Poster Submission Rules & Format Guidelines

Summer Meetings and Exhibition
Baltimore Convention Center
Baltimore, MD
June 11-15, 2016

WHAT IS A POSTER PRESENTATION

Poster Presentations are informal discussions among meeting attendees about current projects in pharmacy practice. Poster presentations provide an excellent opportunity to pick up ideas that have been successful in other healthcare systems.

ASHP is seeking poster presentations from students, residents, fellows and practitioners. Please see page 4 for a list of practice area categories.

Poster abstracts are classified as one the following:

- **D = Descriptive Reports:** Describes new, improved or innovative roles or services in pharmacy practice, or unusual clinical cases in one or a few patients that have not been formally evaluated but are of such importance that they must be brought to the attention of practitioners. Descriptive reports must contain detailed rationale of the project or case, and the importance of the report to pharmacy practice.
- **E = Evaluative Study Reports:** Describes original research, including clinical research on drug effects in humans, drug-use evaluations, and evaluations of innovative pharmacy services. Evaluative study reports must include scientific results and/or data to support the conclusions, and indicate that all clinical research represented in the abstract was approved by the appropriate ethics committee or institutional review board and, if appropriate, informed consent was obtained for all subjects.
- **C = Case Reports:** Describes an unusual patient-specific case that was not part of a study but the findings are of interest to clinical pharmacists. Case Reports do not need the headings Purpose, Methods, Results, or Conclusions.

SUBMISSION DEADLINE

March 15, 2016 at 11:59 pm (Pacific) – Abstracts must be complete and submitted by this date; no new submission or edits will be accepted after this deadline. ASHP will not edit abstracts. Incomplete abstracts will be deleted from the system after this deadline.

TASKS TO COMPLETE FOR YOUR ABSTRACT PROPOSAL ONLINE

NEW SUBMISSION PROCESS

Our new online submission tool requires the Primary Author to complete six (6) tasks to submit their poster. **Some of our guidelines have changed**, therefore, it is important that the primary author carefully read the information on the screen and follow the submission guidelines.

PRIMARY AUTHOR

The person entering the information online is considered *the **primary author*** as well as the primary presenter. The primary author's name will *automatically* appear first on the citation and the abstract, and it is their contact information that will be printed on the published version of the abstract. **The primary author is responsible for verifying that all coauthors are aware of the content of the abstract and support the data**.

Multiple abstracts on the same topic from one author or institution will not be accepted. Your poster presentation at the meeting must not differ from the original accepted title and abstract content in your submission. An author of the abstract (preferably the primary author) is required to register for the meeting to present the poster.

LOGIN – EMAIL ADDRESS & ACCESS KEY

To submit an abstract, you must create a profile which includes your contact information, mailing address, and your access key.

- Your email address and the access key you created will be used as your login information for the poster site. **The email that is used for logging into the ASHP Poster Abstract Submission site must belong to the primary author** – not an assistant or colleague.

You must click "Continue" button on every screen in order to save your information

Do not delete or alter the email address that is shown on your profile. Deleting the email address on this screen will cause your submission to be incomplete and will not be included in the review process.

POSTER ABSTRACT TITLE

Be sure your title accurately and concisely reflects the abstract content. Submissions with titles that are NOT in the correct format will be rejected. **IMPORTANT: Only put the title of the abstract in the title field. DO NOT put it in the abstract content field**.

- **Title Format**
  - Please use **sentence case** to format your titles. Titles in all uppercase or lowercase letters will not be accepted.
  - Do NOT use proprietary (brand) names in the title
  - Use Capitalized letters only for acronyms or proper nouns (e.g. countries, etc.).
  - Do not use "A," "An," or "The" as the first word in the title
- **Title Format Examples**

  Incorrect: IMPLEMENTATION OF COMPUTERIZED PRESCRIBER ORDER ENTRY (CPOE) IN A SURGICAL UNIT: ONE YEAR LATER

  Incorrect: Implementation of Computerized Prescriber Order Entry In A Surgical Unit: One Year Later

  CORRECT: **Implementation of computerized prescriber order entry (CPOE) in a surgical unit: One year later**

PRACTICE AREA CATEGORY

All submission must select one category from the dropdown that appropriately reflects the content of the abstract. It will be used to match your submission with the reviewer for the peer-review process.

Practice Area Categories:

- Administrative Practice/ Financial Management / Human Resources
- Ambulatory Care
- Automation/ Informatics
- Cardiology/ Anticoagulation
- Clinical Services Management
- Critical Care
- Drug-Use Evaluation/ Drug Information
- Emergency Medicine/ Emergency Department/ Emergency Preparedness
- General Clinical Practice
- Geriatrics
- I.V. Therapy/ Infusion Devices/ Home Care
- Infectious Diseases
- Leadership
- Oncology
- Pain Management
- Pediatrics
- Pharmacokinetics
- Pharmacy Law/ Regulatory/ Accreditation
- Practice Research/ Outcomes Research/ Pharmacoeconomics
- Preceptor Skills
- Quality Assurance/ Medication Safety
- Small and Rural Pharmacy Practice

TASK 1: POSTER ABSTRACT CONTENT

Enter your poster abstract content details. Only completed submissions will be included in the review process.

ABSTRACT CONTENT MUST:

- ✓ **Be complete at the time of submission**. Planned projects or descriptions of projects still being implemented will not be accepted.
- ✓ Contain **Purpose, Methods, Results and Conclusions.**
- ✓ **NOT** contain the statement "**details/results will be discussed**". Abstracts with this statement will not be accepted.

All clinical research involving patients must have been approved by the appropriate **ethics committee** or **institutional review board.** If review was not designed as required by the institution, a statement to this effect must be included in the abstract.

- ✓ Be supported by **scientific merit**. Methodology is consistent with sound research design; study designed in a manner likely to answer the research questions; research questions aligned with proposed data collection and conclusion.
- ✓ **Exhibit a balanced presentation**. Abstracts must be non-promotional in nature and free of commercial bias. Abstracts written in a manner that promotes a company, service or product will not be accepted.
- ✓ Support a topic of **relevance** and **importance** to our attendees.

ABSTRACT FORMAT:

- **Correctly** format your title. **(See page 3 for details on correct title format.)**
- **Word Limits** – your entire abstract should be approximately 400 - 625 words
- **Do not** use special functions such as tabs, underlines, trademarks, superscript, subscript, bold, or italics.
- **Spell out** special symbols - Greek letters, degrees, plus and/or minus signs, greater than or less signs, percentage, etc. Use standard abbreviations.
- **Do not include** graphs, tables, or illustrations in your abstract.
- Spell out all pharmaceutical **acronyms**.
- Do not include the title or authors in the body of the abstract.
- **Abstracts in outline form will be rejected**.
- Submission Type – Your abstract must be a Descriptive Report, Evaluative Study Report, or a Case Report.

Word Limits

Purpose	**~ 100 words**
Methods	**~ 225 words**
Results	**~ 200 words**
Conclusion	**~ 100 words**

Total ~ 625 words max

IMPORTANT

- **Abstracts that we feel have been ghostwritten or have been commissioned by a commercial entity for the express purpose of positive publicity for a product or service will not be accepted.**
- **Your abstract will be peer reviewed and evaluated based on the guidelines provided in this document.** (See page 7 for details on the peer review process.)
- **Abstracts submitted for presentation must not have been presented or published previously. Exceptions are those presented at a state society meeting or an international meeting held outside the U.S.**
- **ASHP does not retain the exclusive rights of publication to poster.**

Task 2: Primary Author

Primary Author

Primary Author –Primary author's (submitter) name automatically appears first on the poster citation, and their contact information will be printed in the published version of the abstract.

Review the primary author's information and make necessary edits. Click the **Continue** button to save your changes. Click the **Save Primary Author** button to move to the next task. Remember:

- **Do not use ALL CAPS**
- **Include a period after your middle initial**
- **Do not place degrees in the "Last Name" field**
- **Add degrees in the credentials field**

Task 3: Primary Author Affirmation

Affirmation of Content – The primary author must affirm the content of the submission on behalf of all authors listed on the abstract. Affirmation include that all co-authors are aware of the content and the primary author or one of the co-authors will present the poster during the time assigned if the abstract submission is accepted. Other items include:

- ASHP Membership
- Federal affiliation (if applicable)

Click the **Continue** button for the next step

Task 4: Co-Authors

Additional Authors / Co-Authors – Each submission may have to up to five (5) authors, the primary author and four (4) additional authors. The primary author:

- Must submit the names and email addresses using the co-author task.
- Is responsible for ensuring all authors are included and in the order they will appear on the abstract, citation, and on the poster display.

ASHP will not add "forgotten" authors or make changes to the order of the authors.

Task 5: Financial Relationship Disclosure

Disclosures – Only the financial relationships of the primary author must be disclosed.

- Click your name to complete the required information for this task.
- Disclose any financial relationships for you and/or your spouse/partner.
- Type your name to verify the information is correct and move to the next task.

Task 6: Conflict of Interest Agreement

The primary author must complete and sign the conflict of interest agreement terms for their submission. This includes agreeing to display the disclosures on the poster display. The primary author must:

- Read and sign the agreement.
- Click **Submit Agreement** button to complete the task.

CONFIRMATION & PROPOSAL ID NUMBER

When all the submission tasks are completed (shown with a green check mark) you must save your submission before you can submit it. Click the **Save Submission** button and the screen will show a summary of your submission. It will also indicate that you have completed all the required tasks for your abstract proposal.

- Click the **Submit** button to submit the abstract.
- You will automatically get a confirmation email with your submission details. Please save it for your records.
- Your abstract title will appear on the screen with a link to preview the content or send a confirmation email.

Proposal ID Number: Your Proposal ID will appear on the screen with the list of tasks you completed as well as in your email confirmation. Save this number for your records.

INCOMPLETE SUBMISSIONS

Incomplete submissions will be deleted from our online system (i.e. missing required elements, etc.).

PEER REVIEW

All poster submissions undergo a blinded peer-review process. We do not supply names or author affiliations to reviewers; however, if you want your review to be completely blinded, do not include the name of your institution in the body of your abstract.

Each reviewer will be given the same criteria for reviewing your submission, so it is important that your abstract is well written and meets the guidelines provided in this document. Abstracts will be evaluated only on the data submitted.

Peer Reviewers will evaluate content based on the following criteria:

- Presentation balance
- Relevance and importance of topic to our attendees.
- Scientific merit
- Abstract format

COMMON REASONS FOR REJECTION

- Instructions not followed; format indicated in instructions is not utilized
- Misleading title
- Commercial tone or a biased conclusion
- Research/project is not original
- Lack of scientific quality or validity; poor quality of research methodology; methods are not reproducible; lack of data or measurable outcomes
- Data collection is ongoing or has not begun
- Inconsistent or ambiguous data
- Lack of conclusions or conclusions that do not match objectives
- Several abstracts from the same study submitted
- Incomplete author disclosure statement (lack of details) or no disclosure statement

Authors that are members of ASHP will be given acceptance priority over non-ASHP members, should acceptable submissions exceed space available.

NOTIFICATIONS

After April 13, you will receive an email notification about the status of your submission. All correspondence including confirmations, reminders, and accept/reject notifications will be sent to the primary author's email address only. It is the primary author's responsibility to notify the coauthors of the status of the submission. It is imperative that this email address is a working email address that is not spam-protected. If you do have spam protection, you may not receive our emails. Notification emails will come from posters@ashp.org.

MEETING REGISTRATIONS and CANCELLATIONS

MEETING REGISTRATION

Presenting a poster at our meeting is a voluntary effort and ASHP cannot pay expenses for your participation. If your submission is accepted you, are responsible for your own meeting registration fee and travel. **All presenters must be registered for the meeting,** at least for the day of your poster presentation.

WITHDRAWALS/CANCELLATIONS

Written notification is required for all submission withdrawals. Only the primary author may withdraw a submission. Send your withdrawal request to: posters@ashp.org. Please include your full name, presentation title, and proposal ID number in all correspondence.

Due to early publication deadlines, if you withdraw after receiving your acceptance notice we cannot guarantee that your presentation citation and/or abstract will not appear in print, on the ASHP Website, or in other print or electronic media.

CONTACT INFORMATION

CONTACT US

If you have any questions regarding your submission, please send an email to posters@ashp.org. Please include your name, title of submission, and your abstract submission number. ASHP will provide information only to the primary author.

Thank you for your interest in presenting a poster at an ASHP meeting.

ABSTRACT EXAMPLES

Descriptive Report Poster Abstract Sample

PLEASE NOTE: Do not include the field names – **Purpose, Methods, Results, and Conclusion** – in the body of your abstract.

Title: Assessing pharmacist competency for processing adult chemotherapy orders in a community hospital

Purpose: The avoidance of errors in the processing of chemotherapy orders is an important component in the pharmacy department's medication-use safety initiatives. Chemotherapy order processing was identified as a needed competency assessment to heighten awareness in recognizing and preventing chemotherapy medication errors. This project was designed to uncover and correct gaps in the knowledge that pharmacists needed for the safe processing of chemotherapy orders at a community hospital.

Methods: A pharmacist with advanced training (specialty residency) in oncology wrote a certification module and a competency assessment examination. The certification module included readings, the hospital policy on processing chemotherapy orders, and a chemotherapy order-processing checklist designed for the pharmacist. The assessment examination used three actual patient chemotherapy orders, each with specific patient demographics, laboratory values, and imbedded errors. Pharmacists taking the examination needed to identify the errors to process the orders safely. All staff pharmacists were required to complete the examination and instructed to work independently. A score of 100 percent was required to pass the competency assessment.

Results: Twelve pharmacists completed the module. Seven pharmacists correctly identified all the medication order errors in the competency assessment examination. Five pharmacists needed additional training in their identified areas of deficiency and took a customized assessment examination to address those areas specifically. All five pharmacists successfully completed the second assessment examination. The pharmacy director and clinical coordinators felt that the competency assessment examination was successful in identifying gaps in knowledge. The pharmacists indicated that they were more confident processing chemotherapy orders after successful completion of the module and competency assessment.

Conclusion: Competency assessment was helpful in identifying and correcting knowledge gaps and may be useful in medication order processing of high risk medications as part of the pharmacy department medication-use safety plan.

Evaluative Study Abstract Sample

PLEASE NOTE: Do not include the field names – **Purpose, Methods, Results, and Conclusion** – in the body of your abstract.

Title: Effect of carvedilol or atenolol combined with a renin-angiotesin blocker on glycemic control

Purpose: Beta-blockers decrease cardiovascular risk in patients with hypertension and diabetes mellitus (DM). However, their use has been associated with increased fasting glucose and HbAlc levels in these patients. The purpose of this study was to determine whether carvedilol or atenolol had more favorable glycemic effects on patients with diabetes and hypertension who were also using a renin-angiotensin (RAS) blocker, which is known to improve glycemic control.

Methods: The institutional review board approved this open-label, randomized, and controlled group study. Men and women aged 18-65 provided informed consent and enrolled if they had Type 2 DM and stage 1 or 2 hypertension controlled by medication. Patients taking a non-ocular beta-blocker within the past 3 months and those with pulmonary, cardiovascular, or kidney disease were excluded. Antihypertensive treatment must have included an RAS blocker, such as an angiotensin-converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB). Following a washout period to discontinue all other antihypertensive treatments, 48 patients were randomized to receive either carvedilol (n equals 25) or atenolol (n equals 23) for 24 weeks. Study medication was titrated from carvedilol 6.25 mg twice daily and atenolol 12.5 mg twice daily to a maximum dose of 25 mg and 100 mg twice daily, respectively, at two-week intervals toward target blood pressure levels (less than or equal to 130/80 mmHg). The primary outcome measure was a change from baseline in HbAlc after 6 months of treatment. Secondary outcomes included changes in blood pressure and heart rate. It was determined that 23 participants per treatment group would yield 80 percent power to detect a difference of 0.20 percent between groups for the primary outcome. Data are expressed as means with 95 percent confidence intervals, and evaluation of primary and secondary outcomes utilized analysis of variance.

Results: The mean difference between carvedilol and atenolol in the change in HbAlc from baseline was 0.21 percent (95 percent CI, 0.04 percent to 0.27 percent, P equals 0.004). HbAlc levels increased with atenolol administration (0.23 percent; 95 percent CI, 0.08 percent to 0.31 percent, P less than 0.001) but did not change significantly with carvedilol (0.02 percent; 95 percent CI, -0.06 to 0.08 percent, P equals 0.65). Effects on blood pressure and heart rate were comparable.

Conclusions: Use of carvedilol in the presence of RAS blockade did not affect glycemic control. However, atenolol was associated with a slight increase in HbAlc after 6 months of treatment. The clinical significance of these effects must be determined in larger, long-term clinical trials.

Case Report Abstract Sample

PLEASE NOTE: Do not include the field name **"Case Report"** in the body of your abstract. *The entire abstract is entered in the Case Report Field.*

Title: Potential risk of transdermal alcohol application in patients on warfarin

Case Report: This case series illustrates the potential risk of transdermal alcohol application in patients on warfarin. Patient 1 is being treated with warfarin for heart failure. The patient has a goal INR between 2 and 3 and has had therapeutic INRs at the last twenty-two clinic visits. He presented to clinic with an INR of 4.2. He denied symptoms of heart failure exacerbation, changes in diet, or changes in medications. The patient reported that he had been applying rubbing alcohol to a back injury. At this visit, patient was instructed to discontinue rubbing alcohol, hold two doses of warfarin, and then resume his current warfarin regimen. He returned to clinic four weeks later and his INR was 2.3. His INR remained in the therapeutic range for the next three follow-up visits. Patient 2 has been prescribed warfarin secondary to an atrial valve replacement and has a goal INR range of 2 to 3. After six consecutive therapeutic visits, the patient presented with an INR of 3.2. She denied medication or diet changes, but reported that she had applied rubbing alcohol to sore legs several days prior to the clinic visit. At this visit she was told to discontinue the rubbing alcohol, hold one dose of warfarin, and then resume her previous regimen. The patient returned to clinic four weeks later and her INR was 1.8. Patient's INR remained in the therapeutic range for the next five visits. Patient 3 is being treated with warfarin for recurrent venous thromboembolism (VTE) and protein S deficiency. Her therapeutic INR range is 3.0 to 3.5 due to recurrent VTE despite therapeutic INR levels. Her INR in clinic was 4.3 following a recent dose increase of her warfarin. She reported that she had been using four ounces of hand sanitizer daily. She was asked to hold her warfarin dose that night, and then resume her current regimen. She returned to clinic seven days later and her INR was 3.7. Despite being counselled on the risk associated with the alcohol-based hand sanitizer, she continued to use approximately four ounces daily. Over the next two months the patient's INR fluctuated greatly with all but one INR in the supratherapeutic range. The patient finally discontinued use of the instant hand sanitizer and her INR fell to 2.6. Although the patient's INR was never completely stable the two months following discontinuation of the hand sanitizer, the INR fluctuations were more predictable. As this case series suggests, the application of transdermal alcohol has the possibility to affect INRs in patients being treated with warfarin. Although more study is needed to further elucidate this interaction, it is important for providers to inquire about the topical application of alcohol and alcohol-containing products.