

Comfort With Sharing Food Insecurity Risk for Clinical Care Among Individuals With and Without a Cancer History: Findings From a National Survey



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Introduction: Food insecurity negatively affects timely access to care, treatment adherence, quality of life, and survival among cancer survivors. There is limited knowledge about cancer survivors' comfort with sharing food insecurity risk for clinical care on a national scale. This study aims to assess comfort with sharing food insecurity risk for clinical care among adults with and without a cancer history and to identify factors that may be associated with comfort for sharing food insecurity risk.

Methods: Data were obtained from the National Cancer Institute's Health Information National Trends Survey 6, which was administered from March 7, 2022, to November 8, 2022. Descriptive statistics were calculated to describe the study sample, and sample characteristics were compared by comfort with sharing food insecurity risk for clinical care. A multivariable logistic regression model was conducted to estimate the probability of comfort with sharing food insecurity risk for clinical care. Full-sample weights were applied to calculate population-level estimates, and jackknife replicate weights were applied to calculate SEs.

Results: The weighted sample included 188,146,395 participants (6.7% were cancer survivors). Overall, most cancer survivors (64.9%) and adults without a cancer history (58.7%) reported comfort with sharing food insecurity risk for clinical care. Controlling other factors, cancer survivors reported a similar comfort level with sharing food insecurity risk (OR=1.33; 95% CI=0.97, 1.80) compared to individuals without a cancer history. Controlling other factors, individuals reporting at or above the mean patient-centered communication (OR=1.52; 95% CI=1.24, 1.87) were more likely to report comfort with sharing food insecurity risk than individuals reporting below the mean patient-centered communication. Individuals experiencing food insecurity reported a similar comfort level with sharing food insecurity risk (OR=0.93; 95% CI=0.5, 1.31) compared to adults not experiencing food insecurity.

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Conclusions: Study findings suggest that screening for food insecurity risk may be acceptable to cancer survivors and that patient-centered communication may support participation in food insecurity screening. Future studies are needed to assess cancer survivors' preferences for sharing food insecurity risk for clinical care (what, when, where, and how data are shared) to ensure that implementation is aligned with patient preferences.

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INTRODUCTION

Food insecurity negatively affects healthcare quality, access, and outcomes among cancer survivors. Prior studies have shown that food insecurity can negatively affect timely access to care, treatment adherence, quality of life, and survival among cancer survivors.^{1–6} Given the important role food insecurity plays in cancer care delivery and outcomes, there has been growing recognition of the need to screen cancer survivors for food insecurity.^{7–10} Healthcare accreditation agencies, such as the Joint Commission, and healthcare payers, such as the Centers for Medicare and Medicaid Services, have introduced standards, payment models, and billing codes to incentivize screening for and addressing social risks, such as food insecurity, in healthcare settings.^{11–13} In response, cancer centers, community oncology practices, and other care settings (e.g., primary care) where cancer survivors receive care have started screening for social risks, including food insecurity.^{14,15} As implementation is unfolding, there is a need to obtain input from cancer survivors to inform the design of food insecurity screening programs.

Several studies have started to collect input from cancer survivors about social risk screening, including comfort with sharing social risk information to inform clinical care (e.g., changing a patients' chemotherapy regimen to require fewer in person visits due to transportation barriers).^{16,17} Two single-site pilot studies found that most cancer survivors surveyed felt comfortable sharing social risk information with their healthcare team.^{16,17} However, there has been limited study of the factors that may affect comfort level among cancer survivors. Studies outside of cancer care have noted important differences in comfort with sharing social risk information, such as food insecurity, on the basis of patient characteristics (e.g., race/ethnicity, sex, age) and healthcare system characteristics, such as patient-centered communication.^{18–20}

To build upon this research and address current gaps, this study aims to (1) assess comfort with sharing food insecurity risk for clinical care among adults with and without a cancer history and (2) identify factors that

may be associated with comfort with sharing food insecurity risk. Study findings could inform the ongoing implementation of social risk information collection in cancer care and other healthcare delivery settings.

METHODS

The National Cancer Institute (NCI)'s Health Information National Trends Survey (HINTS) collects nationally representative data on health behaviors from adults living in the U.S. Data were obtained from the HINTS 6, which was administered from March 7, 2022 to November 8, 2022. Sampling was stratified on the basis of census-tract level characteristics of respondents' address, including (1) urban versus rural area and (2) highminority versus low-minority area. Additional details regarding the sampling frame and survey methodology can be found in the NCI HINTS methodology report.²¹ The overall survey response rate was 27.7%.

Study Population

Of 6,252 survey participants, individuals were excluded ($n=891$) if they did not report having a healthcare visit in the past year ([Appendix File 1](#), available online). Individuals were also excluded if they had any missing data on the variables of interest (<5% for each variable) ([Appendix File 1](#), available online). The final unweighted sample size included 4,601 doors.

Measures

To guide variable selection, a directed acyclic graph was constructed using the DAGitty web application (Version 3.1) ([Figure 1](#)).²²

Food insecurity was the study's primary outcome. To measure comfort with sharing food insecurity risk for clinical care, the HINTS survey asks participants, *If you were experiencing one of the issues below, how comfortable would you be with your health care providers sharing information about these issues with each other for your treatment purposes?* The issues included affording or accessing healthy food, issues with transportation that make it difficult getting to work or medical appointments, and issues with housing (e.g., concerns about

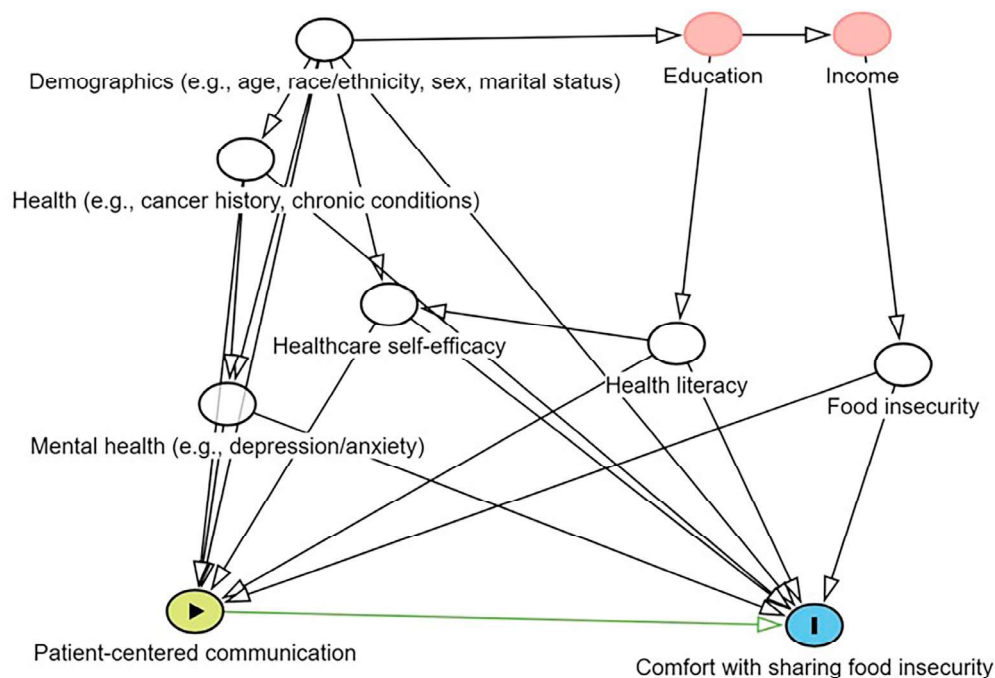


Figure 2. Directed acyclic graph of hypothesized relationship between patient-centered communication and comfort with sharing food insecurity risk.

eviction, making mortgage payments, lead paint or asbestos). The response options were very *comfortable*, *somewhat comfortable*, *somewhat uncomfortable*, and *very uncomfortable*. For ease of interpretation, 3 binary variables were created to classify whether patients were comfortable (very comfortable, somewhat comfortable) or uncomfortable (very uncomfortable, somewhat uncomfortable) with sharing information about (1) food insecurity, (2) transportation insecurity, and (3) housing insecurity. Although food insecurity is the primary outcome of interest, the authors report descriptive statistics on transportation and housing insecurity for the study sample to see how comfort level compares across the 3 social risks.

Potential explanatory variables were also measured. Cancer survivor status was defined as a self-reported history of cancer. The authors included individuals with all cancer types reported (e.g., nonmelanoma skin cancers) because the authors did not have a hypothesis that their perceptions about sharing food insecurity risk for clinical care would differ from individuals with other cancer types (e.g., breast cancer). Prior studies suggest that patient-centered communication may affect participation in social risk screening.^{18–20} Patient-centered communication is defined as communication that creates a shared understanding between providers and patients about how a patients' care can be aligned with their goals, values, and preferences.²³ Patient-centered

communication has been shown to affect cancer survivors' engagement with health care, such as their participation in medical decision making and use of technology (e.g., patient portals).^{24,25} Therefore, the authors hypothesize that patient-centered communication may be positively associated with comfort with sharing food insecurity risk. Patient-centered communication is measured using a 7-item scale on the basis of the Epstein and Street (2007) conceptual model of patient-centered communication.²³ Survey participants are asked about how frequently healthcare providers (1) *give you the chance to ask all the health-related questions you had*, (2) *give the attention you needed to your feelings and emotions*, (3) *involve you in decisions about your health care as much as you wanted*, (4) *make sure you understood the things you needed to do to take care of your health*, (5) *explain things in a way you could understand*, (6) *spend enough time with you*, and (7) *help you deal with feelings of uncertainty about your health or health care*. Participants rate each item on a scale of 1 (never) to 4 (always), and items are summed to produce an overall score. Prior research has demonstrated the reliability and validity of the NCI HINTS measure of patient-centered communication.²⁶ For ease of interpretation, the authors dichotomized patient-centered communication on the basis of whether a participants' score fell at or above the mean score or below the mean score.

Covariates were also considered. Past research has shown that patient characteristics may be associated with patients' willingness to participate in social risk screening and perceptions among patient-centered communication.^{27–29} To adjust for potential confounders, the following variables were included: age, sex, race/ethnicity, marital status, food insecurity, health literacy, self-reported history of anxiety or depression, multiple chronic conditions, and healthcare self-efficacy. Health literacy was defined on the basis of a survey item, *How confident are you filling out medical forms by yourself?* A binary variable was created on the basis of the 4 response options, including high literacy (very confident) and low literacy (somewhat, a little, or not at all confident). Healthcare self-efficacy was defined on the basis of a survey item asking participants, *Overall, how confident are you about your ability to take good care of your health?* A binary variable was created on the basis of the 5 response options, including high efficacy (e.g., completely or very confident) or low efficacy (somewhat, a little, or not at all confident). Multiple chronic conditions were selected on the basis of health conditions that are included in the NCI HINTS survey and defined as self-reported history of 2 or more of the following conditions: diabetes, high blood pressure, heart condition, or lung disease. Food insecurity was defined on the basis of self-report of anyone in the household cutting back on the size of meals, skipping meals, or not being able to afford balanced meals in the past year. The survey also measures transportation insecurity, which was defined on the basis of self-report of lack of reliable transportation that prevented anyone in the household from getting to work, getting to medical appointments, or getting things needed for daily living in the past year, and housing insecurity, which was defined on the basis of self-report of anyone in the household worrying about being forced to move (e.g., due to eviction or foreclosure) in the next year. The authors descriptively report outcomes on transportation and housing insecurity for the sample to establish how common food insecurity is relative to these other social risks but do not include transportation and housing insecurity in the analyses.

Statistical Analysis

Descriptive statistics were calculated to describe the study sample, and sample characteristics were compared by comfort with sharing food insecurity risk for clinical care using a Pearson's chi-square test. The authors also compared comfort with sharing food insecurity risk by cancer survivor status using a Pearson's chi-square test. A multivariable logistic regression model was conducted to estimate the probability of comfort with sharing food insecurity risk for clinical care. The authors conducted a

sensitivity analysis to see whether model results were sensitive to coding patient-centered communication as a binary variable by running an additional model where patient-centered communication was coded as a continuous variable ([Appendix File 2](#), available online). Because the results were the same, the authors report the model with patient-centered communication coded as a binary variable for ease of interpretation. Full-sample weights were applied to calculate population-level estimates, and jackknife replicate weights were applied to calculate SEs on the basis of NCI HINTS guidance.²¹ All statistical tests were 2 sided. A $p < 0.05$ was used as the cut off for statistical significance. Results are reported using AORs and 95% CIs. The study was deemed exempt by the University of North Carolina at Chapel Hill IRB. The study is reported in accordance with the STROBE statement.³⁰

RESULTS

Overall, the weighted sample included 188,146,395 participants ([Table 1](#)). Approximately 6.9% of participants reported a history of cancer. About half of participants were female (53.5%). The age distribution of the sample was 18–34 years (23.8%), 35–49 years (25.4%), 50–64 years (28.9%), 65–74 years (13.7%), and ≥ 75 years (8.2%). Most participants identified as non-Hispanic White (65.1%), followed by non-Hispanic Black (11.0%), Hispanic/Latino (14.4%), and non-Hispanic additional racial categories (9.5%). In the past year, 18.9% of participants reported experiencing food insecurity. Participants were less likely to report transportation insecurity (12.2%) or housing insecurity (10.7%).

Most participants (59.1%) reported being comfortable with sharing food insecurity risk for clinical care. Results were similar for comfort with sharing housing insecurity risk (57.1%) and transportation insecurity risk (62.3%). Participants who reported high healthcare self-efficacy were more likely to report comfort with sharing food insecurity risk than participants who reported low healthcare self-efficacy (72.5% vs 27.5%, $p = 0.01$). Participants who had a patient-centered communication score at or above the mean were more likely to report comfort with sharing information about food insecurity than participants who had a patient-centered communication score below the mean (58.7% vs 41.2%; $p < 0.001$).

Comfort with sharing food insecurity risk for clinical care was similar for cancer survivors and adults without a cancer history ([Table 2](#)). Overall, 64.9% of cancer survivors reported comfort with sharing food insecurity risk for clinical care compared with 58.7% of adults without a cancer history ($p = 0.06$). About a third of cancer survivors (35.1%) reported being very comfortable

Table 1. Sample Characteristics

Characteristics	Total sample ^a	Comfort with sharing food insecurity risk: yes	Comfort with sharing food insecurity risk: no	p-value
<i>n</i>	188,146,395 (100%)	111,192,429 (59.1%)	76,953,966 (40.9%)	
Age, years, <i>n</i> (%)				
18–34	44,853,829 (23.8%)	27,149,514 (24.4%)	17,704,315 (23.0%)	0.25
35–49	47,821,839 (25.4%)	27,735,975 (24.9%)	20,085,864 (26.1%)	
50–64	54,293,592 (28.9%)	30,475,278 (27.4%)	23,818,314 (31.0%)	
65–74	25,755,123 (13.7%)	15,448,532 (13.9%)	10,306,591 (13.4%)	
≥75	15,422,013 (8.2%)	10,383,130 (9.3%)	5,038,883 (6.5%)	
Sex, <i>n</i> (%)				
Male	87,477,304 (46.5%)	50,655,822 (45.6%)	36,821,482 (47.8%)	0.34
Female	100,669,091 (53.5%)	60,536,607 (54.4%)	40,132,484 (52.2%)	
Race/ethnicity, <i>n</i> (%)				
Non-Hispanic White	122,490,177 (65.1%)	71,682,121 (64.5%)	50,808,055 (66.0%)	0.93
Non-Hispanic Black	20,774,623 (11.0%)	12,461,764 (11.2%)	8,312,858 (10.8%)	
Hispanic/Latino	27,027,132 (14.4%)	16,287,741 (14.6%)	10,739,391 (14.0%)	
Other	17,854,464 (9.5%)	10,760,803 (9.7%)	7,093,661 (9.2%)	
Married or living with partner, <i>n</i> (%)				
No	78,894,786 (41.9%)	47,522,175 (42.7%)	31,372,611 (40.7%)	0.49
Yes	109,251,609 (58.1%)	63,670,254 (57.3%)	45,581,355 (59.2%)	
Health literacy, <i>n</i> (%)				
Low	25,624,691 (13.6%)	13,544,850 (12.2%)	12,079,842 (15.7%)	0.05
High	162,521,704 (86.4%)	97,647,580 (87.8%)	64,874,124 (84.3%)	
Food insecurity, <i>n</i> (%)				
No	152,566,761 (81.1%)	91,474,217 (82.2%)	61,092,544 (79.3%)	0.27
Yes	35,579,634 (18.9%)	19,718,212 (17.7%)	15,861,422 (20.6%)	
Cancer survivor, <i>n</i> (%)				
No	175,153,775 (93.1%)	102,760,147 (92.4%)	72,393,627 (94.1%)	0.06
Yes	12,992,620 (6.9%)	8,432,282 (7.6%)	4,560,339 (5.9%)	
Multiple chronic conditions, <i>n</i> (%)				
No	148,819,518 (79.1%)	89,517,520 (80.5%)	59,301,998 (77.1%)	0.08
Yes	39,326,877 (20.9%)	21,674,909 (19.5%)	17,651,968 (22.9%)	
Depression or anxiety, <i>n</i> (%)				
No	130,032,282 (69.1%)	77,190,083 (69.4%)	52,842,199 (68.6%)	0.77
Yes	58,114,113 (30.9%)	34,002,346 (30.6%)	24,111,767 (31.3%)	
Healthcare self-efficacy, <i>n</i> (%)				
Low	57,382,155 (30.5)	30,608,750 (27.5%)	26,773,405 (34.8%)	0.01
High	130,764,240 (69.5)	80,583,679 (72.5%)	50,180,561 (65.2%)	
Patient-centered communication score, mean (SD)				
Score below the mean, <i>n</i> (%)	86,430,267 (45.9%)	45,861,520 (41.2%)	40,568,747 (52.7%)	<0.001
Score at or above the mean, <i>n</i> (%)	101,716,128 (54.1%)	65,330,909 (58.7%)	36,385,219 (47.3%)	

^aSample and replicate weights were used to account for the complex survey design in variance estimation and to produce population-level estimates in accordance with the NCI data analysis recommendations for the HINTS.

^bSample characteristics were compared by comfort with data sharing about food insecurity using the Pearson's chi-square test. HINTS, Health Information National Trends Survey; NCI, National Cancer Institute.

Table 2. Comfort With Sharing Food Insecurity Risk for Clinical Care

Participants' comfort level	Total sample (weighted N=188,146,395) ^a	Cancer survivor: yes (weighted n=12,992,620) ^b	Cancer survivor: no (weighted n= 175,153,775)	p-value
Comfort with sharing, binary, n (%)				
No	76,953,966 (40.9%)	4,560,339 (35.1%)	72,393,627 (41.3%)	0.06
Yes	111,192,429 (59.1%)	8,432,282 (64.9%)	102,760,147 (58.7%)	
Comfort with sharing by level, n (%)				
Very comfortable	55,138,360 (29.3%)	4,562,526 (35.1%)	50,575,835 (28.9%)	0.10
Somewhat comfortable	56,054,069 (29.8%)	3,869,756 (29.8%)	52,184,312 (29.8%)	
Somewhat uncomfortable	40,904,193 (21.7%)	2,546,749 (19.6%)	38,357,444 (21.9%)	
Very uncomfortable	36,049,773 (19.2%)	2,013,589 (15.5%)	34,036,183 (19.4%)	

^aSample and replicate weights were used to account for the complex survey design in variance estimation and to produce population-level estimates in accordance with the NCI data analysis recommendations for the HINTS.

^bComfort with sharing food insecurity risk was compared by cancer survivor status using the Pearson's chi-square test. HINTS, Health Information National Trends Survey; NCI, National Cancer Institute.⁴⁹

with sharing food insecurity risk compared with adults without a cancer history (28.9%) ($p=0.10$) (Table 2). About a third of cancer survivors (29.8%) reported being somewhat comfortable, 19.6% reported being somewhat uncomfortable, and 15.5% reported being very uncomfortable, a distribution similar to that of adults without a cancer history (Table 2).

Controlling other factors, cancer survivors had odds of comfort with sharing food insecurity risk (OR=1.33; 95% CI=0.97, 1.80) similar to those of adults without a cancer history. Individuals experiencing food insecurity had odds of comfort with sharing food insecurity risk (OR=0.93; 95% CI=0.5, 1.31) similar to those of adults not experiencing food insecurity. Controlling other factors, individuals reporting at or above the mean patient-centered communication (OR=1.52; 95% CI=1.24, 1.87) were more likely to report comfort with sharing food insecurity risk than individuals reporting below the mean patient-centered communication. Controlling other factors, adults aged >75 years (OR=1.51; 95% CI=1.04, 2.20) were more likely to report comfort with sharing food insecurity risk than individuals aged 18–34 years. Controlling other factors, race/ethnicity, sex, marital status, health literacy, depression/anxiety, multiple chronic conditions, and healthcare self-efficacy were not associated with comfort with sharing food insecurity risk (Table 3).

DISCUSSION

The goal of this study was to assess comfort with sharing food insecurity risk for clinical care among adults with and without a cancer history and to identify factors that may be associated with comfort with sharing food insecurity on a national scale. Overall, most cancer survivors and individuals without a cancer history reported being

comfortable with sharing food insecurity risk for clinical care, and differences were not observed on the basis of cancer history. The authors also observed that individuals experiencing food insecurity reported being comfortable with sharing food insecurity risk, an important consideration when designing future social risk screening programs. Contrary to prior studies that have identified nonmodifiable factors (e.g., race/ethnicity) as determinants of comfort with social risk screening, this study's findings suggest that key determinants may be modifiable factors, such as patient-centered communication.

This study's findings suggest that cancer survivors are comfortable with sharing food insecurity risk for clinical care. This adds to the growing literature that screening for social risks, such as food insecurity, in cancer settings may be acceptable to cancer survivors.^{16,17} Additional work is needed to test social risk screening assessments in cancer care. The National Academies of Sciences, Engineering, and Medicine has advanced a framework for integrating social care into healthcare delivery that recommends 5 strategies: awareness, adjustment, assistance, alignment, and advocacy.³¹ Screening for food insecurity falls within the first strategy and requires the use of standardized tools, ensuring that implementation is consistent with patient preferences and needs (e.g., referring patients to resources if they indicate a preference for referral) and electronic health record documentation.⁹ There are several screening tools and frameworks that include food insecurity that have been developed to guide healthcare systems with collecting social risk information. Common screening tools that are used include the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences; the Accountable Health Communities Screening Tool; and the Health Leads Toolkit.^{32–34} Currently, no cancer-specific tools exist,

Table 3. Factors Associated With Comfort With Data Sharing About Food Insecurity

Participant characteristics	Total sample N=188,146,395		
	AOR ^a	95% CI	p-value
Age, years			
18–34 (ref) ^b			
35–49	0.93	(0.61, 1.40)	0.73
50–64	0.85	(0.61, 1.19)	0.34
65–74	1.00	(0.70, 1.43)	0.95
≥75	1.51	(1.04, 2.20)	0.03
Sex			
Male (ref)			
Female	1.06	(0.86, 1.31)	0.55
Race/ethnicity			
Non-Hispanic White (ref)			
Non-Hispanic Black	1.11	(0.81, 1.53)	0.48
Hispanic/Latino	1.15	(0.86, 1.55)	0.32
Other	1.17	(0.77, 1.76)	0.43
Married or living with partner			
No (ref)			
Yes	0.89	(0.71, 1.12)	0.34
Health literacy			
Low (ref)			
High	1.22	(0.89, 1.68)	0.20
Food insecurity			
No (ref)			
Yes	0.93	(0.65, 1.31)	0.67
Cancer survivor			
No (ref)			
Yes	1.33	(0.97, 1.80)	0.06
Multiple chronic conditions			
No (ref)			
Yes	0.77	(0.59, 1.02)	0.06
Depression or anxiety			
No (ref)			
Yes	1.06	(0.82, 1.38)	0.62
Healthcare self-efficacy			
Low (ref)			
High	1.23	(0.95, 1.60)	0.10
Patient-centered communication score			
Score below the mean (ref)			
Score at or above the mean	1.52	(1.24, 1.87)	<0.001
Constant	0.87	(0.53, 1.41)	0.57

^aSample and replicate weights were used to account for the complex survey design in variance estimation and to produce population-level estimates in accordance with the NCI data analysis recommendations for the HINTS. Weighted sample size N=188,146,395.

^bref refers to the reference group for the calculation of the OR. HINTS, Health Information National Trends Survey; NCI, National Cancer Institute.

which may be useful given the important role nutrition plays in cancer treatment and outcomes.^{1–6}

In addition to increased testing of screening tools, additional research is needed to determine best practices for implementation, such as how to design programs to ensure consistency with patient preferences and how to educate patients on data collection (e.g., what data are being collected, how they are being used, who they are being shared with). Prior research has shown that trust in data systems (e.g., health information exchange) is influenced by complex factors, such as attitudes toward privacy and confidentiality, perceived usefulness of the data, and customizable design features (e.g., can patient control what data are shared with whom?).^{35–38} Future studies should test consent strategies to determine the ideal way of making patients aware of social risk data collection and its purpose, such as a dynamic consent model, which allows patients to consent electronically, track how their information is being used, and make modifications to their initial consent.^{39–42} Given the long-term consequences of cancer (e.g., prolonged financial hardship), there is also a need to determine how often cancer survivors should be screened for food insecurity and where screening should be integrated within the survivorship continuum (e.g., acute survivorship versus extended survivorship).⁴³

This study's findings suggest that patient-centered communication may be associated with greater comfort with sharing food insecurity risk in clinical settings. These findings are consistent with past research that suggests that patient–provider communication may improve patients' willingness to share data in clinical settings.^{18,20,44,45} Future studies could test patient-centered communication training among healthcare team members who are designated to assist with and respond to food insecurity risk assessment. Prior research has shown that patient-centered communication training can lead to improvements in patient–provider communication in oncology.⁴⁶ Additional qualitative research is also needed to explore cancer survivors' preferences for how food insecurity discussions should be facilitated (e.g., what member of the care team should facilitate the conversation, would they prefer data to be collected in person by a care team member or electronically?). Studies outside of cancer care suggest that patients may prefer social risk discussions to be led by social workers, patient navigators, or nurses over other members of the care team.²⁹ Studies have also tested innovative methods, such as the use of social robots, to facilitate data

collection for patients who may need assistance with data completion in healthcare settings where staff are overburdened and may not have time to assist patients.⁴⁷ Research is needed on strategies for facilitating communication and data collection for social risk assessment among cancer survivors.

Limitations

The study has several limitations. First, the survey does not capture actual data-sharing patterns; therefore, it is not possible to determine whether comfort with sharing food insecurity risk is associated with the actual sharing of data. Prior studies suggest that patient comfort with data sharing is associated with data sharing with clinicians, suggesting that comfort with data sharing may be an appropriate proxy for actual data sharing.⁴⁸ Second, the survey items measuring comfort with sharing food insecurity risk were collected at a single time point, precluding the ability to track changes in patient comfort over time due to the increasing implementation of social risk screening. Future longitudinal studies should examine comfort with sharing food insecurity and other social risk information over time. Third, the survey does not capture information about other social risks, such as employment insecurity or immigration support. Future studies are needed to explore patients' comfort level with sharing other social risks to determine whether some data elements are viewed as more sensitive than others. In this study, participants reported similar levels of comfort with sharing food insecurity risk, housing insecurity risk, and transportation security risk. Fourth, the survey does not capture the modality of information sharing (e.g., in person, electronic, verbally collected by clinician). Given that modality may affect comfort level, future studies are needed to assess patient preferences for social risk data collection. Fifth, the survey does not include enough non-English-speaking adults to assess how language preference may affect comfort. Future studies are needed in this area. Despite these limitations, this study is the first, to the authors' knowledge, to use NCI HINTS questions on social risks to explore comfort with information sharing among cancer survivors. This information can guide future interventions designed to implement social risk screening among cancer survivors.

CONCLUSIONS

Food insecurity plays a critical role in health and healthcare outcomes for cancer survivors. Despite its important role, food insecurity screening is not routinely implemented in cancer care. Findings from this study suggest that food insecurity screening may be acceptable among cancer survivors and that patient-centered

communication may affect acceptability. As healthcare systems increasingly adopt social risk screening, future studies are needed to test strategies to facilitate patient-centered communication about screening and to ensure that screening is implemented consistent with cancer survivors' preferences.

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SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at <https://doi.org/10.1016/j.focus.2025.100395>.

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