Abstract Assessment Guidelines

Introduction

The conference will accept abstracts for assessment of integrated care practices, policies and research and theory. All accepted abstracts will be published in the International Journal for Integrated Care.

Accepted abstracts will appear in the programme as a formal workshop (60 or 90 mins), oral presentation (20 mins), oral poster (inc 5 minutes PowerPoint presentation) or display only poster (no presentation time), as deemed appropriate by the scientific committee.

Special consideration is given to papers that can demonstrate active people involvement in either or all of design, implementation and evaluation!

Abstract assessment process:

1. Abstract is submitted via online tool https://www.conftool.net/ICIC19/

   a) Author to ensure paper is appropriate to conference theme(s) (see Appendix A)

   b) Author to choose submission format (Oral Presentation, Poster Presentation, Workshop) (Appendix B)

   c) Author to choose which conference topic is most appropriate and submit the paper according to the guidelines (Research, Policy or Practice) (see guidelines in Appendix C)

   d) Author to choose which conference track the paper is most appropriate to (see Appendix D)

2. Scientific Coordinator will allocate abstract submitted to 2 potential reviewers based on topic relevance and country of origin.

   a) Members of the SAC should inform the Scientific Coordinator which topic (Appendix C) and which conference track (Appendix D) they are more interested to review (if any).

3. Abstract will be peer reviewed by 2 members of the SAC:

   a) The online tool offer reviewers the following option:

      - Score each abstract using the criteria established by the SC

      - Leave a comment to the authors

      - Leave a comment for other reviewers and the Scientific Coordinator

      - Propose an abstract for an award

b) Abstract Revisions: an invitation to authors to revise will be sent if requested and agreed by the 2 reviewers. In that case the authors need to resubmit within a week. The Scientific Coordinator to inform the reviewers when resubmission has been done.

c) Disagreements: In case of disagreement from the reviewers, the Scientific Coordinator in liaison with the chair will decide.

4. Once all abstracts have been finally scored, the Scientific Coordinator will develop draft full program with accepted abstracts in liaison with the conference chairs.

5. The Organizing Committee and the Scientific Committee will revise and comment on proposed draft full program.

6. Once full program has been agreed the authors are informed of the decision.

Criteria for assessment:

1. Quality of Content (10% - Does the quality of the content merit presentation? Is it of high scientific or practical quality? Do the authors clearly demonstrate involvement of people?)

2. Significance (10% - Does the abstract present significant advancements in theory or implementation, including people involvement, either for the context or more general)

3. Originality (10% - Does the abstract present innovative, new approaches to the problem, including active people involvement; either through true innovation or by adapting for the integrated care context)

4. Thematic relevance (10% - Does the abstract fit into the scope of the conference themes? – Appendix A)

5. Presentation (10% - Does the abstract adhere to the guidelines? Is there a clear structure and is it comprehensible?)

6. Overall Recommendation (50% - Overall, would you want to see this abstract presented at the conference? Overall, does this paper demonstrate active people involvement in either or all of design, implementation and evaluation?)

Appendix A ICIC19 Title, Themes and Sub-Themes
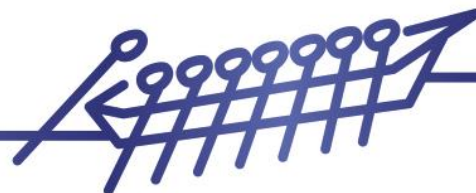
Conference Title

A shared culture for change: Evaluating and implementing models of integrated people-centred services

Conference Themes

Integrated health and social care for people at home
- Importance of home (in its broader sense) as social and health ecosystem
- Palliative Care/End of Life Care
- Role of carers (family, volunteers, professionals)
- Role of the pharmacy offices in the community.

Engaging and empowering people and communities to become equal partners in care
- Patient empowerment: from theory to practice (implementation and evaluation)
- The patient as an active agent in health, patients' engagement
- Support networks with patients and carers for self-management of health conditions
- Community health networks
- Learning from people´s experience (patients, families and professionals)
- Codesign and coproduction in care
- Social design
- Innovative strategies to activate the community
- Community assets mapping
- Strategies and resources to build community and to reinforce care
- People´s and community´s participation in integrated care systems.

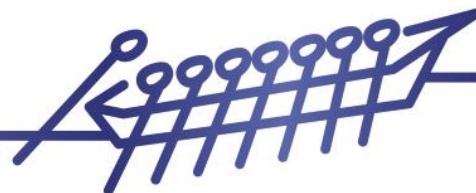**Creating shared cultures, norms and values across organisations, professionals and people**
- The challenge of interdisciplinary work and the cultural shift
- Changing working culture towards a more collaborative approach among professionals
- Tools for team building with professionals
- New roles, skills and training
- Strengthening leadership and change management
- Managing beliefs, expectations and priorities.

Building a stronger integrated primary care
- Importance of primary care leadership in care integration and its alliances with the social sector
- Primary care in care integration: organizational options
- Reassessing health promotion, disease prevention and community health.

Models of care for people

- Integrated care and its dimensions: clinical, professional, functional, organizational, systemic, regulatory, etc.
- Organizational models in Integrated Care
  - o Transition from pilot experiences to level-system implementation
  - o Role of the macro level (institutional/political) on the agreements fostering, role of the meso level (social and health commissions, etc.) and role of the micro level (social and health care teams)
  - o Integrated care real experiences (i.e. Nurse Family Partnerships, home, etc.)
- New models of funding for social and health care systems
- Patients flow and improvement of care pathways between care levels and organizations
- Focus on vulnerable populations and populations at risk.

Defining measures and outcomes that matter to people
- Assessing integrated care performance, from people´s and community´s view - Quantitative and Qualitative approaches.
- Tools for health results assessment: improving social and health monitoring and health results (eg Social and health care scorecard)
- Health promotion, social and health care, community health networks and primary care leadership in the care integration process (including results)

Impact of Digital Health
- Potential and evaluation of digital technology to transform the access and delivery of care
- Social and Health Care information systems
- Risk prediction analytical tools
- Risk stratification tools
- Shared electronic records (clinical record, social and health record)
- Big data
- Role of people and community in the appropriation of digital health: codesign of tools

APPENDIX B Submission Format

Oral Presentation

1) Presenters will have a maximum of 15 minutes to formally present your paper (maximum 15 slides)

2) A total of 20 minutes is allocated to the presentation to allow for questions so please be careful to stick to time or you will not have time for questions

3) Questions will be taken immediately after the presentation unless otherwise agreed with the chairperson to take questions as a group

4) Presenters should submit their photo and biography and finalise the presentation title and speaker details to the conference organising team by deadlines – follow briefing instructions carefully

5) Conference programme is subject to change and some presentations may be moved as the conference develops

Poster Presentation

1) Presenters are responsible for the design of their poster

2) Presenters do not have to submit the poster in advance

3) Presenters should bring the poster with them on the day or follow briefings to have poster printed locally and delivered to the venue

4) Presenters can collect posters from registration desk and will be given a poster number. Posters can be mounted from 7.30am on the first day using materials supplied at the venue

5) Posters remain on display in the exhibition area for the full conference

6) Presenters should be at their posters during the refreshment breaks to answer questions from delegates. It is a good idea to include contact details on the poster for follow up!

7) There is no formal poster walk

Oral Posters

8) Some posters who score high enough will also be included in the programme as an Oral Poster

9) You will have a maximum of 5 minutes to formally present the findings of your poster as part of a breakout session

10) There is no time allocated to questions, so slides should be kept to a minimum (and no more than 5) and messages succinct
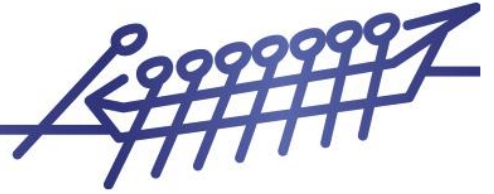
Workshop

1) Workshops are allocated 60 or 90 minutes as part of the either a conference stream or breakfast or lunchtime workshop

2) You may choose your own format within the time allowed. We recommend limiting your presentation time to allow lots of time for interactivity and discussion

3) Remember only fully-fledged workshop submissions including a programme outline with timings and speaker details will be accepted in the submission process

APPENDIX C Topics of abstracts

1. General guidelines

1) All abstracts should be relevant to 1 or more of the conference themes/topics

2) All abstracts should include full contact details all authors

3) All abstracts should include a summary that is understandable to the readers who have not read the rest of the paper or do not know the practice and its context.

4) The abstract summary should be limited to 500 words.

5) The abstract summary should be structured, and content key information requested for each type of paper. Please revise subtitles needed for abstract on integrated care practice, policy and research and theory below.

6) If references are included they should follow IJIC reference style (Vancouver) - See www.ijic.org

7) All abstracts should identify a lead presenter for inclusion in the programme

2. RESEARCH - Structured Summary for abstracts on Science of Integrated Care

1) An introduction (comprising background and problem statement)

2) Theory/Methods

3) Results

4) Discussions

5) Conclusions (comprising key findings)

6) Lessons learned

7) Limitations

8) Suggestions for future research

3. POLICY - Structured Summary for abstracts on Knowledge of Integrated Care

1) An introduction (comprising background and problem statement)

2) Description of policy context and objective

3) Targeted population

4) Highlights (innovation, Impact and outcomes)

5) Comments on transferability
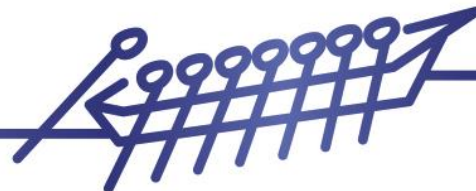
6) Conclusions (comprising key findings, discussion and lessons learned)
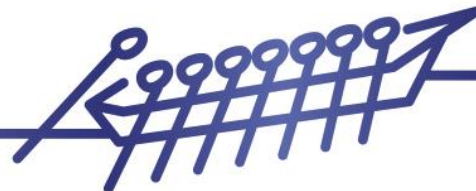
3. PRACTICE - Structured Summary for abstracts on Application of Integrated Care

1) An introduction (comprising context and problem statement)

2) Short description of practice change implemented

3) Aim and theory of change

4) Targeted population and stakeholders

5) Timeline

6) Highlights (innovation, Impact and outcomes)

7) Comments on sustainability

8) Comments on transferability

9) Conclusions (comprising key findings)

10) Discussions

11) Lessons learned

4. Structured Summary for abstracts relating to Workshop

1. Background

2. Aims and Objectives

3. Format (timing, speakers, discussion, group work, etc) – if timings and speakers are not included then the workshop will be rejected!

4. Target audience

5. Learnings/Take away

APPENDIX D Conference Tracks

When submitting the paper, authors should select one of the following tracks that is most appropriate – understanding that papers may fit across several tracks please choose the one track that stands out. This will inform us during programme development but does not mean that the paper will necessarily be within the track in the final programme.

1) **Population Health**

   This subject area includes (but is not limited to):
   • Positive Health
   • Social-determinants
   • Healthy Communities
   • Children, youth and families and place
   • Cross-sector and multi-organisational approaches

2) **Policy Development**

   This subject area includes (but is not limited to):
   • Governance
   • Frameworks
   • Strategies
   • Networks
   • Value-based approaches
   • Principles
   • Regulation and Inspection

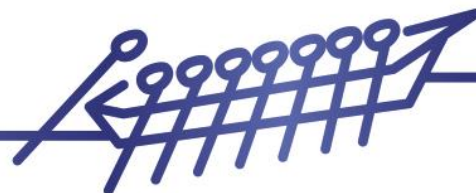3) **Whole System Transformation**

   This subject area includes (but is not limited to):
   • Integrated Care best practice case study examples
   • Change Management and Leadership
   • Implementation

4) **Tools and Methods for Supporting Care Coordination**

   This subject area includes (but is not limited to):
   • Case management
   • Technologies
   • Polypharmacy
   • Care at 'home'
   • Self-management

5) **Financing Integrated Care**

   This subject area includes (but is not limited to):
   - New models of funding and payments
   - Outcomes-based commissioning
   - New contracting models
   - Incentives and opportunities for investment

6) **Vulnerable Populations**

   This subject area includes (but is not limited to):
   - Mental Health Care
   - Homelessness
   - Drug and Alcohol Users
   - Refugee and Asylum Seekers
   - Remote and Rural Populations
   - Indigenous Communities, Ethnic and Racial Minorities

7) **Care of Older People**

   This subject area includes (but is not limited to):
   - Frailty
   - Dementia
   - Technologies
   - Multi-morbidities
   - Role of pharmacy
   - Community-based care

8) **Education and Training**

   This subject area includes (but is not limited to):
   - Skills
   - Workforce Development
   - Capabilities
   - Inter-professional Development
   - Educational Courses
   - New roles

9) **Data Analysis**

   This subject area includes (but is not limited to):
   - Evaluation
   - Health Economics
   - Risk Management Tools
   - Big Data

10) **Palliative and End of Life Care**

11) **Intermediate Care and Care Transitions**