EDITORIAL

Food Insecurity: A Key Social Determinant of Health for Older Adults

The number of older adults experiencing food insecurity—the lack of enough affordable, nutritious food to live a healthy, active lifestyle—has doubled since the turn of the century.[1] In 2017, 7.9% of all US households with at least one adult aged 65 years and older experienced food insecurity, and 8.6% of households composed of an adult aged 65 years and older living alone were food insecure.[2] With the number of adults aged 65 and older expected to rise from 49.2 million in 2016 to more than 73 million by 2030,[3] the number of older adults living in food-insecure households will likely continue its dramatic rise in the absence of improved interventions.

These demographic trends are important for clinicians because food insecurity among older adults is associated with multiple negative health outcomes. Food-insecure older adults are more likely to be in fair or poor health, with frequently associated comorbidities including diabetes, depression, hypertension, heart disease, and gingivitis.[4,5] Food-insecure older adults are also more likely to have limitations in activities of daily living.[5,6]

Food insecurity and multimorbidity may create a negative feedback loop. In some cases, it is thought that food insecurity increases morbidity risk. This may be the case for conditions that are highly sensitive to diet or medication adherence because food-insecure older adults must frequently make difficult choices to afford either healthy food or medications. In other cases, it is likely that poor health increases the risk for food insecurity. Out-of-pocket healthcare expenditures associated with poor health can substantially impact the household food budget. In addition, functional impairments (physical disability, limited visual acuity, poor dentition, cognitive impairment, and social isolation) can make chronic disease self-management both more challenging and more expensive.[7] Access to healthy food in this population may be further limited by challenges with transportation.

As a result, clinicians may be regularly addressing the causes and consequences of food insecurity in the clinical setting, often without recognizing it or knowing how best to address it.[8] Recognizing food insecurity can be especially challenging given the frequent co-occurrence of food insecurity and obesity in the United States because dietary intake in food-insecure households frequently shifts away from healthier, more expensive foods and toward cheaper foods that are typically more obesogenic.

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There is good evidence, however, that programs supporting food security can improve health outcomes and the likelihood of aging in place among older adults, suggesting that clinical interventions are warranted. For example, participation in the Supplemental Nutrition Assistance Program (SNAP), the largest food support system in the United States, is associated with reductions in avoidable healthcare utilization including nursing home stays, hospitalizations, and emergency department visits.[9,10] SNAP participation is also associated with reductions in cost-related medication nonadherence among food-insecure older adults.[11]

CLINICIAN'S ROLE

Although food insecurity poses challenges for maintaining health and preventing chronic disease complications, the frequency with which many older adults interact with the health system provides opportunities for integrating discussions about health needs, food security, and community resources for food and nutrition. Food insecurity may at times be addressed as part of routine clinical care. For example, a frail homebound older adult may present as malnourished and be referred for home-delivered meals, incidentally addressing the patient's food insecurity through treatment of a medical condition. Other times, lack of recognition of food insecurity may hamper clinical care. For instance, a clinician treating an older adult with diabetes experiencing frequent episodes of hypoglycemia may respond first by reducing medication doses, rather than uncovering that the root cause of the hypoglycemia is an inability to afford food, a barrier that could be better addressed by referral to a food and nutrition support program.

Health systems and providers across the United States are therefore adopting systems for screening for food insecurity in the clinical setting and referring food-insecure patients to appropriate services to support their patients in managing chronic disease, maintaining health, and continuing independent living. To best support older adults, clinicians can consider three activities:

1. **Screen patients:** Unlike other nutrition-related complications, like obesity or frailty, food insecurity may be episodic and hidden from view. Therefore, screening programs are essential. Because of elevated risk, all older adults should be screened for food insecurity at least once, such as at the time of the Medicare Total Health Assessment.[12] More frequent screening should be considered for populations at greatest risk including Medicaid and dual Medicare-Medicaid enrollees and patients with multiple comorbidities (especially if they include malnourishment, failure to thrive, diabetes, or depression). The Hunger Vital Sign™, a two-item screening tool,

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was validated for clinical use and is highly sensitive and specific among older adults.[13] Its use among older adults has been endorsed by multiple organizations including the AARP Foundation.

2. **Intervene clinically:** Clinicians and practice teams should become familiar with and refer food-insecure patients to publicly or privately funded nutrition programs known to support food security (Table 1), ideally by creating systems that make such referrals time efficient. Such programs include SNAP, congregate meals, and home-delivered meals, all of which are supported to some extent by federal funding. In addition to supporting food security and improved dietary intake, these programs are associated with reductions in isolation, depression, preventable healthcare utilization, and healthcare costs.[9,10,14–16]

   Underenrollment in SNAP is of particular concern for older adults. Fewer than half of eligible older adults participate in SNAP, despite its proven health benefits and entitlement structure.[17] Common barriers to SNAP participation among older adults include cumbersome state or local application processes, misunderstanding of program benefits, lack of eligibility awareness, and stigma.[18] Clinicians and health systems are in a unique position to address many of these barriers, such as reframing food assistance as a benefit that can support health and independence.
3. **Advocate for systems change:** Clinicians play a critical role in advocating for policies, programs, and practices that support the health of their patients, such as SNAP and other community and federal nutrition programs. The experiences of clinicians treating food-insecure patients offer important insights for leaders. Three key advocacy opportunities for clinicians working with older adults include:

   - Promoting more widespread screening for food insecurity in the clinical setting, documentation in the medical record, and referrals to food and nutrition resources;
   - Closing the gap in older adult participation in SNAP; and
   - Ensuring the dollar value of SNAP benefits is adequate to meet the dietary needs of older adults.

Table 2 provides examples of specific clinical strategies and policy solutions related to these opportunities. In addition, the Food Research & Action Center (FRAC; www.frac.org) and the AARP Foundation (www.aarp.org/aarp-foundation) provide numerous resources and tools for local, state, and federal advocacy efforts focused on food insecurity and poverty among older adults.

OPPORTUNITIES/EARLY SUCCESSES

Clinical programs and systems to screen for and intervene on food insecurity are being scaled across the United States. A 2017 review identified 22 healthcare entities that have implemented systematic food-insecurity screening programs for older adults.[21] Kaiser Permanente Colorado and Hunger Free Colorado, for instance, entered into a partnership in 2011, leveraging their unique assets to screen patients for food insecurity during clinical visits, refer food-insecure patients to community specialists with expertise in community and federal nutrition programs, and support enrollment in appropriate programming.[22]

Other clinical systems have adopted on-site solutions. For example, ProMedica health system has screened all patients for food insecurity since 2015. In the primary care setting, food-insecure patients are referred to an on-site Food Pharmacy. In the inpatient setting, patients are provided with emergency food at hospital discharge, if needed.[20,23]

Table 1. Examples of federal and local food assistance programs for older adults[a]

Name of program	General program eligibility	Program overview
Supplemental Nutrition Assistance Program (SNAP; formerly known as "Food Stamps")	Low-income individuals who meet income and asset tests (that can vary by state); there are special program rules for adults aged 60 and older	Monthly benefits provided in the form of an Electronic Benefit Transfer (EBT) card that works like a debit card to purchase food at SNAP-authorized retailers
Congregate Meal Program	Adults aged 60 and older; preference is given to those with the greatest economic and social need	Provides group meals at participating sites (eg, churches, senior housing, and other community spaces)
Home-Delivered Meals	Adults aged 60 and older who are frail, homebound, or isolated; preference is given to those with the greatest economic and social need	Meals delivered to place of residence
Commodity Supplemental Food Program (CSFP)	Adults who are aged 60 and older and meet state-specific income thresholds	Provides a monthly food box of items, generally received at a food pantry
Senior Farmers Market Nutrition Program	Adults aged 60 and older who are at or below 185% of the federal poverty line, but some states tie eligibility to other means-tested program participation	Annual vouchers to use for eligible foods at participating farmers' markets, roadside stands, and community-supported agriculture programs
Child and Adult Care Food Program (CACFP)	Nonresidential adult day care centers that serve adults age 60 and older and/or individuals who are functionally impaired	CACFP provides reimbursement to adult day care facilities that serve nutritious snacks and meals to older adults
Food pantries	Targeted to low-income people of all ages; eligibility criteria vary	Provides free food and grocery items that are picked up in-person by the individual or a proxy
Medically-tailored meals	Eligibility criteria vary	Home-delivered meals tailored to meet the needs of a specific health condition or combination of conditions

[a]Adapted with permission from the Food Research & Action Center's *Federal Nutrition Programs and Emergency Food Referral Chart for Older Adults* (2018). Primarily for use in healthcare settings, the referral chart includes key information on nutrition programs available to older adults and can be tailored to include local resources. The chart is available at www.frac.org.

Table 2. Strategies for reducing food insecurity among older adults

Promote screen and intervene efforts in clinical settings
Clinical strategies
• Educate peers, staff, and leadership on the connections between food insecurity and health through workshops, grand rounds, and discussions at staff meetings.
• Champion implementation of systematic food security screening within the health system, ideally using the Hunger Vital Sign, including documentation of the results in the medical record.[a]
• Create and regularly update food insecurity intervention processes in collaboration with the practice team. Connect patients who screen positive for food insecurity to SNAP, congregate meals, home-delivered meals, and other community-based resources.
• Support the practice team in learning about the importance of food insecurity screening, administration of the screening tool, documentation of screening results, and intervention processes.
• Increase awareness of food insecurity in the broader community and identify community-based resources and partnerships that can benefit food-insecure patients.
• Develop on-site food pharmacies, food pantries, or meal programs to provide food or meals to vulnerable patients and their families.
Policy solutions
• Use money from the healthcare system's community benefit programs for screen and intervene programming in clinical settings.[b]
Close the gap in older adult participation in SNAP
Clinical strategies
• Work with community partners to enroll Medicaid beneficiaries in SNAP.
Policy solutions
• Streamline enrollment of SNAP-eligible older adults by implementing an Elderly Simplified Application Project (ESAP) that shortens the SNAP application, provides 36-month certification period, and eliminates need for a recertification interview for some older adults.
• Enable clients to apply for SNAP using telephonic signatures.
• Leverage data from other programs, such as Supplemental Security Income (SSI) and Medicaid, to streamline enrollment of low-income older adults onto SNAP.
• Invest in SNAP education and application assistance projects to help older adults navigate the complex SNAP enrollment and recertification processes.
Ensure the dollar value of the SNAP benefit is adequate to meet the dietary needs of older adults
Clinical strategies
• Engage with local hunger or food policy councils to add expert health professional perspectives to important policy discussions.
• Ensure on-site nutrition education is sensitive to the needs of food-insecure patients, particularly the need for budget-neutral strategies to improve dietary intake.
Policy solutions
• Establish a SNAP Standard Medical Deduction (SMD) to simplify the process by which older adults can have excess medical costs taken into consideration in determining SNAP benefit levels.
• Coordinate SNAP and low-income energy payments to provide older adults enrolled in SNAP with appropriate utility deductions and SNAP benefit levels that better position them to avoid competing "heat or eat" demands.
• Use state or local government funding to supplement the $15 federal minimum monthly SNAP benefit received by many older adult SNAP participants

[a]*An Overview of Food Insecurity Coding in Health Care Settings Existing and Emerging Opportunities* describes how to record food security in the health record (http://childrenshealthwatch.org/foodinsecuritycoding/).[19]

[b]The *Delivering Community Benefit: Healthy Food Playbook* describes this strategy (foodcommunitybenefit.noharm.org).[20]

CLINICIAN RESOURCES FOR ADDRESSING FOOD INSECURITY AMONG OLDER ADULTS

Several resources exist to help clinicians identify and address food insecurity among older adults.

- ***Screen and Intervene: Addressing Food Insecurity Among Older Adults*** is a free online course for clinicians that describes risk factors for food insecurity among older adults; negative health outcomes associated with food insecurity among older adults; the Hunger Vital Sign screening tool; and strategies to connect older adults to SNAP and other appropriate resources (www.seniorhealthandhunger.org).
- ***Implementing Food Security Screening and Referrals for Older Patients in Primary Care: A Resource Guide and Toolkit*** is intended to aid clinicians in implementing systematic food security screening and referral processes (www.impaqint.com/OASDOH).
- ***Clinical algorithms*** exist to support clinicians in screening and appropriately responding to food insecurity. The Centers for Disease Control and Prevention's NOPREN algorithm provides clinicians with simple steps tailored to older adults (www.nopren.org/working_groups/hunger-safety-net/clinical-linkages/).
- ***Combating Food Insecurity: Tools for Helping Older Adults Access SNAP*** offers practical tips to organizations of all sizes interested in supporting older adults with SNAP enrollment through education, outreach, and application assistance (http://www.frac.org/research/resource-library/combating-food-insecurity-tools-helping-older-adults-access-snap-2).

CONCLUSIONS

Food security is important for the physical and mental health of older adults. Clinicians can address food insecurity among

older adults by systematically screening patients for food insecurity, intervening when a food-insecure patient is identified to establish a connection with a program supporting food security, and advocating for policies, programs, and practices that reduce food insecurity among older adults.

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