

American Academy of Pediatrics
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FRAC
Food Research & Action Center

Addressing Food Insecurity: A Toolkit for Pediatricians

February 2017



About the Food Research & Action Center (FRAC)

The Food Research & Action Center (FRAC) is the leading national organization working for more effective public and private policies to eradicate domestic hunger and undernutrition. For more information about FRAC, or to sign up for FRAC's Weekly News Digest and (monthly) Meals Matter: School Breakfast Newsletter, go to www.frac.org.

About the American Academy of Pediatrics (AAP)

The American Academy of Pediatrics is an organization of 66,000 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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Introduction

Food insecurity — the limited or uncertain access to enough food — is a critical child health issue that impacts children and families in all communities. Unfortunately, one in six U.S. children lives in a food-insecure household. Children who live in households that are food insecure, 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.

In a policy statement, *Promoting Food Security for All Children*, the American Academy of Pediatrics (AAP) recommends that pediatricians screen for food insecurity and intervene accordingly.

In order to assist pediatricians in meeting this recommendation, AAP has partnered with the Food Research & Action Center (FRAC) to provide a variety of tools and resources to help pediatricians and their practice teams do the following:



Screen for food insecurity in practice, using the Hunger Vital Sign™, a validated two-question screening tool developed by Children’s HealthWatch;



Connect families with food and nutrition resources in the community; and



Support national and local policies that increase access to adequate healthy food for all children and their families.

“*One in six children suffers from food insecurity and hunger. If children are poor, then almost one in two is food insecure. 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 food.*”

- Benard P. Dreyer, MD, FAAP
President, American Academy of Pediatrics (2016)

This infographic highlights the key information pediatricians need to know to effectively address food insecurity among children. [Download this infographic](#) to share with your practice team or other colleagues.

Pediatricians play a critical role in protecting children from food insecurity

KEY FACTS ABOUT CHILDHOOD FOOD INSECURITY

Childhood food insecurity can lead to:

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

1 in 6

U.S. children
lives in a food-insecure household

Childhood food insecurity may present

- Developmental Delays
- Behavioral Problems
- Obesity
- Poor Growth
- Inappropriate Feeding Practices

NUTRITION PROGRAMS TO KNOW

The federal nutrition programs play a critical role in improving food security, health, and well-being

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 MEALS

Prepare

Educate and train staff on food insecurity and the need for universal screening

Follow AAP's recommendation of screening at scheduled check-ups or sooner, if indicated

Incorporate food insecurity screening into the institutional workflow

Show sensitivity when screening for 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

Support advocacy and educational efforts to end childhood food insecurity

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For more information, visit:
<http://www.frac.org/aaptoolkit>

Food Research & Action Center

What Health Providers Need to Know About Food Insecurity

KEY FACTS ABOUT CHILDHOOD FOOD INSECURITY

1 in 6

U.S. children
lives in a food-insecure
household

One in six U.S. children lives in a food-insecure household. Certain types of households and children face higher risks.

Food insecurity is a critical child health issue that impacts children and families in all communities. [In 2015](#), 13.1 million U.S. children lived in households without consistent access to adequate food for resource-related reasons. The U.S. Department of Agriculture’s (USDA) official definition of a food-insecure household is one in which “access to adequate food is limited by a lack of money and other resources.”

Food insecurity is not an isolated or concentrated phenomenon in the U.S., but rather, it impacts every state, every county, and every community. [State food insecurity rates](#) ranged from 8.5 percent of North Dakota households to 20.8 percent of Mississippi households in 2013–2015 (three-year average).

No matter your practice or setting, it is likely or possible that you will be treating children from food-insecure households. You may not be able to tell who is food insecure just by looking at a child or family. However, certain [children and households are more likely to be food insecure](#).

- Households with children are nearly twice as likely to be food insecure as households without children.
- Food insecurity rates for black and Hispanic households are substantially above the national average.
- Households outside metropolitan areas (more rural areas) are seeing considerably deeper struggles with food insecurity compared to those within metropolitan areas.
- Unemployment and underemployment are strongly associated with food insecurity.
- Children in immigrant families, large families, families headed by single women, families with less education, and families experiencing parental separation or divorce are at greater risk for food insecurity.

While recognizing that some families may be more at risk, all families in inpatient and outpatient settings should be screened. You cannot necessarily tell by outward appearance who is food insecure. [Download the *Who’s Hungry?* poster.](#)



Food insecurity — even marginal food insecurity — is detrimental to children’s health and well-being. For example, food insecurity can lead to poor health status, developmental risk, and mental health problems.



Multiple adverse health outcomes are strongly correlated with [food insecurity](#), as highlighted in this selection of research findings.

- Children 36 months old or younger who live in food-insecure households have poorer overall health and more hospitalizations than do children who live in food-secure households.
- Children between four and 36 months of age who live in low-income, food-insecure households are at higher risk of developmental problems, compared with children of the same age living in low-income, food-secure households.
- Among children of all ages, food insecurity is linked with lower cognitive indicators, dysregulated behavior, and emotional distress.
- Children and adolescents with food insecurity are more likely to be iron deficient.
- Longitudinal studies have shown that food insecurity in kindergarten students predicts reduced academic achievement in math and reading over a four-year period.
- The inability to consistently provide food creates stress in families, contributing to depression, anxiety, and toxic stress.
- Adolescents in food-insecure families are more likely to experience dysthymia and suicidal ideation.
- 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.

The inability to consistently provide food creates stress in families, contributing to depression, anxiety, and toxic stress.

The content presented here is primarily based on AAP’s policy statement, [Promoting Food Security for All Children](#).

Common ways food insecurity may present in children include developmental delays, behavioral problems, obesity, poor growth, and inappropriate feeding practices.

Because of the associated health consequences of food insecurity, food insecurity may present in children in a number of ways, including:

- Developmental delays;
- Behavioral problems;
- Depression, anxiety, or stress (parent or child);
- Iron deficiency anemia or other nutrient deficiencies;
- Obesity;
- Poor growth;
- Inappropriate feeding practices; and
- Dental caries.

Childhood food insecurity may present as:

Developmental Delays
Behavioral Problems
Obesity
Poor Growth
Inappropriate Feeding Practices

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

- [*Poverty and Child Health in the United States*](#)
- [*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 end childhood food insecurity.

See the advocacy section on page 36 for additional information.

More information on food insecurity statistics, risk factors, and consequences is available on [*FRAC's website*](#).

The content presented here is primarily based on AAP's policy statement, [*Promoting Food Security for 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

Director, GROW Clinic for Children at Boston Medical Center

Founder and Principal Investigator, Children's HealthWatch

Preparations to Screen for Food Insecurity



Educate and train staff on food insecurity and the need for universal screening.

Follow AAP's recommendation of screening at scheduled check-ups or sooner, if indicated.

Incorporate food insecurity screening into the institutional workflow.

Show sensitivity when screening for food insecurity.

As food insecurity has harmful impacts on the health and well-being of children and their families in both the short and long terms, a growing number of pediatricians – as well as other health care providers and community based organizations – across the nation screen for food insecurity using AAP's recommended tool, the Hunger Vital Sign™. Screening is occurring in a wide range of clinical and community settings, and increasingly is embedded into institutional workflows and electronic health/medical records.

This section provides helpful steps for pediatricians relatively unfamiliar with, or new to, food insecurity screening, and also for those who wish to validate, modify, or expand their own food insecurity screening practices.

STEP 1

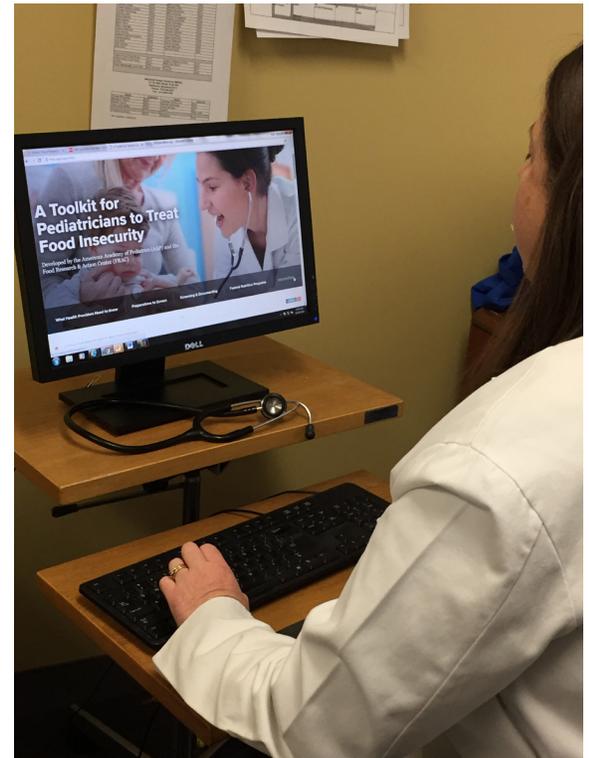
Educate and train leaders and staff on food insecurity and the importance of universal screening. Also, collaborate with the practice team to identify ways to screen for food insecurity.

- **Train staff and leadership** (e.g., pediatricians, nurses, physician assistants, registered dietitians, social workers, administrators, etc.) on the pervasive, yet invisible, nature of food insecurity through workshops and discussions at staff meetings. Start by distributing AAP's [Promoting Food Security for All Children](#) policy statement. Review the “treatments” and interventions available for patients who screen positive to reassure the practice team that something can be done to address this problem, and they do not have to “fix” everything on their own.
- **Collaborate with other pediatricians, the practice team, and support staff** to identify sustainable ways to screen for food insecurity in your practice. For larger institutions, it is important to identify someone in a leadership position who supports incorporating food insecurity screening in the workflow. For case studies of screening efforts across the nation, visit the [National Repository of Resources and Information on Screening for Food Insecurity](#), developed by Children's HealthWatch.
- **Train the practice team** on the importance of screening, how to administer the screening tool, how to document the results, and how to intervene if someone screens positive. Gaining the practice team's buy-in and support is critical for success.
- **Identify a “Hunger Champion”** in your practice who can stay abreast of food insecurity policy and programs; create and update your practice's food insecurity screening and intervention processes; and increase awareness of food insecurity in the broader community. This individual also can help get buy-in from staff and leadership.

STEP 2

Follow AAP's recommendation of screening at "scheduled health maintenance visits or sooner, if indicated."

- **AAP recommends screening at "scheduled health maintenance visits or sooner, if indicated."** The practice team should consider screening all patients at all visits, including inpatient settings, given the often cyclic and hidden nature of food insecurity. For instance, families may struggle more during the summer months when children are not receiving school meals. Furthermore, [one recent 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 screening at all health care interactions.
- 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, obesity, 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., parent mentions recent job loss, child is anemic or struggling with behavioral problems, patient requires a special diet or expensive medication).



STEP 3

Incorporate food insecurity screening into the institutional workflow so it is sustainable, such as adding a screening tool into existing registration or intake procedures, or into the electronic health record.

- **Incorporate the screening tool into existing registration and intake procedures and workflow** (e.g., routine paperwork, vital signs, nutrition assessment, while waiting for care). A range of practice team members can screen for food insecurity, such as pediatricians, physician assistants, nurses, nurse practitioners, patient care technicians, registered dietitians, and social workers. Decide what will work best and be sustainable for your practice, ideally with the input of other practice team members.
- **Incorporate the screening tool into electronic health records.** For example, the Hunger Vital Sign™ is already built into the Epic Foundation System (under "Hunger Screening").

STEP 4

Show sensitivity when screening for food insecurity (e.g., inform patients that the practice screens all patients, normalize the screening tool questions).

- **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, relying on emergency food assistance, and participating in federal nutrition assistance programs. Some may even worry that discussing food insecurity puts the family at risk of a 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, are more aware of their families' food insecurity than their parents realize.
- Not only may parents try to hide food insecurity from their children, but they also may try to hide it from their friends, family, coworkers, and health care providers. **Hunger may be lurking behind a well-groomed and well-dressed appearance.** 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 or unexpected expenses, or struggling to pay for other basic needs. Furthermore, *food insecurity can coexist with obesity*, and the practice team should not be surprised that someone may be simultaneously struggling with weight issues and food insecurity. In short, hunger is often invisible.
- **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 like the Supplemental Nutrition Assistance Program (SNAP) or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- **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.

Tips from Practitioners on How to Address Food Insecurity in a Sensitive Manner

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



Screen for Food Insecurity in a Sensitive Manner

- Screen all patients at all health care interactions so no one feels singled out. Universal screening in inpatient and outpatient settings also prevents the practice team from making possibly incorrect assumptions about which patients and families may or may not be in need.
- Decide whether to administer the screening tool in writing or verbally. Some providers prefer administering the screening tool in writing rather than verbally (e.g., in the waiting room as part of routine paperwork or while waiting in the examination room), while others prefer the opportunity to talk directly to patients. 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.
- Normalize the screening tool statements by saying at the outset, for example, "I'm seeing so many people that are having a hard time affording food, so I'm asking all of my patients some questions about this. Please let me know if either of these statements is true for you and your family..."
- Administer the screening tool in the parent's preferred language. The AAP-recommended Hunger Vital Sign™ screening tool has been validated in both [English and Spanish](#).



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 most people across the country need 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, 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 you have an on-site food pantry or shelf, make sure it is located where patients can access food in private.
- Use physical environment cues (e.g., posters, brochures) that address food insecurity or 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 that 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.
- Immigrant families may be of “mixed status” and include members who are not U.S. citizens, and may believe that their children are not eligible for food assistance, or have misgivings about accessing federal nutrition programs, even if their children are eligible. While traditionally, immigrants have been able to access many federal nutrition programs, the future is uncertain and many families will likely be experiencing anxiety and stress.
 - Before referring immigrant families to nutrition programs, [contact your state anti-hunger group](#) or a national or local [immigrant advocacy group](#) for the most up-to-date eligibility standards for immigrant children and families to access public benefit programs. Legal advocates, including lawyers associated with Medical-Legal Partnerships, also can address these complicated immigration issues as well as assist families access other benefits and programs.

- Provide reassurance that many people struggle financially at some point in their lives, especially with high food prices. Acknowledge that sometimes people are embarrassed to admit that they are struggling or that they need help. Commend the parent or caregiver for his/her honesty about the issue and reassure him/her that they are not a bad parent for needing assistance.

For additional information, see the AAP News story, [*Experts Advise Sensitive Approaches to Food Screening*](#).

“*It is often difficult for parents to talk about food insecurity in their household, so I always preface my conversation by saying, ‘Food is important to health. I want to make sure you have enough food and the right types of food, so I ask all my patients these questions.’*”

- Hillary Seligman, MD, MAS, Associate Professor of Medicine at
University of California San Francisco’s Center for Vulnerable Populations

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 USDA’s 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.



AAP recommends that pediatricians use the Hunger Vital Sign™ to screen for food insecurity in practice. The two questions are:

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

Households are at risk of food insecurity if the response is “often true” or “sometimes true” to either or both statements (i.e., screens positive for food insecurity). If a family screens positive for food insecurity, 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 not yet impacted its food security status. It also is important to note that 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 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. 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™, including screening language and translations, is available from [Children’s HealthWatch](#).

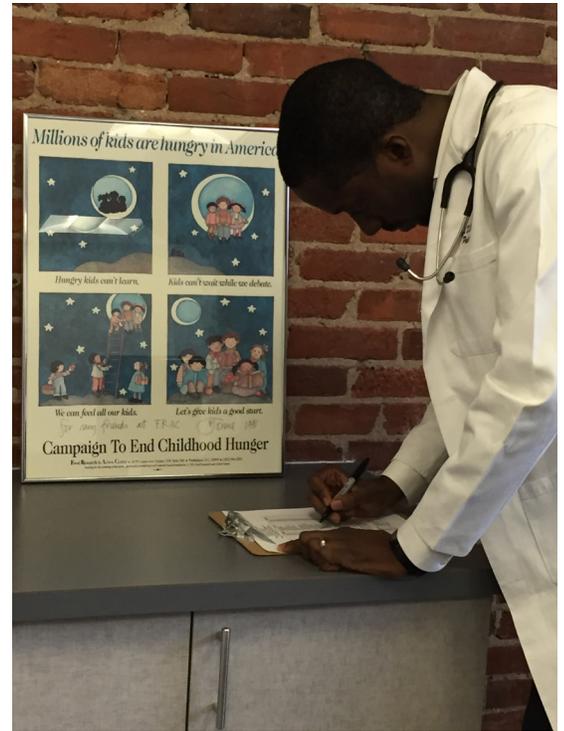
Using an Alternative Food Insecurity Tool

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 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.



Document and Code Food Insecurity Screening and Interventions in the Patient's Medical Record

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

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 should be documented in the patient's medical record.

Diagnosis 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). For the Hunger Vital Sign™, a patient screens positive for food insecurity if the response is “often true” or “sometimes true” to either or both of the 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., patient was referred to 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. How a practice handles this documentation will depend on your practice model and electronic medical records interface.

Providers may want to embed a list of the federal nutrition programs and emergency food resources into the electronic medical records 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. Another option is to build out your systems SNOMED codes to respond to ICD-10-CM Diagnosis Code Z59.4 (lack of adequate food and safe drinking water).

What Health Providers Need to Know About Federal Nutrition Programs

NUTRITION PROGRAMS TO KNOW

The federal nutrition programs play a critical role in improving food security, health, and well-being



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 MEALS



According to [AAP](#), the federal nutrition programs “serve as critical supports for the physical and mental health and academic competence of children.” The federal nutrition programs include the Supplemental Nutrition Assistance Program (SNAP); Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); child care meals; school meals; afterschool snacks and meals; and summer food.

Not only are these programs proven, effective ways to help struggling families access needed nutrition, the programs also draw millions of federal dollars into communities. Overall, research shows that these programs:

- Reduce food insecurity;
- Improve health outcomes;
- Improve academic achievement and early childhood development;
- Encourage healthier eating;
- Increase family economic security; and
- Stimulate the local economy.

More information on the health and economic benefits of these programs is available on [FRAC's 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, schools, or nonprofits. Many of the programs can serve all those in need who qualify — they are entitlement programs without quotas on the number of people who can be served:

Supplemental Nutrition Assistance Program (SNAP)	Age of Patient	How It Works	Who Can Apply
	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 \$31 for the week – or about \$1.47 per person, per meal	Gross income typically at 130% of the federal poverty level but can be higher in some states Asset tests may apply in some states Many low-income employed individuals

The ***Supplemental Nutrition Assistance Program (SNAP)***, previously known as food stamps, is the largest federal nutrition program. SNAP benefits are loaded onto an Electronic Benefit Transfer (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 need. 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 82 percent of all benefits go to households with a child, a senior, or a person with a disability.

National School Lunch Program and School Breakfast Program	Age of Patient	How It Works	Who Can Apply
	Children K-12 	Free, reduced-priced, or paid school meals in participating schools Updated meal patterns feature more whole grains, 0 grams of trans fat per portion, appropriate calories by age, more fruit, and reduction of sodium	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

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 healthy nutrition standards. Recent changes in the law allow high-poverty schools to offer all students free breakfast and lunch, which has a very positive impact on those schools and students.

- The ***School Breakfast 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 in the United States 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.

Child and Adult Care Food Program (CACFP)	Age of Patient	How It Works	Who Can Apply
	Typically, children up to age five 	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 Updated nutrition standards in 2016 means healthier meals	Children attending eligible child care centers and homes; Head Start; and Early Head Start

The **Child and Adult Care Food Program (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 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 domestic violence and homeless shelters.

Afterschool Nutrition Programs	Age of Patient	How It Works	Who Can Apply
	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

The **Afterschool Nutrition Programs** provide federal funding to school-based, agency-based, and community-based programs operating in low-income areas after school, on weekends, and during school holidays to serve meals and snacks to youth 18 years of age and under. The free nutritious snacks and meals help draw children and adolescents to programs that provide a safe place for them to be engaged and to learn.

Summer Nutrition Programs	Age of Patient	How It Works	Who Can Apply
	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 No need to show identification

The **Summer Nutrition Programs** provide meals to children 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. This ensures that children who receive school meals during the school year receive continued good nutrition over the summer. 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 their funding is capped. This means that once allocated funds are depleted, the program cannot serve more participants. These programs include the following:

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Age of Patient	How It Works	Who Can Apply
	Pregnant, postpartum, and breastfeeding women; infants; children up to age five	Nutritionally tailored monthly food packages (worth approximately \$50/month) 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 infants and children up to age five deemed nutritionally at risk by a health care professional Income eligibility typically at or below 185% of the federal poverty level Families on Medicaid

The ***Special Supplemental Nutrition Program for Women, Infants, and Children (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 the age of five 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.

Fresh Fruit and Vegetable Program (FFVP)	Age of Patient	How It Works	Who Can Apply
	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

The ***Fresh Fruit and Vegetable Program (FFVP)*** provides federal funding to elementary schools with large 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.

The Emergency Food Assistance Program (TEFAP)	Age of Patient	How It Works	Who Can Apply
	All ages 	Emergency food distributed to local partners that may include pantries, schools, faith-based groups, etc. Many food items are shelf-stable U.S. commodities, but many food banks commit to distributing more fresh produce	Access depends on site requirements; some sites require referrals

The Emergency Food Assistance Program (TEFAP) supplements the diets of low-income individuals by providing free emergency food. States provide the food 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.

For program eligibility at a glance, review the [Federal Nutrition Program 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.

Interventions to Address Food Insecurity



Whether you are a health care provider at a hospital or a small practice, in a large city or a rural area, there are effective interventions health care providers like you are using across the country to address food insecurity. Pediatric medical teams can intervene on four fronts:

- Administer appropriate medical interventions for the patient per your protocols.
- Connect patients and their families to the federal nutrition programs and other food resources.
- Document and track interventions in the patient's medical record. See page 17 for more information.
- Support advocacy and education efforts to end childhood food insecurity, and that promote the nutrition, well-being, and economic security of low-income families. See page 36 for more information.

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.

Support advocacy and educational efforts to end childhood food insecurity.



Administer Appropriate Medical Interventions for the Patient per Your Protocols

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



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

The following steps will help pediatric practices connect patients and their families 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 — SNAP, WIC, school meals, child care meals, and out-of-school time meals — and how to access these programs in your community. Referring patients to the federal nutrition programs is the AAP-recommended intervention for addressing food insecurity. Most of these programs — with the primary exception of WIC — have no caps on funding, so they are available to anyone who satisfies program eligibility.

Connecting patients to emergency food sources, such as food banks and food pantries (also known as food shelves), is also a viable option, especially for addressing immediate needs. However, emergency food sites may not be available in your area, have limited hours of operation and food options, or have limits on the amount of food they 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.

Become familiar with the [Federal Nutrition Program 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.



Tips:

Almost every state has an anti-hunger group that serves as the go-to organization on 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.

Anti-hunger organizations can help educate your team by:

- Providing information on your state’s use of federal nutrition programs targeted to children and families;
- Explaining how to manage common barriers and challenges to accessing federal nutrition programs and emergency food resources in your community and state;
- Training medical staff on federal nutrition resources and local policies and procedures;
- Localizing the [Federal Nutrition Program and Emergency Food Referral Chart](#); and
- Providing data on the extent of food insecurity and food hardship in your area.

In addition to anti-hunger organizations, other groups are available to help you get started. Consider contacting your local food bank, community action agency, or social service organizations.

“ 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”

STEP 2

Decide who in your practice can help connect patients and their families to nutrition programs and food assistance and where 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 in-patient 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.

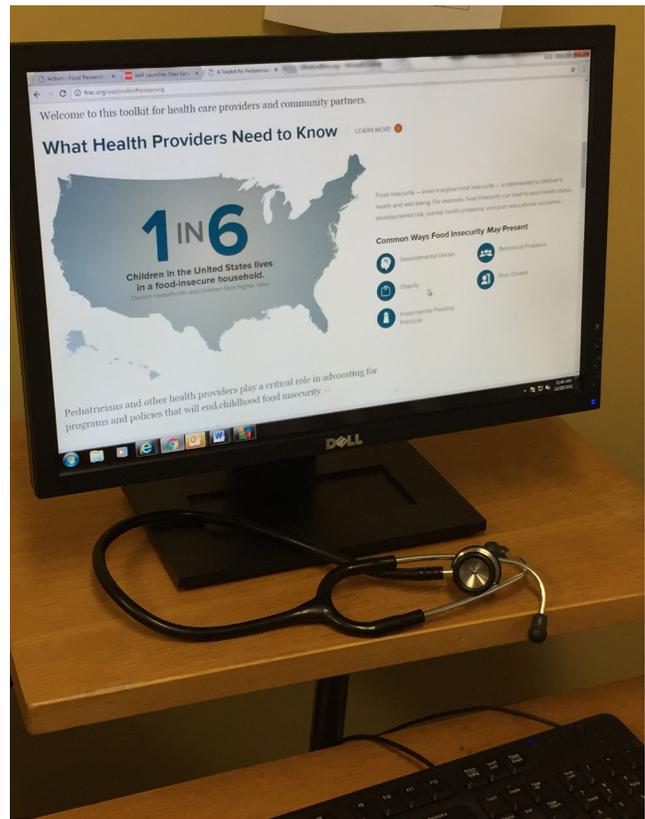
However, not every practice will be able to devote sufficient internal staff time to individually screen and connect all patients on site to the range of available nutrition and emergency food programs, especially those additional interventions identified in Step 4 (see page 32). As such, there are different ways 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. Case studies in [Boston](#) and [Minneapolis](#) as well as [best practices](#) are available from Children’s HealthWatch.

Developing Internal Capacity

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

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





Activities:

There are multiple ways that your practice can promote and connect patients and their families to nutrition programs and food resources. Many of these responsibilities do not require much staffing time and can be easily integrated into existing job responsibilities, 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 you won't be able to do everything. Determine what is most important for your patients/families and most feasible for your practice. Practices can:

- Promote the nutrition programs and “[prescribe](#)” them to patients;
- Screen patients for SNAP and, when indicated, provide application assistance to eligible patients;
- Screen patients to determine eligibility for child nutrition and other food programs (e.g., WIC; 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 related to referrals and applications into existing health records;
- Manage community partnerships;
- Provide referrals to community partners;
- Post positive messaging (see page 31);
- Update nutrition program and emergency food referral information; and
- Follow up with families after a community referral has been made to determine completion and outcomes.



Tips:

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;
- In states where [applications for SNAP](#) are online (42 states currently have applications online for SNAP);
- Out-patient or in-patient settings where designated staff already are helping people apply for Medicaid or other social safety net programs; and
- States where individuals can apply for both SNAP and Medicaid through an online application. (Note: Applying to SNAP in addition to Medicaid typically requires that an applicant answer a few more questions related to housing and utility costs that are not required for Medicaid but are required for SNAP. Additionally, even if a patient does not have the information to complete these fields on the application, the state agency should still process the combined application for benefits and send the client notice of any necessary steps required to complete the application for SNAP.)

Developing Community Partnerships

Partnering with a range of community partners can enhance a practice's ability to help patients and their families connect to nutrition and food resources and, in some cases, provide families 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-Links, 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.



Activities:

Sample partnerships include:

- Sending a community organization the names of interested patients who consent to be screened for federal nutrition and food resources so that the organization can reach out and call them;
- Referring patients to the help line of a local partner who can identify nutrition resources tailored to the family's needs;
- Giving patients a "*prescription*" to apply for SNAP at a partner organization; and
- Finding a local group who 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. Community partners 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, free summer meals, and afterschool meals. In some instances, community partners may support additional interventions (see page 32) when the health care site does not have sufficient internal capacity to staff these efforts.



Activities:

Sample partnerships include:

- Inviting a partner to come into the practice to provide one-on-one application assistance for SNAP and promote available nutrition programs like WIC, school meals, CACFP, and summer and after school meals;
- 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.



Tips:

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 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? What HIPAA concerns need to be addressed?

STEP 3

Post information on federal nutrition programs in your waiting room 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. The messaging also can reinforce how the programs benefit nutrition, health, and well-being.

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](#)



Tips:

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.

STEP 4

Assess the capacity of your practice to implement other strategies to address food insecurity.



Connecting families to federal nutrition and existing emergency food programs is the critical first step to address food insecurity. However, not every patient will be eligible for programs like SNAP and WIC, and benefits for these programs are not issued in a single day. Additionally, many families already are benefitting from SNAP, but may run out of benefits before the end of the month. Others may not be able to locate an emergency food site or may already be receiving WIC or summer meals.

AAP encourages you to pursue advocacy opportunities to strengthen these evidence-based nutrition programs, but at the practice level, some providers are exploring additional interventions aimed at providing on-site assistance (see chart on page 33).



Tips:

When deciding whether you can pursue any of these additional interventions, ask your practice team:

- Is the practice maximizing opportunities to ensure that eligible patients and families are connected to the federal nutrition programs?
- How many patients will the intervention reach?
- What is the nutritional quality of the food?
- How can the model be sustained over time?
- Can we evaluate the intervention?

How Health Care Systems Are Connecting Patients to Food and Nutrition Services

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 when someone screens positive for food insecurity. 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 chart briefly describes the most common interventions to support patients struggling with food insecurity.

Program	Pros	Cons
<p>Supplemental Nutrition Assistance Program: 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</p>	<p>Benefits are 100 percent federally funded and are available for all who qualify</p> <p>SNAP is effective in reducing food insecurity and improving health outcomes</p> <p>Available in every state and the District of Columbia</p>	<p>Not every patient will be eligible for programs like SNAP</p> <p>Benefits for these programs are not issued in a single day</p> <p>Many families already are benefitting from SNAP, but may run out of benefits before the end of the month</p>
<p>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. For more information on how to connect patients to these programs, visit: http://www.frac.org/aaptoolkit</p>	<p>All programs – with the exception of WIC – are entitlement programs so they can serve all eligible children without the need for additional federal appropriations</p> <p>Programs not only reduce food insecurity, but also improve academic achievement, early childhood development, and encourage healthier eating</p>	<p>Patients may not meet age requirements</p> <p>May be limited availability of summer or afterschool meals sites in some communities</p>
<p>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 for which patients get free food items and how often varies</p>	<p>Responds to immediate need</p> <p>Supplements food available from the federal nutrition programs</p> <p>Supports nutrition needs of food-insecure households who 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 five and older)</p>	<p>Requires funding</p> <p>Reach may be limited</p> <p>Model not sustainable unless ongoing funding is secured</p> <p>Space constraints</p> <p>Staff time needed</p> <p>Food in the food shelf or grocery bags may not be tailored to nutrition needs of patients</p> <p>Doesn't build on programs (e.g., SNAP and WIC) that integrate food insecure families into normal commercial channels</p>
<p>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</p>		
<p>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</p>		

Program	Pros	Cons
<p>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 of age and under ready 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</p>	<p>Sustainable federal funding available to cover meal costs and some administrative costs</p> <p>Supports children’s nutritional needs</p> <p>Can partner with in-house food services or community partner to implement model</p> <p>Can serve children in the surrounding community</p>	<p>Need dedicated staff (or volunteers) to run meal program</p> <p>Need space to serve meals in a group setting</p> <p>Free meals not provided for parents</p> <p>Not all medical practices will be located in low-income areas eligible for participation in program</p>
<p>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 of age and under. 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</p>	<p>Sustainable federal funding available to cover meal costs and some administrative costs</p> <p>Supports children’s nutritional needs</p> <p>Can partner with in-house food services or community partner to implement model</p> <p>Can serve children in the surrounding community</p> <p>Children benefit from enrichment activities</p> <p>Can reach children on weekends and during school holidays, as well as after school</p>	<p>Need dedicated staff (or volunteers) to run meal program and enrichment activities</p> <p>Need space to serve meals in a group setting</p> <p>Free meals not provided for parents</p> <p>Not all medical practices will be located in low-income areas eligible for participation in the program</p>
<p>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</p>	<p>Integrated into the hospital services and some staffing costs may be covered</p> <p>Existing personnel can help staff the clinic</p> <p>Dietitian on hand to help connect patients to appropriate food selections based on existing medical conditions</p> <p>Connects patients to SNAP, WIC, and other nutrition resources</p> <p>Nutrition services included in patient’s medical records</p>	<p>Requires additional funding</p> <p>Requires partnership with food bank or funding to secure food for pharmacy</p> <p>Requires dedicated space</p> <p>Cannot serve every patient who screens positive for food insecurity</p>

Program	Pros	Cons
<p>Veggie Prescription Programs: Typically, the Veggie Rx program provides 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 onsite, 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</p>	<p>Increases fruit and vegetable consumption</p> <p>Improves health outcomes and shopping habits of participants (as noted in some models’ evaluations)</p> <p>Integrated into medical practice</p> <p>Uses normal commercial channels</p>	<p>Requires additional funding, and is challenging to sustain</p> <p>Can only reach a small number of patients</p> <p>Need proximity to participating farmers’ markets, grocery stores, or both</p>
<p>Farmers’ Market: Across the country, more health practices and hospitals are bringing farmers’ markets on-site so patients and staff can access healthy, local food. This model can support families facing food insecurity if the market is able to accept SNAP benefits, accept WIC cash value vouchers, and participates in the federal WIC Farmers’ Market Nutrition Program (FMNP)</p>	<p>Provides access to local produce</p> <p>Can accept federal nutrition program benefits</p> <p>May offer nutrition education at the market</p>	<p>Limited reach for addressing food insecurity</p> <p>Families may have already exhausted SNAP and WIC monthly benefits</p> <p>WIC FMNP coupons only available to members of WIC households and members receive less than \$25 in vouchers per year</p> <p>Not all states participate in WIC FMNP, and WIC is only available for pregnant and postpartum women and children under five years of age</p>

Support Advocacy and Educational Efforts to End Childhood Food Insecurity

Whether at the federal, state, or local level, pediatricians have long advocated to improve the food security, nutrition, and health of children by strengthening the federal nutrition programs — including the Supplemental Nutrition Assistance Program (SNAP); Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); child care meals; school meals; afterschool snacks and meals; and summer food.

Advocacy Actions

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

- Informing stakeholders and decision-makers of the extent of food insecurity in the U.S. and its harmful consequences to child health and well-being;
- Sharing 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” ([AAP Promoting Food Security for All Children](#));
- Championing policies that strengthen the federal child nutrition programs to further improve their quality and access; and
- Fighting back against harmful proposals (e.g., block grants) aimed at cutting the ability of the federal nutrition programs to reach millions of low-income families or to respond to increased need during an economic downturn or natural disaster.

Read how AAP members have already taken these important advocacy actions.

Download the full [Ten Advocacy Actions Pediatricians Can Take to Address Childhood Food Insecurity](#).

“Congress must act to improve SNAP by increasing benefit levels to align with the Low-Cost Food Budget to help families stave off food insecurity for the full month. It should also lift the cap on the shelter deduction so the program can take into consideration the needs of families with high housing costs.”

– *AAP Blue Print for Children: How the Next President Can Build a Foundation for a Healthy Future*

Ten Advocacy Actions Pediatricians Can Take to Address Childhood Food Insecurity

- 1) Write an Op-Ed or Letter to the Editor.
- 2) Meet, Brief, Call, Write, or Email Congressional Representatives.
- 3) Testify Before Congress in Support of Key Federal Nutrition Programs.
- 4) Take the SNAP Challenge.
- 5) Work with Your State AAP Chapter to Prioritize Food Insecurity.
- 6) Support State Legislation.
- 7) Push for State Appropriations.
- 8) Serve on a Hunger Task Force.
- 9) Testify Before a Local Body.
- 10) Educate the Next Generation of Doctors.

Learn More about AAP Opportunities



AAP offers multiple ways for pediatricians to get involved in advocacy efforts around food insecurity, including:

- Supporting AAP recommendations in the [Promoting Food Security for All Children](#) policy statement. The statement not only encourages pediatricians to screen and intervene to address food insecurity, but also to engage in advocacy and education;
- Visiting the [AAP Federal Advocacy](#) website, which includes information on child nutrition and food security; and
- Attending [AAP's Legislative Conference](#).

Learn More about FRAC Opportunities

FRAC offers multiple ways to get involved in anti-hunger and anti-poverty advocacy, including:

- Visiting [FRAC's Legislative Action Center](#) to learn more about priorities for Child Nutrition Reauthorization (CNR) and the reauthorization of SNAP through the Farm Bill;
- Exploring opportunities to work with state or local anti-hunger groups in your area;
- Signing up for [FRAC's electronic publications](#) to get the latest news, tools, and research on hunger and the federal nutrition programs; and
- Attending the [National Anti-Hunger Policy Conference](#).

Additional Resources for Pediatricians to Address Food Insecurity

[Federal Nutrition Programs and Emergency Food Referral](#) (Chart)

Free Healthy Food for Your Growing Child (Poster)

- [English](#)
- [Spanish](#)

[Prescription for Free Healthy Food](#) (Handout)

[Pediatricians Play a Critical Role in Protecting Children from Food Insecurity](#) (Infographic)

[Promoting Food Security for All Children](#) (AAP Policy Statement)

[Ten Advocacy Actions Pediatricians Can Take to Address Childhood Food Insecurity](#) (Handout)

[Who's Hungry? You Can't Tell By Looking](#) (Poster)

Children's HealthWatch Materials:

- [National Repository of Resources and Information on Screening for Food Insecurity](#)
- [Hunger Vital Sign™ Questions in English and Spanish](#)
- [The Hunger Vital Sign™: Best Practices for Screening and Intervening to Alleviate Food Insecurity](#)
- The Hunger Vital Sign™: [Boston Case Study](#) and [Minneapolis Case Study](#)



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