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The Clinician's Response to Food Insecurity

A Practical Guide

Hannah Cai, MS, RD

MSKCC IHCD FOOD pantry at Elmhurst Hospital and Lincoln Hospital | Image: Hannah Cai

Introduction

Early in my academic career, I had the opportunity to witness the complex interplay between a life-altering medical diagnosis, poverty, and immigration. At hospitals in Queens or The Bronx, Memorial Sloan-Kettering cancer care navigators and I would move pantry staples - canned salmon, bags of dried beans, jars of peanut butter, pasta, rice, oatmeal, applesauce, and more - from storage closets to the room where we ran Food to Overcome Outcome Disparities (FOOD), a program within the Immigrant Health and Cancer Disparities department, which seeks to improve patients' food security, adherence to clinical treatments, and quality of life.

Throughout the morning, we'd greet familiar faces who either arrived for their regular chemotherapy treatments or stopped by on behalf of a family member with cancer. As one of the MSK navigators conducted surveys to evaluate and monitor patients' needs for social services, I'd fill bags with their preferred items.

One morning, I began asking one new patient the routine questions, “Le gustaria frijoles negros o rojos?” *Would you like black beans or red?*

Her eyes welled up and with an “Oh!”, her hand fluttered to her heart. She couldn’t remember the last time she’d been offered the luxury of making a food choice.

This formative experience exposed the disparities patients can face and made the concept of social determinants of health very real for me as a student. Yet it was patients’ resilience – in the face of food insecurity, inadequate transportation, stressful housing situations, language barriers, the fear of deportation, and other comorbidities on top of their cancer diagnosis – that left the deepest impressions and keeps hunger at the forefront of my attention as a pediatric dietitian today.

Elmhurst Hospital (above), Produce from an MSKCC IHCD Community Event (below) | Image: Hannah Cai

Whether patients are encouraged to calorie boost their meals for weight gain or increase their consumption of fruits, vegetables, whole grains, and lean proteins as a component of their healthy lifestyle plan, they cannot implement nutritional recommendations without affordable, stable, dignified access to food. Try as we may to effectively educate about choosing foods appropriate for a medical diagnosis, if our patients do not have the means to act on their knowledge, what lifestyle, mental health, and clinical changes can we as clinicians expect to see?

As I've begun to incorporate food insecurity screening into my outpatient visits, I've discovered that many of my patients and their families worry about or do not have enough money to get enough food for the month. In this challenge to find practical ways to address my patients' hunger, I'm reconsidering my own role and brainstorming creative ways in which I can apply my connections, voice, and credentials towards hunger relief, acute and long-term. Most importantly, I'm noticing a greater need for multidisciplinary and multisectoral cooperation to bridge urgent gaps and develop lasting solutions.

Hunger directly affects disease risk, adherence to treatment, and health outcomes. At the same time, clinicians are uniquely positioned to directly help patients with food insecurity (Texas Medical Association). This guide offers practical steps to consider for those interested in prioritizing hunger screening as a part of their clinical workflow and ideas to help patients combat hunger.

Hunger in the U.S.

Nobody is immune to the effects of rising food costs, but the costs disproportionately affect people groups along geographic, racial, and ethnic differences. In 2020, over 38 million Americans (11.8% of the population) faced food insecurity or lacked access to an affordable, nutritious diet. Among those impacted by food insecurity, 21.7% were Black households and 17.2% were Latinx, over two times the rate of food insecurity among White households (7.1%) (FRAC). There is limited data on food insecurity in Native communities, but available research indicates that they experience some of the highest rates of hunger (FRAC). Loss of food sovereignty, increased food costs, and high poverty rates in Tribal areas are associated with growing nutrition, health, and social disparities.

The effects of hunger are far-reaching. Consider this conceptual framework by the Global Alliance for the Future of Food (page 9). Food insecurity directly contributes to stunting, wasting, micronutrient deficiencies, obesity, chronic diseases, communicable diseases, and mental illness, 7 of the 9 health outcomes listed.

A Call for Collaboration

The national baby formula shortage has intensified partnerships between families, clinical dietitians and other healthcare providers, local WIC dietitians and program staff, formula companies and representatives, pharmacies, durable medical equipment companies, and policy makers in order to keep the youngest in our country fed. Parents are sharing formulas through Facebook groups, fact-checking organizations are informing the public about the hazards of homemade recipes, public and private sectors are communicating to bridge supply gaps by sending formula samples.

Now imagine the multisectoral, multi-pronged approach needed to effectively end hunger. Envision the food system, its complex web of activities and relationships. So many of us are regularly involved in food production or feeding to some degree. Reflect on your skills, gifts, position, contacts, platforms, influence. What first step might you take?

10 Practical Steps

1. Promote awareness

Make clinicians and support staff aware that food insecurity is a primary concern

Train health providers about food insecurity's pervasiveness, risk factors, how it may present, and its effects on physical and mental health, growth and development, and well-being. Equip future generations of healthcare providers by involving residents, medical, dietetic, nursing, and other students in training sessions. Alternatively, do you have a student working with you and would they be interested in researching and then educating clinical staff about federal nutrition assistance programs, eligibility requirements, and benefits offered?

Consider priming yourself with the toolkit published jointly by the American Academy of Pediatrics and Food Research Action Center (FRAC) in 2021: https://frac.org/news/fracaaptoolkit2021

2. Conduct routine screeners

The Hunger Vital Sign is a 2-item, validated questionnaire widely used to screen for food insecurity in children, adolescents, and adults.

Make screening a standard part of care in initial and annual visits. Identify individuals on your multidisciplinary team who will be responsible for screening. Ideally, these individuals collectively will interact with all patients.

Train these individuals to deliver the screener with sensitivity and cultural competence. The topic of food insecurity may invite feelings of shame and embarrassment, and it is necessary to engage with compassion and care. Always screen in privacy and be flexible in allowing parents to answer in an “adults only” conversation in pediatric or family practice settings. Using normalizing language can also help patients feel more comfortable. Consider, “Once a year, I ask all of my patients two questions about food access to help me be more sensitive to their needs. There are no right or wrong answers. Your responses help me know whether the resources I can offer apply.”

Embed this screener into EMR note templates to streamline workflow and offer translations in the most common languages spoken among your patients. During follow ups, continue to monitor changes to patients' food security status. Remember, food security can change over time due to changes to employment and cost of living. Regardless of who is tasked with the principal responsibility of screening, all patient-facing staff should be aware of the food security referrals and resources available.

See additional resources for implementation from Health Care Without Harm and consider this overview of a workflow for addressing food insecurity in health care settings from Feeding America.

3. Make referrals

to WIC, SNAP, Meals on Wheels, and medically tailored meal programs (ie. local Food is Medicine programs, such as Community Servings, God's Love We Deliver)

There are myriad federal and local programs that offer food and meal assistance to qualifying individuals and families. Eligibility is updated annually and varies by program and state. Consider which programs are most applicable to your patient population and familiarize yourself with the general eligibility requirements. For example, WIC is available to qualifying pregnant and lactating women, and children under 5 years old.

A social worker could help guide patients and families through the available options. If a social worker is unavailable, offer a list of local organizations that can help guide your patients through documentation requirements and the enrollment process. Take care to recognize barriers to enrollment, such as fear of deportation (FRAC), fear of discrimination, a mismatch between a person's gender identity and the sex assigned at birth documented on accepted forms of identification (FRAC), language barriers, illiteracy, and lack of transportation.

Also ask patients if they are currently participating in any nutrition assistance programs. They may need a new WIC form to be sent from a physician's office or they might not be aware of other benefits available to them. For example, SNAP participants may be able to double their purchasing power through the Double Up Bucks program at participating farmers markets.

4. Provide a list of food insecurity resources in the patient's area

If a student is available to help, this may be a great project to collaborate on. Develop a list of food pantries, hot meal sites, community gardens, school backpack programs, and Double Up Food Bucks markets (or similar programs) in the most common counties your patients live in. Investigate your local area for innovative hunger-relief initiatives. Reach out to university-based cooperative extension programs, faith organizations, farmers markets, and schools.

While composing this list, try to keep the information accessible by offering versions in patients' most commonly spoken languages. During clinic encounters, educate patients on making healthy choices based on the available foods provided through these resources.

Examples of innovative initiatives

In Brookline, Massachusetts, Brookline Food Pantry (BFP) partners with the local public schools and school food service to bridge the food and educational equity gap by providing breakfast and lunch for students to take home over the weekend. A program of BFP, Brookline Thrives even offers food bags that are allergen-friendly, kosher, and vegetarian.

In Ithaca, New York, farmers partner together through Healthy Food for All to offer a sliding-scale community supported agriculture (CSA) program. Low income households pay no more than 50% of a share to receive a selection of seasonal produce every week and access to various food preparation workshops.

In New Brunswick, New Jersey, Global Grace Farms offers spaces for refugees and asylees to grow culturally appropriate foods. In connecting them with land and food-growing infrastructure, Global Grace Farms also empowers them to share their agricultural knowledge and skills as they apply organic, no-till farming practices.

Global Grace Farms | Image: Hannah Cai

5. Consider posting signs for food-finding tools

While screening tools assess food insecurity directly, signs and brochures posted throughout clinic spaces can offer resources indirectly. They do not allow for the attentive navigation a provider can offer, but they offer support to families who choose not to disclose food insecurity. Additionally, they familiarize everyone who passes by with the widespread reality of food insecurity, which may help destigmatize the experience.

See an example outreach tool from WhyHunger.

6. Encourage participation in child care and school meal programs as much as possible

School lunch experiences are diverse. Some may hold memories of limited or undesirable choices. Some may have enjoyed salad bars with produce picked from the school garden. Others may have never had the opportunity to eat school lunch because their school did not offer it.

Regardless of individual experience, there has been political groundswell over the past few years, in part due to how the COVID-19 pandemic exposed the national burden of food insecurity, to increase the accessibility of school lunches, and there are reasons to encourage participation in school lunch programs.

While the types of ingredients procured, the menus developed, and the execution may vary across schools, all schools participating in the National School Lunch Program (NSLP) are required to meet specific nutritional requirements in order to receive state-specific federal reimbursement for each lunch served (USDA). These requirements include the number of cups of red/orange and dark green vegetables, ounces of grains, ounces of meat or meat alternatives, and calories served each week, all tailored according to grade levels. Requirements for maximum sodium levels, servings of whole grains, and the percentage of fat in fluid milk have gathered controversy, especially in light of the NSLP's origins as a commodity program, but it is difficult to argue against the opportunity to offer a child a nutritionally balanced meal that they may not otherwise receive.

Moreover, children may require 10-15 exposures before they accept new foods, and school food programs can help provide these exposures. It is unreasonable for any clinician to expect a child, whose family cannot afford the time, energy, and money to purchase fruits and vegetables, prepare them in various manners, and offer them regularly, to simply "eat more fruits and vegetables" for a desired health outcome.

Financially, school food service directors walk a tight balance between expenditure and earnings. In certain states (ie. California, Maine) and areas with high levels of eligibility for free lunch, all students have access to free lunch. In other districts, the ability to manage personnel, equipment, operating, and ingredient costs depends upon participation from students who can pay full price. Federal reimbursement may not be sufficient to keep programs running, let alone able to grow, expand, and improve.

If a patient attends a school that offers lunch, including free and reduced lunch, encourage them to participate as able. Keep the stigma of receiving free and reduced lunch in mind, and draw upon the other benefits that school food may offer, such as the opportunity to try new foods, enjoy favorite foods, and save parents' time. Those who do not have enough time to eat breakfast before the school day may find themselves concentrating better, having more energy, and performing stronger in their classrooms if they participate in the School Breakfast Program (SBP). Suggest that your patient and their family review a weekly lunch menu ahead of time to determine which days they'd like to eat school lunch and which to pack a lunch for.

Most schools do not take place year round, but hunger never takes a break. If able, share a link to the Summer Meal Site finder on flyers throughout your clinic or take a few minutes to help your patient locate a site near their home.

Learn more about federal child food and nutrition programs

- FNS-101: Child and Adult Care Food Program
- The National School Lunch Program
- School Breakfast Program
- The Special Milk Program
- How to Participate in Summer Food Service Program

7. Consult with a social worker or case manager

A family experiencing food insecurity may also benefit from additional support in areas not limited to affordable housing; healthcare and medication costs; transportation to appointments; and access to mental health care, child care and education. A skilled social worker or patient navigator is most familiar with national and community programs, eligibility requirements, and application processes. SNAP eligibility alone is highly nuanced; a person granted asylee status and an immigrant child under 18 years are eligible to receive benefits without meeting residential requirements (Mass Legal Help). On the other hand, an immigrant, able-bodied adult is not eligible until at least 5 years of residence in the U.S.. As this example illustrates, families benefit from being connected to a social worker who is highly knowledgeable about available resources.

8. Consider opportunities to start on-site community outreach programs

Several hospitals have started on-site food distribution sites, hospital gardens, health screening fairs, and other community outreach programs to improve patients' food security and adherence to medical or nutritional recommendations, lower their risks of disease-related complications, and support their overall well-being. Consider these case study examples from five NYC Hospitals.

Starting and sustaining a successful program requires institutional buy-in, staff and administrative support, careful assessment of your patient population's greatest needs, a targeted intervention with measurable outcomes, an established plan for monitoring and evaluation, space and staffing to implement the program, community partnerships and outreach, and funding.

9. Participate in local food programs

In addition to personally learning about the interventions already existing in your community, you may have opportunities to learn directly from food system leaders and people with lived experiences with hunger. Consider volunteering at a food pantry. Observe how staff inquire about food access and familiarize yourself with the types of resources offered. Witnessing, firsthand, what community food security programs look like in action will help you make informed referrals in the future.

Take note of the additional extenuating social circumstances that program participants face, the limitations food insecurity imposes on other aspects of their daily living, and their resilience. With greater awareness, you may find yourself being able to inquire about nuanced aspects of food security with greater sensitivity while screening patients. Are there certain gaps in care that your patients frequently face and are there opportunities for community organizations to intervene through existing programs? What resources or connections do community organizations have that may be of assistance to your patients?

At the same time, your position as a clinician grants you unique perspectives on hunger and food insecurity. Contribute your expertise on health and nutrition; advise on what foods or interventions may be most beneficial for health. What do you know about family eating habits or cultural foodways that may be useful for the organization you volunteer with? Do your patients have praise or constructive feedback to note about the community services they've received?

10. Advocate for change

State and federal-level advocacy focus on changes that can improve system-wide equity and social justice by addressing root cause issues, including poverty and systemic racism, both of which contribute to food insecurity. Clinicians play an essential role in not only improving the health of their patients during an encounter, but also through avenues that affect population-wide disease prevention, health equity promotion, and overall access to care (Canadian Medical Education Journal).

As a healthcare provider, you hold considerable public respect and have invaluable resources: expert-level information, elevated social status, social capital. Leverage the authority of your credentials to advocate for system-wide changes that advance the availability, accessibility, utility, and cultural appropriateness of food safety net programs.

Below are only a few examples of policy topics to pay attention to:

- Advance funding for SNAP, WIC, and school food programs
- Advocate for universal free school breakfast and lunch. Making school meals accessible to all would help destigmatize school meals and encourage participation among all, but especially those who cannot afford to buy or bring their own lunch.
- Advocate to expand eligibility criteria for SNAP enrollment and increase efforts to promote public awareness (For example, in the state of NJ, only 70% of SNAP eligible households are enrolled in the program, FRAC).
- Advocate to increase the benefits allotted to senior citizens and disabled enrollees.
- Advocate to increase participants' purchasing power at farmers markets in response to rising food prices. The Double Up Food Bucks program is a great idea, but its full potential cannot be achieved if participants cannot afford to pay premium prices. Keep in mind that farmers may not be able to compete with supermarket prices due to economies of scale or are disinterested in subsidizing some crops to preserve their high value.
- Ask to increase the availability of healthy, culturally appropriate food options offered through federal safety net programs
- Lobby lawmakers for health insurance companies to pay for food insecurity screeners

Stay up to date

Consider subscribing to some of the following resources to stay informed about the state of food insecurity, food and agricultural policy in the US through mailing lists, LinkedIn pages, Twitter, podcasts.

- FRAC
- Children's HealthWatch
- Politico (Weekly Agriculture)
- Feeding America Hunger and Health Digest
- Healthy Eating Research
- Duke Sanford World Food Policy Center
- Share Our Strength (Food Justice Series)

Conclusion

Hunger is a pervasive, complex problem in the U.S. And clinicians are uniquely positioned to help support patients in navigating food insecurity.

The suggestions listed in this guide are preliminary and by no means exhaustive, and I invite you to continue the conversation.

What resources do you offer your patients? What is your organization doing? What ideas do you have for maximizing partnerships between healthcare institutions and local communities? What additional concerns should we be mindful of?

How can we shift our focus from charity to justice (environmental, land, social, racial)? Who in the community is actively tackling some of the roots of food insecurity, such as poverty and structural racism, and how can we partner with them? In what additional ways can we leverage the authority of our voices as clinicians to advocate for justice?