2016 National Case Management Conference & 17th Annual ACMA Meeting
April 3-9, 2016 • Tampa Convention Center
Tampa, FL

2016 ACMA POSTER SESSION TOOLKIT

I. Presentation Guidelines
II. Important Dates & Deadlines
III. Tips
IV. Frequently Asked Questions
V. Sample Posters

Contact us:
Email posters@acmaweb.org or call ACMA at 501-907-2262
I. **Poster Presentation Guidelines**

*Please review the following information to assist you in developing your poster.*

**Session Description:**
Presenters display information on a bulletin board. Attendees review posters and meet with presenters during the attended and non-attended sessions.

**Guidelines for Developing and Presenting a Poster:**

1. Plan and develop your poster and poster components. Components may include:
   - **Title Banner** – It is recommended that the title run across the top and be readable from 15-20 feet. Authors’ names and organization should be part of this banner but may be presented in smaller font.
   - **Introduction/Purpose** – The introduction should identify the project statement and the objectives and/or purpose of the research/project/study.
   - **Project Summary & Methods** – This section should provide an overall description including tools and procedures for gathering and analyzing data.
   - **Data/Results** – Data and findings should be highlighted. Avoid small print tables. Self-explanatory graphics should be used with minimal text.
   - **Implications** – Summarize the significance of your project/initiative on existing or future processes.
   - **Conclusion/Outcomes** – This section should include clear and brief statements that highlight what has been achieved relative to the objectives. Bulleted lists are recommended.

2. ACMA will provide a bulletin board for display purposes. The dimensions of the poster must be 48” wide by 36” high or smaller. ACMA will provide push pins.

3. In an effort to support ACMA’s green initiatives, **we require submission of electronic copy handout, including author contact information by March 7, 2016.** On your handout, you may summarize your presentation or simply copy the poster to handout size. Your handout will be available online for attendees to reference/download.

4. Bring your completed poster to the designated poster session location for set-up. Additional set-up and tear-down information will be sent to presenters closer to date.

5. Staff your poster with a minimum of one representative. Two presenters work well with the volume of attendees and questions.

6. No AV equipment allowed (including laptops). ACMA is not liable for any display products or security.

Please reference the poster samples enclosed and also available online at www.acmaweb.org/posters

II. **Important Dates & Deadlines**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>October 13, 2015</td>
<td>Information Webinar at 1pm (Eastern)</td>
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<tr>
<td>November 11, 2015</td>
<td>Call for Poster Presentation Deadline</td>
</tr>
<tr>
<td>February 5, 2016</td>
<td>National Conference Early Registration Deadline</td>
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<tr>
<td>March 7, 2016</td>
<td>Poster Handout Submission Deadline</td>
</tr>
<tr>
<td>April 3, 2016</td>
<td>Poster Set-up in designated location – Time TBD</td>
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<tr>
<td>April 3 – 4, 2016</td>
<td>Poster Presentations – Time TBD</td>
</tr>
<tr>
<td>April 5, 2016</td>
<td>Poster Tear-down – Time TBD</td>
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</tbody>
</table>
TIPS for Submitters

- Use spell check and have others proofread your abstract before you submit it. Spelling and grammar matter to the judges. Also make sure to complete all fields including poster title.
- Ask others to review your material to get a good understanding of your project. If they can’t understand the material, the committee probably won’t understand it either.
- Make sure the outcomes from your project are clearly identified
- Even if all your outcomes data isn’t in, include any preliminary findings/data

TIPS for Poster Presenters

- The poster should be a clear and self-explanatory presentation of your research/project/initiative
- Your poster should allow you to present findings in a concise, visual form
- Plan to arrive with plenty of time to get settled and get your poster set up
- Do a practice run of your poster set up before you come to the conference- it’s a great idea to present the poster to other employees in your department or hospital to get an idea of what questions you might be asked
- Set your poster up, step back 4-5 feet, and see if you can read everything
- If you ship your poster, make sure you track delivery to ensure it arrives on time
- Put your contact information on your electronic handout and bring business cards onsite
- Wear comfortable clothing and shoes for presentation time- you will be on your feet

IV. Frequently Asked Questions

Application Process

Do I have to be a member of ACMA in order to be a poster presenter?
No, you do not have to be an ACMA member to be a poster presenter. However, when you register to attend the conference as a non-member, a one year ACMA membership is included in the cost of registration.

Where can I find the application?
Application is now available for download on the ACMA website, www.acmaweb.org/posters

What is the deadline to submit a poster?
Poster submissions must be completed by November 11, 2015. Late submissions will not be accepted.
How do I know if my work would make a good poster?
Ask your co-workers, friends and family. If they find it interesting, others will too; also trust your own judgment. If you have a program that you feel has positive outcomes and has provided a valuable resource to your patients and facility/agency, then submit an application. Suggested topics are:

- ACO / Medical Home Models
- CM Models / UM Models
- Collaboration / Teams / Education
- Community Resources / Relationships
- Denial Management / Reimbursement
- Discharge Planning / Discharge Barriers
- Disease Management / Specific Patient Populations
- Documentation
- End of Life / Palliative Care / Ethical Dilemmas
- Interfacility Collaboration
- Leadership
- Performance Improvement
- Physician / Physician Advisor / Hospitalist
- RAC – Recovery Audit
- Reporting / Data / LOS
- Social Work Initiatives / High Risk Population
- Strategic Planning / Financial Plans
- Transitions of Care

What is the poster committee looking for when accepting posters?
We are always looking for new and innovative ways to help our patients. ACMA is moving towards evidence-based poster presentations and we are especially looking for abstracts that have some evidence of a positive outcome. Although statistical validation is certainly welcome, any measure to support the successful outcome of the project is helpful.

What am I committing to if I submit a poster application?
You are committing to putting together a poster presentation of your project, attending the national conference, and being at your poster for up to 4 hours during the specified time at the conference. Your poster must be set up and ready for the judges at least one hour prior to the start of the poster session. During this time, other conference attendees walk through, stop to visit with you, and ask questions about your project and how they could use this information in their practice. Frequently, two people present a poster so there is time for one member of the team to look at all of the posters while their partner remains at their poster to present.

Do I get a discount on conference registration?
Unfortunately, a discount is not available.

What are the qualifications of a poster presenter?
All presenters must be employees of a hospital/healthcare system and/or patient provider organization. Submissions from vendor companies and consultants are not eligible.

How will I know if my poster submission was accepted?
The committee will convene early December 2015 to review all submissions. Decision letters will be emailed by January 11, 2016.

Preparing your Poster

How will I display my poster?
ACMA will provide a bulletin board and tags for your use.

How big should my poster be?
The dimensions of your poster must be 48” wide by 36” high or smaller. The design/background of your poster presentation may be of your choice.
Should I bring handouts?
In an effort to support ACMA’s green initiatives, we require submission of electronic copy handout, including author contact information by March 7, 2016. On your handout, you may summarize your presentation or simply copy the poster to handout size.

Is this a “formal” presentation?
Actually this is one-on-one or at most a small group as the attendees move through all the posters.

I’ve never done this before, what words of encouragement can you give me?
The whole process, from the application to take down is, in one word, easy! The hard part is putting that great idea or process you have on paper. For the application, give a brief but inclusive summary of what you intend to show on your poster. Focus on outcomes data – both quantitative and subjective or qualitative. Remember that learning objectives should begin with an action verb, for example, “Recognize opportunities to apply principles of crisis intervention across varying situations; or, “Identify additional opportunities to assign/correct status on all surgical procedures.”
If you would like to see examples of actual posters, go to www.acmaweb.org/posters. If you have additional questions, please email your inquiry to posters@acmaweb.org.

Am I allowed to bring marketing materials from my hospital?
No. A table will not be available as all posters are now displayed on bulletin boards.

Can I have audiovisual equipment at my poster display?
No audio visual, including laptops, is permitted.

When do I take my poster down?
Tear-down information will be communicated to presenters closer to date. Those posters not removed by the owners will be considered trash.

How will my poster be judged?
The scoring/judging criteria will be shared with presenters in advance.

V. Sample Posters

Poster handouts from our three 2015 poster winners are included in this toolkit as samples for reference.
BACKGROUND

While hospitals have been diligently working to reduce their 30-day readmission (RA) rates, it is anticipated that the Centers for Medicare & Medicaid Services will implement a similar Value-Based Purchasing program for skilled nursing facilities (SNFs) within the next five years. A Medicare Payment Advisory Commission analysis showed that 23.5% of all patients who were discharged to SNFs were readmitted within 30 days, and 78 percent of these readmissions were potentially avoidable at a cost of $3.39 billion. Toles et al. found that 22.1% of patients had an emergency department (ED) visit or were readmitted within 30 days upon discharge from SNF to home. Patients transitioning from hospital to SNF and from SNF to home often have numerous comorbidities and medications. As the medication experts, pharmacists are uniquely qualified to identify and manage medication-related problems as patient transition from one setting to another. One primary intervention is medication reconciliation, which is defined as the process of a patient and pharmacist creating an accurate list of all medications that the patient is taking by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. At each transition point, inaccurate medication reconciliation increases patients’ risk of hospital RA.

While many hospitals have incorporated pharmacy technicians in the ED workflow to obtain prior-to-admission medication histories and/or decentralized their inpatient pharmacies to coastal patients who discharge from hospital to home, very few hospitals have pharmacist involvement upon patients’ transfer from hospital to SNF and from SNF to home. There is tremendous opportunity as one study identified at least one medication discrepancy in 71.4% of SNF admissions. In addition, Sivani et al. found that 100% of SNF pts were discharged home with more medications than their initial admission to hospital.

OBJECTIVES

• Reduce SNF 30-day RA rates
• Conduct a needs assessment in regards to medications as patients transition from hospital to SNF and subsequently from SNF to home
• Identify barriers in optimal medication management along the continuum of care and how they can be overcome

METHODS

In January 2014, the Care Transitions (CT) pharmacists at Frederick Memorial Hospital began a pilot project with three local SNFs. Pharmacists identified high-risk patients in the hospital and followed patients as they transitioned from hospital to SNF and subsequently from SNF to home. Pharmacists reconciled medications, recommended medication therapy changes to improve outcomes, identified necessary medication monitoring, and provided medication education along the continuum of care. The primary outcome of this project was the reduction in SNF 30-day RA rates.

RESULTS & DISCUSSION

• The CT pharmacists followed approximately 150 high-risk patients through the care continuum for 6 months.
• For SNF #1, the RA rate decreased from 12.5% to 8.33% during that time period. For SNF #2, the RA decreased from 27% to 15.56%.
• In FY 2011, the FMH SNF RA rate was 24.99%. In FY 2014, the SNF RA rate decreased to 15.33%.
• Due to the success of the pilot, the CT team has expanded the program to include all SNFs in Frederick County. Despite the success in RA rates, multiple barriers were encountered along the way. The CT team is offering an in-service to SNFs to help improve the discharge process to further reduce RA rates.

Figure 1: Barriers to Optimal Medication Management upon Transfer from SNF to Home

• There was large variability in medications as well as Rx provided.
• Instructions on bubble packs & unit doses were difficult to read.
• Discontinued meds were not listed.
• Therapeutic interchanges led to inaccuracies in medication reconciliation.
• Access to meds (cost, transportation to the pharmacy, prior auths) was an ongoing concern.

Figure 2: Discharge Medication Lists from Two SNFs in Frederick County

Patients had difficulty deciphering and understanding the SNF medication lists. It is essential to consider patients’ level of health literacy, social support, and ability to teach-back medication names, doses, and frequencies to ensure a safe transition into the community.

Table 1: Ideal Components of a SNF Discharge Medication List

• Generate an electronic med list rather than retyping to minimize human error
• List both brand and generic medication names (Example: “furosemide or Lasix”)
• Avoid medical abbreviations (Example: “congestive heart failure” rather than “CHF”)
• Include indications for all medications
• Provide indications in layman language (Example: “high blood pressure” rather than “essential hypertension”)
• Ensure appropriate medication indications (See Figure 2: amiodarone is not used for essential hypertension)
• Determine if holding parameters are appropriate and assess if patient and/or caregiver will be able to follow (Do they have a blood pressure cuff? Do they know how to check their blood pressure and heart rate?)
• Maximize readability by considering font size and layout of medication list (Remove irrelevant information)
• Only specify times of administration if relevant when considering patient-specific lifestyle

Figure 3: SNF Discharge Checklist

Our needs assessment found multiple opportunities to improve medication management as patients transfer from hospital to SNF and subsequently from SNF to home. Two opportunities include creating a patient-friendly discharge medication list and utilizing a SNF discharge checklist to ensure a safe transition.

REFERENCES


ACKNOWLEDGEMENTS

The authors wish to thank Heather Kirby, MBA, LBSW, ACM, Jackie Dinterman, BSW, MA, LBWA, and the rest of the Care Transitions team for their guidance and support throughout this project. We also thank the SNFs in Frederick County for their openness in collaborating with our Care Transitions team.

DISCLOSURES

The authors have nothing to disclose.
Background and Overview

- Sentara Medical Group (SMG) is comprised of more than 150 primary care and specialty practices across Hampton Roads Virginia, Northern Virginia and Northeastern North Carolina.
- In 2012, as part of primary care redesign, SMG established a comprehensive, radically-different (i.e. non-embedded, remote, or telephonic) RN Care Management model to manage the care of very important patients (VIPS) who were:
  - High risk patients (high cost and high utilizers)
  - Chronic disease patients (CHF, Diabetes, COPD/Asthma and Renal)
- VIPS were identified across 11 SMG Patient Centered Medical Home (PCMH) sites and all payers, including Sentara’s health plan (Optima). The Optima population was studied to determine if RN Care Management interventions could decrease the total cost of care in a high risk, chronic disease population.
- In 2013, the scope of work expanded to include all 30 adult SMG primary care sites. The practice of the RN Care Management was enhanced by implementing an intense 30-day transition process for all medical discharges across all venues of care and an ED “First-Call” process. Work continues to support system initiatives to:
  - Decrease 30-day all cause admissions
  - Decrease ED visits
  - Decrease total cost of care
  - Increase 7-day post-hospital follow-up with PCP
  - Increase Advanced Care Planning completion and documentation in the electronic medical record
  - Measure Quality of Life

Care Delivery Model and Interventions

- SMG Care Management Services are delivered by experienced BSN-prepared RNs who are required to have or obtain specialty certification within 2 years of hire. The RN Care Managers provide care to patients and families through a variety of modalities to include office, hospital, home and group visits, as well as telephonic and virtual visits. The SMG RN Care Managers are integral members of the interdisciplinary PCMH healthcare team. Their role is the cornerstone for:
  - Providing community-based, patient-centric complex care management
  - Managing patients across venues of care
  - Establishing long-term relationships with patients and their families/caregivers through engagement strategies
  - Safely transitioning medical discharges from the hospital and other venues to avoid unnecessary readmissions and ED visits
  - Facilitating the establishment of Advance Care Plans
  - Monitoring and improving patients’ perceptions of physical and emotional/mental health over time
  - Providing resources for improving medication adherence and self-care management
  - Participating in MD office huddles to address recent hospital and ED discharges
  - Reviewing cases at monthly PCMH meetings
  - Providing after-hours and weekend access
  - Establishing a process for patients to call their RN Care Manager before going to the ED
  - Using Lasix and Insulin Protocols to reduce unnecessary ED visits and admissions
  - Leveraging the EMR for communication with the healthcare team

Results

- Significant decreases in hospitalizations and ED visits for the VIPS population were noted. Data from June 2010-December 2011 (baseline) through December 2013 for patients being followed by SMG Care Management Services demonstrated:
  - 46% decrease in all-cause admissions
  - 27% decrease in 30-day all cause readmissions
  - 42% decrease in ED visits
  - 17% decrease in total cost of care (Optima)
  - 84% increase in 7-day hospital follow-up with PCP
  - 50% increase in completed and documented Advance Care Plans

- The SF-12 Health Survey® is a 12-question survey to measure functional health and well-being from the patient’s perspective. The SF-12 Health Survey® was administered to VIPS at the beginning of RN Care Management engagement and repeated after 6-months to determine if the patient’s perception of their physical health and emotional/mental health had improved. The results demonstrated:
  - 47% decrease in rate of patients at risk for 1st stages of positive depression
  - 43% decrease in rate of patients’ perception of physical status to be “below normal”
  - 6% decrease in rate of patients’ perception of emotional/mental status to be “below normal”

Conclusion and Implications

- The SMG RN Care Management model demonstrates the effectiveness of targeted patient population management by leveraging RN Care Managers across a large multi-specialty medical group.
  - This innovative community-based care management model can serve as a guide for other medical groups interested in managing targeted populations.

Acknowledgements

Mary Morin, RN, NEA-BC, Vice President/Nurse Executive, Sentara Medical Group
There is strong research that states sitting versus standing at a patient's bedside significantly impacts patient compliance with the treatment plan, provider-patient rapport, and patient satisfaction [1]. These factors are known to decrease lengths of stay and costs, as well as improve clinical outcomes. While you can generalize these results, there is a lack of evidence on the impact of sitting at the bedside specific to Case Managers (CM) and Medical Social Workers (MSW), as well as evidence supporting the effectiveness of this intervention on medical-surgical patients in the hospital. Our evaluation address these gaps in the research literature.

**PROJECT S.I.T. D.O.W.N.**

Laurie Biscaro, RN, ACM; Jaclyn Hagon, MSN, RN; Ashley May Ronaldson, BSN, RN; and Case Management and Medical Social Work Team; at Santa Barbara Cottage Hospital

“Stop, Interview, Take-Time; Discuss, Options, Wants, & Navigate”

There is strong research that states sitting versus standing at a patient's bedside significantly impacts patient compliance with the treatment plan, provider-patient rapport, and patient satisfaction [1]. These factors are known to decrease lengths of stay and costs, as well as improve clinical outcomes. While you can generalize these results, there is a lack of evidence on the impact of sitting at the bedside specific to Case Managers (CM) and Medical Social Workers (MSW), as well as evidence supporting the effectiveness of this intervention on medical-surgical patients in the hospital. Our evaluation address these gaps in the research literature.

Project S.I.T. D.O.W.N. was implemented in two Phases (30 days each):

**Phase 1** – designated program administrators (PAs) collected data on the amount of “real time” the CM/MSW stood at the bedside while performing an assessment. They then administered a survey within one hour of the initial assessment, asking 5 questions that were catered to meet the needs of this specific project (See Appendix A). Upon completion of the first month of surveys (standing) Phase 2 was implemented.

**Phase 2** - Portable chairs were distributed. During the 30 days, PAs followed the same procedure and collected data on the amount of “real time” the CM/MSW staff sat at the bedside. Surveys asking the same 5 key questions were conducted within one hour after the initial assessment.

### RESULTS

Patients perceived the CM/MSW as present at their bedside longer when they sat, even though the actual time they spent at the bedside did not change significantly whether sitting or standing. Patients with whom the CM/MSW sat:

- Reported a more positive interaction.
- Increased understanding of what they could expect during their hospital stay.
- Participated more fully in their discharge planning.

#### Actual Patient Comments

“*She didn’t rush she sat with me, yes very appropriate*”

“*She was quite a gal, very impressive good amount of time*”

### LESSONS LEARNED

Sitting instead of standing at the bedside impacts:

- The patient experience
- Patient compliance
- Provider-patient rapport

**AND**

You are eye level with the patient instead of ‘standing over’ them, which makes patients feel vulnerable:

- Sitting down has a calming effect, like an adult moving to the same level as a child:
- Sitting down creates an open, friendly and relaxed atmosphere; and MOST IMPORTANTLY,
- Sitting down says “You have my undivided attention.”

All healthcare providers on a patient’s care team should consider these findings while new ways of enhancing the patient care experience are being developed. Any healthcare provider has the power to have a positive effect on patient satisfaction with the quality of the visit [2].

### PRACTICE IMPLICATIONS

The TEAM

**The TEAM**

### Appendix A

<table>
<thead>
<tr>
<th></th>
<th>Standing (n = 175)</th>
<th>Sitting (n = 104)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>89 (50.9%)</td>
<td>49 (47.1%)</td>
<td>0.546</td>
</tr>
<tr>
<td>Female</td>
<td>86 (49.1%)</td>
<td>55 (52.9%)</td>
<td>0.546</td>
</tr>
<tr>
<td>Age &gt; 65</td>
<td>94 (53.7%)</td>
<td>54 (51.9%)</td>
<td>0.772</td>
</tr>
<tr>
<td>Q1. Patient felt staff spent appropriate amount of time in room</td>
<td>146 (83.4%)</td>
<td>102 (98.1%)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Q2. Satisfied with Staff</td>
<td>157 (89.7%)</td>
<td>102 (98.1%)</td>
<td>0.004</td>
</tr>
<tr>
<td>Q3. Staff Understood Needs</td>
<td>162 (92.6%)</td>
<td>104 (100%)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Q4. Staff included me in plan of care</td>
<td>141 (80.6%)</td>
<td>100 (96.2%)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Q5. Mean Staff LOS in Room (see Graph)</td>
<td>8.3 (5)</td>
<td>15.9 (8.2)</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

*P-value below 0.05 considered statistically significant.*

### References
