Barriers	The largest barrier encountered was that the resources for data extraction and analysis (technical or operational) were not as rich as the group had originally anticipated. We worked to overcome this challenge by acknowledging missing gaps and remaining flexible to adjust project approaches while keeping our goals on target.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to have a strong leadership sponsor to help manage change and clear system obstacles for the project.

The Christ Hospital Health Network, Cincinnati, OH
Smoking Cessation Project

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Background: Our aims were to design a smoking cessation program and to standardize the documentation of smoking status with the goal of improving the health of a subset of underserved patients in the internal medicine clinic.

Methods: We educated residents and nursing staff in how to review and record smoking status in the patient's chart during each visit, created an algorithm that residents and nurses could follow when educating patients on smoking cessation, and implemented follow-up phone calls by a nurse after the patient agreed to stop smoking. We collected data from 2010–2015 of all the patients in the medical residency clinic and assessed their smoking status. After the implementation of the smoking cessation program, we looked at the data from February 2016 to February 2017 to assess improvement of smoking documentation.

Results: Comparing the preintervention and postintervention data showed improved smoking status documentation. From preintervention to postintervention, the number of documented current smokers decreased from 1,684 to 584, the number of patients documented as former smokers decreased from 1,173 to 634, the number of patients who had never been assessed decreased from 227 to 1, and the number of patients documented as never having smoked decreased from 1,621 to 769. Creating a follow-up program called the "Don't Do It" protocol helped to support patients in their efforts to quit smoking. This intervention included close nursing follow-up with phone calls to monitor progress and to document any medication side effects.

Conclusion: Patients benefit from improved documentation and follow-up in their smoking cessation efforts. The smoking cessation project increased smoking status documentation and smoking cessation counseling. A long-term goal is to screen patients for lung cancer with low-dose CT scans who should qualify for screening with correct smoking history documentation. This project will be continued as a quality improvement project by future residents with the goal of decreasing the number of smokers.

PROJECT MANAGEMENT PLAN – Smoking Cessation Project

Vision Statement	Lung cancer, coronary artery disease, and chronic obstructive pulmonary disease are the 3 leading causes of death in Hamilton County, Cincinnati, OH. The Smoking Cessation Project is a sustainable program in the Internal Medicine Resident Clinic at The Christ Hospital that will improve documentation of smoking status and involve the design of a smoking cessation program that includes educating nursing staff and medical residents in smoking cessation clinical skills. The implementation will have a meaningful positive impact on the established underserved population from the Internal Medicine Residency Clinic community by improving early detection of lung cancer.
Team Objectives	Our objective was to design a smoking cessation program and to standardize documentation of smoking status. Our project requirements were to educate residents and nursing staff on how to review and record smoking status in a patient's chart during each visit, to create an algorithm that residents and nursing staff can follow when educating a patient on smoking cessation, and to implement follow-up phone calls by a nurse after the patient has agreed to stop smoking. Our goal was to achieve 100% documentation of smoking status in our clinic patient population. A long-term goal was to provide low-dose CT scans at no charge to high-risk patients once their smoking history was documented correctly.

Success Factors	The most successful parts of our work were as follows: • Improving smoking status documentation • Creating a follow-up program called the "Don't Do It" protocol to help support our patients in their efforts to quit smoking (this included close nurse follow-ups with phone calls to see how they were doing and to check on any medication side effects) • Inadvertently assuring that smoking status documentation was correct so that patients who should qualify for the low-dose CT scans for cancer screening did qualify. This came about when we realized that updating a smoking status when a patient had cut back could skew the numbers and make the patient's smoking history appear to be less than it actually is in the EMR. Once we noticed this, correct documentation helped them qualify through insurance to get the screening they needed. We were inspired by the progress we made in improving smoking status documentation and counseling. This, along with implementing an entirely new follow-up program for smoking cessation, showed that we could leave a lasting impact on our Internal Medicine Resident Clinic.
Barriers	The largest barriers encountered were patient demographics and willingness/insight to quit smoking. Another barrier was the number of residents and nurses who needed to be educated about documentation and our new follow-up program. All were extremely busy with their other duties, so to reach everyone and have them remember was difficult. To overcome the barrier with our patient population, we tried to incentivize them and follow-up closely to help them quit smoking. We hung signs in patient rooms showing how much money they would save if they quit smoking, and we created the "Don't Do It" protocol for nurse phone calls after their visit. To overcome the barrier of reaching and educating everyone, we had multiple venues with education about how to correctly document smoking status at each visit and about the "Don't Do It" protocol.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to know as early as possible what to focus on in the project.

TriHealth, Cincinnati, OH

The Effect of a Mobile Produce Market on Dietary Habits in Two Low-Income Urban Neighborhoods

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Background: Low-income neighborhoods in Cincinnati, OH lack access to fresh fruits and vegetables. TriHealth partnered with a local food bank to start a year-round mobile market in 2 metro areas. The aim of our quality improvement project was to increase access to fresh fruits and vegetables in food-scarce neighborhoods.

Methods: Food perception data were obtained from patients who visited Samaritan Faculty Medical Center and Obstetrics Clinic and Bethesda Family Practice on the day that the mobile food bank was present. Participants completed the Fruit and Vegetable Inventory survey, an evaluation tool for nutrition education programs serving low-income communities. The survey was repeated 6–8 months after enrollment via a phone call from residents and physicians. Preparticipation and postparticipation body mass indexes (BMIs) were collected when possible.

Results: We successfully partnered with a local food bank to provide our patients with weekly access to purchase fruits and vegetables. We established and maintained a customer base. Although no statistically significant data were obtained, the intervention appeared to have a positive influence on attitudes regarding fruit and vegetable intake. We saw an increase in the percentage of participants who reported a perceived benefit in a diet containing fruits and vegetables and a perceived risk of a diet void of fruits and vegetables. The majority of participants had an improvement in their perceived diet quality. BMI analysis of 20 patients showed no change during the study period.