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SCREEN AND INTERVENE:

A Toolkit for Pediatricians to Address Food Insecurity

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Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity

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The American Academy of Pediatrics (AAP) is an organization of 67,000 pediatricians committed to the optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. For more information about AAP, go to www.aap.org.

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Food Research & Action Center

About the Food Research & Action Center

The Food Research & Action Center (FRAC) 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, or to sign up for FRAC's e-newsletters, go to www.frac.org.

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Anthem® Foundation

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Introduction

Food insecurity — the limited or uncertain access to enough food — is a critical child health issue that impacts millions of infants, children, youth, and families in all communities across the U.S. Children of all ages who live in households with food insecurity, even at the least severe levels of food insecurity, are likely to be sick more often, recover from illness more slowly, and be hospitalized more frequently.[1,2]

Unfortunately, 1 in 7 U.S. children lives in a household experiencing food insecurity. These levels have only deepened during the COVID-19 pandemic. Black and Hispanic/Latino households with children continue to face disproportionately high rates of food insecurity before and during the pandemic.[3]

1 Northwestern Institute for Policy Research. (last updated July 2020). Food insecurity resources. Available at: https://www.ipr.northwestern.edu/what-we-study/trending-policy-topics/food-insecurity.html. Accessed on December 7, 2020.

2 Food Research & Action Center. (2017). *Hunger and Health — The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being*. Available at: https://frac.org/research/resource-library/hunger-health-impact-poverty-food-insecurity-poor-nutrition-health-well. Accessed on December 7, 2020.

3 Schanzenbach, D., contributing economist for the Food Research & Action Center. (2020). *Not Enough to Eat: COVID-19 Deepens America's Hunger Crisis*. Available at: https://frac.org/wp-content/uploads/Not-Enough-to-Eat_Hunger-and-COVID.pdf. Accessed on November 12, 2020.

Pediatricians can play a critical role in addressing food insecurity, a health-related unmet social need with harmful impacts on child health, development, and well-being.

In a policy statement, *Promoting Food Security for All Children*, the American Academy of Pediatrics (AAP) recommends that pediatricians

- **SCREEN AND IDENTIFY** children at risk for food insecurity;
- **CONNECT** families to needed community resources; and
- **ADVOCATE** with other key partners and stakeholders for federal, state, and local policies that support access to adequate and healthy food so that all children and their families can be nourished, active, and healthy.

In order to assist pediatricians in meeting these recommendations, the AAP partnered with the Food Research & Action Center (FRAC) to update this toolkit (first published in 2017) and its accompanying materials and resources. The revamped toolkit will help pediatricians, their practice teams, and community partners

- **LEARN** about food insecurity, including rates among families with children, its negative impacts on child health, development, and well-being, and how it may present in a family;
- **SCREEN** for food insecurity by using Hunger Vital Sign™ (this is a validated two-question screening tool developed by Children's HealthWatch);[4]
- **CONNECT** families to federal nutrition programs and other state and local community resources; and
- **SUPPORT** national and local policies that address food insecurity and its root causes, including poverty, inadequate wages, housing insecurity, food deserts, and structural racism.

4 Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. A., Casey, P. H., Chilton, M., Cutts, D. B., Meyers, A. F., & Frank, D. A. (2010). *Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity*. Available at: https://childrenshealthwatch.org/wp-content/uploads/EH_Pediatrics_2010.pdf. Accessed on December 8, 2020.

"One in 7 children experiences food insecurity and hunger. Unless you ask, you won't be able to tell which child is going to bed hungry, and you won't be able to connect their families to resources, like SNAP, WIC, or food pantries, that will help them get the nutrition they need."

LEE BEERS, MD, FAAP
President, American Academy of Pediatrics (2021)

This infographic highlights the key information that pediatricians need to begin addressing food insecurity among children and their families. Download this infographic to share with your practice team or other colleagues.

KEY FACTS: CHILDHOOD FOOD INSECURITY AND THE ROLE OF PEDIATRICIANS

1 in 7* U.S. children live in households with food insecurity

** COVID-19 has increased that number to as many as **1 in 4***

CHILDHOOD FOOD INSECURITY IS ASSOCIATED WITH:

Poor Health Status | Developmental Risk | Mental Health Problems | Poor Educational Outcomes

FOOD INSECURITY MAY PRESENT IN A FAMILY AS:

Food Anxiety | Diet Monotony | Decreased Nutrition Quality | Inadequate Food Intake

THE FEDERAL NUTRITION PROGRAMS IMPROVE THE FOOD SECURITY, HEALTH, AND WELL-BEING OF CHILDREN

- **Supplemental Nutrition Assistance Program (SNAP)**
- **Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**
- **Child Care Meals**
- **School Breakfast and Lunch**
- **Afterschool Meals**
- **Summer Nutrition Programs**
- **Pandemic-EBT** (available during COVID-19 school closures)

THREE STEPS FOR SUCCESS

PREPARE

- **Educate and train** staff on food insecurity, federal nutrition programs, and local food and income resources
- **Follow AAP's recommendation** of universal screening at scheduled check-ups or sooner, if indicated
- **Incorporate efforts** to address food insecurity into the institutional workflow
- **Practice** having empathetic and sensitive conversations when addressing food insecurity

SCREEN

Use the AAP-recommended Hunger Vital Sign™:

1. "Within the past 12 months, we worried whether our food would run out before we got money to buy more."

☐ OFTEN TRUE ☐ SOMETIMES TRUE ☐ NEVER TRUE ☐ DON'T KNOW/REFUSED

2. "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more."

☐ OFTEN TRUE ☐ SOMETIMES TRUE ☐ NEVER TRUE ☐ DON'T KNOW/REFUSED

*Patients screen positive for food insecurity if the response is "**often true**" or "**sometimes true**" for either or both statements.*

Document and code the administration and results of screening in medical records.

INTERVENE

- **Administer** appropriate medical interventions per your protocols
- **Connect patients** and their families to the federal nutrition programs and other food resources
- **Document and track** interventions in medical records
- **Advocate and educate** to address food insecurity and its root causes, e.g., poverty, inadequate wages, housing insecurity, and structural racism

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What Pediatricians Need to Know About Food Insecurity

Rates and Risk Factors

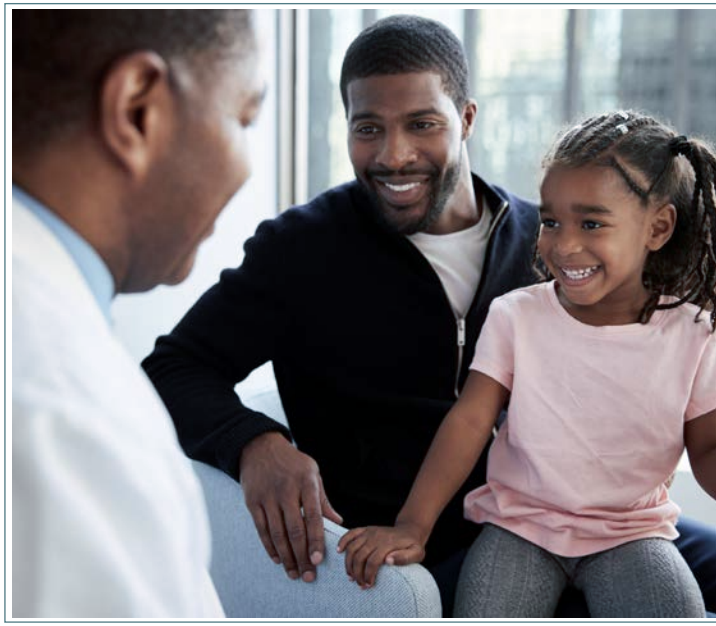
Consequences to Children, Adolescents, and Families

1 in 7 U.S. children lives in a household experiencing food insecurity. Certain types of households face higher risks.

COVID-19 has dramatically increased the number of children experiencing food insecurity, with one estimate projecting as many as **1 in 4** children experiencing food insecurity in 2020.[5] Longstanding racial disparities in food insecurity rates among Black and Hispanic/Latino families have only been exacerbated during the COVID-19 crisis.

5 Feeding America. (2020). *The Impact of the Coronavirus on Food Insecurity in 2020*. Available at: https://www.feedingamerica.org/sites/default/files/2020-10/Brief_Local%20Impact_10.2020_0.pdf. Accessed on November 12, 2020.

Rates and Risk Factors



Food insecurity is a critical child health problem that impacts children and families across the country in rural and urban settings.

In 2019, 35.2 million people — including 10.7 million children — lived in households experiencing food insecurity, "meaning their access to adequate food is limited by a lack of money and other resources."[6]

Food insecurity is not an isolated or concentrated phenomenon in the U.S.; it impacts every state, county, and community. State food insecurity rates ranged from 6.6 percent of New Hampshire households to 15.7 percent of Mississippi households in 2017–2019 (three-year average). Households located outside of metropolitan areas (more rural areas) are experiencing considerably deeper levels of food insecurity compared to those within metropolitan areas.

Certain children and households are more likely to experience food insecurity. Rates of food insecurity in 2019 were statistically significantly higher than the national average of 10.5 percent for the following households:

- **all households with children**;
- **household that include a child under age 6**;
- **households headed by a single parent or caregiver**;
- **Black and Hispanic/Latino households**; and
- **households with incomes under 185 percent of the federal poverty line**.[7]

Additionally, children in immigrant,[8] Native American, and Alaska Native households experience higher levels of food insecurity[9] as do households with a member who has a disability.[10] Low-income households with young children who have special health care needs are at risk for food insecurity, regardless of child Supplemental Security Income receipt and household participation in other public assistance programs.[11]

Prior to COVID-19, the nation was making strides in addressing the spikes in food insecurity rates among households with children brought on by the Great

6 Coleman-Jensen, A., Rabbitt, M. P., Gregory, C. A., & Singh, A. (2020). *Household Food Security in the United States in 2019.* Available at: https://www.ers.usda.gov/webdocs/publications/99282/err-275.pdf?v=9606.7. Accessed on November 12, 2020.

7 Coleman-Jensen, A., Rabbit, M. P., Gregory, C. A., & Singh, A. (2020). *Household Food Insecurity in the United States in 2019.* (page 15) Available at: https://www.ers.usda.gov/webdocs/publications/99282/err-275.pdf?v=9004.7. Accessed on November 20, 2020.

8 Chilton, M., Black, M. M., Berkowitz, C., Casey, P. H., Cook, J., Cutts, D., Jacobs, R. R., Heeren, T., Ettinger de Cuba, S., Coleman, S., Meyers, A., & Frank, D. A. (2009). *Food Insecurity and Risk of Poor Health Among US-Born Children of Immigrants.* Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661461/. Accessed on November 17, 2020.

9 Jernigan, V. B. B., Huyser, K. R., Valdes, J., & Simonds, V. W. (2016). *Food Insecurity among American Indians and Alaska Natives: A National Profile using the Current Population Survey–Food Security Supplement.* Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5422031/. Accessed on November 20, 2020.

10 Coleman-Jensen, A., & Nord, M. (2013). *Disability Is an Important Risk Factor for Food Insecurity.* Available at: https://www.ers.usda.gov/amber-waves/2013/may/disability-is-an-important-risk-factor-for-food-insecurity#:~:text=Disabilities%20may%20increase%20the%20likelihood,as%20well%20as%20reduced%20earnings.&text=About%209%20percent%20of%20households,poverty%20line%20were%20food%20insecure. Accessed on November 20, 2020.

11 Rose-Jacobs, R., Goodhart Fiore, J., Ettinger de Cuba, S., Black, M., Cutts, D. B., Coleman, S. M., Heeren, T., Chilton, M., Casey, P., Cook, J., & Frank, D. A. (2016). *Children with Special Health Care Needs, Supplemental Security Income, and Food Insecurity.* Available at: https://pubmed.ncbi.nlm.nih.gov/26836641/. Accessed on December 7, 2020.

Recession (December 2007–June 2009). Despite these declines, food insecurity still harms millions of households with children. In 2019, 13.6 percent of all households with children struggled with food insecurity. Per Figure 1, rates among Black non-Hispanic and Hispanic households with children continue to be disproportionately high when compared to White non-Hispanic households with children.

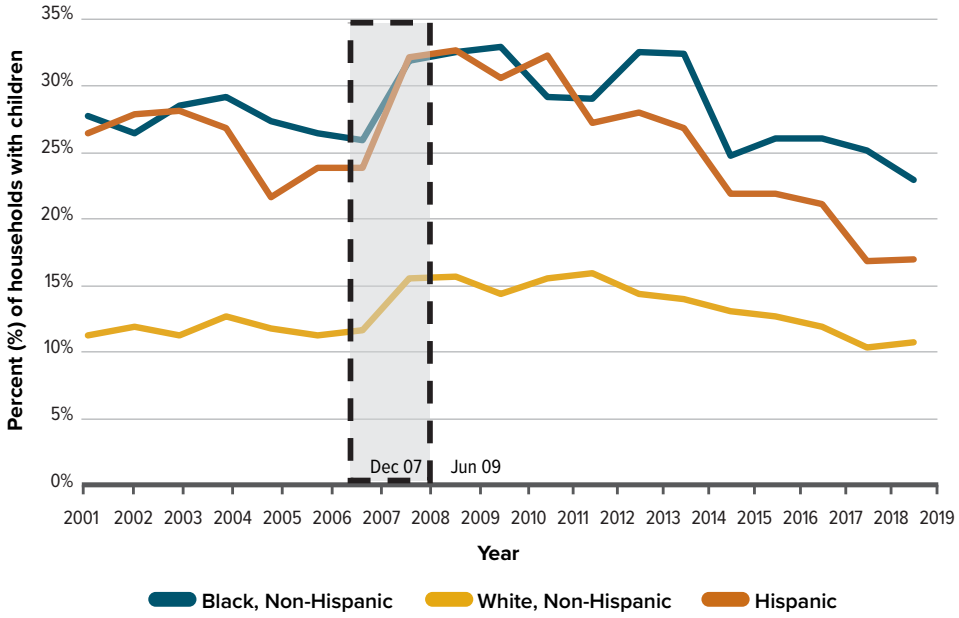
Unfortunately, this progress has been unraveled by the COVID-19 pandemic, which has dramatically deepened America's hunger crisis since the pandemic began in early 2020.

Food insecurity rates have increased dramatically during the COVID-19 pandemic. Additionally, households with children are facing higher levels of food insecurity. One study estimates that the food insecurity rate is 32 percent for adults with children.[12] Black and Hispanic/Latino households have continued to face disproportionately high rates of food insecurity when compared with White households — fueled by systemic inequalities and racism — during the pandemic.

No matter the practice or setting, pediatricians will likely be caring for children from households experiencing food insecurity. Pediatricians should not assume which patients are experiencing food insecurity. While recognizing that some families may be more at risk, all families in inpatient, emergency, and outpatient settings should be screened.

Download *Hunger Could Be Hiding in Plain Sight*.

FIGURE 1: Trends in Food Insecurity in Households With Children by Race/Ethnicity of Household Head, 2001–2019



Source: FRAC using Current Population Survey Food Security Supplement data.
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Hunger Could Be Hiding in Plain Sight
YOU CAN'T TELL IF YOU DON'T SCREEN

Millions of U.S. children live in a household struggling with food insecurity
Join AAP in universally screening for food insecurity

More information on food insecurity statistics and risk factors is available on FRAC's website.

"Food insecurity has numerous detrimental impacts on the health and well-being of children and their families. Screening for food insecurity allows pediatricians to identify children and families in need and connect them with resources."

COLIN J. ORR, MD
Assistant Clinical Professor, Department of Pediatrics, UNC-Chapel Hill, Chapel Hill, North Carorlina

12 Schanzenbach, D., contributing economist for the Food Research & Action Center. (2020). *Not Enough to Eat: COVID-19 Deepens America's Hunger Crisis.* Available at: https://frac.org/wp-content/uploads/Not-Enough-to-Eat_Hunger-and-COVID.pdf. Accessed on November 12, 2020.

Consequences to Children, Adolescents, and Families

Food insecurity — even marginal food insecurity — is detrimental to children's and adolescents' health, development, and well-being.

CHILDHOOD FOOD INSECURITY IS ASSOCIATED WITH:

- Poor Health Status
- Developmental Risk
- Mental Health Problems
- Poor Educational Outcomes

Food insecurity, and even marginal food insecurity (a less severe level of food insecurity[13,14]), is especially detrimental to the health, development, and well-being of children,[15,16] and is associated with some of the most common and costly health problems and behaviors in the U.S. Multiple adverse health outcomes are strongly correlated with food insecurity as highlighted in this selection of research findings.

- Newborns with food insecurity are more likely to experience birth complications, birth defects, or low birth weight.[17,18]
- Children between four and 36 months who live in low-income households with food insecurity may have higher rates of developmental problems when compared with children of the same age living in low-income households without food insecurity.[19]
- Among children of all ages, food insecurity is linked with lower cognitive indicators, dysregulated behavior, and emotional distress.[20]
- Children and adolescents with food insecurity are more likely to have overall worse general health, increased emergency department utilization, and higher rates of forgone medical care.[21]

13 Cook, J. T., Black, M., Chilton, M., Cutts, D., Ettinger de Cuba, S., Heeren, T. C., Rose-Jacobs, R., Sandel, M., Casey, P. H., Coleman, S., Weiss, I., & Frank, D. A. (2013). *Are food insecurity's health impacts underestimated in the US population? Marginal food security also predicts adverse health outcomes in young US children and mothers.* Available at: https://www.researchgate.net/publication/234134086_Are_Food_Insecurity%27s_Health_Impacts_Underestimated_in_the_US_Population_Marginal_Food_Security_Also_Predicts_Adverse_Health_Outcomes_in_Young_US_Children_and_Mothers. Accessed on November 12, 2020.

14 Grineski, S. E., Morales, D. X., Collins, T. W., & Rubio, R. (2018). *Transitional dynamics of household food insecurity impact children's developmental outcomes.* Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6263731/pdf/nihms967951.pdf. Accessed on November 12, 2020.

15 American Academy of Pediatrics. (2015). *Promoting food security for all children.* Available at: https://pediatrics.aappublications.org/content/early/2015/10/20/peds.2015-3301. Accessed on November 12, 2020.

16 Shankar, P., Chung, R., & Frank, D. A. (2017). *Association of food insecurity with children's behavioral, emotional, and academic outcomes: a systematic review.* Available at: https://childrenshealthwatch.org/wp-content/uploads/Shankar-et-al-JDBP-2017.pdf. Accessed on November 12, 2020.

17 Borders, A. E., Bryant, M. D., Grobman, W. A., Amsden, L. B., & Holl, J. L. (2007). *Chronic Stress and Low Birth Weight Neonates in a Low-Income Population of Women.* Available at: https://journals.lww.com/greenjournal/Fulltext/2007/02000/Chronic_Stress_and_Low_Birth_Weight_Neonates_in_a.16.aspx. Accessed on November 18, 2020.

18 Carmichael, S. L., Yang, W., Herring, A., Abrams, B., & Shaw, G. M. (2007). *Maternal Food Insecurity Is Associated with Increased Risk of Certain Birth Defects.* Available at: https://academic.oup.com/jn/article/137/9/2087/4664860. Accessed on November 18, 2020.

19 Rose-Jacobs, R., Black, M. M., Casey, P. H., Cook, J. T., Cutts, D. B., Chilton, M., Heeren, T., Levenson, S. M., Meyers, A. F., & Frank, D. A. (2008). *Household Food Insecurity: Associations With At-Risk Infant and Toddler Development.* Available at: https://pediatrics.aappublications.org/content/121/1/65. Accessed on November 18, 2020.

20 American Academy of Pediatrics. (2015). *Promoting Food Security for All Children.* Available at: https://pediatrics.aappublications.org/content/early/2015/10/20/peds.2015-3301. Accessed on November 18, 2020.

21 Thomas, M. M. C., Miller, D. P., & Morrissey, T. W. (2019). *Food Insecurity and Child Health.* Available at: https://pediatrics.aappublications.org/content/144/4/e20190397. Accessed on December 7, 2020.

"The lack of adequate food not only has important physical impacts on our patients (such as not focusing in school, fatigue) but more importantly has emotional impacts. As humans, we love to feed those we love. Parents that do not have the resources to feed their children adequately definitely feel that they are not showing this love and the children may, with time, feel let down, not only by their families but by society in general. Thus, we are screening for this to both help solve acute issues but also longer-term human development issues."

ALEX RAKOWSKY, MD, FAAP
Primary Care Clinic, Nationwide Children's Hospital, Columbus, Ohio

- Longitudinal studies have shown that food insecurity in kindergarten students predicts reduced academic achievement in math and reading over a four-year period.[22]
- The inability to consistently provide food creates toxic stress in families, contributing to a trade off of other essential household necessities.[23]
- Adolescents in families with food insecurity are more likely to experience a variety of mental health disorders, such as depression, anxiety, and suicidal ideation.[24,25,26]
- Health effects of food insecurity and associated malnutrition may persist beyond early life into adulthood. A substantial body of literature links early childhood malnutrition to adult disease, including diabetes, hyperlipidemia, and cardiovascular disease.[27]

While food insecurity may be described as invisible, there are common ways food insecurity may present in children and families.

Because of the associated health consequences of food insecurity, both children and their families may experience a range of negative health associations of which pediatricians should be aware. Common ways food insecurity may present in families include food anxiety, diet monotony, decreased nutrition quality, and inadequate food intake.[28,29,30]

People in households experiencing food insecurity often describe feeling higher levels of anxiety and stress, especially observed through the preoccupation and maladaptive behaviors associated with food and meals. Families will often simplify food variety and transition from nutritionally dense foods to cost-effective, highly processed, shelf-stable, and calorically rich foods to stretch food budgets and decrease spending.

As food insecurity progresses, adults in families may choose to experience a decrease in the amount and quality of their food intake, doing everything possible (e.g., eat less food, skip meals, barter, access foods in socially uncomfortable ways) to prevent the child from experiencing food deprivation.

With recent data showing that although adults believe they are shielding their children, children are emotionally, cognitively, and physically aware of these changes in their household, and often compensate to help support their family (e.g., barter, skip meals, eat less at mealtime, earn money).[31]

Insights From the Field

"The chronic and toxic stress of food insecurity appears crippling to many of my families. Often with financial challenges, food hardships are one of the first things to predominate. Families want to consume more fruits and vegetables, but struggle with those types of foods' shorter shelf lives and the fear of waste. When I do probe into a family's experience, parents share that they are worried about providing enough food for their households. This undue stress leads families to spend limited resources on the more reliable and highly processed shelf-stable foods to satisfy their hunger.

Pediatricians must recognize that the first step that families are trying to address in times of hunger is getting 'enough food' and not meeting 'our' health goals."

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Community Pediatrician, Children's National Hospital; Assistant Professor of Pediatrics, Director, Community & Urban Health Scholarly Concentration, The George Washington University School of Medicine and Health Sciences

22 Jyoti, D. F., Frongillo, E. A., & Jones, S. J. (2005). *Food Insecurity Affects School Children's Academic Performance, Weight Gain, and Social Skills.* Available at: https://academic.oup.com/jn/article/135/12/2831/4669915. Accessed on November 18, 2020.

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28 Radimer, K. L., Olson, C. M., & Campbell, C. C. (1990). *Development of indicators to assess hunger.* Available at: https://pubmed.ncbi.nlm.nih.gov/2243303/. Accessed on December 7, 2020.

29 Alaimo, K. (2005). *Food insecurity in the United States.* Available at: https://www.researchgate.net/publication/271680455_Food_Insecurity_in_the_United_States. Accessed on December 7, 2020.

30 Essel, K., & Courts, K. A. (2018). *Epidemiology and Pathophysiology of Food Insecurity*. Available at: https://link.springer.com/chapter/10.1007%2F978-3-319-76048-3_1. Accessed on December 7, 2020.

31 Fram, M. S., Frongillo, E. A., Jones, S. J., Williams, R. C., Burke, M. P., DeLoach, K. P., & Blake, C. E. (2011). *Children Are Aware of Food Insecurity and Take Responsibility for Managing Food Resources.* Available at: https://academic.oup.com/jn/article/141/6/1114/4600285. Accessed on November 18, 2020.

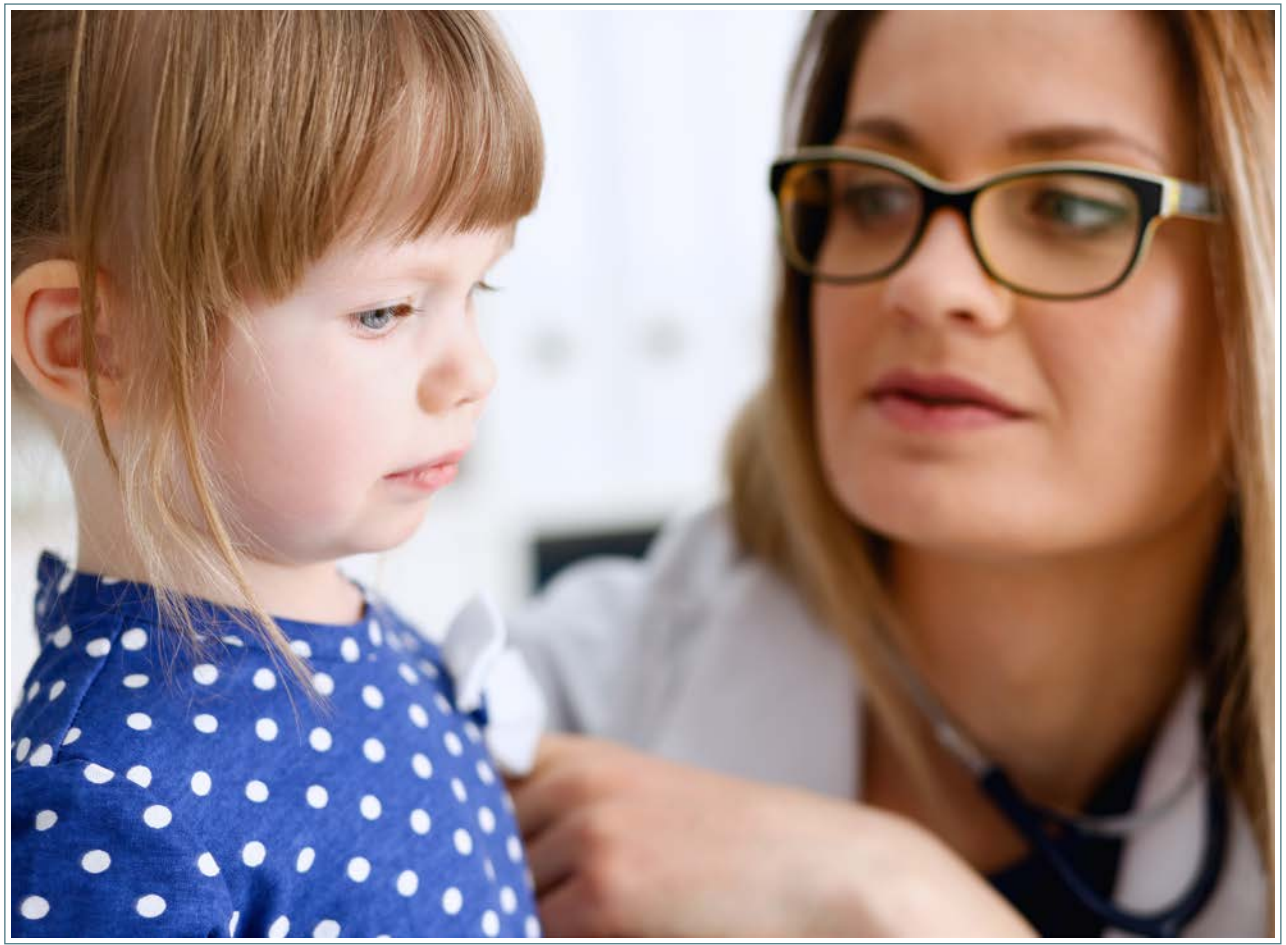
Children who are experiencing food insecurity may present signs of nutritional deficiencies that can manifest in the following ways:

- **developmental delays;**
- **behavioral problems;**
- **depression, anxiety, or stress (parent, child or adolescent);**
- **iron deficiency anemia or other nutrient deficiencies;**
- **underweight or overweight;**
- **slow growth;**
- **inappropriate feeding practices; and**
- **dental caries.**

Children and families who are impacted by food insecurity may experience additional poverty-related hardships (e.g., housing insecurity, transportation issues, lack of affordable child care, low wages). The AAP provides recommendations for pediatricians to screen and refer for poverty-related issues in these policy statements:

- *Poverty and Child Health in the United States*; and
- *Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity*.

Pediatricians and other health providers play a critical role in screening for food insecurity. They also play a vital role in advocating for programs and policies to undo and prevent childhood food insecurity.



The content presented here draws from AAP's policy statement, *Promoting Food Security for All Children*. For more on the research about the impact of food insecurity on child health, see *Food Insecurity and Health: Practices and Policies to Address Food Insecurity among Children* and FRAC's *Hunger and Health – The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being*.

More information on food insecurity statistics, risk factors, and consequences is available on FRAC's website.

Prepare

Preparing to Address Food Insecurity Among Patients and Families

STEP 1: Educate and train staff on food insecurity, federal nutrition programs, and local food and income resources

STEP 2: Follow AAP's recommendation of universal screening

STEP 3: Incorporate efforts to address food insecurity into the institutional culture and workflow

STEP 4: Practice having empathetic, sensitive, and culturally effective conversations when addressing food insecurity

Preparing to Address Food Insecurity in a Sensitive and Culturally Effective Manner

Preparing to Address Food Insecurity Among Patients and Families

A growing number of pediatricians across the nation are addressing social determinants of health for their patients, including food insecurity, for many reasons:

- no matter the location or type of practice, it is likely that some families are struggling to put food on the table;
- the need to act, given the extensive body of research on how food insecurity — even at moderate levels — threatens children's health and achievement, and is associated with increased health care utilization and costs;
- the availability of existing tools to identify food insecurity, in particular the validated Hunger Vital Sign™ screening tool; and
- the availability of key federal nutrition programs — such as the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and other child nutrition programs — that are available to eligible children and families in every community.

Backed by these reasons, pediatricians in a wide range of clinical and community settings are increasingly working to address food insecurity, partnering with community organizations, and embedding this work into institutional workflows and electronic health and medical records.

According to *Pediatrician Survey Findings: Addressing Food Insecurity Among Children — Pediatrician Beliefs, Practices, and Resource Needs*,

- **96 percent** of pediatricians **agree or strongly agree** that patients should be screened for food insecurity in a pediatric clinical setting;
- **96 percent** of pediatricians **agree or strongly agree** that patients should be referred to SNAP; and
- **98 percent** **agree or strongly agree** that patients should be referred to WIC.

This section highlights key steps for pediatricians and their teams to prepare for addressing food insecurity at their practice.

STEP 1: Educate and train staff on food insecurity, federal nutrition programs, and local food and income resources.

- **Identify a "Hunger Champion"** in the practice who is passionate about this work and can help get buy-in from staff and leadership; this individual does not need to be a physician. This champion can stay abreast of food insecurity policy and programs in the community; become familiar and create relationships with key community partners; create and update the practice's food insecurity screening and intervening processes; and help educate and train staff. Having an electronic health record (EHR) champion to ensure screening questions and interventions are incorporated is helpful. Joining the Hunger Vital Sign™ Community of Practice, co-convened by Children's HealthWatch and FRAC, is a great way to keep engaged.
- **Train staff and leadership** (e.g., front office staff, medical assistants, pediatricians, nurses, nurse practitioners, physician assistants, registered dietitians, social workers, administrators) on the pervasive, yet invisible, nature of food insecurity and how it impacts health, which can be done through workshops and discussions at staff meetings. Start by distributing this toolkit's infographic, Key Facts: Childhood Food Insecurity and the Role of Pediatricians, and AAP's *Promoting Food Security for All Children* policy statement. Make sure to identify how federal nutrition program rules may change during natural disasters or pandemics. Reassure the practice team that they do not have to "fix" everything on their own. There are food and nutrition assistance

programs available and local community partners who may already be actively engaging in this work.

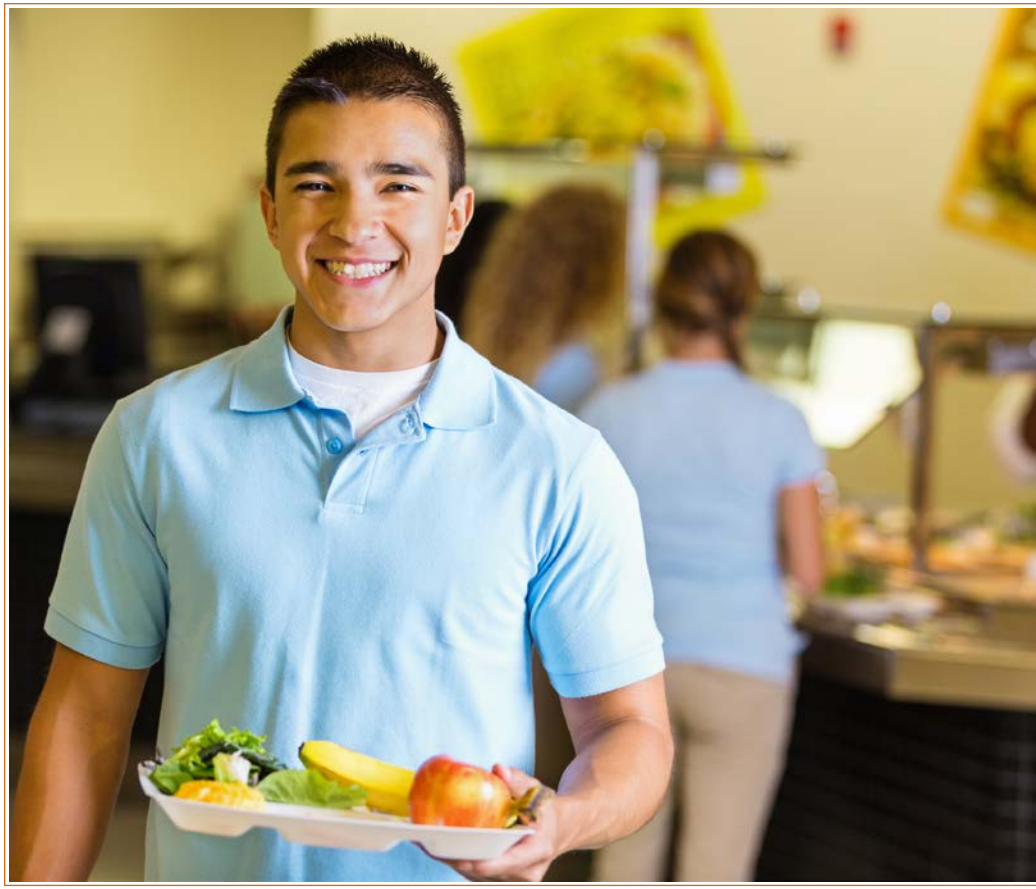
- **Identify sustainable ways to address food insecurity** in the practice in collaboration with other pediatricians, the practice team, and core staff members so that the work does not hinge on one committed team member. For larger institutions, it is important to identify someone in a leadership position who supports the incorporation of food insecurity screening, management, and making referrals in the workflow.

STEP 2: Follow AAP's recommendation of universal screening.

- The practice team should consider screening all patients at all visits, including inpatient settings and subspecialty visits, given the often cyclical and hidden nature of food insecurity. For instance, families may face greater challenges during the summer months when children are not receiving school meals. Furthermore, one study found that caregivers of hospitalized children who were previously screened for unmet social needs were more likely to ask for help at subsequent visits, highlighting the importance of repeated opportunities for screening at every health care interaction.
- If you need to limit the number of visits at which a patient is screened, **prioritize screening at the following:** routine well-checks; visits for nutrition-related conditions (e.g., diabetes, weight concerns, food allergies); emergency room visits; hospital admissions; and newborn care before discharge. The practice team also should screen for food insecurity if indicated during the visit (e.g., a parent mentions a recent job loss, a recent move, or the need to stay with friends; a child is anemic or struggling with behavioral problems; or a patient requires a special diet or expensive medication).

STEP 3: Incorporate efforts to address food insecurity into the institutional culture and workflow.

- **Incorporate screening, counseling, and intervening to address food insecurity into existing registration and intake procedures and workflow** (e.g., while filling out routine paperwork, taking vital signs, waiting in the examination room, or during standard check-out or discharge procedures for every visit) so that screening and necessary intervening can be sustained. A range of practice team members can support this work. Pediatricians, physician assistants, nurses, nurse practitioners, patient care technicians, care navigators, registered dietitians, social workers, and the reception staff can all play a role in supporting the work to address food insecurity. Screenings can take place verbally or in writing; however, written is recommended.[32] Follow-up discussions can help solidify the urgency of the family's food needs and whether emergency food is necessary. Helping patients and their families access federal nutrition programs, emergency food, and other nutrition resources can take place through conversations with different staff members, as well as by distributing materials and posting informative messaging. Decide, ideally with the input of other practice team members, what will work best and be sustainable for your practice.



32 Palakshappa, D., Goodpasture, M., Albertini, L., Brown, C. L., Montez, K., & Skelton, J. A. (2019). *Written Versus Verbal Food Insecurity Screening in One Primary Care Clinic*. Available at: https://pubmed.ncbi.nlm.nih.gov/31629943/. Accessed on December 7, 2020.

- **Incorporate the screening tool and referrals into EHRs.** More EHR systems are building out models to document efforts to screen and intervene to address food insecurity. For example, the Hunger Vital Sign™ is already built into some systems (under "Hunger Screening"). However, it may be necessary to identify a bioinformatics champion to support screening, documenting, and tracking results in the EHR. Other 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 social services.
- When screening families with adolescents, consider screening adolescents separately from parents and incorporating their perspective in possible clinical and community-based interventions. Despite shielding, adolescents are often aware of the home food environment.[33]

STEP 4: Practice having empathetic, sensitive, and culturally effective conversations when addressing food insecurity.

- **Food insecurity is a sensitive subject.** Parents and caregivers may be embarrassed, ashamed, uncomfortable, or even afraid to admit that they struggle to meet the food needs of their families. They may cope by skipping meals themselves, purchasing lower quality food to stretch their dollars, and forgoing assistance from emergency food and federal nutrition programs. Some may even worry that discussing food insecurity puts the family at risk of a child-neglect report.
- Parents and caregivers also may be reluctant to talk about any of this in front of their children. **Parents often try to protect their children from food insecurity** by, for example, sacrificing their own food and nutrition needs so that their children can eat. Research shows, however, that children, particularly older children and adolescents, are more aware of their families' food insecurity than their parents realize.
- Not only might parents try to hide food insecurity from their children, they may also try to hide it from the rest of their family, friends, coworkers, and health care providers. **Hunger may be lurking where you might least expect it.** A family may have private insurance but still have difficulty putting food on the table. Families also may have possessions that give the appearance of financial stability (e.g., vehicles, cell phones), but they actually could be struggling due to recent unemployment, unexpected expenses, or a recent divorce or separation. Furthermore, food insecurity can coexist with obesity or underweight, and the practice team should not be surprised that someone may be simultaneously struggling with weight issues, either underweight or overweight, and food insecurity. In short, hunger is often invisible and may transcend socioeconomic status.
- **Families also may experience shame or embarrassment** when medical providers suggest that the family apply for food assistance programs or visit local emergency food sites. Stigma surrounding assistance programs and emergency food has long been identified as a barrier to participation. Negative perceptions or experiences can lead to embarrassment or shame in inquiring about assistance, going to a food pantry, or participating in programs, for example, SNAP or WIC. It is important when inquiring about or referring to food assistance programs that providers reassure families in a supportive, empathetic, culturally effective, and nonjudgmental way.
- **Many practices also face additional challenges in addressing food insecurity** in a sensitive manner with patients from different cultures or whose preferred language is not English. Consider translating screening tools into multiple languages and using certified interpreters to communicate in a culturally effective manner. If providing emergency food on site, tailor it to families' food preferences.

TIP

SPECIAL CONSIDERATIONS FOR ADDRESSING FOOD INSECURITY AMONG IMMIGRANT FAMILIES

If you work with immigrant families, some families may be reluctant to disclose struggles with food insecurity or concerns with accessing nutrition and food resources due to multiple immigration-related fears. You can help fight fears and misinformation with facts about how immigrant status intersects with program eligibility and implement strategies to help make families more comfortable with accessing programs.

Almost all federal nutrition programs, including school meals and WIC, are available to anyone who meets the other eligibility requirements, regardless of immigration status. The exception is SNAP, which is available to some non-citizens. Nonetheless, many members of immigrant households are eligible for SNAP, including U.S. citizen children, even if their parents are not themselves eligible. For example, they could be refugees, asylees, children who are Lawful Permanent Residents (LPRs), and LPR adults who have been in the U.S. for at least five years.

Families may have concerns about a recent U.S. Department of Homeland Security (DHS) public charge rule, which includes SNAP as a potential factor in a public charge determination. However, most families eligible for SNAP do not have to worry about public charge. No other federal or local nutrition or food program is included in the DHS public charge test. For community-facing materials on public charge that can better equip immigrants with what they need to know to make the best decision for themselves and for their families, visit Protecting Immigrant Families Campaign.

If the practice team works with immigrant families, it can help to have a certified interpreter who speaks the language of the immigrant community (if Limited English Proficient) or is a member of that community. This may increase the comfort level with immigrant families in discussing food insecurity-related concerns. Also, local organizations that serve immigrant communities can be great partners.

33 Dush, J. L. (2020). *Adolescent food insecurity: A review of contextual and behavioral factors.* Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/phn.12708. Accessed on November 18, 2020.

Preparing to Address Food Insecurity in a Sensitive and Culturally Effective Manner

The practice team should provide a safe, nonjudgmental environment for parents, caregivers, and adolescents to openly discuss food insecurity. Here are strategies pediatricians report using to screen for food insecurity and to intervene in a sensitive manner.

Screen for Food Insecurity in a Sensitive Manner

- Screen all patients at every health care interaction so that it is routine and no one feels singled out. Universal screening in inpatient, emergency, and outpatient settings also prevents the practice team from making assumptions about which patients and families may or may not be in need. It may also capture those who cycle in and out of food insecurity throughout the year.
- Decide whether to administer the screening tool in writing or electronically, such as via electronic tablets or questionnaires through online patient portals. The preferred method of administering the screening tool is in writing or electronic format (e.g., in the waiting room as part of routine paperwork or while waiting in the examination room) rather than verbally; some providers may prefer the opportunity to directly ask patients, but given the stigma of food insecurity, fewer positive screens may be elicited. Discuss with your team which model will work best for your practice.

- If the screening tool is administered verbally, consider doing so when the child is not in the room or is distracted by something else. In addition, be respectful of the family's privacy by asking the questions away from other patients and staff.
- Consider screening adolescents separately from their parents and incorporating their perspective in potential clinical and community-based interventions. Given the close association between food insecurity and adolescent mental health, discussion about the need for referring to a behavioral health provider should be considered.
- Normalize the screening tool statements by saying something at the outset, for example, "I'm seeing so many people who are having a hard time affording food, so I ask all of my patients a few questions about access to food. There are many community resources available that are free and may be useful to you."
- Considering explicit statements that food insecurity is not a sign of neglect or poor parenting, and discussing the reason for screening (e.g., at least in part to connect the families to resources that they may not already be connected to) may be important to emphasize and to decrease fear and stigma.
- Administer the screening tool in the parent's preferred language. Consider translating screening tools into multiple languages and using certified interpreters to communicate in a culturally effective manner. The AAP-recommended Hunger Vital Sign™ screening tool has been validated in English and Spanish.
- Whatever the results of the screening, it is a good idea to give all families a list of available community resources.

Insights From the Field

"We know that many families are experiencing food insecurity. This is not only a source of significant stress on the family — having to choose between paying bills or buying food — but it also impacts the health and well-being of all family members. Hunger can adversely impact the development of a young child. Screening and engaging the family about this sensitive topic is important, particularly in this pandemic. Readying your practice to do this is essential. Don't start screening today if you haven't made a plan for how you talk to families and how you can link them with support. Screening should utilize validated questions, and The Hunger Vital Sign™ is the tool to use. Reviewing the responses with the family, whether positive or negative, opens the conversation to respond to immediate need, or to identify your practice as a source of support should the need arise. This toolkit explains national resources, such as WIC, SNAP, and school meal programs, but it is also important to identify what is available in your community as well. Your practice needs to have identified and networked with resources in your community prior to implementing screening, and ideally be able to link families using a warm handoff, not just handing them a resource list. Screening, conversing, and partnering with the family is a fundamental part of the longitudinal relationship between the pediatrician and family."

MARIAN F. EARLS, MD, MTS, FAAP
Chair, AAP Addressing Social Health and Early Childhood Wellness (ASHEW); Chair, AAP Mental Health Leadership Work Group, North Carolina

Intervene in a Sensitive Manner When a Patient Screens Positive for Food Insecurity

- Consider discussing the responses and next steps when the child is not in the room or is distracted by something else.
- Inform the parent that assistance is available and everyone needs assistance at some point in their lives. This will help take away the stigma of using emergency food assistance and federal nutrition program assistance.
- Encourage parents to seek assistance for the benefit of all family members, but especially for the health and well-being of their children. Talk positively about federal nutrition programs, like SNAP or WIC, and be clear that you are recommending food assistance just as you would prescribe a medication. For instance, "SNAP will help you buy the fruits and vegetables your child needs to grow and stay healthy."
- If patients have used nutrition programs before, ask about their experiences with these programs in the past and any challenges faced in accessing these programs that they may need assistance with addressing.
- Families may already be participating in SNAP or not be eligible. SNAP benefits often run out before the end of the month since the benefit level is inadequate. Consequently, it is important to identify a range of nutrition and other resources that can help families.
- If you have an on-site food pantry or food shelf, make sure it is located where patients can access food in private. When deciding what food items to include, ensure these are culturally effective and tailored to families' food preferences.
- Use physical environmental cues (e.g., posters, brochures) that address food insecurity or federal nutrition assistance programs, which helps normalize program participation. Some pediatricians even wear a button about SNAP or WIC, or, if you are comfortable, share personal stories about food assistance (e.g., "When I was a child, my family used SNAP," or "I have other patients who use SNAP and it is really helpful").

This can help put patients at ease and assure them that it is safe to talk about these topics with their pediatrician.

- Provide reassurance that many people face financial hardship at some point in their lives, especially during the pandemic or after a job loss. Acknowledge that sometimes people are embarrassed to admit that they are struggling or that they need help. Commend the parent or caregiver for their honesty about the issue and how their willingness to seek assistance shows how much they care about their child's health and well-being.
- If staffing allows, make calls to programs, such as WIC, or complete applications for SNAP while the family is still present.
- Consider developing partnerships with community organizations or local SNAP or WIC agencies to help ease patient access to programs.

For additional information, see the AAP News story, *Experts Advise Sensitive Approaches to Food Screening*.

Screen

Use the Validated and AAP-Recommended Hunger Vital Sign™ to Screen for Food Insecurity

Use of Alternative Food Insecurity Screeners

HUNGER Vital Sign™

The Hunger Vital Sign™ provides a more practical food insecurity screening tool for use in clinical settings and in community outreach.

Use the Validated and AAP-Recommended Hunger Vital Sign™ to Screen for Food Insecurity

The Hunger Vital Sign™ is a validated two-question food insecurity screening tool. The two questions are drawn from the U.S. Department of Agriculture's (USDA) 18-question Household Food Security Scale, which is the "gold standard" for food security measurement and used primarily for surveillance and research purposes. The Hunger Vital Sign™ provides a more practical tool for use in clinical settings and in community outreach. The screening tool was validated by Children's HealthWatch researchers.

Households are at risk of food insecurity if the response is "often true" or "sometimes true" to either or both statements in the screening tool (i.e., screens positive for food insecurity). If a family screens positive for food insecurity, health care practices can connect patients to federal nutrition programs and food resources and can make referrals to appropriate community resources and services.

A family may still be in need of, and qualify for, food assistance even if the response is "never true" to both statements. For instance, a parent may have been too embarrassed or afraid to respond in the affirmative, or a family may be struggling financially but it has

Use the AAP-recommended Hunger Vital Sign™:

1. "Within the past 12 months, we worried whether our food would run out before we got money to buy more."

☐ OFTEN TRUE ☐ SOMETIMES TRUE ☐ NEVER TRUE ☐ DON'T KNOW/REFUSED

2. "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more."

☐ OFTEN TRUE ☐ SOMETIMES TRUE ☐ NEVER TRUE ☐ DON'T KNOW/REFUSED

*Patients screen positive for food insecurity if the response is "**often true**" or "**sometimes true**" for either or both statements.*

Document and code the administration and results of screening in medical records.

not yet impacted its food security status. All families can benefit from participating in the federal nutrition programs.

In the validation study by Children's HealthWatch that controlled for covariates, children in households that affirmed either or both statements were more likely to be in fair or poor health, to have been hospitalized, and to be at risk for developmental delays. Caregivers in households that affirmed either or both statements were more likely to be in fair or poor health and to report depressive symptoms.

This screening tool does not identify individual family members who are food insecure or detect differences in how family members are affected by food insecurity. In short, the Hunger Vital Sign™ is an important screening tool for identifying households at risk for food insecurity and, by extension, at risk for the adverse effects of food insecurity.

More information on the Hunger Vital Sign™ screening tool — including screening language and translations — is available from Children's HealthWatch.

Use of Alternative Food Insecurity Screeners

While the Hunger Vital Sign™ is recommended as a simple, validated screen for food insecurity, your practice may already be asking questions on food or economic hardship. If another tool that addresses food insecurity is already being used in a sustainable practice model, you should consider whether or not it makes sense to add the Hunger Vital Sign™ to your work flow. What is most important is to screen for food insecurity, and then intervene accordingly.

For example, the Survey of Well-being of Young Children (SWYC) includes the following question:

"In the past month, was there any day when you or anyone in your family went hungry because you did not have enough money for food?"

The Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education Survey Instrument (WE CARE) and the Safe Environment for Every Kid (SEEK) Parent Screening Questionnaire also inquire about food insecurity. More information on these and other tools is available on AAP's website.

"It is often difficult for parents to talk to clinicians about food insecurity in their household, so I always start the conversation with, 'Food is important to your health. I want to make sure you have enough food and the right types of food, so I ask all my patients these questions.'"

HILARY SELIGMAN, MD, MAS
Professor of Medicine at University of California San Francisco's Center for Vulnerable Populations, San Francisco, California

Document, Track, and Code Food Insecurity Screenings, Assessments, and Interventions in the Patient's Medical Record

Pediatricians and their practice teams are well aware of standardized health care terminology. Almost everything from the point of screening through diagnosis and interventions can be encoded; and terminology drives evaluation, research, and payment.

An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities[34] highlights how the documenting of screening, assessments, and interventions — as they are related to food insecurity — in EHRs is critical for the following actions:

PROVIDING comprehensive health care to individual patients experiencing food insecurity;

OBTAINING population data for clinical resource planning;

IMPROVING reimbursement for food insecurity assessment and intervention;

FOSTERING research and quality improvements related to food insecurity; and

COLLABORATING with outside entities, including payers, community agencies, and other healthcare providers and health systems.

However, the terminology needed for documenting and tracking data for patients' social risks, including food insecurity, is often missing or not quite suited for the situation.[35] Recent efforts, particularly those of the Gravity Project, a UCSF SIREN initiative, have accelerated efforts to capture this 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 FHIR.

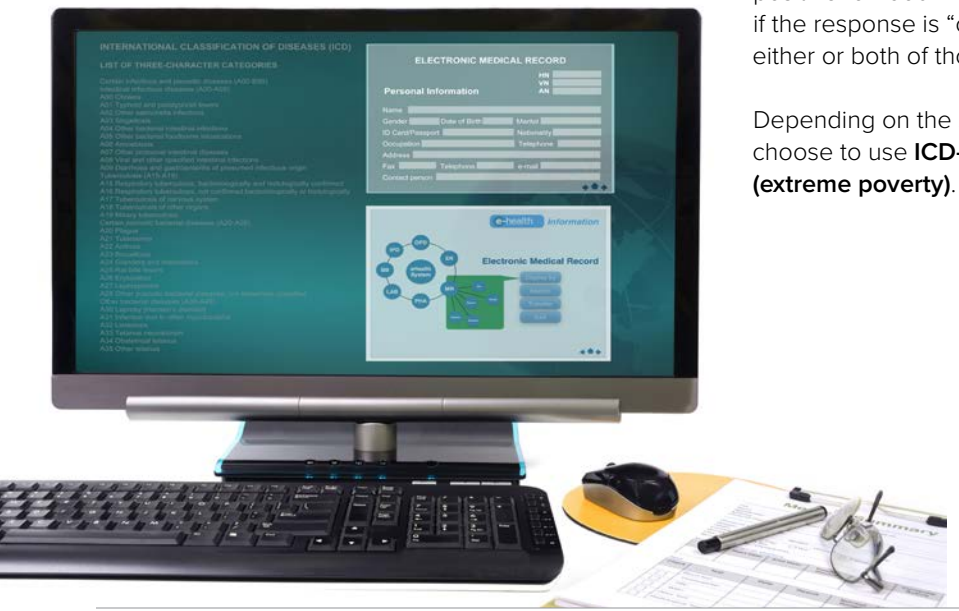
34 DeSilvey, S., Ashbrook, A., Sheward, R., Hartline-Grafton, H., Ettinger de Cuba, S., & Gottlieb, L. (2018). *An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities.* Available at: https://childrenshealthwatch.org/foodinsecuritycoding/. Accessed on November 19, 2020.

35 Arons, A., DeSilvey, S., Fichtenberg, C., & Gottlieb, L. (2019). *Documenting social determinants of health-related clinical activities using standardized medical vocabularies.* Available at: https://academic.oup.com/jamiaopen/article/2/1/81/5260817. Accessed on November 19, 2020.

How to get Started

Review the Gravity Project's food insecurity data set, which includes the following:

- **§24 Screeners:** a range of screeners for food insecurity;
- **§8 Diagnoses:** ways to document food insecurity and food insecurity severity;
- **§6 Goals of Care:** goals related to the care of patients experiencing food insecurity; and
- **§109 Interventions:** interventions to address food insecurity, including connecting patients to clinic programs, community programs, and federal and tribal programs, such as
  - » **Resource/Benefits Assistance:** Benefits Enrollment Assistance, Community Resource Assistance, Community Action Agency;
  - » **Nutrition and Food Support Programs:** SNAP, WIC, Summer Nutrition Programs, community meals programs, home-delivered meals, food pantries, food and nutrition incentives programs, the Child and Adult Care Food Program (CACFP), the Food Distribution Program on Indian Reservations (FDIPR), food prescription programs, food provision programs, and more.



Document the administration and results of the food insecurity screening in the patient's medical record.

The AAP recommends that the Hunger Vital Sign™ be used by pediatricians to screen for food insecurity. The administration and results of this or other food insecurity screening tools and discussion with families (regardless of the result) should be documented in the patient's medical record.

Document the diagnosis code or problem code.

The following diagnosis code can be used for positive screens: **ICD-10-CM Diagnosis Code Z59.4 (lack of adequate food and safe drinking water)**. This maps to the SNOMED CT code of "food insecurity" for documenting in patient problem lists. A patient screens positive for food insecurity via the Hunger Vital Sign™ if the response is "often true" or "sometimes true" to either or both of those statements.

Depending on the situation, some providers may choose to use **ICD-10-CM Diagnosis Code Z59.5 (extreme poverty)**.

Document and track the interventions in the patient's medical record (e.g., the patient was referred to a WIC or SNAP office).

Just as it is important to track a patient who screens positive for food insecurity, it is also important to include and track interventions to address food insecurity in a patient's chart.

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 referred to and print out a corresponding referral list for the patient. 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 social services.

Serious consideration should be given to having a staff person do more than just give the family a list of referrals and resources. Efforts can start with a warm referral to a community partner who can help support patients and provide feedback regarding whether a patient follows up. If staffing allows, appointments to access the resources or applications for benefits can be made while the family is present.

Closing the referral loop in order to ascertain whether a patient has been able to access nutrition and food resources is particularly important. EHRs and community resource platforms are developing software features that can better track whether a patient accesses a community resource, with some models even interfacing with community agencies' platforms.

Ultimately, how a practice handles this documentation will depend on their practice model and EHR interface, as well as what bioinformatics support is available.

What Pediatricians Need to Know About the Federal Nutrition Programs

- Supplemental Nutrition Assistance Program (SNAP)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Child Care Meals
- School Breakfast and Lunch
- Afterschool Meals
- Summer Nutrition Programs
- Pandemic-EBT (available during COVID-19 school closures)

According to the AAP, the federal nutrition programs "serve as critical supports for the physical and mental health and academic competence of children" for tens of millions of children across the nation. The key federal nutrition programs include SNAP, WIC, child care meals, school meals, afterschool snacks and meals. and summer food. Additionally, the nation's emergency food network — composed of food banks, food pantries, food shelves, soup kitchens, and other entities — often receive support from The Emergency Food Assistance Program (TEFAP) and other federal commodity programs.

Not only are these programs proven, effective ways to help struggling families access needed nutrition, but they also have a range of positive outcomes for children's health and development. Overall, research shows that these programs have numerous benefits:

- **reduced food insecurity;**
- **better health outcomes;**
- **improved academic achievement and early childhood development;**
- **healthier eating;**
- **increased family economic security; and**
- **a stimulated local economy.**

During COVID-19, the Families First Coronavirus Response Act created the Pandemic Electronic Benefit Transfer (P-EBT) program to provide families nutrition assistance when schools close and children lose access to free or reduced-price school meals. To compensate for lost meals, families receive an EBT card loaded with the value of the free school breakfast and lunch reimbursement rates (about $5.70 per student per day). The card, which works like a debit card, can be used to purchase food at tens of thousands of food retailers across the country that accept SNAP. Using P-EBT benefits does not impact a family's immigration status. The public charge rule does not apply to P-EBT benefits. In response to COVID-19, numerous waivers were adopted to help families improve access to SNAP and child nutrition programs, including a waiver that allows schools to offer free school meals to all children.

Despite all the attributes of these programs, not every eligible family is accessing them.

More information on the health and economic benefits of these programs is available on FRAC's Hunger and Health website and in AAP's *Promoting Food Security for All Children*.

Almost all of the federal nutrition programs that help children and their families are administered nationally by USDA and operated by states, cities, towns, Indian Tribal Organizations, schools, or nonprofits. Many of the programs can serve everyone who qualifies to participate because they are entitlement programs without quotas on the number of people who can be served. What follows is a summary of some of the largest and most critical federal nutrition programs.

SNAP, previously known as food stamps, is the largest federal nutrition program. SNAP benefits are loaded onto an EBT card so that participants can purchase food at supermarkets, farmers' markets, and other food stores. SNAP helps low-income individuals and families buy food, lifts people out of poverty, and expands during hard economic times or a natural disaster to meet rising needs. SNAP is not only effective in reducing food insecurity, but the program also provides well-documented benefits to children's health, development, and well-being. Benefits reach some of America's most vulnerable households, and more than 80 percent of all benefits go to households with a child, an older adult, or a person with a disability.

School Meals boost children's nutrition, health, and educational achievement by reimbursing public and nonprofit private schools that provide school meals and snacks to children. Federally funded school meals must comply with national nutrition standards. Through community eligibility, high-poverty schools can offer all students free breakfast and lunch, which has a positive impact on those schools and students.

"It's well-established that SNAP is the single most effective anti-hunger program in the country, especially when it's accessed alongside the Child Nutrition Programs. Simply put, these programs boost families and support child health."

DR. MEGAN SANDEL, MD, MPH

Associate Director of the GROW clinic at Boston Medical Center, a Principal Investigator with Children's HealthWatch and Associate Professor of Pediatrics at Boston University Schools of Medicine and Public Health, Boston, Massachusetts

NAME OF PROGRAM & AGE OF PATIENT (CLICK FOR MORE INFO)	HOW IT WORKS	WHO CAN APPLY
Supplemental Nutrition Assistance Program (SNAP) Note: Program may be called something else in your state **AGE:** All ages	**Monthly benefits** to purchase food at grocery stores, farmers' markets, and food retail outlets across the country that accept SNAP Benefits loaded onto an **EBT card** (much like a debit card) **The average benefit is about $29 for the week per person – or about $1.39 per person, per meal.**	Gross income typically at 130% of the federal poverty level but can be higher in some states (SNAP income eligibility guidelines at: https://www.fns.usda.gov/snap/eligibility) Asset tests may apply in some states (check state and local regulations for details). Many low-income employed individuals SNAP has restrictions on which non-citizens are eligible.

NAME OF PROGRAM & AGE OF PATIENT (CLICK FOR MORE INFO)	HOW IT WORKS	WHO CAN APPLY
National School Lunch Program AND **School Breakfast Program** **AGE:** Children at participating schools	**Free, reduced-priced, or paid school meals** in participating schools Meals meet federal nutrition standards, which require schools to serve more whole grains, fruits, and vegetables.	Children of families at low or moderate income levels can qualify for free or reduced-price meals. Free to all students at schools adopting community eligibility, which allows schools with high numbers of low-income children to offer free breakfast and lunch to all students without collecting school meal applications

- **The School Breakfast Program** offers a nutritious meal to start the school day, helping millions of children learn and thrive. The program works best when schools offer free breakfast to all students and make it part of the school day through alternative delivery models (e.g., breakfast in the classroom, "grab and go," second chance breakfast). Participation in the program is associated with improvements in food security, health outcomes, and academic achievement.
- **The National School Lunch Program** makes it possible for all school children to receive a nutritious lunch every school day. Participation in the program has favorable impacts on a number of outcomes, including food security, dietary intake, obesity, and health status.

CACFP funds free nutritious meals and snacks for young children in child care centers, family child care homes, and Head Start or Early Head Start programs. Research demonstrates that the program improves the dietary intake and health of participating children, as well as the quality of care. The program can also serve children 18 years of age and under at emergency shelters, including for families experiencing homelessness or domestic violence.

The Afterschool Nutrition Programs provide federal funding to school-based, agency-based, and community-based programs that provide enrichment activities — that operate in low-income areas after school, on weekends, and during school holidays — to serve meals and snacks to youth 18 years old and younger. The free and nutritious meals and snacks help draw children and teens to programs that provide a safe place for them to be engaged and to learn.

The Summer Nutrition Programs provide meals to children and teens 18 years of age and under at school-based, public agency-based, and nonprofit sites that offer educational, enrichment, physical, and recreational activities during the weeks between the end and start of the school year. When school lets out, millions of low-income students lose access to the school breakfasts, lunches, and afterschool snacks and meals they receive during the regular school year. The Summer Nutrition Programs help fill this gap by providing free meals and snacks to children and teens who might otherwise go hungry. Research shows that children are more vulnerable to food insecurity during the summer break. Summer meal sites must be located in a low-income area or serve a majority of children who qualify for free or reduced-price school meals.

USDA administers additional federal nutrition programs for children and families, but funding for these programs is capped. This means that once allocated funds are depleted, the program cannot serve more participants. These programs include the following:

NAME OF PROGRAM & AGE OF PATIENT (CLICK FOR MORE INFO)	HOW IT WORKS	WHO CAN APPLY
Child and Adult Care Food Program (CACFP) **AGE:** Typically, children up to age 5	**Up to two free meals and a snack** to infants and young children at child care centers and homes, Head Start, and Early Head Start CACFP can provide meals to children 18 and under at emergency shelters. Updated nutrition standards provide healthier meals.	Children attending eligible child care centers and homes, Head Start, and Early Head Start

NAME OF PROGRAM & AGE OF PATIENT (CLICK FOR MORE INFO)	HOW IT WORKS	WHO CAN APPLY
Afterschool Nutrition Programs *(Available through CACFP or the National School Lunch Program)* **AGE:** Children 18 and under	**Free, healthy snacks and/or meals** meeting federal nutrition standards in enrichment programs running afterschool, on weekends, or during school holidays	Children can access free meals at participating enrichment programs offered at community sites, including schools, park and recreation centers, libraries, faith-based organizations, or community centers.

NAME OF PROGRAM & AGE OF PATIENT (CLICK FOR MORE INFO)	HOW IT WORKS	WHO CAN APPLY
Summer Nutrition Programs **AGE:** Children 18 and under	**Up to two free meals at approved school and community sites during summer vacation** Meals must meet approved federal nutrition standards.	Children can access meals at participating community sites, which can include schools, park and recreation centers, libraries, faith-based organizations, or community centers. There is no need to show identification.

WIC provides nutritious foods, nutrition education and counseling, and access to health care for low-income pregnant and postpartum women, new mothers, infants, and children up to 5 years old who are at nutritional risk. Research shows that WIC is effective at reducing food insecurity, improving dietary intake, addressing obesity, and improving other health outcomes.

The Fresh Fruit and Vegetable Program (FFVP) provides federal funding to elementary schools with high numbers of low-income students to serve fruits and vegetables as snacks. The program aims to increase the variety of fruits and vegetables children consume and to create healthier school food environments. Limited federal funding is available to schools in all 50 states and the District of Columbia.

TEFAP and the Emergency Food Network: TEFAP supplements the diets of low-income individuals by distributing free emergency food. States provide the USDA Foods and administrative funds to local organizations, often food banks, which then distribute the food to local pantries, food shelves, and soup kitchens that directly work with low-income populations. The amount of food and funds received by a state varies based on its low-income and unemployed populations. Additionally, many emergency food sites purchase food or receive food donations to distribute.

For program eligibility at a glance, review the Federal Nutrition Programs and Emergency Food Referral Chart. It provides an overview of the key federal nutrition programs, and allows you to customize referral information to your local area.

TIP

For pediatricians working with Native American or Alaska Native communities, there are additional federal nutrition programs that may be available. For example, the Food Distribution Program on Indian Reservations (FDPIR) provides USDA Foods to income-eligible households living on Indian reservations.

NAME OF PROGRAM & AGE OF PATIENT (CLICK FOR MORE INFO)	HOW IT WORKS	WHO CAN APPLY
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) **AGE: Pregnant, postpartum, and breastfeeding women and mothers; infants; children up to age 5**	**Nutritionally tailored monthly food packages** (worth approximately $40 per month per person, though amounts vary based on the participant's age) that families redeem in grocery and food stores that accept WIC **Breastfeeding support, nutrition services, screening, immunization, and health referrals**	Low-income pregnant, breastfeeding, and postpartum women and mothers, and infants and children up to age 5 deemed nutritionally at risk by a health care professional Income eligibility typically at or below 185% of the federal poverty level Families on Medicaid

NAME OF PROGRAM & AGE OF PATIENT (CLICK FOR MORE INFO)	HOW IT WORKS	WHO CAN APPLY
Fresh Fruit and Vegetable Program **AGE: Elementary school-age students**	The Fresh Fruit and Vegetable Program **provides federal funding to elementary schools** to serve fruits and vegetables as snacks to help young students improve their diets and establish healthy eating habits. Limited federal funding is available in all states.	Elementary schools with high numbers of low-income students

NAME OF PROGRAM & AGE OF PATIENT (CLICK FOR MORE INFO)	HOW IT WORKS	WHO CAN APPLY
The Emergency Food Assistance Program (TEFAP) **AND** **The Emergency Food Network** **AGE: All ages**	**Through TEFAP, participating food banks distribute U.S. commodities to local partners,** including pantries, food shelves, soup kitchens, social service agencies, and faith-based groups. Additionally, many emergency food sites purchase food or receive food donations. Many food banks are committing to distributing more fresh produce in addition to shelf-stable foods.	Access depends on site requirements; some sites require referrals.

Intervene

Interventions to Address Food Insecurity

Administer Appropriate Medical Interventions for the Patient per Your Protocols

Connect Patients and Their Families to the Federal Nutrition Programs and Other Food and Community Resources

STEP 1: Educate the medical team on available federal nutrition programs and emergency food resources

STEP 2: Decide who in your practice can help connect patients and their families to nutrition programs and food assistance, and when you need to enlist the help of a partner

STEP 3: Post or distribute the most up-to-date information at your practice on federal nutrition programs to encourage program participation

Interventions to Address Food Insecurity

Whether you are a health care provider at a hospital or a small practice, in a large city or rural area, there are effective interventions for pediatric practices across the country to address food insecurity. Pediatric medical teams can intervene in the following ways:

- **ADMINISTER** appropriate medical interventions for the patient per your protocols;
- **CONNECT** patients and their families to the federal nutrition programs and other food and community resources;
- **DOCUMENT** and track discussions with families and interventions in the patient's medical record; and
- **ADVOCATE** and educate to address food insecurity and its root causes, e.g., poverty, inadequate wages, housing insecurity, and structural racism.

Administer Appropriate Medical Interventions for the Patient per Your Protocols

Food insecurity places children at risk for poor nutrition, and is associated with adverse health and developmental outcomes.

Pediatricians can consult the *AAP Pediatric Nutrition Handbook* for the latest evidence-based guidelines on addressing childhood nutrition issues. Developed by the AAP Committee on Nutrition, the handbook provides helpful resources and guidance to support pediatricians in promoting nutrition and the healthy development of all children.

"Pediatric clinicians are confronted daily with children whose health is at risk and whose bodies and brains may never reach their highest potential if they continue to be exposed to food insecurity. Food insecurity is a hidden hazard to children's health, which we must rapidly identify and address."

DEBORAH A. FRANK, MD
Founder, Grow Clinic for Children at Boston Medical Center;
Founder and Principal Investigator, Children's HealthWatch;
Professor of Child Health and Well-Being,
Boston University School of Medicine

Insights From the Field

"Pediatricians can improve health, development, and the food and economic security of the families they serve by promoting the benefits of the federal nutrition programs, including SNAP and WIC, asking families if they are currently enrolled in these nutrition programs, and facilitating enrollment in the programs.

Medicaid beneficiaries are an ideal target population for enrollment in SNAP and WIC as they are likely to be food insecure, financially eligible for WIC, and the majority are eligible for SNAP. Enrollment can be facilitated during clinic visits or at the time of enrollment or recertification in the Medicaid program.

Maximizing enrollment in all federal nutrition assistance programs is critical. Families need sustainable, evidence-based programs."

SANDRA HOYT STENMARK, MD, FAAP
Clinical Professor of Pediatrics, University of Colorado School of Medicine, Aurora, Colorado

Connect Patients and Their Families to the Federal Nutrition Programs and Other Food and Community Resources

The following steps will help pediatric practices partner with patients and their families to help connect them to federal nutrition programs and other food resources.

STEP 1: Educate the medical team on available federal nutrition programs and emergency food resources.

To get started, become familiar with key federal nutrition programs, such as SNAP, WIC, school meals, child care meals, and out-of-school time meals, build connections with staff from these programs, and learn the best ways to access these programs in your community. *Referring patients to the federal nutrition programs is the AAP-recommended primary intervention for addressing food insecurity*. Most of these programs — with the exception of WIC — have no caps on funding, so they are available to anyone who satisfies program eligibility. These programs are critical interventions to address food insecurity but cannot end hunger on their own without also advocating to address the root causes of food insecurity, for example, poverty, unfair wages, food deserts, housing insecurity, and structural racism.

Ensuring that families are able to participate in all of the available federal nutrition programs is the critical first step to addressing food insecurity. These programs are critical interventions to address food insecurity and improve the nutrition, health, and well-being of children. Not every patient, however, will be eligible for programs, like WIC, and benefits for these programs are not issued in a single day. Additionally, many families may already be benefitting from some programs, such as SNAP, but may run out of benefits before the end of the month. Others already may be benefitting from some programs, e.g., school meals and summer meals.

As such, connecting patients to emergency food sources, such as food banks and food pantries (also known as food shelves), is also an important option in many communities, especially for addressing immediate needs. That said, emergency food sites may not be available in every area, they may have limited hours of operation and food options, or have limits on the amount of food they can provide. Even when emergency food sites are available, a family may not have transportation to get to a site or meet the criteria for getting free food from the site.

Some practices are exploring additional interventions to connect families to food resources on site (e.g., grocery distributions, produce prescriptions, food pharmacies, farmers' markets, community gardens, and other models) to support families struggling with food insecurity. Additionally, pediatric practices are engaging in broader efforts to connect patients with unmet social needs to a range of resources (e.g., housing, utility assistance, child care, job counseling, and more) that can help alleviate the root causes of food insecurity.

Another adjunct resource to highlight is Food is Medicine initiatives. Most recently they have become novel ways to integrate nutritious and often medically tailored meals to families based on risk for diet-related chronic diseases. Very few initiatives exist in the pediatric medical arena, but may potentially offer an adjunct approach supported by Managed Care Organizations for future use. They currently are limited by resources and data showing their longitudinal benefits.

TIP

Become familiar with the Federal Nutrition Programs and Emergency Food Referral Chart. It provides an overview of the key federal nutrition programs, and it allows you to customize referral information to your local area.

Overview of How Pediatric Practices Are Connecting Patients to Food and Nutrition Programs: the Pros and Cons of Various Models

The federal nutrition programs are the first line of defense against food insecurity, which is why health care providers should connect patients to these critical programs. In addition to connecting patients to these programs, some providers across the country are exploring additional interventions aimed at providing on-site (e.g., at hospitals, clinics, or medical practices) food assistance to patients and their families. This table briefly describes the most common food and nutrition interventions to support families with children struggling with food insecurity.

TABLE 1: How Pediatric Practices Are Connecting Patients to Food and Nutrition Programs: the Pros and Cons of Various Models

PROGRAM	PROS	CONS
Supplemental Nutrition Assistance Program (SNAP) SNAP is the foundation of the food security safety net and helps low-income individuals and families buy food at supermarkets, farmers' markets, and other food retail outlets. Health providers can help patients apply for SNAP, often in conjunction with an application for Medicaid, or connect patients to a community partner.	Benefits are 100 percent federally funded and are available for all who qualify. SNAP is effective in reducing food insecurity and improving health outcomes. SNAP is available in every state and the District of Columbia. Some communities have programs that double SNAP benefits at participating farmers' markets and food retailers. Learn more about Double Up and SNAP Doubling.	Not every patient will be eligible for SNAP (e.g., may be over-income, may not have requisite immigrant status). Benefits for these programs are not issued in a single day. Many families already are benefitting from SNAP, but may run out of benefits before the end of the month.
Child Nutrition Programs The main child nutrition programs are the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); child care meals; school meals; afterschool snacks and meals; and summer food. Health providers can either help families access these programs directly or refer families to community partners.	All programs — with the exception of WIC — are entitlement programs, so they can serve all eligible children without the need for additional federal appropriations. Programs not only reduce food insecurity, but also improve academic achievement, early childhood development, and encourage healthier eating. The new public charge rule does not apply to these programs.	Patients may not meet age requirements. There may be limited availability of summer and/or afterschool meals sites in some communities.
Food Shelf A health provider, often in partnership with a local food bank or as the result of an internal food drive, collects non-perishable food staples that are stored on site. Criteria varies for which patients get free food items and how often. **Grocery Bags** Through a partnership with a local food bank, health providers distribute bags of groceries to patients periodically, typically once a month. The medical team and/or the food bank partner determine criteria for which patients get free food items. **Gift Cards to Local Supermarket** Practitioners distribute gift cards to a local supermarket to families in need of immediate food assistance. The practice determines the criteria for which patients receive the cards.	Responds to immediate need. Supplements food available from the federal nutrition programs. Supports nutrition needs of households experiencing food insecurity that may not be eligible for SNAP (e.g., over-income, cannot satisfy citizenship or permanent legal residency requirements) or WIC (e.g., over-income, children more than 4 years old).	Requires funding Reach may be limited. This model is not sustainable unless ongoing funding is secured. Space constraints Staff time needed Food may not be tailored to the nutritional needs or cultural preferences of patients. This doesn't build on programs (e.g., SNAP and WIC) that integrate families with food insecurity into normal commercial channels.

TABLE 1: How Pediatric Practices Are Connecting Patients to Food and Nutrition Programs: the Pros and Cons of Various Models (cont.)

PROGRAM	PROS	CONS
Summer Meal Site Instead of referring children to summer meal sites that may or may not be conveniently located, some health providers are hosting their own summer meal sites. This allows patients 18 years old and younger access to up to two free meals in a safe and convenient setting. Meals must meet nutrition standards, be served in a group setting, and cannot be taken home. Sites get reimbursed for meals served as well as some of the administrative costs of the program.	There is a sustainable amount of federal funding available to cover meal costs and some administrative costs. This program supports children's nutritional needs. Providers can partner with in-house food services or with a community partner to implement the model. Providers can serve children in the surrounding community.	There is a need for dedicated staff (or volunteers) to run the meal program. There is a need for space to serve meals in a group setting. Free meals are not provided for parents. Not all medical practices will be located in low-income areas that are eligible to participate in the program.
Afterschool Meal Site Through available federal funding, health care providers are offering out-of-school time meals after school, on weekends, or during school holidays to children 18 years old and younger. Meals must meet nutrition standards, be served in a group setting, and cannot be taken home. Afterschool meal program sites are required to offer enrichment activities. For example, a site can offer a nutrition education class that highlights how the food served supports the nutrition of children.	There is a sustainable amount of federal funding available to cover meal costs and some administrative costs. This program supports children's nutritional needs. Providers can partner with in-house food services or a community partner to implement the model. Providers can serve children in the surrounding community. Children benefit from enrichment activities. The program can reach children on weekends, during school holidays, and after school.	There is a need for dedicated staff (or volunteers) to run the meal program and enrichment activities. There is a need for space to serve meals in a group setting. Free meals are not provided for parents. Not all medical practices will be located in low-income areas that are eligible to participate in the program.
Food Pharmacy Selected patients who screen positive for food insecurity are referred to a medical center's food pharmacy where they meet with a staffer — often a dietitian — who identifies what foods are indicated for treatment of their medical condition. The patient then selects indicated foods from the food pharmacy and receives referrals to return once a month for six months. The dietitian also can screen patients for SNAP and other federal nutrition resources. ProMedica in Ohio developed an innovative food pharmacy model and is working to expand it to other hospital settings.	This is integrated into the hospital services and some staffing costs may be covered. Existing personnel can help staff the clinic. There is a dietitian on hand to help connect patients to appropriate food selections based on existing medical conditions. This program connects patients to SNAP, WIC, and other nutrition resources. Nutrition services are included in the patient's medical records.	This program requires additional funding. This program requires partnership with a food bank or funding to secure food for the pharmacy. This program requires dedicated space. This program cannot serve every patient who screens positive for food insecurity.

TABLE 1: How Pediatric Practices Are Connecting Patients to Food and Nutrition Programs: the Pros and Cons of Various Models (cont.)

PROGRAM	PROS	CONS
Veggie Rx and Veggie Incentive Programs Typically, the Veggie Rx and Veggie Incentive programs provide targeted patients (e.g., who screen positive for food insecurity, diabetes, or obesity) with a "prescription" that can be used like cash and redeemed for fresh produce. Some programs only allow participants to redeem their prescriptions at participating farmers' markets or provide fruit and veggie boxes on site, while others partner with both farmers' markets and grocery stores. The structure of the program and the value of the "prescription" patients receive varies depending on the model. Wholesome Wave's Fruit and Vegetable Prescription Program (FVRx) provides $1 per day per household member.	The program can provide targeted support to patients diagnosed with diet-related chronic diseases to access fruits and vegetables.	Dedicated funding is required for this program. Can only reach a small number of patients Need proximity to participating farmers' markets, grocery stores, or both
Farmers' Markets Across the country, more health practices and hospitals are bringing farmers' markets and mobile markets on site so patients and staff can access healthy, local food. This model can better support families facing food insecurity if the market is able to accept SNAP benefits, WIC cash value vouchers, and participates in the federal WIC Farmers' Market Nutrition Program (FMNP).	This model provides access to local produce. Many markets can accept federal nutrition program benefits. This model may offer nutrition education at the market.	Dedicated staff and funding are needed to help implement this model; this is less so if a local farmers' market or mobile market is available to partner. Families may have already exhausted SNAP and WIC monthly benefits and may not have money to purchase food at markets even if markets accept these benefits. The reach of WIC FMNP is limited. Market location and hours may not be convenient for families.

"Given the high prevalence of food insecurity among U.S. families with children, and given its potential health effects, pediatricians need to be aware of resources that can mitigate food insecurity and know how to refer eligible families."

— AAP'S PROMOTING FOOD SECURITY FOR ALL CHILDREN

TIP

Almost every state has an anti-hunger group that serves as the go-to organization for expertise on the federal nutrition programs. Find an anti-hunger group in your state. Additionally, contact your local food bank to learn more about emergency food and other resources. Some communities have 211 help lines or online community referral platforms.

Anti-hunger organizations can help educate your team by

- **PROVIDING** data on the extent of food insecurity and food hardship in your area;
- **LOCALIZING** the Federal Nutrition Programs and Emergency Food Referral Chart; and
- **TRAINING** the pediatric team on best practices for connecting families to federal nutrition programs and food resources.

In addition to anti-hunger organizations and local food banks, other groups are available to help you get started. Consider contacting community action agencies, child advocacy organizations, or social service organizations.

STEP 2: Decide who in your practice can help connect patients and their families to nutrition programs and food assistance, and when you need to enlist the help of a partner.

Patients are more likely to connect with nutrition resources if they receive immediate assistance (e.g., during medical visits or inpatient stays) instead of having to go to a new location to apply for a program, such as SNAP, or make a series of phone calls to find out where they can access services.

However, not every practice will be able to devote sufficient internal staff time to individually screen and connect all patients on site to the range of available nutrition and emergency food programs. As such, there are different ways that the wide range of pediatric practices — from big to small, from urban to rural — are intervening to address food insecurity.

General guidance is provided below for developing internal capacity and community partnerships. For additional resources, visit the Children's HealthWatch Hunger Vital Sign™ page.

Develop Internal Capacity

To create a sustainable intervention model, it is important to identify internal staff or volunteers who can work with families to access nutrition and other benefits (e.g., Medicaid, Temporary Assistance for Needy Families [TANF], housing, utility assistance, child care subsidies), as well as address legal issues (e.g., benefits denials, wage theft, unsafe housing).

The following individuals may be able to assist with this work: social workers, case managers, care navigators, receptionists, community health workers, financial assistance counselors, medical residents, student interns, an in-house lawyer/paralegal with Medical-Legal Partnerships, Health Leads desks (i.e., patient navigators), or AmeriCorps volunteers.

Activities

There are multiple ways that your practice can promote and connect patients and their families to nutrition programs and food and community resources. The essential place to start is ensuring that patients and their families are accessing all federal nutrition programs for which they are eligible. Many of these responsibilities do not require much staffing time and can be easily integrated into existing job responsibilities and workflows, while others may need a full-time or part-time position, depending on the size of your practice.

The following list includes suggested activities for practices. Recognize that a practice won't be able to do everything. Determine what is most important for your patients and their families, and what is most feasible for your practice. Practices can

- screen patients for participation in SNAP, WIC, school meals, child care meals, and out-of-school time meals;
- when indicated, provide application assistance for SNAP to eligible patients;
- screen patients to determine eligibility for child nutrition and other food programs (e.g., child care meals; school meals; afterschool snacks and meals; summer food; emergency food), and provide specific information on where patients can access these programs locally;
- integrate patient information that is related to referrals and applications into existing health records;
- **PROMOTE** the federal nutrition programs to patients;
- manage community partnerships;
- provide referrals to community partners;
- post positive and non-stigmatizing messaging (see page 29);
- update federal nutrition program and emergency food referral information;
- follow up with families after a community referral has been made to determine completion and outcomes; and
- use online community resource platforms that can be integrated into the health record to refer patients.

TIP

Assigning internal staff to address food insecurity will be an easier task in the following situations and locations:

- in settings where institutional and leadership buy-in exists for addressing food insecurity;
- in community health care settings, like hospitals and health centers, where case managers, social workers, community health workers, patient navigators, and nurses already connect patients to resources;
- outpatient or inpatient settings where designated staff already are helping people apply for Medicaid or other social safety net programs; and
- states where individuals can apply for SNAP and Medicaid through a combined online application.

NOTE: Applying to SNAP typically requires that an applicant answer a few more questions related to housing and utility costs, which are not required for Medicaid, but are required for SNAP. Additionally, even if a patient does not have the information to complete these fields in the application, the state agency should still process the combined application for benefits and send the client a notice of any necessary steps required to complete the SNAP application. Unlike Medicaid, SNAP requires an interview as part of the application process, which can be done over the phone in most states.

Develop Community Partnerships

Partnering with a range of community allies can enhance a practice's ability to help patients and their families connect to nutrition and food resources and, in some cases, provide families with support to connect to other benefits (e.g., TANF, utility assistance) and services (e.g., housing, legal assistance).

Sample partners can include anti-hunger groups, food banks, Health Leads, Medical-Legal Partnerships, Community Action Program (CAP) agencies, faith-based organizations, social service organizations, home-visiting nurses, or a local SNAP or WIC agency. Local public health, nonprofit, and faith-based organizations may also be key partners.

MODEL 1: Providing referrals to a community partner. The medical team identifies a local organization that can help patients and families access federal nutrition programs, locate emergency food, or identify other nutrition interventions. This model works best when the community partner receives the contact information of a patient interested in learning about available nutrition resources, as opposed to giving the patient the community partner's contact information and putting the onus on the patient to take action. Patients' preferences are also important to consider.

Activities

Below is a list of sample partnerships:

- sending a community organization the names of interested patients who consent to being screened for federal nutrition and food resources so that the organization can reach out and call them (make sure to address any HIPAA concerns that may arise);
- referring patients to the help line of a local partner who can identify nutrition resources tailored to the family's needs; and
- finding a local group that can update the medical practice's database of available community food and nutrition resources.

MODEL 2: Hosting a community partner to provide on-site assistance or enabling community partner access to the EHR. Community partners can send staff to medical sites on selected days to help interested patients apply for SNAP and access other programs and resources, such as WIC, school meals, summer meals, and afterschool meals. In some cases, community partners may support additional interventions when the health care site does not have sufficient internal capacity to staff these efforts. Additionally, some EHRs enable community partners to access a read-only version of the EHR through which direct referrals may be sent. Partnerships may require helping the community partner acquire funding.

Activities

Below is a list of sample partnerships:

- inviting a partner to come into the practice to provide one-on-one application assistance for SNAP, and promote available nutrition programs, e.g., WIC, school meals, CACFP, and summer and afterschool meals;
- enabling a community partner to have read-only access to the EHR for direct referrals;
- having a local partner operate a summer meal site at your practice;
- having a WIC clinic co-located on site;
- having a food bank distribute groceries on site; and
- having a local group operate a community-supported agriculture pick-up site at your location that provides free or discounted rates for produce for eligible patients.

TIP

From the onset in developing community partnerships, it is critical to set out clear guidelines for the roles of the partner and the medical practice. Creating and signing a memorandum of understanding (MOU) is a promising strategy for forming agreed-upon expectations. The following are some items to consider including in the MOU.

- **SCOPE OF PARTNERSHIP:** How many patients do you expect to refer to the community organization? What is the timeframe? What services do you expect the community organization to deliver? What is your role? Is the partnership sustainable?
- **FUNDING:** Will the partnership require funding? If so, can the community organization apply for funding or will funding be pursued jointly? If the community organization has funding to use toward the partnership, what does it need to fulfill the grant requirement? Can the partners draw down matching dollars from USDA by being part of the state's SNAP outreach plan? If you are a nonprofit hospital, does the community health needs assessment include nutrition or anti-hunger activities where community benefit dollars may be available?
- **TRACKING:** Can information on patient referrals or the use of federal nutrition programs or food resources be collected? If so, what is the process? How do you protect the privacy of the patients and families?
- **HIPAA:** What HIPAA concerns need to be addressed? For more on this, check out Food Banks as Partners in Health Promotion.

STEP 3: Post or distribute the most up-to-date information at your practice on federal nutrition programs to encourage program participation.

Families may be embarrassed to ask or apply for food and nutrition assistance. Posting federal nutrition program messaging in public areas of your practice is one way of destigmatizing the use of federal nutrition programs. Making flyers, brochures, and other print resources available to patients would also be valuable.

Helpful messaging can reinforce how the programs benefit nutrition, health, and well-being and how everyone needs help at some point.

The AAP and FRAC have developed posters and flyers on federal nutrition programs for use in health care settings. These materials contain national numbers for accessing federal nutrition programs, but local referral information can be added, too.

- English poster
- Spanish poster
- Mandarin poster

Document and track interventions in the patient's medical record.

For guidance on how to track interventions, like referrals to the federal nutrition programs and emergency food resources, refer to the toolkit section Document, Track, and Code Food Insecurity Screenings, Assessments, and Interventions in the Patient's Medical Record.

TIP

Check with your state or local anti-hunger group, food bank, SNAP agency, WIC agency, or state education agency (typically responsible for school meals, child care meals, and out-of-school time meals for children) to see if useful outreach materials are available. For instance, these organizations or agencies may have locally tailored guides on how to apply for SNAP, or a poster with the hours and days of operation of free summer meal sites in your area.

Advocate and Educate to Address Food Insecurity and its Root Causes

STEP 1: Review resources and opportunities to engage in advocacy

STEP 2: Decide what advocacy opportunity to engage in

STEP 3: Learn from examples of other AAP members

STEP 4: Sign up for AAP advocacy emails

Pediatricians bring expertise, a unique perspective, and a powerful voice to the advocacy arena. By providing examples of how food insecurity can negatively impact children and families, such as the devastating consequences to a family's health and well-being, pediatricians can do three key things:

- **RAISE** attention to childhood hunger and food insecurity and its effects on child health and well-being;
- **IDENTIFY** and advocate for strategies to address childhood hunger and food insecurity; and
- **PARTNER** with anti-hunger advocates to amplify messages by applying a medical lens to the problem and solution.

Whether at the federal, state, or local level, pediatricians have long advocated to improve the food security, nutrition, and health of children by addressing the root causes of food insecurity and strengthening the federal nutrition programs — which include SNAP, WIC, child care meals, school meals, afterschool meals and snacks, and summer food. Poverty, inadequate wages, housing insecurity, and structural racism are among the societal issues that fuel food insecurity rates and must be addressed if the nation is going to end hunger. What follows are **four steps to get started in becoming an anti-hunger advocate.**

TIP

Review AAP's *Transition Plan: Advancing Child Health in the Biden-Harris Administration*, which lifts up the federal nutrition programs' positive health benefits and identifies opportunities, such as the quoted excerpt below, for the Biden-Harris Administration to address food insecurity and its root causes.

> "Invest in policies and programs we know help lift children out of poverty and improve their health. Federal anti-poverty and safety net programs, including those that provide health care (and access to health care through Medicaid and CHIP), early education (such as Head Start and Early Head Start), quality child care, affordable housing and home visiting, as well as critical nutrition assistance programs like WIC, SNAP, school meals, and summer feeding programs must be protected and accessible to all families in need."

STEP 1: Review resources and opportunities to engage in advocacy.

AAP has multiple resources and opportunities for pediatricians to get involved in advocacy efforts that address food insecurity and its root causes:

- *Promoting Food Security for All Children* is a policy statement that not only encourages pediatricians to screen and intervene to address food insecurity, but also to engage in advocacy and education;
- the AAP Federal Advocacy website has information on child nutrition and food security;
- the AAP Advocacy Action Center serves as a way for AAP members to contact their Members of Congress on child health issues and learn about the AAP's federal advocacy priorities; and
- the AAP Advocacy Conference presents an opportunity for participants to learn about how to become effective child health advocates through interactive workshops and in-depth training sessions.

FRAC offers several ways to get involved in anti-hunger and anti-poverty advocacy:

- FRAC's Legislative Action Center provides updates and actions to take in support of a strong Child Nutrition Reauthorization (CNR) bill and to protect SNAP through the Farm Bill legislative process;
- FRAC has state anti-hunger partners who can help you find opportunities to work with state or local anti-hunger groups in your area;
- FRAC's electronic publications share the latest news, tools, and research on hunger and the federal nutrition programs; and
- FRAC and Feeding America's National Anti-Hunger Policy Conference provides training and networking opportunities for advocates with any level of experience.

"Pediatricians can meet with, call, write, email, or Tweet their Members of Congress — you have instant credibility on issues of child health! We need to emphasize how common food insecurity is among children and how federal nutrition programs can effectively reduce food insecurity and improve children's health."

CALLIE L. BROWN, MD, MPH
Assistant Professor of Pediatrics, Wake Forest School of Medicine, Winston-Salem, North Carolina

STEP 2: Decide what advocacy opportunity to engage in.

The AAP encourages pediatricians to pursue advocacy opportunities to end childhood hunger. Advocacy efforts can focus on strengthening these evidence-based federal nutrition programs, as well as addressing the root causes of hunger.

Pediatricians can advocate for greater food security, better nutrition, and the improved overall health of children and their families in the following ways:

- **INFORM** stakeholders and decision-makers of the extent of food insecurity in the U.S. and its harmful consequences to child health and well-being;
- **SHARE** how key federal nutrition programs not only reduce food insecurity, but also "serve as critical supports for the physical and mental health and academic competence of children" (Promoting Food Security for All Children);
- **CHAMPION** policies that strengthen the federal child nutrition programs to further improve their quality and access; and
- **FIGHT BACK** against harmful proposals (e.g., funding cuts, administrative rules that weaken nutrition standards) that are aimed at minimizing the ability of the federal nutrition programs to reach millions of low-income families.

STEP 3: Learn from examples of other AAP members.

The following are 10 advocacy actions pediatricians can take at the local, state and federal levels to address food insecurity among children and their families.

1) WRITE AN OP-ED, BLOG, OR LETTER TO THE EDITOR

These actions are an opportunity to dive deeper on a specific issue while offering an invaluable personal perspective alongside research and policy recommendations. All of these are highly effective ways to communicate a message to the public and lawmakers who regularly read the editorial pages of their local newspapers.

During the COVID-19 pandemic, Dr. Christina Moellering of the Missouri chapter of AAP had a guest column calling for an increase in SNAP that was published in the Springfield News-Leader.

Dr. Kimberly Montez wrote for the AAP Voices Blog about seeing patients during COVID-19: "While the pandemic has wreaked havoc on everyone's lives, it has been particularly challenging for low-income families with children — like the families I see every day as a pediatrician in Winston-Salem, N.C."

2) MEET, BRIEF, CALL, WRITE, OR EMAIL CONGRESSIONAL REPRESENTATIVES

Appealing directly to your Members of Congress and their staff allows you to offer expert information on the health and well-being of children and the role of the federal nutrition programs in promoting healthy growth and development.

In response to an AAP action alert asking pediatricians to weigh in with their Members of Congress about the importance of ensuring children can access nutritious foods throughout the COVID-19 pandemic, over 250 AAP members emailed their representatives.

3) TESTIFY BEFORE CONGRESS IN SUPPORT OF KEY FEDERAL NUTRITION PROGRAMS

Offering your expertise during a legislative hearing is an effective strategy to raise awareness of childhood food insecurity and the multiple health and nutrition benefits of the federal nutrition programs.

Olanrewaju Falusi, MD, FAAP, testified on behalf of AAP before the U.S. Senate Committee on Agriculture, Nutrition, and Forestry about the impact that child nutrition programs, like WIC, have on the health of her patients.

4) TAKE THE SNAP CHALLENGE

Taking the SNAP Challenge allows participants to share their experiences about living on a food budget of about $29 per week and it adds some personal experience that can buttress advocacy actions for increasing SNAP benefits. For more information, visit FRAC's SNAP Challenge page.

Lewis First, MD, Chief of Pediatrics at Vermont Children's Hospital and Chair of the Department of Pediatrics at the University of Vermont College of Medicine, took the 3SquaresVT (this is the state's program name for SNAP) challenge to highlight the problem of childhood hunger.

5) WORK WITH YOUR STATE AAP CHAPTER TO PRIORITIZE FOOD INSECURITY

Elevating the issue of childhood food insecurity as a chapter priority provides a valuable way to connect practitioners to evidence-based opportunities to screen and intervene.

The AAP Michigan Chapter has included access to healthy, nutritious foods as a key component of its Michigan Blueprint for Children. The chapter is advocating at the state level for increasing SNAP and WIC eligibility, promotion, and access as well as expanded SNAP benefits.

TEN ADVOCACY ACTIONS Pediatricians Can Take to Address Childhood Food Insecurity (continued)

6) SUPPORT FEDERAL, STATE, OR LOCAL LEGISLATION

Supporting legislation allows pediatricians to promote policy changes that are important to addressing food insecurity and improving children's health. It also can provide opportunities to connect with new and interested stakeholder groups.

Numerous AAP state chapters signed this letter of support urging Congress to support H.R. 7887 (the Pandemic Child Hunger Prevention Act), which would provide free school meals to all children during the 2020–2021 school year.

7) PUSH FOR STATE APPROPRIATIONS

Weighing in for increased funding for state anti-hunger efforts helps lawmakers understand the need for adequate funding and resources to safeguard children against food insecurity.

In 2019, the AAP Maryland chapter was part of a coalition that successfully advocated for funding for the summer school lunch program. State funding allows summer meal programs to provide outreach to determine the location of eligible students and provide transportation to distribute meals.

8) SERVE ON A HUNGER TASK FORCE

By joining a local task force or broader state coalition, pediatricians can add tremendous value to coalition activities and influence goals and priorities.

Stephen Cook, MD, of Rochester, New York, was appointed by Governor Andrew Cuomo to the New York Anti- Hunger Task Force. Dr. Cook was appointed due to his tireless advocacy for children's food security, which included testifying before the U.S. Senate Committee on Agriculture, Nutrition, and Forestry and being active on social media in staunch support of SNAP.

9) TESTIFY BEFORE A LOCAL BODY

Engaging with local lawmaking bodies, such as a school board or city council, supports local actions to address childhood food insecurity, including the successful implementation of new local policies.

Marsha Raulerson, MD, of Brewton, Alabama, testified before her local school board on the importance of healthy food and the Community Eligibility Provision, which allows high-poverty schools to serve breakfast and lunch at no cost to all enrolled students.

10) EDUCATE THE NEXT GENERATION OF DOCTORS

Educating future doctors bolsters the network of individuals who are capable of addressing food insecurity and effectively advocating for federal nutrition programs.

The Carolinas Collaborative, a dual state learning health community between the eight pediatric residency advocacy programs across North Carolina and South Carolina, works to educate trainees on screening and intervening for food insecurity in clinical settings. The collaborative is supported by The Duke Endowment and the AAP CPTI.

STEP 4: Sign up for AAP advocacy emails.

Join thousands of pediatricians who are armed with the most up-to-date knowledge on federal legislation affecting children and pediatricians. This network has also provided the tools to speak up during critical decision points in the legislative process. Email kids1st@aap.org with your name, AAP ID, if known, and your preferred email address to sign up.

Screening and Intervening Models in Practice

The screening and intervening model a pediatric practice chooses to implement will depend on multiple factors as discussed in the above sections. Below are some examples of what screening and intervening to address food insecurity looks like in practice.

"Physicians want to know what the problem is and what to do about it. One of the challenges is that these problems are often complex. We screened 92,000 patients in the last year. My role is to direct our food insecurity work and help providers figure out what to do when a food need is identified. We have a paper process of screening families and have our medical assistant staff put responses into the electronic medical record. If the answers are positive, the provider is alerted that it's something that needs to be discussed in the visit.

We have been working with our local food bank to document a closed-loop referral. That's a little bit harder electronically, will look different in smaller practices than large health systems, and will depend on the interest and capacity within each local community. There is not a one-size-fits-all solution for making the electronic connection, although there are a great number of opportunities to pursue if there is interest from the practice with Aunt Bertha, NowPOW, and Unite Us. A number of communities are improving how they communicate via health information exchanges.

We hope to establish a communication with our food bank data system to identify when a referral for food has been fulfilled, but we would also like to know when and how often our patients have accessed food and if there are health gaps, like overdue well-check appointments or outstanding immunizations in patients accessing local food bank services. We are thinking about the roles community health workers and care coordinators play in ensuring the family gets to where they need to be."

JOEL DAVIDSON, MD, FAAP
Co-Chair Social Determinants of Health Committee, Akron Children's Hospital

"At my practice, where we see approximately 6,000 children each year, we screen every child during a well-visit for food insecurity using the Hunger Vital Sign™ questions. I make it a point to always ask kids if they are getting SNAP, school breakfast, and other federal nutrition programs. Members of my practice team are trained to help with benefit assistance. We also have a referral sheet that we give to all of our patients, which includes information on where to apply for SNAP, WIC or where to access food pantries. We'd love to host a WIC staff member on site to more readily connect families to WIC."

DR. VALERIE SMITH, MD, FAAP, MPH
Pediatrician, CCHH Director, St. Paul Children's Medical Clinic, Tyler, Texas

"At my clinic, the front desk hands the patient a packet of information to complete. This includes a piece of paper with the two Hunger Vital Sign™ (HVS) questions and additional social history questions. (The HVS is administered at 0 months, 6 months, 12 months, and every year thereafter.) Patients give the information to the provider, and I review the response and patient history. I document the responses in the EMR template and make sure to code for positive findings.

I will ask during the social history if the family uses TANF, WIC, or SNAP. Before concluding the visit, I address the responses by talking to the family about the resources that are available to help them access food. If they are not accessing SNAP or WIC, I talk about accessing those programs with the help of our in-house social worker. We also have a WIC expert that has office hours during the week that takes referrals. Depending on the season, I print and share additional food resources (e.g., farmers' markets, summer meals, emergency resources), and highlight the programs they should consider. I follow up at a later visit to see how the family is doing in accessing food.

The grand majority of my families are on Medicaid, and most are already on SNAP. However, some families have trouble accessing SNAP from a legal standpoint. In those cases, I will refer patients to the Medical-Legal Partnership at my institution or D.C. Hunger Solutions. Universally screening with the HVS questionnaire is key to successfully identifying and addressing the needs of the families that come to my clinic."

ANTHONY MCCLENNY, MD, MPH
Washington, D.C. (Pediatric Resident)

"We implemented screening in our primary care clinic several years ago, in line with the AAP statement on Promoting Food Security. We have gone through several iterations in screening our families, trying to find the best fit for our clinic flow and also working within the rules and policies of the health system we are a part of. We were lucky to have a strong partnership early on with the Houston Food Bank, which helped provide some training for our doctors and staff, and helped us develop pantry resources to share with our patients who screen positive. The screening has become more routine now, with our nursing team taking the lead on asking the Hunger Vital Sign™ questions and our doctors or social worker then following up to further assess for needs.

Since we are also a teaching site for the pediatric residency program, it has additionally given us the opportunity to teach our trainees about screening, how to feel comfortable screening for social determinants, like food insecurity, and have them learn about the local resources to address food insecurity.

More recently, the Houston Food Bank has helped us connect our families more directly to assistance with enrolling for SNAP benefits through an outreach program they offer clinics. We know that SNAP is an important way to address food insecurity for many families, and being able to offer them one-on-one assistance with completing the SNAP application helps reduce some of the barriers to accessing this benefit. I think it also highlights the importance of working with community partners so that when we do screen and identify families in need, we can direct them to resources that we know can make a difference."

ANA C. MONTERREY, MD, MPH, FAAP
Assistant Professor, Baylor College of Medicine, Houston, Texas

Additional Resources for Pediatricians to Address Food Insecurity

Key Facts: Childhood Food Insecurity and the Role of Pediatricians — infographic

Federal Nutrition Programs and Emergency Food Referral — chart

Free Healthy Food — handout

Hunger Could Be Hiding in Plain Sight — flyer

Free Healthy Food for Your Growing Child — flyer or handout
English | Spanish | Mandarin

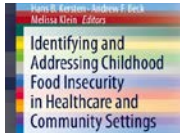
How Pediatric Practices Are Connecting Patients to Food and Nutrition Programs: the Pros and Cons of Various Models — chart

Ten Advocacy Actions Pediatricians Can Take to Address Childhood Food Insecurity — handout

Background Resources

Promoting Food Security for All Children — AAP Policy Statement

Pediatrician Survey Findings Addressing Food Insecurity Among Children — Pediatrician Beliefs, Practices, and Resource Needs — brief



Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings — brief

Children's HealthWatch Materials

Children's HealthWatch Hunger Vital Sign™ page

Hunger Vital Sign™ Questions in English and Spanish

American Academy of Pediatrics

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