JMCP

Poster Presentation Resources

JMCP

Poster Orientation

The purpose of this module is to (1) introduce posters as a format to present research findings and to (2) give tips on avoiding common pitfalls.

Poster Presentations 101

- Summary of a research project
- May be a pilot or preliminary study
- Generally precedes a full paper
- Opportunity to solicit early feedback
- Abstract published in a journal supplement – citable

Poster Content

Structure and Implementation Environment of Performance-based Pharmacy Payment Models

UNC Eshelman School of Pharmacy, Center for Medication Optimization

Chloe Richard, MS[1], Ben Urick, PharmD, PhD[1], Shweta Pathak, MPH, PhD[1], John Jackson, BPharm, MPH[2], Melanie Livet, PhD[1]

[1]UNC Eshelman School of Pharmacy, Chapel Hill, NC

[2]Monash University, Australia

Monash University

BACKGROUND

- There has been a shift in the United States (US) towards value-based health care models which seek to improve patient outcomes while reducing health care spending.[1,2]
- Many payers have started to use performance-based pharmacy payment models (PBPPMs) (e.g., IEHP[3]).
- There is growing opportunity for community pharmacists to engage with these models.
- PBPPMs incentivize pharmacists to improve patient care by tying reimbursement to performance measures.[4,5]
- The design and implementation of PBPPMs is not well understood and needs to be further described to facilitate their uptake.

OBJECTIVES

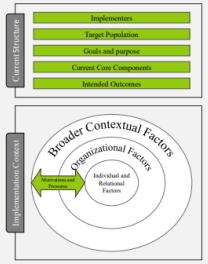
Aim 1: Describe the current structure of PBPPMs in the US.

Aim 2: Identify the contextual and motivational influences that need to be considered when implementing these models.

METHODS

- Figure 1 outlines the study roadmap which was informed by implementation science thinking.
- A literature search of peer-reviewed and gray literature on value-based care, pay-for-performance, and performance-based models in pharmacy settings was conducted.
- 17 semi-structured stakeholder interviews were conducted with community pharmacists, payers, quality measure developers and vendors, academics, and pharmacy advocacy organization leaders.

Figure 1. Study Roadmap



RESULTS

- PBPPMs are implemented in different contexts (e.g., independent pharmacies, chain pharmacies), by a variety of entities (e.g., pharmacists health plans), and are utilized with Medicare, Medicaid, and commercial populations.
- The ***primary goals of these models*** are to decrease total cost of care and improve patient care.
- Results highlighted ***four major components of PBPPMs*** as well as key considerations surrounding these components (**Table 1**).
- Key implementation influences surrounding PBPPMs were also captured (**Table 2**).

Table 1. Components of PBPPMs

Component	Key Considerations
Attribution	• Attributing patients to pharmacies • Delineating impact of one provider vs. another
Performance and Quality Measures	• Lack of measure alignment • Current emphasis on process as opposed to outcomes measures • Use of inapplicable measures for pharmacy/pharmacists
Incentive Structure	• Lack of transparency • Often focused on penalties over rewards • No recognition for improvement towards goal • Incentives applied at pharmacy level, not pharmacist or patient • Mismatch between incentives and patient care goals
Patient Care Services	• Lack of patient receptivity • Payer resistance to fee-for-service payments • Regulatory barriers to expanded scope of practice

Table 2. Implementation Considerations of PBPPMs

Key Influences	Key Implementation Considerations
Individual and Relational Factors	• Multiple stakeholders with conflicting viewpoints • Unrealistic expectations for pharmacies • Maintaining buy-in and engagement of pharmacists and patients
Organizational Factors • Culture • Information Technology • Workflow Operations • Training	• Culture of engagement, flexibility, and innovation • Size and type of pharmacy • Ability to share performance and quality metrics • Shift in workflow operations to provide patient care • Training on measures, incentives, platforms, and interventions
Broader Contextual Factors	• Healthcare business culture focused on incentivizing quality-related patient care services • Embracing shift from dispensing activities to provision of patient care
Motivations and Pressures	• Desire to practice at top of license • Professional satisfaction when seeing results of patient care provided • Lack of individual financial rewards • Pressure to provide additional patient care

CONCLUSIONS

- In summary, to enable uptake of PBPPMs it is first essential to understand their current design and implementation.
- These results suggest four major components of PBPPMs in the US: (1) attribution, (2) performance and quality measures, (3) incentive structures, and (4) patient care services.
- Critical implementation considerations surrounding these models were organized into individual and relational factors, organizational factors, broader contextual factors, and other motivations and pressures.
- Recommendations to improve the design of PBPPMs and facilitate their uptake include improved transparency and alignment of measure with incentive structure; embracing innovative business models, utilization of implementation roadmaps, and fostering a culture of quality.
- Future work should focus on commonalities and differences in perspectives across stakeholder groups and investigate effectiveness of these models on financial and patient care outcomes.

REFERENCES

1. Hillary W, Justin G, Bharat M, Jitendra M. Value based healthcare. *Adv Manag.* 2016;9(1):1.
2. Health Care Payment Learning and Action Network. APM Measurement: Progress of Alternative Payment Models 2019 Methodology and Results Report. Published 2019. Accessed August 19, 2020. http://hcp-lan.org/workproducts/apm-methodology-2019.pdf
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5. Pringle JL, Ruckle L, Dennan D, Clare C, Tice B, Bates AL. Applying value-based incentive models within community pharmacy practice. *Am J Pharm Benefits.* 2016;8(1):22-29. https://www.ajpb.com/journals/ajpb/2016/AJPB_January/February2016/applying-valuebased-incentive-models-within-community-pharmacy-practice

CONTACT AND FUNDING INFORMATION

- ***Correspondence:*** Chloe Richard; chloe.richard@unc.edu

- ***Funding Source***: Funded by PharmAlliance
- ***Conflict of Interest***: Authors declare that they do not have any conflicts of interest.

Want to learn more about what makes PBPPMs work?

We will be presenting as part of the "Get to the Point: A Managed Care Pharmacy Research Podium Session" from 4:00-5:00pm on Wednesday 10.21.20!

SCAN HERE for details

THE ROLE OF SOCIAL DETERMINANTS OF HEALTH IN ADULT INFLUENZA VACCINATION: A NATIONWIDE CLAIMS ANALYSIS

Justin Gatwood, PhD[1] Sujith Ramachandran, PhD[2] Sohul A. Shuvo, MS[1] Michael Behal, PharmD[1] Tracy Hagemann, PharmD[1] Kenneth Hohmeier, PharmD[1] Chi-Yang Chiu, PhD[1]

[1]University of Tennessee Health Science Center, [2]University of Mississippi School of Pharmacy

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

THE UNIVERSITY OF MISSISSIPPI Center for Pharmaceutical Marketing and Management

Background

- The health and economic benefits of the annual influenza vaccine are well defined, yet vaccination rates in the United States are below the Healthy People 2020 goal.[1]
- Perceived hesitancy toward immunization drives suboptimal vaccination but is poorly understood in adult patients.
- The impact of social determinants of health (SDoH) on influenza vaccination among adults remains largely unknown particularly in the context of the vaccine hesitancy matrix (Table 1).[2]

Table 1. Elements of the Vaccine Hesitancy Matrix

Contextual	Individual/Group	Vaccine-Specific
Communication/Media Leaders Religion/Culture Socio-economic Politics Geography Industry perception	Experiences Beliefs/Attitudes Knowledge Health system Risks vs. benefits	Administration Schedule Cost Recommendations Risks vs. benefits Newness

Objective

- Determine the impact of certain social determinants of health on adherence to annual influenza vaccination in American adults.

Methods

- Retrospective observational cohort study using IBM MarketScan Commercial Claims and a 5% Medicare databases
- Adults aged ≥18 years who were continuously enrolled for 3 consecutive years between 2013 and 2016 were eligible:

- Select social determinants of health from publicly-available sources were linked by metropolitan statistical area: voting records, poverty, health literacy, Internet access [3-5]
- Logistic regression assessed the impact of SDH on adherence to influenza vaccination in all three included seasons, controlling for patient demographics and resource use.

Results

Figure 1. Proportion of adults vaccinated in each season

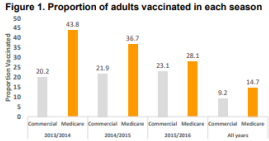

Table 2. Patient demographics

Characteristic	Commercial Insurance N (%)	Fee-for-Service Medicare N (%)
Total	6,086,487	605,084
Age		
18-24	492,368 (8.1)	
25-34	823,622 (13.5)	
35-44	1,418,404 (23.3)	
45-54	2,008,912 (33.0)	
55-64	1,346,181 (22.1)	
65-74		346,263 (57.2)
75+		258,821 (42.8)
Male	2,498,307 (41.0)	233,487 (38.6)
Region		
Northeast	1,129,361 (18.6)	122,196 (20.6)
North Central	1,269,158 (20.7)	145,522 (24.5)
South	2,763,947 (45.4)	216,149 (36.5)
West	933,275 (15.3)	109,127 (18.4)
Rural	856,186 (14.1)	67,095 (11.1)
Plan Type		
Comprehensive	141,897 (2.4)	
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PPO/EPO	3,763,641 (62.3)	
CDHP/HDHP	780,072 (12.9)	
Immunocompromised	1,654,087 (27.2)	289,138 (47.8)

- Only 9.2% were vaccinated against seasonal influenza in all 3 years observed (Figure 1).
- A majority of commercially-insured adults (63.9%) were unvaccinated across all 3 years
- Higher proportions of vaccine adherence were observed in: females (9.6%), the immunocompromised (10.8%), rural residents (9.9%) (all p<0.0001), and those in a high-deductible health plan (10.3%).
- Odds of vaccine adherence were higher in areas with higher health literacy and poorer Internet access as well as among individuals with more prescription fills and who did not move during the observation period (Table 3).

Figure 2. Influenza vaccine adherence (Commercial)

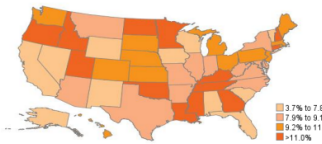

Figure 3. Influenza vaccine adherence (Medicare)

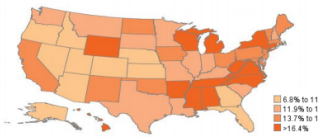

Table 3. Odds of adherence to annual influenza vaccination

Characteristic	Commercial Insurance	Fee-for-Service Medicare
	Odds Ratio (95% CI)	Odds Ratio (95% CI)
Poverty	1.015 (1.014-1.017)	1.01 (1.005-1.012)
Health literacy	1.036 (1.036-1.037)	1.001 (0.999-1.003)**
Democratic voters	0.998 (0.998-0.998)	0.996 (0.996-0.997)
Limited Internet access	1.001 (0.999-1.003)**	1.007 (1.004-1.010)
Urban*	0.87 (0.867-0.881)	1.12 (1.098-0.150)
Relocated (No)	1.08 (1.067-1.089)	1.31 (1.265-1.362)
Inpatient admissions	0.92 (0.917-0.925)	0.88 (0.860-0.895)
Outpatient visits	1.002 (1.002-1.003)	1.002 (1.002-1.003)
ED visits	0.928 (0.927-0.930)	0.977 (0.975-0.979)
Prescription fills	1.007 (1.00-1.007)	1.001 (1.001-1.001)
Immunocompetent	0.83 (0.826-0.836)	0.92 (0.907-0.936)

Models controlled for age, sex, and region (plan type for commercial insurance)
*Separate model run for population density due to lack of SDoH values in rural areas
**p>0.05, all others p<0.0001

Conclusions

- Key social determinants of health are important factors of vaccine adherence and can guide policy and intervention efforts toward addressing potential hesitancy.
- Community-level analyses applying vaccine determinants are needed to develop specific approaches

References

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Poster Content – Connect the Dots

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

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Geography		Newness
Industry perception		

Objective

- Determine the impact of certain social determinants of health on adherence to annual influenza vaccination in American adults.

Methods

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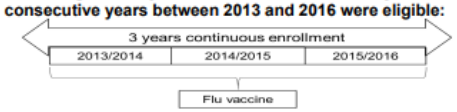

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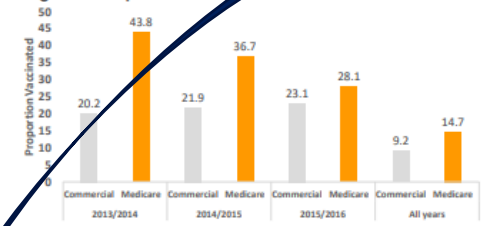

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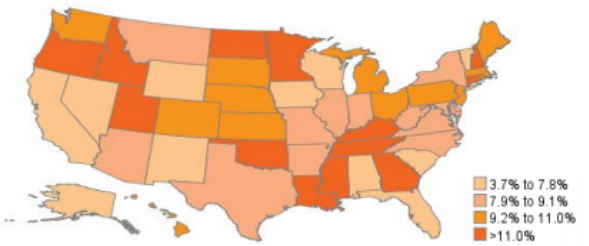

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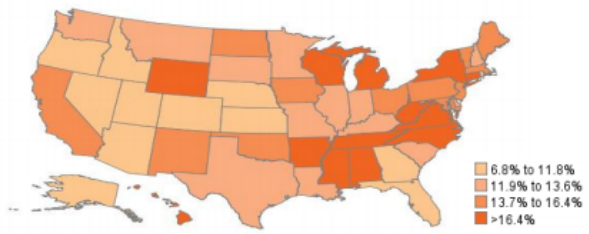

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AMCP Nexus 2021
October 18-21, 2021
Gaylord Rockies ♦ Denver, CO

GUIDELINES FOR POSTER PRESENTERS

POSTER PRESENTATION DATES & TIMES

Authors/Researchers will present their posters on **Wednesday, October 20 from Noon-2:30pm MT.** Please note that **at least one author per poster should be available** during the poster presentation to discuss findings on **Wednesday, October 20.**

ONSITE & SETUP

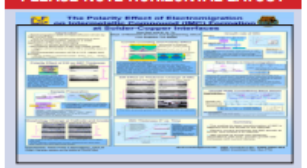
You will have access to set up your poster in **The Exchange, AMCP's Exposition, in Aurora 1/2 in the Gaylord Rockies** from **11am - Noon MT** on **Tuesday, October 19.** You should arrive at **Aurora 1/2** no later than **2:30 pm** to allow time for set up. **There will be staff available on a first-come, first-serve basis to assist with hanging your poster during setup hours.** When you enter the hall, you can easily locate your poster board by finding the corkboard identified with your poster number. There will also be an AMCP-staffed table near the poster area for any questions or assistance you may need during your setup. Poster numbers will be included in the *JMCP* Meeting Supplement at www.jmcp.org/pages/MeetingAbstracts by mid-September and will also be available on the Nexus 2021 mobile app available for download in late September.

POSTER BOARD MATERIALS

- One (1) single-sided cork board approximately 8′ wide × 4′ high
- Pushpins to mount your poster.

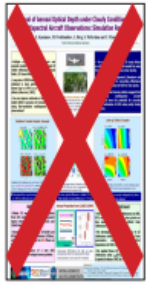
As long as the combined size of your poster materials fits within the 8′ wide × 4′ high horizontal frame, you may tailor the size and format of your materials in any fashion conducive to the effectiveness of your presentation. If you choose to have a handout, limit the content to educational information that pertains directly to the poster presentation. We recommend that you bring 100 copies of handout material for distribution to meeting attendees. There will be hanging folders available for handouts at the AMCP poster info desk. **(AMCP is not responsible for your handout duplication).**

PLEASE NOTE HORIZONTAL LAYOUT



REGISTRATION

At least 1 author MUST register for the meeting to present the poster. You are responsible for your own meeting registration fee and securing your own travel and housing arrangements for AMCP Nexus 2021. Active members of AMCP are eligible to register at the discounted early bird member rate through August 19. Special discounted rates also are available for student members and resident/fellow/graduate members.



MEETING LOCATION

Gaylord Rockies Resort & Convention Center
6700 North Gaylord Rockies Boulevard
Aurora, CO 80019

ONSITE PRINTING SERVICES

FedEx Office Print & Ship Center
6700 N Gaylord Rockies Blvd
Aurora, CO 80019
303-390-9121
***Additional info coming soon**

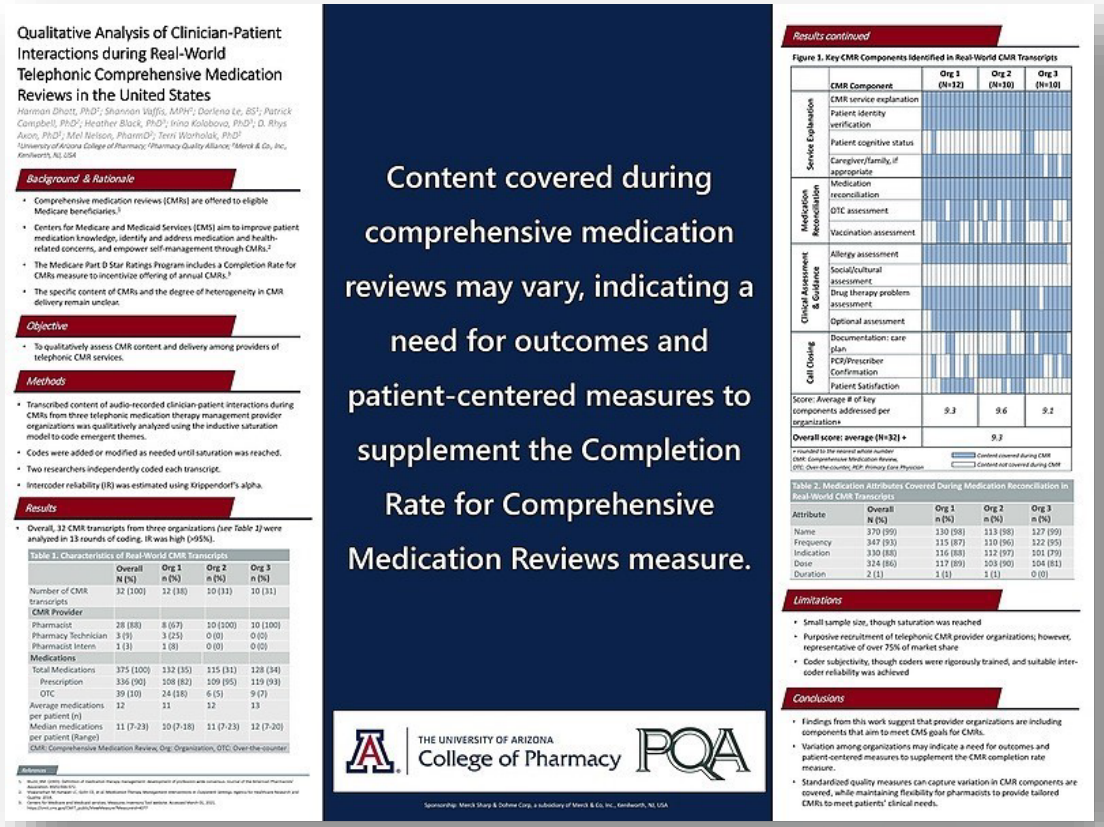
MEETING INFORMATION

If you need information about AMCP Nexus 2021, please visit www.amcpmeetings.org.

TIPS FOR POSTER PRESENTATIONS

- The poster corkboard provided is approximately 8′ wide×4′ high horizontal frame. Your poster materials should be a little smaller than this area so they do not overlap the edges of the poster board.
- Be sure to include the abstract title, author name(s), and the institution where the work was completed in large letters centered at the top of the poster.
- The presentation number assigned to the poster presentation should **NOT** be placed on your poster. The poster boards will be numbered for you.
- Hand carry your poster to the meeting, using tubular packaging or a portfolio case. Do not mail your poster to AMCP headquarters or the Convention Center.
- Come prepared with any relevant handouts and business cards to share.

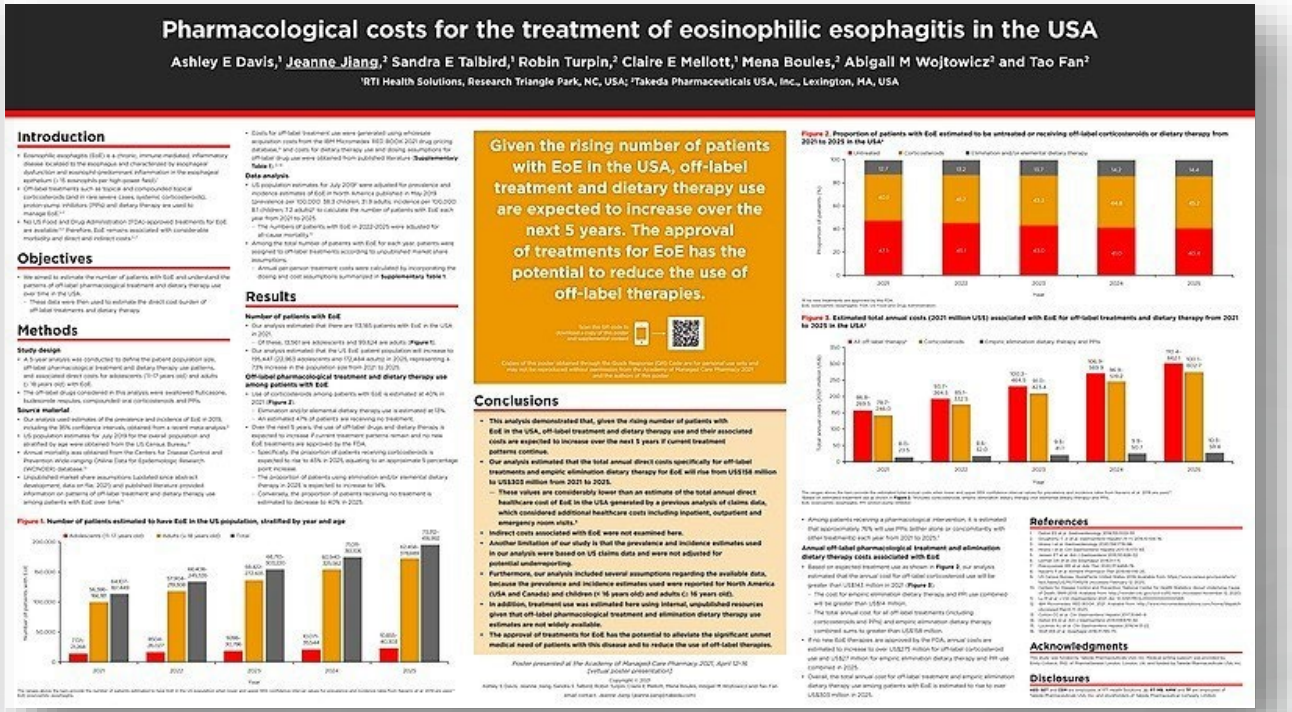
Instructions are important



Qualitative Analysis of Clinician-Patient Interactions during Real-World Telephonic Comprehensive Medication Reviews in the United States

Content covered during comprehensive medication reviews may vary, indicating a need for outcomes and patient-centered measures to supplement the Completion Rate for Comprehensive Medication Reviews measure.

THE UNIVERSITY OF ARIZONA College of Pharmacy PQA



Pharmacological costs for the treatment of eosinophilic esophagitis in the USA

Ashley E Davis,[1] Jeanne Jiang,[2] Sandra E Talbird,[1] Robin Turpin,[2] Claire E Mellott,[1] Mena Boules,[2] Abigail M Wojtowicz[2] and Tao Fan[2]

[1]RTI Health Solutions, Research Triangle Park, NC, USA; [2]Takeda Pharmaceuticals USA, Inc., Lexington, MA, USA

Given the rising number of patients with EoE in the USA, off-label treatment and dietary therapy use are expected to increase over the next 5 years. The approval of treatments for EoE has the potential to reduce the use of off-label therapies.

Emerging Trends

Key Takeaways:

1) Connect the dots.
2) Read the conference instructions.
3) Use of technology can help you emphasize your key message.

Background and Objectives

The purpose of this module is to describe how study background and objectives should be presented in a poster.

Background – Set up the need for the study

BACKGROUND

- There has been a shift in the United States (US) towards value-based health care models which seek to improve patient outcomes while reducing health care spending.[1,2]
- Many payers have started to use performance-based pharmacy payment models (PBPPMs) (e.g., IEHP[3]).
- There is growing opportunity for community pharmacists to engage with these models.
- PBPPMs incentivize pharmacists to improve patient care by tying reimbursement to performance measures.[4,5]
- The design and implementation of PBPPMs is not well understood and needs to be further described to facilitate their uptake.

- Leads into the objective
- Highly focused, brief
- Includes citations

Objective – Clearly state hypothesis or objective

OBJECTIVES

Aim 1: Describe the current structure of PBPPMs in the US.

Aim 2: Identify the contextual and motivational influences that need to be considered when implementing these models.

- As defined in study protocol
- Separate section in the poster

Background

Background

- The health and economic benefits of the annual influenza vaccine are well defined, yet vaccination rates in the United States are below the Healthy People 2020 goal.[1]
- Perceived hesitancy toward immunization drives suboptimal vaccination but is poorly understood in adult patients.
- The impact of social determinants of health (SDoH) on influenza vaccination among adults remains largely unknown particularly in the context of the vaccine hesitancy matrix (Table 1).[2]

Table 1. Elements of the Vaccine Hesitancy Matrix

Contextual	Individual/Group	Vaccine-Specific
Communication/Media	Experiences	Administration
Leaders	Beliefs/Attitudes	Schedule
Religion/Culture	Knowledge	Cost
Socio-economic	Health system	Recommendations
Politics	Risks vs. benefits	Risks vs. benefits
Geography		Newness
Industry perception		

Objective

Objective

- Determine the impact of certain social determinants of health on adherence to annual influenza vaccination in American adults.

Key Takeaways:

1) The background should be concise, focused, and referenced.
2) The objective should stand-alone and reflect the study protocol.
3) The background should lead directly into the objective.

Methods

The purpose of this module is to provide guidance on how to summarize the manner in which the study subjects were selected and the analyses were conducted

Methods – Describe subjects and approach

- Describes study design, how subjects were selected, and the statistical methods

- Use **bold** text to differentiate the components of the methods, with bullet points beneath
  - The following labels represent one approach
    - Study design
      - Data source
      - Time periods
      - Inclusion and exclusion criteria
      - Outcome measures
    - Statistical analyses

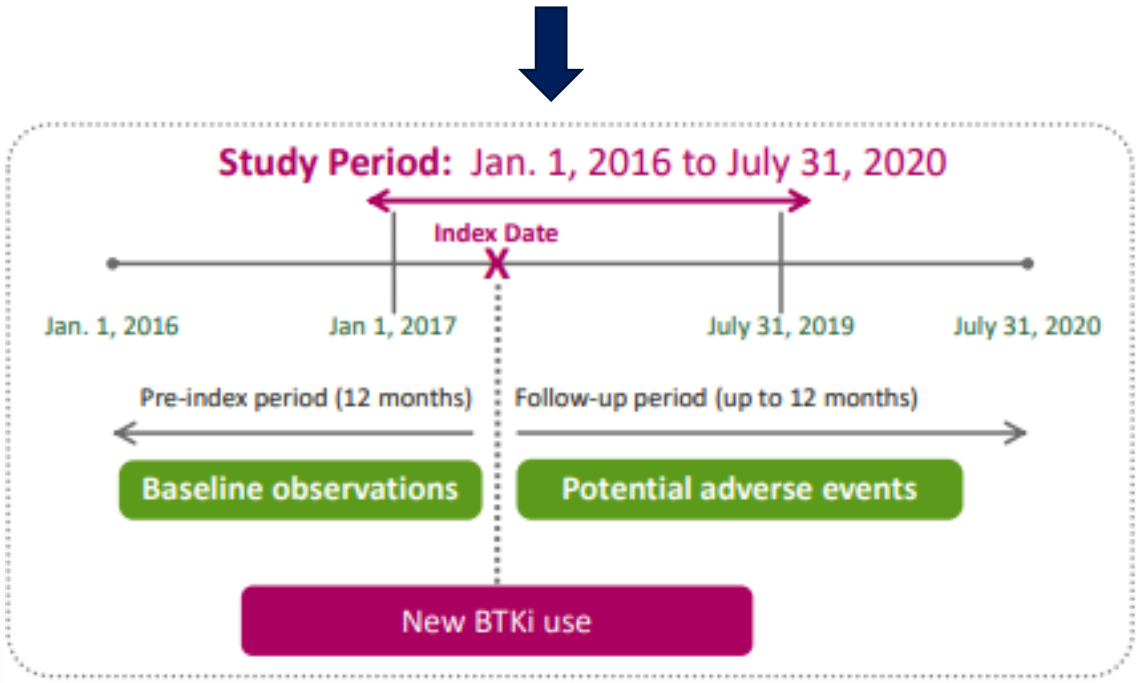
Methods

Methods

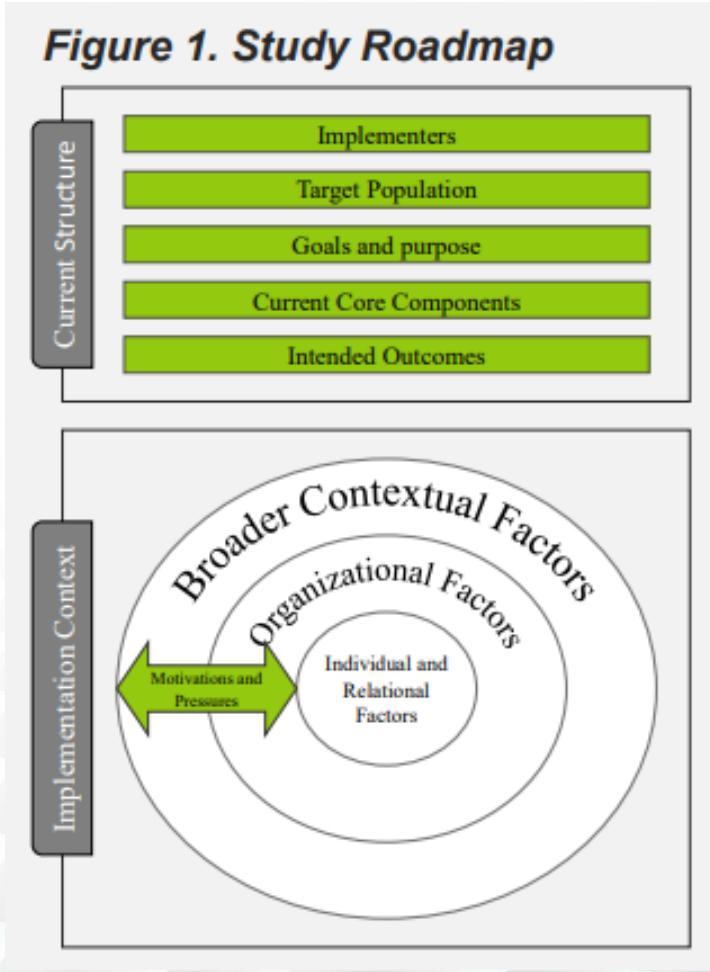
- **Study Design:** Retrospective claims analysis
- **Patient Selection:**
  - Patients enrolled in a Humana Medicare Advantage with Prescription Drug plan (MAPD)
  - Initiation of ibrutinib (Imbruvica®) or acalabrutinib (Calquence®) between the index period of January 1, 2017 and July 31, 2019
  - Enrollment 12 months prior to and after index period
  - No claim for a BTKi within 6 of the months pre-index date
  - Patients enrolled in a Commercial plan, Prescription Drug Plan only (PDP), or a plan restricted from research were excluded
- **Index Date:** First date of BTKi (ibrutinib or acalabrutinib)
- **Measures:**
  - Patient characteristics were identified as of the index date
  - Deyo-Charlson Comorbidity Index was measured based on medical claims diagnoses during the 12 months prior to the index date
  - BTKi treatment use was measured based on days of supply. Persistence was based on days covered with supply until a gap >45 days was observed. Adherence was based on Proportion of Days Covered (PDC) ≥0.8
  - Inpatient and emergency department diagnoses representing potential adverse drug events were identified by ICD10 diagnosis codes within the first three claims positions during the 12 months prior to the index date and the 12 months post-index date. Potential ADEs with a greater occurrence rate after initiation of a BTKi considered to represent ADEs.

Methods – Figures can help illustrate

- Can be used to illustrate selection criteria
- Useful for showing study design



- Are useful for qualitative studies to visually show approach



Key Takeaways:

1) The Methods should include information on both study design and statistical methods
2) The Methods should be succinct, yet fully describe how study was conducted
3) The Methods should provide the context for the findings to be presented next in the Results section

Poster Results

The purpose of this module is to describe what to include in the Results section of a poster and provide suggestions on how to report this information.

General Considerations for the Results Section

- Reported content should parallel the measures described in the Methods section
- The content in the Results section should focus on presenting findings but should avoid interpretation of these findings
- Content should generally include:
  - measures characterizing the study population
  - study outcome measures after reporting measures that characterize the study population

Report Measures Characterizing the Study Population

Table 2. Patient demographics

Characteristic	Commercial Insurance N (%)	Fee-for-Service Medicare N (%)
Total	6,086,487	605,084
Age		
18-24	492,368 (8.1)	
25-34	823,622 (13.5)	
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PPO/EPO	3,763,641 (62.3)	
CDHP/HDHP	780,072 (12.9)	
Immunocompromised	1,654,087 (27.2)	289,138 (47.8)

- Key population characteristics are often summarized at the beginning of the Results
- These characteristics may be presented in a table or figure
  - if using a table, be careful to select the appropriate rows and columns
  - if using a figure, consider what type of figure is appropriate
- Depending on formatting and the amount of information presented, it may be helpful to draw attention to some of the most relevant characteristics in a couple bullet points

Reporting Outcome Measures

- After reporting measures that characterize the study population, the poster should present outcome measures
- Generally, figures or tables should be used to present study outcomes
- Consider the best way to visualize study outcomes if using a figure
- Similar to population characteristics, it is may be helpful to highlight some key outcomes using bullets

Figure 1. Proportion of adults vaccinated in each season

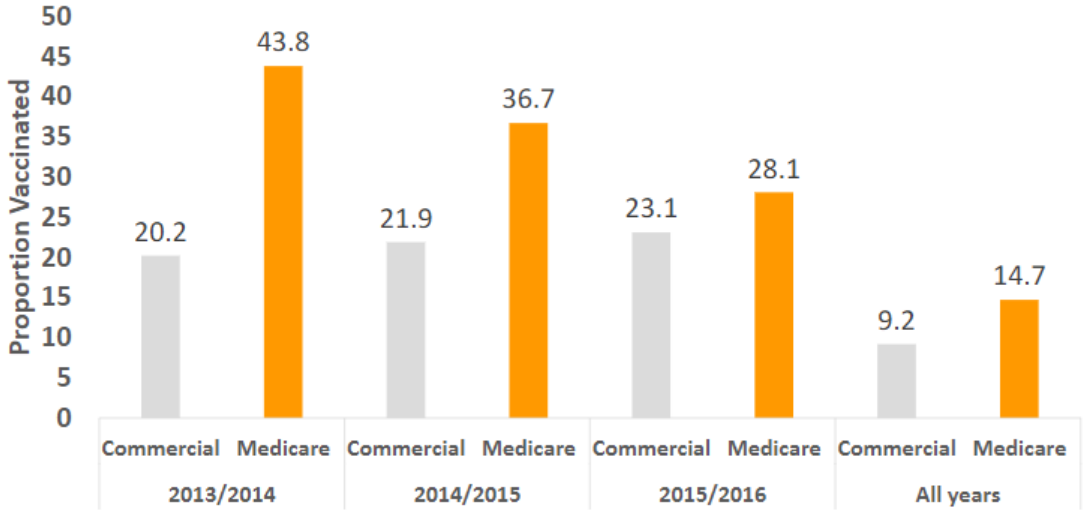


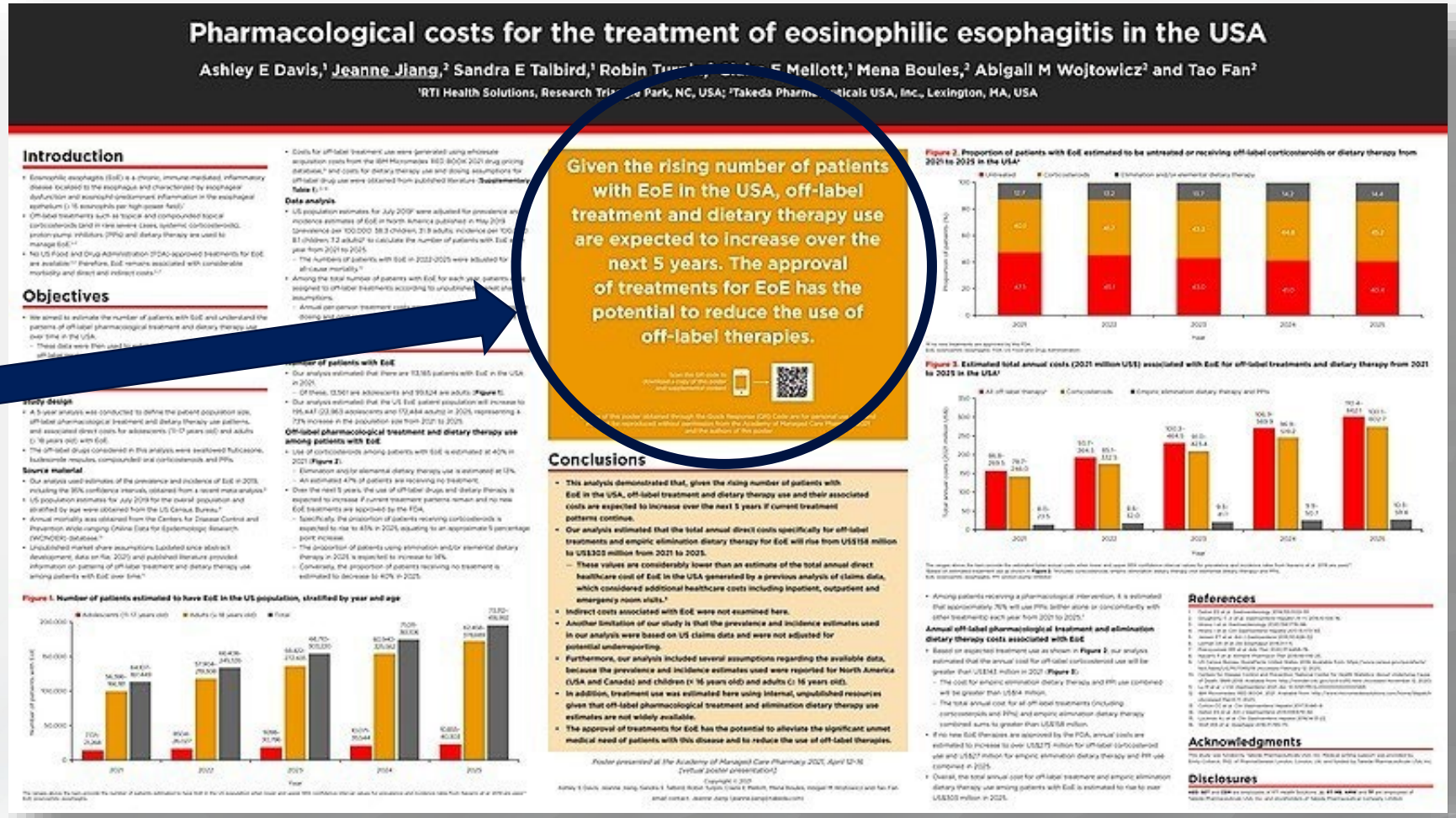
TABLE 2

Total Cost of Care Pre to Post Change after Starting Sacubitril-Valsartan among 658 Commercially Insured Members

	Pre-index		Post-Index		Pre/Post Change in Mean Costs
	Mean (SD)	Median (5th, 95th Percentile)	Mean (SD)	Median (5th, 95th Percentile)	
Medical costs	$41,677 ($87,644)	$12,917 ($62, $152,345)	$25,953 (64,013)	$6,455 ($467, $115,243)	-$15,724
Hospitalization	$23,892 ($72,204)	- (-, $109,829)	$7,360 ($35,453)	- (-, $35,343)	-$16,532
ER	$541 ($1,852)	- (-, $2,929)	$378 ($1,258)	- (-, $2,324)	-$163
Office visit	$11,369 ($25,655)	$2,892 (-, $60,068)	$12,876 (24,736)	$3,546 ($291, $69,179)	$1,507
Other	$5,876 ($37,217)	$751 (-, $16,064)	$5,338 ($39,213)	$704 (-, $12,731)	-$538
Pharmacy costs	$4,565 ($13,117)	$1,101 (-, $17,052)	$10,112 ($13,612)	$6,974 ($3,699, $25,883)	$5,547
Total	$46,242 ($89,058)	$18,973 ($151, $160,221)	$36,065 ($66,006)	$15,787 ($4,786, $128,851)	-$10,177

Emerging Trends

Depending on your approach to poster design, you can consider calling out key results (and conclusions) on the poster as seen in this poster example



Key Takeaways:

1) Reported content should follow measures described in the Methods
2) Include measures to describe the study population and study outcomes
3) Avoid interpretation of study findings

Poster Conclusion

The purpose of this module is to describe key considerations and content for the Limitations and Conclusion sections in a poster.

General Considerations for the Conclusions Section

- Provides an opportunity for summarizing and interpreting the study results
- Typically brief, with 2-3 bullet points
- This section usually does not provide full context for the results (e.g., does not include a summary of other relevant literature) as the Discussion section of a manuscript would
- Consider including a separate Limitations section to qualify research findings

Limitations Section

- Often included to explain limitations of the research presented
- Reasonable to add this section before or after the Conclusion section as a separate section
- May include 2-3 bullets with each highlighting a limitation that is helpful to consider when interpreting results

Limitations

- **Generalizability**: This study included one platform within independent and regional pharmacies, using a population from one health plan in one region of the United States.
- Pharmacist **education**: pharmacists may not have received the same training (e.g., tool use, immunization assessment), given that they came from different regional chains and independent pharmacies with differing operational models.
- Gap closure was not captured but could be an additional build.

Limitations

- Potential ADEs were identified from administrative claims for inpatient hospitalizations or emergency department claims, so potential ADEs of lower severity were may not have been observed.
- Ibrutinib represented nearly all BTKi utilization so the observations may not be generalizable to patients using acalabrutinib.
- The newer agent zanubrutinib was not included in the study due to expectations of small sample and lack of adequate follow-up time for patients who might have initiated this drug.

Conclusion Section

- Summarize key results in 1-2 bullets without directly restating what is reported in the Results
- Can include comments on implications of the findings
- Summary and commentary should be aligned to the research objective/hypothesis(es)
- Can also mention potential future research directions to build on the findings presented

Conclusions

- **Key social determinants of health are important factors of vaccine adherence and can guide policy and intervention efforts toward addressing potential hesitancy.**
- **Community-level analyses applying vaccine determinants are needed to develop specific approaches**

Key Takeaways:

1) Provide a brief summary of key findings
2) Add a separate Limitations section to qualify the findings/support interpretation of the findings
3) Interpret findings and consider commenting on next steps or future research options

Putting the Poster Together

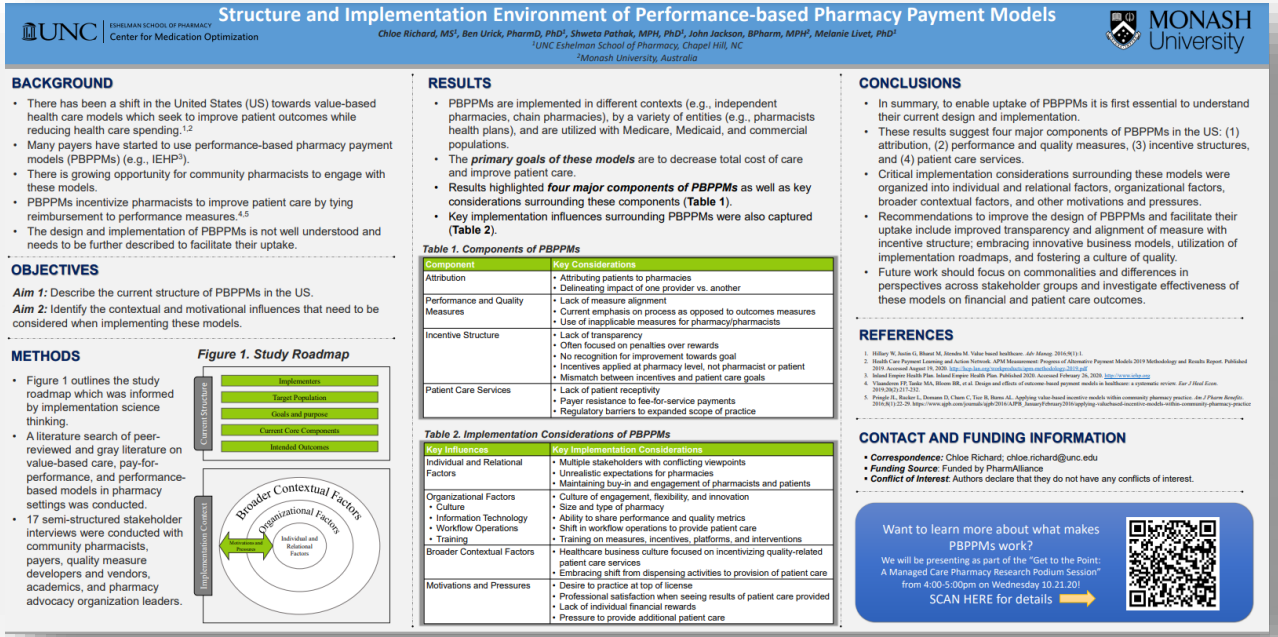
The purpose of this module is to show poster presenters how to format posters for readability and ease of understanding

Poster Sizing

- Check guidelines from conference website
- AMCP Nexus 2021 poster board: 8’ wide x 4’ high
- Poster materials should not overlap the edges of the board
- Mounting
  - AMCP Nexus use push pins
  - Other conferences may use large spring clips

Layout

Rearrange sections to fit your project type and context



Structure and Implementation Environment of Performance-based Pharmacy Payment Models

Chloe Richard, MS[1], Ben Urick, PharmD, PhD[1], Shweta Pathak, MPH, PhD[1], John Jackson, BPharm, MPH[2], Melanie Livet, PhD[1]

[1]UNC Eshelman School of Pharmacy, Chapel Hill, NC

[2]Monash University, Australia

BACKGROUND

- There has been a shift in the United States (US) towards value-based health care models which seek to improve patient outcomes while reducing health care spending.[1,2]
- Many payers have started to use performance-based pharmacy payment models (PBPPMs) (e.g., IEHP[3]).
- There is growing opportunity for community pharmacists to engage with these models.
- PBPPMs incentivize pharmacists to improve patient care by tying reimbursement to performance measures.[4,5]
- The design and implementation of PBPPMs is not well understood and needs to be further described to facilitate their uptake.

OBJECTIVES

Aim 1: Describe the current structure of PBPPMs in the US.

Aim 2: Identify the contextual and motivational influences that need to be considered when implementing these models.

METHODS

- Figure 1 outlines the study roadmap which was informed by implementation science thinking.
- A literature search of peer-reviewed and gray literature on value-based care, pay-for-performance, and performance-based models in pharmacy settings was conducted.
- 17 semi-structured stakeholder interviews were conducted with community pharmacists, payers, quality measure developers and vendors, academics, and pharmacy advocacy organization leaders.

Figure 1. Study Roadmap

RESULTS

- PBPPMs are implemented in different contexts (e.g., independent pharmacies, chain pharmacies), by a variety of entities (e.g., pharmacists health plans), and are utilized with Medicare, Medicaid, and commercial populations.
- The ***primary goals of these models*** are to decrease total cost of care and improve patient care.
- Results highlighted ***four major components of PBPPMs*** as well as key considerations surrounding these components (**Table 1**).
- Key implementation influences surrounding PBPPMs were also captured (**Table 2**).

Table 1. Components of PBPPMs

Component	Key Considerations
Attribution	• Attributing patients to pharmacies • Delineating impact of one provider vs. another
Performance and Quality Measures	• Lack of measure alignment • Current emphasis on process as opposed to outcomes measures • Use of inapplicable measures for pharmacy/pharmacists
Incentive Structure	• Lack of transparency • Often focused on penalties over rewards • No recognition for improvement towards goal • Incentives applied at pharmacy level, not pharmacist or patient • Mismatch between incentives and patient care goals
Patient Care Services	• Lack of patient receptivity • Payer resistance to fee-for-service payments • Regulatory barriers to expanded scope of practice

Table 2. Implementation Considerations of PBPPMs

Key Influences	Key Implementation Considerations
Individual and Relational Factors	• Multiple stakeholders with conflicting viewpoints • Unrealistic expectations for pharmacies • Maintaining buy-in and engagement of pharmacists and patients
Organizational Factors • Culture • Information Technology • Workflow Operations • Training	• Culture of engagement, flexibility, and innovation • Size and type of pharmacy • Ability to share performance and quality metrics • Shift in workflow operations to provide patient care • Training on measures, incentives, platforms, and interventions
Broader Contextual Factors	• Healthcare business culture focused on incentivizing quality-related patient care services • Embracing shift from dispensing activities to provision of patient care
Motivations and Pressures	• Desire to practice at top of license • Professional satisfaction when seeing results of patient care provided • Lack of individual financial rewards • Pressure to provide additional patient care

CONCLUSIONS

- In summary, to enable uptake of PBPPMs it is first essential to understand their current design and implementation.
- These results suggest four major components of PBPPMs in the US: (1) attribution, (2) performance and quality measures, (3) incentive structures, and (4) patient care services.
- Critical implementation considerations surrounding these models were organized into individual and relational factors, organizational factors, broader contextual factors, and other motivations and pressures.
- Recommendations to improve the design of PBPPMs and facilitate their uptake include improved transparency and alignment of measure with incentive structure; embracing innovative business models, utilization of implementation roadmaps, and fostering a culture of quality.
- Future work should focus on commonalities and differences in perspectives across stakeholder groups and investigate effectiveness of these models on financial and patient care outcomes.

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CONTACT AND FUNDING INFORMATION

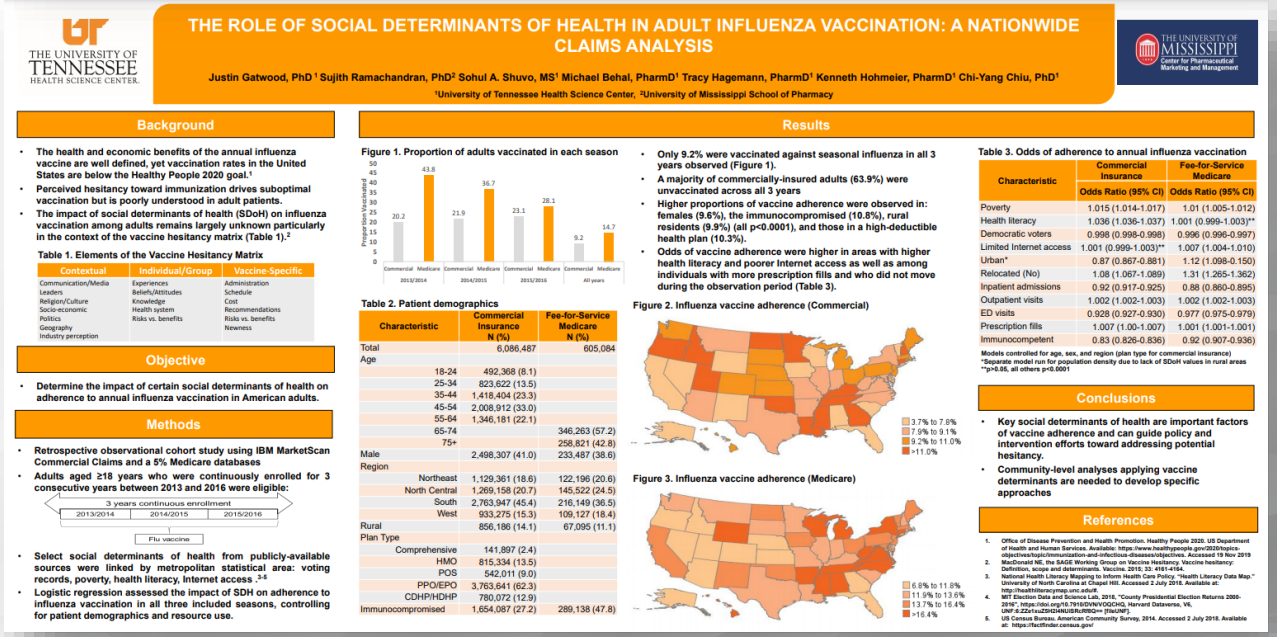
- ***Correspondence:*** Chloe Richard; chloe.richard@unc.edu

- ***Funding Source:*** Funded by PharmAlliance
- ***Conflict of Interest:*** Authors declare that they do not have any conflicts of interest.

Want to learn more about what makes PBPPMs work?

We will be presenting as part of the "Get to the Point: A Managed Care Pharmacy Research Podium Session" from 4:00-5:00pm on Wednesday 10.21.20!

SCAN HERE for details



THE ROLE OF SOCIAL DETERMINANTS OF HEALTH IN ADULT INFLUENZA VACCINATION: A NATIONWIDE CLAIMS ANALYSIS

Justin Gatwood, PhD[1] Sujith Ramachandran, PhD[2] Sohul A. Shuvo, MS[1] Michael Behal, PharmD[1] Tracy Hagemann, PharmD[1] Kenneth Hohmeier, PharmD[1] Chi-Yang Chiu, PhD[1]

[1]University of Tennessee Health Science Center, [2]University of Mississippi School of Pharmacy

Background

- The health and economic benefits of the annual influenza vaccine are well defined, yet vaccination rates in the United States are below the Healthy People 2020 goal.[1]
- Perceived hesitancy toward immunization drives suboptimal vaccination but is poorly understood in adult patients.
- The impact of social determinants of health (SDoH) on influenza vaccination among adults remains largely unknown particularly in the context of the vaccine hesitancy matrix (Table 1).[2]

Table 1. Elements of the Vaccine Hesitancy Matrix

Contextual	Individual/Group	Vaccine-Specific
Communication/Media Leaders Religion/Culture Socio-economic Politics Geography Industry perception	Experiences Beliefs/Attitudes Knowledge Health system Risks vs. benefits	Administration Schedule Cost Recommendations Risks vs. benefits Newness

Objective

- Determine the impact of certain social determinants of health on adherence to annual influenza vaccination in American adults.

Methods

- Retrospective observational cohort study using IBM MarketScan Commercial Claims and a 5% Medicare databases
- Adults aged ≥18 years who were continuously enrolled for 3 consecutive years between 2013 and 2016 were eligible:

- Select social determinants of health from publicly-available sources were linked by metropolitan statistical area: voting records, poverty, health literacy, Internet access [3-5]
- Logistic regression assessed the impact of SDH on adherence to influenza vaccination in all three included seasons, controlling for patient demographics and resource use.

Results

Figure 1. Proportion of adults vaccinated in each season

Table 2. Patient demographics

Characteristic	Commercial Insurance N (%)	Fee-for-Service Medicare N (%)
Total	6,086,487	605,084
Age		
18-24	492,368 (8.1)	
25-34	823,622 (13.5)	
35-44	1,418,404 (23.3)	
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Region		
Northeast	1,129,361 (18.6)	122,196 (20.6)
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Comprehensive	141,897 (2.4)	
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PPO/EPO	3,763,641 (62.3)	
CDHP/HDHP	780,072 (12.9)	
Immunocompromised	1,654,087 (27.2)	289,138 (47.8)

- Only 9.2% were vaccinated against seasonal influenza in all 3 years observed (Figure 1).
- A majority of commercially-insured adults (63.9%) were unvaccinated across all 3 years
- Higher proportions of vaccine adherence were observed in: females (9.6%), the immunocompromised (10.8%), rural residents (9.9%) (all p<0.0001), and those in a high-deductible health plan (10.3%).
- Odds of vaccine adherence were higher in areas with higher health literacy and poorer Internet access as well as among individuals with more prescription fills and who did not move during the observation period (Table 3).

Figure 2. Influenza vaccine adherence (Commercial)

Figure 3. Influenza vaccine adherence (Medicare)

Table 3. Odds of adherence to annual influenza vaccination

Characteristic	Commercial Insurance Odds Ratio (95% CI)	Fee-for-Service Medicare Odds Ratio (95% CI)
Poverty	1.015 (1.014-1.017)	1.01 (1.005-1.012)
Health literacy	1.036 (1.036-1.037)	1.001 (0.999-1.003)**
Democratic voters	0.998 (0.998-0.998)	0.996 (0.996-0.997)
Limited Internet access	1.001 (0.999-1.003)**	1.007 (1.004-1.010)
Urban*	0.87 (0.867-0.881)	1.12 (1.098-0.150)
Relocated (No)	1.08 (1.067-1.089)	1.31 (1.265-1.362)
Inpatient admissions	0.92 (0.917-0.925)	0.88 (0.860-0.895)
Outpatient visits	1.002 (1.002-1.003)	1.002 (1.002-1.003)
ED visits	0.928 (0.927-0.930)	0.977 (0.975-0.979)
Prescription fills	1.007 (1.00-1.007)	1.001 (1.001-1.001)
Immunocompetent	0.83 (0.826-0.836)	0.92 (0.907-0.936)

Models controlled for age, sex, and region (plan type for commercial insurance)
*Separate model run for population density due to lack of SDoH values in rural areas
**p>0.05, all others p<0.0001

Conclusions

- Key social determinants of health are important factors of vaccine adherence and can guide policy and intervention efforts toward addressing potential hesitancy.
- Community-level analyses applying vaccine determinants are needed to develop specific approaches

References

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Less Text, More Visual

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

THE ROLE OF SOCIAL DETERMINANTS OF HEALTH IN ADULT INFLUENZA VACCINATION: A NATIONWIDE CLAIMS ANALYSIS

Justin Gatwood, PhD[1] Sujith Ramachandran, PhD[2] Sohul A. Shuvo, MS[1] Michael Behal, PharmD[1] Tracy Hagemann, PharmD[1] Kenneth Hohmeier, PharmD[1] Chi-Yang Chiu, PhD[1]

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THE UNIVERSITY OF MISSISSIPPI Center for Pharmaceutical Marketing and Management

Bulleted Lists

Charts

Tables

Images

Background

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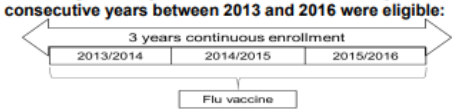

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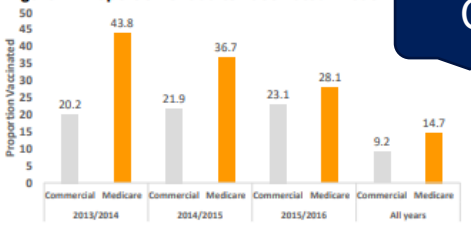

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West	933,275 (15.3)	109,127 (18.4)
Rural	856,186 (14.1)	67,095 (11.1)
Plan Type		
Comprehensive	141,897 (2.4)	
HMO	815,334 (13.5)	
POS	542,011 (9.0)	
PPO/EPO	3,763,641 (62.3)	
CDHP/HDHP	780,072 (12.9)	
Immunocompromised	1,654,087 (27.2)	289,138 (47.8)

…accinated against seasonal influenza in all 3 …Figure 1).

…mercially-insured adults (63.9%) were unvaccinated across all 3 years

- Higher proportions of vaccine adherence were observed in: females (9.6%), the immunocompromised (10.8%), rural residents (9.9%) (all p<0.0001), and those in a high-deductible health plan (10.3%).
- Odds of vaccine adherence were higher in areas with higher health literacy and poorer Internet access as well as among individuals with more prescription fills and who did not move during the observation period (Table 3).

Figure 2. Influenza vaccine adherence (Comm…

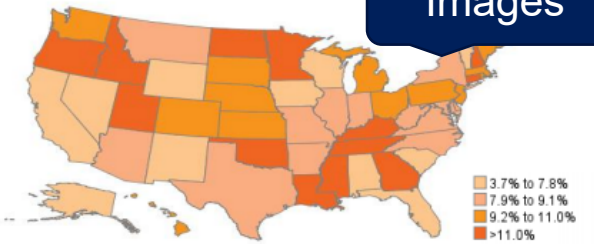

Figure 3. Influenza vaccine adherence (Medicare)

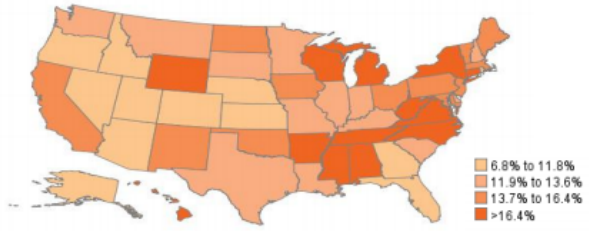

Table 3. Odds of adhere… …on

Characteristic	…ce
	Odds R… …% CI)	Odds Ratio (95% CI)
Poverty	1.015 (1.014-1.017)	1.01 (1.005-1.012)
Health literacy	1.036 (1.036-1.037)	1.001 (0.999-1.003)**
Democratic voters	0.998 (0.998-0.998)	0.996 (0.996-0.997)
Limited Internet access	1.001 (0.999-1.003)**	1.007 (1.004-1.010)
Urban*	0.87 (0.867-0.881)	1.12 (1.098-0.150)
Relocated (No)	1.08 (1.067-1.089)	1.31 (1.265-1.362)
Inpatient admissions	0.92 (0.917-0.925)	0.88 (0.860-0.895)
…utpatient visits	1.002 (1.002-1.003)	1.002 (1.002-1.003)
…D visits	0.928 (0.927-0.930)	0.977 (0.975-0.979)
…escription fills	1.007 (1.00-1.007)	1.001 (1.001-1.001)
…mmunocompetent	0.83 (0.826-0.836)	0.92 (0.907-0.936)

Models controlled for age, sex, and region (plan type for commercial insurance)
*Separate model run for population density due to lack of SDoH values in rural areas
**p>0.05, all others p<0.0001

Conclusions

- Key social determinants of health are important factors of vaccine adherence and can guide policy and intervention efforts toward addressing potential hesitancy.
- Community-level analyses applying vaccine determinants are needed to develop specific approaches

References

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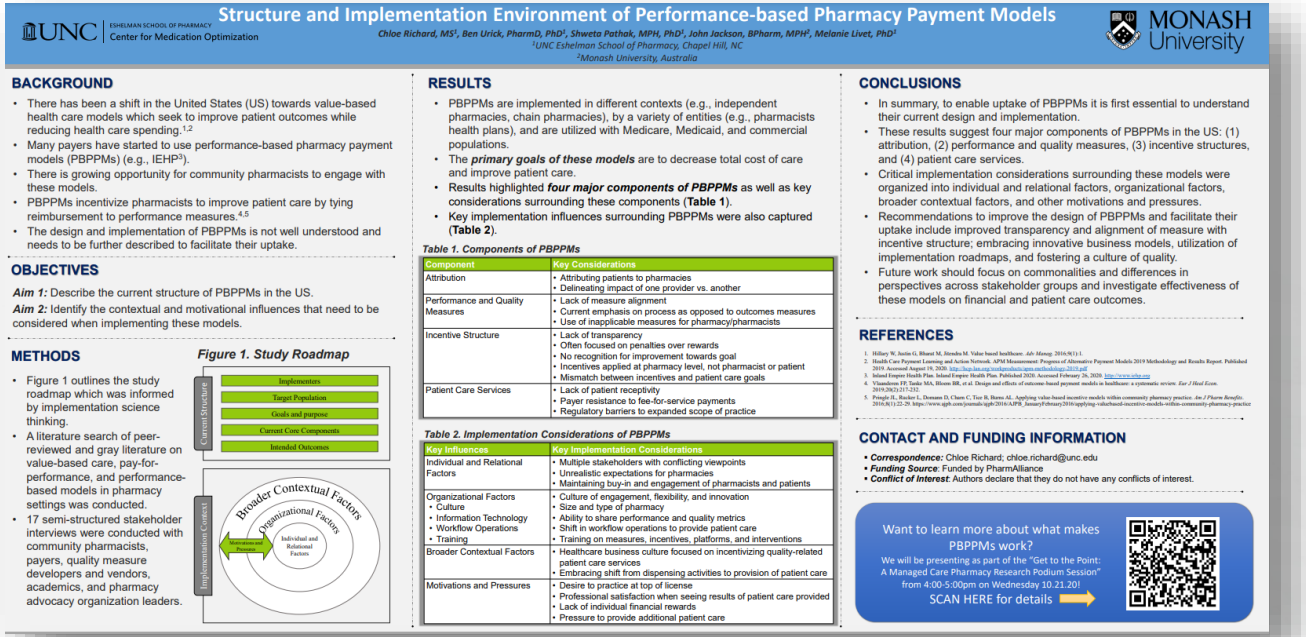
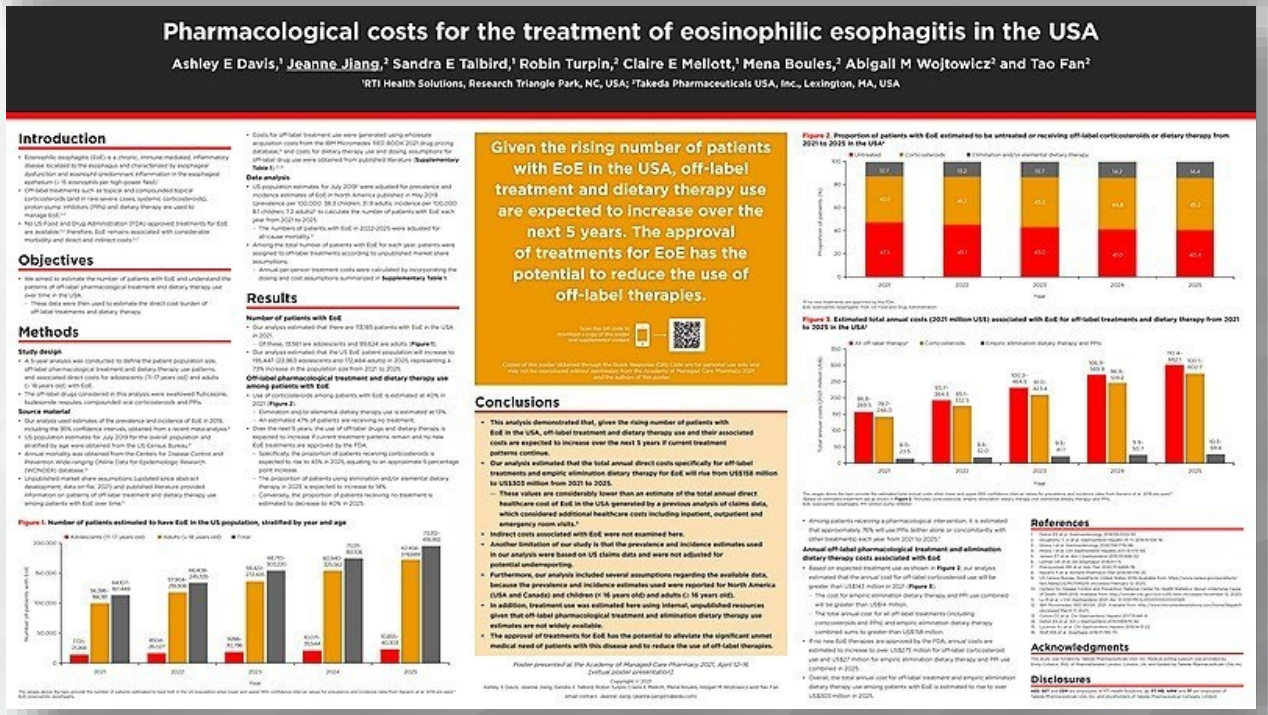
2. MacDonald NE, the SAGE Working Group on Vaccine Hesitancy. Vaccine hesitancy: Definition, scope and determinants. Vaccine. 2015; 33: 4161-4164.
3. National Health Literacy Mapping to Inform Health Care Policy. "Health Literacy Data Map." University of North Carolina at Chapel Hill. Accessed 2 July 2018. Available at: http://healthliteracymap.unc.edu/#.
4. MIT Election Data and Science Lab, 2018, "County Presidential Election Returns 2000-2016", https://doi.org/10.7910/DVN/VOQCHQ, Harvard Dataverse, V6, UNF:6:ZZe1xuZ5H2I4NUiSRcRf8Q== [fileUNF].
5. US Census Bureau. American Community Survey, 2014. Accessed 2 July 2018. Available at: https://factfinder.census.gov/

Formatting

- Use dark background with light text OR light background with black text
- Keep colors simple
- Allow for appropriate white space between items





Layout and Formatting

- Same font and size for similar elements (section heading, section body, table/figure titles)
- Use sans serif fonts (Calibri, Arial, Gill Sans, etc.)
- Use Alignment, Guides, or Gridlines in PowerPoint

Title

Abstract Title

Research Institution

Author name(s)

Key Takeaways:

1) Apply formatting techniques to appropriately layout your poster
2) Use a mix of text and visuals
3) Make sure your poster can be read from a distance

JMCP

How to Present a Scientific Poster

How to Present a Scientific Poster

Goal(s): Learn how to prepare for a scientific poster presentation. Understand how to adapt the in-person scientific poster presentation to a virtual presentation.

Scientific; *Tips for presenting your scientific poster at a conference* https://www.scientifica.uk.com/neurowire/tips-for-presenting-your-scientific-poster-at-a-conference accessed 8/24/2021

Preparation: Before the Poster Presentation

Before the Poster Day In-Person:

- Pay attention to the conference or meeting instructions
  - Size limits, layouts, printing options, timelines, etc.
- How do you secure your poster at the session (tape, Velcro tabs, push-pins, clay)?
- What is the display time, and when do you have to put your poster up and then take it down?
- When is the poster session and any additional instructions?

Preparation: Before the Poster Presentation

The Elevator Speech:

1. Prepare a concise synopsis of your research:
    a. No more than 3 sentences or 2 minutes
    b. Contains three vital things:
        I. What is your research topic?
        II. What have you found?
        III. Why is that important?
2. Get your poster attendees hooked and wanting more.
        I. Keep the bigger picture in mind.
        II. Be sure your pitch is punchy and relevant

Preparation: Before the Poster Presentation

A Handout

1. A takeaway for your attendees to remind them about your research and why they were interested.
2. What you need on your handout:
    a. Project title
    b. Your name and affiliation
    c. Your professional email address or another way you want people to contact you
    d. The key information from your poster.
    e. Any supporting materials not on the poster may be helpful.
3. Copy of your poster

Preparation: Before the Poster Presentation

1. Your Story: Is the narrative of your research. Like all great stories, it needs a beginning, a middle and an end. Plan for 10 minutes or less.
2. Introduction: set the scene and introduce the main concepts
    a. What is the necessary background information about your research topic that the audience must know?
    b. How did this lead you to your research question and what were you hoping to find out and why?
    c. Who are the main characters (i.e., a disease, a drug) and what are the relevant parts of the story.

Preparation: Before the Poster Presentation

1. Your story's middle is the adventure. It answers:
    a. How did you get from your research question to your conclusion? Why did you choose to take that route?
    b. What did you find on the way? Were there any interesting twists?
2. The final section is the conclusion to the story:
    1. What is the ultimate consequence? What does this mean for your characters?
    2. Is this the end, or are there plenty more things still to come? What might they be?

Preparation: Before the Poster Presentation

1. Practice
    a. Practice makes perfect and you will be more confident during your presentation. Rehearse what you will say and practice presenting on your friends and family. Make sure you:
        1) Understand all the figures on the poster and that you can explain them
        2) Have your synopsis memorized.
        3) Know all the key points to your research without referring to written notes
        4) Know your story, and be ready to answer questions with confidence.
        5) Be ready to deal with difficult questions you might not be able to answer fully.

Now you are prepared and ready for your poster presentation and to showcase your research.

Presentation Day: Live Poster Presentation

1. Dress for the Occasion: Scientific conference: business casual
    a. Traditional shirt or blouse with smart trousers or a skirt.
    b. Dress shoes, but be sure they are comfortable
2. Be Welcoming, Attentive, Helpful, not Hovering
    a. Stand at your poster for the whole session
    b. Smile and greet everyone walking past. If they seem interested, ask if they would like you to talk them through it
    c. Talking to someone and someone else walks up? Acknowledge them by making eye contact and smiling. Once finished, ask the newcomer what they missed or if they have questions.
    d. If someone is asking too many details, nicely ask to meet or call at another time to review.
3. Most importantly, make the most of the opportunity you've been given!

Virtual Presentation Considerations

NIH Identified: Four Types of Virtual Poster Sessions:

1. Online gallery: You will upload a poster image ahead of time. These images are maintained for some time in the gallery. The poster must be able to “stand alone” for the attendees.
2. Synchronous “flipped” session: Participants view the uploaded poster ahead of time. During the scheduled session, the organizer, audience, and you meet to discuss the poster using streaming software.
3. In asynchronous session: either the poster presentation is pre-recorded or it is presented live with a time followed by 5 minutes of questions.
4. Poster galleries with audience discussion boards: this is a non-video option. The poster is uploaded to the gallery. Then participants can comment on it online using specific interactive “boards,” and you respond back on the board.
5. Virtual reality: this feels like you are walking into a room with posters hanging up. You are presenting and reacting with the audience.

Virtual Presentation Considerations

Considerations for a Virtual Presentation:

1. Think about the type of presentation, technology, and how you will prepare.
    a. For example, you may want to print out your poster and practice presenting it if you are using video technology or are pre-recorded.
2. If your poster will go into a gallery, you want to be sure the poster information is “stand-alone” as you may not be able to discuss it fully.
3. If your poster must be uploaded, there may be a size limit.
    a. NIH has identified 25MB is often the limit, of which too many pictures can use up that space rapidly.