FRAC
Food Research & Action Center

HEALTH CARE PROVIDER SURVEY FINDINGS

Addressing Food Insecurity Among Older Adults — Health Care Provider Beliefs, Practices, and Resources

JUNE 2023 | WWW.FRAC.ORG

HEALTH CARE PROVIDER SURVEY FINDINGS

Addressing Food Insecurity Among Older Adults — Health Care Provider Beliefs, Practices, and Resources

JUNE 2023

Acknowledgments

The Food Research & Action Center (FRAC) gratefully acknowledges AARP Foundation for its support of FRAC's work to explore how health care providers who work with patients ages 50 and older are addressing food insecurity.

FRAC also wishes to acknowledge the essential contributions to this project and report of Dr. Rachel Zimmer, Atrium Health Wake Forest Baptist, and Dr. Kimberly Montez, Wake Forest University School of Medicine, and of the following AARP Foundation staff: Jackie Budilov, Lisa Lanier, and Erin Bowdren. Thanks to Richard Sheward of Children's HealthWatch for his feedback on the report's recommendations.

FRAC wishes to acknowledge and thank the health care providers who participated in the survey on which this report is based. This project would not have been possible without the willingness of the respondents to share their expertise and time. We are grateful to them.

This project was led by FRAC's Alexandra Ashbrook and Susan Beaudoin, and Olu Adeniran, formerly of FRAC. The report was authored by Susan Beaudoin, Alexandra Ashbrook (contributing author), and Olu Adeniran (editorial contributor).

This survey and report build on past work to understand and enhance efforts to screen for food insecurity and intervene by connecting patients to nutrition programs and other resources. In 2016, FRAC and AARP Foundation conducted a similar survey to inform development of the *Screen & Intervene: Addressing Food Insecurity Among Older Adults* online course. Special appreciation to Heather Hartline-Grafton, DrPH, RD, formerly of FRAC, for her work on the 2016 project.

About FRAC

The Food Research & Action Center improves the nutrition, health, and well-being of people struggling against poverty-related hunger in the United States through advocacy, partnerships, and by advancing bold and equitable policy solutions. For more information about FRAC, go to www.frac.org.

AARP Foundation®
For a future without senior poverty.

FRAC
Food Research & Action Center

Table of Contents

I. INTRODUCTION **2**

Background and Purpose 3

Summary of Key Findings 3

Summary of Key Recommendations 3

II. METHODOLOGY **4**

Eligibility and Distribution 4

Responses 4

Analysis 4

III. RESPONDENT DEMOGRAPHICS **5**

IV. FINDINGS **6**

Knowledge, Skill, and Attitudes Related to Food Insecurity 6

Current Screening and Intervening Practices 7

Screening Practices 7

SNAP Participation Screening 8

Intervening Practices 9

Centers for Medicare & Medicaid Services Food Insecurity and Nutrition Risk Improvement Merit Based Incentive Payment System 11

Impact of the COVID-19 Pandemic on Food Insecurity and Patients 12

Obstacles to Screening or Addressing Food Insecurity 13

Supports Needed to Better Address Food Insecurity Among Patients 14

V. RECOMMENDATIONS **15**

Training and Technical Assistance 15

Connect health care providers to existing training opportunities and available technical assistance. 15

Develop more targeted trainings and technical assistance based on the needs of health care providers. 16

Systems Integration 16

Provide assistance in integrating screen and intervene efforts into electronic health records, including systems to close the referral loop. 16

Funding 17

Explore opportunities for health care providers to secure funding for this work, including health care coverage. 17

VI. CONCLUSION **18**

APPENDIX **18**

I. INTRODUCTION

Across the U.S., millions of households with older adults[1,2] experience food insecurity. Certain older adult communities face disproportionate rates of food insecurity. Older adults, ages 50–59,[3] experience higher rates of food insecurity than those ages 65 and older. Furthermore, structural racism has driven and exacerbated higher rates of food insecurity among Black and Latinx older adults,[4,5,6] and among LGBT older adults,[7] and these disparities deepened during the COVID-19 pandemic.[8]

Food security is widely recognized as a critical social determinant of health.[9] Poor access to nutrition has been linked to some of the most severe and costly health problems in the nation.[10,11] Food insecurity has particularly detrimental effects on older adult nutrition, health, and wellness.[12]

As trusted voices on health, well-being, and so much more, health care providers are well-positioned to help identify and address food insecurity among their older adult patients. Across the nation, a growing number of health care providers are screening patients for food insecurity and intervening by connecting patients to federal nutrition programs and other nutrition resources.[13, 14] These efforts are referred to as "screening and intervening" to address food insecurity.

KEY TERMS

FOOD INSECURITY: According to the U.S. Department of Agriculture, "food insecurity is the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways."[15]

HEALTH CARE PROVIDER: For this survey and report, the term "health care provider" is used broadly and included physicians, physician assistants, nurse practitioners, nurses, social workers, administrators, and registered dietitians or nutritionists.

PATIENTS: This survey focused on assessing screening and intervening work specifically as it relates to providers' work with older adult patients. In this report, we use the term "patients" to mean patients who are ages 50 and older.

SCREEN AND INTERVENE: The practice of identifying whether a patient is or may be experiencing food insecurity and taking steps to address food insecurity among patients.

SOCIAL RISK FACTORS: The adverse social conditions, such as food insecurity, that are associated with poor health outcomes.

The Food Research & Action Center and AARP Foundation collaborated with Dr. Rachel Zimmer of Atrium Health Wake Forest Baptist and Dr. Kimberly Montez, Wake Forest University School of Medicine, and conducted a survey to learn more about current efforts and promising opportunities for doctors, nurses, and other health care providers to address food insecurity among their patients 50 years of age and older. This report summarizes the findings of the survey responses from 144 health care providers. It also provides recommendations to enhance efforts by health care providers to address food insecurity informed by the survey findings.

1 Food Research & Action Center. (2023). *Rate of Food Insecurity Among Households With Older Adults (Age 60+), by State, 2019-2021*. Available at: https://frac.org/hunger-poverty-america/senior-hunger#FImap. Accessed on June 1, 2023.

2 AARP. (2022). *Over 9 Million Adults Ages 50 and Older Faced Food Insecurity in 2020*. Available at: https://doi.org/10.26419/ppi.00162.001. Accessed on June 1, 2023.

3 Ashbrook, A. (2022). *Older Americans Month: Understanding Food Insecurity Among Older Adults*. https://frac.org/blog/older-americans-month-part-one-. Accessed on June 1, 2023.

4 U.S. Department of Agriculture, Economic Research Service. *Household Food Security in the United States in 2021*. Available at: https://www.ers.usda.gov/publications/pub-details/?pubid=104655. Accessed on June 1, 2023.

5 Odoms-Young, A. (2018). *Examining the Impact of Structural Racism on Food Insecurity: Implications for Addressing Racial/Ethnic Disparities. Fam Community Health*. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5823283/. Accessed on June 1, 2023.

6 Ashbrook, A. (2023). *Food Insecurity Among Older Adults Is Often Invisible*. Available at: https://frac.org/blog/food-insecurity-among-older-adults-is-often-invisible. Accessed on June 1, 2023.

7 Williams Institute, UCLA School of Law. (2023). *LGBT Adults Aged 50 and Older in the U.S During the COVID-19 Pandemic*. Available at: https://williamsinstitute.law.ucla.edu/publications/older-lgbt-adults-us/. Accessed on June 1, 2023.

8 AARP. (2021). *Pandemic Widens Food Insecurity Disparities Among Older Adults*. Available at: https://blog.aarp.org/thinking-policy/pandemic-widens-food-insecurity-disparities-among-older-adults. Accessed on June 1, 2023.

9 Food Research & Action Center. (2017). *Hunger & Health: The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being*. Available at: https://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf. Accessed on June 1, 2023.

10 Berkowitz, S.A., Basu, S., Gundersen C., and Seligman, H.K. (2019). *State-Level and County-Level Estimates of Health Care Costs Associated with Food Insecurity*. Available at: http://dx.doi.org/10.5888/pcd16.180549. Accessed on June 1, 2023.

11 Food Research & Action Center. (2017). *Hunger & Health: The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being*. Available at: https://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf. Accessed on June 1, 2023.

12 Food Research & Action Center. (2019). *Hunger is a Health Issue for Older Adults: Food Security, Health, and the Federal Nutrition Programs*. Available at: https://frac.org/wp-content/uploads/hunger-is-a-health-issue-for-older-adults-1.pdf. Accessed on June 1, 2023.

13 Taira, B.R., Yadav, K., Perez, Y., et al. (2023). *A Formative Evaluation of Social Care Integration Across a Safety-Net Health System. NEJM Catalyst Innovations in Care Delivery*. Available at: https://catalyst.nejm.org/doi/10.1056/CAT.22.0232. Accessed on June 1, 2023.

14 Nguyen, C.J., Gold, R., Mohammed, A., Krancari, M., Hoopes, M., Morrissey, S., Buchwald, D., and Muller, C.J. (2023). *Food Insecurity Screening in Primary Care: Patterns During The COVID-19 Pandemic By Encounter Modality.* Available at: https://doi.org/10.1016/j.amepre.2023.03.014. Accessed on June 1, 2023.

15 U.S. Department of Agriculture, Economic Research Service. (2022). *Food Security in the U.S.: Measurement.* Available at: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/measurement/#insecurity. Accessed on: June 1, 2023.

Background and Purpose

Through this survey, FRAC, AARP Foundation, and Drs. Zimmer and Montez sought to:

- Assess the state of screening and intervening practices among health care providers who work with older adult patients (ages 50+).
- Identify obstacles that routinely prevent health care providers from engaging in screening and intervening.
- Identify supports that would help health care providers to engage in screening and intervening work; and elevate opportunities for enhancing this work.

Summary of Key Findings

- **Health care providers believe that they have a role to play in identifying food insecurity and recognize the importance of food security to patient health.** Nearly all survey respondents agreed or strongly agreed that screening for food insecurity in a clinical setting is important, and 96 percent agreed or strongly agreed that food insecurity contributes to poor health outcomes among adults 50 years of age and older.
- **Health care providers widely screen for food insecurity, and most feel prepared to do so, but many would benefit from increased preparedness.** Of those surveyed, 88 percent indicated that patients are screened for food insecurity at their practice/hospital. Twenty-one percent strongly agreed when asked if they feel prepared to screen patients for food insecurity and another 55 percent agreed that they feel prepared to screen patients for food insecurity. The tools and practices related to screening varied across respondents.
- **Health care providers widely intervene to address food insecurity, and most feel prepared to do so, but many would benefit from additional supports.** More than half of respondents indicated that their practice/hospital has systems in place and have staff assigned to do this work. An additional 19 percent of respondents reported that they have started this work and are building it out. When asked if they felt prepared to address food insecurity for a patient who is identified as food insecure, 18 percent of respondents strongly agreed, and 66 percent agreed. The actions providers take to address food insecurity varied substantially.
- **Health care providers recognize the importance of patients being connected to the Supplemental Nutrition Assistance Program (SNAP).** Nearly three-quarters of respondents reported that they either, ask patients who may be food insecure if they are participating in SNAP (54 percent), or ask all patients about SNAP participation (19 percent). The top two most frequently selected options for what happens if a patient is identified as being food insecure were: "Refer to a Social Worker" (44 percent), and "I help the patient apply for the Supplemental Nutrition Assistance Program (SNAP, Food Stamps) and other assistance programs" (41 percent). During, the COVID-19 pandemic, more than two-thirds (65 percent) of respondents responded that they saw an increase in patient need related to SNAP and other nutrition resources.
- **Health care providers face many obstacles in screening for and addressing food insecurity.** Respondents reported facing multiple and different types of obstacles that routinely prevent them from screening for or addressing food insecurity, particularly time constraints, obstacles related to lack of knowledge about or availability of resources to address food insecurity, lack of available staff, such as social workers or community health workers to help connect patients to resources, or other concerns around not being able to address food insecurity.
- **Health care providers need additional support for work to screen for and address food insecurity.** This comes in the form of training on connecting patients to nutrition programs and resources (62 percent), funding for community partners (45 percent), support on closed loop referrals (e.g., embedding interventions in the electronic records) (42 percent), and health care coverage for food insecurity interventions (36 percent), among other supports.

Summary of Key Recommendations

- **CONNECT** health care providers to existing training opportunities and available technical assistance.
- **DEVELOP** more targeted trainings and technical assistance based on the needs of health care providers.
- **PROVIDE** assistance to health care providers in integrating screen and intervene efforts into electronic health records, including creating systems to close the referral loop.
- **EXPLORE** opportunities for health care providers to secure funding for this work, including health care coverage.

II. METHODOLOGY

Eligibility and Distribution

For this survey, the term "health care provider" was used broadly and included physicians, physician assistants, nurse practitioners, nurses, social workers, administrators, and registered dietitians or nutritionists. An emphasis was placed on recruiting physicians, physician assistants, and nurse practitioners. However, a wide range of types of health care providers screen for food insecurity and intervene to address patient food insecurity, so perspectives from a range of types of providers were sought.

In order to be eligible to participate in the survey, the health care provider had to meet both of the following criteria: be an active health care provider (i.e., not retired); and currently provide care to patients 50 years of age and older.

The online survey was distributed via email in February and March 2023 to health care providers through outreach to provider associations, email listservs, and message boards, including the American Academy of Home Care Medicine, American Geriatrics Society, the Health and Human Service Research Geriatric Academic Career Award recipients, Gerontological Advanced Practice Nurses Association, and the Root Cause Coalition. It also was distributed to AARP's Center to Champion Nursing in America.

Prior to distribution, the survey was approved by the Wake Forest University School of Medicine Institutional Review Board (IRB00093279).

Responses

One hundred and fifty-seven individuals began the survey. Two individuals were deemed ineligible based on their responses to the eligibility screener, and the survey ended automatically for them. Eleven eligible respondents started the survey but stopped directly or shortly after passing the eligibility screener and were excluded from the analytic sample. There are 144 respondents included in the analytic sample.

Analysis

Our analysis of the survey data was primarily descriptive, focusing mainly on frequency measures. Subsequently, to further understand the trends in the data, we used visual aids such as bar charts, histogram, and pie charts.

III. RESPONDENT DEMOGRAPHICS

As detailed in Table 1, overall, survey respondents provided representation from a range of health care professions, specialties, medical settings, years of practice, and geographic areas. Of note, more than three-quarters of respondents were medical doctors, nurse practitioners, or physician assistants. The largest share of respondents were specialized in geriatrics (31 percent), followed by family medicine (15 percent).

TABLE 1: Characteristics of Survey Respondents (n = 144)

Type of Health Care Provider	Percent	Frequency
Medical Doctor (MD/DO/ND)	39%	56
Nurse Practitioner	22%	32
Physician Assistant	15%	22
Other (please describe)*	13%	18
Administrator or Operations	11%	16
Type of Specialty	**Percent**	**Frequency**
Geriatrics	31%	45
Family Medicine	15%	21
Psychiatry	9%	13
Primary Care	8%	12
Internal Medicine	8%	12
Nursing	6%	9
Case Management	6%	8
Nutrition/Dietetics	6%	8
Community Health Worker	4%	6
Other (please describe)**	4%	6
Social Work	2%	3
Administration or Operations	1%	1

**Responses to "other" for type of health care provider included: registered nurse/registered nurse and nurse practitioner; licensed clinical social worker; registered dietician nutritionist/registered dietician; care manager; health educator; PharmD; recovery care coordinator; and nursing assistant/aide.*

*** Responses to "other" for specialty included: health education; home visiting doctor; urgent care/primary care clinic; emergency medicine; critical care medicine; emergency medical services; nursing aid; and gastroenterology.*

Respondents also were asked to answer optional questions on race and ethnicity and on gender. More than half of respondents (53 percent) identified as White, and more than 60 percent identified as female. Table 2 includes details on the race, ethnicity, and gender of the 135 respondents who responded to the relevant questions.

Type of Community in Which the Provider Practices	Percent	Frequency
Urban	58%	83
Suburban	26%	38
Rural	16%	23
Type of Medical Setting in Which the Provider Practices	**Percent**	**Frequency**
Hospital	33%	48
Private practice or health system clinic	31%	44
Other (please describe)	22%	32
Public health department-operated clinic	18%	26
Rehabilitation facility	16%	23
Veterans Affairs hospital or clinic	12%	17
Senior center	11%	16
Rural health clinic	9%	13
Community health center	8%	12
Senior living facility	8%	12
Medical home	6%	8
Migrant health center	4%	6
Years Working in Health Care	**Percent**	**Frequency**
Still in training (e.g., resident, student, intern, fellow)	3%	4
Less than 5 years	22%	31
6 to 10 years	22%	31
11 to 15 years	17%	25
16 to 20 years	14%	20
More than 20 years	23%	33

Of particular importance, the majority of respondents (67 percent) reported that they treat patients who are experiencing difficulty in making ends meet. In terms of health insurance coverage, nearly half (47 percent) of respondents indicated that they have patients who do not have health insurance, and more than half (60 percent) of respondents indicated that they have patients enrolled in Medicaid. Table 3 provides details on these and other forms of patient health insurance coverage reported.

TABLE 2: Demographic of Select Respondents (n = 135)

Race/Ethnicity (multiple responses allowed)	Percent	Frequency
White	53%	71
Hispanic or Latino/Latina/Latinx	17%	23
Native Hawaiian or other Pacific Islander	13%	18
Asian	12%	16
Black or African American	9%	12
American Indian or Alaska Native	4%	6
Other	1%	2
Gender	**Percent**	**Frequency**
Female	61%	82
Male	38%	51
Non-binary	1%	1
Prefer not to disclose	1%	1
Prefer to self-describe	0%	0

TABLE 3: Patient Insurance Coverage/ Financial Circumstances (n = 144)

Patient Insurance Coverage/Financial Circumstances (multiple responses allowed)	Percent	Frequency
Patients struggling to make ends meet	67%	97
Patients with Medicare	67%	97
Patients with private insurance	65%	93
Patients enrolled in Medicaid	60%	87
Patients who do not have health insurance	47%	67
I don't know	0%	0

IV. FINDINGS

Knowledge, Skill, and Attitudes Related to Food Insecurity

Respondents were asked a series of questions on their level of knowledge — using the options of no knowledge, somewhat knowledgeable, or very knowledgeable — on topics related to food insecurity and food and nutrition resources. As shown in Figures 1 and 2, overall, most respondents indicated that they were either "somewhat knowledgeable" or "very knowledgeable" about the range of topics — with opportunity for moving to a higher level of knowledge, particularly with respect to how a medical team can intervene to address food insecurity among older adult patients and food and nutrition resources.

FIGURE 1: Knowledge Related to Food Insecurity Among Older Adults (n = 144)

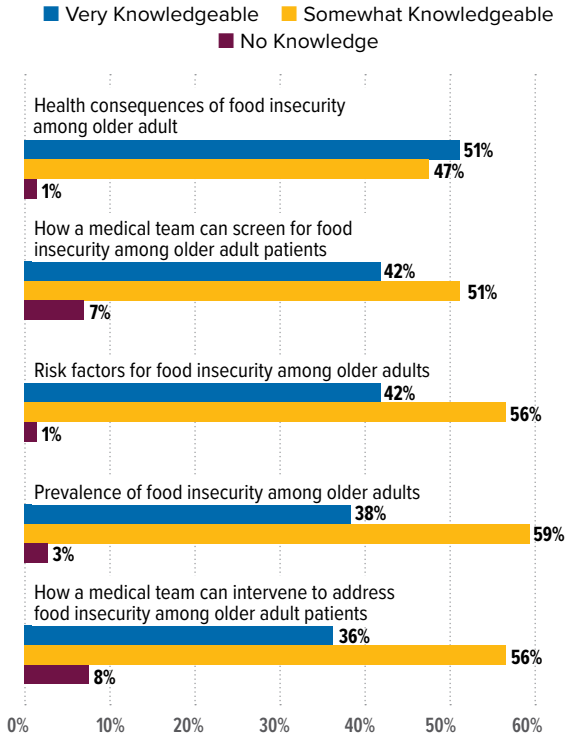
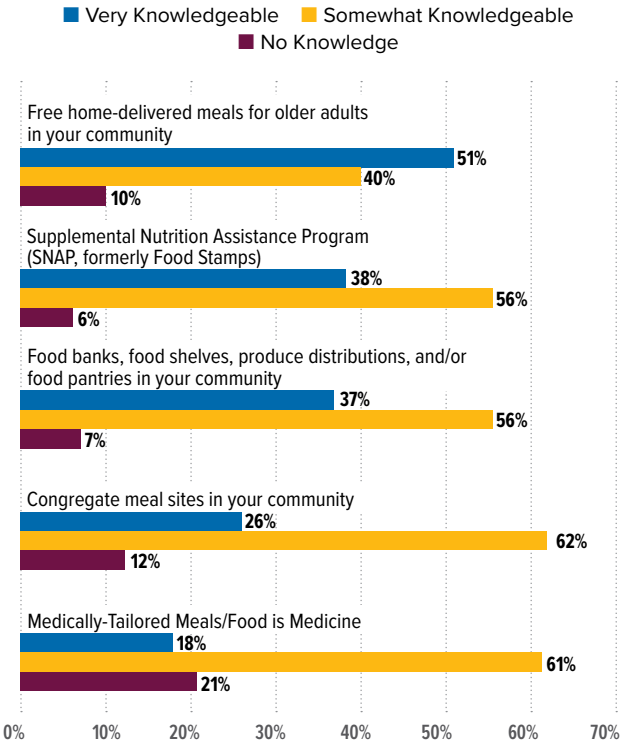


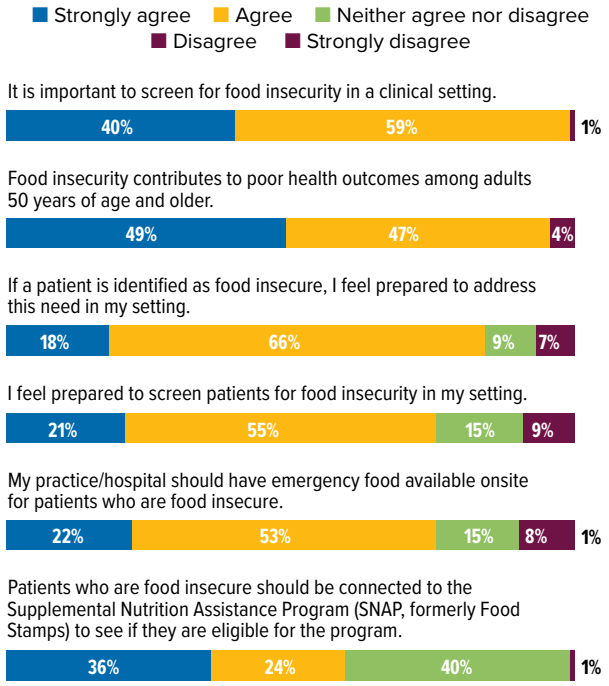
FIGURE 2: Knowledge of Food and Nutrition Resources (n = 144)



Respondents were asked to indicate their level of agreement with a selection of statements related to food insecurity, screening and intervening, and connections to food and nutrition resources. Overall, as shown in Figure 3, responses indicate that the respondents recognize the importance of screening for food insecurity, the health impacts of food insecurity, and that most have some preparedness to screen and/or intervene to address food insecurity, but many would benefit from increased preparedness.

Specifically, nearly all respondents indicated that they strongly agree or agree that food insecurity contributes to poor health outcomes among adults 50 years of age and older (49 percent strongly agree; 47 percent agree), and on the importance of screening for food insecurity in a clinical setting (40 percent strongly agree; 59 percent agree). Most respondents agreed with statements on whether they felt prepared to screen for food insecurity and intervene, but with a lower percentage of respondents indicating that they strongly agreed: I feel prepared to screen patients for food insecurity in my setting (21 percent strongly agree; 55 percent agree); and if a patient is identified as food insecure, I feel prepared to address this need in my setting (18 percent strongly agree; 66 percent agree). Many respondents strongly agreed or agreed with statements on whether patients who are food insecure should be connected to food and nutrition resources: Supplemental Nutrition Assistance Program (36 percent strongly agree; 24 percent agree); emergency food available onsite (22 percent strongly agree; 53 percent agree).

FIGURE 3: Attitudes and Skills Related to Food Insecurity (n = 144)



Current Screening and Intervening Practices

Screening Practices

Respondents were asked if they screen patients for food insecurity and for malnutrition or nutrition risk. As shown in Figure 4, 88 percent of respondents indicated that patients are screened for food insecurity, either all patients (23 percent) or some patients (65 percent). Even more (92 percent) indicated that patients are screened for malnutrition or nutrition risk.

The 126 respondents who indicated that they screen some or all patients for food insecurity were asked a series of follow-up questions on their screening practices. The respondents demonstrated variety in when and how screening is carried out at their practice/hospital.

Respondents were asked when patients are screened for food insecurity, with multiple responses allowed. Respondents cited a range of types of visits at which they screen patients for food insecurity, with the most frequently selected option being screening at annual physicals (43 percent). Only 29 percent of respondents report that they screen at all visits, 32 percent screen at sick visits, and 25 percent at new patient visits, showing potential opportunity for additional screening points.

Respondents also were asked what screening tool they use. Again, respondents had varying responses, as shown in Table 4. The screening tool option that the most respondents reported using was "'I don't always have enough money to buy the food I need.' or 'Do you always have enough money to buy the food you need?'" The screening option that respondents most frequently used is part of the 10-item DETERMINE Your Nutritional Health Checklist, which is used by health care providers to identify older adult patients or clients who are at nutritional risk.

FIGURE 4: Prevalence of Screening for Food Insecurity (n = 144)

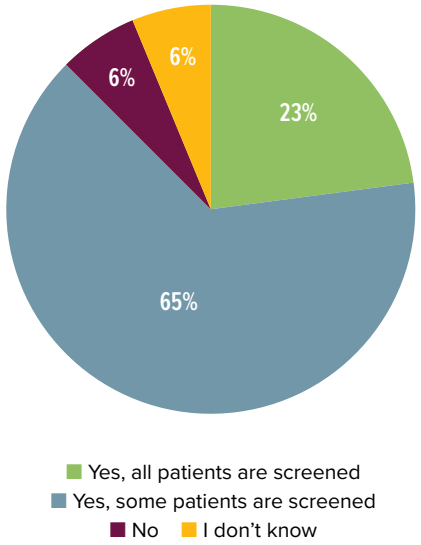


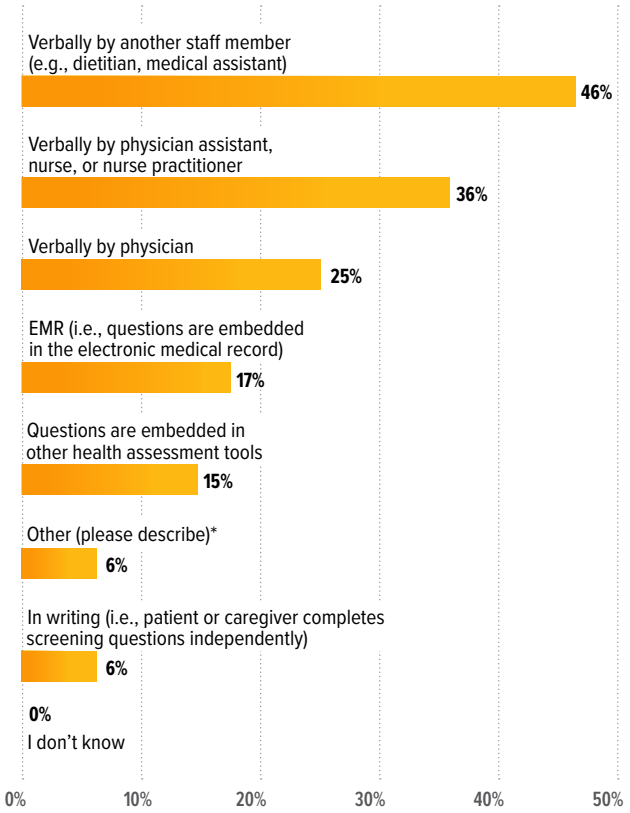
TABLE 4: Type of Screening Tool Used (n = 126)

Screening Tool	Percent	Frequency
"I don't always have enough money to buy the food I need." or "Do you always have enough money to buy the food you need?"	39%	49
"Within the past 12 months we worried whether our food would run out before we got money to buy more." and "Within the past 12 months the food we bought just didn't last and we didn't have money to get more." (These are known as the Hunger Vital Sign™).	21%	27
"Within the past 12 months we worried whether our food would run out before we got money to buy more."	19%	24
I don't know what we use in our practice.	10%	12
We don't use formal questions or statements like these in our practice.	9%	11
We use something else in our practice. Please describe, if possible.*	2%	3
"Within the past 12 months the food we bought just didn't last and we didn't have money to get more."	0%	0

** Responses to "We use something else in our practice": The six-question USDA module; we ask in detail about food supply and diet overall; and we ask about money but also about access (ex. do they need food delivered because they are homebound).*

Respondents also were asked about the mode in which patients are screened for food insecurity. As Figure 5 demonstrates, again, there was variation reported with the three most frequently selected responses related to verbal screening: "verbally by another staff member (e.g., dietitian, medical assistant)" (46 percent); verbally by physician assistant, nurse, or nurse practitioner (36 percent); and "verbally by physician" (25 percent).

FIGURE 5: Ways in Which Patients Are Screened for Food Insecurity (n = 126)

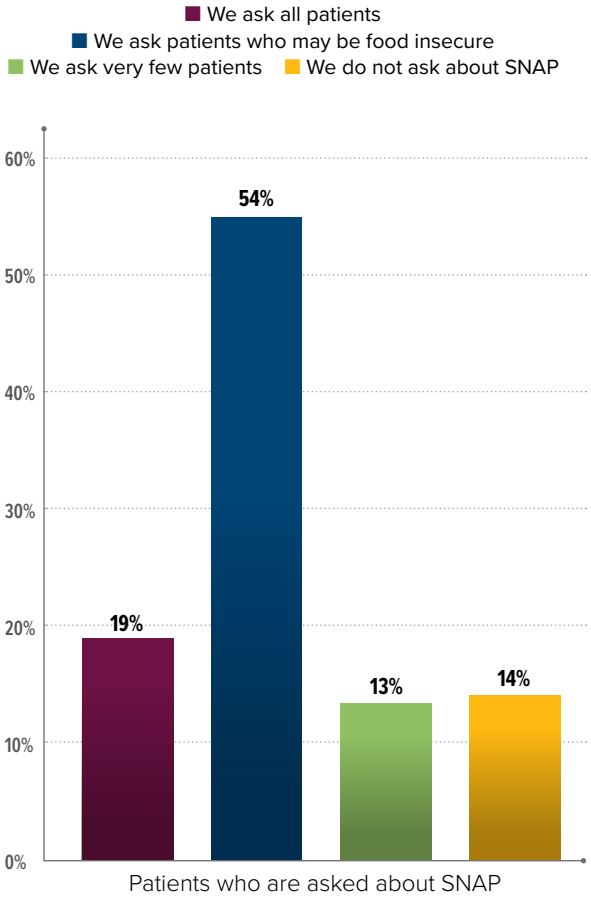


** Responses to "Other": psychosocial assessment by social worker; social worker; by social work team; social worker and BHC; as needed by verbal questions by physician; my social worker interviews the patients; we have an app called MASLOW that screens for SDoH [social determinants of health] issues and is used by all clinicians; and social worker.*

SNAP Participation Screening

All respondents, regardless of whether they screen for food insecurity or not, were given a question on whether they ask patients about SNAP participation. As shown in Figure 6, more than half (54 percent) of respondents indicate that they ask patients who may be food insecure if they are participating in SNAP. **Another 19 percent of respondents reported that they ask all patients about SNAP participation.**

FIGURE 6: Which Patients Are Asked About Supplemental Nutrition Assistance Program Participation (n = 144)



"While we have systems in place, adequate staffing continues to be a barrier."

"Interventions are patchy, referrals clinician-dependent."

"We have a robust screening and referral process that works very well."

"We need buy-in from the top down to support this program."

"We are making a more formal effort to screen our patients for all the social determinants of health."

Intervening Practices

One hundred and thirty-six respondents were asked a series of questions related to current intervening practices at their practice/hospital to determine what happens when patients are identified as being food insecure. This sample consisted of respondents who completed the questions on screening practices, as well as those who reported that they do not screen but still connect patients to resources. This allowed us to gain a fuller picture of intervening work among the respondents.

When a patient is identified as having food insecurity, providers reported engaging in a number of actions. Multiple responses were allowed. The top two most frequently selected options for what happens if a patient is identified as having food insecurity were: "Refer to a Social Worker" (44 percent); and "I help the patient apply for the Supplemental Nutrition Assistance Program (SNAP) and other assistance programs" (41 percent). The least frequently selected options were: "Provide groceries or meals through a health care plan (e.g., private insurance, Medicare Advantage, Medicaid, etc.)" (4 percent) and "Provide a food voucher or certificate (e.g., Veggie Rx, grocery store gift card, farmers market coupon)" (4 percent). Table 5 shows the five most frequently selected options for intervention actions. (The report appendix includes a table with all actions).

In terms of how referrals to food and nutrition resources are made, the top responses both included giving information on nutrition and food resource(s) to the patient, with variation in the mode. The most frequently selected option was related to the patient being given the information on paper (41 percent); and second most selected being verbally (35 percent). Additional responses are included in Table 6. Multiple responses were allowed.

When asked about who makes referrals to food and nutrition resources, respondents cited an array of different types of staff, as shown in Figure 7. The top response was "social worker" (44 percent) followed by "nurse, health worker, or other non-clinician staff members" (38 percent) and "clinician" (32 percent).

TABLE 5: Top Ways Providers Are Intervening When Patients Are Screening as Potentially Food Insecure (n = 136)

Actions (multiple responses allowed)	Percent	Frequency
Refer to a social worker	44%	60
I help the patient apply for the Supplemental Nutrition Assistance Program (SNAP) and other assistance programs	41%	56
I provide referrals	27%	37
Refer to an emergency food resource, such as food bank or food pantry	25%	34
Discuss with caregiver or family member of patient	24%	33
I don't know	0%	0

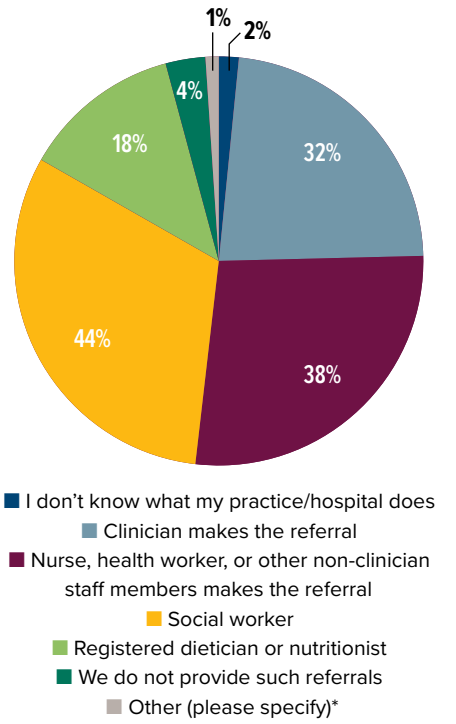
TABLE 6: How Providers Make Referrals (n = 136)

How Referrals Are Made (multiple responses allowed)	Percent	Frequency
Paper with information on nutrition and food resource(s) given to patient	41%	56
Verbal information on nutrition and food resource(s) given to patient	35%	47
Introduce or walk patient to another provider or service located in the same building	31%	42
Through the electronic medical record (EMR)	28%	38
Send patient's contact information to a partner organization for follow-up	20%	27
Make appointment for patient	13%	17
Through a community resource platform (e.g., Aunt Bertha)	11%	15
We do not provide such referrals	9%	12
I don't know what my practice/hospital does	7%	9
Other (please specify)*	7%	9
Automated referral (e.g., fax)	5%	7

** Responses to "other": Sent message via EHR to my social worker in my practice or verbally inform her; MASLOW app geo-locates closest referral source and send text or emails with referral information; in process of starting with Unite Us a community resource platform; SW is notified and makes/schedules a separate home visit; all of our homebound patients are seen by a nutritionist/dietician because they are high risk for food insecurity-on admission, annually, and as needed; provide on-site food bags as often as weekly for those that need it; discuss with our social worker; community health workers and patient navigators help with these referrals; and I call Senior Resource Alliance.*

> *"As SNAP benefits are getting cut for many of my patients, funding to support community partners is needed."*

FIGURE 7: Who at the Practice Makes Referrals (n = 136)

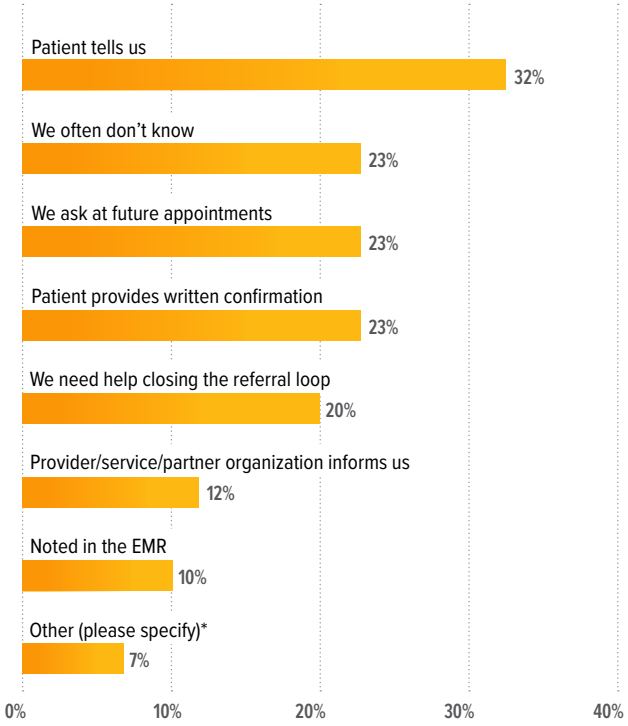


**Responses to "Other" included DTR [Dietetic Technician, Registered].*

Respondents also were asked how they know if a patient followed up on a referral. Multiple responses were allowed. As shown in Figure 8, 23 percent indicated that they often don't know if a patient has followed through on a referral, and 20 percent reported that they need help closing the referral loop.

Respondents were asked how they would characterize their practice/hospital's current efforts to address food insecurity among their patients using a list of options.

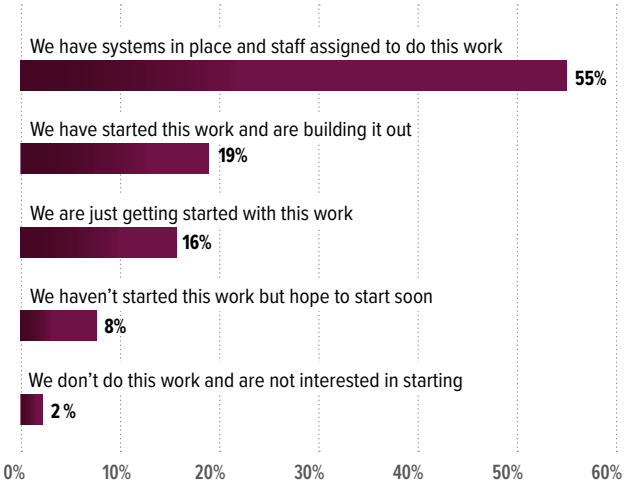
FIGURE 8: How the Practice Knows if a Patient Has Followed Through on a Referral (n = 136)



**Responses to "Other": For most referrals, we utilize Unite Us where you can follow the status of their referral to a SNAP outreach coordinator; we hand it out and document in EMR [Electronic Medical Record]; social worker follows up with patient or caregiver; I don't know; not sure; keep records of those that use our own food pharmacy; social worker follows up; social work and community health worker will often follow up; and I don't know.*

As demonstrated in Figure 9, more than half of respondents indicated that they: have started this work and are building it out (19 percent); are just getting started with this work (16 percent); or have not started this work but hope to soon (8 percent). More than half of respondents indicated that their practice/hospital has systems in place and have staff assigned to do this work. Only 2 percent are not doing this work and are not interested in starting.

FIGURE 9: Characterization of Practice/Hospital's Current Work to Address Food Insecurity (n = 135)



> *"I think standardizing the process and making a smooth referral pathway would be helpful. Our social worker is well versed, but is very busy and cannot do it all herself."*

> *"I need to better understand what processes already exist to prevent duplication and work better within my own system."*

Respondents were asked an optional, open-ended follow-up question where they could provide a brief (one–two sentence) description of their practice's current work to address food insecurity. Respondents approached this question in a variety of ways. For some of the responses, it is difficult to determine the full extent of the practice/hospital's work with the information provided. Even so, some themes across the responses emerged. Below are a few examples of the responses organized by these themes.

Limited or No Screening and/or Intervening Work Exists:

- "Most of our patients have family members caring for them in their home and make sure that the patient is properly cared for and fed. If needs arise, Dept. of Aging is contacted."
- "I am a solo practice and if there is a clue that the patient is food insecure I will call Senior Resource Alliance or DCF [Department of Children and Families]."

Some Screening Work Exists or Is Being Built Out:

- "We are making a more formal effort to screen our patients for all the social determinants of health."
- "We are beginning a formal survey using the ACH [Accountable Health Communities] Health Related Social Needs (HRSN) Screening Tool and plan to screen all patients at least annually."

Some Intervening Work Exists or Is Being Built Out:

- "There are people that put food boxes together. We can request food boxes for patients."
- "There are family service workers who make referrals to community resources, but I don't know [the] details."

Additional Work or Inputs Are Needed:

- "While we have systems in place, adequate staffing continues to be a barrier."
- "We have limited patient resources at this time. The main resource is a weekly Food Bank schedule which we post on a bulletin board."

Built Out Screening and/or Intervening Work Exists:

- "My social worker integrates this into her many screening questions when a new patient establishes care with our program."
- "Follow up if a patient endorses experiencing food insecurity. We have both onsite resources available as well as robust connections with community resources."

Unknown:

- "I don't know what our health system is doing to address this."

Centers for Medicare & Medicaid Services Food Insecurity and Nutrition Risk Improvement Merit Based Incentive Payment System

In 2022, the Centers for Medicare & Medicaid Services (CMS) released a food insecurity and nutrition risk improvement Merit Based Incentive Payment System (MIPS) activity for eligible clinicians. The MIPS was "designed to tie payments to quality and cost-efficient care, drive improvement in care processes and health

outcomes, increase the use of health care information, and reduce the cost of care."[16] This helps support clinicians to integrate into their practice activities that improve clinical practice, care delivery, and outcomes related to food security.[17] Respondents were asked if they were familiar with this new MIPS activity. **More than half (58 percent) of respondents indicated that they are very familiar or somewhat familiar with this MIPS activity**. Respondents who indicated that they are familiar with the MIPS activity were asked a follow-up question on how the new MIPS activity has changed their practice/hospital's protocol and/or billing. More than 20 percent of those who responded to a follow-up question shared that it has had an effect on practice/hospital protocols and/or billing.

16 https://qpp.cms.gov/mips/traditional-mips

17 Malnutrition Quality Improvement Initiatives. (2022). *MQii Resources for MIPS Participants*. Available at: https://malnutritionquality.org/mips-improvement-activity-resources/. Accessed on: June 1, 2023.

Impact of the COVID-19 Pandemic on Food Insecurity and Patients

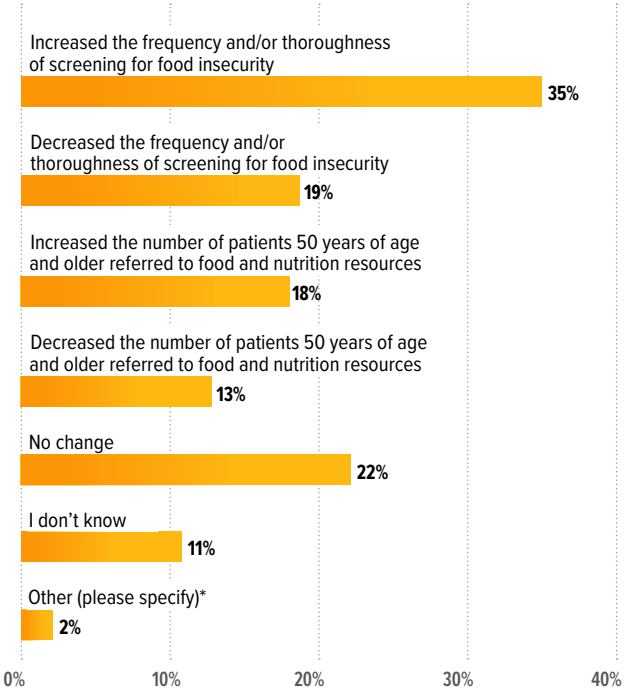
The COVID-19 pandemic's dual economic and health crises exacerbated rates of food insecurity, and hit certain individuals, including older adults, especially hard. It also had dramatic impacts on health care providers who were stretched to the limit and beyond.

Respondents were asked a set of two questions about the impact of COVID-19 on their practice/hospital's work related to food insecurity and on patient need.

When asked if they saw an increase in patients asking for or in need of SNAP and other nutrition resources, more than two-thirds (65 percent) of respondents responded yes. Only 11 percent of respondents indicated that no, they did not see an increase in patients asking for or in need of SNAP and other nutrition resources.

Respondents were also asked about how their practice/hospital made changes related to food insecurity practices during the COVID-19 pandemic. Multiple responses were allowed. As shown in Figure 10, respondents reported that the COVID-19 pandemic impacted their practice/hospital in different ways when it came to food insecurity. More than one-third (35 percent) of respondents reported increased frequency and/or thoroughness of screening for food insecurity, compared to 19 percent who decreased frequency and/or thoroughness of screening. Eighteen percent increased the number of patients referred to food and nutrition resources, while 13 percent decreased this. Twenty-two percent saw no change.

FIGURE 10: Changes in Addressing Food Insecurity Made by the Practice/Hospital in Response to the COVID-19 Pandemic (n = 140)



**Responses to "Other": There was a grant program for a while to send money to families with need. Not sure exactly who got screened and how referred; we opened after the pandemic; and I recently started working here, so I do not know if there were any changes that were made.*

Obstacles to Screening or Addressing Food Insecurity

All respondents were asked about obstacles that routinely prevent them from screening for or addressing food insecurity among their patients. Multiple responses were allowed.

As detailed in Table 7, respondents report facing multiple and different types of obstacles that routinely prevent them from screening for or addressing food insecurity. The most frequently cited obstacle was time constraints, which approximately one-third of respondents selected. Obstacles related to lack of knowledge about or availability of resources to address food insecurity, as well as concerns that asking about food insecurity will open up a range of issues that the health care provider may not be able to address, also were commonly cited obstacles. Twenty-five percent of respondents noted that they faced obstacles related to limited patient cognitive function. Nearly one-quarter of respondents reported that insurance coverage was an obstacle. Only 8 percent of respondents reported that none of the provided options were obstacles that prevent them from routinely screening or addressing food insecurity.

> *"Often individuals with food insecurity have many other social and medical challenges to address."*

TABLE 7: Obstacles That Routinely Prevent Screening or Addressing Food Insecurity at the Practice/Hospital (n = 140)

Obstacles (multiple responses allowed)	**Percent**	**Frequency**
Time constraints	33%	46
Community interventions that address this issue are unknown to me	29%	41
I am worried that talking about food insecurity will open up a range of issues that I may not be able to address	29%	41
Limited patient cognitive function makes questions about food insecurity challenging	25%	35
Insurance does not cover addressing food insecurity	24%	33
Resources addressing this issue are unavailable to me	21%	29
I don't know enough about available resources to address food insecurity	19%	26
I'm worried that questions about food insecurity are too sensitive for my patients	14%	20
The electronic medical record (EMR) system we use does not include food insecurity screening or adding it is cost-prohibitive	14%	20
Lack of buy-in from other staff to address food insecurity	13%	18
Lack of buy-in from leadership to address food insecurity	8%	11
I don't know enough about the issue	7%	10
I don't know how to ask questions about food insecurity	5%	7
I don't think food insecurity exists in my patient population	5%	7
Other (please describe)*	4%	5
Food insecurity shouldn't be addressed in a health care setting	1%	2
None of the above	8%	11

**Responses to "Other" included: Too many other issues going on; I don't always feel that the system in place and staff to help with it are that effective; often, individuals with food insecurity have many other social and medical challenges to address; adequate staffing levels.*

Supports Needed to Better Address Food Insecurity Among Patients

Respondents were asked to select the supports that would help them better address food insecurity at their practice/hospital. Multiple responses were allowed. As shown in Table 8, respondents most frequently selected: "Training for myself and/or staff on connecting patients to resources like SNAP, meals, and local resources" (62 percent); followed by "Funding to compensate anti-hunger/community partners to support my patients in accessing programs/resources" (45 percent) and "Support on closed loop referrals (e.g., embedding interventions in the electronic records)" (42 percent).

Respondents were then asked an open-ended follow-up question on the one support most needed. In response to this question, funding or financial support was by far the top response. Other supports frequently cited as the one support most needed were those centered on topics related to training, knowledge-building, and technical assistance; staff (more time for current staff or more staff); and systems improvements.

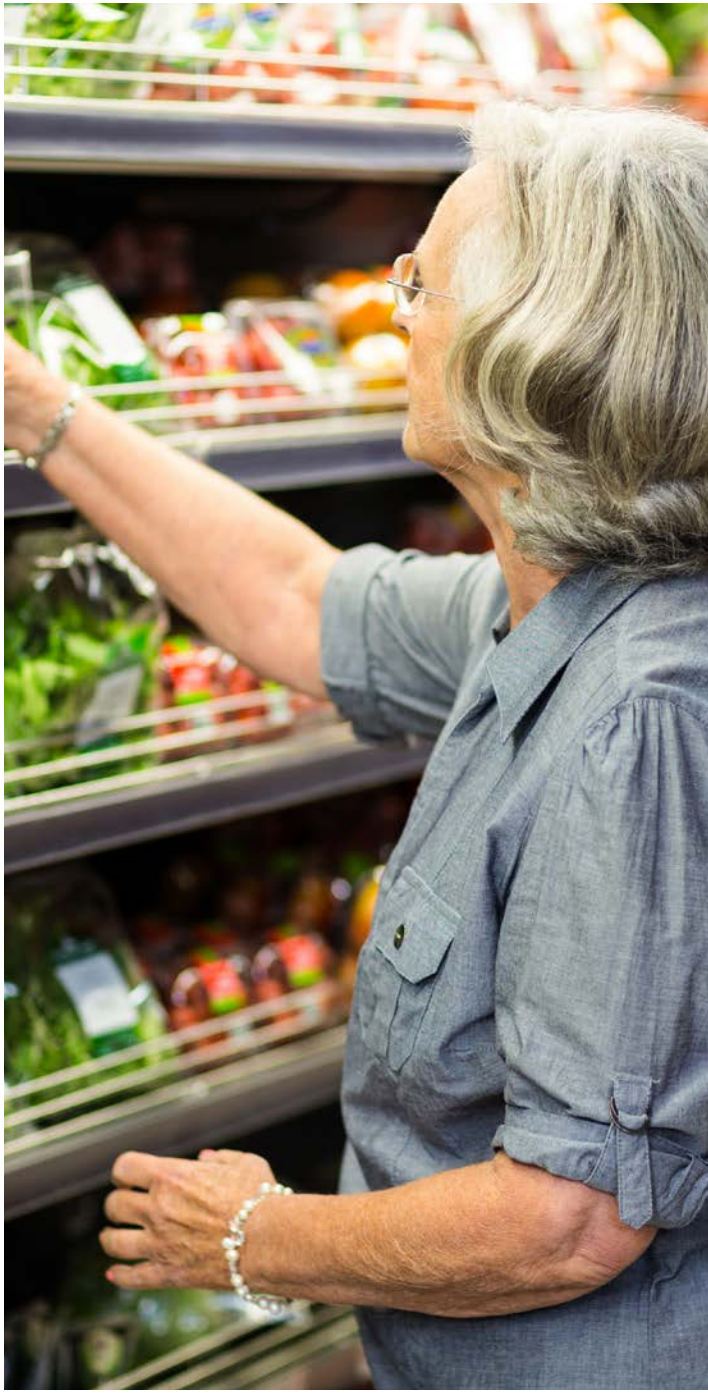
TABLE 8: Supports That Are Needed to Enable the Practice/Hospital to Better Address Food Insecurity (n = 139)

Supports Needed (multiple responses allowed)	Percent	Frequency
Training for myself and/or staff on connecting patients to resources like SNAP, meals, and local resources	62%	86
Funding to compensate anti-hunger/community partners to support my patients in accessing programs/resources	45%	62
Support on closed loop referrals (e.g., embedding interventions in the electronic records)	42%	59
Health care coverage for food insecurity interventions	36%	50
Training for myself and/or my practice team on screening	35%	48
Funding for additional staff time for this work	33%	46
Technical assistance setting up relationships with local partners that can support my patients	28%	39
Other (please specify)*	4%	6
None	2%	3

**Responses to "Other" included: Addressing at the highest levels of hospital administration the importance and prevalence of food insecurity in multiple disease states and investing in support of these programs; more encouragement to screen for food insecurity even in places where one would not expect to see it; work with the community on food deserts; funding to develop and create infrastructure to electronically connect clinical settings and community programs/resources. Faxing info and applications is ridiculously inefficient, outdated, and hard to track; I'm not sure but I think that raising the issue with the director of the facility would be the best start; and order set in EMR to connect office visit with community resource.*

TABLE 9: The Single Most Needed Support to Enable the Practice/Hospital to Better Address Food Insecurity (n = 139)

Theme (some responses included multiple themes)	Percent	Frequency
Financial support/more funding	41%	57
Staffing (more time or more staff)	12%	16
Systems improvements	12%	16
Training/knowledge-building	11%	15
Tools/resources	9%	13
Funding for programs/food resources (responses were not specific, so could include onsite as well as partner) and/or community partners	8%	11
Non-response/unsure/other commentary	8%	11
None or N/A	7%	10
Partnerships	3%	4
Other patient supports (health care coverage, balanced diet, education)	3%	4



V. RECOMMENDATIONS

The results of this survey solidify that health care providers overwhelmingly agree that they have a role to play in addressing food insecurity. Of the survey respondents, 88 percent indicated that patients are screened for food insecurity at their practice/hospital. Of those who responded to questions on intervening practices, nearly all responded that their practice/hospital is intervening to address food insecurity in some way. More than half of respondents indicated their practices have systems in place and staff assigned to screen and intervene, while 16 percent of practices are just beginning this work.

While needs vary, many respondents identified supports needed across the following categories:

- **Training and technical assistance:** Respondents indicated that need for "training for myself and/or staff on connecting patients to resources like SNAP, meals, and local resources" (62 percent); "training for myself and/or my practice team on screening" (35 percent); and "technical assistance setting up relationships with local partners that can support my patients" (28 percent).
- **Systems integration:** Respondents acknowledged the need for IT integration support to sustain and track efforts to address food insecurity. In particular, respondents indicated the need for "support on closed loop referrals (e.g., embedding interventions in the electronic records" (42 percent).
- **Funding:** Respondents identified funding needs for both internal work to screen and intervene, as well as compensation for community partners. Respondents shared the need for "funding to compensate anti-hunger/community partners to support my patients in accessing programs/resources" (45 percent) and "health care coverage for food insecurity interventions" (36 percent).

Key recommendations to address these needed supports for health care providers are described below.

Training and Technical Assistance

Connect health care providers to existing training opportunities and available technical assistance. Outreach by screen and intervene stakeholders — including medical and health associations, nonprofits, researchers, and funders — is needed to ensure that health care providers are aware of current training and technical assistance opportunities. For instance:

- FRAC and AARP Foundation offer a free, online course[18] (approved for 1 AMA PRA Category 1 Credit™), available to help educate providers on the basics of food insecurity, its harms to the health and nutrition of older adults, screening practices, and SNAP and other federal nutrition programs and nutrition interventions available to address food insecurity. The course was updated in July 2022 to include a section on malnutrition.
- The Social Interventions and Research Evaluation Network (SIREN)[19] has a research library that includes research on and examples of how health care providers are addressing food insecurity.
- The American Academy of Family Physicians EveryONE Project[20] has an array of trainings and materials to address social determinants of health — such as food insecurity, including those focused on helping practitioners become more confident in their ability to address their patients' social needs.
- The American Board of Pediatrics has a Quality Improvement Project Template[21] for food insecurity based on quality improvement methods used by pediatric practices that measurably improved screening for hunger, identification of hunger, and strategies to improve screening for hunger, leading to a decrease in the severity of food insecurity in pediatric patients. This template can be used in nonpediatric clinical settings.

Organizations or medical membership groups for health care providers who work with older adults, ages 50 and older, can be essential points of information and connection. These groups can be tapped to offer training tailored for members, often for Continuing Medical Education, ranging from webinars, peer-to-peer learning cohorts, and conference sessions.

Anti-hunger groups can provide targeted training and technical assistance on connecting patients to programs, including SNAP, home-delivered meals, congregate meals, and other food interventions (e.g., produce prescriptions and medically tailored meals). AARP/AARP Foundation, FRAC, Feeding America, National Council on Aging, Meals on Wheels America, National Association of Nutrition and Aging Services Programs, USAging, and other national organizations have information on state and community-based groups that can potentially be tapped as partners.

18 Food Research & Action Center and AARP Foundation. (2022). *Screen & Intervene: Addressing Food Insecurity Among Older Adults*. Available at: https://frac.learnercommunity.com/. Accessed on June 1, 2023.

19 Torres, J., De Marchis, E., Fichtenberg, C., Gottlieb, L. (2017). *Identifying Food Insecurity in Health Care Settings: A Review of the Evidence*. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/identifying-food-insecurity-health-care-settings-review-evidence. Accessed on June 1, 2023.

20 American Academy of Family Physicians. (2023). *Center for Diversity and Health Equity*. Available at: https://www.aafp.org/family-physician/patient-care/the-everyone-project/aafp-center-for-diversity-and-health-equity.html. Accessed on June 1, 2023.

21 The American Board of Pediatrics. (2022). *ABP ADDS NEW ACTIVITIES IN 2022*. Available at: https://www.abp.org/news/press-releases/abp-adds-new-activities-in-2022. Accessed on June 1, 2023.

Develop more targeted trainings and technical assistance based on the needs of health care providers.
Given the variety of health care practice types as well as the different stages of the implementation of screen and intervene work among providers, targeted and specialized training is needed to respond to the different needs of practitioners. Screen and intervene stakeholders — including medical and health organizations, nonprofits, researchers, and funders — can partner to develop new trainings and provide technical assistance. Drawing from the results of this survey, the following topics are prime candidates for more in-depth training and technical assistance:

- creating sustainable models to address food insecurity for practitioners just getting started;
- how and when to screen patients for food insecurity (e.g., examining the implications of research on how verbal screening has yielded lower positive response rates for food insecurity compared to written screening,[22] addressing patient fears that disclosing information about food insecurity status could trigger a report to child or adult protective services, creating an environment where patients feel safe in sharing information with medical staff);
- responding to the worry that discussing food insecurity with a patient may open up a range of issues that a provider does not feel able to address;
- documenting whether patients are participating in SNAP;
- educating on and fostering available community partnerships (e.g., highlighting the importance of active referrals, which are shown to improve access to resources)[23];
- how to screen and intervene when patients have limited cognitive function; and
- exploring the new Centers for Medicare & Medicaid Services food insecurity and nutrition risk improvement Merit Based Incentive Payment System.

Additionally, medical and health associations and medical and nursing schools should examine their offerings related to the provision of trainings and technical assistance to support addressing food insecurity. For instance, many medical schools are falling short of the minimum requirement of 25 hours of nutrition education set by the National Research Council in 1985 despite the significant impact of diet on health.[24] Better adherence to this standard could equip doctors with more knowledge so as to advise patients on nutrition and the importance of the federal nutrition programs.

Systems Integration

Provide assistance in integrating screen and intervene efforts into electronic health records, including systems to close the referral loop.
As work to screen and intervene to address food insecurity has become more commonplace in a wide range of hospital, clinical, and community settings across the country, electronic health records systems are developing to embed this work into institutional workflows. A key step to supporting this work is for screen and intervene stakeholders — including medical and health associations, nonprofits, researchers, and funders — to partner with health care providers to ensure providers are aware of existing opportunities and resources. For instance:

- The Hunger Vital Sign™ is already built into some Electronic Health Records (EHRs) (under "Hunger Screening").
- The food security code was recently changed from the lack of adequate food and safe drinking water to allow for greater accuracy and specificity. Now providers can utilize the two ICD-10-CM codes (Z59.4 Lack of adequate food, Z59.41 Food insecurity) to document and better address the health needs of patients struggling with food insecurity.
- Recent efforts, particularly those of the Gravity Project,[25] a University of California San Francisco SIREN initiative, have accelerated efforts to capture social risk data by identifying and building coded social risk data elements, value sets, and standards for sharing data with clinic and community partners through a standard called HL7 Fast Healthcare Interoperability Resources Specification.
- Some health care providers are using community resource referral platforms to refer and track patients' access to nutrition and food programs, as well as a range of other social services. Some of these platforms are embedded in the EHRs and can support closed loop referrals (e.g., enabling a provider to track that a patient was referred to SNAP and whether the patient enrolled or did not enroll).

Health care practices should identify an EHR champion to lead this integration process. Providers may want to embed a list of the federal nutrition programs and emergency food resources into the EHR so that a provider can simply check the programs that a patient is using, referred to, or enrolled in and update the list as necessary. Ultimately, how a practice integrates screen and intervene efforts will depend on their practice model and EHR interface, as well as what bioinformatics support is available.

An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities[26] highlights how the documenting of screening, assessments, and interventions — as they are related to food insecurity — in EHRs is critical and identifies steps to support these efforts.

22 Palakshappa, D., Brown, C.L., Skelton, J.A., Goodpasture, M., Albertini, L.W., Montez, K. (2022). *Social Risk Screening and Interventions in Healthcare Settings: Opportunities, Challenges, and Future Research*. Available at: https://doi.org/10.1016/j.acap.2022.08.001. Accessed on June 1, 2023.

23 Marpadga, S., Fernandez, A., Leung, J., Tang, A., Seligman, H., Murphy, E.J., (2019). *Challenges and Successes with Food Resource Referrals for Food-Insecure Patients with Diabetes*. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6380483/. Accessed on June 1, 2023.

24 Bassin, S.R., Al-Nimr, R.I., Allen, K., and Ogrinc, G. (2020). *The State of Nutrition in Medical Education in the United States*. Available at: https://doi.org/10.1093/nutrit/nuz100. Accessed on June 1, 2023.

25 Confluence, Gravity Project. (2023). *Food Insecurity*. Available at: https://confluence.hl7.org/display/GRAV/Food+Insecurity. Accessed on June 1, 2023.

26 DeSilvey, S., Ashbrook, A., Sheward, R., Hartline-Grafton, H., Ettinger de Cuba, S., and Gottlieb, L. (2018). *An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities*. Available at: https://childrenshealthwatch.org/foodinsecuritycoding/. Accessed on June 1, 2023.

Funding

Explore opportunities for health care providers to secure funding for this work, including health care coverage.

Health care providers are seeking opportunities to fund their internal work as well as support community-based food and nutrition partners. A key benefit of connecting patients to federal nutrition programs is that there is government funding to support participation. The SNAP benefit is 100 percent federally funded and available to any older adult who meets eligibility criteria. Older American Act nutrition programs (congregate meals and home-delivered meals) are free to participants in communities where the programs are available. Support for health care providers and partners can help ensure patients are connected to these and other key programs. Promising opportunities for funding include:

- **Medicaid, Medicare, and health insurance funding streams:** A range of health care providers and nutrition providers are leveraging Medicaid,[27] Medicare, and other health care funding streams to pay for screening and/or connecting patients to federal nutrition programs and other food interventions like medically tailored meals.
  - » Some of these streams are made possible through: the CMS Section 1115 waivers that can be leveraged to cover appropriate food and nutrition interventions; state Medicaid plans that can include screening performance measures; and Medicare Advantage Plans that can cover funding for groceries or other food interventions. Of note, in 2022, Arkansas,[28] Oregon, and Massachusetts[29] received approval from CMS to use a portion of their Medicaid funds to pay for food programs, including medically tailored meals, groceries, and produce prescriptions.
  - » States may authorize Medicaid managed care plans to pay for alternative services instead of standard Medicaid benefits[30] without the need for waiver approval, when it is medically appropriate and cost-effective to do so, such as providing medically tailored meals to Medicaid members.
  - » CMS included a food insecurity and nutrition risk improvement activity in the 2022 Physician Fee Schedule Final Rule[31] to support work on Food Insecurity & Nutrition Risk Improvement Activities.[32]
- **Community Health Needs Assessments (CHNAs):** Identifying the need for screening and intervening work in a CHNA can help make the case for funding. CHNAs are conducted every three years by nonprofit hospitals to help identify areas for hospitals to invest in funding. The Public Health Institute's Tackling Hunger project,[33] *Making Food Systems Part of Your Community Health Needs Assessment*, provides guidance on local food systems and food security that can provide useful information in making the case for funding.

Finally, private foundations and donors have proved essential in funding these efforts, often funding partnerships between health care providers and food banks, anti-hunger groups, and other community-based organizations. The Food Is Medicine Coalition[34] has a range of resources to help providers harness funding to connect patients to medically tailored foods. Additionally, the National Hunger Vital Sign Community of Practice serves as a clearinghouse on topics like funding.

27 Center for Health Care Strategies and Association for Community Affiliated Plans. (2023). *Financing Approaches to Address Social Determinants of Health via Medicaid Managed Care: A 12-State Review*. Available at: https://communityplans.wpenginepowered.com/wp-content/uploads/2023/02/Financing-Approaches-to-Address-Health-Related-Social-Needs-via-Medicaid-Managed-Care.docx.pdf. Accessed on June 1, 2023.

28 U.S. Department of Health and Human Services. (2022). *HHS Approves Arkansas' Medicaid Waiver to Provide Medically Necessary Housing and Nutrition Support Services*. Available at: https://www.hhs.gov/about/news/2022/11/01/hhs-approves-ar-medicaid-waiver-to-provide-medically-necessary-housing-nutrition-support-services.html. Accessed on June 1, 2023.

29 U.S. Department of Health and Human Services. (2022). *HHS Approves Groundbreaking Medicaid Initiatives in Massachusetts and Oregon*. Available at: https://www.hhs.gov/about/news/2022/09/28/hhs-approves-groundbreaking-medicaid-initiatives-in-massachusetts-and-oregon.html. Accessed on June 1, 2023.

30 Manatt, Phelps & Phillips, LLP. (2023). *New Federal Guidance on In Lieu of Services*. Available at: https://www.jdsupra.com/legalnews/new-federal-guidance-on-in-lieu-of-4886394/. Accessed on June 1, 2023.

31 U.S. Department of Health and Human Services. (2021). *CY 2022 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B*. Available at: https://public-inspection.federalregister.gov/2021-23972.pdf. Accessed on June 1, 2023.

32 Malnutrition Quality Improvement Initiatives. (2022). *MQii Resources for MIPS Participants*. Available at: https://malnutritionquality.org/mips-improvement-activity-resources/. Accessed on: June 1, 2023.

33 Center to Advance Community Health and Equity. *Tackling Hunger to Improve Health in Americans*. Available at: https://www.thecachecenter.org/tackling-hunger-1. Accessed on June 1, 2023.

34 Food is Medicine Coalition. *The Medically Tailored Meal Intervention*. Available at: https://www.fimcoalition.org/our-model. Accessed on June 1, 2023.

VI. CONCLUSION

There is growing awareness among the health care sector of the paramount importance of addressing food insecurity among older adults, and the vital role health providers can play in this work. The results of this survey clearly show that health care providers agree that they have a role to play in identifying food insecurity and recognize the importance of food security to their patients' health. The survey results also demonstrate that while many health care providers are already performing a critical role by screening for food insecurity and intervening to connect patients to SNAP and other food and nutrition programs, additional support is needed and there is room to expand this work.

Moving forward, there are key opportunities to support health care providers who have already started this work and to engage more health care providers in efforts to identify and address food insecurity. Key opportunities for supporting health care sector efforts are laid out in the White House National Strategy on Hunger, Nutrition, and Health, including in Pillar 2, *Integrate Nutrition and Health: Prioritize the Role of Nutrition and Food Security in Overall Health — Including Disease Prevention and Management — and Ensure that Our Health Care System Addresses the Nutrition Needs of All People*. This pillar includes the following actions:

A. Provide greater access to nutrition services to better prevent, manage, and treat diet-related diseases.

B. Screen for food insecurity and connect people to the services they need.

C. Strengthen and diversify the nutrition workforce.

This call to action from the White House Conference on Hunger, Nutrition, and Health, the heightened awareness of food insecurity and its detrimental impact on health that developed during the COVID-19 pandemic, and new social care standards (quality measures, standards, regulations, and more) are just some of the key opportunities that can be leveraged to continue and build food insecurity screen and intervene efforts. Harnessing these and other key opportunities will support health care providers and benefit older adult patients by addressing food insecurity, improving health, nutrition, and well-being through access to nutrition and food programs, and ultimately, lower health care costs.

35 The White House. (2022). *Biden-Harris Administration National Strategy On Hunger, Nutrition, And Health*. Available at: https://www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf. Accessed on June 1, 2023.

36 Gottlieb, L.M., DeSilvey, S.C., Fichtenberg, C., Bernheim, S., Peltz, A. *Developing National Social Care Standards*. Available at: https://www.healthaffairs.org/content/forefront/developing-national-social-care-standards. Accessed on June 1, 2023.

APPENDIX

How Providers Are Intervening When Patients Are Screening as Potentially Food Insecure (n = 136)

Actions (multiple responses allowed)	**Percent**	**Frequency**
Refer to a social worker	44%	60
I help the patient apply for the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) and other assistance programs	41%	56
I provide referrals	27%	37
Refer to an emergency food resource, such as food bank or food pantry	25%	34
Discuss with caregiver or family member of patient	24%	33
Refer to an Area Agency on Aging	24%	32
Refer to a Registered Dietitian or nutritionist	23%	31
Refer to federal nutrition assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps)	16%	22
Have a trained staff member, intern, or volunteer review a list of local resources with the patient and connect them to these resources	13%	18
Provide a brochure on available food and nutrition resources	13%	17
Refer to a community-based anti-hunger organization	11%	15
Refer to a food is medicine/medically tailored meals program	7%	10
Refer to nutrition therapy	6%	8
Provide a food box or food bag	5%	7
Other (please describe)*	4%	6
Provide a food voucher or certificate (e.g., Veggie Rx, grocery store gift card, farmers market coupon)	4%	5
Provide groceries or meals through a health care plan (e.g., private insurance, Medicare Advantage, Medicaid)	4%	5
I don't know	0%	0

** Responses to "other": I am the RD. I have created a Community Resource Guide that is regularly updated by myself. I use this guide to refer to the best programs for each patient. I do the sign up for Meals on Wheels and refer to SNAP for sign up; provide meals while on service; utilize in-house SW, RD, nursing team to resolve all issues; order through Instacart for patient; connect patient with community health worker to help apply for appropriate food programs and resources that they are eligible for; and we have a food pharmacy in place on site in six of our 12 dialysis units in coordination with the local food bank in our area.*

FRAC
Food Research & Action Center

Food Research & Action Center
1200 18th Street, NW, Suite 400
Washington, DC 20036
202.986.2200 | www.frac.org

@fractweets
facebook.com/foodresearchandactioncenter
@fracgram
linkedin.com/company/food-research-and-action-center