ARE YOU PONDERING A POSTER?

INFORMATION AND TIPS FOR POTENTIAL POSTER PRESENTERS

2017-2018
AGENDA

- Introductions
- About the poster session
- Tips for submitters
- Application & Deadlines
- Sample Poster & Templates
2017/2018 POSTER SESSION COMMITTEE

- **Committee Chair:** Stacy Wright
- **Board Liaison:** Beverly Wagner
- **Staff Liaison:** Rachel Allen

- **Committee Members:**
  - Jackie Dinterman
  - Karen Smith
  - Caroline Segovia-Marquez
  - Jackie Moore
  - Susan Culbreath
  - Jamiee Lowman
  - Bonnie Schuster
  - Sarah Bradshaw
  - Amal Elanouari
  - Theresa Horowitz
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

- Wait
  - Wait for a determination letter

- Plan
  - Plan the poster and handouts

- Come
  - Come to Houston, April 24-26
POSTER PRESENTER QUALIFICATIONS

- Employee of hospital or healthcare system (no vendors)
- Presenter names must be on 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 CM
- 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 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?

- All 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
  - Positive improvement
  - Compelling negative finding

- 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Can I bring branded materials from my institution?</td>
<td>Yes, as long as materials are from a hospital and/or healthcare system (no vendors). Keep in mind only a bulletin board will be provided (no tables)</td>
</tr>
<tr>
<td>Can I use audiovisual equipment?</td>
<td>No</td>
</tr>
<tr>
<td>How big should my poster be? May I have a cloth poster?</td>
<td>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.</td>
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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 March 10, 2018 to be considered for judging**
- 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?

- Poster
- ACMA to provide bulletin board and push pins
HOW ARE POSTERS JUDGED?

- Committee members visit posters during display time

- Presenter gets 3-5 minutes to provide brief executive summary to judges

- Executive summary to include:
  - A summary of the poster’s main conclusions and justification for recommendations
  - An explanation of the problem/improvement studied
  - 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 & 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
The ACMA website: www.acmaweb.org/posters

Applications due by **October 20, 2017**

Important Dates & Deadlines
- October 20, 2017: Call for Poster Presentation Deadline
- TBD, 2018: National Conference Early Registration Deadline
- March 9, 2018: Poster Handout Submission Deadline
- April 24, 2018: Poster Set-up in designated location – Time TBD
- April 24–26, 2018: Poster Presentations – Time TBD
- April 26, 2018: Poster Tear-down – Time TBD
WANT TO KNOW MORE?

- www.acmaweb.org/posters
- Poster Session Section
  - Application
  - Poster Session Toolkit
    - Presentation Guidelines
    - Important Dates & Deadlines
    - Tips
    - Frequently Asked Questions
  - Sample Posters
Successfully Aging In Place: Planning Rather Than Reacting to Life’s Crises
Anne Selitzer, MSW, LSW; Vanessa Ramirez-Zohfeld, MPH; Lee A. Lindquist, MD, MPH, MBA
Northwestern University Feinberg School of Medicine, Division of General Internal Medicine & Geriatrics, Chicago, IL

Introduction/Purpose
- Seniors wish to age-in-place in their homes but often do not understand their health trajectory or future needs.
- Subsequently, when a health crisis occurs (e.g. hospitalization, fall, Alzheimer’s), family and friends must react to the emergency.
- One of the most frightening things we repeatedly see is that seniors become hospitalized or decline, and family members must scramble to find help or choose a rehabilitation place after the hospitalization.
- Instead of reacting to emergencies, we sought to provide a means for seniors, their loved ones to plan for them.
- “Different than end-of-life, ‘Lifespan Planning’ or ‘4th Quarter Planning’ helps seniors and their families plan for the 5-20 years before death (e.g. 70’s, 80’s, 90’s), when seniors may become more disabled and require more assistance.

Project Summary
- PlanYourLifespan.org is an online tool, created through a community-research partnership between social workers, seniors, nurse, area agencies on aging, communication experts, geriatricians, and researchers.
- The content provides education on home support options following health crises (e.g. hospitalizations, falls, dementia), connects seniors to local resources, and facilitates sharing the seniors’ plans to family members around.
- PlanYourLifespan.org features videos of seniors presenting their real-life experiences, the decisions that they had to make, and offer advice they wish they had to other seniors and their families, while social workers discuss a variety of resources available.
- Users can make personalized choices and print/email their choices to family members in case a health crisis occurs.
- PlanYourLifespan.org is nationally available and free-to-use.

Methods
- Multi-site, two-armed randomized controlled trial of PlanYourLifespan vs. an attention control arm in rural, urban settings in Chicago, IL; Fort Wayne, IN; & Houston, TX.
- Participants were English-speaking individuals 65 years and older who currently live independently in the community.

Data/Results
- Table 1. Participant Demographics (N=385)

<table>
<thead>
<tr>
<th>Treatment Arm</th>
<th>Mean Age (SD)</th>
<th>% Female</th>
<th>% Married</th>
<th>% Widowed</th>
<th>% Unmarried/unpartnered</th>
<th>% College Graduate</th>
<th>% Household Income ≤$30,000</th>
<th>% ≤$40,000</th>
<th>% ≤$50,000</th>
<th>% ≤$60,000</th>
<th>% ≤$70,000</th>
<th>% ≤$80,000</th>
<th>% ≤$90,000</th>
<th>% ≤$100,000</th>
<th>% ≤$100,000</th>
<th>% ≤$100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Arm</td>
<td>72.9 (10.1)</td>
<td>57.4</td>
<td>62.2</td>
<td>83.8</td>
<td>5.5</td>
<td>18.0</td>
<td>88.0</td>
<td>91.6</td>
<td>94.0</td>
<td>95.3</td>
<td>96.0</td>
<td>95.3</td>
<td>90.0</td>
<td>94.0</td>
<td>95.3</td>
<td>96.0</td>
</tr>
</tbody>
</table>

Conclusions/Implications
- PlanYourLifespan.org is a revolutionary means of helping seniors and their families plan for the crisis (hospitalization, falls, Alzheimer’s disease).
- Seniors enrolled in the Randomized Controlled Trial found significant benefit from using the website.
- PlanYourLifespan.org connects seniors and their families to local and national resources for home and facility-based services.
- Case Managers can implement Lifespan planning as a means of helping seniors age in place and plan their future.

Dissemination/Outcomes
- PlanYourLifespan.org is currently being disseminated nationally and can be accessed free of charge.
- If you are interested in materials to disseminate to your group or speakers on the project, feel free to contact planyourlifespan@northwestern.edu.
- PlanYourLifespan.org is revolutionary in helping seniors plan for their future and have their voices heard during health crises.

Acknowledgments
- Study participants and stakeholders:
- Funding: Patient Centered Outcomes Research Institute

Data/Results
- Figure 3. Selected Quotes, 1 year post-PYL intervention

- It’s a great website and I thought it was initially, but now that I’ve had some of these experiences I think it became my arm. I think it has become even more important.
- The website opens your eyes to some of the things you could do with... PlanYourLifespan.org helps me identify what I need in the future... This isn’t an easy thing to think about but I’ll have peace of mind once I have more concrete plans in place.
Improving Accuracy of Discharge Predictions: Engaging the Patient and Team in a Medical Readiness Transition Pathway

"Discharge When"

**Background**
- **UPMC Mercy hospital had 20% of all discharges that were Surprise Discharge** (Patient & Team not aware of discharge 24 hours in advance) from October 2014 to December 2014.
- Communication failures were 76% of the cause for Surprise Discharges.
- Lack of communication causes rushed discharges which lead to an unprepared patient and team. This negatively impacts the patient experience.

**12T Average Surprise Discharges (Surprises over Discharges) = 27.3%**
- **Smart Aim:** Decrease Surprise Discharge on 12T by 10%
  - 27.3% to 24.8% by June 2015
  - Surpassed Smart Aim June 2015 = 16.1%

**Global Aim:** Improve overall discharge prediction accuracy throughout the hospital by improving communication.
- Team planning with the patient for transition date 24 hours in advance.

**Methods**

**Phase One**
- Raised awareness of Surprise Discharges: April 2014
- Discharge prediction accuracy sent to CM daily
- Monthly staff meetings, team meetings & UM Committee meetings to report performance opportunities
- Script CM to request transition date
- Bucket & trend reasons for the Surprise Discharges
- Revision of morning huddle with CM to lead huddle & enter discharges in tele-tracking: Feb 2015
- Tele-tracking Education of frontline staff on entering data off shift

**Phase Two**
- Team developed "Discharge When" (Medical Readiness White Board Transition Pathway) for 12T Pilot (CHF, PNA, COPD & Genetic): March 2015
- CM enter cardiopulmonary teaching as a nursing measure
- Pilot Transition Pathways with Hospitalist Group GM6 on 12T
- Team updates patient daily on medical readiness & anticipated discharge date using whiteboard transition pathway
- Patient Experience Interviews
- Designate 1 patient 24hrs post discharge - troubleshoot
- Shared Surprise Discharge data with team & department monthly
- Process Replication of pilot with GM7 on 10T: May 2015
- Process Replication of pilot with GM5 & GM6 on 10T & 12T: Jul 2015

**“Discharge When” Outcomes**

**12T April-June 2015**
- **Patient experience:** 79% patients report pathway helpful
- **Surprise Discharges:** Not-pilot = 18.1% Pilot = 3.7%
- **Readmission Rate of Surprise Discharges:**
  - Not-pilot = 30%
  - Pilot = 14.3%

**10T May-July 2015**
- **Patient experience:** 73% patients report pathway helpful
- **Surprise Discharges:** Not-pilot = 16.3%
- **Readmission Rate of Surprise Discharges:**
  - Not-pilot = 6.3%
  - Pilot = 9%

*Cardiopulmonary Consults on pilot floors increased from 16 in March to 43 in June.*

**Overall Outcomes**

- **12T Discharge When Discharge Rate:**
  - GM6: 88.1%
  - GM7: 86.4%
- **10T Discharge When Discharge Rate:**
  - GM5: 94.7%
  - GM6: 96.1%
- **10T Discharge When Discharge Rate:**
  - GM7: 92.4%

**Next Steps**
- **Continue Discharge When Discharge Partner**
- **Follow-up:** Discharge When to 12T Feb 2015
- **Outcome Roll-out of Discharge When Hospital-wide**
- **Team bird's eye view of Discharge When:**
  - GM6: 96.1%
  - GM7: 92.3%
- **Other departments: GM2 & GM3**
  - GM2: 94.7%
  - GM3: 96.1%
  - GM2 & GM3 have initial goal of 90%
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 addresses these gaps in the research literature.

APPENDIX A

<table>
<thead>
<tr>
<th>Appendix A</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>
</tbody>
</table>

The TEAM

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].

References
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-embalmed, 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 intensive 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 RN-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 sites, 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 Laski and Insulin Protocols to reduce unnecessary ED visits and admissions
  - Leveraging the EMR for communication with the healthcare team

Vision and Goals for SMG RN Care Management

- VISION
  - Improve healthcare for patients within our current healthcare model

- IMPROVEMENTS
  - Improve Critical Outcomes
  - Improve Quality of Care
  - Increase Facilitated Advanced Care Planning
  - Increase 7-day Follow-up with PCP
  - Reduce Rehospitalizations
  - Reduce readmissions
  - Reduce Total Cost of Care (Optima)
  - Provide Care Coordination Across the Continuum

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
The Pharmacist’s Role in Improving Transitions of Care in Skilled Nursing Facilities
Andrea Backes, PharmD, BCACP, Patricia Cash, PharmD, CGP, Jessica Jordan, Bsc, BScPhm, RPh
Care Transitions Pharmacists
Frederick Memorial Hospital, Frederick, Maryland

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% of these readmissions were potentially avoidable at a cost of $53.39 billion. To et al. found that 22.3% of patients had an emergency department (ED) visit or were readmitted within 30 days upon discharge from SNF to home.1

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 identifying the most accurate list of 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.2 At each transition point, inaccurate medication reconciliation increases patients’ risk of hospital readmission.3

While many hospitals have incorporated pharmacy technicians in the ED workflow to obtain prior- to-admission medication histories and/or de-identified their inpatient pharmacists to counsel 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 that at least one medication discrepancy in 18.8% of SNF admissions. In addition, To et al. found that 100% of SNF pts were discharged home with more medications than their prior admission to hospital.1

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 recorded 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 230 high-risk patients through the care continuum for 4 months.
  • For SNF #1, the RA rate decreased from 22.1% to 13.1% during that time period. For SNF #2, the RA rate decreased from 20.9% to 15.6% for SNF #3, the RA rate decreased from 23.2% to 3.5%
  • In FY 2013, the overall RA rate was 28.9%. In FY 2014, the RA rate decreased to 15.39%.
• 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 for 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 being provided.
• Instructions on bubble packs & unit dose were difficult and incomplete.
• Discontinued meds were not listed.
• Therapeutic interchanges left in inaccuracies in medication reconciliation.
• Access to meals (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 threats literacy, social support, and ability to teach-back medication names, doses, and frequencies to ensure a safe transition into the community.

CONCLUSION

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 comprehensive medication list and utilizing a SNF discharge checklist to ensure a safe transition.

REFERENCES

ACKNOWLEDGEMENTS

The authors wish to thank Heather Erby, MBA, LSPhK, ACM, Jackie Ginterman, RPh, MA, LSPhK, 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.