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.

Abstract #: 02ETC039

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

S. Inrig[1], J. Tiro[2], R. Higashi[2], L. Roberts[3], S. Lee[2]; [1]*Mount St. Mary's University, Los Angeles, CA/US,* [2]*UT Southwestern Medical Center, Dallas, TX/US,* [3]*Mount St. Mary's College, Los Angeles, CA/US*

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.

Abstract #: 02ETC040

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

G.A. Jacquet[1], J. Tupesis[2], M. Rybarczyk[1], M.M. Fleming[1], S. Gadiraju[3], A.S. Hayward[4], P. Modi[5], J.G. Myers[6], R.A. Umoren[7], S.G. Weiner[5], S. Sarfaty[1]; [1]*Boston University School of Medicine, Boston, MA/US,* [2]*University of Wisconsin School of Medicine and Public Health, Madison, WI/US,* [3]*Baylor College of Medicine, Waco, TX/US,* [4]*Yale School of Medicine, New Haven, CT/US,* [5]*Brigham & Women's Hospital, Boston, MA/US,* [6]*University of North Carolina School of Medicine, Chapel Hill, NC/US,* [7]*Indiana University School of Medicine, Indianapolis, IN/US*

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.