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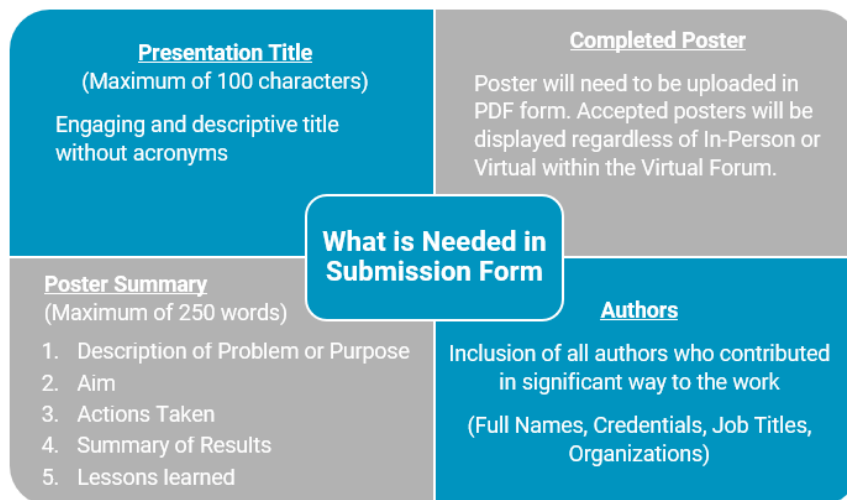
Overview of IHI Forum Poster Displays

Poster displays at the IHI Forum and Scientific Symposium chronicle specific improvement projects. They are an integral part of the conference, providing an opportunity for organizations to share their improvement strategies and celebrate their successes with other attendees. Posters should not advertise products or services.

Exhibit booths for the In-Person conference are available for those who would like to generate interest and leads for their products or services. For more information on exhibit space, please contact our exhibit booth sales manager, Sara Kolovitz at SmithBucklin Corporation at (312) 673-4779 or skolovitz@ihi.org.

Submitting your Final Poster and Supporting Information through IHI.org

You are required to enter in the following information:



Please note: we ask you submit only for yourself and not for colleagues

Important Notes

- **Posters submitted for the Virtual Forum are on display in a virtual library and are not orally presented.**
- You are required to upload your final poster as a PDF file.
- Please ensure that all of the information you submit is complete and final as you will not have the opportunity to edit your information.
- You will receive an automatic email from our system confirming that your information was uploaded successfully. If you do not receive an email from our webmaster account, please contact posters@ihi.org confirm that your poster was uploaded successfully.

You will receive further information from Lauren Cameron, IHI's Event Manager, at a later date.

Tips for Creating a Poster on Quality Improvement in Health Care

Improvement Advisors at the Institute for Healthcare Improvement developed the following recommendations for creating posters that demonstrate quality improvement projects in health care. Your submission should include the following:

Aim Statement - Clearly defined (what measurable change was expected over what period of time)

Change Explanation - What was made to achieve improvement in the process/outcome

Graphical Representation of Improvement - The use of annotated run charts or Shewhart (control) charts is preferred to demonstrate the performance of data over time. Tables, bar and pie charts can supplement run charts but should not be used alone in describing improvement over time.

Lessons Learned - A short summary from the work and/or the message for readers

Multiple Measures – How they were used to understand and show improvement in the target process

Multi-disciplinary Team – Who was involved in achieving improvement (elements may include: content experts, patients, leadership, etc.)

Outline - Project design/strategy for change that explains how you planned to reach your Aim, and the team that was involved in achieving improvement

Sustainability – Evidence for sustainability in improvement, or a scale up or sustainability plan.

Tested Changes - An indication that changes were tested and/or adapted to the local environment/organization prior to implementation.

Please note: these are recommendations and not requirements for submission. Posters without one or more of these elements will also be considered.

Layout

Aim to create an attractive display that will draw Forum participants to your poster and communicate clearly the main points of your display. The following guidelines may be found helpful:

Appearance

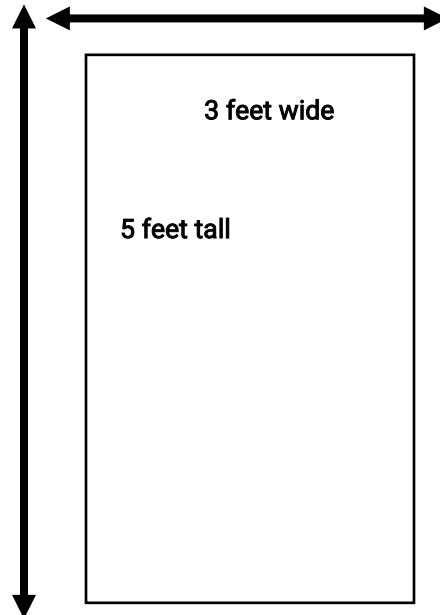
Creative use of pictures, graphs, text blocks, color, headlines, etc., can attract others to your poster, prompt conversation, and enhance communication of your message. Avoid making your poster too “text heavy.” Focus on the highlights of your display. If it can be communicated with numbers, graphs, or other visuals do so.

Virtual Forum

All content on the poster must fit on one page. There is no specific layout or size needed. The electronic posters will be made available during and after the IHI Forum. The maximum file size of the poster is 10MB.

In-Person Forum

Posters will be mounted on 3 foot x 5 foot panel boards. The usable posting space is the full 3 feet wide x 5 feet high.



Handouts (In-Person Forum)

Due to space restrictions, distributing handouts at the poster display is not recommended. If you have brochures, documents, or other information you think would be helpful to those interested in your quality improvement project, we suggest that you collect business cards from those who want further information in order to send it to them after the conference. You may attach a manila envelope for attendees to drop their business cards in, or attach an envelope filled with a supply of your handouts to your board. Unfortunately, there is not sufficient space to supply tables for the posters.

Shipping (In-Person Forum)

We strongly recommend that presenters hand-carry their printed posters to the conference to minimize the risk that a board could be lost or damaged during shipping. If you need to ship your poster, all cartons should be labeled with your name and return address. If you are not staying at the Orlando World Center Marriott, please ship your poster to the hotel you are staying at for the week. If you are staying at the Orlando World Center Marriott, you can pick up your board from the Shipping and Receiving area at the hotel. **IHI will not be responsible for receiving, delivering, or storing any posters.**

Orlando World Center Marriott Resort & Convention Center
8701 World Center Drive Orlando, Florida, USA 32821
Attn: **Your Name** (Poster Presenter at the IHI Forum)

Set-up, Staffing, and Breakdown (In-Person Forum)

The 2022 Poster Display is located in the Exhibit Hall in Cypress.

Poster Set-up:

Monday, December 05 from 12:00 PM – 4:00 PM

Tuesday, December 06 from 7:00 AM – 8:00 AM

The hook side of Velcro is the only material that will adhere to the display board. IHI will provide each poster presenter with 1 strip of Velcro or T-pins for cloth posters.

Poster Display:

Tuesday, December 06 from 8:00 AM – 4:30 PM

Poster representative presence is not required.

Poster Reception:

Tuesday, December 06 from 4:30 PM – 6:30 PM

Plan to be at your poster to answer questions and discuss your project with attendees.

Poster Breakdown:

Wednesday, December 07 from 7:00 AM – 1:00 PM

Please remove your poster by 1:00 PM. All posters left after 1:00 PM will be discarded.

Conference Registration

In-Person Forum

All in-person poster presenters must register for the IHI Forum General Conference, December 6-7, 2022.

Virtual Forum

All virtual poster presenters are invited to register for the IHI Virtual Forum. As the virtual posters are solely on display in a virtual library and are not orally presented, attendance is not required.

Group Discounts: Groups of five or more individuals from the same organization or system are eligible to receive a 15% discount off the per-person regular rate at the Virtual Forum or In-Person general conference. Please be sure that all individuals within the same Group using the Group Rate have the same organization listed along with the same group leader's name and email address.

For more information regarding group discounts, please [visit our fees page](#).

For more ideas about poster formats go here:

[To Save The Science Poster, Researchers Want To Kill It And Start Over Inside Higher Ed #betterposter](#)

[Virtual Storyboard Online Submission Link](#)

Poster Examples

A few poster examples have been included below.

Chasing Sepsis: Early Recognition and Treatment of Sepsis Outside of Critical Care

Andre Vovan, MD – Director of Critical Care Medicine
Deborah Lepman, RN, MPH, CEN – Director, CCU/CVICU/Sub-ICU
Robin Myran, RN, BSN, PCCN – Sepsis Coordinator

Background
Hoag Hospital has had a sepsis team in place since the first treatment guidelines were published in 2004. The initial implementation efforts focused on early recognition in the emergency department, and prompt transfer of patients to the intensive care unit to receive early goal-directed therapy (EGDT) that was consistent with Surviving Sepsis Campaign (SSC) guidelines. By doing this Hoag was able to reduce the mortality rate from 40% to 28% over 3 years. After recognizing that the mortality rate had plateaued and bundle compliance had decreased, efforts were focused on earlier recognition and treatment in the non-ICU setting.

Project Aim
Patients presenting to the emergency department (ED) with SIRS criteria rather than severe sepsis or septic shock and those with evolving sepsis outside of critical care were not readily identified for protocol initiation. A sepsis and septic team set forth to revise the current sepsis orders and create a clear and concise protocol that could be implemented hospital-wide in order to improve quality and standardize the treatment for sepsis, severe sepsis, and septic shock.

Project Design/Strategy
An interdisciplinary committee was formed consisting of executive leadership, emergency medicine physicians, intensivists, hospitalists, neurologists, attending and consulting physicians, nursing leadership and nursing staff, and representatives from performance improvement, information technology, pharmacy and the laboratory. This committee met biweekly for planning, protocol development, and outcomes evaluation.

Changes Made
To increase recognition, a sepsis screening tool was developed. A revised protocol incorporating the bundle recommendations from the SSC as top priorities. Specific markers, such as complete blood count with manual differential, lactate level, and procalcitonin level were incorporated to more accurately determine the presence of sepsis and prevent unnecessary tests and therapies. Criteria were established to better support designation of ongoing patient care into three levels of sepsis care: Critical Care, Sub-ICU, and Medical/Surgical/Intensivists units with separate orders sets for each level. Expansion of the Rapid Response Team (RRT) to include a dedicated Sepsis RN available to respond to any "Code Sepsis" called throughout the hospital was integral for initial management and protocol implementation. A final component was the Sepsis Clock, which helped facilitate documentation and tracking of bundle elements.

Outcomes
Mortality - All Sepsis Cases

Next Steps
In 2013, senior leadership identified sepsis as a top organizational priority to address the significant increase in the volume of cases as well as the high cost per case. This along with the recently published new guidelines from the SSC created the perfect opportunity to re-evaluate and reinvigorate the sepsis program once again. After 10 years by the interdisciplinary team have included development and implementation of a simplified Sepsis Early Detection Algorithm that we customized to our institution, updated order sets, and real-time alerts extraction from the EMR regarding compliance with the SSC bundle elements. This electronic surveillance system provides a weekly dashboard to the sepsis coordinator and key stakeholders so that improvement opportunities can be addressed in a timely manner. Data gathered since the launch of the new algorithm initially has shown an increase in protocol utilization and bundle compliance as well as an additional decrease in mortality.

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Dementia and Responsive Behaviours (D&RB) Capacity-Building in the Acute Care Setting



Jeanine Loeblein DSc, PhD, MEd, CML, CMP (Thrust); Sreeja Sivankutty RN, BSc, MScN; Victoria Zeflik RN, BScN, MPH; Nakita Goody RN, BSc, MEd, MScN (Adult); Laysa Shabat RN, BSc, MScN; Ingilo Carlin RN (Ont); Rhonda Soane BSW - Gerontology; Tracy Wong, JASc

Description

The Behaviour Supports Ontario – Dementia Observation System (BSO-DOS®) is a paper tool used by clinicians that provides objective and measurable data about persons living with dementia, facilitating the development of accurate behaviour support plans. In March 2021, through partnership with the BSO, Humber River Hospital became the first acute care hospital in Ontario to launch an electronic BSO-DOS® (eBSO-DOS®) into its Electronic Health Record. As seniors with dementia in Canada experience a 65% higher hospitalization rate, twice as long hospital stay, and higher incidence of hospital harm than seniors without dementia, initiatives to improve outcomes in this population are essential.

Aim

The eBSO-DOS® was implemented to increase staff competence, reduce restraint use, and facilitate home/community discharges.

Actions Taken

Through collaboration with stakeholders, a 12-week D&RB capacity-building pilot took place on a geriatric inpatient unit. This consisted of weekly education sessions that focused on responsive/expressive behaviour assessment and management. As the eBSO-DOS® was introduced during week 3, staff became familiar with D&RB concepts prior to using the tool.

Summary of Results

Survey results revealed 69% of staff felt the education sessions increased their knowledge related to assessing and managing responsive/expressive behaviours by a lot or a great deal. Next steps involve implementation of the D&RB capacity building initiative to other medicine units, training all nurses on the eBSO-DOS®, and monitoring compliance.

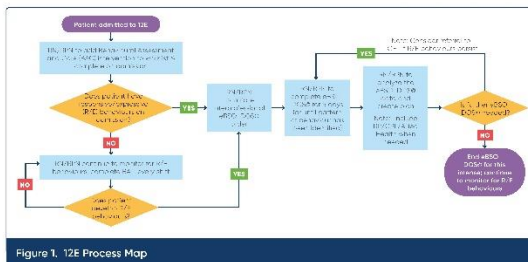


Figure 1. 12E Process Map

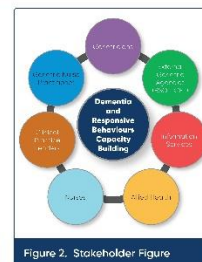


Figure 2. Stakeholder Figure

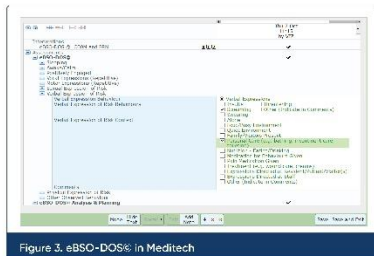


Figure 3. eBSO-DOS in Meditech

Survey Question	Answered: "A great deal" + "A lot"		% Change
	Pre-Pilot	Post-Pilot	
I feel confident in my ability to assess and manage responsive/expressive behaviours in my patients.	24%	28%	7% increase
I feel confident in my ability to assess and manage responsive/expressive behaviours in my patients.	24%	22%	8% increase
I feel confident in my ability to assess and manage responsive/expressive behaviours in my patients.	24%	24%	0% increase
I feel confident in my ability to assess and manage responsive/expressive behaviours in my patients.	24%	24%	0% increase
I feel confident in my ability to assess and manage responsive/expressive behaviours in my patients.	24%	24%	0% increase

Table 1. Pre-Pilot and Post-Pilot Survey Results

Aligning ICD Shock Status with Patient Goals of Care in a Diverse Safety-Net Hospital Population

UTSouthwestern Medical Center | Parkland

Brendan Garrett, BS; Christine Chen, BA; Arlen Suarez, BA; Mark Bertacher, MD; Carol Abousaab, MD; Rohit Badia, BS; Patricia Griffith, MBA; Kelley Newcomer, MD; Simon Lee, PhD; Colby Ayers, MSS; Kristin Alvarez, PharmD; Melanie S. Sulisto, MD

Introduction & Background

- Guidelines recommend implantable cardioverter defibrillators (ICDs) for prevention of sudden cardiac death,¹ with >700,000 ICDs placed annually
- Most patients still have poor understanding of ICD purpose and settings, which precludes informed decisions and goals of care²
- Informed decision-making is critical at the end-of-life, when up to 1/3 of patients receive ICD shocks³
- Vulnerable or diverse patient populations are not well represented in major ICD trials and analyses, even though race, gender, and ethnicity associate with different care preferences at end-of-life⁴

Aim

Ensure 100% of patients referred to Palliative Care with implantable cardioverter defibrillators (ICDs) have alignment between the shocking function of their device and their goals of care by Dec 30, 2021.

We are using the DMAIC methodology

1. Define

Setting: Dallas County's Parkland Health & Hospital System (PHHS), which serves as safety-net for county residents

Figure 1: demographics of surveyed patient population (n=28)

Figure 2: Patient recruitment strategy

Position Care Registry: Outpatient or inpatient palliative care consult within the last 18 months OR Future outpatient appointment in palliative care in the next 12 months. Only patients with an ICD included.

Demographic strat review of patients palliative ICD consult (n=12)

Survey Patient? (n=26)

Reasons for exclusion:

Deceased	46
Unable to contact	33
Deceased	8
Other	2
Total Excluded	87

2. Measure

Percent of Patients Answering Correctly for ICD Knowledge Scores

Question	Thylen, et al (n = 108)	Current study (n = 26)
In order to turn off the defibrillating shocks in an ICD, the ICD must be removed by surgery	74%	31%
When an ICD's defibrillating shocks are turned off, the heart stops beating	88%	54%
The ICD's defibrillating shocks can be turned off using a device outside the body (a programmer)	88%	54%
When the ICD's defibrillating shocks are turned off, the pacemaker function in the ICD is also turned off	52%	19%

Figure 3: Percentage of respondents answering correctly is shown and compared to respondents from Thylen, et al.⁶ Interviews were conducted via phone calls.

3. Analyze

An expert committee with representatives from General Cardiology, Electrophysiology, Heart Failure Clinic, and Palliative care was convened to analyze our measurements.

Figure 4: Fishbone Diagram

Figure 5: 5 Why's exercise

Problem: Patients want to keep ICD shocks on even if misaligned with GOC

- Why #1: Control the delivery of ICD shocks will stop them
- Why #2: Message that ICD shock is kept alive is responsible for person's call
- Why #3: Confusion about difference between ICD and external device like the heart rate (HR) and personal function
- Why #4: Patients receive the message that their shock will stop automatic pacing
- Why #5: Inadequate patient being, message ability of people engaged about ICD function and operation

4. Improve

The expert committee decided to focus on patient education by creating an informational video. We are conducting a pilot with 14 patients to see if the video is effective at increasing knowledge.

Figure 6: Process Map for initial pilot including 14 patients

5. Control/Next Steps

- Meet with cardiology, palliative care to determine how the video fits into their workflow; train on how to share video
- Pilot implementation of video in cardiology, palliative care and collect data on video usage
- Define efficient process to manage when a patient desires to turn off ICD shocks
- Monitor video use in various departments, ICD status as it relates to patient goals of care

Conclusions/Lessons Learned

- Majority of patients are unaware of critical information related to deactivating shocks
- Knowledge deficits were worse than those in previously described studies, suggesting inadequate education especially for under/un-insured and minority patient populations
- Empowering patients with knowledge about ICDs is critical and will require novel process implementation
- Involving key stakeholders early allowed for increased buy-in from all parties. This contributed greatly to the project's success thus far.

Acknowledgements:

Special thanks to Dr. Nimesh Patel, Dr. Aljesh Amin, Mrs. Megan Kelly, Dr. Elizabeth Paulk, Ms. Kristin Alvarez, Mr. Damon Begley, Dr. Gary Reed, Parkland Health and Hospital System, The Parkland Center for Clinical Innovation, and the UTSW Quality, Safety, and Outcomes Education department for their contributions to this project

References:

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