	• Patients can read and understand the 2-question food insecurity screening tool • Patients can be contacted and have the means to obtain food boxes Our measures of success were as follows: • Implementation of a food insecurity screening program with a screening rate >40% • Identification and referral of patients identified as food insecure
Success Factors	The most successful part of our work was implementing a simple tool that has uncovered a significant healthcare disparity in our patient population (food insecurity). We were inspired by the alarming number of individuals who are food insecure in our community.
Barriers	The largest barrier encountered was engaging patients and physicians to consistently complete the 2-question food insecurity screening tool at every office visit. We worked to overcome this challenge by integrating this screening tool into our EHR to identify patients who have already been screened. We decreased the frequency of screening to every 6 months and will continue to reevaluate the process and make adjustments to the workflow.
Lessons Learned	The most important advice to provide another team embarking on a similar initiative is (1) to have an established form of documentation of screening questions prior to starting the initiative, preferably embedded into each patient's EHR; (2) to try to collaborate with a food distributor prior to kicking off your food insecurity screening tool so that resources will be available for those in need at the time of diagnosis; (3) to find creative methods to consistently engage providers and patients to complete the questionnaire while also identifying EHR tools to mainstream and standardize the questionnaire.

Kaiser Permanente Northern California, Oakland, CA

Health Equity and Disparities Track

Thomas Baudendistel, MD; Nailah Thompson, DO; Calvin Wheeler, MD; Theresa Azevedo; Michelle Loaiza

Background: Kaiser Permanente Oakland serves an incredibly diverse population. Nationally, such diversity is usually matched by discrepancies in healthcare outcomes, but Kaiser Northern California is a significant exception to this rule, thereby providing a unique window to observe a model of healthcare delivery that can reduce or even eliminate disparities in healthcare outcomes in a diverse population. We developed a Health Equity and Disparities track within the Internal Medicine-Oakland residency program to give trainees the opportunity to examine Kaiser's population-based healthcare delivery system alongside a community health model, positioning graduates of the track to understand varied health outcomes and actively engage in solutions to eliminate health disparities.

Methods: Our program expanded the number of ACGME-accredited internal medicine residency positions by 2 residents each training year over a 3-year period. The 3-year track consisted of 4 components: (1) longitudinal clinical experiences, (2) didactic experiences, (3) scholarly activities, and (4) community advocacy. Residents received in-depth patient care experience in Kaiser and non-Kaiser care models, learning the resources to study strategies for eliminating health disparities. We recruited a track program director and marketed the track externally through recruitment and a website.

Results: We projected 6 new residency positions between 2017–2020 and one new Community Medicine fellow or Health Equity and Disparities fellow to precept residents in the community setting. We had 252 applicants for the disparities track only and 1,155 applicants for the disparities track with one or more additional tracks. The track development increased communication between Kaiser and federally qualified health centers; demonstrated financial commitment by Kaiser leadership; and increased interest internally and externally from medical students, residents, and faculty, leading to discussions of track expansion in other residency programs and locations.

Conclusion: At full development (2020), 6 residents in collaboration with a community partner will provide healthcare to under/uninsured and underrepresented patients in the community. We aim to assess educational outcomes of

this track and initiate similar programs in other residencies. We are committed to developing leaders and eliminating health disparities in the communities we serve.

PROJECT MANAGEMENT PLAN – Development of a Health Equity and Disparities Residency Track

Vision Statement	Kaiser Permanente is a leader in identifying, measuring, and helping to eliminate disparities in health and healthcare. We will deepen our engagement in the promotion of health equity and the elimination of health disparities through research, advocacy, education, and dissemination of such work with the communities we serve.
Team Objectives	Kaiser Permanente developed a Health Equity and Disparities track within the Internal Medicine-Oakland residency program. The residency is located in a diverse community with socioeconomic differences, as well as vast health disparities. Through advocacy, research, and direct community involvement, trainees will better understand the construct of public health, social determinants of health, and disparities. Trainees will be able to identify and implement strategies that support healthy communities.
Success Factors	We were inspired by the vision and dedication of our organization to serve the needs of the community through the development of the Health Equity and Disparities track. We received leadership support to (1) recruit a track program director, (2) expand the residency program, and (3) consider integration of the track concept into additional Kaiser Permanente residency programs.
Barriers	The largest barrier encountered was identification of a community-based continuity clinic for consistent resident rotations. We worked to overcome this challenge by considering additional community partners/sites that may not have otherwise considered resident education in their setting. The development of a Community Medicine fellowship to precept the residents reduced concerns of patient care access/faculty time.
Lessons Learned	Important advice for another team embarking on a similar initiative is as follows: • Ensure that executive leadership is educated early in the development of a track to receive buy-in and support, including financial resources • Allocate a project manager to coordinate communication and project milestones • Promote the track at medical student marketing events early in the interview season • Recruit a track program director early in the track development • Understand community partner concerns about resident rotations in their healthcare settings

Main Line Health System, Wynnewood, PA
Linking Patients to Community Resources Via a Smartphone App

Joseph A Greco, MD; Chinwe Onyekere, MPH; April Lockley, DO; Sharon Iannucci; Jennifer Banas

Background: Medical student advocates (MSAs) have located and vetted more than 600 community resources for vulnerable patient populations and listed them on a Wikipedia page. Residents were disconnected from these efforts and found it challenging to efficiently provide resource information at the bedside. The Main Line Heath (MLH) System Strategic Plan stresses the importance of improving the health of the community and to “seek, identify and ameliorate disparities in care.” Our aim was to provide a smartphone app to residents to facilitate referrals of patients to community services at the bedside and thereby address the strategic plan mandate.

Methods: Residents and MSAs attended a GME-sponsored dinner to learn about patient and provider needs and the resources identified on the MSA Wikipedia page. Categories include food, transportation, utilities, child care, job training, education, and legal services. Residents were asked to complete an anonymous questionnaire to assess their knowledge and opinions about linking patients to community resources and to upload a link to the Wikipedia page to their smartphones. GME collaborated with the Texas A&M School for Public Health to enlist MLH as a sponsor for the MyHealthFinder app.