Results: The average rate of readmissions was decreased by 22.4% after enrollment in the MAP. Seventy-nine patients had a reduction in readmissions after enrollment in the MAP. Flexible criteria for MAP enrollment allowed us to serve the Medicare and Medicaid population when resources were insufficient to support their needs. An active partnership with administration and medical staff enabled a robust number of patient referrals.

Conclusion: A MAP increases indigent patients' access to unaffordable treatment and thus improves patient compliance, clinical outcomes, and quality of life. A MAP directly decreases readmissions.

A Second Chance at a First Impression: Creating an LGBTQ-Friendly Environment

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Background: Advocate Illinois Masonic Medical Center (AIMMC) is located in the nation's first municipally recognized LGBTQ neighborhood and has been named a "Leader in LGBT Healthcare Equality" in the Human Rights Campaign Healthcare Equality Index for the past 7 years. The LGBTQ community is a significant portion of the patient population. Health disparities in the LGBTQ community include (1) decreased access to healthcare/insurance; (2) low rates of pap smears and mammograms; (3) higher rates of suicide, depression, and substance abuse; and (4) an unknown proportion of LGBTQ patients in the practice.

Methods: We administered a 19-question survey assessing participants' comfort in interacting with LGBTQ patients to 27 providers and staff at the AIMMC – Ravenswood Family Medicine Clinic. Response rates were as follows: attending physicians (26%), resident physicians (26%), medical assistants (19%), nurse practitioners (11%), registered nurses (4%), patient service representatives (7%), and other office ancillary staff (11%).

Results: The respondents indicated that the intake forms do not adequately capture gender identity. Providers and staff also signaled their interest in educational opportunities regarding LGBTQ issues. In response, 2 interventions were developed. The first intervention was training in providing an inclusive environment for all patients with topics on sharing difficult patient encounters, addressing patients at the front desk, asking for preferred pronouns, developing comfort discussing gender identity, and taking a complete sexual history. The second intervention was the development of a new intake form. On the current form, all questions are separated by sex. The form does not offer a gender pronoun area for transgender patients, and the number of sexual partners equates to sexual health, resulting in inadequate assessment of risk. The proposed new intake form is unisex and has space for name choice and gender pronoun. The review of systems questions are broad and can be discussed further with individual providers, and the sexual history question is more relevant to sexual risk. Plans are to conduct a follow-up meeting and administer a survey after a trial period of the new form.

Conclusion: Providers and staff are not confident in their approach to care for LGBTQ patients, but they are eager to learn how to better serve this population. Making changes to the way we address our patients does not have to be painful, and changes can be fluid and incremental.

PROJECT MANAGEMENT PLAN – Medication Assistance Program and LGBTQ Community Initiative

Vision Statement	The medication assistance program (MAP) was introduced to reduce health disparities, promote medication adherence, and lower readmissions by providing uninsured and underinsured patients access to prescribed medication. Our aim was to engage a resident physician in the CHNA to improve the process of identifying and addressing community health needs. We envision an environment where all patients, regardless of their gender or sexual orientation, have health access and equity; where all providers and staff feel comfortable and confident with each patient encounter; and where ongoing education for providers and staff on specific population-based healthcare needs is provided.

Team Objectives	Our objectives were as follows: • Compare the readmission rates 1 year before and after enrollment in the MAP (January 1, 2014 through December 31, 2015) • Include a resident physician in the hospital CHNA process to provide a resident's perspective on community needs and interventions to address those needs • Compare recommendations of the Community Health Council to the recommendations of resident physicians • Educate and engage residents/fellows and other members of the healthcare team about the MAP • Develop and implement a LGBTQ educational program for current and new physicians and associates • Identify opportunities to improve relationships with community agencies that support our LGBTQ community • Collaborate with patient access to improve the system to ensure appropriate data fields to support gender identity
Success Factors	The most successful part of our work was having all stakeholders at the table, sufficient lead time to plan, open and honest communication of barriers, data-driven outcomes, and support and commitment from the C-suite. We were inspired by team members' enthusiasm, topic expertise, and level of engagement.
Barriers	The largest barrier encountered was finding time for residents to work on the project because of patient responsibilities and schedules and time for leaders to attend the monthly meeting. We worked to overcome these barriers by narrowing the scope of the project and resident representation and by having only one of the leaders attend the monthly meetings.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to have an active partnership with all stakeholders and to clearly identify roles.

Advocate Lutheran General Hospital, Park Ridge, IL

60018: Improving Health Equity

J Gravdal; L Kelly; P Hyziak; P Besler; M Stock; S Barrera; R Sanchez; C Victor; H Graham; S Verma; S Saldana; E Munoz

Background: Diabetes disproportionately impacts the Hispanic community. Within the Advocate Lutheran General Hospital (ALGH) primary service area (PSA), ZIP code 60018 has twice the Hispanic population of other PSA ZIP codes. The 60018 initiative was developed to explore data on diabetes, partner with the 60018 Hispanic community, and improve the resident curriculum, thereby aligning our CHNA, population health, and GME goals.

Methods: We reviewed the CHNA, ALGH hospital data, and community survey data and conducted a literature review. We conducted a family medicine residency tour of the community and recommended curriculum revisions after performing a curriculum and literature review. We established a partnership with St. Stephen Protomartyr Catholic Church, offering free diabetes screenings and diabetes education.

Results: Through the partnership with St. Stephen Protomartyr Catholic Church, we obtained 23 completed surveys, conducted 3 focus groups with 20 participants, screened 23 patients, and held 4 education sessions with 12-15 attendees at each session. The screenings identified 8 individuals with an A1c of 5.7%-6.4% and 8 individuals with an A1c >6.5% (2 with an A1c >11%). The NI V work was incorporated into the new revision of ALGH's CHNA. Grant money was secured to sustain the work, and family medicine residency curriculum changes were implemented.

Conclusion: Our partnership with St. Stephen Protomartyr Catholic Church is a step toward preventing and reducing the impact of diabetes in the Hispanic community via culturally appropriate screening and diabetes prevention. However, cultural skepticism has a history, and trust takes time to build. ALGH has committed to long-term support of the work.