step in the program's evolution will therefore be to have targeted UHM faculty join the program and to track their progress, following both what educational sessions they attend as well as how their performance on a range of educational activities changes over time. This will provide us with discrete data allowing for improved program evaluation and refinement. Other challenges include increasing the interactivity of educational sessions — modeling what we teach — and better bridging the language gap between teachers and participants.

Funding: There is no specific funding for this project.

Abstract #: *02ETC039*

Reciprocal learning: Learning from global health programs to improve domestic health outcomes and global health pedagogy

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Program/Project Purpose: Despite national success of the CDC's Breast & Cervical Cancer Early Detection program, only one third of Texas counties housed BCCS providers in 2010, and less than 1% of eligible women received mammograms through this federal-state initiative. Thus, North Texas reports suboptimal mammography rates, especially among rural communities. Drawing from international health programs in lower-capacity rural areas, we developed a decentralized regional delivery model that addresses barriers to breast cancer screening and patient navigation in rural Texas. The program has also created pedagogical opportunities for undergraduates to conduct real-world comparative health systems analysis.

Structure/Method/Design: Using international health literature and other sources, we developed a county-specific Readiness Assessment Tool that determined county capacity for completing Breast Cancer outreach and navigation processes. To facilitate clinical navigation, we implemented a computer-based application documenting clinical patient flow across the breast screening continuum in counties. Among 74,000 screen eligible, low-income women in 17 rural, underserved counties, we have, to date, screened and navigated over 14,500. Approximately 80% of symptomatic and 90% of asymptomatic patients reported incomes < 200% FPL. Over 86% of asymptomatic and 96% of symptomatic women lacked insurance. 48% of patients self-identified as Hispanic. Using Glasgow's RE-AIM model, we are 1) assessing county capacity to implement program components and 2) monitoring county process and outcome measures, providing appropriate booster trainings. We will also interview program staff and work with undergraduates to design curriculum comparing rural delivery models in high-, medium, and low-income settings.

Outcomes & Evaluation: Early data indicates the program effectively links vulnerable women to care. No-show rates for screening mammograms was 6%. Clinical resolution time averaged 19 days; 21 days for symptomatic women (BCCS standard = 60 days). As of August 2014, the program had diagnosed 283 cancers, diagnosing ~80% of these early stage (Texas average = 60%). However, heterogeneity in rural infrastructure and breast cancer screening capacity — e.g. number of mammography units; provider distance — hamper consistent expansion of decentralized navigation and delivery programs.

Going Forward: Significant barriers to implementing 'comprehensive' national or international programs may require supplemental programmatic or infrastructural support to succeed. States and donors must create reimbursement mechanisms that include screening services to offset funding gaps, local provider liquidity, and capacity constraints. Results to date suggest adapting appropriate international delivery models domestically can maintain/improve key quality markers among vulnerable populations. Preliminary qualitative findings suggest significant pedagogical opportunity inherent in including students in the implementation and evaluation of such programs. With undergraduate education increasingly engaging in experiential learning that explores connections between local and global, this project's design offers students a unique environment in which to conduct comparative health systems analysis. Increasingly globalized health systems and workforces demand such comparative global learning experiences.

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Abstract #: *02ETC040*

Global health preparation and reentry modules: An innovative, interactive, online, open-access, modular curriculum for global health rotations and projects

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Program/Project Purpose: A study published in 2013 showed that 55% of Emergency Medicine (EM) residency programs were involved in global health projects, the majority being resident electives (68%). A cross-institutional survey reported that 86% of EM residents voiced interest in participating in a global health rotation and that the majority of residents ranked EM programs with global health rotations higher than those without them. These findings are mirrored in other specialties as well. Global health rotations place trainees in high risk situations with regard to ethics, cultural sensitivity, and personal safety. It is important that academic institutions provide proper guidance and education to prepare trainees for safe and effective global health rotations. Many sources such as the CDC Global Health website and the book International EM: A Guide for Clinicians in Resource-Limited Settings (EMRA 2013) provide information about global health rotations, however none of these resources provides a timeline-based schedule for preparation. In addition, none of these resources provides an online interactive environment for participation, or an evaluation tool that residency program directors and medical school deans can track electronically.

Structure/Method/Design: We are creating a series of interactive modules that will prepare learners including medical students, resident physicians, and fellows to safely and effectively participate in global health rotations and projects. This series of timeline-based and interactive preparatory modules spans early preparation to readjustment on return. The curriculum will be a resource that all academic institutions can utilize; additionally the curriculum will be open-access, permitting faculty, other international practitioners, and the general public to use them as well. To our knowledge, the timeline-based and interactive structure of these modules makes them the first of their kind. The modules have been written by a team of global health experts including faculty and fellows, with contribution from residents and medical students. Upon finalization of the site design, American College of Emergency Physicians (ACEP) Information Technology will implement the design and hosting using the ACEP electronic Continuing Medical Education (eCME) system.

Outcomes & Evaluation: The outlines and content of all modules have been finalized, and online media and material is currently being constructed. In order to prepare for online release, the modules will initially be piloted by global health experts. Once modules have been released online and are available to all residencies, data can be collected tracking completion, performance, and corresponding ACGME milestone levels for residents and medical students.
Going Forward: The modules will be piloted in early 2015; the final product will be available soon thereafter. Input from participants and program directors will be gathered to track use, efficacy, and impact on training and to inform future improvements.
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Creating a pandemic of health: Big ideas for a new initiative on global health equity and innovation

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Background: In 2012, a new University-wide Institute for Global Health Equity & Innovation (IGHEI) was established based in the University of Toronto's Dalla Lana School of Public Health with the mission of focusing on "complex global health equity problem-solving that could not otherwise be successfully addressed by a single discipline or research group." In this panel, we will describe the results of the Institute's 18 month process of strategic planning culminating in its November 2014 Global Health Summit, "Creating a Pandemic of Health", an event involving local and global representatives from academia, government, non-governmental organizations, and the private sector. The foundational theme of the Summit is the critical importance of appreciating health as a concept far broader than simply being free of disease. Two aspects are emphasized: (1) health is also the ability of individuals or communities to (a) adapt, self-manage and thrive in the face of physical, mental and social challenges, including ageing and the presence of incurable chronic disease(s) and multimorbidity; (b) heal when damaged; and (c) to expect death peacefully. New scholarship has developed on methods for measuring health from this perspective that include dimensions such as functioning and the experienced quality of life; and (2) the notion that some aspects of health are amenable to social contagion. Studies have shown that obesity, smoking, alcohol consumption, depression and happiness can "spread". Health and/or determinants of health may be amenable to this phenomenon, an attribute that has created new opportunities for scholarship and progress in promoting health. Subthemes for the Summit were developed that address the idea that "…humans worldwide are becoming an urban species plagued by non-communicable diseases (incurable by definition), financial crises, social disparities, global warming and ineffectual polarized political structures that are threatening the sustainability of the species". The subthemes that emerged include "Preventing the preventable, treating the treatable, transcending the inevitable", "Urbanism, health, and the growth of megacities", "Politics, privilege and power", "Achieving convergence", and "Global big data". The aim of the Institute for Global Health Equity & Innovation is to work with global partners across multiple sectors to utilize these ideas and themes to drive new multi-disciplinary, multi-sectoral, local and global approaches to research, training and knowledge translation that are solution-focused and policy relevant, fuelled by initiatives that promote equity at all levels, from the individual through the community to the planetary. The process, results and associated successes and failures of this nascent Institute may afford lessons for others involved in similar University initiatives and partnerships.
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Decreasing health disparities for vaccine preventable diseases among adults in Viet Nam and Thailand

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Program/Project Purpose: In low- and middle-income countries (LMIC), health disparities increase barriers for adult immunization uptake. These barriers include lack of information or access to resources about immunization as well as a lack of mechanisms to track coverage among high-risk groups. In LMIC, there is need for adult vaccine programs and policies to increase coherent and integrated approaches to reduce vaccine-preventable diseases. The Global Health Initiative (GHI) at Henry Ford Health System (HFHS) has formed a partnership with the Mahidol University Faculty of Tropical Medicine (Thailand) and the National Institute of Hygiene and Epidemiology (Vietnam) as well as community health worker (CHW) programs in each country, to implement a mobile- and electronic-health program to identify and address barriers to adult immunization uptake. Over the next three years, the objectives of the program are to: 1) enhance local health providers' and CHWs' outreach efforts to mitigate health disparities; 2) increase equitable access to healthcare and adult immunization services across targeted high risk populations within Vietnam and Thailand; 3) develop a mobile- and electronic-health education and outreach platform; and, 4) establish a research and program model that can be adapted for use in other LMIC.
Structure/Method/Design: The project takes an interdisciplinary approach including public health, medicine, anthropology, international law, policy research, and technology. Through a mixed methods approach, we will identify both policy and programmatic barriers for adult immunization. The project targets both underserved populations (e.g., migrant workers, ethnic minorities) and high risk groups (e.g., elderly, PLWHA). Community health workers and local health providers will be an integral part of the project both in terms of education, data collection, and engagement in outreach to targeted populations and groups.
Outcomes & Evaluation: The primary outcome is increased knowledge, positive perceptions, and engagement with existing adult immunization programs among multiple stakeholders including providers, CHWs, and members of targeted populations and groups. We will conduct a randomized control trial (RCT) of the electronic- and mobile-health intervention in both Vietnam and Thailand. Outcome evaluation data will be collected at baseline and one-year