MISSION WEST COOPERATIVE DEVELOPMENT CENTER

FARM TO HEALTHCARE IN MONTANA

LESSONS LEARNED

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This report was researched and written by Brianna Ewert, Cooperative Development Program Manager at Mission Mountain Food Enterprise Center a division of Lake County Community Development Corporation in Ronan, MT. Today Lake County Community Development Corporation is called Mission West Community Development Partners' This report was funded through a USDA Rural Cooperative Development Grant.

Mission West Community Development Partners (previously named Lake County Community Development Corporation) established a Cooperative Development Center in 1999 under funding from USDA-Rural Development's Rural Cooperative Development Grant (RCDG). As one of two cooperative development centers in the state of Montana, LCCDC provides resources, education and technical assistance to existing and developing cooperatives. Find more information about Mission West Community Development Partners and the Cooperative Development Center at www.missionwestcdp.org.

INTRODUCTION

In 2011, Mission Mountain Food Enterprise Center's (MMFEC) Farm to Institution program was established to work with schools to develop local value-added food products and to pre-plan demand and processing through cooperative ordering that enabled efficient and cost-effective processing of local foods. For the last two years, with support from the USDA Agricultural Marketing Service's Local Food Promotion Program, MMFEC has built on the successes, lessons learned, and processes established working with schools to expand the Farm to Institution program to hospitals and healthcare facilities. Our goal was to expand institutional markets for producers and increase the consumption of healthy, regionally produced food for patients, visitors, and staff at hospitals. This report summarizes the project and the results of in-depth interviews with food service personnel, including managers and executive chefs, at healthcare facilities in Montana; highlights key lessons learned; and identifies next steps for the Farm to Institution program's work with hospitals and healthcare facilities. This summary is designed to share with project partners and others interested in Farm to Healthcare and local food procurement in healthcare facilities.

MISSION MOUNTAIN FOOD ENTERPRISE CENTER AND THE FARM TO INSTITUTION PROGRAM

The Mission Mountain Food Enterprise Center (MMFEC), a division of Lake County Community Development Corporation, is located in rural Ronan, Montana on the Flathead Indian Reservation. MMFEC's mission is to enhance regional and state economic opportunities by providing client services for value-added agriculture and specialty food businesses through the management and operation of a viable community-based food processing center. It is a fully functioning food processing facility that is inspected by the United States Department of Agriculture (USDA), Food and Drug Administration (FDA), and Montana Department of Agriculture Organic Program.

Mission Mountain Food Enterprise Center's Farm to Institution Program is a result of a 2008 Flathead Indian Reservation Food and Fitness Project. The goal of the project was to make food and fitness a norm on the Flathead Indian Reservation. A recommendation that emerged from the initial two-year community assessment was that increasing health education and access to nutritious fresh foods in schools was an important and necessary next-step to improve the health of community members and increase economic opportunities for area farmers and ranchers.

In our experience with schools, value-added processing addresses a number of barriers to local procurement for institutions, including the seasonality of local produce and the lack of labor or equipment for handling whole, fresh produce in some institutional food service. Value-added processing expands market opportunities for producers and increases access to healthy, local food in institutions through minimal processing and freezing. Value-added processing also adds a market for second quality fruits and vegetables, reducing food waste. Cooperative ordering has also enabled processing efficiencies that reduce the cost for institutions while still paying farmers a fair price. MMFEC has processed more than 50,000 pounds of local produce a year for institutions.

Through our Farm to Institution program, MMFEC has experience working with institutions, producers, and distributors to identify product needs, required price points, barriers to local procurement, and cooperative solutions and to establish production planning and memorandums of understanding (purchasing commitments). MMFEC has a strong partnership with the Western Montana Growers Cooperative (WMGC), a cooperative of 40 growers in the surrounding area that aggregates, markets, and delivers products. MMFEC and WMGC had an established track record in the Farm to School market; hospitals were a natural extension to grow the Farm-to-Institution Program.

PROJECT BACKGROUND

In the two year project Farm to Hospital: Augmenting Consumption of Regionally Produced Fruits, Vegetables, and Value-Added Products to Contribute to Patient Health and Increase Market Opportunities for western Montana Agricultural Producers, MMFEC sought to use lessons learned from the farm-to-school program to increase the consumption of regional agricultural products and expand year round markets for growers by working with three area hospitals to expand the institutional market and create wealth in Montana's rural communities. Expanding the supply chain to the hospital market could potentially offer a year round market to producers; this is especially important in the height of the harvest season when schools are typically out of session. By developing value-added products, MMFEC and WMGC will grow the capacity of the farm-to-institution program.

In year one of the project, MMFEC identified current and future needs of partner hospitals by understanding food management contractual constraints of partner hospitals; analyzing current local food procurement policies of hospitals and providing options for hospitals to increase their purchases through informal memorandum of understandings (MOUs), organizing an advisory committee that includes representatives from hospitals, MMFEC, and WMGC to establish needs from all parties, and based upon meetings with stakeholders, developing value-added products specific to institutional needs and budgets in months when local produce is not readily available. By year two of project, MMFEC had developed four value-added products that meet the needs of hospitals, signed an MOU with one partner hospital, and completed a program evaluation. The following report highlights the lessons learned from this two year project and a recent program evaluation.

HEALTHCARE FACILITIES

The facilities are primarily located in Western Montana in the Flathead, Mission, and Missoula valleys. One additional hospital outside this area but with a strong commitment to local sourcing was included to have more representation from hospitals with developed local food programs. Eleven facilities were contacted. Nine Executive Chef or Food Service Manager/Directors completed the interview.

Of the nine healthcare facilities included in this research, six are hospitals, two are residential health care centers, and one is a continuing care retirement center. The hospitals range in size from 20-150 beds. Two of the hospitals include residential facilities: one with an attached nursing home and one with a skilled care facility for transitional and rehabilitative care, long-term care, and hospice care. The residential health care centers and continuing care retirement center offer similar services including independent and assisted living, transitional and rehabilitative care, and long-term, skilled and hospice care.

Six of the facilities are not-for-profit, and three operate as for-profit facilities. Among the six non-for-profit facilities, five are either community-owned or owned by a locally-based organization; one facility is owned by a regional not-for-profit healthcare organization. Two of the not-for-profit facilities have a formal affiliation with other locally-based, not-for-profit healthcare facilities. One for-profit facility is jointly owned by a state, not-for-profit healthcare organization and a national hospital network. Two are owned by national for-profit parent companies.

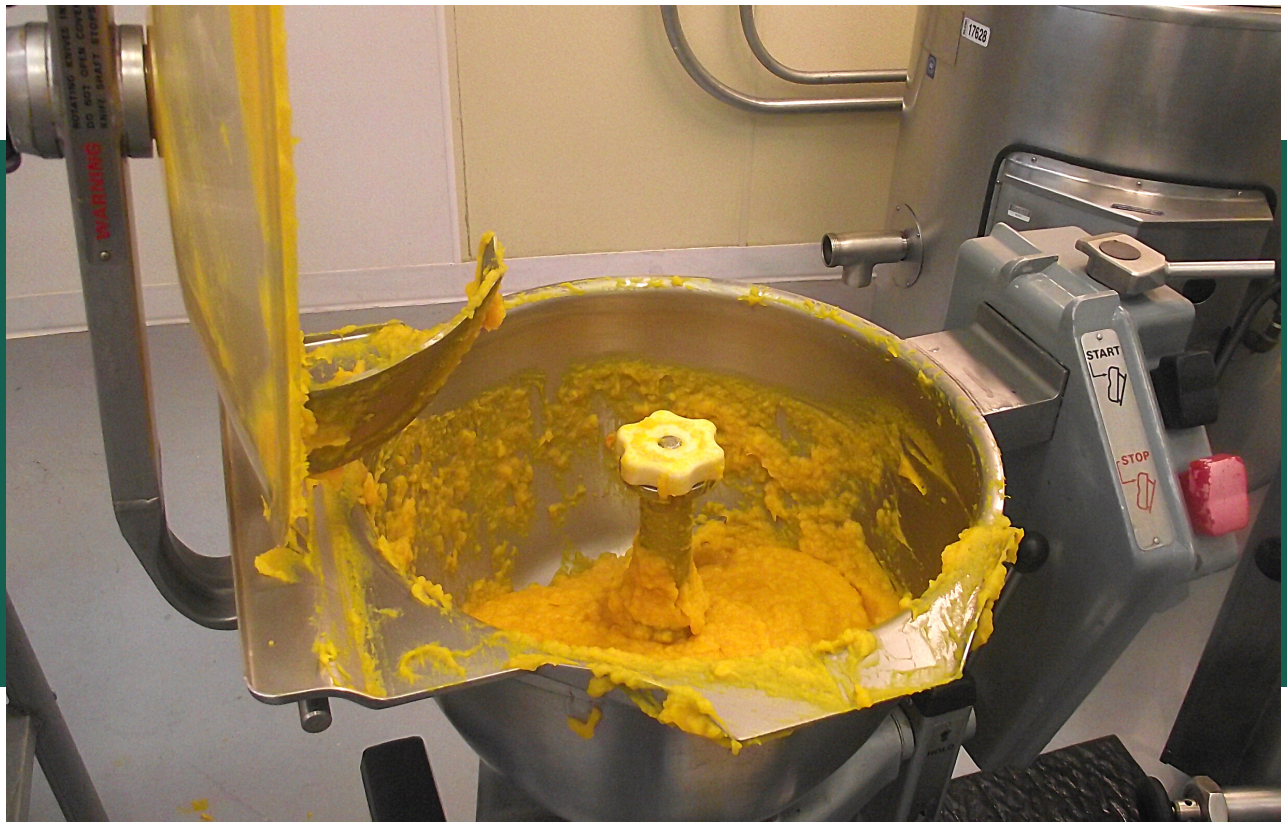
The food service at four of the facilities is contracted with a food service management company. Food service at three of the facilities is self-operated. The food service at an additional two facilities is self-operated but under a national parent company and resemble a food service management company in many ways. Of the two food service operations that purchase the most local food, one is self-operated and one is managed by a contracted food service management company.

The healthcare facilities all serve breakfast, lunch and dinner for a total of approximately 3,600 meals per day (average 400, range 70-1,800). Two facilities serve 70-100 meals/day; five serve 200-350 meals per day; and one serves 1,800 meals per day.

SUMMARY OF RESULTS

Food Service Structure The management staff of food service operations have many responsibilities and different priorities depending on their background. There can be frequent turnover in staff, which hinders progress on local sourcing. The structure of food service varies significantly across facilities in areas from management to menus to purchasing requirements. Both self-operated and contracted food service can be very successful in local food procurement. Food service in healthcare facilities prioritize making foods from scratch and reducing processed foods to improve the quality and healthfulness of the foods. Direct relationships with food service staff at facilities can be successful and are essential to local food procurement efforts, but in some cases working at the regional level may be necessary, either to secure new contracts (or MOUs) or changes in existing contracts that impede local procurement. Healthcare facilities are trying – and struggling – to implement many food related initiatives to increase the healthfulness and/or sustainability of food service operations. Healthcare facilities generally lack sustainability and local procurement policies across the institution. There is a lack of awareness and engagement among food service staff in national initiatives to increase healthy foods in healthcare facilities, including through local procurement.

Farm to Healthcare Local food procurement is limited at most healthcare facilities in this study, but important to food service staff at all of them. The potential economic impact is significant ($2.5 million in local food purchases at one facility) and so is the reach for food access (3,400 meals/day). Food service staff's definitions of "local food" focused on geographic distances, but the reasons why they value local food go beyond distance to local economic impact and increased quality, especially nutrient density. There is room to expand local procurement both at new sites and within existing sites (through different products, including minimally processed and/or frozen local produce and Montana crops available year-round, such as legumes). For healthcare facilities not sourcing local food, the top barriers they identified are costs, consistent availability, and the time required to get started with ordering. Several also need contracts and reliable delivery in order to purchase local food. Among the institutions that are regularly purchasing local food, consistent availability of products is also the top challenge. Easy, convenient ordering systems – and good relationships – and reliable delivery facilitate their local procurement. Few of these healthcare institutions track their local food purchases. Most food service staff have goals to increase local procurement and expand Farm-to-Hospital programs at their facility. The most valuable resources for local food procurement are relationships: connections between people, support from organizations, and attending events. MOUs are possible and seem to be an effective tool.



KEY LESSONS AND OBSERVATIONS

LOCAL FOOD IS VALUED

There is an interest in and demand for local food among healthcare food service personnel. All respondents reported that purchasing local food is a priority and articulated reasons why. Those that are not currently purchasing local food would like to be. There are obstacles to local purchasing, but for those interviewed, the case for local purchasing has been made.

SELF-OPERATED VS FOOD SERVICE MANAGEMENT COMPANY

Both self-operated and food service management contracted operations can have large, successful local procurement programs at healthcare facilities. In fact, of the two largest programs in this research, one is at a facility with self-operated food service and one is at a facility that contracts the food service to a management company. It is worth noting that this management company has positioned itself to offer local procurement, realizing that this is a value for many clients.

RELATIONSHIPS ARE KEY TO SUCCESS

Food service personnel identified relationships as the most valuable resource for local food procurement: connections between people, support from organizations, and attending events. This finding is unsurprising, as the local food movement has been built on close relationships, but it underscores the importance of continuing to develop these connections to further expand institutional purchasing of local food.

AND MOTIVATED INDIVIDUALS ARE THE DRIVERS

Local procurement in hospitals and healthcare facilities in Montana has, so far, been driven by motivated chefs and food service directors. These individuals, with passion and determination, have sought out producers and overcome the various obstacles to buying local food. This may not be replicable at every institution, and it is beyond the scope of this research to identify the differences between the individuals who have been successful and those who say they want to source local food but haven't. But other healthcare institutions may need to try other strategies, such as a team approach to support local purchasing or including expectations in job descriptions and goals or thresholds for local purchasing in contracts with food service management companies.

ON-CONTRACT PURCHASING COMPLIANCE RATES: OBSTACLE?

The on-contract purchasing requirements common in institutional food service, especially when contracted with a food service management company, can be a disincentive and limitation to off-contract purchasing from local farms and food businesses (FINE Toolkit http://www.farmtoinstitution.org/food-service-toolkit#4-food-service-personnel). However, these interviews indicated that healthcare facilities with the largest local procurement programs are dealing with on-contract purchasing requirements for broadline distributors similar to facilities that cited those requirements as an obstacle. Some respondents cited compliance rates around 80% as an obstacle, while others said that same threshold left plenty of room for local purchasing.

Some contracts are more restrictive, requiring 90-100% of purchases (typically for produce) from a particular vendor. These contracts set at the regional level with regional

vendors, not broadline distributors, seemed to be the most limiting contracts to local procurement. In these cases, managers and executive chefs do not have the latitude to select vendors. Often the regional purchasing manager is not located in the same area. Although no respondents made this observation, it is possible that having a regional purchasing manager located in another area would make it more difficult to develop the relationships between producers and food service personnel that are the basis of most local procurement. Their regional contracts are also often used to secure volume discounts that may not be as feasible from smaller local vendors.

NEXT STEPS

1. Connections between producers and food service personnel: Some food service personnel have strong relationships with local producers, but many, especially those just starting local buying, do not. Relationships have been essential to the development of Farm-to-Healthcare. There are also areas, such as food safety, where producers and food service personnel need to share information with each other, such as producers explaining the steps they are taking to meet food safety standards and implement traceability, and healthcare food service buyers sharing their needs.

2. *Working with other stakeholders in healthcare facilities:* Support from other stakeholders is essential. Food service management staff have many responsibilities to balance: support from administrators and other stakeholders can help pave the way for a food service manager trying new ways to improve food procurement. That support may also help food service managers who want to try sourcing more local food but are struggling to get started.

3. *Food service personnel sharing knowledge:* The food service staff that actively source local food said that they have learned from peers, both other chefs they know and at conferences or events. And it was evident conducting this research that there are some respondents who have successfully tackled the obstacles that other respondents are currently facing. Food service staff could share with one another strategies for balancing budgets while sourcing locally and best practices for working with local sanitarians. This knowledge sharing is starting to happen among the staff at different locations with the same management company, but at independent hospitals or within self-operated food service, the staff may need connections to other people in their position with the knowledge and expertise they are developing.

4. Legumes and grains: Local food means more than produce, especially in Montana. As many food service personnel are purchasing local meat as produce, but not many are purchasing other Montana crops such as legumes and whole grains that are nutritious, shelf stable, and available year-round. It is not clear why this is, so some additional research may be needed to identify the obstacles (ex. lack of awareness that these are Montana crops or about the healthfulness and affordability of these foods, customer preferences) and resources needed (ex. recipes, educational materials for customers about nutritional benefits).

5. Start small: A lesson from one of the respondents in this study and also from lessons learned by MMFEC in Farm-to-School is that starting small, with even one product, can make getting started with local procurement more manageable and can serve as a

launching point. The respondent in this study who started with one product, Montana beef, now sources millions of dollars in local food each year. The Harvest of the Month program, originally designed for schools in Montana, features one local food each month and provides promotional materials, both of which have made getting started sourcing local food easier according to school food service directors. This program is currently being adapted for use in healthcare facilities.

6. Guide to MOUs and templates: Only one healthcare facility in this study has used an MOU to coordinate demand and ordering with a group of local producers. This tool has benefits for both the producers and the institution. Most respondents indicated that an MOU would be possible – and, in some cases, a contract will be required for any local purchasing. Except in cases where a contract is required, an MOU may be more appropriate once ordering from a local vendor has been established and trialed. This gives both sides an opportunity to refine the process and understand the needs of the other before making a longer term commitment.

7. Tracking local food purchases: Few healthcare facilities track local purchases which will make it difficult to track progress in this area or to describe the impact. The Healthy Food in Healthcare Challenge, part of Health Care Without Harm's Green Guide for Health Care, provides resources and tools for tracking purchases.

8. Community Health Needs Assessment: Under the Affordable Care Act, nonprofit hospitals are required to regularly conduct a Community Health Needs Assessment (CHNA) and then develop Community Health Improvement Plans (http://thefoodtrust.org/uploads/media_items/ lankenau-partnership.original.pdf). In a review of the current CHNA reports from western Montana hospitals, most do not ask about food access, despite the relationship between chronic disease and lack of access to healthy food. There is an opportunity to learn more about food access and the relationship to health issues by including relevant questions on the CHNA surveys or by simply adding "food access" as a possible answer to existing closed-answer survey questions. Hospitals typically update the CHNA every three years, and the surveys are usually written by a team of collaborators that sometimes include community members.



APPENDIX: METHODS

The researcher conducted semi-structured interviews between late August and mid September, 2016. Semi-structured interviews with open-ended questions were used (instead of a paper or computer based closed-question survey) because the goal was to gain deep, specific knowledge of food service at healthcare facilities in Montana and the barriers to purchasing local food and to continue building relationships between hospital and program staff. The interviews were conducted by the Farm to Institution Program Manager at Lake County Community Development Corporation's Mission Mountain Food Enterprise Center (MMFEC), located in Ronan, Montana. The initial contact was made by email to request participation and both email and phone contact were used for follow ups if there was not a reply and to schedule interview times. Healthcare facilities and contacts were initially identified from the sales records of a local distribution company. The researcher added additional hospitals based on knowledge of Farm-to-Hospital in the region. Additional contacts, if needed, were located with internet searches. The facilities were primarily located in western Montana in the Flathead, Mission, and Missoula valleys. One additional hospital outside this area but with a strong commitment to local sourcing was included to have more representation from hospitals with developed local food programs. Eleven facilities were contacted. Nine Executive Chef or Kitchen Manager/Directors completed the interview.

Interviews were completed by phone using an interview guide with follow up questions and clarification as needed. Interviews lasted between 30 minutes and one hour 45 minutes. Responses were transcribed during the interviews. Based on their answers to previous questions, respondents were not asked all subsequent questions. For example, respondents were asked a different set of follow up questions depending on whether the facility buys local food or not. If respondents had already addressed a question in an earlier answer, they were still asked the question and given an opportunity to add any further response. Several respondents missed questions at the end of the interview guide because they ran out of time and had to end the call.

APPENDIX: RESULTS

Results from the interviews are compiled here with quotations from respondents to further illustrate responses.

RESPONDENT ROLES AND RESPONSIBILITIES

Four of the nine respondents hold the position of Executive Chef in their institution; the titles of the other five are Culinary Services Director, Food Service Director, Dining Services Director, Food and Nutrition Services Manager, and Dietary Manager. Although their titles vary, their responsibilities consistently include overseeing and managing the kitchen and food production and quality; staff management (hiring, training, evaluation, scheduling); inventory management and ordering; and cooking or covering positions as needed. Most are also responsible for writing menus and recipes. Other responsibilities listed by some respondents include invoicing and other accounting paperwork, budget management, managing kitchen maintenance, and overseeing safe food handling and food safety records. Two respondents also manage or directly monitor nutritional services as dietitians.

RESPONDENT TENURE AND BACKGROUND

The nine Food Service Directors and Executive Chefs have worked in their current position at the current institution an average of three years. Their tenure ranges from eight months to nine years. Notably, there was a cluster of respondents particularly new to their position: three had been in their position less than one year and one for a year and a half. The background and training or college degrees of respondents were evenly split between business management, culinary arts, and dietetics (with some respondents having training two areas).

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FOOD SERVICE

The food service at four of the facilities is contracted with a food service management company. Food service at three of the facilities is self-operated. The food service at an additional two facilities is self-operated but under a national parent company and resemble a food service management company in many ways. Of the two food service operations that purchase the most local food, one is self-operated and one is managed by a contracted food service management company.

The healthcare facilities all serve breakfast, lunch and dinner for a total of approximately 3,600 meals per day (average 400, range 70-1,800). Two facilities serve 70-100 meals/day; five serve 200-350 meals per day; and one serves 1,800 meals per day.

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All facilities serve three meals a day plus beverages and snacks. At least two of the facilities operate two kitchens. Food is served a la carte or buffet style in cafés and cafeterias and through room service for patients. Residents typically have a choice between a restaurant style setting or a dining room and room service. Several facilities also offer catering (internal and external). Food is served to patients, residents, staff, family members, community members, and children (through an on-site day care and a contract for food service with a school).

FOOD SERVICE

Menus within the facilities are structured in a variety of ways. At one end of the spectrum are two facilities that do not use any rotation; the chefs write the menu week-to-week based on what is available (and, at least in one case, on resident requests). Two facilities use a monthly menu, set in house, with popular items repeated (and no stated focus on seasonal availability). Three facilities use a 6-12 week rotation with four seasonal menus. These menus are set at the facility level by the respondent and incorporate feedback and favorites from customers. Some of these menus do use recipes from a database of tested recipes maintained by the organization. At the other end of the spectrum are three facilities that purchase a 5 week cycle menu from a broadline distributor (such as FSA or Sysco); one of these cycle menus does have a spring/summer and fall/winter version. Two of the facilities that purchase a cycle menu are in the process of creating their own “healthier menus”, still a 5 week rotation, with the “goal of using local, organic and sustainable ingredients”; these menus will be set at the national level by the parent company. A note about purchased cycle menus: they come with all nutritional information and analysis completed and are, according to one manager, “created by experts.” (One facility uses a purchased cycle menu for residents and an in-house monthly menu for the cafeteria, so numbers in this section add to ten instead of nine.) Most hospitals also have at least two menus for different areas of food service: for example, a set menu for room service that does not change day-to-day and a rotational menu written in house for the cafeteria.

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COOKING FROM SCRATCH AND READY MADE FOOD

When asked how much of the food served in the facility is ready to eat versus scratch made, respondents reported preparing from scratch anywhere from 50% to 99% of food served, but this self-reporting appears to be unreliable for comparisons. A follow up question about what finished or ready-made products are used revealed tremendous variation in what respondents consider “scratch-made” or “ready to eat.” For example, some respondents focused on ready to eat entrees such as lasagna, stuffed peppers, and desserts, whereas others included components of meals like breads and salad dressings, snack items and nutritional supplements, and even cheese and cut meats (i.e. not whole animals) in the definition of ready to eat. However, a consistent theme across all responses is the value placed on scratch cooking. All facilities either reported that they use very little ready to eat food or that they are currently transitioning to as much scratch cooking and eliminating as much processed food as possible.

NUTRITIONAL REQUIREMENTS

The nutritional requirements in healthcare facilities vary widely. No respondents reported challenges in meeting nutritional requirements. In independent living and hospital café/cafeterias, food service functions like a restaurant: nothing is physician ordered and there are not laws or rules governing nutritional requirements. Several of these food service settings do, however, have their own voluntary standards for calories, fat and sodium. Patients, on the other hand, are often on therapeutic diets, and hospitals and residential facilities have state regulations and inspections. Two respondents note that there are few limits for patients because “we don’t serve much we wouldn’t serve them.” For example, one of these respondents does not have a fryer in the kitchen and uses limited salt and butter. The other respondent has an express goal of “liberalizing” patients’ diets as much as possible; that is, serving healthful, quality food so that patients can adhere to nutritional requirements without feeling like they are on a restricted diet.

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TARGET COST

Respondents report that their institutions do have target costs per meal, although not all knew the exact number. The target cost also varies depending on the setting where the meal is served (for example, in one facility the catering service, a la carte cafeteria and patient trayline have different per meal targets). The reported target costs range from $2.12 to $5.50, with an average of $3.62. This average, however, disguises the general trend for patient and resident trays to represent the lower end of the range ($2.12-$3.65) and cafeteria meals to represent the higher end ($4.92-$5.50). (The respondent reporting a target cost of $2.12 per patient tray also expects that amount to increase soon.)

Respondents were not asked if their department is expected to operate at a profit. However, three did say that the food service operates at and budgets for a loss; they are not expected to be a revenue generating department and offer value to the facility in other ways. (For example, staff at many facilities receive discounts on food and free beverages.) Other facilities do operate at profit generating departments and have expected margins for the food they serve (at least for catering and cafes).

VENDORS

All respondents work with a broadline distributor. Four use US Foods as their prime vendor, two use FSA, and two use Sysco. One additional respondent uses Sysco on a limited basis.

Four respondents report purchasing from a regional distributor. In all cases, the facility is purchasing produce from Spokane Produce or Charlie's Produce. Three of the four are required by contracts set by their organization at a regional level to purchase 90-100% of produce from this vendor. In some cases, the produce may be local, although for one distributor local is "anything from the United States." One of these regional distributors is also able to provide processed produce.

Five respondents report purchasing from local distribution companies, either Western

APPENDIX: RESULTS

Montana Grower's Cooperative or Quality Food Distributing (one of the five reports only purchasing "specialty items" from a local distributor "once a month").

Only two respondents report purchasing directly from farmers. One explains that she has made this part of the expectations for her staff:

> "One barrier you always hear: you have to deal with so many producers and distributors, so many invoices, so many people and deliveries. Make that part of the job, know that you have to do it. You can negotiate price points better. I emphasize: this is what our job is, it's what we do. I have a chef who does all the ordering – it's a lot but he's passionate about it."

Among the reasons reported for not purchasing from local farmers, respondents say:

> "Because of regulations we have to be able to trace back – FSA and Sysco we can trace [food] back. Cooks have things at home or find them at the farmers market and want to bring them in– but what if there was an outbreak?"

> "I've really steered away from farmers that can't provide a product that's ready to eat – washed, certified, inspected. Until you can distribute through a distributor, I'm hesitant. My perception is of a lack of quality and a lack of quality control."

VENDOR SELECTION AND APPROVAL

Typically the broadline and regional distributors are selected and contracts set at the regional or national level (by parent companies or the food service management company). No respondents reported being involved with selecting these distributors or setting the contracts. Respondents consistently reported that these relationships with distributors predated their time at the institution. One commented that "having been with FSA as long as we have, we have good relationships with representatives, established good relationships."

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At most institutions, vendors have to complete a new vendor form or packet to be approved. One institution is going to begin requiring electronic invoicing, which the respondent identified as a potential barrier for smaller vendors. Several respondents did know what other requirements vendors had to meet. The requirements for inspection and insurance coverage varied, from one to five million dollar policies to no insurance requirement:

> "[Vendors] have to be USDA inspected, have insurance coverage ($1 million), and complete a new vendor packet"

> "Producers have to have enough coverage – good clean products with good clean water sources, not above ground water unless they have $5 million in coverage because of the risk of salmonella."

> "I always think about liability, where it's coming from. I use established distribution companies, sign contracts with big distributors, pay on 30 day, inspect food as it comes in, cook to certain temperatures, follow food safety – don't worry about [local farmers] bringing in kale – I don't worry about it because I know I am handling it correctly – I don't ask for GAP or question it. When I started this in 2007 – I've worked with three or four county sanitarians now – the first one was like 'Absolutely you can do this, you take the liabaility, are you handling it correctly? Are you doing due diligence?' Proteins come from USDA and state inspected facilities, come fresh or frozen in a refrigerated truck. Produce –we handle it appropriately, use good sanitary practices. All staff are Servsafe certified. We're not as strict as other hospitals , don't require million dollar insurance policies. We have a good relationship with the county sanitarian: I always ask him if I have any questions – I'm as transparent as possible with county sanitarian so he knows what we're doing – we have a good relationship and he's forward thinking so we're good."

ON-CONTRACT PURCHASING

Contracts with vendors often require a certain percentage of purchases be made from that vendor. Seven of the nine respondents report a requirement for on-contract purchasing from a broadline distributor that ranges from 74% to 90% (mode: 80%). Several respondents did not know the percentage required; in most cases this seemed to be because almost all purchasing was from the prime vendor, but in one case, the facility does mostly local sourcing and the prime vendor does not enforce the requirement.

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Contracts with vendors often require a certain percentage of purchases be made from that vendor. Seven of the nine respondents report a requirement for on-contract purchasing from a broadline distributor that ranges from 74% to 90% (mode: 80%). Several respondents did not know the percentage required; in most cases this seemed to be because almost all purchasing was from the prime vendor, but in one case, the facility does mostly local sourcing and the prime vendor does not enforce the requirement. Interestingly, some respondents note on-contract purchasing requirements as an obstacle to local sourcing, whereas others say that the same threshold (ex. 80%) leaves plenty of room for local sourcing.

At the two facilities without on-contract purchasing thresholds, one attributes that to not being part of a large organization and reports having to justify food costs that exceed historical costs. The other facility receives price reductions through the prime vendor that are available to healthcare nonprofits and are not based on volume.

FOOD SERVICE PHILOSOPHY

When asked about the food philosophy of their food service, institution or parent company, eight of nine respondents articulated a philosophy that underlies the food they serve. Themes include better quality food and healthy food (four each), made from scratch or whole/minimally processed foods (three), local, sustainable, nutrient dense, reasonably priced, and customer driven (two each).

> “Nothing written in stone – more general, want food to be sustainable, healthy and better quality to give better quality of life”

> “New mission [for our parent company]: whole and minimally processed foods with focus on local, sustainable and organic ingredients and 75% plant based ingredients and recipes”

> “pure, nutrient dense wholesome food at a reasonable price, prepared as nicely as possible, [we] care about quality”

> “My philosophy is [for food to be] as simple and local as I can and delicious. What residents want. I like to show off a bit. Residents being Montanans, they appreciate local, not too fancy.”

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> "I have priorities. I wrote this a long time ago and posted it in the department: healthy (ex. low in saturated fats), cost effective, low waste, appealing (visually, smell, presentation), customer driven without sacrificing the above. Doesn't say anything about local or sustainable, but when we talk about quality, that's where it fits – it's better produced, shows in the product."

> "Our facility's mission statement – focusing on care in all areas; stress importance of quality, balanced nutritionally and enjoyable."

> "Minimally processed, raised naturally, and nutrient dense creates healthy foods."

Some respondents in organizations with a food philosophy referenced that philosophy in their answer, while others still articulated their own philosophy. Respondents reporting no formal philosophy gave their own philosophy or referred to the organization's larger mission.

FOOD RELATED INITIATIVES

According to respondents, the healthcare facilities are making efforts to improve their food service in a number of ways. Five report efforts to reduce food waste, including through composting. Two are trying to serve better quality meat (ex. grass-fed or free of routine antibiotic use); this number may actually be higher as some facilities have already made this change. Other responses include no msg in food (one), removing the fryer from the kitchen (two), no additives or coloring in food (one), offering reusable containers in the cafeteria (one), differential pricing to encourage healthier choices and offset the cost of healthier options (one), reducing use of paper products (one), using biodegradable or compostable wares (two), and growing some of their own food (three). One facility is considering eliminating sales of soda. This question was asked as an open ended question (instead of having respondents choose from a list), so some facilities may be implementing one of these initiatives but did not mention it (there is some evidence for this as respondents mentioned similar initiatives in response to other questions, but not when directly asked about initiatives).

APPENDIX: RESULTS

SUSTAINABILITY POLICIES

No respondents reported knowledge that their facility or parent/management company has a sustainability plan or policy in place. One had a sustainability committee that proposed a sustainability policy that was not adopted, although the facility is conscientious about sustainability efforts (ex. energy-saving); this committee has become less active over time. Another facility is in the process of forming a group of doctors who have been pushing for recycling and other sustainability efforts. A third reports that the Director of Maintenance tried to implement a sustainability policy but met with opposition. Several other mentioned complaints about specific changes that have been made (ex. increasing prices for soda and junk food, switching to biodegradable products).

LOCAL PROCUREMENT POLICIES

Two respondents reported that their facility has a policy or preference regarding local contractors or procurement. At one facility, all purchases over $200 require approval from administration, and the purchasing department solicits prices from three vendors; the CEO wants at least one of the three vendors to be local. At the other facility, bid solicitations are put to local contractors first for construction work and other projects. The facility has tracked dollars spent in the county for major projects such as construction.

NATIONAL INITIATIVES

Out of the nine respondents, six were not familiar with the national organizations Practice Greenhealth and Health Care Without Harm or their pledge/challenge programs in support of healthy foods in hospitals, including a focus on local sourcing. When the programs were described in the question, two of the six requested more information about them.

Of the three remaining respondents, one had looked at the pledges and was considering signing; one was familiar with the organizations and pledges from working in other

hospitals that had signed on; and one reported signing both pledges but not doing anything further.

FARM TO HOSPITAL

When asked how they define “local food”, respondents’ answers varied – and reflected the lack of consensus more broadly over a definition – but focused on geographical distance:

> “For me personally, anything produced or farmed here in town or within the general area. I try to buy more local and fresh and from farmer’s markets for myself. I prefer not manufactured food.”

> “Farm to Table”

> “Montana grown. Company defines it as USA grown – have to go with company, more regionally grown.”

> “The Slow Foods standard is 250 miles away. Local food, close to home, even 25-50 miles away. Slow Food is a good movement, 250 is sort of a compromise.”

> “Anything Northwest, even Washington. Seattle is pushing it, but doesn’t have to be specifically Montana grown.”

> “I don’t have a strict definition but have preferences: within [this county] first, then [the neighboring counties] – as close to home as we can – within Montana. Keep dollars in the state. Have purchased from Wyoming, Idaho, Denver – can’t be that strict but try to source from [this county] first and go out from there. We differentiate between [this county] and [the rest of] Montana in tracking.”

> “Trying to purchase or source all of your food locally. Local is different for everybody – is that 100 mile radius or bigger or smaller? Trying to stay in the community, supporting your local growers in your community, living within your means as far as what’s available. You can’t get a pineapple [grown in Montana]. From a nutritional

standpoint, it's important to get a variety of foods. It's tough for me – I love a variety of foods, I love avocado, if someone told me I couldn't have them again, it would be tough for me. Trying to grow as much as you can local."

"Definition is as unique and vague as size and shape of fruit, nobody is saying the same thing. Find 250 miles to be reasonable but you could shrink that in other geographical areas. Here the Bitterroot would be out."

"Here in Montana, the way to define it is Montana . In Washington, we defined it as 150 miles, which let me go all the way into Portland and eastern Washington. If you say Montana made, people see it as local."

Eight respondents were asked if purchasing local food is a priority and why (or why not). Regardless of how much local food the facility is currently purchasing, all eight reported that purchasing local food is a priority and offered a variety of reasons for why that is:

"There's information and data coming out about GMOs being harmful, pesticides. We've all seen Food Inc here. We refer to it a lot. Prepackaged, manufactured food became so easy and cheap, we got used to using it, saved money and labor, but it's not necessarily healthy for you as a person. We're realizing fresh is better."

"[Local food] is important to [our company], want to support the local economy, have more understanding and closeness to food you are preparing. We're not where I'd like to be. It's important to support what's around you. Nutrient density is important – get the food quicker from tree to plate, less time on the truck, getting gassed, food is fresher."

"Just think it's important – support the local economy, support local farmers, and the product is freakin delicious."

"It's an economic driver, and the quality of the food is better, more nutrient dense. It's important to try to be as self-reliant as a community as possible – I do think the more we can encourage people or our county to produce as much food, it would be nice to know we can rely on it if we need it (I'm not a doom and gloomer). I love idea of victory gardens (even if reason for it wasn't good). I like the self reliant piece, we all know big ag isn't heading in the right direction. Keep conversation going to get people back in touch with being able to do this themselves."

> "From a health standpoint, if it's local, it's going to be more nutrient dense, better for you, better for the environment. We all need to focus on the environment and how we can keep the planet healthy. The sustainability factor, exposing people to local food and farming, getting people involved and excited so we see more of it."

> "Taking care of our regions and land, nutrient dense food – vine ripened brings more flavor and nutrients to table. [Local food] keeps money within local systems."

> "We've enjoyed it. It's worth its while, especially if you market it on the menu – people appreciate it and are willing to pay more and buy more."

When asked if there is support from the hospital administration for local food purchasing, six of seven respondents gave a clear yes:

> "Yes – tons."

> "Yes, without that we wouldn't be moving forward."

> "There is ... the Chief Medical Officer is very into local, sustainable, healthy foods – loves to come in the cafeteria and order healthy food, wants to see more."

The other respondent did not report a clear stance from the hospital administration: "We do and we don't – [they] haven't asked for it or not asked for it. They trust us on most things as long as we keep costs where they should be – if it's good within the price point, they don't give a hoot."

LOCAL FOOD PURCHASING

When asked if the healthcare facility purchases any local food, five respondents reported that yes the facility does purchase local food and three replied no but with qualifications. All three have purchased local items occasionally for special events, and two of the three report trying local products in the past. One additional respondent reports purchasing local food but not being aware of what is and is not local, although she thinks she could get sources from distributors if she asked. The local foods in this case come from a

regional distributor (this distributor defines local as within the United States) and a broadline distributor who claims to carry as much local as possible.

Respondents were asked what local foods the facility has purchased. The top items, each identified by four respondents, are produce, bread, and meat. Milk, coffee/tea, and legumes were each reported by two respondents, and ice cream, grains, and eggs by one each. Three reported purchasing value-added local food items, such as minimally processed or frozen produce.

BARRIERS AND NEEDS OF FACILITIES NOT SOURCING LOCAL FOOD

The four respondents who reported not purchasing local food (or not knowing what is local) were asked to identify the barriers to purchasing local food for their institution and what they would need to make local food purchasing happen. Answers for these two questions are combined because of significant overlap.

The top two barriers (or needs), each identified by three of the four respondents, are the lack of consistent product availability and delivery and the cost of local foods. (Notably, cost was not always mentioned as a barrier; sometimes effective cost was given as a need to make local purchasing possible.) Two respondents discussed contracts: for one, existing contract requirements are a barrier to purchasing local food, and for the other, contracts for local purchasing and a decision from a regional director on vendors is needed (and in progress). One respondent mentioned minimum order sizes as a barrier. Additional needs identified by respondents included ease of ordering and getting set up to order (two), quality products (one), time to train and educate staff on using products (one), and starting small with ordering just one or two local products (one).

STRENGTHS AND CHALLENGES OF LOCAL SOURCING FOR FACILITIES THAT BUY LOCAL FOOD

The five respondents who reported purchasing local foods were asked what factors have made purchasing local food work well and what challenges they have encountered. The top two strengths, identified by three respondents each, were a convenient and easy ordering process and reliable delivery (with, respondents added, refrigerated trucks and

no delivery fees). Two respondents talked about relationships and having a dedicated sales person or getting to speak with the vendor/producer weekly as an important factor. Other responses (one each) included good prices, being able to get the products needed, the "deliciousness" of products, and the variety of products available (including value-added products).

Among the challenges, one stood out. Four of five respondents identified inconsistent availability of products as a major challenge when ordering local products. It's worth noting that this inconsistency is not related to seasonality: respondents discussed products being out of stock (ordering is first come, first serve so some products run out) or products are listed as available when they are out of stock (several had issues ordering something that was not delivered; products were listed as available and they received no communication that it was out of stock until it was missing from the delivery). As one respondent said, "there are some things I serve consistently, I'm wary of things I can't get consistently, I need things to be consistent." Related to the inconsistent availability is the challenge of communication around ordering and product availability.

Other challenges mentioned by one respondent each included limited time (to get set up for ordering, to find new products, to place orders); seasonality, especially of produce; the short shelf life and sell-by dates of some dairy products; and limited access because they can't get the volume of a product they need.

TRACKING LOCAL FOOD PURCHASES AND GOALS

Only two respondents report tracking local food purchases. When asked about tracking, one other respondent said "not yet, but I see it in my future." One additional respondent said that he could get the total dollar value of local food from the accountant but that that information was not readily available.

Of the two respondents tracking local purchases, both report surpassing a common benchmark of spending 20% of their budget on local food. One reports spending 28% of the total food budget on local food (23-34% depending on the season, 34% of animal proteins, 16% of produce). The other reports spending 35-40% of the total budget each quarter, depending on the season, on local food, totaling over $2.5 million for the year.

APPENDIX: RESULTS

GOALS

Several respondents identified goals related to local foods:

> "I would love to source 100% on proteins/meats [locally]. Get a system, process and procedure down to make it easier for us. Poultry is very difficult. I would love to use more local poultry. Thought it would be easy. Price is high. Can't get small cuts [because producers] don't have production staff to butcher themselves. Going 100% Slow Food on produce is possible. Don't think 100% organic is possible. As local as possible."

> "Putting in a home garden, composting. Purchasing local, the more the better, campuswide... I can't convince the other manager that she can do it and that it's affordable." [Note: this facility has two kitchens with separate managers.]

> "Put in a production garden with therapeutic and pollinator areas. I want to hire a master gardener to run it... a student in landscape design came up with most gorgeous design... We already have some donations. I want to brand [our café]. I want to do 500 meals a day instead of 200. I want people jazzed about the food. It's not about popularity; I want people exposed to this, to realize they do like beets and wheatberries, to expand people's taste and exposure so they go home and do it too. They think it's cool and go live it."

RESOURCES

When asked what resources have been most helpful to their institution in locating and purchasing local foods, building relationships and making connections was the theme throughout all answers. Of the five respondents answering this question, three identified specific people (other chefs and farmers in the community, producers reaching out to them, even knowledgeable family members); three identified organizations (Mission Mountain Food Enterprise Center, Western Sustainability Exchange, EcoTrust, Farm to Institution New England); and two identified attending events where they heard speakers or got to meet vendors and farmers featuring their products.

APPENDIX: RESULTS

Without prompting, two respondents also identified resources they need, in both cases connections to farmers and producers:

> "I heard about Western Montana Grower's Cooperative through [my wife]. I had no idea it existed. I need emails, updates, what's available. There have to be more local NW food providers and I don't even know where to look. Need inform people of what's there."

> "Getting to know the local farmers – learning about their products – would be helpful. How things are raised and grown, that would be helpful to see and learn more."

PURCHASING COMMITMENTS AND MOUS

Six respondents were asked if they could commit to buying products one year in advance (to enable growers to plan for production to meet the projected demand). Four responded yes and explained that they have a good idea of what they will be ordering. Two thought it would be possible, with one saying he needed to do a better job of projecting and that he now has a better understanding of what foods and recipes the customers and patients like and one saying it would be difficult because he does not always know if residents will like recipes until he tries them.

Three respondents were asked if a Memorandum of Understanding (MOU) would be possible. Two gave positive answers that it was a possibility, and one wanted more information before responding with any confidence.

One respondent has had an MOU with a local farmer-owned distribution group and a local processor for minimally processed (ex. chopped, blanched) and frozen local produce. His assessment of the MOU was positive:

> "[The MOU] holds everyone accountable. Our field is transient – chefs, cooks come and go. The MOU reduces this by providing a contract, guarantees everyone will get paid so we can project next year's usage. Without that, I don't know how [producers, distributors, and processors] would project usage. It gives peace of mind and protection. I wanted it - don't want processors to do a bunch of [processing] without a guarantee it's going to come out of the freezer. [The product] is there because we want it - we can guarantee movement, [they] can guarantee lower prices."