Conclusion: Increased access to fruits and vegetables appears to have a positive impact at least on attitude toward eating a more healthy diet. Future studies can see if this change in attitude results in a change in behavior by identifying if customers are study participants. A mobile food market appears to be a viable option to address food deserts.

PROJECT MANAGEMENT PLAN – The Effect of a Mobile Produce Market on Dietary Habits in a Low-Income Urban Neighborhood

Vision Statement	Our vision is to develop a sustainable process for addressing food disparities in our community and making a healthy diet a consistent part of medical care. We are developing a culture in which GME is leading the path toward improving healthcare disparities within the TriHealth community. We hope to set an example of stewardship in addressing our community's healthcare needs. We envision equipping medical trainees with tools to effect change in the communities in which they will practice.
Team Objectives	The primary purpose of this project was to measure the impact of the mobile food market among Samaritan Faculty Medical Center and Obstetrics Clinic and Bethesda Family Practice patients with the aim to influence their fruit and vegetable consumption. The secondary purpose of the study was to measure the impact of a mobile food market among the residents of low-income communities of Northern Kentucky and Cincinnati with the aim to improve the availability and accessibility of fruits and vegetables.
Success Factors	The most successful part of our work was the engagement with the institution and the staff. People took pride in this work and felt they were contributing to a noble cause. We were initially inspired by the AIAMC work that Main Line Health had done regarding food insecurities and in providing fresh produce at their clinic. Our TriHealth team learned through our CHNA that our resident clinic sites were located in food deserts and that food insecurity was an issue for many of our patients. Our GME team decided to pursue addressing food insecurity for our NI V project. In addition, we are always inspired by our patients and their desire to eat better and lead healthier lives.
Barriers	The largest barrier encountered was that nutrition department reorganization and turnover kept them from engaging in our project. We worked to overcome this challenge by promoting the market through our own residents and staff. We still have work to do on this.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to connect your idea/initiative to a mission/objective of your health system and identify a C-suite champion.

UnityPoint Health, Des Moines, IA

Improving Pediatric Asthma Management by Using Care Coordination to Reduce ED Visits

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Background: The control of asthmatic symptoms in pediatric patients is an important medical concern. Without optimized medical care, children are at risk for repeated exacerbations and unnecessary medical encounters. Recurrent ED visits for asthma-related symptoms in pediatric patients may be minimized with better outpatient management. Our goal was to decrease the number of ED encounters for pediatric patients with asthma symptoms by improving care coordination with increased follow-up office visits, decreased time to follow-ups, and more comprehensive assessments/management.

Methods: We reviewed 765 (n = 553 unique patients) ED encounters from the historic and prospective time periods, with 148 (136 unique patients) and 176 (130 unique patients), respectively, eligible. For the prospective group, an ED manager contacted the patients/guardians after the encounter and encouraged them to have a follow-up outpatient clinic visit within 7 days. At the clinic visit, the patient was evaluated using questionnaires that assessed barriers and goals. Subsequent clinic telephone contacts were made to the patient as needed. If

suspected eligible, the patient was referred to a community partner for home assessment. A multidisciplinary team including an ED physician, ED care manager, pediatric and family medicine residents, pediatric and family medicine clinical care coordinators, and medical education department staff was assembled, and hospital and community resources were used to conduct follow-up and analyze the data.

Results: The prospective period patients had a 4 (RR: 95% CI 2.1, 7.5) times greater rate of at least an additional ED encounter than historic period patients, rates being 9% (95% CI 5%, 16%) vs 35% (95% CI 27%, 47%). Follow-up visit rates were 59% vs 66% for the historic and prospective periods, respectively. Of referrals made to the community health partner, 59% were from the study's health system, which represented more than all other community hospitals combined. Of referred patient families, 59% received some type of service, including asthma education, home supplies, and home repairs.

Conclusion: Management of asthma symptoms in pediatric patients is a dynamic problem with many contributing factors. The present study focused on creating a greater collaborative relationship between pediatric ED, primary care clinics, and community partners. Results were encouraging although it was difficult to control for possible data dependencies for patient observations within and between study periods, and it was also difficult to attribute outcomes to interventions in a nonrandomized study, although many future opportunities were revealed.

PROJECT MANAGEMENT PLAN – Reducing Disparities in Pediatric Asthma

Vision Statement	In an effort to address the social and environmental needs of children presenting with uncontrolled asthma, we will identify patients who present to the ED with an acute asthma exacerbation (or asthma-related diagnoses) and implement protocols to increase follow-up rates to primary care clinics after the acute episodes. Our plan is to implement long-term strategies/programs that assess and address obstacles to children obtaining access to routine asthma care and to control of the environmental causes of asthma.
Team Objectives	Our objectives were as follows: • Reduce the disparities, improve healthcare, and increase follow-up in asthma-related cases • Reduce the disparities in the management of outcomes in better care coordination, education, medication compliance, and patient education • Funnel potential patients into the Healthy Homes Program for assessment of environmental causes contributing to asthmatic exacerbations
Success Factors	Success depends on vision and commitment, persistence, relationships, and sweat equity. Collaboration with community partners is key. We believe that the hard wiring of that collaboration with a dedicated department at UnityPoint Health-Des Moines is important for success.
Barriers	One barrier encountered was that patients could have been seen at EDs or clinics outside of our health system, limiting the accuracy of documented outcomes. Another barrier was that the processes implemented were dependent on individual employees to manually produce notes and letters, as well as to contact patients. These functions could be automated to improve efficiency.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to embed study components into personnel job descriptions so the process is role-based rather than dependent on specific people. Otherwise, it is difficult to adjust when employees are reassigned or on extended leave.

Virginia Mason Medical Center, Seattle, WA

Identifying and Helping People With Unhealthy Alcohol Use in Primary Care

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Background: Alcohol misuse is a spectrum ranging from risky consumption to alcohol use disorder, and approximately 30% of the US population suffers from alcohol misuse. Brief multicontact interventions in primary