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.

PROJECT MANAGEMENT PLAN – Collaborating with Our Hispanic Population to Improve Diabetic Education, Prevention, and Care

Vision Statement	Our vision is to serve the health needs of the Hispanic community through a holistic approach with an emphasis on education as an immediate step toward preventing and reducing the impact of diabetes. Markers of success were as follows: • Build sustainable partnerships with the 60018 Hispanic community • Increase awareness and understanding of risk factors for and management of diabetes mellitus in the 60018 Hispanic community • Improve education and involvement of residents and attending physicians in understanding disparities and improving health equity in this population
Team Objectives	ZIP code 60018 in our primary service area (PSA) has twice the Hispanic population of our other PSAs. It is well known that diabetes disproportionately impacts the Hispanic community. We first seek to understand the medical and community needs and resources and then to work with them to address their needs.
Success Factors	The most successful part of our work was obtaining executive leader sponsorship and grant dollars to sustain and expand the work of our NI V team. We were inspired by the people in the community who enthusiastically participated in the screening and educational sessions.
Barriers	The largest barrier encountered was the unrecognized challenges within our partner church. We worked to overcome this challenge by being patiently and respectfully persistent as well as flexible in developing a community health worker position when the church was unable to commit to a faith community nurse.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to be prepared to listen to both the words and the nonverbal communication with an open and flexible mind.

Aurora Health Care, Milwaukee, WI

Disparities in Colorectal Cancer Screening

Jonathan Blaza, MD; Jasmine Wiley, MD; Wilhelm Lehmann, MD; Jeffrey Stearns, MD; Deborah Simpson, PhD

Background: Colorectal cancer (CRC) is a national healthcare priority, as well as an Aurora Health Care (AHC) quality metric and a care gap per AHC's CHNA. Our residency clinics face challenges associated with urban underserved populations, and the clinics are currently under the goal for the CRC screening quality metric. Studies have identified disparities in CRC screening, with screening less prevalent among patients who are uninsured and/or of lower socioeconomic status, African American/black, Asian, or non-English speaking Hispanic. Information on age-related disparities in CRC screening rates among eligible patients is limited.

Methods: A team of residents/faculty framed our approach using the Institute for Healthcare Improvement Model for Improvement. Providers at 2 family medicine clinics identified barriers to CRC screening using a fishbone approach to engage them in the improvement process. A retrospective analysis of all patients eligible for CRC screening at 2 targeted clinics, a control clinic (a residency clinic in the same ZIP code), and our care region during a 12-month period (December-November 2015) was completed in collaboration with AHC quality improvement specialists. The percentage of patients achieving the CRC screening metric was reported by REAL-G (race, ethnicity, age, language, gender) and insurance status. Categories with an $n<25$ were omitted. The criterion for disparity within a category was identified as >10%. The analysis was repeated in January 2017 for the intervention period (January-December 2016).

Results: The analysis showed that screening rates at all facilities and in the care region overall were lowest among patients in the 50- to 54-year-old age bracket. Identifying a specific disparity group provided a focus for improvement. After the intervention, screening rates in this age group increased in the 2 targeted clinics and overall.