



Food Insecurity: Hidden Problems, Real Remedies

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Key Points

- Food insecurity is one of the most prevalent social problems in the US. It is common among ED patients and is a risk factor for increased ED utilization.
- Food insecurity is invisible unless actively inquired about; brief questionnaires that evaluate food insecurity are readily available.
- Multiple interventions exist for ameliorating the effects of food insecurity. The most basic include providing a meal within the ED. Referrals to local food pantries and soup kitchens can help meet additional needs. Food pantries within the hospital can make an immediate difference for patients who present with food insecurity.
- Federal programs such as Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are important for long-term management of food insecurity. Creating systems to connect patients and patients' families to these programs either within the ED or through referrals to community resources are important system-level interventions.
- Emergency providers should advocate for improvements in the safety net to address the social and economic factors associated with food insecurity.

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Foundations

Background

Food insecurity is one of the most prevalent social problems in the US. In 2018, an estimated 1 in 9 people, over 37 million Americans, including 11 million children, were food insecure [2].

Defining and Measuring Food Insecurity

Since 1995, the US Department of Agriculture (USDA) has annually measured food security in the US. Currently, they define two levels of food insecurity [3]:

- Low food security: reports of reduced quality, variety, or desirability of diet; little or no indication of reduced food intake
- Very low food security: reports of multiple indications of disrupted eating patterns and reduced food intake, including skipping meals and going to bed hungry

The prevalence of food insecurity, describing households with difficulty meeting basic food needs, has fluctuated noticeably over the past 26 years [4]. In 1999, 10% of American households were food insecure. During the Great Recession, a significant spike occurred, with a peak of 14.9% of American households food insecure in 2011; by 2018 food insecurity had decreased to 11.1% of households. Households with very low food security, whose members may regularly skip meals or go to bed hungry, has ranged from 3% to a peak of 5.7% of American households in 2011. In 2018, 5.3 million households (4.3%) experienced very low food security [2].

Challenging financial circumstances frequently lead to food insecurity, and thus food insecurity has the highest prevalence among low-income households. Among families with incomes below 185% of the federal poverty level (which translates to an income less than or equal to \$46,435 for a family of four in 2018), 29.1% were food insecure in 2018. The COVID-19 pandemic has the potential to cause enormous economic instability and, consequently, food insecurity across the US could increase to record high levels and remain there for years. Estimates suggest food insecurity in 2020 during the COVID-19 epidemic rose to 15.6% (50.4 million people) including 23.1% of all children (17.0 million children).¹ The prevalence of food insecurity also varies by race/ethnicity. In 2018, among non-Hispanic Black households, 21.2% were food insecure, among Hispanic households 16.2% were food insecure, while among non-Hispanic White households 8.1% were food insecure [2].

Households with children present a mixed picture of food insecurity. In 2018, 13.9% of families with children, representing 12.5 million children, were food

¹Feeding America. The Impact of the Coronavirus on Food Insecurity in 2020 [Internet]. October 2020. Available from: https://www.feedingamerica.org/sites/default/files/2020-10/Brief_Local%20Impact_10.2020_0.pdf.

insecure. In nearly half of these households only the adults were food insecure, implying there were challenges procuring food but the children had enough to eat. However, in 51% of these households, representing 6 million children, the children also experienced food insecurity. Over 540,000 US children experienced very low food security, characterized by reduced food intake and disruptions in their eating patterns. In households with children led by a single mother, the food insecurity rate was 27.8% and the very low food security rate was 9.4% [2].

Programs That Address Food Insecurity

Programs that address food insecurity include federal programs, statewide and national nonprofit programming, as well as smaller local social programs. Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infant, and Children (WIC) are two of the better-known federal programs to help with food insecurity in low-income individuals and families.

SNAP, formerly known as “Food Stamps,” is the largest federal program focused on food insecurity among poor individuals and families. Eligibility for SNAP at the national level is income-based and in some states asset-based as well. Overall, gross monthly income must be below 130% of the federal poverty line, \$2183 per month for a family of four in 2020 (\$26,200 annually). Forty states use “categorical eligibility,” allowing the state to provide more households with benefits. Categorical eligibility gives states the option to automatically align gross income and asset requirements with Temporary Assistance for Needy Families (TANF) and other assistance programs (i.e., if you qualify for TANF, you are enrolled in SNAP) [5]. Though SNAP participation reduces the risk of food insecurity [47], more than half of households receiving SNAP are still food insecure due to the relatively limited amount of support SNAP provides. On average, families receive \$1.40 per person per meal. The average SNAP household receives \$256 per month [6].

WIC provides supplemental foods including formula for infants and healthy foods for pregnant and breastfeeding women and children up to age 5 years old. WIC also provides nutrition education, breastfeeding support, and referrals to healthcare and other services, free of charge, to families who qualify [7]. Income eligibility includes families with gross incomes below 185% of the Federal Poverty Level [8]. Some states have automatic income eligibility based on enrollment in TANF, Medicaid, or SNAP.

Food banks are nonprofit organizations that distribute food to hunger-relief charities. In 2018, Feeding America, which distributes food to 60,000 food pantries across the US, fed 40 million people, including 12 million children [9]. Meal programs, which are sometimes referred to as soup kitchens, offer prepared food and hot meals to the hungry for free or at reduced prices. They frequently have limited hours and days of the week of service and may serve only select geographic or demographic groups; they can reach only a fraction of people living with food insecurity on a constant basis.

Additional programs that provide meals to some low-income people include Meals on Wheels (for elderly and disabled) and school breakfast and lunch programs. The Child and Adult Care Food Program (CACFP) is a federal program that provides reimbursements for nutritious meals and snacks to eligible children and adults who are enrolled for care at participating child care centers, day care homes, and adult day care centers. Over 4.2 million children and 130,000 adults receive meals and snacks through this program on a daily basis [10].

Understanding these services can provide a framework to help address food insecurity, especially with the recognition that a meaningful proportion of those eligible for these programs are not enrolled. In 2017, 45 million people were eligible for SNAP and 84% of eligible participants used SNAP, up from 69% utilization in 2007 [6]. In 2014, 15 million people were eligible to receive WIC but only 55% enrolled; participation rates vary by state [11]. A little over two million of those eligible were infants, which is 62% of all infants born in the US. Participation rates were 80% for eligible infants compared to 50% of eligible pregnant women [11]. Participation lags behind eligibility for these programs for multiple reasons including (1) lack of understanding about eligibility, (2) social undesirability and stigma, (3) concerns about disqualification for immigration, (4) language and social barriers, (5) difficult forms, and (6) complicated asset tests and high burden of proof. Further, many of these programs are not entitlements but rather are contingent on funding legislation, and availability may vary by allocation and by state policy. The federal programs have strict eligibility based on income, assets, and immigration status while many food pantries and soup kitchens do not, which is especially important as changing federal regulations may cause people to lose their eligibility for programs they used to receive.

Evidence Basis

Food Insecurity and Health

The harmful health consequences of food insecurity have been well documented in the literature. The suspected mechanisms behind the negative relationship between food insecurity and health are numerous but not fully understood. Food insecure households are more likely to purchase inexpensive, energy-dense, and nutritionally low-quality food [12, 13]. This diet is associated with increases in body mass index, hypertension, elevated cholesterol, elevated HgbA1C, and other risk factors for poor health [14]. The strain associated with food insecurity likely has negative effects through non-dietary mechanisms which include (1) toxic stress that activates the hypothalamic-pituitary-adrenal axis, (2) decreased ability to manage other health-related social needs thus leading to accumulated social problems, (3) unhealthful coping behaviors such as smoking and excessive alcohol use, and (4) decreased ability to manage chronic diseases [15–18].

Among food insecure patients, there is a high rate of obesity, advanced hepatic fibrosis, and nonalcoholic steatohepatitis cirrhosis (NASH), which is a leading

cause of liver transplantation in the US [19]. In a study of 13,518 adults, those living in very low food security households had more than a twofold increased risk of 10-year cardiovascular disease [20]. Children with food insecurity have nearly twofold higher risks of fair/poor health and 50% increased rates of parental concern for developmental delay compared to children without food insecurity [21, 22]. In very low food security households, families may not consume daily minimal requirements of calories and appropriate nutrients, in some cases leading to malnutrition. Food insecurity has also been associated with the presence of mental health disorders. Adults who are food insecure are about 3 times more likely to report frequent mental distress compared to those who are food secure [23]. Caregivers of children in food insecure households have over threefold higher rates of depressive symptoms [24]. In the US, children from food insecure households have 28% higher rates of depression than children from food secure households [25].

Food Insecurity and ED Utilization

People who are food insecure have higher rates of ED visits than those who are food secure. Simultaneously, surveys of patients in the ED have demonstrated higher prevalence of food insecurity among ED patients than in the general population [26, 27]. Adults with food insecurity have nearly a 50% increased rate of ED visits and hospitalizations, as well as longer hospitalization lengths, compared to those who are food secure [28, 29]. Among adults with type II diabetes, food insecure patients have a twofold increase in ED visits [30]. Children in food insecure households use the ED at up to 37% higher rates compared to food secure households [28, 35], and their risk of hospitalization is a third greater than children in food secure households [22]. Among vulnerable populations, people who are homeless and who have food insecurity have nearly threefold higher rates of ED utilization compared to homeless people who are not food insecure [31]. Among HIV+ homeless patients, those who were food insecure had 50% higher rates of ED utilization [32].

Food Insecurity and Health-Related Social Problems

As one of the most common health-related social problems, food insecurity is frequently an indicator of other health-related social needs. Food insecure patients are over four times more likely to have cost-related medication underuse compared to food secure patients, a major risk for poorly controlled health and worse disease outcomes [33]. A study of young adults found that patients with low and very low food security reported two- to fourfold higher rates of problems with healthcare access, education, housing, income security, and substance use compared to patients with high food security [34]. Among children with special healthcare needs, food insecurity is associated with a nearly two-fold increase in material hardships including unmet needs such as well-child checks, dental care, prescription medications, physical, occupational, or speech therapy, mental health counseling, or access to a range of medical equipment [35, 36]. In these contexts, food insecurity may be both a marker for other health-related social problems and a contributing factor.

Food Insecurity and Medical Cost

The medical costs in the US associated with food insecurity are likely far greater than realized by policy makers. A Massachusetts study in 2016 estimated the direct and indirect hospital costs of food insecurity at \$1.9 billion [37]. Medicare patients with food insecurity have mean annual Medicare costs \$5527 higher than food secure patients [28]. A large national study demonstrated higher average annual healthcare expenditures among food insecure individuals compared to food secure individuals (\$6072 vs. \$4208), equating to an estimated additional \$77.5 billion in annual healthcare expenditures across the US associated with food insecurity [38].

Federal, state, and local programs are buffers for people with food insecurity. WIC has been shown to improve pregnancy and birth outcomes such as reduction in low birthweights [39, 40]. Children receiving WIC benefits have lower rates of anemia, and longer duration of WIC utilization is associated with enhancements in IQ scores [41, 42]. Similarly, the use of SNAP has been linked with many positive outcomes including improved diet, lower ED utilization [43], and better asthma control [44]. At a population level, SNAP may reduce all-cause mortality by 1–2% [45]. SNAP participants incur \$1400 less in medical costs per year compared to other low-income adults [46].

The following sections aim to familiarize emergency providers with tools to identify and then alleviate food insecurity among the patients they serve. ED providers should recognize both the prevalence of food insecurity and the significant impact food insecurity has on the health of our patients. Ideally, the hospitals will embrace the importance of these interventions and recognize the essential safety net role of EDs for connecting patients to appropriate food resources.

Emergency Department and Beyond

Bedside

Many EDs serve as the entry point to healthcare for underprivileged individuals and families. Unless actively queried, food insecurity will remain an invisible, though prevalent, problem among ED patients. Standardized universal screening of ED patients has expanded in recent years to include concerns such as alcohol and drug abuse, depression and suicidal ideation, and intimate partner violence, among others. Such screening has become relatively common, albeit cumbersome, to ED staff. The use of screening tools such as the Hunger Vital Sign™ (below) would enable the identification of food insecure patients and families [1]. The integration of such screening represents an opportunity for culture change in our approach to food insecurity.

Children's HealthWatch established the two-question "Hunger Vital Sign™" which has a sensitivity of 97% and specificity of 82% for food insecurity compared to the gold standard USDA Household Food Security Scale [49]. The two Hunger Vital Sign™ questions are:

“Within the past 12 months we worried whether our food would run out before we got money to buy more.” (“Often true” or “Sometimes true” vs. “Never true”)
“Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.” (“Often true” or “Sometimes true” vs. “Never true”)

A response of “often true” or “sometimes true” to either of the two questions is considered a positive screen.

Unlike screeners for many other health-related social needs, the Hunger Vital Sign™ has been well-validated and is the clear first choice for food insecurity screening in healthcare settings. This questionnaire, originally designed for families with young children but also validated for adults [50], has become the standard in healthcare settings and is used in the Center for Medicare and Medicaid Innovation’s Accountable Health Communities (CMS AHC) three million person ongoing innovation model [51]. Preliminary qualitative and quantitative studies of the CMS AHC questionnaire—which includes the two Hunger Vital Sign™ questions along with eight other social need questions—among primary care and ED patients show strong support from patients for asking these social needs questions [52, 53]. In a randomized trial of screening for food insecurity in the ED, 86% of families endorsed the concept of routine screening for food insecurity within the ED [54]. Within the ED, screening could be performed at triage, by the nurse during intake, by the primary clinician caring for the patient, or by social workers or other trained staff during the course of a patient’s ED visit. Some methods of screening can even be done while patients are in the waiting room. A new study in North Carolina will evaluate the role of screening and referral for food resources from the ED [55], and an ongoing study in the ED at Boston Children’s Hospital is evaluating the role of social screening and referral using patients’ smart phones vs. tablets [56].

Studies have shown that both paper and electronic questionnaires are feasible in the healthcare setting [57–61]. However, the method by which patients are screened may influence the responses they provide. Administering sensitive questions one-on-one may be the easiest way to universally screen, but analyses comparing one-on-one, paper, and electronic formats suggest that screening via personnel asking patients questions directly may decrease positive responses (lowers sensitivity) for sensitive issues [62]. In one study, specific to food security screening, the change from an oral to a paper screening of patients using the Hunger Vital Sign™ increased positive response rates from 10.4% to 16.3% [63]. A randomized trial of screening for food insecurity in the ED showed that via tablets 23.6% of patients screened positive compared to 17.7% screening positive via verbal screening [54].

While understanding the prevalence of food insecurity within one’s ED patient population is important, having a systematic approach to offer assistance is crucial. Information about local resources (e.g., food pantries, soup kitchens) that are geographically relevant can be readily provided via online tools (e.g., United Way 211 system, HelpSteps, Aunt Bertha, NowPow) [59, 64–66]. Limited literature from outpatient clinics has shown that providing pre-printed forms that list local food pantries and contact information is effective in connecting patients to community resources [67].

If the electronic medical record (EMR) is used to record the answers to the food security questionnaire, ideally positive responses can trigger a social work consult or the inclusion of a food resource referral sheet with the discharge paperwork. At a minimum, making referral sheets available within the EMR that include local food resources may ease the process of clinicians providing patients with this important information [68]. Food insecurity can be documented using ICD-10 codes (Z59.4) to help quantify the extent of this problem within a patient population that the ED serves.

When it comes to patients' desire for help with food, it is important to realize that screening positive for food security problems is not the same as food referral needs. Not all people who are food insecure will want referrals, and likewise, families that are "food secure" via screening questionnaires still may desire referrals. In a study of low-income families in a primary care clinic, 46% of food insecure families did not request referrals; among food secure families, 15% still requested food assistance [60]. Thus, screening processes should offer patients the ability to identify their referral needs (i.e., I want help with SNAP or WIC or finding a food pantry) even if such patients do not meet the standard definition of food insecurity.

If universal screening of food insecurity with validated questions has not been instituted, simply asking a patient in the ED (when clinically feasible) if they would like something to eat is an immediate and kind way to provide a meal. The price of food in many hospital cafeterias and the chain food stores located in hospitals are often too expensive for low-income families, and their ED visits may exacerbate hunger. Having food immediately available and/or hospital cafeteria vouchers that cover the cost of a meal can make a significant difference in families' lives during a stressful time and may also improve the therapeutic relationship. If clinicians ask about food needs at the bedside, it is critical to have access to food to respond to them.

Hospital/Healthcare System

At the hospital level, food insecurity screening procedures and interventions should be developed based on resources and partnerships with state, federal, and community organizations. Several large hospital networks and individual clinics have recognized the importance of food security on the health of their patients and perform universal screening for food insecurity [69, 70]. In a program supporting food insecure families with infants, parents were provided supplemental formula, educational materials and referrals to social workers, medical-legal partnerships, or food pantries directly from the clinic [71]. In other programs, hospitals provided vouchers for on-site or local farmers markets [72, 73]. Many medical centers such as Boston Medical Center, Massachusetts General Hospital, and St. Christopher's Hospital for Children in Philadelphia have on-site food pantries or partner with local organizations to bring mobile food pantries to their clinics on a weekly basis. Studies have shown that caregivers and patients find these programs both acceptable and desirable [74, 75].

Multi-stakeholder partnerships are especially important to link at-risk children to needed food service programs [61, 62]. An intervention at the Children's Hospital

of Philadelphia in collaboration with federal and community partners provided free lunch to ED pediatric patients and their siblings during a summer food service program. In the 7-week pilot, 367 meals were distributed to children, and their families were referred to the US Department of Agriculture (USDA) Summer Food Service Program developed to bridge the summer food gap for those who receive free or reduced-price lunch during the school year [76]. Arkansas Children's Hospital provides access to free, nutritious meals for all children seen at the hospital as part of USDA's Child and Adult Care Food Program (CACFP) At-Risk Afterschool Meals Component [77].

Benefit Assistance and Referrals

Applications for SNAP and WIC can be completed and submitted from the hospital and/or by working with local community partners [66, 78, 79]. Boston Medical Center has an on-site WIC office and on-site SNAP application assistance [48]. Depending on the state and the cross-eligibility with other federal programs, SNAP may require documentation regarding income. The approach of filling out applications while at the hospital has been used in EDs with great success for enrollment in the State Children's Health Insurance Program [80] and could be similarly applied to SNAP and WIC applications. Local student organizations and other volunteers can help patients under the guidance of social workers in the ED.

Societal Level

As a society, it is important to recognize food insecurity not simply as an unfortunate problem of individuals and families but rather as a result of systematic efforts to keep wages low, leading to widespread poverty, while at the same time denying access to food resources for vulnerable populations. Increased expenditures on social services have been shown to reduce food insecurity in multiple countries. Unfortunately, the US ranks second to last among developed countries in public expenditure on families [81]. In the US, rather than supporting families' success in gaining small steps toward economic stability, small increases in income can lead to a loss of SNAP eligibility, thus increasing the risk of food insecurity and poor health [82].

Despite the vast unmet need for food resources and the success of many local and federal programs, multiple ongoing efforts to reduce access to SNAP and other programs will likely exacerbate food insecurity in the US. In December 2019, the Department of Agriculture gave its final approval to the first set of measures to cut more than 700,000 people from SNAP [83]. The loss of SNAP eligibility includes immigrants threatened with the loss of eligibility for permanent legal status ("green cards"), decreased eligibility for Able-Bodied Adults Without Dependents ("ABAWDs"), changes in broad-based categorical eligibility (i.e., TANF enrollment no longer qualifies as an automatic eligibility for SNAP), and changes in the calculation of the standard utility allowance (the household's heating and utility expenses) used to calculate SNAP benefits. A New York Times headline from

March 20, 2020, clearly captures the impending worsening food insecurity crisis in the US: “Coronavirus and Poverty: A Mother Skips Meals So Her Children Can Eat” [84].

At a societal level, it benefits our nation when the population has food, whether the benefit is measured through healthcare savings, educational gains, socioeconomic improvements, or the knowledge that children are not going to bed hungry. One practical needed reform is to eliminate disqualifications for those who otherwise meet SNAP eligibility requirements, such as low-income college students [85]. The move from paper forms to electronic applications for SNAP and WIC benefits could improve the ease and speed with which people receive benefits. Automating enrollment in SNAP and WIC for those receiving TANF, Medicaid, and other programs focused on low-income people would also increase utilization rates.

Emergency clinicians can advocate for these and other ways to mitigate poverty such as expanding access to the earned income tax credit, TANF, child and dependent care credit, Section 8, public housing, and Medicaid. The use of these programs are all mechanisms that would free up families’ limited financial resources for the purchase of food [81]. Heating fuel subsidies are especially important in areas of the country that have significant fluctuations in the weather. Children’s HealthWatch has noted the “Heat or Eat” phenomenon that leads to measurable stunting of children’s growth in winter months [86].

Recommendations for Emergency Medicine Practice

To emphasize: the ED could play a powerful role as portal of entry to existing social service programs for a large population in need. While the limited availability of food resources such as food pantries may be an obstacle in some circumstances, for many patients what is lacking is simply the connection to already existing programs. To facilitate this connection in an effective and successful fashion, a comprehensive approach is needed, which ranges from education at the level of the individual clinician to systemic approaches to screening and to having institutional resources available to address identified food insecurity both immediately and longitudinally. The American Academy of Pediatrics and the Food Research & Action Center has a toolkit for pediatricians and others to address patients’ food insecurity (<https://frac.org/aaptoolkit>) [87].

Basic

- Train clinicians. Despite the fact that clinicians routinely ask about personal and sensitive medical topics, they may feel uncomfortable asking about sensitive food security issues that may have stigma associated with them. A script can be helpful. For example, simply prefacing a question about food insecurity with

“Do you mind if I ask...” may allow clinicians to overcome the hurdle of initiating the conversation.

- Ask patients about their immediate food needs (i.e., are they hungry right now?). Provide food directly and/or have mechanisms that help families cover costs of in-hospital food if necessary.
- Extend the conversation. Understand whether patients have food insecurity beyond the ED visit, ask if they need help identifying food resources, and be prepared to connect them to experts such as social workers or provide referral sheets with food resources.

Intermediate

- Institute universal screening for and documentation of food insecurity in the ED. Consider use of the two-question Hunger Vital Sign™, which is well-validated and widely used.
- Provide ready access to information about food resources via the electronic medical record (EMR) or pre-printed sheets.
- Develop connections to local food pantries, soup kitchens, and WIC offices that serve people who need food resources.
- Connect patients to federal programs. Have application forms available and social workers, other experts, and even trained volunteers that can assist families.

Advanced

- Provide food resources directly to patients such as via in-hospital food pantries.
- Set up programs that help food security during high-risk times of need such as summer food programs for children and additional food resources in winter months when families might need to choose between paying heating bills and paying for food.
- Advocate at the state level to ease restrictions on SNAP applications.
- Advocate at the national level to increase eligibility for SNAP and WIC. Advocate for larger benefits for individuals and families in need. Advocate for living wages to help lower the number of patients living in poverty.

Teaching Case

Clinical Case

An 8-year-old girl with asthma presents to the ED at a tertiary care academic pediatric hospital. She has significantly increased work of breathing and is speaking in one-word sentences. She is tachypneic and hypoxic and requires immediate intervention.

While initiating albuterol treatments, steroids, and placing an IV for further management, the resident turns to the mother to obtain additional history. When asked how long the patient has been having trouble breathing, the mother responds this has been going on for a few days. She ran out of her albuterol inhaler 3 days ago. The resident does not say anything immediately, but has a questioning look on her face. The mother goes on to explain that the family had to choose between buying food or asthma medications for the patient, as they didn't have enough money for both so they chose to buy food.

The patient responds to the initial treatments but is persistently tachypneic with marked wheezing and poor aeration. She requires admission to the ICU for a higher level of care.

Prior to being transferred to the ICU, the mother asks to speak with the resident. She hesitates, the resident believes out of pride, but then finally asks if the ED has any meal vouchers for food from the hospital cafeteria. Even sacrificing their meager funds for food over albuterol, they are still hungry.

Teaching Points

Patients with circumstances similar to this present every day in the ED, but the contribution of food insecurity to a variety of clinical presentations is often invisible. Proactive approaches to making food insecurity a more visible health-related social problem are the first steps to addressing it.

1. In this situation, the patient's parent was able to articulate her needs. In other circumstances, the clinician must be able to:
 - Consider the possibility of food insecurity
 - Be able and willing to inquire about food insecurity
 - Have immediate (e.g., hospital food vouchers) and ideally longitudinal resources (WIC, SNAP, or local food pantries) to share
2. The institution should create programs to screen for food insecurity. Systematic screening has the potential to identify patients that would otherwise not self-identify as food insecure.
3. The department should create educational programs for all clinicians about the need to screen for food insecurity. Provider education about the way to approach these sensitive issues is important.
4. Clinicians should codify a spectrum of easily accessible resources to address food insecurity. Screening does not help a patient if there are no resources available to assist them, ideally in both the immediate- and long-term timeframes.

Discussion Questions

1. The resident was uncomfortable with exploring the reason why the patient was not using her medication. She did not know how to respond when the family disclosed severe food insecurity. How does this compare to your own experiences with following through with these types of questions? How do you determine if you should ask about food insecurity?

2. In what way does the patient's food insecurity affect the emergency physician's decision-making? What are the responsibilities of the ED for helping not just the patient but also the family supporting them?
3. What resources are available in your institution to help families with food insecurity? Is there free, nutritious, and satisfying food available? Many EDs limit their food immediately available for distribution to saltines, pudding, juice, cereal, and maybe a turkey sandwich. What message are we sending our patients? Is the food in the cafeteria financially accessible for families in need?
4. What opportunities are available for partnerships outside of the ED? Do you know the names and locations of food pantries and soup kitchens that are in your patient populations' neighborhood? Do you have social workers or other organizations that can help patients fill out SNAP or WIC forms?
5. What are the challenges to identifying and helping patients with food insecurity? How do they differ or feel the same compared to other social problems?

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