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

	• 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