

NUTRITION SECURITY SCREENING

Bistate Primary Care Pilot 2026—Evidence-Based Tips for Clinical Staff

A guide to asking nutrition security questions sensitively, responding effectively, and integrating screening into clinical workflows.

Why Screen? The Evidence Base

Structural and social factors, including food access and diet quality, are strong predictors of chronic disease, hospital readmission, and health outcomes. Evidence from social determinants of health (SDOH) screening research shows that when healthcare workers ask about these issues sensitively, they are better equipped to identify and address these underlying health challenges.

What the evidence tells us:

- Screening for food and social needs during routine visits leads to greater referral to social support resources and improved outcomes at 12-month follow-up. (*Garg et al., 2018*)
- Universal screening — asking everyone, regardless of apparent need — ensures no patient is missed and is endorsed by the American Academy of Pediatrics and the American Academy of Family Physicians. (*Hunger Vital Sign endorsements; Phreesia Clinical Guidance 2025*)
- Patients may experience stigma around food hardship. Most will not raise this challenge unprompted. Proactive screening normalizes the conversation. (*Phreesia Clinical Guidance 2025; Dolezal & Gibson 2022*)
- The Centers for Medicare and Medicaid Services (CMS) has mandated SDOH screening in inpatient settings (2024), and food insecurity is explicitly included. Embedding additional screening for nutrition security can well-position your clinic to keep pace with evolving standards. (*CMS Hospital IQR Program; JAMA Ethics 2025*)

1. How to Ask: Framing and Sensitive Language

Frame it before you ask

Before presenting any screening questions, briefly explain why you are asking. Research consistently shows that patients respond more openly when they understand the clinical purpose and know that screening is routine.

Suggested framing language:

“At this clinic, we ask everyone a few questions about things outside the exam room that can affect health — like food, housing, and transportation. There are no right or wrong answers, and your responses help us connect you with support if you want it.”

Source: Quality Interactions SDOH Integration Guidance 2025; ASHA SDOH Integration 2024

Use person-first, non-judgmental language

The words you choose signal whether you see the patient as a person or a problem. Research from the AMA Journal of Ethics (2025) highlights that person-first language that centers on circumstances helps patients feel seen and reduces shame barriers to disclosure. Examples of centering circumstances are illustrated below.

Instead of saying...

Consider saying...

"Do you need help getting nutritious foods?"	"Would information about local food resources be useful to you?"
"You're nutrition insecure."	"It can be challenging to get nutritious foods. Would you like to talk more about that? Our clinic is interested in finding ways to make that easier for our patients. "
"You qualify for..."	"Some of our patients find these programs helpful. Would you like to know more?"

Explain confidentiality and data use proactively

Patients want to know who will see their responses, how data will be used, and how long it will be stored, especially in small or rural communities. Address this before screening begins.

Suggested privacy framing:
"Your answers are part of your medical record and are protected by the same privacy rules as the rest of your health information."
 Source: Upside Health Research Network 2025

Embed screening in routine intake practices

Asking nutrition security questions alongside standard intake items (address, medications, insurance, and other SDOH questions) may make these questions feel routine rather than targeted. Evidence from SDOH implementation in diverse clinical settings shows that embedding questions in standard forms reduces stigma and improves disclosure rates.

Research from northern New England primary care practices found that framing and explaining the purpose of screening before patients completed forms significantly increased acceptability.

Source: Addressing Food Insecurity in Rural Primary Care, BMC Primary Care 2024; ASHA SDOH Integration 2024

2. Reducing Patient Shame and Stigma

Understand why stigma is a clinical barrier

Shame around food hardship can be part of a trauma response. Research in shame-sensitive practice (Dolezal & Gibson, 2022, PMC) identifies shame as a core aftereffect of adversity that actively prevents patients from engaging with services.

Key insight from the literature:
 Shame-sensitive practice goes beyond trauma-informed care. It requires actively avoiding language, tones, and processes that could make a patient feel judged, exposed, or diminished. This applies to all staff who interact with patients during screening.
 Source: Dolezal & Gibson (2022). Beyond a trauma-informed approach and towards shame-sensitive practice. PMC7612965

Apply trauma-informed principles throughout the encounter

The Substance Abuse and Mental Health Services Administration (SAMHSA) framework for trauma-informed care identifies six principles that translate directly to nutrition security screening:

Safety	Ensure the room is private. Avoid asking sensitive questions in hallways or at check-in desks within earshot of others.
Trustworthiness	Be transparent about what happens with screening results. Follow through on referrals you offer.
Peer Support	When possible, mention that many patients in your practice have shared similar needs. Normalize by numbers, not pity.
Collaboration	Ask permission before exploring a positive screen in more depth: "Would you like to talk more about this today?"
Empowerment	Frame resources as tools the patient can choose to use.
Cultural Humility	Recognize that food and nutrition are deeply cultural.

Source: SAMHSA TIC Framework; Dietitians on Demand Trauma-Informed Nutrition Guide 2026; AAP TIC Policy Statement 2021

Honor patient autonomy

Some patients will decline to answer, skip questions, or deny need despite evidence to the contrary. This should be respected without follow-up pressure. Some versions of the NSS have included "Don't Know" and "Declined to Answer" as options for the first item. This is appropriate to implement if patients do not feel comfortable responding.

3. Responding to Positive Screens

Have a response protocol before you screen

Asking about food hardship without a plan for follow-up can erode trust and leave patients feeling exposed without support. Before implementing the NSS tool in your clinic, gathering resources can make you more prepared for positive screens. Resources may include:

- An up-to-date list of local food resources (food banks, pantries, SNAP/WIC enrollment support, and other local resources)
- A designated staff member or role responsible for following up on positive screens
- A warm handoff process that connects patients directly with resources, referrals, or Food is/as Medicine programs in your community
- A way to document screening results and referrals in your electronic health record system or patient files to monitor and track over time

Source: AAP/FRAC Screen and Intervene Toolkit 2021; Case Study of FI Screening and Referral, PMC 2025; Center for Care Innovations 2021

Acknowledge what you can and cannot fix

Patients appreciate honesty. If your clinic does not have immediate solutions, it is appropriate to say:

Suggested response when resources are limited:

“Thank you for sharing that with me. We may not be able to fix this today, but knowing about it helps me take better care of you. Let me see what I can connect you with, and we’ll revisit this at your next visit.”

Document and track

If a patient declines a referral, document that the screen was positive and that options were offered. This information is clinically relevant for future visits, informs population-level data, and supports continuity of care.

Source: Upside Health Research Network SDOH Integration 2025; Clinical-Community Partnerships, CDC PCD 2017

4. Workflow and Implementation Tips

Distribute responsibility across the care team

Clinics implement SDOH screening in various ways. Physicians, nurses, medical assistants, social workers, and front-desk staff can all play a part in this effort. Clarity about who asks, who responds, and who documents is essential for consistent implementation.

Role	Suggested Responsibility
Front desk / intake	Distribute or administer screening form if not done online before the appointment; explain framing language; ensure privacy of the screening environment
Medical assistant / nurse	Review completed screen before provider entry; flag positive results; confirm patient comfort with follow-up
Physician / APP	Acknowledge positive screen during visit; make or authorize referrals; document in EHR
Social worker / care coordinator	Conduct warm handoffs; maintain and update local resource directory; follow up with patients post-referral
All staff	Use person-first, non-stigmatizing language at all touchpoints; complete any required training on trauma-informed approaches

Source: Center for Care Innovations 2021; Qualifications Interactions SDOH Guide 2025

Designate a program champion

Programs with a dedicated “staff champion” who is accountable for screening consistency, staff training, and resource directory maintenance are significantly more likely to screen reliably and follow up on positive results.

Source: Center for Care Innovations 2021

Consider self-administered over staff-administered screening for sensitive items

Evidence suggests that for sensitive areas, self-administered screening (patient completing a paper or digital form independently, including before the appointment) can be effective and enhance response quality. This may be particularly relevant for nutrition security, given the associated stigma.

Quick Reference: Key Do's and Don'ts

✓ Do	✗ Avoid
<i>Screen universally by asking every patient</i>	Selecting patients based on appearance, income signals, or intuition
<i>Explain the purpose of questions before asking</i>	Leading with questions before patients know why they are being asked
<i>Use person-first, non-stigmatizing language</i>	Labels like "nutrition insecure" or "needy" in direct conversation
<i>Describe confidentiality proactively</i>	Assuming patients know how their data will be used
<i>Ask permission before exploring further</i>	Probing deeply without checking in with the patient first
<i>Offer a warm handoff to resources</i>	Handing patients a resource list and ending the conversation
<i>Document positive screens even when referral is declined</i>	Treating non-disclosure or refusal as a closed matter
<i>Maintain a non-judgmental tone when administering questions</i>	Re-asking or pressuring after non-response

Key References

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This tip sheet was developed to support clinical implementation of a nutrition security screening pilot. It does not constitute legal, regulatory, or clinical guideline advice.