to self-management support and team-based chronic illness care for people with diabetes world-wide. The results provide a first systematic framework for benchmarking countries through survey responses from people with diabetes, family members, healthcare professionals as well as from policy and patient organisation experts.

**Conclusions**
A comprehensive scientific benchmarking framework has been developed for diabetes, including multi-national psychometrically validated population surveys and national policy and programme assessments relevant to person-centred diabetes care. The results reveal important opportunities for cross-fertilisation between cross-disease and disease-specific efforts for the advancement of person-centred chronic care which take a starting point in the voice of people with the condition and of the family members living with them.

**Effects on well-being, quality of care and costs of the combined Chronic Care Model and a population health management model: Embrace**
Klaske Wynia

K Wynia1,2, SLW Spoorenberg1, RJ Uittenbroek1, B Middel1, BPH Kremer2, SA Reijneveld1

1University Medical Center Groningen, Department of Health Sciences, Community and Occupational Medicine, University of Groningen, Groningen, The Netherlands
2University Medical Center Groningen, Department of Neurology, University of Groningen, Groningen, The Netherlands

Contact: k.wynia01@umcg.nl

**Background**
Embrace is a new care model for elderly people living in the community, which combines the Kaiser Permanente (KP) triangle with the Chronic Care Model (CCM). The KP triangle is a population health management model that divides patients with chronic conditions into three distinct groups based on their degree of need. Embrace encompasses an Elderly Care Team per General practitioner (GP), an Electronic Elderly Record System, decision support instruments, and a self-management support and prevention program. Its intensity of care and support varies per profile: Robust, Frail and Complex needs.

**Methods**
We assessed the effectiveness of Embrace concerning well-being and complexity of care needs of the elderly, quality of care, service use and costs with a Randomized Controlled Trial among elderly people (aged 75 years and older) living in the community. The intervention occurred from January 2012 to April 2013. Embrace was delivered by Elderly Care teams led by a GP and further consisted of an elderly care physician, a district nurse, and a social worker (both district nurse and social worker acting as case managers).

**Results**
In total, 1476 elderly people registered in 15 GP practices in the province of Groningen were included in the study and were stratified to the three Embrace profiles: 59% to the Robust profile, 16% to the Frail profile and 25% to the Complex needs profile. Next patients were randomized to the control group (n = 719) that received care-as-usual, or to the intervention group (n = 757) that received Embrace care and support. The results after one year of intervention will be presented. We expect improved well-being and decreased care needs for the elderly people, improved quality of care and decreased – or at least stable – overall levels of service use and costs.

**Conclusions**
We succeeded to develop and to realize a promising new care model that includes all CCM key-elements in combination with a population health management model (KP-triangle). Effectiveness of this model was examined with a strong design. The follow-up period may be too short to demonstrate cost effectiveness because of the so-called ‘investment effect’. Therefore, the intervention period is prolonged in order to measure the real long-term effectiveness of Embrace.