Operator: Welcome to the VA HSR&D Investigator Insights Podcast Series. In this episode, QUERI Dissemination Coordinator Diane Hanks speaks with Dr. Alicia Cohen of the HSR&D Center for Long term Services and Supports for vulnerable Veterans about her work in the area of Food and Security among Veterans.

Diane Hanks: First I want to talk about the notion of food and security cause I think it’s probably a term that a lot of people aren’t familiar with.

Dr. Alicia Cohen: Yeah, absolutely and there’s actually a number of definitions of Food and Security. One that’s used fairly commonly and I like the one that the USDA uses.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: Which is limited or uncertain availability of nutritionally adequate and safe foods. So yeah, one thing about that, is a lot of times people think about financial barriers to accessing food, which is actually absolutely a huge piece of it in a huge barrier, but then also –

Diane Hanks: But not the whole piece?

Dr. Alicia Cohen: Not the whole piece so access as well whether it’s are you living someplace where there’s nutritionally and adequate and safe food available. Are you disabled or elderly or frail and homebound and having difficulty accessing food. There could be a number of things that can impact food ability and access.

Diane Hanks: And I heard, I know there’s been some focus on people who live in urban areas, and just not having access.

Dr. Alicia Cohen: Yeah absolutely, and access can really vary very much by locality and region. And I absolutely remember one conversation I was having with someone actually in Detroit, and she was saying that – and she didn’t have access to a car.

Diane Hanks: Wow.

Dr. Alicia Cohen: There wasn’t good public transportation near her that could take her to any major grocery store or supermarket. And so she was primarily relying on the corner store and gas station for her day-to-day food.

Diane Hanks: Yeah.

Dr. Alicia Cohen: And you know, that’s really a compelling quote that stayed with me, she said “I can get banana flavored pudding, but I can’t get bananas.” And so that’s one of those things that are bad, cost is a huge piece, and also so nutritionally adequate foods are much more expensive than some of the calorie dense nutrient junk foods.

Diane Hanks: Right.

Dr. Alicia Cohen: So a lot of the people will end up getting junk food or like a box of pasta that can feed your family, right, for less than the cost – than the cost of a piece of fruit.

Diane Hanks: Right.

Dr. Alicia Cohen: So people are having to make decisions about how to stretch limited funds, and then later on kind of what’s available. And I think that certainly in urban areas, there are very specific barriers, and some urban areas have really robust urban farming and other food places available. So I know people start talking about the charm, you know food desert which is kind of a controversial time anyway. But about – there’s just so many components that go into food access. And people living in rural areas can face other barriers to food access. So, it’s really a –

Diane Hanks: Yeah.

Dr. Alicia Cohen: -- an individualized –

Diane Hanks: And I think it’s misunderstood because I think people look at homeless people and think oh, they’re not getting enough food. But if you’re not homeless, and they look at you, and especially because there’s such a problem with being overweight and obesity among Veterans, among the general population, and they look at people who are overweight or obese and they think, well they’re getting enough food obviously, but they’re not getting the right food. They’re getting the foods that are going to bring on diabetes or that aren’t healthy for them.

Dr. Alicia Cohen: Yeah, it’s a huge misperception.

Diane Hanks: Yeah.

Dr. Alicia Cohen: I mean yes, obviously not having enough food is bad for your health.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: But not having the right foods is also bad to your health and we actually see that food insecurity is absolutely associated with higher rates of, and poorer control of obesity, diabetes, hypertension, high cholesterol, all kinds of diet related conditions for the very reason that sort of the junk food is both more readily accessible, you can get it at the corner stores, the gas stations, the vending machines, anyplace.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: And it’s cheaper.

Diane Hanks: Yeah.

Dr. Alicia Cohen: And so often, that’s kind of where people go to stretch their dollars.

Diane Hanks: Yeah.

Dr. Alicia Cohen: Particularly if they’re trying to provide not only for themselves but also for family.

Diane Hanks: Pressure.

Dr. Alicia Cohen: Yeah, and so yeah, it’s a big issue. And the other thing that I kind of are constantly talking to people about, particularly clinicians, is that our eyeball test is really poor. You cannot tell looking at someone.

Diane Hanks: No, if they’re hungry, you can’t.

Dr. Alicia Cohen: No, you cannot tell if somebody is able to put food on the table. You can’t tell if somebody is struggling to –

Diane Hanks: Exactly.

Dr. Alicia Cohen: -- pay their rent. And we need to ask, which is part of why this work is so important, and why the VA clinical \_\_\_\_\_[00:04:51] is so important. Because if we’re not asking, we’re not going to know.

Diane Hanks: So tell us about your study and how you hope it will have an impact on people who don’t have access to enough good food?

Dr. Alicia Cohen: Oh absolutely. So the VA has really kind of been a national leader in trying to address some of the terms of health, particularly homelessness. And more recently has really been looking at food and security. And in July of 2017, actually based on a pilot by Tom O’Toole and colleagues, and so based on that, they actually found in the homeless packs, almost 15% of Veterans who were homeless or had housing instability, also reported insecurity.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: And then 2015 – November 2015, there were congressional briefings on Veterans with insecurity, which then actually spurred the charter of the VHA ensuring Veteran Security Workgroup that was really tasked with trying to both understand the scope of Veteran food and security, and ways to better address it. And one of the alcoves of that workgroup of which Tom O’Toole and Kelly Thomas, who were coauthors on this study, were founding members of the workgroup. One of the alcoves was this clinical \_\_\_\_\_[00:06:14]. So in July of 2017, the food industry \_\_\_\_\_[00:06:24] was piloted at six sites across the country. And then in October of 2017, the Food and Security Clinical Reminder was rolled out nationally. And the goal of the reminder, which has actually been incorporated into the homelessness clinical reminder, which has been in place for quite some time.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: And so the goal is to screen all Veterans who are not currently long-term residents of nursing homes or other long term care facilities where they’re receiving food as part of their – as part of being in long-term care facility. So to screen all non-institutionalized Veterans who are receiving care at the VA for food and security at least annually.

Diane Hanks: Okay, so this isn’t just homeless Veterans?

Dr. Alicia Cohen: This is all Veterans.

Diane Hanks: All Veterans.

Dr. Alicia Cohen: All Veterans receiving care, all non-institutionalized Veterans receiving care at VA, are supposed to be screened annually.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: And so, as a Clinician working as in primary care, we actually work in both our homeless pact at the Providence VA and also the Women’s Health Clinic. But for all of primary care providers. And it’s actually not even limited to primary care. Actually anybody can administer the food and security clinical reminder, and sometimes not infrequently, it’s administered by social workers or potentially by dieticians or by others. And so the – it’s a single question screener that asks about food access. And then if the Veteran screens positive, they are then offered a referral to social work and/or to a dietician.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: And so the clinical reminder was rolled out nationally, and there’s uniformity in the question being asked and sort of the specific follow-up protocols being offered their referrals.

Diane Hanks: Right, right.

Dr. Alicia Cohen: But a lot of the other specifics of how it was rolled out was really left up to individual sites in terms of who’s administering the screening, in what setting, is it before the visit, is it during the visit. And how they’re asking a question, if it’s scripted.

Diane Hanks: Right.

Dr. Alicia Cohen: The more context they’re asking the question –

Diane Hanks: Right.

Dr. Alicia Cohen: And then really kind of what the follow-up protocols are, where they are offered a referral, the social work, or and/or dietician. But then in terms of what happens afterwards, what resources are offered sort of \_\_\_\_\_[00:08:50]. How that positive screen is addressed.

Diane Hanks: Right.

Dr. Alicia Cohen: It was really kind of left up to the individual sites based on their kind of put together culture and resource ability. Which is actually where the FEMA is trying to understand what that variation is nationally. And I’m also actually part of the ensuring that our security workgroup and sort of part of the conversations that we’ve been having is really recognizing that this needs to be an interdisciplinary approach. And so thinking about how every member of the team really has to come together from potentially the AMSA, who’s doing potentially who’s kind of a patient doing the screening.

Diane Hanks: Right.

Dr. Alicia Cohen: And there again, the reason I say, because sometimes it’s a person doing the screening, sometimes it’s the provider, sometimes – but as a provider when someone has a cognitive screen, I’m thinking about a lot of things. One, I’m thinking what referrals do I need to place, and who do I connect them to, to try to get them the resources that they need.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: But I’m also thinking let me look at their medication list. Are there any medications they’re taking right now that are putting them at risk for hypoglycemia, are there any medications that – you know are they taking their medications, are they having difficulty affording their medications.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: Even within VA thinking about copays can obviously \_\_\_\_\_[00:10:10] status and other factors. And there was one national study outside of VA, but a national survey that found that among people reporting at least one chronic medical condition, one in three said that they were having difficulty having to choose between food and medicine.

Diane Hanks: Yeah.

Dr. Alicia Cohen: And 13% said that they couldn’t afford either.

Diane Hanks: Wow.

Dr. Alicia Cohen: So again, these are question that we’re asking you know by Veterans and we talk a lot about medication adherence and our people “complying” with what we’re doing.

Diane Hanks: Yeah.

Dr. Alicia Cohen: And if we’re with the treatment that we’re prescribing or hunting. And I think that we really kind of need to think about –

Diane Hanks: The basics.

Dr. Alicia Cohen: Yeah, the basics. That’s when the people are having difficulty affording food or helping, or needing other basic needs. Both kind of – sometimes they will have to choose between food and medicine or housing and medicine. And we’ll make good choices and not be taking their medications. And also sometimes just the tremendous stressors that they would provide for themselves and their families can really make it really difficult to try to do a lot of different competing priorities. And can both exacerbate underlying chronic medical conditions and also precipitate new conditions both mental health related and sort of – like we talked about, that potentially kind of took somebody over the edge in terms of diabetes or hypertension.

Diane Hanks: Right, does food and stability affect more Veterans who are older, or is it across the board. And I’m wondering like with the Veterans who have families, if one of the indicators would be are the children getting so-called free lunch from school. Because that would be an indication that the family can’t afford to pay for school lunch, so therefore you know.

Dr. Alicia Cohen: Yeah, it’s a great question, and it’s interesting kind of what we’re able to look at using VA data.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: Which in certain ways is I mean it’s national data, we have access thinking about other things that are available in the medical record that we can look at. But then also thinking about the limitations of things we don’t have in the medical record, like we don’t know. We don’t even necessarily routinely in any kind of way that we can systematically extract, come right out how many people \_\_\_\_\_[00:12:45] and certainly we don’t – I would love it if sometime we could, but we don’t routinely find out are people receiving SNAP food stamps or other federal assistance programs.

Diane Hanks: But just tackling the stigma must be a big part of what you’re doing.

Dr. Alicia Cohen: Absolutely. I think that the stigma is very real. I think that the neon sign problem is very real. And there are a number of these across the country where actually we’re trying to get a tally of that right now, \_\_\_\_\_[00:13:18] group. But we know that at least around 40 VA’s across the country who actually have a food pantry on site.

Diane Hanks: Right.

Dr. Alicia Cohen: And then there’s a formal partnership with Feeding America. And there are currently 17 – at the moment 17 VA’s. There’s more, they are currently working with Feeding America and to have sort of formal Feeding America partner food banks on site.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: At the VA, which is an important step. But as you said, if people – if there is stigma, I think –

Diane Hanks: Yeah, and I wonder if there’s been studies about your available for this, but are you taking advantage of it, and if you’re not taking advantage of it, is it because you’re feeling embarrassed and is there another way that we can deliver the food, or is there another way we can get it to you so that you don’t have to –

Dr. Alicia Cohen: It’s a great question. I mean even in terms of just where the pantry is located.

Diane Hanks: Exactly, exactly.

Dr. Alicia Cohen: And people look online. And we’ve also kind of anecdotally had conversations with Veterans who, even in terms of federal food assistance programs, thinking about something like SNAP where they just said oh no, I’m getting by, I want to leave those benefits for somebody else. Not realize no, actually wait - \_\_\_\_\_[00:14:32].

Diane Hanks: Yeah, yeah.

Dr. Alicia Cohen: Quite sure you ought to be able to get SNAP. You have to be – your net income has to be below 100% of the federal poverty level, which is quite low. And so if you qualify no, in fact you very much deserve these resources. And I think part of the destigmatizing is really kind of talking about the fact that this is important for you, and it’s important for your health. And you know I think part of \_\_\_\_\_[00:14:55] your conversations around thinking about social determinants of health and unmet health \_\_\_\_\_[00:15:02] of social needs, and really kind of bringing that into the medical and clinical realm.

Diane Hanks: Right.

Dr. Alicia Cohen: It’s sort of normalizing, these are important conversations to be having. Not only are these okay and appropriate conversations to be having with your provider, these are necessary. And this is absolutely part of your medical care. And you think that’s – like it’s a huge piece of the conversation we’re having both with providers and with Veterans and sort of the patients and other settings is you know, this – our hope is that at least right now, and there’s sort of algorithms in terms of Veterans should be screened at minimum once a year for food and security, Veterans who identify high risk, some of them are being screened more often. But also knowing that things can – sand can shift so easily and people who may be okay when they happen to get screened, a month later or four months later may not be.

Diane Hanks: Right.

Dr. Alicia Cohen: And so I think the other piece is really normalizing is to the extent where even if it’s not brought up in a particular visit, hopefully empowering Veterans to be able to say hey you know, this is okay for you to talk about, and you talk about with your provider about any number of other medical conditions. This is impacting your health and we care. And we have resources to try to help.

Diane Hanks: Sometimes there are medical conditions that require you to eat certain foods. And so just that emphasis on if you want to get well, this is what you need to do and this is how we’re going to help you do it.

Dr. Alicia Cohen: And that again kind of goes back to \_\_\_\_\_[00:16:33]. There have been a fair amount of press recently looking at medically tailored programs, whole other medically \_\_\_\_\_[00:16:42]. And Kelly Thomas and David Dozants and others who have done really remarkable work, specifically looking at Meals on Wheels for Veterans.

Diane Hanks: Yeah.

Dr. Alicia Cohen: But I think one thing is, a lot of times people kind of think oh if somebody screens positive, we click the box for social worker for all, and then we’re done. And again, I kind of think really broadly, we have to think about what that team-based approach is.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: And a lot of the efforts that come with the workgroup, and kind of thinking about specifically with social work and with nutrition and food services. How do they work together, and so when you have a dietician who’s both sort of able to do a really comprehensive assessment of what a Veteran’s nutritional needs are, but then also thinking about some of these specific circumstances. So if you have a Veteran who – how do they navigate a low salt diet if they aren’t getting food from a food pantry.

Diane Hanks: Yeah.

Dr. Alicia Cohen: Or if they only have a hot plate, or they only have a microwave, how can they – or they have other kinds of disabilities, how can they get the assistance that they need, and how can they prepare food. Both obtain the food but then also really thinking about preparing it in a way that’s nutritionally appropriate for them.

Diane Hanks: Yeah.

Dr. Alicia Cohen: Even thinking about sort of other members of the care team, thinking again about medication and pharmacists and kind of trying to help identify other options that may be less cost prohibitive. Or thinking even about physical therapy and occupational therapy. And particularly if people are having in-home assessments for other reasons. And so it’s a really unique window into people’s like circumstances. And kind of thinking about do people have other limitations to food access that we should be thinking about. So it’s really – I mean I think the packed model in general is one that very much applies to this situation.

Diane Hanks: Right.

Dr. Alicia Cohen: Even if just important notes we found that female Veterans, Veterans of color, were at increased risk for food insecurities in the screen. And we also interestingly found that \_\_\_\_\_[00:19:02] Veterans under 65 were actually at higher risk for food insecurity and there have been other studies to show that Iraq and Afghanistan War Veterans are at much higher risk for insecurity and those Veterans recently returning from active service are at higher risk for a number of reasons. And then I think when you kind of do sub-analysis looking specially at older Veterans, we do find that they are uniquely at risk in different ways. So there’s a lot of complexity around it. And then the other thing that we found, just in terms of who is particularly at risk for food insecurity, so not surprisingly lower income Veterans are at higher risk. But then also Veterans with depression, Veterans with a trauma, PTSD, military sexual trauma absolutely places people at higher risk for food insecurity. And I think the other pieces, both stressing the need for kind of universal screening. Because again, we can’t tell looking at somebody whether or not they’re food insecure. But then also thinking about some of these groups that we know are at higher risk, and maybe doing both targeted screening within those groups. So maybe if we find out that someone has experienced military sexual trauma, knowing that they are then at higher risk for food insecurity, while we’re thinking about trauma and \_\_\_\_\_[00:20:27] lens, maybe we should specifically be, I would say that we should indeed specifically among the other things we’re screening for, ask about you know, food and health and economic stability. And then even thinking about ways that we can target interventions.

Diane Hanks: Uhm-hmm.

Dr. Alicia Cohen: To specific target and teller interventions, to specific high-risk populations recognizing that it’s not going to be a one size fits all. And so that’s really where a lot of our work is focusing is both the kind of understand just the scope of Veteran food and security in general, and this work is obviously limited to those Veterans receiving from the VA. But understand the scope and then who’s at risk. But sort of the other work that we’re doing right now is looking at variation across sites, trying to characterize different implementations, variances, and really kind of identify hopefully some promising practices.

Diane Hanks: Yeah.

Dr. Alicia Cohen: And the other key piece, and this kind of gets back to something you mentioned earlier, is that we’re really hoping to do interviews with Veterans to hear about their experiences. To hear about their experiences of food insecurity in general, longitudinal and also to hear about their experiences with the screening and referral process. And so what happened once they got screened, what resources were they offered, did they take advantage of them.

Diane Hanks: Yeah, were they coming from Iraq.

Dr. Alicia Cohen: If they didn’t take advantage, kind of work with a barrier, what got in the way. Were their needs met, what outstanding needs still remain so that we can really try to figure out how we can – obviously, screening is an essential first step, but it’s a means to an end. We want to screen so we can find out with food and security so then we can try to help address it.

Diane Hanks: Right.

Dr. Alicia Cohen: And so I think really the direction of the future work is figuring out how we can best address those needs and how we can best tell our individualized responses in a way that’s also scalable.

Diane Hanks: Right.

Dr. Alicia Cohen: And so that’s kind of where we will be next.

Diane Hanks: And if you feel like you’re getting the support that you need in the VA and then it’s a good place to conduct this research.

Dr. Alicia Cohen: Incredibly grateful to be doing this work in the VA. I think it is an extremely supportive environment, I think it’s an extraordinary receptive environment, also particularly as a physician researcher, I am very proud to be a provider within the VA. And I’m so grateful daily for being in an integrated healthcare system, particularly the fact that I’m working with high-risk populations in terms of homeless Veterans and female Veterans and the resources that we have available and kind of the fact that when I am with somebody, and then if I need mental health services or connection with social worker or connection with a dietician or sort of any number of needs that sometimes it’s literally right next door.

Diane Hanks: Right.

Dr. Alicia Cohen: Or I pick up the phone, I know who to call. I can connect people in a way that I wasn’t able to when I was outside of the VA. So the integrated healthcare model is just an incredible place to be.

Diane Hanks: Great.

Dr. Alicia Cohen: And then I think there’s a really kind of unique integration of thinking about clinical care and research. And just the support for research. I mean this sincerely, kind of thinking within the HSR&D and in QUERI rounds I think that there’s tremendous brain trust to drive home. And it’s a very, very supportive environment particularly for a career researcher, so I’m very grateful for that.

Diane Hanks: Great.

Operator: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D funded research, and do not necessarily reflect current or to be implemented VA policy. To learn more about this research, visit the VA HSR&D website at www.hsrd.research.va.gov.