Table of Contents

Overview of IHI Forum Poster Displays

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

Submitting your Final Poster and Supporting Information through IHI.org

You are required to enter in the following information:

- Poster Title (15 or less words)
- Description (100 or less words)
- Aim (15 or less words)
- Actions Taken (50 or less words)
- Summary of Results (50 or less words)

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

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 storyboards@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:

1. A clearly defined Aim Statement with an expected change in outcome indicator and time to expected change in the outcome indicator.
2. An outline of your project design/strategy for change that explains how you will reach your aim.
3. An explanation of the changes made to achieve improvement in the targeted process.
4. Graphical representation of improvement. The use of statistical process control (SPC) tools (especially annotated run charts or Shewhart control charts) is preferred to demonstrate the performance of data over time. Bar and pie charts should not be used when building a poster for Quality Improvement projects.
5. An indication that changes were tested and/or adapted to the local environment/organization prior to implementation.
6. An explanation of how multiple measures were used to understand and show improvement in the target process.
7. A listing of the multi-disciplinary team that was involved in achieving improvement (elements may include: content experts, patients, leadership, etc.)
8. A demonstrated sustainability in improvement indicated by the data (if possible).
9. A short summary of the lessons learned from the work and/or the message for readers.

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

Layout

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. 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.

Conference Registration

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.

Virtual Conference Fee: $750

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.

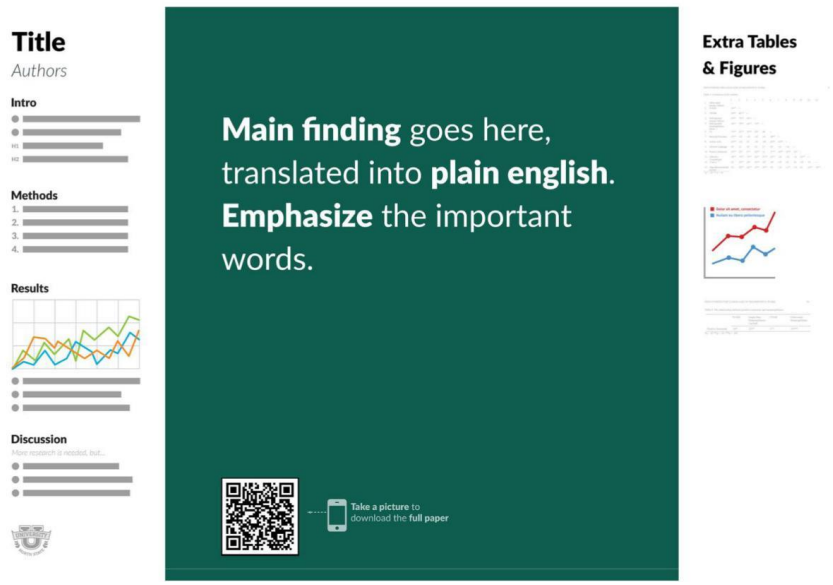
Poster Examples

A few poster examples have been included below.

For more ideas about poster formats go here:
https://www.npr.org/sections/health-shots/2019/06/11/729314248/to-save-the-science-poster-researchers-want-to-kill-it-and-start-over

https://www.insidehighered.com/news/2019/06/24/theres-movement-better-scientific-posters-are-they-really-better

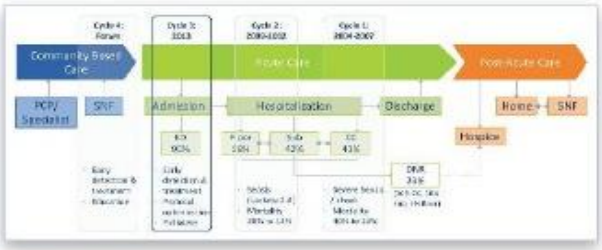
Virtual Poster Online Submission Link
https://conferences.ihi.org/eSites/605964/Login



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 revitalized sepsis 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.

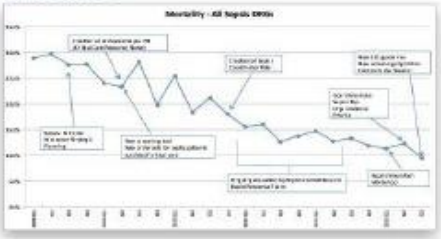
Project Design/Strategy

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

Changes Made

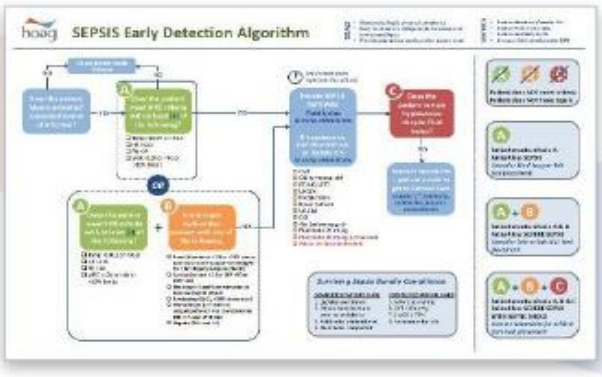
To increase recognition, a sepsis screening tool was developed. A revised protocol incorporating the bundle recommendations from the SSC set fluid challenges and delivery of antibiotics as top priorities. Specific markers, such as complete blood count with manual differential, lactate level, and procalcitonin 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/Telemetry 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



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 offered the perfect opportunity to re-educate and reinvigorate the sepsis program once again. Efforts this year 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 nearly real-time data 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 in July has shown an increase in protocol utilization and bundle compliance as well as an additional decrease in mortality.



HOAG MEMORIAL HOSPITAL PRESBYTERIAN