Journal of Agriculture, Food Systems, and Community Development
ISSN: 2152-0801 online
https://foodsystemsjournal.org

Understanding caregiver perspectives to improve food security screening in healthcare settings: A focus group study

Garrett M. Broad [a] *
Rowan University

Yvette Ng [b]
City University of New York and
New Jersey Food Democracy Collaborative

Jeanine Cava [c]
New Jersey Food Democracy Collaborative

Mahbubur Meenar [d]
Rowan University

Kathia Ramirez [e]
CATA

Jose Spellman-Lopez [f]
CATA

Submitted October 18, 2025 / Revised December 23, 2025, and February 12 and March 19, 2026 /
Accepted March 20, 2026 / Published online June 18, 2026

Citation: Broad, G. M., Ng, Y., Cava, J., Meenar, M., Ramirez, K., & Spellman-Lopez, J. (2026). Understanding caregiver perspectives to improve food security screening in healthcare settings: A focus group study. *Journal of Agriculture, Food Systems, and Community Development*, *15*(3), 81–96. https://doi.org/10.5304/jafscd.2026.153.015

Abstract

Healthcare institutions are increasingly engaged in efforts to screen patients for food insecurity and connect households to supportive resources, often in direct collaboration with community development practitioners and aligned with Food Is Medicine initiatives. Evidence of the effectiveness of these efforts, however, is limited. Drawing on data from six focus groups with a total of 42 participants, conducted in both English and Spanish, this study explores how low-income parental caregivers experience and understand food security screenings within healthcare settings. From there, it identifies communication barriers and opportunities for improvement. The analysis was guided by communication infrastructure theory (CIT), a framework for understanding how a community's "storytelling

---

[a] * *Corresponding author:* Garrett M. Broad, Associate Professor, Department of Communication Studies, Rowan University; 260 Victoria Street, 6th Floor; Glassboro, New Jersey USA; broad@rowan.edu;
https://orcid.org/0000-0001-5217-1862

[b] Yvette Ng, CUNY Urban Food Policy Institute, City University of New York, and New Jersey Food Democracy Collaborative; yvette.ng@sph.cuny.edu;
https://orcid.org/0000-0001-7996-1231

[c] Jeanine Cava, New Jersey Food Democracy Collaborative; jeanine@njfooddemocracy.org

[d] Mahbubur Meenar, Department of Geography, Planning, and Sustainability, Rowan University; meenar@rowan.edu;
https://orcid.org/0000-0002-0869-3249

[e] Kathia Ramirez, CATA; kramirez@cata-farmworkers.org

[f] Jose Spellman-Lopez, CATA; jspellmanlopez@cata-farmworkers.org

Conflict of Interest Disclosure
We have no known conflicts of interest to declare.

Funding Disclosure
Funding for this project was provided by a grant from the South Jersey Institute of Population Health (SJIPH)—Cycle 3, Project ID #278.

network," consisting of local residents, organizations, and media, can be harnessed for health promotion. Findings revealed a complex mix of trust and skepticism. While some caregivers appreciated efforts to connect families with resources, many expressed concern and fear related to stigma, privacy breaches, and potential intervention by child protective services. Spanish-speaking participants also highlighted linguistic barriers that increased frustration with the process. Participants recommended that screening processes prioritize choice and provide follow-through with tangible resource connections, ideally facilitated through trusted community intermediaries. Applying CIT, our analysis suggests that healthcare institutions can strengthen food security outreach by building relationships with familiar individuals and organizations in the community's storytelling network. Doing so requires fostering trust through transparent, empathetic engagement. Overall, the findings demonstrate an important role for practitioners in food systems and community development to develop community-based communication strategies with healthcare institutions. This study both advances theory and offers actionable guidance to make food security screening more equitable, effective, and responsive to caregivers' lived realities.

Keywords

caregivers, communication infrastructure theory, community-based research, Food Is Medicine, focus groups, food insecurity, food security, healthcare, social needs screening, storytelling

Introduction

An estimated 13.7% of all households in the U.S, (18.3 million households) were considered food insecure in 2024, meaning they had difficulty at some time during the year providing enough food for all household members due to a lack of resources. Food insecurity rates are even higher in households with children, at 18.4% (6.7 million households) (Rabbitt et al., 2025). Rates of food insecurity are highest among households with incomes below the poverty line, as well as those headed by single mothers (Rabbitt et al., 2025). Yet, several million Americans who are eligible for food assistance programs, including the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), do not participate. Notably, estimated SNAP participation rates vary widely between states, as low as 59% and as high as 100%, while immigrant families of varied legal status show pronounced gaps in their uptake of eligible services (Bovell-Ammon et al., 2019; Cunnyngham, 2025).

Food insecurity prevalence is associated with negative health outcomes, and children from households who face food insecurity report poorer health than children from food secure households (Gundersen & Ziliak, 2015). Given these concerns, there has been recent increased emphasis on the role that healthcare providers can play to screen patients and their families for food insecurity and other social risk factors, including stability related to housing, transportation, and safety. Following screening, providers have also sought to connect patients in need to supportive resources (De Marchis et al., 2020). Such efforts have emerged as part of a broader "Food Is Medicine" (FIM) movement (alternately, Food As Medicine), in which health care professionals provide patients with healthy food resources to prevent, manage, or treat specific clinical conditions (Volpp et al., 2023). Preliminary research on the value of FIM is promising, but further evidence to support the efficacy of FIM initiatives, in general, and screening initiatives to improve household food security, specifically, is warranted (O'Connor et al., 2025; Sharma & Sharma, 2024). Indeed, a growing body of research has identified a number of communication barriers, emerging directly from the clinical setting and on account of larger structural inequalities, that stand in the way of accurate social needs screening and effective resource connection in healthcare settings (Drake et al., 2021; Steeves-Reece et al., 2022).

Drawing from a community-based research approach, this article explores the communication dynamics of food security screening in healthcare settings. The analysis is grounded in data from six focus group interviews with a total of 42 low-income parental caregivers in Southern New Jersey, with three groups conducted in English and three in Spanish. Guided by communication infrastructure theory (CIT), the work offers recommendations for improved screening and resource connection by highlighting how healthcare providers can tap into a neighborhood "storytelling network"—composed of residents, community organizations, and local media—to facilitate conversations and outreach related to food security with hard-to-reach community members (Ball-Rokeach et al., 2001; Wilkin et al, 2011). The project has clear relevance for food system and community development practitioners focused on local health promotion, who have increasingly collaborated with healthcare institutions on Food Is Medicine initiatives and other projects that aim to bolster healthy food access (Koempel et al., 2022; Shostak et al., 2025). The insights from this work, therefore, may be useful for both healthcare providers interested in tackling food insecurity and food system professionals engaged in partnerships with healthcare institutions.

Food Security Screening in Healthcare Settings

Healthcare institutions often serve as one of the anchor institutions within a neighborhood, not only in their clinical role but also as core contributors to community development and the building of resilience, particularly during periods of escalated food insecurity and supply chain disruptions (Cunningham et al., 2022). Providers increasingly recognize that the social contexts of their patients have a substantial impact on their health, and engage in concerted efforts to screen patients for unmet social risks such as food insecurity and to develop programs at the intersection of food and healthcare (De Marchis et al., 2020; Warsaw and Morales, 2022). A suite of Food Is Medicine (FIM) initiatives have been advanced within the healthcare sector—including "cashlike" benefits programs such as produce prescriptions, as well as in-kind interventions such as medically tailored groceries or meals—as ways to leverage both the nutritional importance and community development influence of food (Volpp et al., 2023).

Despite the well-intentioned desire to connect patients to food security resources, however, patients have reported that food security screenings and the interventions that follow are often inadequate, irrelevant, restrictive, or inaccessible (Cullen et al., 2020). In some instances, patients have raised concerns related to stigma, discrimination, and fear of deportation or intervention by child protective services. They have also described unsatisfactory information sharing practices and poor experiences with healthcare staff (Steeves-Reece et al., 2022). These findings align with scholarship on the experiences of low-income populations, which finds that they are more likely to avoid healthcare, educational, and social service institutions due to poor experiences or institutional distrust (Lazar & Davenport, 2018). Low-income parental caregivers, in particular, report concerns that institutional surveillance may lead to state interventions that could endanger their parental rights or residential status (Elliott & Bowen, 2018; Fong, 2019).

Investigations into the perspectives of healthcare professionals have shown that substantial majorities support social needs screenings in clinical settings. However, only a minority of these providers are actually confident in their ability to address social needs, noting that they are constrained by lack of time and resources (Schickedanz et al., 2019). In light of these barriers, researchers have explored ways to facilitate more effective food security screening and resource connection. Interviews with patients and clinicians highlighted some pathways for improvement unique to the clinical setting, such as shared decision-making, empathic communication, and accurate information (Drake et al., 2021). They also pointed to broader structural approaches, notably multisector coalition building to advance policy changes that reduce institutional mistrust. A study of parental caregivers at a children's hospital emphasized the need for intentional steps to provide anonymity and reduce stigma in the screening process, as well as for practical ways to better connect patients to resources, such as through mobile health technology, locally accessible resources, and personalized connections (Cullen et al., 2020). Other empirical research and reviews of the literature have further affirmed the importance of building trust between caregivers and staff, giving patients choice in screening methods, helping caregivers navigate benefits applications, and ensuring that provided resources are adequate and relevant to their needs (Knowles et al., 2018; Steeves-Reece et al., 2022).

Research has shown that caregivers have a particular interest in synergies that connect their providers to community-based resources, an approach that has been pursued in the healthcare community but still lacks universal application (Barnidge et al., 2020).

While research has provided a useful foundation for understanding the barriers and facilitators to effective food security screening in healthcare contexts, significant knowledge gaps remain if healthcare providers are to improve their processes for assessing needs of parental caregivers and connecting them to resources. Food insecure adults are already more likely than food secure adults to report worse patient-provider communication experiences in general (Park & Berkowitz, 2025). To improve screening and resource connection, practices such as building trust, destigmatizing interactions, leveraging personal and community connections, and ensuring that information provided is relevant and accurate add complexity to an already challenging communicative interaction.

More broadly, as FIM approaches continue to gain momentum in healthcare settings of various types—including emergency departments, health clinics, pediatric care settings, and specialty providers—systematic evaluations of their effectiveness nevertheless show areas for potential improvement in both clinical and community-based contexts (Fischer et al., 2024; Seligman et al., 2025). More robust engagement with concepts and perspectives from the field of communication, combined with community-based research approaches, can help develop grounded and actionable strategies for food security engagement and outreach.

CIT and Community Health Promotion

This study is informed by core concepts from CIT, a framework for understanding the role of storytelling in building and maintaining community, as well as for advancing community-based social change and health improvement efforts (Ball-Rokeach et al., 2001). As visualized in Figure 1, CIT asserts that a neighborhood contains a "story-

Figure 1. Communication Infrastructure Theory, including the Storytelling Network and Communication Action Context

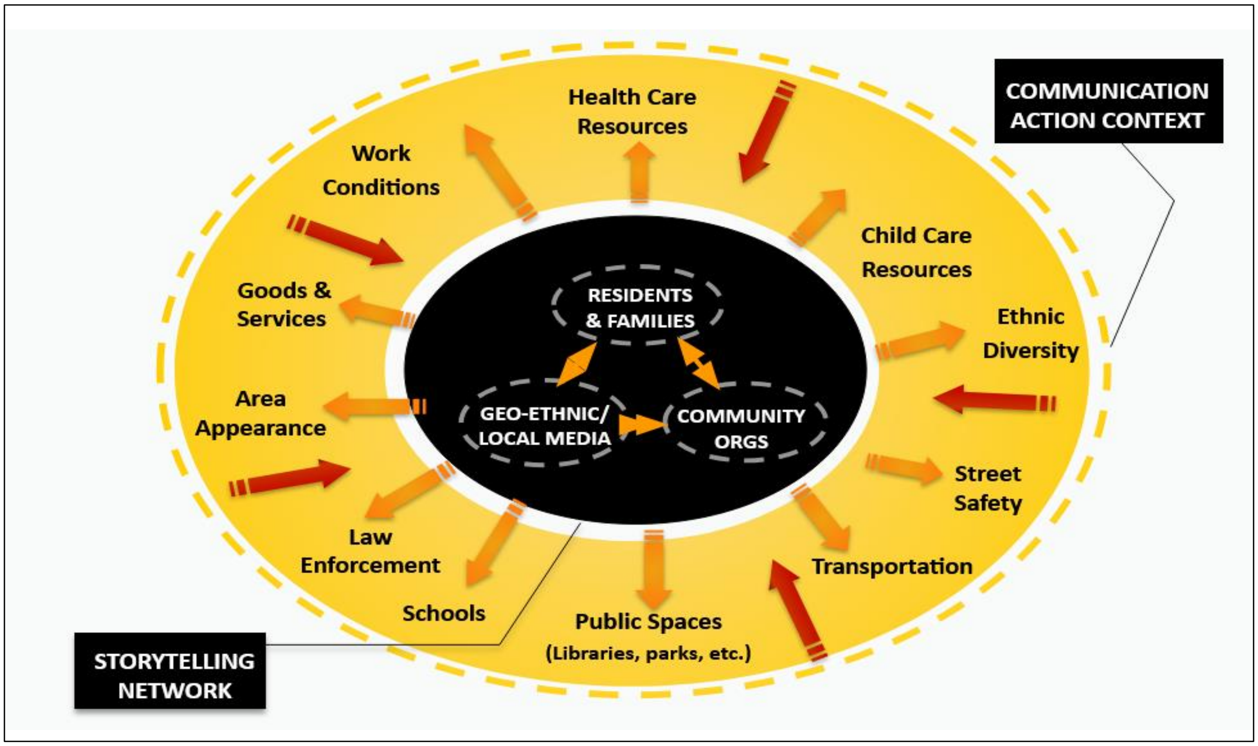

Image credit: Matthew Matsaganis, reprinted with permission telling network" with three main components—residents and their interpersonal networks, community organizations, and community-focused local or ethnic media (sometimes referred to as geo-ethnic media). A storytelling network is situated within a "communication action context," a wide range of elements of the built and social environments that can enable or constrain communication between and among the components of the storytelling network, including but not limited to healthcare resources, schools, public spaces, transportation, and sites for goods and services. The dynamic relationship between the storytelling network and the communication action context forms the foundation of what is termed the local communication infrastructure.

According to CIT, when issues of public concern are addressed productively through shared conversations between the three primary community storytelling components, as well as supported by the communication action context, then a "strong storytelling network" helps residents experience higher levels of neighborhood belonging, civic participation, and collective efficacy (Kim & Ball-Rokeach, 2006). A disjointed storytelling network, by contrast, or one that propagates "bad stories" that are unhelpful or disempowering, can have a negative impact on overall community well-being, depress community participation, or promote stigmatization (Broad et al., 2014; Matei & Ball-Rokeach, 2005).

Not just an academic framework, CIT and related concepts have been employed by applied researchers and community collaborators interested in strengthening the local storytelling network or leveraging its power to advance community health initiatives (Wilkin, 2013; Wilkin et al., 2010). It has proven particularly useful as a guide for targeting "hard-to-reach" community members, including members of low-income communities, immigrants, and linguistic minorities (Katz et al., 2012; Wilkin et al., 2011). CIT-oriented scholarship has investigated how different elements of the storytelling network and communication action context can be used to improve the flow of communication and motivate constructive action. At the individual level, for instance, an important task of scholars has focused on describing the "communication ecologies" of residents—that is, the networks of communication connections that groups or individuals depend upon in order to achieve a particular goal (Broad et al., 2013). Through qualitative, quantitative, and network analytical methods, researchers have used the communication ecology concept to understand how residents engage with trusted elements of the storytelling network to achieve health-related goals (Katz et al., 2012; Spialek & Houston, 2019; Wilkin, 2013).

Additional work has focused on the communicative role of local organizations, community organizers, and peer health advocates in their efforts to advance a range of social justice and health intervention initiatives, including food access and food justice (Broad et al., 2013; Broad, 2016; LeGreco et al., 2021; Matsaganis et al., 2014; Wilkin et al., 2018). Elsewhere, scholars have looked at the role of local media, ethnic media, and community-oriented social media as a force for catalyzing conversations about problems and local resources (Lim et al., 2022; Nah et al., 2021). A related strain of research has demonstrated the importance of the communication action context as a contributor to health and social outcomes (Wilkin et al., 2025). In some instances, this research has involved direct collaboration with community-based organizers as a way to identify local "communication assets," where health information can be effectively shared between members of the storytelling network (Burgess et al., 2021; Villanueva et al., 2016).

Taken together, the background on healthcare providers' interest in serving as a site for effective food security screening and resource connection, combined with the theoretical perspective of CIT, sets the guiding research questions of this study:

RQ1: How do low-income parental caregivers understand and describe the communicative context of food security screenings in healthcare settings?

RQ2: How might insights from low-income parental caregivers inform recommendations for healthcare providers and collaborating food system practitioners to improve food security outreach, screening, and resource connection?

Methods

All elements of the research process were approved by the lead author's institutional review board (PRO-2024-209). The project was carried out by a multidisciplinary team of academic researchers and community research collaborators, representing a range of scholarly and practical areas of expertise, including on the topics of community food security, children and families, immigrant rights, and qualitative research methods. The project built upon previous research efforts, conducted in part by members of the lead community organization partner, that gathered data on the food security screening practices undertaken by staff at New Jersey Federally Qualified Health Centers (FQHCs). That work identified a need to better understand patient perspectives on the screening processes, as well as a need to offer recommendations on ways providers can more effectively connect those patients to supportive resources. With that in mind, focus groups were selected as an optimal method due to their ability to identify shared group experiences and differences, produce nuanced insights on complex topics, and promote solidarity among and between research participants and researchers (Hall et al., 2023; Lunt & Livingstone, 1996). In addition, the convening of a focus group itself was designed as a site for community outreach that could connect participants to additional supportive resources.

Participants were recruited by two partner organizations, both based in southern New Jersey, through their social media channels, e-mail contact lists, posted flyers, and participant snowball sampling. To be eligible, focus group participants had to be at least 18 years old, have at least one child under the age of 18 currently living under their care, report an annual household income of approximately $50,000 or less, and have attended a doctor's appointment for themselves and/or their child at a health clinic or primary care facility. Participants confirmed their eligibility during the informed consent process, and they were compensated for their time with a $50 gift card, refreshments, and childcare during the group discussion. For both methodological and privacy reasons, we did not screen the participants directly for food insecurity, using household income as a proxy instead. Table 1 provides an overview of the study's moderator guide, linked to key objectives and specific prompts used in the focus group interviews.

Focus group study design followed standard procedures as outlined by Krueger and Casey (2001). A total of 42 participants across six focus groups participated in the study, with group size

Table 1. Overview of Focus Group Moderator Guide Sections, Objectives, and Prompts

Moderator Guide Section	Objectives	Sample Prompts
Introductions and Warm-Up	- Build rapport between and among the moderators and participants. - Begin conversations focused at the intersection of food and caregiving.	- Can you tell us about a specific meal you prepared for your family recently? - What are some challenges you face when it comes to feeding your family?
Responding to Food Security Outreach Materials From Local Government and Healthcare Organizations	- Investigate baseline understandings of food insecurity terminology. - Explore experiences with food security outreach and screening processes in healthcare and other contexts. - Examine barriers and challenges for effective food security screening in healthcare contexts.	- We'd like to hear your honest responses to these posters and outreach materials. What do these terms mean to you? What is clear or unclear? - Can you tell us about times and places where you have been asked these questions? - Are there any reasons why you might not want to answer these questions?
Improving Outreach and Connection to Resources	- Identify trusted community communication sources. - Offer strategic recommendations for healthcare organizations and community practitioners.	- What specific people or organizations do you trust to give you information and connect you to resources? - What advice would you offer to healthcare organizations to improve these experiences?

ranging from four to ten participants. Due to the sensitivity of the topic, limited demographic information was collected; in general, the groups were primarily female and included a range of ages, from young adult parents to grandparents serving as primary caregivers. Two focus groups were held in person in English in an urban municipality with an estimated overall poverty rate of 34%, three groups were held in person in Spanish in a dense suburban municipality with an estimated overall poverty rate of 35%, and one group was held virtually in English with participants recruited from both sites. Each focus group lasted approximately 90 minutes and focus group moderation was shared collaboratively between several members of the research team, with practice sessions held to ensure consistency across groups. Research team members concurred that theoretical saturation had been reached following the sixth focus group, which also aligned with the planned and budgeted methodological design.

All focus groups were video and audio recorded using Zoom conferencing software, which created an initial transcript. A research assistant reviewed the transcripts, made corrections while listening to the audio, and replaced identifying information with unique IDs. The focus group conducted in Spanish was translated from Spanish to English using a generative artificial intelligence chatbot (a password-protected version of Microsoft Copilot) and then reviewed and verified by a bilingual research assistant.

The analysis process took place in multiple stages, starting with initial reflections from moderators and community collaborators following the focus group meetings. Several members of the research team analyzed the transcripts in depth to create a report focused on core findings. Then the lead author analyzed the transcripts following the framework outlined by Braun and Clarke (2006), starting with familiarization with the data, then generating initial codes, then searching for themes, defining and naming themes, and finally producing the report. Specifically, the analysis followed "codebook" thematic analysis (Braun & Clarke, 2021), characterized by a structured approach to manual coding, early theme development, and the articulation of themes as topic summaries, in conjunction with a reflexive and interpretive analytical perspective. The analysis was guided by the motivating research questions and the project's theoretical orientation, with a central focus on the perspectives of respondents, levels of intensity, and instances of agreement and disagreement both within and across groups (Krueger & Casey, 2001). We did not strive for objective intercoder reliability, but members of the research team were given opportunities to provide feedback at various points as a way to test and sharpen theme development (Braun & Clarke, 2021), while the initial report was further consulted to ensure overall conceptual and empirical alignment. Illustrative quotes from respondents were extracted to exemplify key perspectives within the themes, lightly edited for clarity with pseudonyms in place of real names.

Results

The results of the focus group analysis are organized into two primary themes: (1) challenges of food security screening, and (2) recommendations for strengthening food security screening.

Challenges of Food Security Screening

Within the theme focused on challenges of food security screening, sub-themes highlighted previous experiences and barriers within healthcare settings, as well as indirect enablers and obstacles to screening that emerged due to forces outside of the healthcare domain.

Experiences and Barriers in Healthcare Contexts

Focus group respondents expressed a range of perspectives related to their knowledge of and experience with food security screening in healthcare settings. Most were familiar with the concept of food insecurity in general, some recalled being asked food security screening questions at healthcare institutions, while others did not recall such instances. Across all these levels of familiarity, participants offered a mix of positive and negative assessments as to whether healthcare facilities represented an ideal site for such outreach. In an example of a positive experience, Rafia (English group 2) discussed routine visits with her newborn child to the doctor, where she was provided with a set of questionnaires on a digital tablet: "You fill all the information and they give all the resources, it's just like 'open if you want to apply'…I think it's very clear—they do ask all these things, they make it easy, so you don't have to search for it."

Others, however, reported a range of reasons for skepticism about the healthcare setting food security screening process, some noting potential dangers to their family well-being and others noting a lack of faith in the utility of the process. Several raised the specific concern that the information could be used against them in a way that would endanger their parental rights. "That's just so iffy," Nicole (English group 1) offered in response to a question about food security screening at a doctor's office. "It's kind of like, why do you want to know? Like, are you gonna low-key call DYFS [Division of Youth and Family Services] on me?" Similar sentiments were offered by Marcus (English group 3): "This is me basically telling you that I'm unable to get food when I want to. That's by extension telling you what my financial status is. … So I'm concerned about who has access to this before I'd be comfortable filling it out."

Across multiple groups, participants discussed a general lack of confidence that healthcare providers were equipped to use the information provided in a food security screening to actually support respondents' food access. Especially among those who attended health clinics rather than having a long-standing relationship with a family doctor, respondents stated that providers did not pay sufficient attention to the unique needs of the respondents due to the fast pace of interactions. Evelyn (Spanish group 1) put it this way: "They're just worried (about) their medical bookings, basically. They are not really gonna worry like, 'Here's all the services.' They're just gonna (say), 'You need to eat more, you gotta change your diet.' But not really guide you." Similarly, for those already familiar with navigating support resources, healthcare providers were not seen as adding much value in terms of connecting respondents to unique services. As Vanessa (English group 2) described it: "Most of the time you're like, 'Oh, I already did that. Oh, I already looked online.' And then that's all they know. Yeah, right, you're gonna have to contact them (the resource provider). They send you back to them. So what's the point? And then they just invaded your privacy. And you answered all these questions honestly, for no reason, and it's like a waste of time, right?"

Indirect Enablers and Obstacles to Screening in Healthcare Contexts

Another key driver of skepticism came not specifically from healthcare institutions, but rather from the broader resource environment, which many parental caregivers struggled to navigate without feeling like they were compromising their dignity or safety. For instance, most participants had extensive experience with major food-related benefits programs, notably SNAP and WIC, as well as elements of the emergency food assistance system, such as food banks, food pantries, and other charitable food giveaways, or other community institutions that offered connections to services. To be fair, respondents in multiple groups were able to recount positive encounters and stories of productive engagement that improved their access to food as well as other overlapping resource needs related to general financial or housing insecurity, transportation barriers, and other household goods and products necessary for healthy food preparation. For example, Carly (English group 3) described the value of community resource fairs where service providers were available for direct conversation: "You can get real answers, instead of sitting on the line on the phone or going online looking. There is one day set where you can go down and get all the information needed, and ask questions, and they even offer other things you still need assistance with."

In Spanish-language groups, most of the focus group participants had immigrated to the U.S. For several of them, support initiatives like the school lunch program were seen as a particularly positive example of state support. As Monica (Spanish group 3) explained: "I tell (my daughter), be grateful. I say, because in Mexico, if your mom didn't bring you your lunch, your breakfast, you went without eating until the end of the day. And here, thank God you are in a country that still gives you a juice, something at school."

Across the groups, however, many respondents described how negative experiences predominated in their customary engagement with these support institutions and programs. Several reported an internal sense of stigma and shame that made it a challenge to reach out for support to begin with, a feeling that could be compounded by stories of intervention by a child protection agency or of poor service in general. Nicole (English group 1) admitted she was sometimes hesitant to offer information about her financial situation: "You can tell one person something, and it can go left," she explained. As an example, she described the story of a friend's daughter who complained to a school employee about not having food the night prior, an admission that Nicole asserted led to a visit to that family's home from DYFS.

Natasha (English group 1) attended the focus group alongside her close friend Nicole, and together they described feeling disrespected by their treatment at a faith-based food bank program, where the quality of food was substandard. She was also frustrated by the SNAP program, due to a history of delays in receiving benefits and a perception of discrimination: "If you give them an attitude, your paperwork won't go through, it won't even be touched. … You got people that really rely on resources there. And the staff are treating people like that, like they're better than us." A member of that same focus group, Ameera (English group 1), had previously worked for the SNAP office and had received benefits herself. This dual identity gave her particularly powerful insights into the dynamics of what was often a stressful environment: "People are already coming there upset because they probably didn't get their food stamps in months. … I loved working there, but I know the struggle. … I used to get people cussing me on the phone trying to say about how broke they are, and I tell them, listen, you think it's cause I work here, I'm still broke too. I'm still struggling as well."

Among the Spanish-speaking Latino/a and particularly the immigrant focus group participants, a whole new set of challenges were presented as they attempted to navigate the system. At a basic level, the term "food insecurity" (translated as "inseguridad alimentaria" on some of the sample outreach materials) was not as universally recognized as it was among the English-speaking respondents. When pressed on its definition with little additional context, multiple respondents equated the idea to being insecure about body weight or body image, while others thought it referred to children feeling insecure about their traditional food cultures in the context of school meals. "These are not basic words in the community," Isabella (Spanish group 3) explained.

In addition, several Spanish-speaking participants described phone calls to service providers, in healthcare and other contexts, that claimed to offer Spanish-language support but that failed to come through. Maria (Spanish group 2) stated: "We ask for someone in Spanish, they say yes, and then it stays there, and the call is lost." In another telling example, Veronica (Spanish group 1) described her experience with the WIC program, which is legally available to non-citizens and should have no effect on an individual's immigration status. Questions from the program, however, deterred her full participation: "I received [WIC] before, but I stopped accepting it because then they started asking more questions about social security and all that. And unfortunately, we are immigrants here without insurance. So I stopped receiving it."

Recommendations for Strengthening Food Security Screening

In the theme focused on recommendations for food security screening, sub-themes included suggestions for practice in healthcare settings and those focused on external collaborations.

Suggestions for Practice in Healthcare Settings

Respondents offered a host of suggestions for ways that healthcare providers could facilitate and improve upon the communication strategy of their food security outreach, screening, and resource connection efforts. At the level of patient-provider interactions, a key insight expressed by participants in multiple groups involved the need to balance respondents' desire for privacy with their interest in engaging in substantive conversations about their needs and potential support resources. Idalis (Spanish group 2) outlined this tension: "For me, having meetings, you express yourself better. But many times in the clinic, if you start talking about something with someone, you don't have that, how do you call it? You don't have the freedom to express yourself because there are more people next to you who don't know you." When asked whether they preferred responding to food security screening questions through face-to-face interactions or, alternatively, by completing a questionnaire with pen-and-paper or a digital tablet, most preferred the latter options since they provided more confidentiality. Nevertheless, and as noted previously, both kinds of option were often viewed as a bureaucratic requirement rather than the starting point of a useful exchange. In other instances, respondents were completely unsure of how the data might be used, as Rose (English group 2) posed: "I have a question. So, if they do ask, but they don't do anything, is it like information for them, like their own data? Or like to the census or something?"

A recurring desire expressed by participants was that food security screening be treated not as a mere checklist, but rather as the start of a conversation—significantly, a conversation into which they could choose to opt in or not, have clear privacy protections, and that could be handled at their own pace. This could mean starting with an in-office flyer with information, or an invitation to fill out an in-office survey with a question that specifically asked whether they would like to speak with a social worker, or a link to an online survey that they could fill out when they were not directly in a medical setting. Harriet (English group 3) explained how she would feel pressured and "put on the spot" if she had to immediately talk about her situation after filling out a screening, preferring instead a multi-step process that begins with an online survey taken off-site: "That was the first step of admitting it. Like, all right, I need the help. And right now I'm in privacy, and I can say it, and then I can work my mind up to talk to someone about it…You can gather yourself before having a conversation. You can prepare yourself for what you're expecting."

Regardless of the specific process, a clear majority of respondents felt it was important that they were given the autonomy to determine when and where the conversation was held, as well as to be informed why the questions were being asked and who would have access to the information. Just as important, they wanted to be sure who would *not* have access to the information, guided by specific concerns about child protective services or immigration officials. Ideally, any face-to-face follow-up would be done by a person known and trusted by the individual, or by someone skilled and experienced in working in community health and social service settings. On this point, respondents were far from unanimous in who exactly they deemed trustworthy—some cited their family's doctor, others a nurse, others social workers affiliated with a local hospital's child well-being program. These perspectives also once again highlighted a tension between caregivers' preference for confidentiality and their desire for substantive engagement, a paradox unlikely to be fully resolved but that might be addressed by building questions about trusted resources into the screening process itself. Finally, respondents insisted that if a screening determined they were experiencing food insecurity, it should be followed through by offering appropriate support, tailored to the individual parental caregiver's needs, with follow-ups delivered in clear and understandable language, and resources offered that were accessible based on their location and schedule. This follow-through had multiple perceived benefits—not only was it simply the right thing for providers to do, but it would also help encourage participants to answer screening questions in the future fully and truthfully, potentially creating a more positive story about such interactions that could spread through their broader social networks.

Indeed, the power of peer storytelling was consistently identified as a vital tool for promoting effective engagement in food security screening and resource connection. The focus groups themselves were frequently pointed to as an example of valuable interpersonal dialogue that was often lacking in their interactions with healthcare professionals and service providers. As Alana (English group 1) suggested: "It helps people feel not so insecure. Like, okay, there is a group of us—we're all struggling some sort, but we all have the strength to come and get that help." Gwen (English group 1), a parent in the same focus group, added: "It's not like you're getting picked on, like one parent. All the parents can talk."

Opportunities for External Collaboration and Coordination

A related set of strategies highlighted by participants across multiple groups were the possibilities of collaboration between healthcare providers and other trusted organizations in the community, including their children's schools, local churches, family success centers, and even local businesses. Such institutions could play a valuable bridging function, as sites where information about food insecurity and resources could be shared, as well as transferring some of the built-in trust in the institutions to the healthcare collaborators. Several participants suggested that the institutions were preferred as the actual sites where screening could take place, because of their existing comfort level as compared to in a medical facility, as Janice (English group 2) proposed: "I feel like they should ask them in school, not in the doctor's office. … You know, like when they have a parent conference, have them (medical providers) come in and talk with the parents, to have like a little meeting with them and talk about the services. Cause you know we probably trust the school more." Having a healthcare provider presence at other community outreach events and resource fairs was also seen as offering a safe and effective space for discussions of food insecurity, as well as potentially discussions with other families in similar situations. As Carly (English group 3) described, these venues were particularly appealing for busy parents: "If people know that it's not gonna take up all their time and it's fast, it's effective because they can get it all done in one setting."

Closely associated with these organizational collaborations were recommendations related to media outreach. Respondents frequently noted that flyers and other informational materials about food insecurity resources were helpful, and suggested they be made available in healthcare settings, at collaborating community institutions and resource events, as well as through the e-mail newsletters and social media of the involved organizations. Social media sites such as Facebook, YouTube, and TikTok were cited by some parents as valuable sources of information about food and cooking in general, platforms where they could get recipes and food preparation tips. In response to prompts about sample food insecurity outreach materials, the participants offered a range of suggestions—they called for clear and concise language; direct narrative appeals to "you" as a parent or caregiver; the use of QR codes, website links, or social media integration to make it easier for people to take immediate action; and more visually oriented designs that could catch their attention as well as be accessible to those with lower literacy levels. Given the diversity of potential audiences, they encouraged diverse modes of communication, as Tiana (English group 3) stated: "Not everyone is tech savvy enough to know how to use the QR codes, especially older parents. … I may want to use the QR code, and the other person may just want to read, just for everyone's comfort. But then so much information could discourage someone. So less words, but more information."

Especially in the Spanish-language focus groups, radio was identified as a media platform where they would often hear about available resources and opportunities for support, but, in general, legacy media such as television or newspapers were rarely mentioned as core sources of information, especially as compared to social platforms. Interestingly, among the most frequently cited media sources was their children's school's classroom management app. These apps were used as a platform to track student progress, allow multi-way messaging between school staff and parents, and post information about upcoming events. Several parents noted that the apps had already been used to post information about free resource giveaways, and in at least one case to provide vouchers to a local farmers market that was co-sponsored by a healthcare institution. As Janice (English group 2) remarked, "There's teachers that post a lot of things, like recently they posted about free coats, you know, and people do go. Because you trust the school."

Discussion

Two central themes emerged from our research on low-income parental caregivers' perspectives on food security screening in healthcare settings. The first theme focused on challenges to food security screening, with a key sub-theme that indicated why many participants were directly skeptical of the healthcare system and its ability to be supportive. Specifically, respondents questioned the capacity of providers to conduct social needs screening and connect them to useful resources. In some instances, they also raised concerns about data privacy and stigma. Beyond the healthcare interaction, participants described frustrations with social service institutions and fears of child protective services, which deepened their mistrust of the screening process. This finding further reinforced a core insight from Drake et al. (2021), that broader structural considerations are often at the root of communication barriers between patients and providers.

The second theme focused specifically on recommendations to address these concerns. Participants expressed a range of ideas related to direct patient-provider interactions, calling for health care professionals to communicate with empathy, provide accurate and linguistically tailored information, and promote patient autonomy and privacy through shared decision making. Respondents also highlighted opportunities for engagement beyond the clinical setting. They emphasized the role of trusted organizations, community-focused media, and shared community spaces as crucial to improving communication and building trust.

Principles and concepts from CIT further inform the implications of these findings and provide a foundation for theory-guided and evidence-based recommendations. The framework helps to explain the important role of storytelling as key to effective food security screening in clinical healthcare settings, particularly among traditionally "hard-to-reach" community members. Notably, focus group participants shared a range of "bad stories"—about fears of child protective services, negative interactions with SNAP, immigration anxieties, and others—that had circulated through media and interpersonal networks, creating feelings of fear, distrust, and stigma (Broad et al., 2014; Matei & Ball-Rokeach, 2005). By acknowledging and validating the concerns of patients, ensuring confidentiality, and clearly demonstrating how the information provided will be used to support their well-being, providers can potentially change the narrative that pervades the local storytelling network over time.

Participants frequently pointed to trusted community organizations and shared spaces as key to forging connections between providers and caregivers. This finding aligns with research on healthcare institutions as community anchors, emphasizing the need for system-level collaborations and the role of local intermediaries as bridging agents (Cunningham et al., 2022; Matsaganis et al., 2014). With this in mind, healthcare providers should recognize the long-term planning and relationship development required to bolster food security outreach and resource connection. Trusted food system and community development practitioners who collaborate with healthcare institutions can play an important role by sharing insights into residents' everyday interests and concerns. These perspectives can help medical professionals better understand community experiences outside clinical settings, and can also benefit policymakers and the policymaking process, particularly at a time when more states are considering implementing FIM programs through Medicaid waivers (Sharma & Sharma, 2024).

One way to advance the bridging function is to analyze and leverage the food and health-related "communication ecologies" of the local caregiver patient population (Broad et al., 2013; Wilkin, 2013). This means working directly to ascertain the trusted organization and media platforms that residents rely upon to receive information and navigate their social environment. Some might be relatively obvious; schools and churches have a particularly well-documented role as trusted institutions, as well as the news and information platforms upon which community members rely. Others might require more investigation to uncover, whether it is a particularly influential radio host or social media account, a local business that serves as a site for community conversation alongside service provision, or any number of other community storytellers that might not be on the radar of the healthcare facility staff. This investigation could be built into the screening process itself, particularly when patients express an interest in accessing additional services.

Relatedly, respondents in the focus groups described a range of obstacles to healthy living that emerged from challenges in the "communication action context," to use CIT terminology. This included issues related to finances, housing, safety, transportation, linguistic barriers, and local food access. Collaborations that create physical spaces or nurture social support groups in which residents identify, discuss, and address these challenges can help build credibility and optimize the impact of healthcare institutions that want to improve patient food security (Wilkin et al., 2025).

Reflecting on these challenges, it may be possible that leaders of healthcare institutions could conclude that they are simply not positioned to be effective partners in advancing food security, and are better off ceding such tasks to other community-based groups. This conclusion, however, would undermine their positioning as community anchor institutions, as well as stunt the growth of the Food Is Medicine movement, which even in its nascent years has demonstrated promising potential (Seligman et al., 2025). Through thoughtful and deliberate cooperation, healthcare institutions can leverage their wide range of financial, physical, and human resources—the latter extending well beyond doctors and nurses to include public health professionals, nutrition and dietetics practitioners, medical students, and others—to amplify the work of food systems and community development and drive impact across shared areas of concern.

Conclusion

This study drew on a series of focus groups with low-income parental caregivers to explore their perceptions of food security screening in healthcare settings. The findings highlighted key barriers to effective screening, pointing to mistrust within clinical encounters and structural challenges in external systems. The study offered a set of actionable recommendations for providers, particularly that the screening process should offer multiple privacy-protective modalities for data collection and include clear explanations of how the information will be used. Providers' communication practices should emphasize empathy, transparency, patient autonomy, and linguistic accessibility. Recommendations included opportunities for collaboration with trusted community partners, as well as comfortable community spaces and audience-centered media outreach as ways to improve engagement. The study employed CIT as an analytical guide, demonstrating how an understanding of the local storytelling network of residents, community organizations, and media could inform healthcare institutions' community engagement practices.

This study also has several notable limitations. Principally, the generalizability of the findings is limited by its focus group methodology, which relies on a small and non-representative sample. Low-income parental caregivers from southern New Jersey likely share many of the same challenges and desires as those from across the country, but these findings should be understood as contextual and preliminary. In addition, aligned with the project's collaborative community-based research approach, we employed multiple focus group moderators, and while efforts were made to promote consistency via a structured moderator guide, differences in facilitator style were present, particularly between the English and Spanish-language groups. Further, while the codebook thematic analysis approach employed in the study aimed to be systematic, it retains subjective characteristics inherent to the method and cannot offer statistical precision (Braun & Clarke, 2021). Future research could further examine the utility of the findings by testing and evaluating recommendations for change in randomized controlled trials and with the addition of quantitative measures. In addition, the timing of this study is notable, with the focus groups held just after the second election of Donald Trump to the presidency in 2024 but prior to the implementation of a variety of executive decisions related to both food security and immigration. These changes are likely to present a number of new barriers and concerns worthy of future study and that will likely require programmatic adaptation.

For those working in healthcare, the many recommendations outlined in this article may seem like a tall task for an already strained system. It is urgent, nevertheless, that healthcare institutions and providers should not go it alone in their efforts to tackle food insecurity among their patient population. Indeed, if they move forward in isolation, they are unlikely to have much success at all. The experience, expertise, and existing community-based relationships of food system and community development practitioners are essential to ensure the effectiveness of FIM initiatives, a perspective supported by both the CIT literature and the collaborative nature of this study, which demonstrates the value of participatory approaches that link academics, healthcare institutions, public health and nutrition professionals, and food system and community development organizations in the process of inquiry and intervention (Villanueva et al., 2016; Wilkin et al., 2018). While such partnerships introduce new layers of logistical complexity, collaborative and action-oriented research projects forge valuable interorganizational relationships, enhance engagement with hard-to-reach populations, promote more authentic community responses, build diverse methodological skills, and help to disseminate knowledge more widely. Ultimately, strengthening both clinical communication practices and community partnerships can help improve food security screening and contribute to healthier, more resilient communities.

Acknowledgments

Special thanks to Kate Cairns for her work in project development; Alicia Newcomb, Soph Milone, and the staff of both CROPS and CATA for focus group support; and Maryela Gallardo for transcription and translation. Additional thanks to SJIPH for its financial and project development support.

References

Ball-Rokeach, S. J., Kim, Y.-C., & Matei, S. (2001). Storytelling neighborhood: Paths to belonging in diverse urban environments. *Communication Research*, *28*(4), 392–428. https://doi.org/10.1177/009365001028004003

Barnidge, E., Krupsky, K., LaBarge, G., & Arthur, J. (2020). Food insecurity screening in pediatric clinical settings: A caregivers' perspective. *Maternal and Child Health Journal*, *24*(1), 101–109. https://doi.org/10.1007/s10995-019-02785-6

Bovell-Ammon, A., Ettinger de Cuba, S., Coleman, S., Ahmad, N., Black, M. M., Frank, D. A., Ochoa, E., & Cutts, D. B. (2019). Trends in food insecurity and SNAP participation among immigrant families of U.S.-born young children. *Children*, *6*(4), Article 55. https://doi.org/10.3390/children6040055

Broad, G. M. (2016). *More than just food: Food justice and community change*. University of California Press. https://www.ucpress.edu/books/more-than-just-food/paper

Broad, G. M., Ball-Rokeach, S. J., Ognyanova, K., Stokes, B., Picasso, T., & Villanueva, G. (2013). Understanding communication ecologies to bridge communication research and community action. *Journal of Applied Communication Research*, *41*(4), 325–345. https://doi.org/10.1080/00909882.2013.844848

Broad, G. M., Gonzalez, C., & Ball-Rokeach, S. J. (2014). Intergroup relations in South Los Angeles—Combining communication infrastructure and contact hypothesis approaches. *International Journal of Intercultural Relations*, *38*, 47–59. https://doi.org/10.1016/j.ijintrel.2013.06.001

Burgess, E. R., Walter, N., Ball-Rokeach, S. J., & Murphy, S. T. (2021). Communication hotspots: How infrastructure shapes people's health. *Health Communication*, *36*(3), 361–371. https://doi.org/10.1080/10410236.2019.1692490

Cullen, D., Attridge, M., & Fein, J. A. (2020). Food for thought: A qualitative evaluation of caregiver preferences for food insecurity screening and resource referral. *Academic Pediatrics*, *20*(8), 1157–1162. https://doi.org/10.1016/j.acap.2020.04.006

Cunningham, N., Conner, D., Whitehouse, C., Blair, H., & Krueger, J. (2022). Beyond procurement: Anchor institutions and adaptations for resilience. *Journal of Agriculture, Food Systems, and Community Development*, *11*(3), 57–73. https://doi.org/10.5304/jafscd.2022.113.006

Cunnyngham, K. (2025). Reaching those in need: Estimates of state Supplemental Nutrition Assistance Program participation rates in 2022. U.S. Department of Agriculture Food and Nutrition Service, Mathematica Policy Research. https://fns-prod.azureedge.us/sites/default/files/resource-files/Reaching2016.pdf

De Marchis, E. H., Hessler, D., Fichtenberg, C., Fleegler, E. W., Huebschmann, A. G., Clark, C. R., Cohen, A. J., Byhoff, E., Ommerborn, M. J., Adler, N., & Gottlieb, L. M. (2020). Assessment of social risk factors and interest in receiving health care–based social assistance among adult patients and adult caregivers of pediatric patients. *JAMA Network Open*, *3*(10), Article e2021201. https://doi.org/10.1001/jamanetworkopen.2020.21201

Drake, C., Batchelder, H., Lian, T., Cannady, M., Weinberger, M., Eisenson, H., Esmaili, E., Lewinski, A., Zullig, L. L., Haley, A., Edelman, D., & Shea, C. M. (2021). Implementation of social needs screening in primary care: A qualitative study using the health equity implementation framework. *BMC Health Services Research*, *21*(1), Article 975. https://doi.org/10.1186/s12913-021-06991-3

Elliott, S., & Bowen, S. (2018). Defending motherhood: Morality, responsibility, and double binds in feeding children. *Journal of Marriage and Family*, *80*(2), 499–520. https://doi.org/10.1111/jomf.12465

Fischer, L., Muleta, H., & Essel, K. (2024). Narrative review: Food as medicine across the pediatric age continuum. *Current Opinion in Pediatrics*, *36*(1), 23–32. https://doi.org/10.1097/MOP.0000000000001313

Fong, K. (2023). *Investigating families: Motherhood in the shadow of Child Protective Services*. Princeton University Press. https://press.princeton.edu/books/hardcover/9780691235714/investigating-families

Gundersen, C., & Ziliak, J. P. (2015). Food insecurity and health outcomes. *Health Affairs*, *34*(11), 1830–1839. https://doi.org/10.1377/hlthaff.2015.0645

Hall, J. N., Mitchel, N., Halpin, S. N., & Kilanko, G. A. (2023). Using focus groups for empowerment purposes in qualitative health research and evaluation. *International Journal of Social Research Methodology*, *26*(4), 409–423. https://doi.org/10.1080/13645579.2022.2049518

Katz, V. S., Ang, A., & Suro, R. (2012). An ecological perspective on U.S. Latinos' health communication behaviors, access, and outcomes. *Hispanic Journal of Behavioral Sciences*, *34*(3), 437–456. https://doi.org/10.1177/0739986312445566

Kim, Y.-C., & Ball-Rokeach, S. J. (2006). Civic engagement from a communication infrastructure perspective. *Communication Theory*, *16*(2), 173–197. https://doi.org/10.1111/j.1468-2885.2006.00267.x

Knowles, M., Khan, S., Palakshappa, D., Cahill, R., Kruger, E., Poserina, B. G., Koch, B., & Chilton, M. (2018). Successes, challenges, and considerations for integrating referral into food insecurity screening in pediatric settings. *Journal of Health Care for the Poor and Underserved*, *29*(1), 181–191. https://doi.org/10.1353/hpu.2018.0012

Koempel, A., Brislen, L., Jacobsen, K., Clouser, J., Vundi, N., Li, J., Williams, M. A., & Williams, M. V. (2022). Growing health: Building partnerships in healthcare and food systems for improved food access in Appalachia. *Journal of Agriculture, Food Systems, and Community Development*, *11*(4), 261–271. https://doi.org/10.5304/jafscd.2022.114.022

Krueger, R. A., & Casey, M. A. (2001). Designing and conducting focus group interviews. In R. A. Krueger, M. A. Casey, J. Donner, S. Kirsch, & J. N. Maack (Eds.), *Social analysis: Selected tools and techniques* (pp. 3–23). Social Development Department, The World Bank. https://documents1.worldbank.org/curated/en/568611468763498929/pdf/282790SDP136.pdf#page=10

Lazar, M., & Davenport, L. (2018). Barriers to health care access for low income families: A review of literature. *Journal of Community Health Nursing*, *35*(1), 28–37. https://doi.org/10.1080/07370016.2018.1404832

LeGreco, M., Palmer, J., & Levithan, M. (2021). We still have to eat: Communication infrastructure and local food organizing as public health responses to COVID-19 in Greensboro, North Carolina. *Frontiers in Communication*, *6*, Article 707144. https://doi.org/10.3389/fcomm.2021.707144

Lim, J. J., Kim, Y.-C., & Koch-Weser, S. (2022). Catalyzing storytelling in communication infrastructure theory: A study of local ethnic media. *Journal of Health Communication*, *27*(5), 312–325. https://doi.org/10.1080/10810730.2022.2105994

Lunt, P., & Livingstone, S. (1996). Rethinking the focus group in media and communications research. *Journal of Communication*, *46*(2), 79–98. https://doi.org/10.1111/j.1460-2466.1996.tb01475.x

Matei, S. A, & Ball-Rokeach, S. (2005). Watts, the 1965 Los Angeles riots, and the communicative construction of the fear epicenter of Los Angeles. *Communication Monographs*, *72*(3), 301–323. https://doi.org/10.1080/03637750500206557

Matsaganis, M. D., Golden, A. G., & Scott, M. E. (2014). Communication infrastructure theory and reproductive health disparities: Enhancing storytelling network integration by developing interstitial actors. *International Journal of Communication*, *8*, 1495–1515. https://ijoc.org/index.php/ijoc/article/view/2566

Nah, S., Kwon, H. K., Liu, W., & McNealy, J. E. (2021). Communication infrastructure, social media, and civic participation across geographically diverse communities in the United States. *Communication Studies*, *72*(3), 437–455. https://doi.org/10.1080/10510974.2021.1876129

O'Connor, E. A., Webber, E. M., Martin, A. M., Henninger, M. L., Eder, M. L., & Lin, J. S. (2025). Preventive services for food insecurity: Evidence report and systematic review for the US Preventive Services Task Force. *JAMA*, *333*(15), 1340–1351. https://doi.org/10.1001/jama.2024.22805

Park, S., & Berkowitz, S. A. (2025). Patient-provider communication among US adults with food insecurity. *American Journal of Preventive Medicine*, *69*(4), Article 107958. https://doi.org/10.1016/j.amepre.2025.107958

Rabbitt, M. P., Reed-Jones, M., Hales, L. J., Suttles, S., & Burke, M. P. (2024). *Household food security in the United States in 2024* (Report No. ERR-358). U.S. Department of Agriculture Economic Research Service. https://doi.org/10.32747/2025.9458834.ers

Schickedanz, A., Hamity, C., Rogers, A., Sharp, A. L., & Jackson, A. (2019). Clinician experiences and attitudes regarding screening for social determinants of health in a large integrated health system. *Medical Care*, *57*(Suppl 6 Suppl 2), S197–S201. https://doi.org/10.1097/mlr.0000000000001051

Seligman, H. K., Angell, S. Y., Berkowitz, S. A., Elkind, M. S., Hager, K., Moise, N., Posner, H., Muse, J., Odoms-Young, A., Ridberg, R., Troxel, A. B., Yaroch, A. L., & & Volpp, K. G. (2025). A systematic review of "Food Is Medicine" randomized controlled trials for noncommunicable disease in the United States: A scientific statement from the American Heart Association. *Circulation*, *152*(4), e32–e46. https://doi.org/10.1161/CIR.0000000000001343

Sharma, V., & Sharma, R. (2024). Food is Medicine initiative for mitigating food insecurity in the United States. *Journal of Preventive Medicine and Public Health*, *57*(2), 96–107. https://doi.org/10.3961/jpmph.23.505

Shostak, S., Kehoe, A., Black, J., & Bindman, R. (2025). Growing community, food sovereignty, and health: A case study of a farm-based produce prescription program. *Journal of Agriculture, Food Systems, and Community Development*, *14*(3), 355–370. https://doi.org/10.5304/jafscd.2025.143.016

Spialek, M. L., & Houston, J. B. (2019). The influence of citizen disaster communication on perceptions of neighborhood belonging and community resilience. *Journal of Applied Communication Research*, *47*(1), 1–23. https://doi.org/10.1080/00909882.2018.1544718

Steeves-Reece, A. L., Totten, A. M., Broadwell, K. D., Richardson, D. M., Nicolaidis, C., & Davis, M. M. (2022). Social needs resource connections: A systematic review of barriers, facilitators, and evaluation. *American Journal of Preventive Medicine*, *62*(5), e303–e315. https://doi.org/10.1016/j.amepre.2021.12.002

Volpp, K. G., Berkowitz, S. A., Sharma, S. V., Anderson, C. A. M., Brewer, L. C., Elkind, M. S. V., Gardner, C. D., Gervis, J. E., Harrington, R. A., Herrero, M.,, Lichtenstein, A. H., McClellan, M., Muse, J., Roberto, C. A., & Zachariah, J. P. V. (2023). Food is medicine: A presidential advisory from the American Heart Association. *Circulation*, *148*(18), 1417–1439. https://doi.org/10.1161/CIR.0000000000001182

Villanueva, G., Broad, G. M., Gonzalez, C., Ball-Rokeach, S., & Murphy, S. (2016). Communication asset mapping: An ecological field application toward building healthy communities. *International Journal of Communication*, *10*, 2704–2724. https://ijoc.org/index.php/ijoc/article/view/5335

Warsaw, P., & Morales, A. (2022). Farm-to-hospital programs and public health: Leveraging local food for organizational and behavioral change. *Journal of Agriculture, Food Systems, and Community Development, 11*(2), 243–261. https://doi.org/10.5304/jafscd.2022.112.017

Wilkin, H. A. (2013). Exploring the potential of communication infrastructure theory for informing efforts to reduce health disparities. *Journal of Communication*, *63*(1), 181–200. https://doi.org/10.1111/jcom.12006

Wilkin, H. A., Matsaganis, M. D., & Golden, A. (2018). Implementing communication infrastructure theory-based strategies in community health access interventions: Lessons learned from two projects in two cities. In Y.-C. Kim, M. D. Matsaganis, H. A. Wilkin, & J.-Y. Jung. (Eds.), *The communication ecology of 21st century urban communities* (Urban communication vol. 6) (pp. 185–202). Peter Lang. https://www.peterlang.com/document/1055905

Wilkin, H. A., Moran, M. B., Ball-Rokeach, S. J., Gonzalez, C., & Kim, Y.-C. (2010). Applications of communication infrastructure theory. *Health Communication*, *25*(6–7), 611–612. https://doi.org/10.1080/10410236.2010.496839

Wilkin, H. A., Nielsen, K., Gayman, M., & Hollibush, J. (2025). Exploring associations between the social and built environment and physical activity through communication infrastructure theory. *Health Communication*. Advance online publication. https://doi.org/10.1080/10410236.2025.2560597

Wilkin, H. A., Stringer, K. A., O'Quin, K., Montgomery, S. A., & Hunt, K. (2011). Using communication infrastructure theory to formulate a strategy to locate "hard-to-reach" research participants. *Journal of Applied Communication Research*, *39*(2), 201–213. https://doi.org/10.1080/00909882.2011.556140