Are you pondering a poster?

Information and tips for potential poster presenters

2020-2021
AGENDA

- Introductions
- About the poster session
- Tips for submitters
- Application & Deadlines
- Sample poster and templates
### 2020/2021 Poster Session Committee

#### Co-chairs
- Co-Chair, Joanne Fletcher, EdD, MSN, RN
- Co-chair, Ketul Patel, MD

#### Board & Staff Liaisons
- Board Liaison, Patricia Resnick, MJ, MBA, RRT, FACHE, CPHQ, CHC
- Board Liaison, Michelle Wright, LCSW, ACM-SW
- Staff Liaison, Jon Vickers

#### Members
- Bonnie Schuster, MSN, RN, ACM-RN
- Andrea Devoti, MSN, MBA, RN, NAHC
- Crystal Brooks, LMSW, ACM-SW
- Karen Nelson, MSW, MBA
- David Duncan, MD
- Kathleen Bellamy, LCSW, ACM-SW
- Sue Troccia, LMSW, MHA, ACM-SW, CCM
- Patricia Blaisdell, FACHE
ACMA POSTER SESSION

- Forum to present new innovations and best practices among organizations
- Collegial, informal sharing of experiences
- Highlighting your successes
- Find out how others have overcome challenges
- Great networking opportunity
**WHAT’S INVOLVED?**

- **Decide**
  - Decide what to present

- **Submit**
  - Submit an application by 10/31/20

- **Wait**
  - Wait for a determination letter

- **Plan**
  - Plan the poster and handouts

- **Come**
  - Come to Orlando April 11-14th 2021
Poster Presenter Qualifications

- Employee of hospital or healthcare system (no vendors)
- Presenter names must be on the application
- ACMA membership **NOT** required
Would my work make a good poster?

- Ask your co-workers and colleagues:
  - Is this project concept compelling?
  - Were the key processes or outcomes addressed, relevant to case management?
  - Has this work provided valuable insights into system design, case management practice or performance improvement?
  - Is there evidence regarding the outcome?
  - Are there lessons to be learned?
  - Would others benefit from the shared knowledge?

- If any are yes, consider a poster submission.
SUGGESTED TOPICS

- Case Management Models
- Collaboration/Teams/Education
- Community Resources/Relationships
- Behavioral Health Case Management
- Denial Management/Reimbursement
- Disease Management/Specific Patient Populations
- Documentation/Reporting Data
- End of Life/Palliative Care
- Hospital Program Initiatives
- Pediatric Case Management
- Physician/Physician Advisor/Hospitalist
- Primary Care Case Management
- Post-Acute Settings (LTAC, SNF, Rehab)
- Readmissions
- Resource Allocation
- Social Work Initiatives
- Strategic Planning/Financial Plans
- Transitions of Care
- Transition Planning/Length of Stay
- Value-Based Care and Bundled Payments
WHAT IS THE POSTER COMMITTEE LOOKING FOR?

- Evidence-based approaches to improve performance
- New and innovative approaches to case management
- Sustainable systems of care
  - Improved system integration
  - Increased accountability
- Team based care
- Ability to replicate
WHAT’S THE COMMITMENT

- Prepare a poster and handouts
  - Submission of electronic copy of handout is required
- Attend the National Conference
- Set up by the specified deadline
- Staff your poster for 3-4 hours to speak with conference participants and poster judges

One poster author required (but teams are encouraged to submit)
HOW ARE APPLICATIONS REVIEWED?

- Identifying information removed
- Committee members review independently
- Conference call for voting
- Generally excluded:
  - Sales pitches
  - Vague descriptions
  - No evidence-basis for study
  - Lack of a clear study methodology
- Not excluded:
  - Well designed negative studies/reports that test questions relevant to clinical case management
KEY DECISION FACTORS

Content
- New system or redesigned system
- Innovative concept
- Timely evaluation of question relevant to CM

Evidence of
- Impact on resources, patient care, system design or planning

Well written and clear presentation

Statistical analysis where appropriate
WHAT HAPPENS WHEN I’M ACCEPTED?

- Review letter of acceptance with information about dates and times for check-in, display and take down
- Send in conference registration
- Make hotel/transportation reservations
- Consult guidelines and toolkit document
- ACMA liaison and/or poster committee can answer display questions
PLANNING YOUR DISPLAY

CAN I BRING BRANDED MATERIALS FROM MY INSTITUTION?
Yes, if materials are from a hospital and/or healthcare system (no vendors. Keep in mind only a bulletin board will be provided (no tables)

CAN I USE AUDIOVISUAL EQUIPMENT?
No

HOW BIG SHOULD MY POSTER BE? MAY I HAVE A CLOTH POSTER?
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. Cloth posters are allowed.
SUBMITTING ELECTRONIC HANDOUTS

- Check electronic handout submission requirements and deadline date
- Submit electronic handout with contact information by specified date
- Must receive electronic poster and handouts by
- Handouts will be available online for attendee access
WHAT SHOULD BE ON THE ELECTRONIC HANDOUTS?

- Important takeaway information from the poster
  - Problem that was addressed
  - Methods employed
  - Outcomes that resulted
  - Lessons learned
  - Significant improvement or compelling negative finding
- Contact information for authors
WHAT DO I NEED TO BRING?

JUST YOUR POSTER!
ACMA TO PROVIDE BULLETIN BOARD AND PUSH PINS
Committee members visit posters during display time

Presenter gets 3 minutes to provide brief executive summary to judges
  - Judges will then have 2 minutes to ask questions

Executive summary to include:
  - A summary of the poster’s main conclusions and justification for recommendations
  - An explanation of the process used to study the problem
  - A summary of the process used to study the problem
  - An outline of the recommendations or decisions for others to replicate
How are the posters judged?

Committee members meet and tally scores

Winners are announced during the ACMA Annual Business Meeting – Date and Time TBD
EXTRA RECOGNITION

BEST PRACTICE

MOST INNOVATIVE TOPIC

ABILITY TO REPLICATE & IMPLEMENT
ANY ADVICE?

The process is easier than you think

Focus on outcomes useful to others

Use the poster session toolkit document

Look at past successful posters for ideas
APPLICATION AND DEADLINES

- www.acmaweb.org/posters
- Deadline for submission: October 31, 2020
- TBD: National Conference Early Registration Deadline
- March 6, 2021: Poster Handout Submission Deadline
- April 11, 2021: Poster Set-up
- April 11-14, 2021: Poster Presentations
- April 14, 2021: Poster Tear Down
TIPS FOR CREATING A POSTER IN PowerPoint
Capture the audience

- Make the title stand out
- Readability of poster
  - Font
  - Background colors
  - Quality images
- Specific sections should be easy to locate

This is an extreme example of a poster that may put readers off because of its bold colors and fonts.
Steps to Creating a Poster

- Gather information
- Choose your main point
- Find a poster template & set dimensions
- Add & edit content
- Modify fonts, background colors, & details
- Print poster & present
I. GATHER INFORMATION

- Do your research
- Basic sections
  - Introduction
  - Objectives
  - Methods
  - Outcomes
  - Conclusions
  - Lessons learned
- Highest quality pictures
- Consider graphs, tables and diagrams
2. CHOOSE YOUR MAIN POINT

- What do you want the audience to remember?
- Do you have a picture or diagram that illustrates that point?

Consider flow and dimensions!!

3. FIND A POSTER TEMPLATE

- Consider sketching your poster onto paper
- Look for free templates through your organization or online

https://www.makesigns.com/tutorials/scientific-poster-planning.aspx
HOW TO SET DIMENSIONS

- PowerPoint 2007 or 2010
  - Design Tab → Page Setup
4. ADD CONTENT TO THE POSTER

- Remember your main point – convey in title!
- Start with figures
- Clear objectives
- Figures and tables should be titled
- Concise conclusions
- EDIT, EDIT, EDIT!

http://hop.berkeley.edu/sites/default/files/ScientificPosters.pdf
5. MODIFY FONTS COLORS AND DETAILS

- Stick to 1-2 fonts
- Font should be large enough to read comfortably
- Align text (rather than justify)
- Less is MORE
- View at 100% size to examine details
6. PRINT POSTER AND PRESENT

- Include contact information
- Print letter size draft first
- Print final poster (online, local or organization)
- Travel with poster in tube or have it shipped
- Prepare 3-5 minute presentation
Improving Care of the Patient at Risk of Suicide While Decreasing ED Length of Stay

Jennifer Chaffer, LMSW ACM-SW

Background
Maintaining compliance with The Joint Commission’s standards around suicide risk assessment and mitigation in the Emergency Department setting requires time and resource-intensive processes, which may be balanced with the need to continually review and manage length of stay. This poster illustrates one hospital’s journey to implement processes and tools to provide better management of the patient at risk of suicide while simultaneously reducing the average length of stay for patients with a primary mental health diagnosis encountered in the ED.

Driving the Work Forward
Risk Management Rep
Internal Medicine Physician
ED Nurse Manager
Risk Management Rep
Security Director
Manager of Inpatient Psych Unit
End User Manager
ED Clinical Nurse Leader
ED Security Manager
Social Work Manager
Process Excellence Facilitator
ED Social Workers

Primary Intervention Strategies - LOS
- Implement use of last page to inform ED of patient with positive suicide screen (reduces volume of calls to EDMD)
- Introduce ED suicide risk tool for MUR response to positive screen
- When possible, station MUR in intake area, for immediate response to positive screen
- Implement novel MUR team (Mary-Care) to respond to late-day volume spikes

LOS (in minutes) of ED Patients with Behavioral Health Chief Complaint

Conclusions
- Delivering care to patients who are at risk of suicide in a high-quality, cost-effective manner does not equate to increasing LOS.
- Empowering frontline colleagues to design and implement new initiatives can help an organization achieve its compliance and LOS goals.

Where Do We Go From Here: The Work Yet to Do
- Sharing existing with compliance with assessment guidelines and safety interventions
- Developing management
- Reducing admissions
- Conclude to select the question: How do we provide excellent care in a way that respects the patient and keeps them safe but doesn’t make them feel like a number and dread coming to help.

Efficiencies
- 5% reduction in suicide risk assessments
- 5% reduction in suicide risk assessments
Ladder to Success
Development and Implementation of a Case Management Clinical Ladder

Author: Kathleen Y. Belfarm, LISW, ACM-6W
Institutions: Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, The Ohio State University Wexner Medical Center, Columbus, Ohio

BACKGROUND
- Clinical ladder programs have been integrated into hospital nursing programs for years.
- Development and expansion of the case manager role has created a need for management to recognize employee satisfaction and professional development.
- While literature searches show benefits of clinical ladder programs, few explore the unique qualities of the said model.
- Successful clinical ladders are tools to promote leadership development and provide strategies to challenge highly recruited staff.
- James Cas Management Department committed to support development of a ladder program in 2012.

OBJECTIVES
1. To provide an opportunity to promote clinical excellence in case management practice.
2. To encourage evidence-based practice and research opportunities in case management.
3. To provide a recruitment tool and increase retention.
4. Create a workplace of choice for our institution and department.

PROJECT DEVELOPMENT
- Creation of a needs-driven committee to spearhead the development processes and conduct needs assessment.
- Development of an comprehensive case manager role description and role delineation.
- Development of a promotion criteria reflective of the goals and objectives of the Clinical Ladder Program.
- Development of a peer review process for the evaluation of the Clinical Ladder Program.
- Development of a mentorship program to support the professional growth of the clinical ladder program participants.
- Development of a training program to support the clinical ladder program participants.
- Development of a communication plan to support the clinical ladder program participants.
- Development of a support system to support the clinical ladder program participants.
- Development of a case management tool to support the clinical ladder program participants.
- Development of a case management tool to support the clinical ladder program participants.

IMPLEMENTATION FRAMEWORK
- Project Design
  - Formulated a program plan to support the clinical ladder program.
  - Established a level of clinical ladder program from Level I to Level IV.
  - Established a level of management program, Level V.
- Implementation
  - Development of a comprehensive case manager role description and role delineation.
  - Development of a promotion criteria reflective of the goals and objectives of the Clinical Ladder Program.
  - Development of a peer review process for the evaluation of the Clinical Ladder Program.
  - Development of a mentorship program to support the professional growth of the clinical ladder program participants.
  - Development of a training program to support the clinical ladder program participants.
  - Development of a communication plan to support the clinical ladder program participants.
  - Development of a support system to support the clinical ladder program participants.
  - Development of a case management tool to support the clinical ladder program participants.
  - Development of a case management tool to support the clinical ladder program participants.

PARTICIPANT DATA
- Clinical Ladder Survey - Leadership
  - Number of leadership members surveyed: 4
  - Number of respondents: 3
  - Question 1: Does the Clinical Ladder Program benefit the department?
    - 100% responded yes.
  - Question 2: Does the Clinical Ladder Program help with recruitment at your level?
    - 100% responded yes.
  - Question 3: Does the Clinical Ladder Program increase the retention of your staff?
    - 85% responded yes.

PROJECT GROWTH
The program has seen increased participation

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants</td>
<td>4</td>
<td>9</td>
<td>12</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>Successful</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

CONCLUSIONS
The clinical ladder program has helped augment a growing case management department in the following ways:
- Staff Retention:
  - Opportunity to provide employees with financial incentives.
  - Provides employee empowerment.
- Professional Development:
  - Increase expertise in the field of case management.
  - Encourages evidence-based practice.
- Job Satisfaction:
  - Professional development.
  - Opportunity to engage in various day to day activities.
  - Personal pride in project results.
  - Increased staff recognition.

REFERENCES
PROJECT S. I. T. D. O. W. N.
Laure Bocar, RN, ACM; Joclyn Hagen, 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 increase lengths of stay, 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 addresses these gaps in the research literature.

**PROCESS**

**RESULTS**

Patients perceived the CM/MSW as present on their bedside sooner 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 more positive interactions
- Thorough understanding of what they could expect during their hospital stay
- Participated more fully in their discharge planning.

**LESSONS LEARNED**

Sitting instead of standing at the bedside impacts:
- Patient experience
- Patient compliance
- Provider-patient rapport

You are eye level with the patient instead of “standing over” them, which makes patients feel more comfortable:
- 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.

**PRACTICE IMPLICATIONS**

All healthcare providers on a patient’s care team should consider these findings while using fewer ways of enhancing the patient care experience are being developed. Any healthcare provider has the power to have a positive effect on patient satisfaction.

**Appendix A**

<table>
<thead>
<tr>
<th></th>
<th>Standing (n = 125)</th>
<th>Sitting (n = 104)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>89 (69.0%)</td>
<td>49 (47.1%)</td>
<td>0.546</td>
</tr>
<tr>
<td>Female</td>
<td>86 (69.1%)</td>
<td>55 (52.3%)</td>
<td>0.546</td>
</tr>
<tr>
<td>Age &gt; 65</td>
<td>94 (75.3%)</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>148 (83.4%)</td>
<td>102 (98.1%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Q2. Satisfied with Staff</td>
<td>157 (85.7%)</td>
<td>102 (95.9%)</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 (E)</td>
<td>15.9 (0.2)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**References**


**The TEAM**

Laurie Bocar, RN, ACM
Cottage Health System
805-964-2115

**The CM/MSW**

<table>
<thead>
<tr>
<th>CM/MSW</th>
<th>Patient Experience</th>
<th>Compliance</th>
<th>Rapport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td>92 (73.6%)</td>
<td>95 (91.3%)</td>
<td>87 (77.8%)</td>
</tr>
<tr>
<td>Standing</td>
<td>81 (64.8%)</td>
<td>86 (80.7%)</td>
<td>80 (72.3%)</td>
</tr>
</tbody>
</table>

**Actual CM/MSW Comments**

"She didn’t rush she sat with me, yes very appropriate" "She was quite a gal, very impressive amount of time"
The Pharmacist's Role in Improving Transitions of Care in Skilled Nursing Facilities

Andrea Backes, PharmD, BCACP, Patricia Cash, PharmD, CGP, Jessica Jordan, BSc, BC-Phm, RPh

Care Transitions Pharmacist

Frederick Memorial Hospital, Frederick, Maryland

BACKGROUND

While hospitals have been diligently working to reduce their in-hospital mortality (IHM) rates, it is estimated that the Centers for Medicare & Medicaid Services will implement a similar Value-Based Reimbursement program for skilled nursing facilities within the next five years. A Medicare Payment Advisory Commission analysis showed that 25.8% of all patients who were discharged from Medicare hospitals within 30 days and 12.3% of those discharged were potentially avoidable at a cost of $158 billion. Out of all patients, 35.2% of patients had an emergency department (ED) visit or were readmitted within 30 days after discharge to a long-term care facility.

Patients transitioning from hospital to SNF face many often overlooked socioeconomic consequences and medications in the medication administration. Pharmacists are uniquely qualified to identify and manage medicines related problems as patients transition from one setting to another. This primary intervention is medication reconciliation, which is defined as the process of identifying the most accurate list of all medications that the patient is taking by comparing the medication record to an actual list of medications administered from a prior, hospital, or other source. A medication transition point, inpatient medication reconciliation increases patient's risk of hospital readmission.

While many hospitals have implemented pharmacist-driven interventions in the ED workflow to obtain prior-to-discharge medication histories and/or discharge medications, pharmacist-driven interventions in skilled nursing facilities for those discharged from hospital to SNF have been few. While SNFs have psychiatric beds for patients, there are barriers to transferring patients from hospital to SNF due to financial and social reasons. This presents a tremendous opportunity as a study identified at least one medication discrepancy in 10.8% of patients at discharge. Pharmacists can have a significant role in ensuring patients receive medication reconciliation at discharge.

OBJECTIVES

1. To verify medication reconciliation at discharge
2. To reduce the number of medication discrepancies at discharge
3. To decrease the number of SNF readmissions

METHODS

In January 2014, the Care Transitions (CT) pharmacy at Frederick Memorial Hospital began a project with three local SNFs. Pharmacists compiled high-risk patients in the hospital and followed patients from hospital to SNF and subsequently from SNF to home. Pharmacists recorded medications, recommended medication therapy changes to improve outcomes, identified necessary medications and ensured transition to a stable medication elimination along the continuum of care. The primary outcome of this project was the medication in 30-day readmission.

RESULTS & DISCUSSION

- The CT pharmacist followed approximately 100 high-risk patients through the care continuum for transitions of care.
- For high-risk patients, the pharmacist integrated the medication reconciliation into this care strategy for successful transitions.
- The pharmacist decreased the number of medication discrepancies from 24.8% to 16.9% for high-risk patients.
- The final project resulted in a 2.3% decrease in readmissions for all patients.
- The project resulted in a 2.3% decrease in readmissions for all patients.
- The pharmacist identified medication discrepancies and intervention recommendations along the way.
- The CT pharmacist is utilizing this experience to help improve the discharge plan for further reduction.

CONCLUSION

Our pharmacist-driven project identified opportunities to improve medication management in patients transferred from hospital to SNF and subsequently from SNF to home. Two opportunities include ensuring a patient-friendly discharge medication list and utilizing a drug discharge education to ensure a safe transition.

REFERENCES

2. Backes, A. 2016. The Role of the Pharmacist in the Care Transition Setup. JCAHOP. AACP. Harrisburg, PA.
3. Backes, A. 2016. The Role of the Pharmacist in the Care Transition Setup. JCAHOP. AACP. Harrisburg, PA.
5. Backes, A. 2016. The Role of the Pharmacist in the Care Transition Setup. JCAHOP. AACP. Harrisburg, PA.

ACKNOWLEDGEMENTS

The authors thank the staff and residents of Halls, MBA, BSN, KCM, Joelle Clement, RN, EdM, SRN, and the rest of the Care Transitions team for their guidance and support throughout this project. We also thank the staff at Frederick Memorial Hospital for their openness to collaboration with our Care Transitions team.

DISCLOSURES

The authors have nothing to disclose.