Barriers	The largest barrier encountered was identifying community members willing to sit in front of 40 residents for 90 minutes! We overcame this challenge by working with our Offices of Community Outreach and Cultural Diversity to identify panelists and by having the project principal investigator meet with them in advance of the panel session.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to pilot the pre- and post-panel surveys with residents.

HealthPartners Institute, Minneapolis, MN
Equitable Care Educational Strategy

Julie Cole, MPP; Allison Rengel; Miguel Ruiz, MD

Background: The HealthPartners organization is a health plan and a health system comprised of several hospitals and clinics in the Twin Cities area. Equitable care has long been a priority of the organization, but most work has been done through individual departments, training programs, or individual entities within the larger organization. In 2015, leadership from Regions Hospital, a HealthPartners hospital, participated in the Disparities Leadership Program. Their work focused on creating an equitable care infrastructure at the hospital, with a goal of reducing healthcare disparities. As a result, the Regions Equitable Care Committee was formed. This committee meets monthly to continue work on identifying and reducing disparities. Members of this group also participate in the health system's larger group, the Equitable Care Sponsors Group. NI V provided the perfect opportunity to create an equitable care educational strategy that aligned with the equitable care work of these committees.

Methods: To align GME with HealthPartners' equitable care priorities, we partnered with leadership from the Regions Hospital Equitable Care Committee and the HealthPartners Equitable Care Sponsors Group, using their 4 main strategy areas to guide our work: (1) reduce disparities with information and best clinical practices; (2) support language preferences; (3) partnerships and engagement; and (4) knowledge, cultural humility, diversity, and inclusion.

Results: The Regions Hospital Equitable Care Video describes the Regions Hospital patient population and HealthPartners' equitable care priorities. The video will be shown at new resident orientation and potentially at all other trainee orientations. The HealthPartners Institute Equitable Care Graduate Education Toolkit is a website of equitable care resources for educators. The toolkit is grouped by the HealthPartners Equitable Care priority areas and is organized in a manner that guides the user's progression through each strategy area.

Conclusion: Both the Equitable Care Video and Toolkit will help give our residents and program directors a solid foundation in understanding healthcare disparities and in how to identify and reduce them. Future work involves identifying resident champions to lead from within their programs and working with the health system to further their community engagement priorities.

PROJECT MANAGEMENT PLAN – Equitable Care Educational Strategy

Vision Statement	Residents are champions of change in reducing healthcare disparities.
Team Objectives	Our objective was to improve health and reduce healthcare disparities by aligning GME with HealthPartners' equitable care and community engagement priorities through development of an institutional equitable care educational strategy and incorporation of residents into the equitable care work of HealthPartners and Regions Hospital.
Success Factors	The most successful part of our work was a deliverable that was truly aligned with our hospital's priorities and that will lay a solid foundation for our continued equitable care work. We were inspired by the interest throughout the larger health system in this project. Many are seeing uses for our Toolkit in their areas.

Barriers	The largest barrier encountered was the increased interest by the health system that resulted in changes to our project scope and the content of our video. The content veered a little from the original intent of the residents to meet the organization's goals. We worked to overcome this challenge by finding other ways to incorporate the residents' perspective in the Toolkit.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to take the time you need to do it right. The time we took to build connections across our organization and to learn about what the organization is working on makes us hopeful that this effort will be sustained.

HonorHealth, Scottsdale, AZ

Utilization of Community Resources to Address Food Insecurity in a Federally Qualified Health Center

Javier Zayas-Bazan, MD; Sue Sadecki, MS, Ed; Cynthia Kegowicz, MD; Ann Garcia, MD; May Mar, DO; Tricia Kruger, MD

Background: The CHNA for HonorHealth Osborn identified food insecurity as a significant health disparity within our community. The USDA defines food insecurity as "a state in which consistent access to adequate food is limited by a lack of money and other resources at times during the year." Overall, 15.9% of all Maricopa County households are food insecure, including 25.4% of Maricopa County children. The Desert Mission (DM) program (established in 1927) began under the John C. Lincoln (JCL) Health Network to help underserved families meet their health and social needs. With the newly merged HonorHealth (Scottsdale Healthcare and JCL), DM expanded its services into a new geographic area.

Methods: We used a 2-question screening tool to identify those with food insecurity at Heuser Family Medicine Center. (1) Within the past 12 months, we worried whether our food would run out before we got money to buy more. This was true "often," "sometimes," "never." (2) Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. This was true "often," "sometimes," "never."

Results: Overall, 1 in 3 patients screened positive for food insecurity. In November, 33.33% of patients screened positive; in December, 31.44% of patients screened positive; and in January, 35% of patients screened positive. Patients meeting criteria were offered services, including emergency food supplies, and were administered a risk assessment to better define their overall social needs.

Conclusion: Implementation of a 2-question screening tool is a rapid, easily reproducible way to identify a previously unseen portion of our patient population that is food insecure. Partnering with community food banks and using their resources can help this vulnerable population address this health inequity. Future efforts targeting EHR integration will make it easier to follow these patients and improve screening efficiency.

PROJECT MANAGEMENT PLAN – Utilization of Community Resources to Address Food Insecurity in a Federally Qualified Health Center

Vision Statement	Our vision is to have a diverse community outreach program that will reduce food insecurity while being a model that others can emulate.
Team Objectives	Our team objectives were as follows: • Identify the prevalence of food insecurity at our practice site • Initiate a triage/referral system to link patients with food resources • Coordinate the distribution of food boxes Our project assumptions were as follows: • Our patient population lives in Desert Mission Food Bank serviceable ZIP codes