	A key goal was to strengthen and create community partners to allow resident work within our community. Two long-term goals were to compile the identified resource tools into an accessible CCHS repository and to create a pathway toward a CCHS Certificate in Diversity and Health Equity based on resident participation and leadership in multiple venues for community and health advocacy.
Success Factors	The poverty simulation event was extremely well received by the inaugural resident trainee class and deemed the highlight of the weeklong orientation by Academic Affairs. The simulation will be included within resident orientation longitudinally. After publication in the CCHS internal magazine *FOCUS*, the poverty simulation received interest across the health system. resulting in requests to repeat the exercise with leadership to better integrate health equity into our clinical operations and strategies. CCHS set aside time for our health system managers and directors to experience the poverty simulation. Early data analysis suggests that the poverty simulation activity did impact resident trainees' attitudes and knowledge regarding health equity topics. A manuscript describing the poverty simulation experience with new residents and interns was accepted for publication in the *Journal of Graduate Medical Education*.
Barriers	The largest barrier encountered was that team members found it difficult to meet with any regularity because of schedule conflicts and the lack of protected time for clinical faculty and residents serving in lead positions. We worked to overcome this challenge by capitalizing on each other's commitment with frequent handoff of key tasks between team members. We leveraged each other's strengths and professional networks and maintained momentum via early morning and late night phone meetings/ email and text communication.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is that team members need to understand early the magnitude of the time commitment necessary for successful project completion. We recommend recruiting a diverse and actively engaged group of core team members who have an identified, institutional commitment to health equity and resident education early in the project. It is important to recognize that the hospital administrative partners who are key to project execution may have competing priorities that make it difficult to establish their commitment to NI V activities.

Cleveland Clinic Akron General, Akron, OH

Improving Primary Care Follow-Up After Sexual Assault

Tricia Olaes, MD; Nancy Murphy, MD; Mohamed Khayata, MD; Cheryl Goliath, PhD; Lily Holderbaum, BSN, SANE-A; Nairmeen Haller, PhD; Titus Sheers, MD; Jennifer Savitski, MD

Background: More than 320,000 US adults are sexually assaulted yearly. Sexual assault nurse examiners provide trauma care and perform forensic medical examinations and evidence collection. Medical follow-up after sexual assault plays a significant role in the physical, mental, and emotional healing process. Essential care provided at a primary care follow-up after the initial forensic medical examination includes injury and medication follow-up, sexually transmitted infections testing, and referrals for counseling and/or advocacy. Historically, the reported follow-up rates after a medical forensic examination for sexual assault are low (31%-35%). Patients who suffer sexual assault often experience a disparity in follow-up healthcare and treatment of related and subsequent medical and psychiatric conditions.

Methods: The study period was May 1, 2016 through October 31, 2016. Coordination of follow-up care was offered to all patients ≥18 years who underwent a forensic medical examination and evidence collection kit for sexual assault. A sexual assault nurse examiner or social worker scheduled follow-up appointments for patients who agreed. Patients with appointments were mailed letters verifying dates, times, and physician locations. Letters including patient information, suggested follow-up testing, and patient needs were mailed to the physicians. Appointment compliance was verified via patient self-report and chart review.

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.