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RESEARCH ARTICLE

Understanding the Reasons Why Patients With Food Insecurity Decline Social Assistance at a Large Academic Medical Center

Alexander Connelley, BS,[1] Abigail Young, BA,[1] Jennifer T. Lee[2], Markell Miller, MPH,[3]
Eileen Spring, MA,[3] Wei Hao, PhD,[4] Julia A. Wolfson, PhD,[5,6] Alicia J. Cohen, MD,[7,8,9]
Minal R. Patel, PhD,[10] Cindy W. Leung, ScD[11]

Introduction: Despite the recent expansions of clinical screening for food insecurity, research shows large discrepancies between the number of patients who report food insecurity and those who request assistance. In this qualitative study of patients with food insecurity who declined social assistance, the authors aimed to understand the patients' reasons for not seeking food-related assistance and explore their perspectives on addressing food insecurity with their healthcare provider.

Methods: At a large academic medical center in southeast Michigan, the authors conducted semi-structured, in-depth interviews with 31 English-speaking adult primary care patients who had screened positive for food insecurity at a previous clinic encounter and subsequently declined assistance from a trained social worker. The interview guide explored patients' reasons for declining social assistance, perspectives on clinical screening for food insecurity and other social risk factors, and the extent to which they discussed their needs with their provider. Interviews were recorded, transcribed, and analyzed using the constant comparative method to reveal emergent themes.

Results: The mean age of the participants was 48.2 years, and 71% were women. The most prominent reasons for patients with food insecurity not seeking social assistance were the belief that the potential resources would be redundant or not helpful and previous negative experiences with receiving food assistance. Several patients also did not remember or know that they had declined assistance. Most patients believed that healthcare providers should be knowledgeable about patients' food insecurity status to better inform care delivery. However, patients expressed discomfort, fear, or embarrassment in revealing this information and emphasized the importance of providers fostering a supportive and empathetic healthcare environment.

From the [1]Undergraduate Education in Public Health, School of Public Health, University of Michigan, Ann Arbor, Michigan; [2]Department of Nutritional Sciences, School of Public Health, University of Michigan, Ann Arbor, Michigan; [3]Food Gatherers, Ann Arbor, Michigan; [4]Department of Biostatistics, School of Public Health, University of Michigan, Ann Arbor, Michigan; [5]Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; [6]Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; [7]Center for Innovation in Long Term Services and Supports, VA Providence Healthcare System, Providence, Rhode Island; [8]Department of Family Medicine, Alpert Medical School of Brown University, Providence, Rhode Island; [9]Department of Health Services, Policy, and Practice, Brown University School of Public Health, Providence, Rhode Island; [10]Department of Health Behavior and Health Education, School of Public Health, University of Michigan, Ann Arbor, Michigan; and [11]Department of Nutrition, Harvard T.H. Chan School of Public Health, Boston, Massachusetts

Address correspondence to: Cindy W. Leung, ScD, Department of Nutrition, Harvard T.H. Chan School of Public Health, 665 Huntington Avenue, Building 2, Room 321, Boston MA 02115. E-mail: cindyleung@post.harvard.edu.

2773-0654/$36.00
https://doi.org/10.1016/j.focus.2025.100320

Conclusions: Strategies to connect patients with food assistance must target multiple levels, including improving assistance methods, increasing provider knowledge, and prioritizing patient comfort.

AJPM Focus 2025;4(2):100320.

INTRODUCTION

Food insecurity is an important social risk factor that affects 1 in 8 U.S. families.[1] Food insecurity is associated with numerous adverse health outcomes[2,3]; however, the experience of food insecurity may not always be obvious. For this reason, many healthcare systems have adopted efforts recommended by medical, public health, and antihunger organizations to universally screen for and address food insecurity within their patient populations.[4−7] Previous studies have shown that screening for social risk factors, such as food insecurity, is highly acceptable and perceived as important by both patients and providers.[8−11] For example, a recent qualitative study in San Francisco found that adult primary care patients appreciated the health-related social needs screening tool as an opportunity to connect patients to local resources.[12] In another study conducted in Southern California, 85% of patients agreed that their health system should ask about social needs, and 88% believed that their health system should address social needs.[13] Although many prior studies have focused broadly on multiple social risk factors, including housing instability, transportation barriers, and lack of social support, fewer studies have focused on food insecurity as the primary social risk factor.[14]

Despite the substantial expansion of screening for food insecurity in clinical practice settings, current research shows large discrepancies between the number of patients who report social risk factors (such as food insecurity) at screening, the number who show interest in receiving social assistance, and an even smaller number who eventually engage with community assistance efforts.[15−19] Several of these studies have been conducted among parents or caregivers of pediatric patients.[20−23] For example, in one pediatrics study, 21% of caregivers reported food insecurity, of whom 75% expressed interest in food referrals, but only 14% connected with food assistance.[19] The number of patients lost at each step raises concerns, particularly when considering that effective interventions to address unmet social needs can lead to measurable improvements in health and well-being.[24,25] Qualitative exploration of why patients decline social assistance has yielded various results ranging from the perception that their needs were not as severe as the needs of others,[26] to beliefs that their social needs could not be alleviated through the healthcare system,[21] and to concern that the provider−patient relationship will be harmed.[27] Although research continues to fill this gap, several previous studies have focused on populations with special needs, including families of pediatric patients[28,29] and patients with chronic diseases,[30−32] or have been broadly inclusive of all unmet social needs.[19,33−35]

Food insecurity is an trivial social risk factor that can be directly targeted by a vast network of community efforts (e.g., charitable food programs), nutrition assistance programs, and economic policies. Common clinical approaches to addressing food insecurity include providing referrals to patients to local food pantries, application assistance for the Supplemental Nutrition Assistance Program (SNAP), vouchers that will be used for meals or groceries, medically tailored meals or groceries, organizing prescription programs, and even establishing on-site food pantries.[7,36] Furthermore, efforts to identify and target food insecurity in clinical settings was a main focus at the 2022 White House Conference on Hunger, Nutrition, and Health[37] and has inspired the growing Food is Medicine movement.[38] Additional research as to why patients with food insecurity decline social assistance in clinical settings is of great interest to healthcare providers and public health practitioners to improve patient outcomes and reduce community food insecurity.

In August 2017, Michigan Medicine implemented routine screening for food insecurity and other social risk factors. At new patient visits or annually at health maintenance examinations, all primary care patients complete a standardized questionnaire that assesses food insecurity and other social risk factors as well as their interest in social assistance.[39,40] Authors' prior study demonstrated that only 1 in 5 patients with food insecurity expressed interest in social assistance.[41] Through semistructured interviews with patients with food insecurity, the goals of this study were to (1) qualitatively understand reasons for not seeking food-related assistance and (2) explore their perspectives on addressing food insecurity with their healthcare provider.

METHODS

Study Population

Study participants were recruited from the primary care patient population at Michigan Medicine, a tertiary care academic medical center and one of the largest healthcare systems in Michigan. Potential participants were identified through their electronic health records by the Michigan Medicine Data Office for Clinical & Translational Research (DOCTR) on the basis of the following inclusion criteria: (1) aged ≥20 years, (2) English speaking, (3) completed social risk factor screening at a primary care clinic encounter between January 2021 and December 2022, (4) documented a positive screen for food insecurity using the Hunger Vital Sign,[40] and (5) declined interest in social assistance from a trained social worker. Declining interest in social assistance was defined as a response of *no* to the question, *Do you want to get connected with resources for any of the above responses?* embedded at the end of the standardized social risk factor questionnaire. The study objective was described to participants as "to better understand food-related needs among Michigan Medicine patients." Eligible participants were sent a recruitment flier by the DOCTR and invited to contact the study coordinator if interested. Those who expressed interest were then contacted by the study coordinator with an online preinterview survey and the online written informed consent form. Once completed, the project coordinator scheduled the participant for an online (Zoom) or phone interview. The recruitment protocol was designed with staff from the Michigan Medicine DOCTR to adhere to institutional privacy regulations. The study's methodology was approved by the University of Michigan Medical School IRB.

Measures

The preinterview survey assessed the participants' sociodemographic characteristics and food security status using the 6-Item Short Form Food Security Survey Module.[42] Affirmative responses were summed, and the following categories were created according to U.S. Department of Agriculture guidelines: high or marginal food security (Scores 0−1), no or few reported indications of problems with food access; low food security (Scores 2−4), some disruptions to eating patterns, reduced diet quality; and very low food security (Scores 5−6), many disruptions to eating patterns, reduced diet quality and intake. An open-ended interview question guide was developed by the project team, adapted on the basis of previous literature.[20,43−46] The final interview guide consisted of 11 questions that explored participants' current experiences with food insecurity, perspectives on social risk factor screening for their recent healthcare encounter, and reasons for declining social assistance at Michigan Medicine (Appendix Table 1, available online).

In total, 54 individuals initially reached out with interest, 23 individuals did not return contact or declined to participate, and 31 individuals completed the study. Participant recruitment was stopped when data saturation was reached, that is, when the content from new interviews began to sound repetitive, and the emergent themes overlapped with those raised in prior interviews.[47] All interviews were conducted between May and August of 2023 by 2 research assistants (undergraduate students studying public health) who completed training in qualitative research methods. The interviews lasted, on average, 20−25 minutes. Upon interview completion, participants were compensated for their time with a $30 gift card to a grocery store of their choosing.

Statistical Analysis

Interviews were professionally transcribed verbatim from audio recordings and checked for accuracy by the study team. Transcriptions of the interviews were analyzed for thematic content using the constant comparative method.[48] Two researchers (AC and AY) reviewed the transcripts line by line to generate codes from the data. The senior author (CWL) compiled and reviewed all codes, refined the wording (if necessary), and organized the codes by domains of the interview guide. Researchers agreed upon the final codebook before independently reviewing each transcript again and applying the relevant codes to the text. Researchers met regularly to resolve discrepancies and achieve consensus. After all transcripts were systematically coded, the researchers used the codes to identify emergent themes and representative quotes from the data, in accordance with the goals of the study. The iterative nature of the analysis, peer debriefing process, examination of researcher positionality, and consultation with the entire project team (clinicians, academic researchers, and local antihunger advocates) on the emergent themes were used to help ensure rigor and trustworthiness of this study. Analyses were conducted in 2023−2024.

RESULTS

Among the 31 participants, the mean (SD) age was 48.3 (2.3) years, 71% were female, and 52% identified as non-Hispanic White (Table 1). The majority of participants (74.2%) were not married or partnered, and 77.4% did not have any children in their home. At the time of the

Table 1. Participant Characteristics

Characteristic	Mean	SD
Age, year	48.3	2.3
Sex, *n* (%)		
Male	9	29.0
Female	22	71.0
Race/ethnicity, *n* (%)		
Non-Hispanic Asian	2	6.5
Non-Hispanic Black	10	32.3
Non-Hispanic White	16	51.6
Other (non-Hispanic)	3	9.7
Educational attainment, *n* (%)		
High school graduate or fewer years	10	32.3
Any college	13	41.9
College graduate	8	25.8
Marital status, *n* (%)		
Not married or partnered	23	74.2
Married or living with partner	8	25.8
Household composition, *n* (%)		
No children	24	77.4
Has children	7	22.6
Food security status, *n* (%)		
High/marginal food security	5	16.1
Low food security	11	35.5
Very low food security	15	48.4

interview, 36% had low food security, and 48% had very low food security.

Thirteen patients with food insecurity explicitly discussed reasons for not seeking social assistance. Two common reasons for patients not seeking social assistance were believing that the potential food-related resources would be redundant or not helpful and having previous negative experiences with receiving food assistance.

One reason patients gave was that potential resources would be repetitive or not helpful. Several patients described being previously referred to the same resources, which led them feeling frustrated. For example, one patient previously connected with a social worker and received the same list of resources at different times. They said, “I had gotten the same information twice before, like the same information packet with the same resources and food banks, blah blah blah. I had gotten that twice before, so that’s why I declined [assistance] the last time because I already have it.” This patient suggested updating the list of pantries periodically to alert existing patients of new resources: “Let’s say a new food bank came up on [the hospital’s] radar. Have a list of people that [the hospital] is currently helping and send those letters out to those people. Let them know that there’s an update on the packet I sent to you.... I just think that would be very helpful because then you’re not giving the same information out to the same people.” Similar to the first patient, other patients were already familiar with their local food pantries and/or receiving assistance from SNAP. One patient said that the last time they sought food assistance, they were referred to a food pantry in a neighboring town but decided that it was not worth “the money in gas to travel somewhere to try to access healthier food.” Another patient also described the inconvenience of navigating food pantry referrals that were not near her home. When asked whether this was why she declined assistance, she remarked, “After a while, you just get tired of the same stuff, and nobody really showing you how they can help you or telling you what programs are available.”

Some patients declined assistance owing to having prior negative experiences with seeking food assistance, including local pantries having poor quality food, being denied SNAP benefits despite having low incomes, and not being able to use food vouchers. One patient described the quality of the food at a local pantry as being so poor that “I think I’d do better not eating.” Another patient previously connected with a social worker who provided them with farmer’s market vouchers but found difficulty in redeeming them: “They were coupons on a piece of paper that they called tokens for the farmer’s market. We went to quite a few of the farmer’s markets. Them people know it was very hard to use them. They don’t take that. I was never able to use them. Never.” The challenges of seeking food assistance were further complicated by patients’ existing medical conditions (e.g., diabetes, cancer, mobility limitations) or special dietary needs (e.g., food allergies, veganism, gluten intolerance). Several patients expressed not being able to find the foods they needed at local pantries.

Ten patients in the study remembered completing the social risk factor questionnaire but did not remember or know that they declined assistance. When researchers explained the team of trained social workers at the healthcare system who could contact them with local resources, several patients said that they would have opted to accept assistance had they had more information about what the question was asking or what resources were available. One patient emphasized the importance of communicating clearly to the patient: “If we fill out the survey and somebody reaches out, maybe just give a little bit more detail, or expand more on it so we can know exactly what it’s about. . .*I*t’s like somebody trying to sell you something. You’re like, ‘I don’t need it.’ But, if you explain it more in a way of why the patient could benefit from it, they might be more willing to want to learn about it.” Another patient, who lived in a rural area, also expressed interest in receiving local referrals and more information: “I think that would have been very helpful to be provided with resources that are tailored to my area—local resources as well as state and federally regulated assisted programs and how to get started with those and qualifications and stuff like that... I know that would be nice to get resources tailored towards people who are living in a more rural area or more food scarce where there are less apparent resources." Eight additional patients did not remember completing the social risk factor questionnaire, nor did they remember declining assistance.

Most patients believed that healthcare providers should be knowledgeable about their patients' food insecurity status to better inform care delivery. Patients expressed the views that knowing their food insecurity status would lead healthcare providers to better tailor treatment approaches, interventions, and recommendations to address not only their medical needs but also their socioeconomic circumstances and nutritional requirements. One patient said, "Well, if I can't eat, I can't be healthy. If I don't have access to healthy foods, then I can't be healthy. It will lead to other health issues. They should be concerned."

Despite the overwhelming belief that healthcare providers should be aware of patients' food-related needs, patients acknowledged that this may not be an easy conversation to have with their healthcare provider. Some patients mentioned not wanting to have the conversation with their provider owing to discomfort and embarrassment. One patient said, "It's embarrassing because we've always worked and we've never been in a situation like this before our whole lives. It was a really tough situation. Our doctor continually asked us about it. The whole thing is embarrassing." Another patient described the situation as uncomfortable despite having a good relationship with their provider: "It was just embarrassing but she was a wonderful doctor. She was good about talking to us about it and she kept saying, 'There's no shame in that. You can't help what happened.' I mean, she was great, but it still is a tough situation to be in." Furthermore, some patients expressed concern about the consequences of having food insecurity documented in their medical chart. For example, one patient said, "Well, if I write this down, what are they going to think of me? Is this going to count negatively towards me?" Another patient echoed, "Anything they put in that chart can be used against you. So, you're careful on what you want to have put in your chart."

In general, patients preferred that providers initiate conversations about their experiences with food insecurity. One patient said, "Some patients will feel shy talking about this issue. If [doctors] are able to give you this time, many patients will talk about [their food-related needs], especially low-income patients...it will be helpful for many patients." Other patients described past experiences of being dismissed or invalidated when attempting to discuss food insecurity or other social needs, which closed the window to further conversations with their provider. As one patient said, "I've been in contact with [doctors] regarding this, it seems like they just wanted to treat me for what I was there for. 'Don't ask any more questions that's not related to that and get to stepping.'" Another patient described a previous encounter where they reached out to her provider for assistance but never received any information about resources or follow-up. They said, "When I had my visit to Michigan Medicine, my primary doctor asked me if I need support with anything. I said, 'Okay, I need support.' But they didn't get back to me... *I*f they reach out to me, they email me at any time, I will just reply to them. But they didn't reach out to me. They didn't contact me." Overall, patients emphasized the importance of fostering a supportive and empathetic healthcare environment where discussions about food insecurity are welcomed, destigmatized, and seamlessly integrated into routine care practices.

DISCUSSION

This study aimed to qualitatively understand the reasons why clinical primary care patients with food insecurity chose not to seek food-related assistance and further explore their perspectives on addressing social needs with their healthcare provider. Several key findings emerged from this research. The primary reasons why patients with food insecurity declined assistance were the belief that the potential resources would be redundant or not helpful or they had prior negative experiences with receiving food assistance. These findings are consistent with previous qualitative and mixed-methods studies that identified discomfort, fear, or embarrassment as prominent reasons why patients with unmet social needs chose not to engage in assistance from their healthcare provider.[15,27,31,34,35] This study builds upon this important research by focusing specifically on patients with food insecurity and how healthcare systems can better address their food-related needs.

Another reason for patients declining assistance was not understanding or remembering that they had explicitly declined assistance on the social risk factor questionnaire. Notably, several patients indicated that they would have accepted assistance had they been worse informed about the resources that the healthcare system could provide. These findings add important context to the authors' prior study showing that only 1 in 5 adult primary care patients with food insecurity at Michigan Medicine had requested assistance.[41] Results from this study suggest improvements to the processes through which patients are screened for social risk factors, and the information communicated to patients before and during this process may influence their willingness to seek assistance. Higher-intensity models could be borrowed from other clinics that improve the process of screening and referrals. For example, this could include directed referrals to food assistance, support for completing applications for SNAP or other programs, navigation support services, and extended navigation support with additional follow-up to encourage patients to follow through with services.[49] Furthermore, clarity from clinics on how the documentation of food or other basic needs insecurities within electronic health records will be used to inform a patient's care management and who will have access to their social risk factor data may help encourage honest responses and allay concerns about how the information might be used.

Along these lines, most patients believed that healthcare providers should be knowledgeable about their food insecurity status to inform more effective care delivery. This perspective highlights patients' awareness that food insecurity can negatively influence their diet and health behaviors, ability to manage chronic conditions, adherence to treatment plans, and overall health maintenance, consistent with the research and provider perspectives.[9,50,51] However, not all patients were willing to engage in discussions on this topic, citing discomfort or embarrassment as salient barriers. It is important for providers to acknowledge that food insecurity is not only an important social risk factor but one that is also inherently stressful and stigmatizing.[45,52] One prior qualitative study that specifically focused on improving patient—provider communication around food insecurity identified empathy, trust, cultural sensitivity, and showing interest in the whole patient as key factors among providers that allowed patients to share their experiences of food insecurity with their provider.[53] Recent strategies to leverage partnerships between clinics and community food banks could also serve to improve providers' motivation to discuss food-related needs with their patients, which can help with normalizing these conversations and destigmatizing food insecurity. These partnerships can also facilitate the development of updated resources for local food pantries and SNAP application assistance. An extension of this is the role of clinical teams to better address patients' complex health and social needs, including multiple primary care clinicians, mental health providers, community health workers, social workers, patient navigators, dietitians, and/or other healthcare staff. The team-based model has been valued by multiple healthcare staff as having the potential to improve patients' health.[54–56]

Limitations

This study has limitations. First, the generalizability of the results may be limited given that all English-speaking adult patients were recruited from 1 large academic medical center in Southeast Michigan. The authors chose English-speaking adults who were aged ≥20 years to identify individuals who may exert control over their household food budget and could describe their household's food security experiences to the study team. Recruitment was conducted through email, necessitating potential participants to have regular email access. Future studies may want to consider conducting similar research in languages other than English to better capture experiences for non-English speakers and to recruit participants using varied methods (e.g., in person, phone). In addition, patients were recruited from the larger pool of prospective participants who had encounters dating back to January 2021. Some patients may have had more difficulties recalling completing the social risk factor questionnaire or engaging in discussions about food-related needs with their healthcare provider, particularly because the encounter window overlapped with the coronavirus disease 2019 (COVID-19) pandemic. However, most patients were able to remember completing the social risk factor questionnaire even if they did not remember declining social assistance. In this study, only 8 patients could not recall completing the social risk factor questionnaire or declining assistance. The pandemic may have also affected the nature of the encounter between the patient and provider, the manner in which the patient completed the standardized social risk factor questionnaire, and the extent to which providers were able to prioritize discussing resources for food insecurity. The authors did not systematically capture the reasons why individuals declined to participate in this study. This information would have been helpful in understanding whether the results from this study might be generalizable to other Michigan Medicine patients. Finally, patients were recruited by a central office that aims to connect researchers with patients and their medical data. Interested patients were encouraged to reach out to the study coordinator for further information. This passive recruitment process may have affected who decided to participate in this study, and the themes from the study may have been different had the authors used a more direct recruitment method.

CONCLUSIONS

Existing efforts to screen for and address food insecurity in healthcare settings have varied in efficacy in connecting patients with social needs to community resources.

Results from this qualitative study suggest that improved coordination between healthcare providers, social workers, and the antihunger community could lead to better navigation of community resources for patients, particularly those who already have existing experiences with food assistance. Furthermore, although the majority of patients emphasized the importance of discussing food insecurity with their providers, others emphasized discomfort, fear, and embarrassment as barriers to engaging in this discussion. Interventions to address these concerns may include better tailoring and updating food assistance resources for patients in surrounding communities; prioritizing new food pantries based on the patient's location that also account for patients' transportation options and hours of availability; and leveraging the roles of the primary care provider, patient navigators, and community health workers to facilitate a warm handoff.

Overall, this study shows that strategies to facilitate connecting patients to social assistance need to target multiple levels, including improving the modalities of offering assistance, increasing provider knowledge and empathy, and prioritizing patient comfort.

ACKNOWLEDGMENTS

The authors thank all the study participants for sharing their experiences and perspectives.

Disclaimers: The funders had no role in the study design; data collection, analysis, and interpretation; or writing of the report.

Funding: This study was supported by Grant Number P30DK092926 (Michigan Center for Diabetes Translational Research) from the National Institute of Diabetes and Digestive and Kidney Diseases. AJC was additionally supported by Grant CDA 20-037 from the Department of Veterans Affairs Health Services Research & Development Service.

Declaration of interest: None.

CREDIT AUTHOR STATEMENT

Alexander Connelley: Methodology, Data curation, Formal analysis, Writing-original draft. Abigail Young: Methodology, Data curation, Formal analysis, Writing-original draft. Jennifer Lee: Methodology, Data curation, Writing-review and editing, Project administration. Markell Miller: Conceptualization, Methodology, Writing-review and editing. Eileen Spring: Conceptualization, Methodology, Writing-review and editing. Wei Hao: Project administration, Writing-review and editing. Julia A. Wolfson: Writing-review and editing. Alicia J. Cohen: Writing-review and editing. Minal Patel: Writing-review and editing. Cindy W. Leung: Conceptualization, Methodology, Formal analysis, Supervision, Project administration, Funding acquisition.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.focus.2025.100320.

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