Abstract Presenter Coaching Call

Oral and Poster Presentations

2011 CityMatCH Urban MCH Leadership Conference

Today's Call Objectives

- Introductions!
  - Who are you?
  - Where are you from?
  - What do you want to know by the time you hang-up the phone?
- Poster Presentations Tips and Tricks
- Oral Presentations Tips and Tricks
- Where to go to find more information

Introductions

1. Who are you?
2. Where are you from?
3. What do you want to know by the time you hang-up the phone?

Poster Presentations: The Good, the Bad, and the Ugly

Tips and Tricks

First Place: MaKenzie Moore, Dublin District 5-1, Telfair Elementary, Georgia

If these 2 posters were side by side, which would you look at first?

Magnetic Field Distortions Produced by Protective Cages Around Sea Turtle Nests: Unintended Consequences for Orientation and Navigation?

William P. Irwin[1], Amy J. Horner[1,2] and Kenneth J. Lohmann[1]

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Introduction

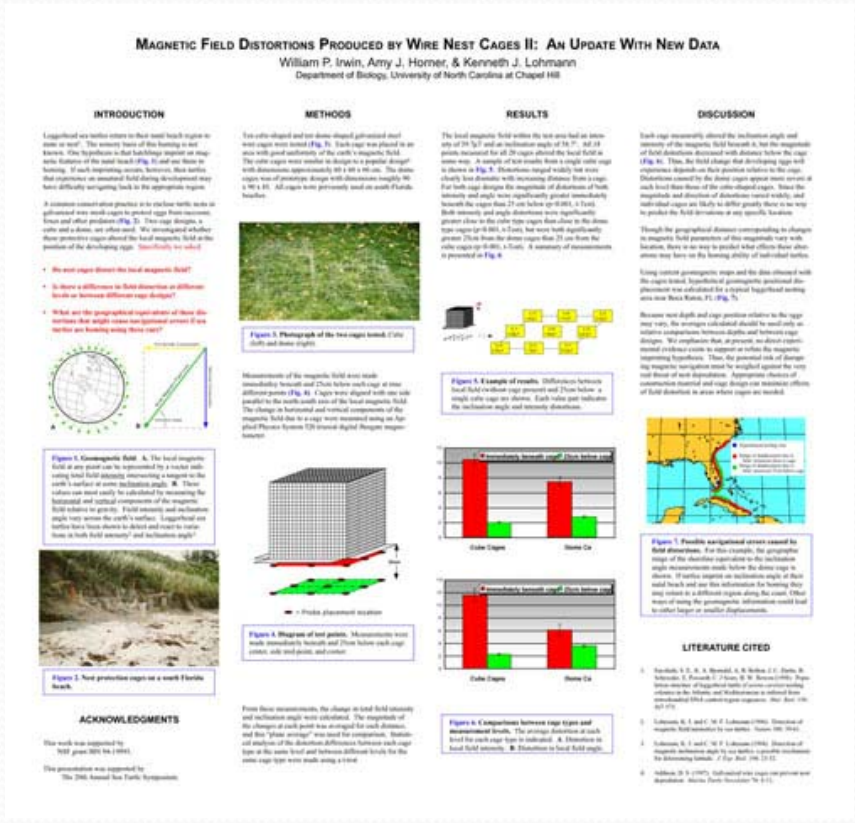
Materials and Methods

Results

Discussion

Acknowledgements

References Cited



Magnetic Field Distortions Produced by Wire Nest Cages II: An Update With New Data

William P. Irwin, Amy J. Horner, & Kenneth J. Lohmann

Department of Biology, University of North Carolina at Chapel Hill

INTRODUCTION

METHODS

RESULTS

DISCUSSION

ACKNOWLEDGMENTS

LITERATURE CITED

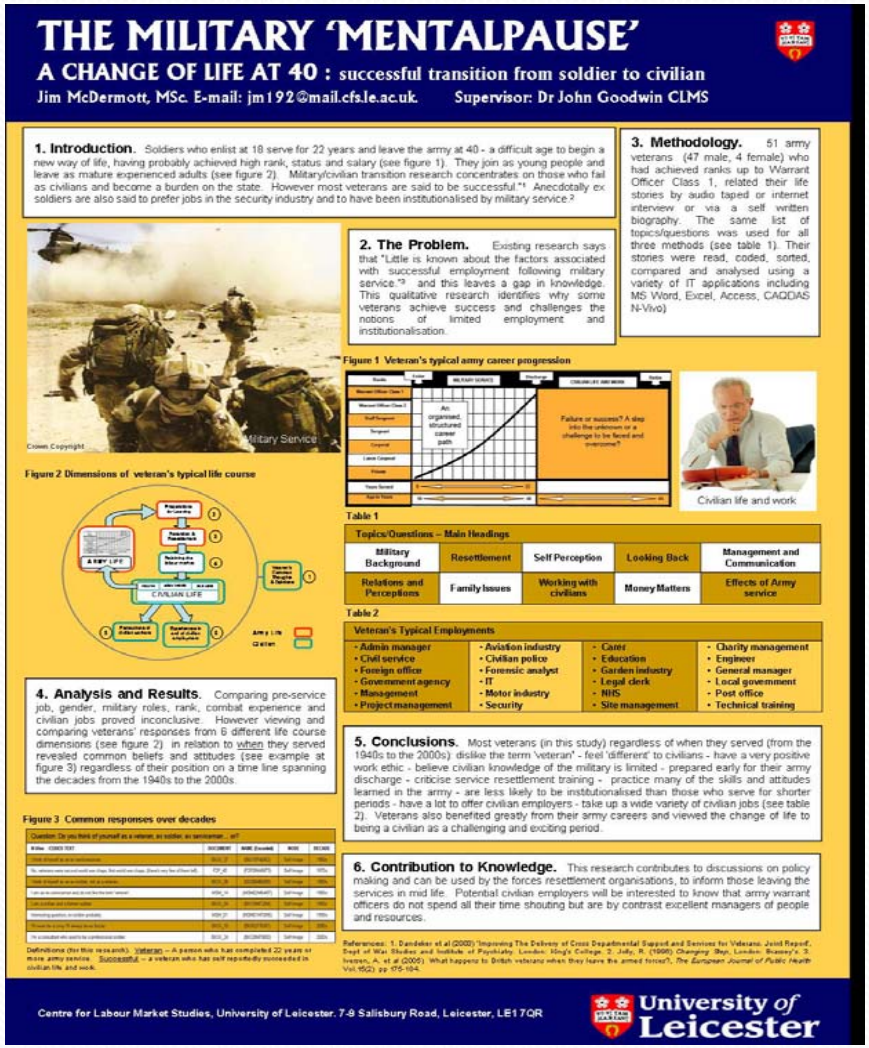
What makes a good poster "good"?

- The "Look"
- Determines whether or not passers-by will **STOP**, **LOOK**, and **LISTEN**
  - **Font sizes:** Use 24 point+ for text and 60 point+ for headings
  - **Text:** Check for grammar, edit, edit, cut, cut, cut
  - **Flow:** Use arrows/signs/symbols as a road map
  - **Color:** Select colors that will aid in ease of readability

- The "Content"
  - **Message Matters:** Prominent take home messages (1-3)
  - **Graphics:** Use graphics/illustrations/data figures in place of text
  - **Presentation:** Engage passers-by and have a 1 minute overview and a 3-5 minute explanation ready

The “Good”

Good and Bad Features



THE MILITARY 'MENTALPAUSE'

A CHANGE OF LIFE AT 40 : successful transition from soldier to civilian

Jim McDermott, MSc. E-mail: jm192@mail.cfs.le.ac.uk. Supervisor: Dr John Goodwin CLMS

1. Introduction. Soldiers who enlist at 18 serve for 22 years and leave the army at 40 - a difficult age to begin a new way of life, having probably achieved high rank, status and salary (see figure 1). They join as young people and leave as mature experienced adults (see figure 2). Military/civilian transition research concentrates on those who fail as civilians and become a burden on the state. However most veterans are said to be successful.[1] Anecdotally ex soldiers are also said to prefer jobs in the security industry and to have been institutionalised by military service.[2]

2. The Problem. Existing research says that "Little is known about the factors associated with successful employment following military service."[3] and this leaves a gap in knowledge. This qualitative research identifies why some veterans achieve success and challenges the notions of limited employment and institutionalisation.

3. Methodology. 51 army veterans (47 male, 4 female) who had achieved ranks up to Warrant Officer Class 1, related their life stories by audio taped or internet interview or via a self written biography. The same list of topics/questions was used for all three methods (see table 1). Their stories were read, coded, sorted, compared and analysed using a variety of IT applications including MS Word, Excel, Access, CAQDAS N-Vivo)

Figure 1 Veteran's typical army career progression

Civilian life and work

Figure 2 Dimensions of veteran's typical life course

Table 1

Topics/Questions – Main Headings				
Military Background	Resettlement	Self Perception	Looking Back	Management and Communication
Relations and Perceptions	Family Issues	Working with civilians	Money Matters	Effects of Army service

Table 2

Veteran's Typical Employments			
• Admin manager • Civil service • Foreign office • Government agency • Management • Project management	• Aviation industry • Civilian police • Forensic analyst • IT • Motor industry • Security	• Care • Education • Garden industry • Legal clerk • NHS • Site management	• Charity management • Engineer • General manager • Local government • Post office • Technical training

4. Analysis and Results. Comparing pre-service job, gender, military roles, rank, combat experience and civilian jobs proved inconclusive. However viewing and comparing veterans' responses from 6 different life course dimensions (see figure 2) in relation to when they served revealed common beliefs and attitudes (see example at figure 3) regardless of their position on a time line spanning the decades from the 1940s to the 2000s.

Figure 3 Common responses over decades

5. Conclusions. Most veterans (in this study) regardless of when they served (from the 1940s to the 2000s) dislike the term 'veteran' - feel 'different' to civilians - have a very positive work ethic - believe civilian knowledge of the military is limited - prepared early for their army discharge - criticise service resettlement training - practice many of the skills and attitudes learned in the army - are less likely to be institutionalised than those who serve for shorter periods - have a lot to offer civilian employers - take up a wide variety of civilian jobs (see table 2). Veterans also benefited greatly from their army careers and viewed the change of life to being a civilian as a challenging and exciting period.

6. Contribution to Knowledge. This research contributes to discussions on policy making and can be used by the forces resettlement organisations, to inform those leaving the services in mid life. Potential civilian employers will be interested to know that army warrant officers do not spend all their time shouting but are by contrast excellent managers of people and resources.

References: 1. Dandeker et al (2002) 'Improving The Delivery of Cross Departmental Support and Services for Veterans. Joint Report. Dept of War Studies and Institute of Psychiatry. London: King's College. 2. Jolly, R. (1996) *Changing Step*, London: Brassey's. 3. Iversen, A. et al (2005). What happens to British veterans when they leave the armed forces?, *The European Journal of Public Health* Vol 15(2) pp 175-184.

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University of Leicester

- The "Look"
  - Good – use of color and contrast
  - Bad – flow a bit confusing
- The "Content"
  - Good – key message in title
  - Good – use of figures
  - Good – titled sections; text limited and highlighted

What Factors are Associated with State Performance on Provision of Transition Services to CSHCN?

Kasehagen, L.,[1] Kane, D.J.,[2] Punyko, J.,[3] Carle, A.C.,[5] Penziner, A.,[6] & Thorson, S.[3,4]

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Introduction

- **Transition services**
  - Definition: "purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-oriented health care systems" (1)
    - 90% of CSHCN survive to adulthood (1-4)
    - CSHCN have ongoing needs compared to other children (6-12)
    - CSHCN with more severe conditions face challenges with transition to adult health care (13-16)
- **Maternal and Child Health Bureau/Health Resources and Services Administration**
  - Title V needs assessment – system indicators
    - "receipt of the services necessary to make transitions to all aspects of adult life" (17)
    - The 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) provides state and national prevalence estimates to assess progress toward achievement of goals
- **Individual, condition-related and system factors influence health care access and transition access for CSHCN** (7; 19-32)
  - Failure to obtain transition services may contribute to
    - Gaps in insurance coverage
    - Delay in obtaining care

Objective

- To examine whether individual, condition-related, and system-related characteristics are associated with state performance in the provision of transition services to CSHCN

Methods

- Analysis of cross-sectional data from the NS-CSHCN
  - Sample
    - Children, aged 12-17 years (n=16,876)
    - Hispanic, non-Hispanic Black, non-Hispanic White
  - Model variables
    - Dependent: State performance of transition services (high, medium, low)
    - Independent:
      - Individual demographic and family characteristics
      - Condition-related factors
      - MCHB-defined system indicators
  - Statistical analysis
    - Polytomous logistic regression with low performance states serving as the referent group
    - Analyses conducted in SAS-callable SUDAAN to appropriately weight estimates and adjust for complex NS-CSHCN sample design

Selected Results

- 73.3% of CSHCN were encouraged to take responsibility for their health care needs
- 38% of CSHCN received anticipatory guidance
- 41% of CSHCN received transition services
- Characteristics* associated with receipt of transition services included:
  - white, non-Hispanic;
  - household education levels greater than high school;
  - household structures with two parents; and
  - household incomes >400% FPL.

*statistically significant at p≤0.05

Selected Results - *continued*

Table 1 – High-performance states

	Crude OR (95% CI)	Adjusted OR (95% CI)
Race/Ethnicity		
Hispanic	0.34 (0.17, 0.34)	0.25 (0.17, 0.37)
Non-Hispanic black	0.41 (0.30, 0.56)	0.44 (0.30, 0.62)
Non-Hispanic white	Referent	Referent
Family Household Structure		
2-parent biological / adoptive	Referent	Referent
2-parent step-parent	0.74 (0.55, 1.00)	0.80 (0.58, 1.10)
1-parent (mother only)	0.58 (0.46, 0.74)	0.78 (0.60, 1.03)
Other	0.81 (0.50, 1.33)	1.21 (0.71, 2.07)
No Medical Home	0.59 (0.48, 0.74)	0.73 (0.57, 0.95)
Lacks Adequate Insurance Coverage	0.63 (0.51, 0.78)	0.73 (0.58, 0.93)

Note: Table edited to highlight key findings

Table 2 – Medium-performance states

	Crude OR (95% CI)	Adjusted OR (95% CI)
Race/Ethnicity		
Hispanic	0.86 (0.64, 1.14)	0.87 (0.63, 1.18)
Non-Hispanic black	0.66 (0.51, 0.84)	0.67 (0.50, 0.90)
Non-Hispanic white	Referent	Referent
Family Household Structure		
2-parent biological / adoptive	Referent	Referent
2-parent step-parent	0.65 (0.49, 0.86)	0.64 (0.48, 0.87)
1-parent (mother only)	0.73 (0.59, 0.91)	0.83 (0.65, 1.07)
Other	0.88 (0.55, 1.41)	1.08 (0.64, 1.81)
No Medical Home	0.79 (0.65, 0.97)	0.82 (0.65, 1.04)
Lacks Adequate Insurance Coverage	0.76 (0.63, 0.93)	0.83 (0.67, 1.03)

Note: Table edited to highlight key findings

Conclusions

Key factors important to state performance in providing transition services to CSHCN were:

- High- versus Low-performance state
  - Race/ethnicity
  - Medical home
  - Adequate insurance coverage
- Medium- versus Low-performance states
  - Race/ethnicity
  - Medical home
  - Adequate insurance coverage
  - Family household structure

Limitations

- Cross-sectional data
- Responses based on parental report
- Sample size
  - Adjusted for families without landline telephones
  - Some populations too small to include

Provider Recommendations

- Continue to monitor, assess, evaluate, and improve performance on system indicators
- Share promising practices
- Develop a practice-based parent advisory group
- Establish transition services as a standard of care
- Establish meaningful, culturally competent partnerships with families of CSHCN

Logo

Title of the Data Study

Logo

PEOPLE WHO DID THE STUDY

AGENCY OR INSTITUTIONAL AFFILIATIONS

Background

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Objectives

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Results

Table 1. Title.

Table 1

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Table 2. Title.

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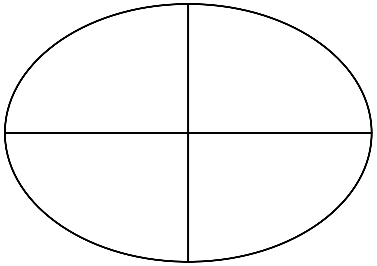
Figure 1. Title



Limitations

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Conclusions

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Public Health Implications

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Logo

Title of the Program / Policy Study

Logo

PEOPLE WHO DID THE STUDY

AGENCY OR INSTITUTIONAL AFFILIATIONS

Issue & Setting

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Picture 1. Title

Project Description

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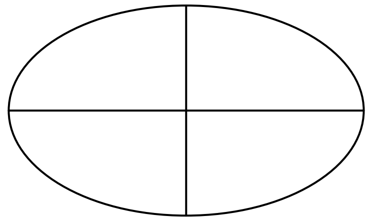
Figure 1. Title



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Results

Table 1. Title.

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Results, cont.

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Table 2. Title.

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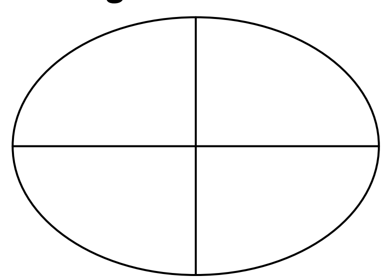
Figure 2. Title



Barriers

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Lessons Learned

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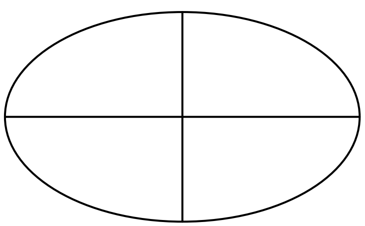
Figure 3. Title



Bibliography

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The “Bad”

A Comparison of Field Methods for Analysis of Soil Organic Carbon

Jennifer Roper

Introduction

In recent years, the interest in soil organic carbon (SOC), as a measure of soil organic matter (SOM), has increased significantly given its ability to act as an indicator of soil quality and as a measure of carbon sequestration in soil. It has been shown that the amount of SOC is directly related to the amount of SOM, given that approximately 58% of its weight comes from carbon. It has been suggested that the dynamics of SOM plays a large role in sustaining fertility and productivity of croplands and it should therefore be efficiently managed and monitored. The storage of carbon in soil is currently being examined as a means of mitigating increased CO_2 concentration in our atmosphere. To efficiently manage SOM farmers and other field professionals must have the ability to measure its content. Given the relationship that exists between SOM and SOC, many methods for analysis have been generated specifically testing for SOC as an indicator of SOM. Many of the techniques presently used for SOC determination are laboratory measurements that can be quite time consuming, costly and may even generate concern for the environmental wastes that they produce.

Objective

The objective of this project is to determine which method of SOC analysis is best suited for use as a field measure of SOC. Suitability will be evaluated both in terms of measurement accuracy and precision, as well as practicality of use and safety. It is hoped that at the end of the project a recommendation will be able to be made as to which method is best suited for use by field personnel.

Methods

Forty-five soil samples were selected to be analyzed for this project, which included eleven soil types with four replications of each soil type. To evaluate the precision of the various methods one soil was analyzed in four reps, totaling forty-eight soils being analyzed. For this project four particular methods were examined.

Dumas combustion was performed using a LECO CNS-1000 instrument, which measures the evolved CO_2 from the organic matter oxidized in a high temperature furnace. This method uses the difference in thermal conductivity of carbon dioxide and oxygen to determine the SOC. Dumas combustion is considered to be the most accurate of all methods.

The Walkley-Black method is an oxidation-reduction method which uses 1N $K_2Cr_2O_7$ and concentrated H_2SO_4 to oxidize SOM in the soil. This creates a color intensity directly proportionate to the SOM present in the soil. The color obtained in the tube is than compared to created standards at three levels of concentration, with the darkest shade of green indicating the highest level of SOM

The Active carbon (Active C) method is based on a color change, directly proportional to the concentration of soil organic carbon in a sample. This color change was brought about by the addition of potassium permanganate and was measured using a Milton Roy Company Spectronic 20.

The Basic EDTA method estimates the amount of soil organic carbon using a solution of Basic Ethylenedinitro tetraacetic acid (EDTA). Basic EDTA is a combination of sodium hydroxide and EDTA disodium salt (Na_2EDTA). This method relies on the fact that the release of SOC is directly proportional to the intensity of the color of the filtrate. The process of determining the concentration of SOC comes down to the visual comparison of soil samples against standards.

Results and Discussion

To effectively manage soils, it is important to have an efficient method for determining SOC that can be used in field situations by either producers or field personnel. In an attempt to find an appropriate method three possible field methods for determining SOC were evaluated based on accuracy, precision, and practicality of use. Accuracy was determined using a least squares means estimator where the three field methods were compared against the standard Dumas combustion method which was considered the most accurate for determining SOC. It was found that the modified Walkley-Black was not significantly different than the standard method. There was a significant difference between both the Active C and Basic EDTA against the standard method. The modified Walkley-Black method proved to be the most accurate method, with a strong positive relationship (Pearson correlation coefficient = 0.835). This was further emphasized visually through the graphical representation of the data (Figure 1A).

Table 1. The mean values of four methods of soil organic carbon determination and their significance, with a standard error of +/- 0.1605.

Methods	Mean
Dry Combustion**	2.23b*
Modified Walkley-Black	1.81bc
Active Carbon	1.72c
Basic EDTA	3.34a

*Means with the same letter are not statistically different, alpha 0.05.
**In this analysis the dry combustion method is equivalent to control.

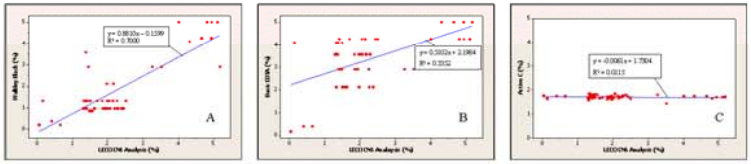


Figure 1. The percent of soil organic carbon content as measured by the Dumas combustion (LECO CNS) and Walkley-Black, Basic EDTA and Active C methods. Pearson correlation coefficients respectively 0.835, 0.579, -0.107.

The coefficient of variance was used as a measure of the precision within methods, where the lower the number the less variability within the data (Table 2). To test this parameter, a single soil sample was analyzed in replicate, four times. The Active C method resulted in the lowest coefficient of variance, indicating that the variability was minimal within the data, which is further seen on a larger scale in the above graph (Figure 1C). The clumping of the data shows high precision in the complete data set, however, very inaccurate measurements. The two other field methods show high coefficients of variance, indicating high variability within the data.

Table 2. The coefficient of variance (%) of a single soil analyzed using four methods of soil organic carbon determination.

Method	Mean	Range	Coefficient of Variance
Dumas Combustion (Standard Lab Method)	**0.606 +/- 0.541**	**0.051-1.330**	**89.252**
Modified Walkley-Black	0.527 +/- 0.534	0.210-1.320	101.173
Active Carbon	1.735 +/- 0.050	1.664-1.780	2.867
Basic EDTA	0.750 +/- 0.913	0.150-2.110	121.677

Table 3. Comparison of field methods for determination of soil organic carbon based on practicality.

	Pros	Cons
Modified Walkley-Black	Easy to follow Reproducible	Safety hazard Creates waste containing strong acid and Cr. Higher standard range difficult to distinguish between
Active Carbon	Safe for field use Simple to follow Easy method Reproducible	Cost of hand held colorimeter
Basic EDTA	Simple to follow Relatively safe for field use Do not require expensive equipment	Standard colors difficult to distinguish Filtration time consuming

The modified Walkley-Black method, although the most accurate method, can be extremely hazardous for both handlers and the environment. For these reasons, it should not be recommended as a field method of SOC determination. The Active C method was the most precise of all the methods, and was also easy to use and highly reproducible. If the cost of the handheld colorimeter wasn't an issue, then perhaps this method may be suffice to use as a field method. Even though the Basic EDTA method was not precise or accurate, it was a simple procedure and inexpensive equipment makes it a potential method to use. Due to the fact that the color identification is so subjective, the use of color chips may be beneficial.

Conclusion

The Walkley-Black proved to be the most accurate method for SOC determination, however would not be adequate for field use given the safety hazards and waste problems associated with its use. The Active C method yielded the most precise results of the tested methods and would be sufficient for field use if funds are available for the purchase of a hand held colorimeter, however, given its low level of accuracy it is not suggested to test SOC. On the condition that color chips are provided, the Basic EDTA method would be sufficient for field use, unfortunately, it does not provide enough accuracy or precision for adequate estimates of SOC.

Given their ease of use and limited safety hazards, Active C and Basic EDTA are both possible methods for field determination of SOC upon further method development.

Acknowledgments

Dr. David Burton, Academic Supervisor and Drucie Janes for her laboratory expertise.

For information, please contact author: jdroper@nsac.ca

ESTIMATING PREVALENCE OF FETAL ALCOHOL SYNDROME IN OREGON

LJ KASEHAGEN[1], JE HUTCHINSON[1], M RUHLIN[1], LA DIXON-GRAY[1], CA GALLIA[2], KD ROSENBERG[1]

OREGON PUBLIC HEALTH DIVISION, OFFICE OF FAMILY HEALTH[1]; OREGON DIVISION OF MEDICAL ASSISTANCE PROGRAMS, RESEARCH & ANALYSIS[2]

BACKGROUND, POPULATION & DEFINITIONS

What is Fetal Alcohol Syndrome (FAS)?

• A disorder of permanent birth defects that occur in the offspring of women who drink alcohol during pregnancy. FAS is typified by a constellation of
  • Growth deficiency in height, weight, or both;
  • Craniofacial abnormalities (smooth philtrum, thin upper lip, short palpebral fissures); and
  • Clinically significant structural, neurological, or functional central nervous system impairment.
• Manifestation of birth defects depends on the amount, frequency, and timing of maternal alcohol consumption.

Oregon FAS Surveillance System
• **Geographic coverage**
  • Statewide surveillance
• **Case inclusion criteria**
  • Mother of child – Oregon resident at time of birth, and
  • Child – Born between 1/1/2001 and 12/31/2006 (inclusive)
• **Case definition (see Positive Phenotype Table below)**

	OREGON FAS SURVEILLANCE SYSTEM POSITIVE PHENOTYPE		
FAS DIAGNOSTIC CATEGORY	**FACE**	**CENTRAL NERVOUS SYSTEM (CNS)**	**GROWTH**
CONFIRMED	**ABNORMAL FACIAL FEATURES consistent with FAS** **OR** **2 OF 3 FEATURES:** • Short palpebral fissures • Abnormal philtrum • Thin upper lip	**At least 1 STRUCTURAL or FUNCTIONAL anomaly** **STRUCTURAL** Head circumference <=10th percentile at birth or any age postnatally **FUNCTIONAL** • Developmental delay • Mental retardation • ADD / ADHD	**GROWTH DELAY in utero or after birth** **INTRAUTERINE** Weight or Height corrected for gestational age <=10th percentile **POSTNATAL** • Weight for Height <=10th percentile for age • Weight for Height <=10th percentile
PROBABLE	Must meet **FACE** criteria	Must meet **EITHER CNS OR GROWTH** criteria	
PENDING	Must meet predetermined criteria from the specific referral source		

See Hymbaugh et al., *Teratology* 2002, 66:S41-S49; Druschel and Fox, *Pediatrics* 2007, Vol. 119(2):e384-e390.

Case-Finding Strategies
• **FAS** (ICD-9 760.71) **OR** a **combination of ICD-9 codes**
  • **Central Nervous System (CNS) diagnoses --** microcephaly (ICD-9 742.1) AND developmental delay (ICD-9 315.xx) OR mental retardation (ICD-9 317.xx, ICD-9 318.xx)
  • **PLUS 1 growth-related diagnosis --** small for gestational age (ICD-9 764.xx) OR low birth weight (ICD-9 765.xx) OR failure to thrive (ICD-9 783.x)

Data Sources
• Oregon Birth Certificates
• Medicaid Management Information System (MMIS) claims data
• Medical records
  • 57 hospitals and hospital pediatric clinics
  • Child Development and Rehabilitation Center clinics, specialty pediatric clinics
  • Genetics clinics

Case-Finding Methods
• Use birth certificates and MMIS claims data to identify children with certain diagnostic codes
• Make requests to hospitals and clinics for medical records on children that
  • Have FAS or the ICD-9 760.71 diagnostic code in the medical record or hospital discharge summary
  • Have a ICD-9 759.x diagnostic code for congenital anomalies
  • Fit surveillance system criteria (specific combinations of ICD-9 codes)
  • Were identified by birth certificate and/or Medicaid claim

PREVALENCE ESTIMATION METHODS

Dual- and Multiple-Record System (DRS / MRS) Estimation Methods

• More commonly known as "capture-recapture"
• Applied to human populations in the 1940s
• First epidemiologic application of methods in 1969

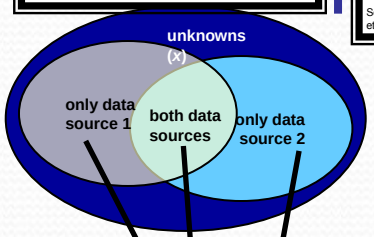
• Modified for use in human populations to estimate
  • Population size
  • Incidence and/or prevalence of disease (primarily chronic diseases)
  • Completeness of surveillance systems or disease registries

• Adapted to different types of data sources
  • Medical records
  • Laboratory results
  • Registries

See IWGDMF, *Am J Epidemiol* 1995, 142:1047-58, 1059-68.

Estimation methods can have as few as 2 sources of data. DRS estimation methods stem from 2 primary techniques

• **Peterson Estimator** for large sample sizes, uses a maximum likelihood estimation method, or
• **Chapman Estimator** for small sample sizes, uses a nearly unbiased estimation method



		1st Data Source	
		Present	Absent
2nd Data Source	Present	a	b
	Absent	c	x

Figure 1. 2 x 2 Table Layout for 2-source Estimation Method using Peterson and Chapman Estimators

Method Assumptions for 2-source Models

• **Closed population** – is the individual in the population for the duration of the study?
• **Identifiability** – can an individual be identified and matched from 1 data source to the next data source?
• **Equal catchability** – is the probability of being "captured" the same for all individuals?
• **Independence** – is the probability of an individual being captured in any 1 sampling event independent of other sampling events?

		1st Data Source			
		Present		Absent	
		2nd Data Source		2nd Data Source	
		Present	Absent	Present	Absent
3rd Data Source	Present	a	b	e	f
	Absent	c	d	g	x

Figure 2. 3-way Table Layout for 3-source Estimation Method using Log-Linear Modeling.

Why use more than 2 sources of data and MRS estimation methods?

• All models are under a unified framework
• Model selection can be easily implemented and carried out in a flexible manner based on data and informed by prior knowledge
• Tests are available for comparing models
• Dependence can be incorporated into models by adding appropriate interaction terms
• All inference is within the mainstream of statistical data analysis

See IWGDMF, *Am J Epidemiol* 1995, 142:1047-58, 1059-68. Chao et al., *Statis Med* 2001, 20:3123-57.

Why use DRS or MRS estimation methods for estimating prevalence of FAS?

• The Centers for Disease Control and Prevention framework for the FAS surveillance system was specifically built upon the premise that case ascertainment relies on data from multiple data sources – a hallmark trait of DRS and MRS estimation.

• DRS / MRS estimation methods do not require complete enumeration of populations and provide a formal means for estimation and adjustment for under-ascertainment.

• FAS is the type of condition that should lend itself well to this type of estimation method, i.e., chronic, detectable.

Violations of Method Assumptions

• **Closed population**
  • Not a true closed population – births, deaths, migration
• **Identifiability**
  • 98% matching
• **Equal catchability**
  • Subjective nature of the diagnosis
  • Poor, inconsistent documentation in medical records
  • Difficulty in locating diagnostic information
  • Phenotypic variation by age
• **Independence**
  • Lack of independence can be addressed via log-linear modeling through the use of interaction terms
  • Residual heterogeneity – Are diagnoses carried forward without independent assessment? Or, are cases independently verified or re-assessed?

RESULTS & LIMITATIONS

Scenario 1. Estimating FAS prevalence (2001-2006) using MRS estimation methods

Model* Data Sources***	N	95% CI	Deviance	Prevalence Estimate**
Chapman 2-source model: MEDI-HOSP	117	96, 182	---	0.4
3-source model: μ MEDI-HOSP = μ BC-HOSP	373	134, 1862	3.9	1.4
3-source model: μ BC-MEDI = μ BC-HOSP	360	126, 2017	5.2	1.3

* Uses confirmed, probable + pending, but excludes any records with missing information
** Per 1,000 live births; Oregon resident births (2001-2006) N = 275,719
*** BC=birth certificates, MEDI=Medicaid claims, HOSP=medical records

Scenario 2. Estimating FAS prevalence (2001-2006) using MRS estimation methods

Model* Data Sources***	N	95% CI	Deviance	Prevalence Estimate**
Chapman 2-source model: MEDI-HOSP	339	289, 456	---	1.2
3-source model: BC-MEDI, BC-HOSP interactions	384	334, 529	15.0	1.4
3-source model: BC-MEDI, MEDI-HOSP interactions	386	329, 610	17.9	1.4

* Uses all available information (including pending); combines confirmed + probable
** Per 1,000 live births; Oregon resident births (2001-2006) N = 275,719
*** BC=birth certificates, MEDI=Medicaid claims, HOSP=medical records

Scenario 3. Estimating FAS prevalence (2001-2006) using MRS estimation methods

Model* Data Sources***	N	95% CI	Deviance	Prevalence Estimate**
Chapman 2-source model: MEDI-HOSP	338	283, 482	---	1.2
3-source model: BC-MEDI, BC-HOSP interactions	406	336, 648	17.1	1.5
3-source model: BC-MEDI, MEDI-HOSP interactions	396	327, 724	22.1	1.4

* Uses all available information for confirmed, probable, and pending
** Per 1,000 live births; Oregon resident births (2001-2006) N = 275,719
*** BC=birth certificates, MEDI=Medicaid claims, HOSP=medical records

Case Ascertainment Challenges / Limitations of Data Sources

• Pediatric developmental / rehabilitation clinics rarely use ICD code 760.71, more apt to use 759.x
• General reluctance of clinicians to "label" children
• No birth defects registry – surveillance from "scratch"
• No FAS diagnostic clinics -- lack of consistent, standardized use of FAS diagnostic criteria
• Difficulty finding supporting documentation for children with "FAS" on birth certificate or Medicaid claim
• Low ascertainment for children who are not on Medicaid
• Target population is "young" in terms of timing of identification and diagnosis
• NE and E geographic regions of Oregon may seek services in Washington or Idaho
• General sentiment against "surveillance"
• Recording errors on birth certificates
• Medicaid billing errors
• "Duplication" of children in surveillance system who had name changes

Then, there is just plain “ugly”

- Remember, do NOT wear your poster . . . no matter how good it sounds when you talk with your colleagues!

What can you do when good posters go “bad”

- Making a “good” poster isn’t easy
  - Sometimes, we don’t have control over the design of our work
  - Sometimes, we have to use colors and templates that do not facilitate telling the story the way you want to
- Engage passers-by
- Smile
- Ask the passers-by a question that could lead into a conversation about your work
- Have a 1 minute overview / a 3-5 minute explanation ready

Logistics

- **Board Size:** 4ft high, 8 ft wide
- **Background Color:** Grey (frame and legs are black)
- **Set Up:** Saturday
- **Tear Down:** Monday evening
- **Handouts**
- **Templates:**
  - http://www.posterpresentations.com/html/free_poster_templates.html
  - http://www.postersession.com/templates.php
  - http://www.makesigns.com/SciPosters_Templates.aspx

Oral Presenters

Tips and Tricks

What makes for a "good" presentation?

- The "Look"
- Determines whether or not audience will **STOP**, **LOOK**, and **LISTEN**
  - **Font sizes:** Use 20+ point for text and 40+ point for headings
  - **Text:** Check for grammar, edit, edit, cut, cut, cut
  - **Flow:** Use a logical, narrative flow
  - **Color:** Select colors that will aid in ease of readability

- The "Content"
  - **Message Matters:** Prominent take home messages (1-3)
  - **Graphics:** Use graphics/illustrations/data figures in place of text
  - **Presentation:** Use an engaging, conversational presentation style; don't read your slides or deliver your talk in a monotone zombie manner
  - **Watch Your Time:** Be respectful of presentation length

The “Look”

- This it not an effective slide because I have an entire paragraph of words and it can be very difficult to read an entire paragraph of words on one slide. Even if I break it up into sentences, one big block of text is one big block of text too many. IF YOU ARE ACTUALLY STILL READING THIS RIGHT NOW, YOUR EYES ARE GROWING TIRED AND hopefully you have received the main point. Don’t write out one paragraph on a PowerPoint slide because it is very difficult to read. Make sure to make good use of space! Separate your heading and text. Use bulleted phrases! Make sure your font is appropriate. Make sure that the color and contrast aid in making your slide clear and readable! Only include key points on the slide.

The “Look”

- PowerPoint is a map/synopsis and visual aid
-

Images Speak LOUDLY!

- Font size: 44, 36, 32, 24, 18
- Handouts

The “Content”

- Tell ‘em what you’re gonna tell ‘em
- Then, tell ‘em
- Then, for good measure, tell ‘em again!

The "Content"

- Have an introduction that piques interest
  - Story
  - Quote
  - Data or an indicator
- Give your *purpose/thesis/hypothesis* and a *brief preview* of the content
- In 8-10 slides, tell audience the main points
- "In conclusion…"
  - Wrap up the story
  - Tell them how the quote is significant to your work
  - Explain how the data changed over time

What can you do when good presentations go “bad”

- Be prepared to give your talk . . .
  - Know your information
  - Be prepared to answer hard or controversial questions
  - Have a ‘plan’ for unforeseen events
    - Shortened presentation time
    - Lengthened presentation time
    - Slide, laptop, or projector failure
- Be courteous
- Be flexible

Logistics

- When is your session?
- Who are you presenting with?
- Rooms vary from 20-60 people (plan on ~30)
- Handouts
- Be in the room 10-15 minutes before to meet with staff member / moderator
- **Bring your presentation on a jump drive!!!**
  - In an abundance of caution, you might want to bring it in .ppt and .pptx formats!

Top 10 Tips from CityMatCH Staff

10. Have a proofreading session with a good friend
9. Practice out loud…
8. … with a stop watch!
7. Make sure the slides readable from a good distance
6. Always have a smile (it can cover up almost anything!)
5. Be ready for good questions
4. Tell the story from your own experience
3. Check your decimal points (and commas, and spellings, *and fill-in-the-blanks*)
2. Keep a good sense of humor and enjoy yourself
1. Check your zipper!

Additional Resources

- CityMatCH
  - 402-561-7500
  - http://www.citymatch.org
- http://www.mchlibrary.info/
- Laurin Kasehagen
  - lkasehagen@unmc.edu
- Carol Gilbert
  - cgilbert@unmc.edu
- Katie Brandert
  - kbrandert@unmc.edu