Results: Sixty patients were included in the study. Of them, 38 (63%) were covered by Medicaid and 16 (27%) were uninsured. Of the 60 patients in the study, 34 (57%) agreed to schedule follow-up appointments. Twenty of those 34 patients (59%) saw their physician for follow-up. Of the 26 patients (43%) for whom appointments were not scheduled, 24 (92%) declined follow-up calls and an appointment, and 2 (8%) were homeless without the ability to receive calls or to get to an appointment. The follow-up for patients who agreed to be contacted and to schedule appointments was higher than historic reports (59% vs 31%-35%), but the follow-up rate for the entire study population remained consistent with previously published data at 30%. Communication and transportation were identified as barriers to follow-up.

Conclusion: Patients who agreed to follow up and scheduled their own appointments had the highest follow-up rates. Further study needs to identify why patients refuse follow-up appointments or calls, but these data will be difficult to obtain because of the nature of the study population presenting after an acute sexual assault. Resources to assist patients with communication and transportation needs may improve follow-up.

PROJECT MANAGEMENT PLAN – Improving Primary Care Follow-Up After Sexual Assault

Vision Statement	Our vision is to decrease healthcare disparities associated with poor medical follow-up after sexual assault by implementing a multidisciplinary plan to improve primary care follow-up for patients cared for in our Sexual Assault Nurse Examiner Program.
Team Objectives	Our objective was to develop an intervention plan that would bridge the communication gap between acute and follow-up care and provide a caregiver education curriculum. Our project assumption was to involve a small sample size because of the expected loss to follow-up. Stakeholders included patients (improved care), caregivers (education), and the community (support mechanism for this patient population). Our measures of success were a 25% increase over reported national average 2-week follow-up rates in this population, tracked ordering and completion of laboratory testing prior to 2-week follow-up visit, and 100% scheduling of 2-week follow-up visits.
Success Factors	We improved follow-up rates by 25% compared to what has been historically reported (31%–35%).
Barriers	The largest barrier we faced was the inability to communicate with patients after the initial encounter because many patients refused follow-up communication and some patients were homeless without communication means. The next largest barrier was lack of transportation for the follow-up appointments. Finally, we were not able to access the health records for all of the patients because some of them received follow-up care outside our health system.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to be prepared for unanticipated results. We were surprised by the number of people who were homeless, without any means of communication, and/or without transportation. This made us more aware of the fundamental lack of resources in our study population.

Crittenton Hospital Medical Center/Wayne State University, Rochester Hills, MI

Health Disparities Educational Initiative for Residents at Crittenton Hospital Medical Center

Markova T; Benson B; Kumar S; Klamo R; Mateo M; Ha M; Takis L; Delpup A; Stansfield RB

Background: Crittenton's 2016 CHNA identified 3 main priorities: (1) obesity/overweight/nutrition/diabetes, (2) mental health, and (3) access to care. Collaborative partnerships are effective in achieving communitywide behavior change and improving population-level outcomes. Curricula that increase resident knowledge about health disparities are an effective strategy for improving understanding about health disparities. Diabetes self-management and education are critical elements of care for people with diabetes and improve patient outcomes.

Methods: We designed an educational curriculum to increase resident awareness of heath disparities and the hospital's CHNA/current priority areas, address disparities in diabetes care, and increase referrals for diabetes self-management education (DSME). The family medicine, internal medicine, and transitional year residency programs committed to faculty and resident participation. Educational intervention I included 4 didactic sessions covering health disparities, CHNA, services provided by the hospital's Diabetes Center/DSME, and resources available through the local chapter of the American Diabetes Association. Pre- and post-didactics session surveys were administered to residents. Educational intervention II was a problem-based learning (PBL) case on health disparities, CHNA, and DSME. Residents completed evaluations of the PBL activity. Data were collected on the number of patient appointments for DSME for periods before the didactics, following the didactics, and following the PBL case.

Results: More than 90% of residents accurately defined health disparities over 2 years (2015/2016), although there was a slight decrease in 2016. The percentage of residents who knew how to access the CHNA slightly increased in 2016. In the pre- vs post-didactics survey results, no significant differences were found in diabetes practice patterns or knowledge about DSME. The low response rate on the post-didactics survey limits the ability to make statistical inferences. Comparing the effectiveness of didactics to PBL, the PBL had a higher mean but not at a statistically significant level (PBL mean = 3.83; didactics mean = 3.78; $P = 0.4$). Pre- and post-didactics data show no effect on DSME appointments for patients referred by residents and program faculty. Following the PBL, the rate of DSME appointments nearly doubled.

Conclusion: Residents arrive at their programs with a good understanding of health disparities, although they may not recognize the disparities that exist in the hospital community in which they practice. Lectures are ineffective in enhancing understanding of community programs/priorities and for applying knowledge. PBL is an effective instructional method for teaching and learning about local health disparities, CHNAs, and DSME.

PROJECT MANAGEMENT PLAN – Health Disparities Educational Initiative for Residents at Crittenton

Vision Statement	This project builds on residents' existing knowledge of health disparities, meaningfully rectifies gaps in resident education about the CHNA and diabetes disparities/services, and triggers resident-driven community interventions and educational initiatives to help reduce healthcare disparities.
Team Objectives	The primary objectives of this project were to educate residents on how disparities manifest in the hospital community and how hospital and community resources can be used to address disparities. We planned to raise resident awareness of healthcare disparities in the community in a sustainable way through meaningful participation in educational initiatives, community health, and quality improvement projects. We began with a baseline assessment of resident knowledge about health disparities, the hospital's CHNA, and diabetes treatment and services. We developed educational interventions including a problem-based learning (PBL) case focused on the hospital's CHNA and diabetes disparities.
Success Factors	The most successful part of our work was the involvement of the residents in the PBL case and the sustainment of the initiative through the GME CLER Council and the Resident Task Force on Health Disparities. A resident suggested using PBL to bridge the gap in knowledge and use of the CHNA, another resident assisted in development of the case, and 9 residents served as small group preceptors for the case. We plan to use the case (or a modified version of it) at our resident orientation to highlight the CHNA and the health disparities in the local community that incoming residents are likely to encounter. We were inspired by the enthusiasm the case generated among the residents and the opportunities for using PBL for other topics.
Barriers	The largest barrier was obtaining a sufficient number of responses to voluntary surveys. We worked to overcome this challenge by using results from existing surveys and adding project-related questions to a mandatory survey. Another barrier was related to the continuity of the project because of changes in personnel.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to get resident buy-in and keep them involved in the planning and execution of project activities. Also, it is a good idea to continuously think about and plan for scale, spread, replication, and sustainment of the initiative during all phases of the project, including at the outset.