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.

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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

care are an effective method of decreasing risky alcohol use, but our primary care clinics lack standard work procedures around screening and treatment of alcohol misuse, and reluctance to address this important health issue creates disparities in care. Our aim was to identify patients in primary care with alcohol misuse and provide them with appropriate interventions both in the clinic and in the community.

Methods: Our background research involved surveys of 80 providers and 25 patients, interviews with 8 Alcoholics Anonymous members, and direct observation and timings of 7 visits. A multidisciplinary team conducted 4 PDSA cycles to create a new screening and treatment process. Through chart review, we measured the screening rates at annual wellness visits of 5 providers at 1 clinic site. Twenty charts preintervention and 50 charts after each intervention were audited, with equal numbers from each physician.

Results: Preintervention observation of screening revealed a 0% appropriate screening rate and the absence of a reliable system. Major barriers to screening were patient preference to defer this discussion to the provider (64%), patient fear of judgment, provider frustration with substance use (70%), and provider knowledge deficits (79%). After 4 PDSA cycles over 1 year, screening for alcohol misuse during annual visits increased to 92%.

Conclusion: We implemented a standard process for screening patients in primary care for alcohol misuse and provided targeted treatment options that engage resources in the clinic and the larger community. Multiple PDSA cycles were key to addressing unforeseen barriers and refining our tools and process. After the series of interventions, screening for alcohol misuse increased to 92%. We have extended our standard process to all 8 of our clinic locations. In the future, we hope to assess screening results and patient outcomes.

PROJECT MANAGEMENT PLAN – Identifying and Helping People With Unhealthy Alcohol Use in Primary Care

Vision Statement	Our aim is to identify patients in primary care with alcohol misuse and provide them with appropriate interventions both in the clinic and in the community.
Team Objectives	Our objective was to create a standardized screening process using validated measures and create treatment tools for patients and providers that are targeted to their level of risk and include community resources.
Success Factors	The most successful part of our work was that we implemented a standard process for screening patients in primary care for alcohol misuse and provided targeted treatment options that engage resources in the clinic and the larger community. As a result of serial interventions, screening for alcohol misuse increased to 92%, and we have begun to expand these efforts to our other clinic locations.
Barriers	The largest barrier encountered was balancing the needs of multiple stakeholders—the patient, clinic staff, providers, and community members.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to involve clinic staff and committees early on.