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IJIC guidelines for "Conference Supplements"

Content

1. Introduction – the aims and scope of IJIC

It is important that prospective authors recognize that IJIC will only consider articles that fit the aims and scope of the Journal.

The focus of **IJIC** is on **integrated care**. We define this as follows:

> *Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients ... cutting across multiple services, providers and settings. [Where] the result of such multi-pronged efforts to promote integration [lead to] the benefit of patient groups [the outcome can be] called 'integrated care'* (Kodner and Spreeuwenberg, 2002).

It is important for prospective authors to recognise that we distinguish between integration and integrated care, noting that the structures and processes that support organisational and service integration may not always result in the enhanced outcomes and patient experience associated with integrated care.

The editorial board of IJIC believes that the primary purpose of integrated care should be to improve quality-of-care, user experiences, and cost-effectiveness of care since such issues give integrated care both a rationale and a common basis on which to judge its impact.

The field of integrated care comprises a broad spectrum of themes. Those that fit within the aims and scope of IJIC include:

1. Integration between health services, social services and other care providers (horizontal integration);

2. Integration across primary, community, hospital and tertiary care services (vertical integration);

3. Integration of care within one sector (e.g. within mental health services);

4. Integration of care between preventive and curative services;

5. Integration of delivery systems that bring together clinicians and managers, funders and deliverers, professionals and patients;

6. The use of new technologies and other innovations that enable and support integrated care to flourish;

7. The use of system incentives, such as governance, guidance, funding and payment mechanisms, that seek to embed and reward integrated care; and

8. Integration between care providers and patients that supports shared-decision making, self-management, and remote care.

9. The impact of integrated care in reducing health inequalities.

10. Integration of health promotion strategies with population-based and patient-centred approaches to health care; and,

11. The relationship between global/International health initiatives in supporting national, regional and local approaches to health and social care integration.

Within these subject fields, we encourage a focus both on integrated care to populations or particular client groups (e.g. older people, or persons with an unspecified chronic or long-term care need) as well as to particular service areas or diseases (e.g. to people with diabetes).

2. Content of Conference Supplements

IJIC is keen to publish the abstracts from conference supplements from peer-reviewed papers presented at conferences that are directly relevant to integrated care. Conference organisers should provide a range of information to ensure the academic quality of their conference, including the abstracts provided for the supplement. They should meet the standards of excellent scientific performance and add relevant and new scientific information to existing knowledge on integrated care, with lessons for integrated care practices

Conference abstracts should primarily report ongoing original research. The material should not have been previously published elsewhere, except in a preliminary form. However, IJIC will also consider as part of the conference supplement peer-reviewed papers based on literature reviews, policy developments or practical innovations.

All abstracts should have been peer reviewed (two or more independent reviewers) from which selection for a conference presentation was made. IJIC will usually not publish papers that have not gone through the peer-reviewed process, though short articles based on key-note speeches or other presentations might be included.

A short editorial paper from the conference leaders that outlines the conference aims and objectives, discusses the review process for the papers and selection for the supplement, and providing some overall comments on their key messages from the event should be provided. This would be included in the supplement as proceedings from the conference.

Conference supplements must include, therefore, all peer-reviewed abstracts in the format required by IJIC and a short paper on proceedings from the conference.

3. Format for conference abstracts

<u>General requirements:</u>

- Abstracts should be written in correct English (preferably UK spelling) and complete in all respects, including figures and tables

- Abstracts should be submitted in Word format. Abstracts should be typed with single space and wide margins on pages of uniform size
- Abbreviations should not be used. Words should be spelt out in full each time
- Where there is a methodology, it should be clearly described under a separate heading
- The summary should normally be usually no more than 500 words or no more than 1500 words when few abstracts have been selected.
- The abstract should contain 3-6 keywords which encapsulate the principal subjects covered by the conference presentation, which will be used for indexing.
- Literature references (if there are any) should be cited at the appropriate places in the text, with numbers in square brackets (for example: [1], [2-3] etc.)
- All references cited in the text should be listed numerical at the end of the manuscript in order of their appearance in the text, not in alphabetical order (1. Author etc.)
- All non-English references should have an English translation of the title between square brackets and the language used in the publication should be mentioned at the end of the reference. For more information on referencing see the IJIC reference guidelines at the IJIC website (http://www.ijic.org/ information, submissions, preparation of manuscripts)

Conference abstracts should be structured in the following way:

- Section: Specify type of abstract (for example: Conference abstract; Keynote abstract; Keynote paper; Editorial; Poster abstract)
- Actual title of the abstract.
- Name(s) in bold, affiliation(s) and address(es): city and country obligatory
- Correspondence to: name and address (preferably only one address of correspondence): e-mail address obligatory
- Heading: Abstract
- Actual abstract structured according to type of abstract (Research, Policy, Projects and Developments):

    - A summary for research papers should include: introduction (comprising background and problem statement), theory and methods, results, conclusions and discussion
    - The summary of a paper on projects and developments or a policy paper reflects the content of the paper: introduction (comprising background and problem statement), description of care or policy practice, conclusion and discussion
    - Headings in bold followed by a colon
    - A summary should be understandable to readers who have not read the rest of the paper. It should not contain any citations of other published work
    - These headings ar e just a guideline, You can deviate if you wish.

- Heading : Keywords
- Actual keywords (3 to 6 as a guideline), no capital, divided by comma's
- Optional: link to presentation slides

See appendix A for an example of a Conference Abstract

4. Fees

All Conference Supplements that are accepted for publication incur a Publication Fee of **€5,000.00 +VAT (€6,000.00) for IFIC Members.** This publishing fee helps the Journal to retain its open-access status.

5. Procedure

All Conference Supplements submitted to IJIC should meet the standards of excellent scientific performance and add relevant information to existing knowledge on integrated care, with lessons for

integrated care policy and practice. Specifically, Conference Supplements must fit the scope of the Journal (section 1 above) and also the guidance provided on content and structure (section 2 above). Submissions should have been peer reviewed so confirm the academic content of the papers presented.

5.1 Submission of proposal to publish a Conference Supplement

A proposal to publish a Conference Supplement should be submitted via email to the IJIC Managing Editor.

The proposal should include:

1. Date, time and place of the conference

2. Description of the peer review process for selection of the abstracts.

3. A confirmation from the organizer that all authors from all abstracts submitted have agreed for IJIC to publish their abstracts and they accept IJIC copyrights.

4. An attached word document that includes all abstracts from the conference and a short piece developed by the organizers. This piece should state the aims of the conference and reflect on proceedings including the author own key messages and conclusions.

5. A list of all abstracts included with their title and authors names.

5.2 Rejection at the point of submission

Conference Supplements will not be accepted for publication if in the opinion of the Editors they do not fit with the scope of the Journal and/or there is poor use of language, construction and referencing and/or didn't follow an appropriate peer review process.

5.3 Supplement accepted for publication

Conference Supplements accepted for publication should be copy edited by the authors following IJIC guidance. The Editors decision on publication is final. Once accepted for publication, the appropriate Publishing fee must be paid.

For more information about this guideline please contact:
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Appendix A: Example of Conference Abstract

Conference Abstract

(0) A development model for integrated care

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Abstract

Purpose: The objective of the study was to identify the elements and clusters of a quality management model for integrated care. An element was defined as an activity focusing on the development (realization, improvement, innovation or sustainability) of integrated care. Also the developmental process of integrated care was researched resulting in the description of four development phases of integrated care.

Context: After the development of the quality management model for integrated care, the model was tested in integrated care practice in the Netherlands. 84 integrated care services for stroke, acute myocardial infarct and dementia patients tested the model in practice, to assess it's generic character and use in practice.

Methods: The Development model for Integrated Care (DMIC) was developed by combining a structured literature study, a three round Delphi study with 31 experts and a Concept Mapping study. This systematic approach resulted in 89 elements of integrated care, which were grouped in nine clusters. For the grouping procedure Concept Mapping was used. By using a questionnaire research an empirical test in three different integrated care setting in the Netherlands: patients with stroke, acute myocardial infarction (AMI), and dementia was executed.

Results and discussion: The development model for integrated care consists of nine clusters and four development phases. The clusters are named 'patient-centeredness', 'delivery system', 'performance management', 'quality of care', 'result-focused learning', 'inter-professional teamwork', 'roles and tasks', 'commitment' and 'transparent entrepreneurship'. The development phases are the 'initiative and design phase'; the 'experimental and execution phase'; the 'expansion and monitoring phase' and the 'consolidation and transformation phase'. The results confirm that although the characteristics of the 84 participating integrated care services differed on numerous aspects, the DMIC was highly recognized in practice. There was a strong relation between the number of implemented elements and the phase of development. The model can serve as a quality management tool for integrated care. Integrated care coordinators stated that the DMIC helps them to assess their integrated care development and that it provides suggestions for further development and implementation of integrated care practice [1,2].

Keywords
development Model for Integrated Care, development phase, model for integrated care

References:
1. Minkman MMN, Ahaus CTB, Fabbricotti IN, Nabitz UW, Huijsman R. A quality management model for integrated care: results of a Delphi and Concept Mapping study. Internationalt Journal for Quality in Health Care 2009;21:66-75.
2. Minkman MMN, Ahaus CTB, Huijsman R. A four phase development model for integrated care services in the Netherlands. British Medical Journal Health Services Research 2009;42:1-11.

PowerPoint presentation available from:
http://www.integratedcare.org/Portals/0/congresses/Minkman%20Integrated%20Care%20Odense%20DEF.pdf