

## Local Food Promotion Program (LFPP) Final Performance Report

The final performance report summarizes the outcome of your LFPP award objectives. As stated in the LFPP Terms and Conditions, you will not be eligible for future LFPP or Farmers Market Promotion Program grant funding unless all close-out procedures are completed, including satisfactory submission of this final performance report.

This final report will be made available to the public once it is approved by LFPP staff. Write the report in a way that promotes your project's accomplishments, as this document will serve as not only a learning tool, but a promotional tool to support local and regional food programs. Particularly, recipients are expected to provide both qualitative and quantitative results to convey the activities and accomplishments of the work.

The report is limited to 10 pages and is due **within 90 days** of the project's performance period end date, or sooner if the project is complete. Provide answers to each question, or answer "not applicable" where necessary. It is recommended that you email or fax your completed performance report to your assigned grant specialist to avoid delays:

LFPP Phone: 202-720-2731; Email: [USDALFPPQuestions@ams.usda.gov](mailto:USDALFPPQuestions@ams.usda.gov); Fax: 202-720-0300

Should you need to mail your documents via hard copy, contact LFPP staff to obtain mailing instructions.

<b>Report Date Range:</b> <i>(e.g. September 30, 20XX-September 29, 20XX)</i>	Sept. 30, 2014 – Sept. 29, 2016
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<b>Recipient Organization Name:</b>	Lake County Community Development Corporation's Mission Mountain Food Enterprise Center
<b>Project Title as Stated on Grant Agreement:</b>	Farm to Hospital: Augmenting Consumption of Regionally Produced Fruits, Vegetables, and Value-Added Products to Contribute to Patient Health and Increase Market Opportunities for Rural Western Montana Agricultural Producers
<b>Grant Agreement Number:</b> <i>(e.g. 14-LFPPX-XX-XXXX)</i>	14-LFPPX-MT-0106
<b>Year Grant was Awarded:</b>	2014
<b>Project City/State:</b>	Ronan, MT
<b>Total Awarded Budget:</b>	\$99,986

LFPP staff may contact you to follow up for long-term success stories. Who may we contact?

Same Authorized Representative listed above (check if applicable).

X Different individual: Brianna Ewert, [brianna.ewert@lakecountycdc.org](mailto:brianna.ewert@lakecountycdc.org), 406-676-5901 x124

1. State the goals/objectives of your project as outlined in the grant narrative and/or approved by LFPP staff. If the goals/objectives from the narrative have changed from the grant narrative, please highlight those changes (e.g. "new objective", "new contact", "new consultant", etc.). You may add additional goals/objectives if necessary. For each item below, qualitatively discuss the progress made and indicate the impact on the community, if any.

**i. Goal/Objective 1: Increase consumption of and access to regionally grown and processed agricultural products to contribute to patient, staff, and visitor health at local hospitals through collaboration with local producers.**

**a. Progress Made:** In the beginning of the project, the program manager conducted outreach to four healthcare facilities: St. Luke's Community Hospital in Ronan, MT; St. Joseph's Medical Center in Polson, MT; Kalispell Regional Medical Center (KRMC) in Kalispell, MT; and Village Healthcare in Missoula, MT. A series of individual meetings was held with staff at St. Luke's and St. Joseph's to understand their kitchen capacity, identify easily interchangeable items (i.e. shredded carrots on the salad bar switched to local carrots) and value-added products needed, and set up the baseline surveys to be conducted in the cafeterias. The baseline surveys of consumers in these two hospital cafeterias revealed an overall positive attitude toward local food: a strong majority of respondents reported that they would like to see more local foods served in the cafeteria and that they would eat at the cafeteria more often if more local foods were served – and many were even willing to pay more for those local foods. An advisory committee including staff from each of the four facilities was also formed; this group met face-to-face and then had subsequent meetings via conference call. The program manager led this group in discussions of seasonal menu planning; identifying local season extended (frozen) and value-added products that would meet hospital needs (product development); and projection planning for local produce needs. Advisory committee members also shared local procurement resources via a shared folder. Two of the facilities placed trial orders with Western Montana Grower's Cooperative, and one, KRMC, completed pre-planning for their vegetable demand and entered a Memorandum of Understanding (MOU) with MMFEC and WMGC for season-extended, minimally processed produce.

**b. Impact on Community:** KRMC increased purchases of local produce year-round (season extended, minimally processed), thereby increasing access to healthy foods for patients, staff, and visitors. This food is reaching a broad group of people. KRMC serves 1,800 meals per day, and at this time, every plate served includes a Montana grown food. This also expanded the market for farmers by providing an additional \$52,000 of sales to KRMC in year 2 of the project compared to the baseline year.

**ii. Goal/Objective 2: Establish production of regionally grown, value-added products that meet the needs of local hospitals.**

**a. Progress Made:** The healthcare advisory group initially identified more “heat and serve” products, such as pizza sauce, marinara sauce and soups, as potential local value-added foods that would meet their needs. These products also overlapped with the needs of local schools, which would have meant larger volumes, processing efficiencies, and lower costs for these products. However, they conflicted with the move in most of these facilities toward cooking from scratch and using less processed foods. MMFEC did develop and test with hospital food service staff a beet marinara sauce and lentil hummus. MMFEC staff also taste tested our existing beef-lentil crumble in two hospital cafeterias, with overwhelmingly positive reviews. But the more promising value-added products turned out to be minimally-processed and frozen produce. With input from the Executive Chef at KRMC, MMFEC staff developed four products: a chopped, blanched and frozen kale; sliced and frozen green beans; diced, frozen tomatoes; and an apple puree. The tomato and apple products in particular can use second grade produce (with cosmetic imperfections), increasing the market for seconds and decreasing food waste. The process and specifications for each product were refined through a series of in-person meetings and phone and email discussions between KRMC, WMGC, and MMFEC staff. For example, a new process was developed to remove more of the kale stem and tomato seeds and the green beans were cut to different dimensions based on feedback from the hospital chef. MMFEC staff developed HACCP plans for these products and costs for the processing, while WMGC staff set prices for the final products. Costs were discussed among all three partners to ensure they met the hospital's needed price points, while also providing fair prices to farmers and covering processing costs.

**b. Impact on Community:** These value-added frozen products make local produce accessible year-round and expand year-round markets for the 40-member farmers of WMGC. In addition to increasing access to healthy regionally grown foods for KRMC patients, staff and visitors and providing additional markets for local farmers, these value-added products have created processing jobs in a rural community, Ronan, MT, supporting the state's only community-based, shared-use, fully inspected food processing facility.

**iii. Goal/Objective 3: Develop new market opportunities for western Montana agricultural producers by expanding the institutional hospital market.**

**a. Progress Made:** The Program Manager started out by working with the Dietary Manager and other staff at St. Luke's Community Hospital to establish a Memorandum of Understanding (MOU) establishing ordering volumes. Meetings were held between MMFEC staff and St. Luke's staff, including the CEO, to discuss an MOU. Information was collected on the volume of produce they use and current price points. This process was repeated after the Dietary Manager left St. Luke's and a new person was hired. After the staff turnover, St. Luke's did not begin ordering as anticipated.

Through a series of in person, phone, and email meetings, an MOU was established between KRMC, WMGC, and MMFEC. The Executive Chef from Kalispell Regional Medical Center developed projections for season-extended produce for the hospital for winter months that served as the basis for the MOU. The Program Manager worked with the Western Montana Grower's Cooperative (WMGC), a farmer-owned marketing and distribution cooperative with 40 members, and attended the growers' annual meeting to discuss the hospitals' projected needs and growing commitments for the season. The Program Manager also developed a price sheet for value-added processing for Mission Mountain Food Enterprise Center (MMFEC), which met the hospitals' and WMGC's need to know in advance the processing price for value-added products (in the past, prices had been set based on the cost of each processing run). Based on feedback from all partners, this MOU was valuable and successful.

**b. Impact on Community:** The MOU provided guarantees for all parties involved. For the KRMC's Executive Chef, he knew that he would receive the volume of produce he needed at a price point that was cost effective for the hospital. WMGC could plan production and secure growing commitments with farmers. They were also assured of a market and knew that any products processed would be sold, reducing the risk of the financial and energy costs associated with processing and freezing that produce. And MMFEC was also given a stable market and could predict the demand for processing services.

**iv. Goal/Objective 4: Conduct evaluation of MMFEC's farm-to-hospital project.**

**a. Progress Made:** A program evaluation was conducted with Executive Chefs and Food Service Directors at nine hospitals and healthcare facilities, a regional buyer for a hospital food service management company contracted by five area hospitals, and the General Manager at WMGC. 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. These interviews were synthesized into a detailed report intended for future program planning and a summary report with key lessons and next steps to share with project partners and others. A video was also filmed that features the successful collaboration between MMFEC, WMGC, and KRMC and highlights the benefits of Farm to Hospital. This video is being used to build enthusiasm and support for expanding Farm to Hospital programs and to promote the work of the collaborating partners. The video was screened at the 2<sup>nd</sup> Governor's Summit on Local Food and Agriculture for an audience of 200 people in Bozeman, MT, and is an official selection of the Flathead Lake International Cinemafest where it will screen in January in Polson, MT. It is also posted on our YouTube channel (<https://www.youtube.com/watch?v=VJRpakwrS74>) and our website (<https://www.lakecountycdc.org/MMFEC%20Landing>).

**b. Impact on Community:** This evaluation provided the basis for planning future and more effective program work, but it also continued to build the relationships that are the foundation of Farm to Hospital procurement through engaging conversations and deep listening. The video has already proven to be an effective tool in building support and excitement for Farm to Hospital and future screenings will reach a broader audience, raising awareness of Farm to Hospital and its benefits.

2. Quantify the overall impact of the project on the intended beneficiaries, if applicable, from the baseline date (the start of the award performance period, September 30, 2014). Include further explanation if necessary.

**i. Number of direct jobs created:** MMFEC created 1 FTE and 4 part-time seasonal jobs

**ii. Number of jobs retained:** MMFEC retained 4.5 FTE

**iii. Number of indirect jobs created:** WMGC created 3 FTE and retained 5 FTE

**iv. Number of markets expanded:** 1 (Thomas Cuisine - KRMC)

**v. Number of new markets established:** 5 (Buffalo Hills Terrace, Hillside Healthcare, Riverside, Healthcare, Village Healthcare, St. Luke's Community Hospital)

**vi. Market sales increased by \$73,606 and increased by 340%.**

**vii. Number of farmers/producers that have benefited from the project:** Western Montana Grower's Cooperative (40 producers); White's Meats and Ranchland (local meat processors); Timeless Seeds (10 growers) **a. Percent Increase:** N/A

3. **Did you expand your customer base by reaching new populations such as new ethnic groups, additional low income/low access populations, new businesses, etc.? If so, how?**

We expanded our customer base by reaching new businesses (healthcare facilities) and the staff, patients, and visitors that eat there. This project primarily worked in Montana's Lake County, Flathead County, and the Flathead Indian Reservation. According to the US Census, in Lake and Flathead Counties the median household income (\$38,732 and \$47,851 respectively) and the per capita income (\$22,278 and \$26,381) are below the national averages (\$53,889 and \$28,930). Lake and Flathead Counties and the Flathead Indian Reservation are considered low-income and rural tracks with pockets of low access areas, according to the USDA Food Access Research Atlas, suggesting that Farm to Hospital programs here would reach the low income and low access populations that these hospitals primarily serve.

4. **Discuss your community partnerships.**

**i. Who are your community partners?** Western Montana Growers Cooperative (WMGC), National Center for Appropriate Technology (NCAT), Montana Food Bank Network (MFBN), Montana Department of Agriculture's Food and Agriculture Development Centers, USDA Rural Development

**ii. How have they contributed to the overall results of the LFPP project?**

WMGC worked closely with the Program Manager to discuss the ability of their 40+ growers to address the needs of institutions and to conduct extensive price planning for value-added products. They also marketed and distributed all value-added products.

NCAT promoted our Farm to Hospital program at their Farm to Hospital Conference in November of 2014; this led to successful program outreach to Kalispell Regional Medical Center and their desire to be on the advisory committee and, subsequently, an MOU and most of the growth in sales of value-added products to hospitals. MMFEC is also partnering with NCAT in their new Harvest of the Month project, adapting educational materials, promotional materials and recipes for local foods originally developed for schools to healthcare settings. MMFEC has brought on board several of the food service directors that we have established relationships with to consult on the development of these

resources for hospitals and healthcare facilities. NCAT also partnered with MMFEC to film, edit and promote the film, “A Culture of Health: Farm to Hospital in Montana.”

The Montana Food Bank Network submitted a Community Food Security Grant to support the processing of fresh fruits and vegetables for their local food banks. They highlighted the work of Mission Mountain Food Enterprise Center and indicated that, if funded, they would work with the Center in meeting their targeted needs of providing local food through their emergency network; they are willing to work with other local producers to backhaul, which can lower costs for institutions and make local fruits and vegetables more competitive with non-local products. Although this project was not funded, they have continued conversations with MMFEC to explore another application for funding.

The Montana Department of Agriculture’s Food and Agriculture Development Center network provides statewide support for value-added agriculture; we are one of four centers in this network. USDA Rural Development also supports our Cooperative Development Center, which is funded to work with food and agriculture cooperatives (including Western Montana Grower’s Cooperative and others).

**iii. How will they continue to contribute to your project’s future activities, beyond the performance period of this LFPP grant?** WMGC will continue marketing and distributing current and new local value-added food products to institutions, including healthcare facilities. They will also continue to work with MMFEC to pre-plan production and processing and refine the specifications for value-added products. NCAT’s Harvest of the Month materials adapted for healthcare facilities will be a valuable educational and marketing tool to promote local foods in those settings and a resource for food service directors trying to start local food procurement in their institutions. NCAT recently received funding to support their Farm to Cafeteria program in working with hospitals and healthcare facilities, and they are actively working to promote the film Farm to Hospital film that we co-produced. NCAT and the Montana Food and Agriculture Development Centers will be active partners in publicizing MMFEC’s project results and promoting local value-added products for hospitals and other institutions. Montana Food Bank Network has indicated they are interested in determining how they might be a partner in distribution of local food to institutions.

**5. Did you use contractors to conduct the work? If so, how did their work contribute to the results of the LFPP project?** Yes. We contracted with the National Center for Appropriate Technology (NCAT) to film and edit our Farm to Hospital video that features the successful collaboration of partners in this project and will be used to promote the results and build support for local food in hospitals and healthcare facilities. Our contract with NCAT leveraged additional financial support to complete the video project. NCAT is actively promoting the video and project.

**6. Have you publicized any results yet?\*** Yes

**i. If yes, how did you publicize the results?** We regularly reach out to community partners, farms, institutions, public agencies and funders about our work. We do this primarily through meetings, phone calls and emails, newsletters, social media, presentations, and tours of our facility. The video created in this project, “A Culture of Health: Farm to Hospital in Montana”, was screened at the Governor’s Summit on Local Food and Agriculture at Montana State University in October and the project results were discussed as part a statewide strategic planning process at this event. Program evaluation results will be published on our website and newsletters and the mailing lists and newsletters of partners such as NCAT and the MT Department of Ag’s Food and Agriculture Development Center network.

**ii. To whom did you publicize the results?** Montana Department of Agriculture’s Growth through Agriculture Program and other agency staff, Montana Farmer’s Union Conference attendees (2014 & 2016), Washington State University Extension tour, USDA Foreign Exchange tour, Wallace Center’s food hub learning community tour, NCAT’s Farm to Hospital conference, Governor’s Local Food & Agriculture

Summit attendees (farmers/ranchers, local food entrepreneurs, nonprofit staff, state and federal government staff, institutional food service staff, academic professionals and students from across MT)

**iii. How many stakeholders (i.e. people, entities) did you reach?** The film screening at the Governor's Summit on Local Food and Agriculture reached over 200 people. Our newsletters are sent to 135 people. On average, our Facebook page reaches over 4,000 people and engages over 800.

*\*Send any publicity information (brochures, announcements, newsletters, etc.) electronically along with this report. Non-electronic promotional items should be digitally photographed and emailed with this report (do not send the actual item).*

**7. Have you collected any feedback from your community and additional stakeholders about your work?** Yes, we have collected feedback from the community and project partners.

**i. If so, how did you collect the information?** The information was collected via two surveys in hospital cafeterias at the outset of the project; through meetings, phone calls and emails during the project, and by semi-structured interviews with three groups of stakeholders near the end of the project.

**ii. What feedback was relayed (specific comments)?** In the surveys at the beginning of the project, we learned that there is tremendous support from the consumers eating in the hospital cafeterias for more local food to be served in that setting (with many going so far as to say they would eat there more often and even pay more for the food). Consumer feedback during a taste test of our Montana beef-lentil crumble was also overwhelmingly positive, with 100% reporting that they liked the crumble and 97% saying they would eat if it was served in the cafeteria. During the project, we solicited feedback on the products we were developing from hospital food service directors and executive chefs. We learned that some of our new products needed to be refined (ex. removing more seeds from diced tomatoes or more stem from chopped and frozen kale, cutting green beans to a different size). We also received feedback on how our products handled and cooked (ex. we learned from a hospital chef that the diced frozen carrots, an existing product for schools, sometimes bruised after they were thawed because the blade in our dicer was dull). During our project evaluation, all hospitals and healthcare facilities expressed a desire to source more local food, but identified obstacles including effective costs, consistent supply, and the hurdle of just getting started. The General Manager of the Grower's Cooperative that we work closely with to provide local food to hospitals expressed satisfaction with our program, services, and relationship. The food service staff at hospitals we have worked with also had positive reviews of our program and products.

**8. Budget Summary: i. As part of the LFPP closeout procedures, you are required to submit the SF-425 (Final Federal Financial Report). Check here if you have completed the SF-425 and are submitting it with this report:  see additional attachment**

**ii. Did the project generate any income?** No

**a. If yes, how much was generated and how was it used to further the objectives of the award?** N/A

**9. Lessons Learned:**

**i. Summarize any lessons learned. Draw from positive experiences (e.g. good ideas that improved project efficiency or saved money) and negative experiences (e.g. what did not go well and what needs to be changed).**

*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 in our program evaluation, 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 in contrast to many food service management companies, this company has positioned itself to offer local procurement, realizing that this is a value for many clients. Their chefs also collaborate across institutions so a good relationship with one can lead to social capital with others.

*Relationships are Key to Success* Food service personnel in our program evaluation 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. Other healthcare institutions may need to try other strategies, such as a team approach to support local purchasing, including expectations in job descriptions and goals, and/or including thresholds for local purchasing in contracts with food service management companies.

#### *On-Contract Purchasing Compliance Rates: Obstacle?*

Often, 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. However, our program evaluation 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. These regional contracts are also often used to secure volume discounts that may not be as feasible from smaller local vendors. Two contracts like this was one of the biggest obstacles to this project. They were implemented by facilities during the course of the project. Staff from those facilities originally served on the project's advisory committee, but dropped off after the contracts were implemented because they were such a barrier to local purchasing.

*Staff Turnover* The other most significant obstacle in this project was unexpected staff turnover in our program and at hospitals. One hospital Dietary Manager, who was on the advisory committee and prepared to sign the HHI pledge and begin local procurement, left her position in the middle of the project. Program staff continued regular outreach to her replacement, but the new hire had a steep

learning curve for her other responsibilities and, despite a professed desire to buy local food, only placed one order for a special event. Since the grant ended, she also left the position, and the hiring process is underway for a second time. This provides an opportunity and challenge to begin developing that relationship again and making the case for local food. Our program evaluation showed that more than half of Manager/Directors or Executive Chefs had been in their position less than 1 ½ years and an Executive Chef we work closely with has said this is a transient field. Because relationships have been key to the success of Farm to Hospital, staff turnover slows or even reverses progress. This also suggests that building support with other stakeholders in hospitals and healthcare facilities is essential and that expectations for local procurement should be included in job descriptions and food service contracts to provide continuity.

**ii. If goals or outcome measures were not achieved, identify and share the lessons learned to help others expedite problem-solving:**

We had mixed results for one of our outcome measures, “2 pilot orders between schools and hospitals.” In our experience with schools, we learned that cooperative ordering between institutions achieved volumes that created processing efficiencies and thereby cost savings that could be passed on to the institutions. Many institutions in rural Montana do not alone order the volume needed to make value-added processing efficient and cost-effective. We hoped to combine orders across schools and hospitals for even greater efficiency. At this point, we achieved this outcome with frozen products: we processed “food service” (or bulk) products (such as peeled, cubed squash and diced carrots) that both the schools and the hospitals use. However, it’s easier to achieve the volumes for frozen products because they can be processed all at once and delivered over time. It’s more difficult to achieve large volumes on fresh processed produce because each batch must be delivered immediately. We have schools that order fresh processed produce (such as bell pepper rings or coiled carrots) on a weekly basis for snacks. But at this point, hospitals have not been ordering fresh processed products. The hospitals that already order conventional fresh processed produce (like shredded carrots for a salad bar) have been slower to begin local food procurement. The hospitals that have led the way in Farm to Hospital have the capacity (both in trained staff and facilities) to handle whole, fresh, unprocessed produce. They do not need our services for fresh processing. We may yet achieve this outcome in the future as we work with additional hospitals that lack the labor or equipment to process fresh produce themselves.

We also changed one of our outcome measures (although it still meets the original goal and objective). In our original proposal, we intended to complete the Healthier Hospitals Initiative’s (HHI) partner case-study document. We were a supporting organization of the Healthier Hospitals Initiative, but when that initiative became a permanent program of Practice Greenhealth, the “supporting organization” designation was eliminated (although we have continued the relationship with Practice Greenhealth to identify ways to increase hospital engagement in our area). They would have still promoted the partner case-study, but the hospitals with the most progress in Farm to Hospital were not signed on to the Healthier Hospitals Challenge so the case study was not appropriate. Practice Greenhealth wants to promote the facilities signed on to their challenge, and the hospitals we worked with that had signed on did not make much progress in local food procurement. So instead of the case study for Practice Greenhealth, we created the film “A Culture of Health: Farm to Hospital in Montana”, which itself is a case study not just of a hospital sourcing local food but of all the partners and relationships that have made Farm to Hospital successful. This film is being (and will continue to be) used to share the project with broad audiences and diverse stakeholders.

**iii. Describe any lessons learned in the administration of the project that might be helpful for others who would want to implement a similar project:**

Lake County Community Development Corporation is set up for fund accounting, which made the financial administration of this grant seamless.

#### **10. Future Work:**

**i. How will you continue the work of this project beyond the performance period? In other words, how will you parlay the results of your project's work to benefit future community goals and initiatives? Include information about community impact and outreach, anticipated increases in markets and/or sales, estimated number of jobs retained/created, and any other information you'd like to share about the future of your project.**

Our Farm to Institution program has parlayed our success in developing value-added products for institutions (including the beef-lentil crumble originally developed for schools and the four value-added products for hospitals developed through this project) into a Specialty Crop Block Grant supporting the development of an additional six value-added local food products for institutions and MOUs with institutions, producers, and distributors. We will also continue processing the value-added products developed in this project; our processing operation is financially self-sustaining as a result of the development work done through Farm to Institution. As a result of this project, we have a better understanding of the needs of hospitals and stronger relationships with stakeholders. We are working on resources to address the obstacles to local procurement in hospitals. And we will be widely promoting the success and benefits of Farm to Hospital with our new film.

**ii. Do you have any recommendations for future activities and, if applicable, an outline of next steps or additional research that might advance the project goals?**

- 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. One of our next steps will be to organize a forum for these discussions.
- 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. Another step we will take is building relationships with other stakeholders at these healthcare facilities. We started this process, including meeting with the St. Luke's Hospital CEO, during this project, but we need to put additional effort into this area and, because of staff turnover in our program, start it anew in some cases.
- 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 our program evaluation 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 the program evaluation 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. One hospital chef 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. We are currently partnering with NCAT to support their work to adapt these materials 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. MMFEC has successfully used MOUs with a hospital and other institutions in the past. We have shared a template when requested, but we need to create a resource guide, including a sample MOU, that could be used to educate and advocate for the use of MOUs.
- 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. Many hospitals and healthcare facilities we work with are not aware of these resources (or forget about them) and need additional outreach.
- 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. 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. Program staff have the opportunity to build relationships with other stakeholders and offer input on these surveys that would hopefully result in more robust research and information on the connection between food access and health in the communities where we work.