Board Vision Exchange
SESSION #2
Second Harvest Heartland Food Bank
July 27 & 28

July 27, 5:30 – 8:30 - Tour SHH Food Bank and Dinner

At 5:30 we will have philosophy tour of the facilities. This tour is not a standard "this is what a freezer looks like" tour and is instead designed to be relevant to food bankers. We will use the points of interest to discuss tactical and strategic thinking, why we are doing things one way versus another, opportunities and challenges.

We will have a reception at 6:30 and then at 7:00 we will have dinner at Punch Bowl Social.

July 28, 8:00 – 3:00 – Program at Second Harvest Heartland, Golden Valley - Community Room

- Introductions and Welcome – Greg Hilding and Rob Zeaske
- Small Group Discussion – what does success look like during today's session?

***8-12 Signature Topic - Hunger and Health. Imagining the Food Bank as a wellness organization*.**

At our Houston Vision Exchange, Brian Greene challenged us to consider how we aim our "engine" at more than just food security. And Matt Knott walked us through the future of the food industry. In our St. Paul conversation, we'd like to argue that our future isn't just in the "food industry" at all – but, perhaps even predominantly in the next 5-10 years, in Health and Wellness. A 2010 study by Brandeis University estimated that America's preventable "hunger-related illness" cost was $130 billion per year, and likely climbing. Food is Medicine – especially for our low-income neighbors – and we are just one of many food banks working to develop new business models to take advantage of incentives aligned with Health Care organizations to use better food to improve food security, lower costs of care and make patients healthier and happier.

- Rob Zeaske – "State of the Nation" introduction to health conversation and Review of Feeding America Slides – the state of hunger and health nationally
    - Does any of the data surprise the board?
    - What does this landscape mean broadly for our food banks?
    - This is evolving quickly – is there a "first mover advantage" as this work unfolds that we need to pursue aggressively?
- Marie Zimmerman, Director of Medicaid, State of Minnesota and Second Harvest Heartland Board Member – "State of the State" - Operating Social Determinants of Health programs at the State Level – opportunities with Medicaid
    - What opportunities are unfolding for food banks from public payers?
    - What are the priorities of state/federal partners?
    - Are food banks well positioned to be a partner of choice for health care organizations? Which ones?

    - What barriers/baggage to food banks bring and what will we have to overcome?
- Generative, participant-led discussion - So What Do We Do? Hunger and Health at the Food Bank Level
    - State of the food banks in the room - what are the top 2-3 health interventions going on now?
    - Why? Rationale/Motivation - Why or why not is your food banks engaging in health initiatives?
    - Small Group - What is Feeding America's role in in the healthcare conversation?
    - How? Business model – How can we break through to sustainable revenue?
    - How? What is it that "only we can do" – our highest and best use in this opportunity? WE have lots of partners who would be happy to play in this space – as we develop our understanding of the value chain, where should we play?
    - Small Group Discussion - What do you see as necessary changes in your food banks to be ready to be a partner of choice to healthcare? How ready are you to make these investments?
    - Vision – With respect to health care partnerships, what will success look like for your food bank in 5 years? What % of your business/programs will it be?

12:30-2:00 Fundraising – getting to the next level in private fundraising.

- How are the best food banks building relevance among the highest giving levels in your communities?
    - Data from MN – pie chart of $1 million+ gifts to MN charities
    - Is this a challenge in your markets and how are you addressing?
    - Have you noticed changes in relevance over time and how are you investing for growth in major gifts?

2:00-3:00 Risk and Scenario Planning – how to deal with and message potential crises

- BCG has been working with Second Harvest Heartland to plan for shocks to our system from economic changes, and federal legislation that could directly affect hunger relief programs or programs that indirectly affect hunger through reduced support for things like energy assistance.
    - Sample slides from current (ongoing/incomplete) work
    - How are other food banks planning for shocks or federal changes? If you have done similar planning, how are you messaging these changes and to whom?
    - How would you think about "don't waste a crisis" moments if really challenging conditions come our way?

Strategic Plan – Executive Summary

Our Assessment:

Our Environment Continues to Change

Meal Gap will increase modestly over the next five years

Traditional sources of food are declining (manufactured)

Public nutrition programs remain dramatically underutilized among eligible neighbors and will require business model innovation

Growth in fresh and perishable products creating more complexity and cost

Nutritional content of food is more important to our community than ever before

Second Harvest Heartland's increased "market share" necessitates a higher degree of service for our agency partners

These strategic priorities will guide us over the next five years:

1. We will better serve the end customer: our hungry neighbor
2. We will focus on hunger
3. We will prioritize opportunities that leverage our scale and reach
4. We will provide and invest in leadership for our broader network of partners

Our focus will be on opportunities with the highest impact to the clients we serve:

FEED

Feed the Line: Increase Food Assistance for Today's Hungry Neighbors

- ❑ Produce: Focus on increasing the capture of available agricultural products and develop partnerships that increase supply of shelf stable produce

Shorten the Line: Decrease the Need for Food Assistance for Tomorrow

- ❑ SNAP: Advance efforts to maximize enrollment of eligible clients
- ❑ Federal Child Nutrition Programs: Focus on increasing enrollment in programs with highest opportunities to add meals

LEAD

- ❑ Advocacy - Amplify a common message that articulates the issue of hunger and its solutions
- ❑ Generate and leverage data to educate and catalyze our partners and the community
- ❑ Promote integrated hunger-relief solutions with the health and education sectors

STRENGTHEN

- ❑ Grow our financial strength to deliver our mission
- ❑ Build infrastructure for the 21st century (facilities and capital)
- ❑ Provide "tailored community solutions" to increase service to clients in high-need and under-served communities
- ❑ Build "hunger labs" to pilot and test opportunities of scale and for replication

FOOD BANKS: PARTNERS IN HEALTH PROMOTION

Hilary Seligman MD MAS

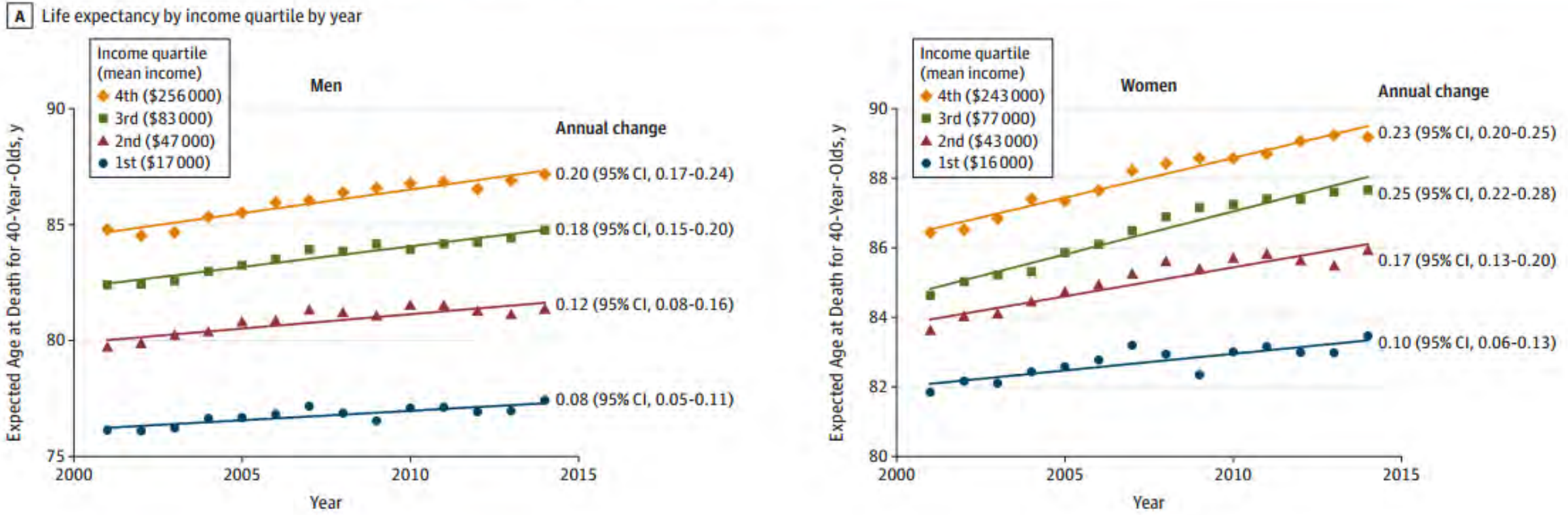
May 18, 2017

FEEDING AMERICA®

UCSF
University of California
San Francisco

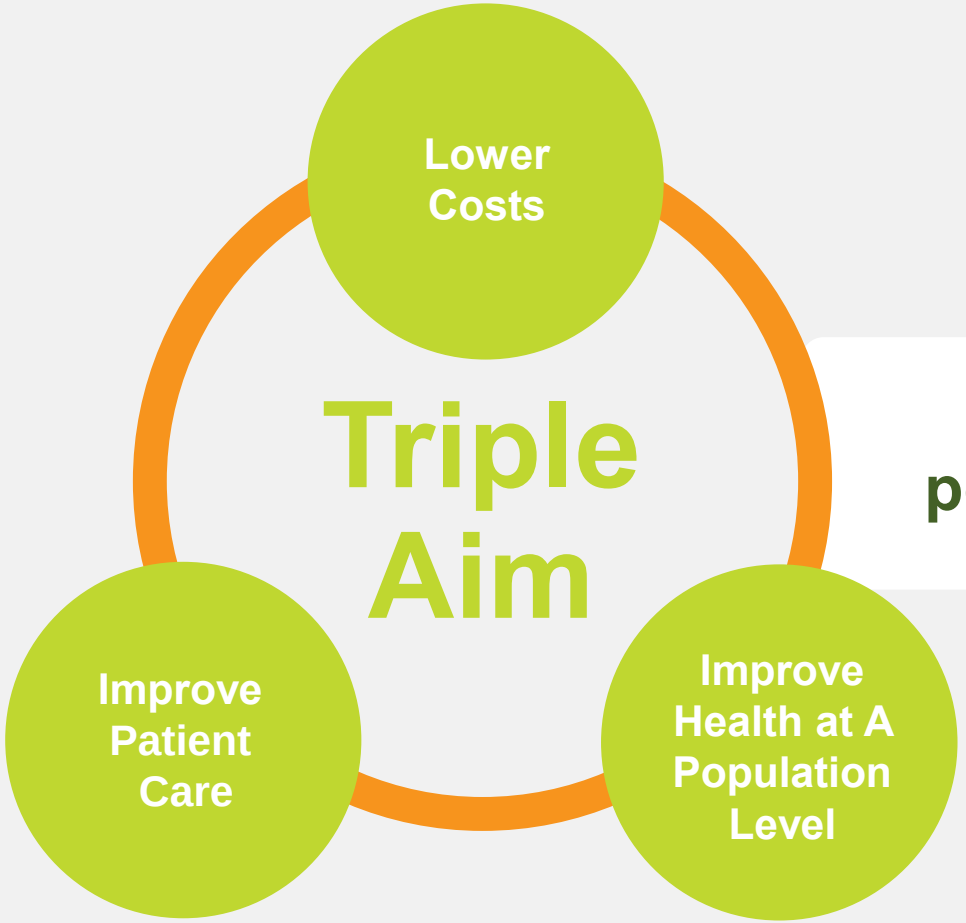
INCOME-RELATED DISPARITIES IN DEATH RATES PERSIST

Figure 3. Changes in Race- and Ethnicity-Adjusted Life Expectancy by Income Group, 2001-2014



Chetty, The association between income and life expectancy in the United States, 2001-2014. JAMA. April 2016.

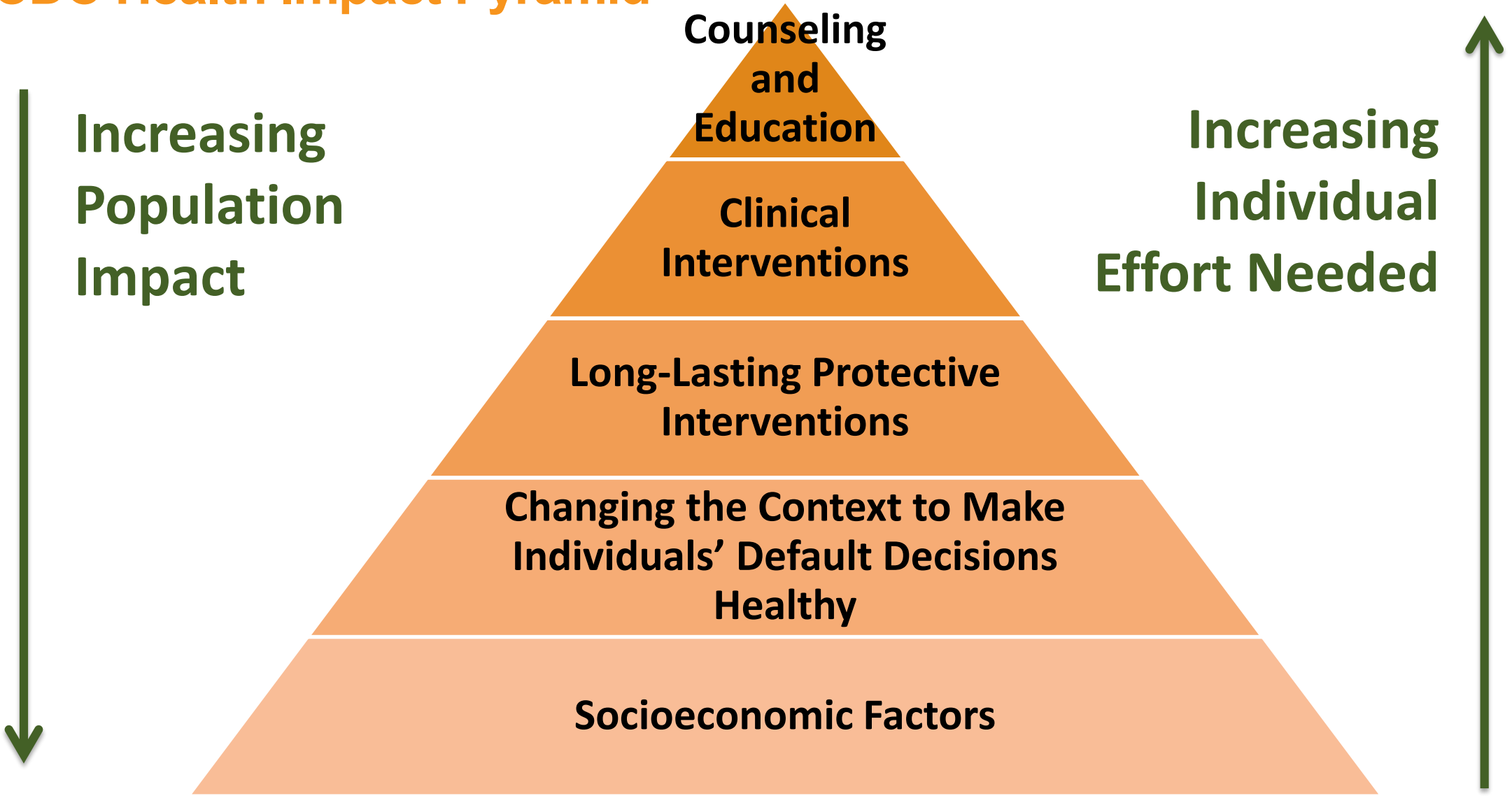
Triple Aim of Health Care



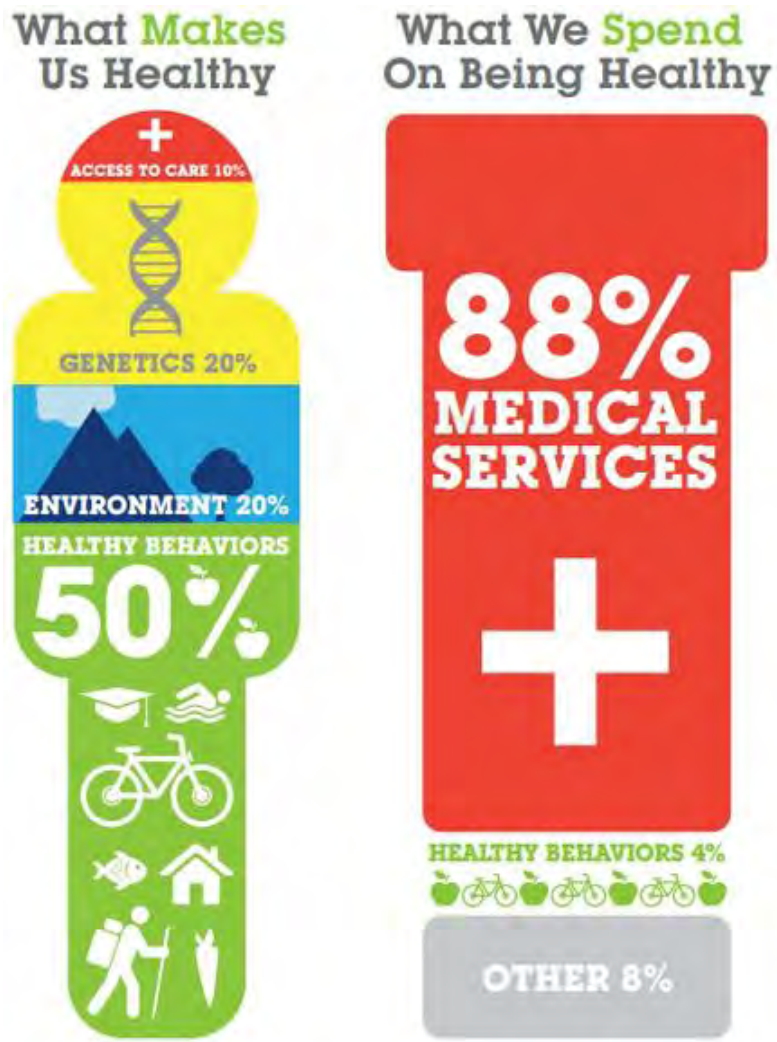
Better care for the whole population at the lowest cost

Source: See Donald M. Berwick et al. The Triple Aim: Care, Health and Cost, 27 Health Affairs 759-769 (2008); Institute for Health Care Improvement

CDC Health Impact Pyramid

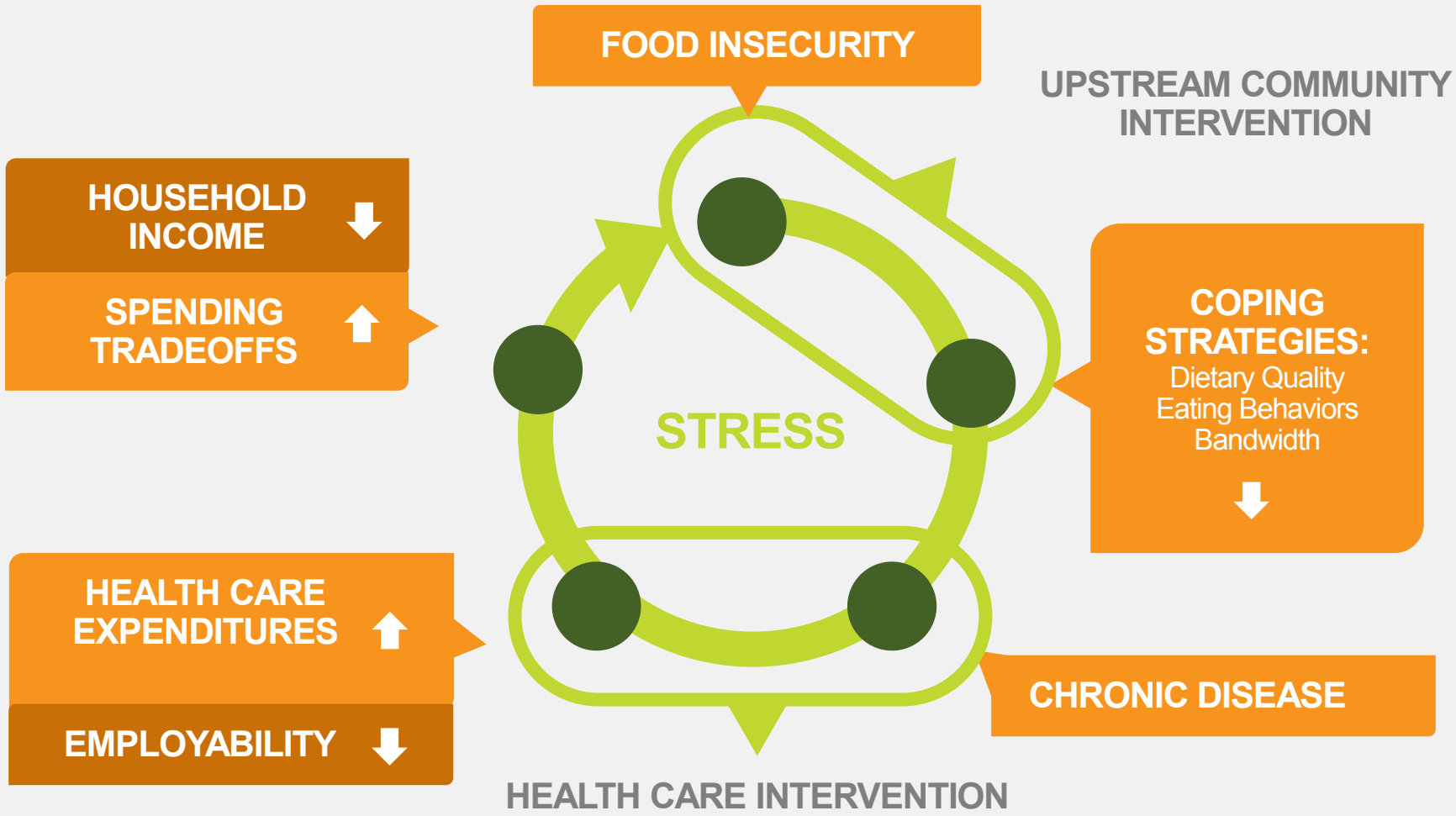


Frieden T. Amer Jl of Public Health, April 2010.



Source: Bipartisan Policy Center (http://bipartisanpolicy.org/projects/lots-lose) • Dakotafire Media (www.dakotafire.net)

A Conceptual Framework: Cycle of Food Insecurity & Chronic Disease



Food Insecurity

What we know today

Across the lifespan, food insecurity is associated with:

- Poorer dietary intake
- Poorer physical, psychological, and behavioral health
- Poorer disease management

What we *think we* know

Improving food security results in:

- Better dietary intake & lower weight
- Improved disease management
- Lower health care costs
- Better health

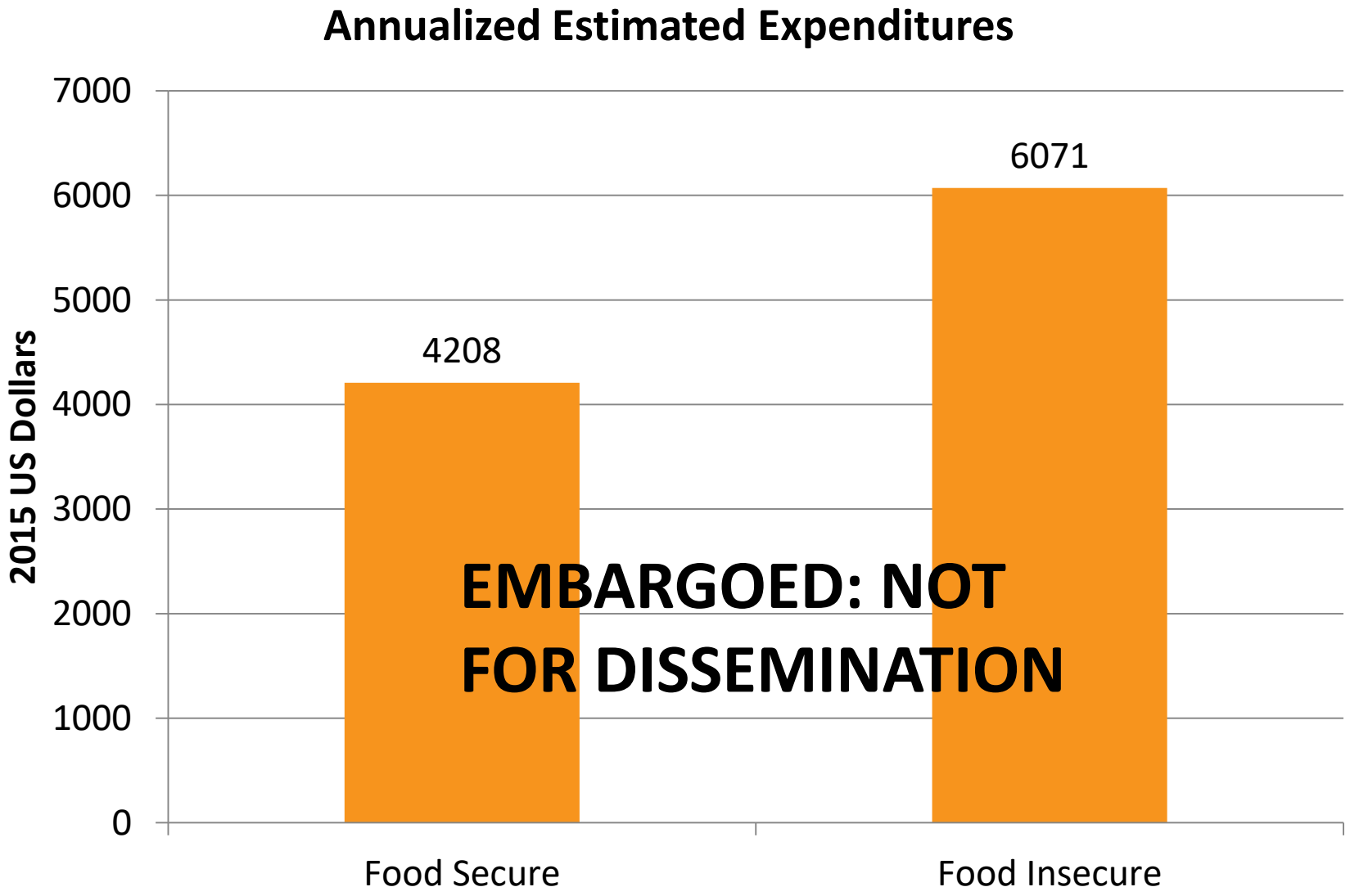
Reducing Food Insecurity May Impact Health in Many Ways

Food Insecurity and Health Care Costs

Variable	Odds of health care expenditure* n = 67 033		Total health care costs per person† n = 59 817	
	Unadjusted OR (95% CI)	Adjusted‡ OR (95% CI)	Unadjusted mean, $ (95% CI)	Adjusted‡ mean, $ (95% CI)
Food insecurity status				
Food secure	1.00 (ref)	1.00 (ref)	1516 (1498–1534)	1438 (1421–1455)
Marginally food insecure	1.03 (0.90–1.17)	1.13 (0.99–1.29)	1748 (1647–1849)	1673 (1579–1767)
Moderately food insecure	1.21 (1.08–1.36)	1.33 (1.18–1.50)	2143 (2037–2249)	1892 (1800–1985)
Severely food insecure	1.54 (1.30–1.81)	1.71 (1.44–2.04)	3078 (2883–3273)	2529 (2370–2688)

Source: Tarasuk, CMAJ, 2015.

US Data on Healthcare Costs Associated with Food Insecurity (NHIS-MEPS data)

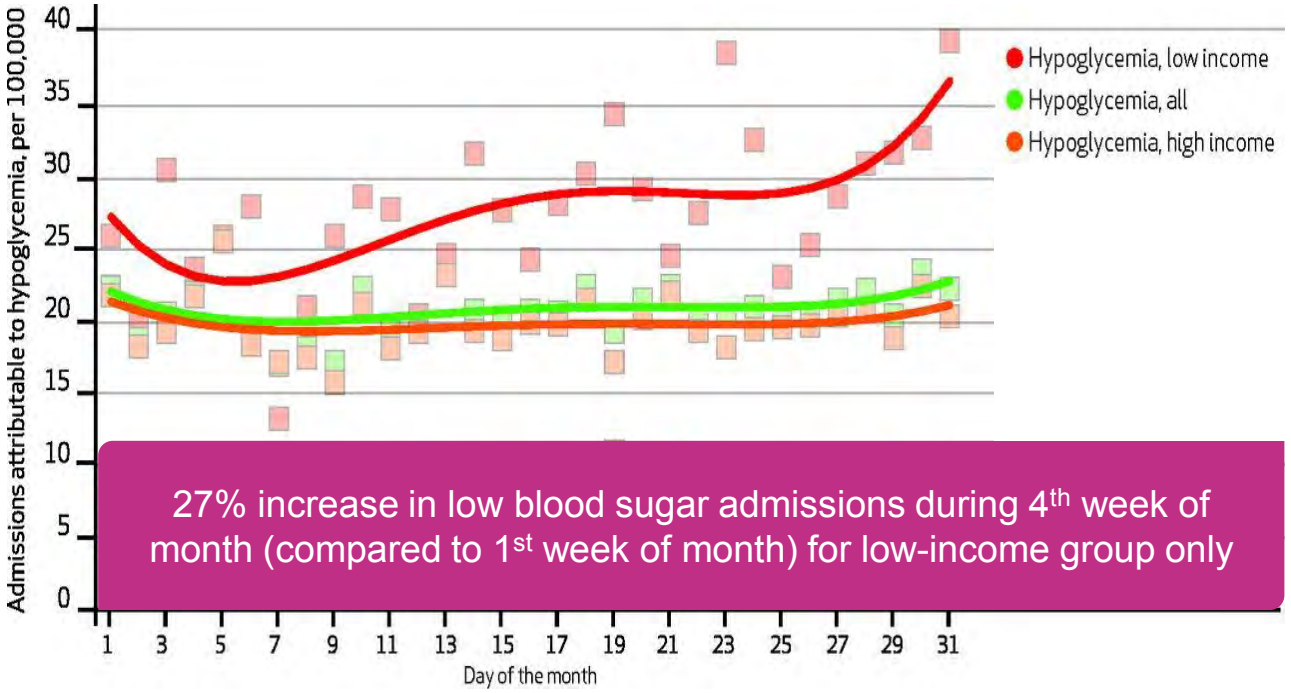


Estimates adjusted for: age, age squared, gender, race/ethnicity, education, income, rural residence, and insurance.

Berkowitz, Basu, and Seligman. Health Services Research: *in press.*

Hospital Admissions Attributable to Low Blood Sugar

Admissions Attributable To Low Blood Sugar Among Patients Ages 19 And Older To Accredited California Hospitals On Each Day Of The Month, By Income Level, 2000–08.



HealthAffairs

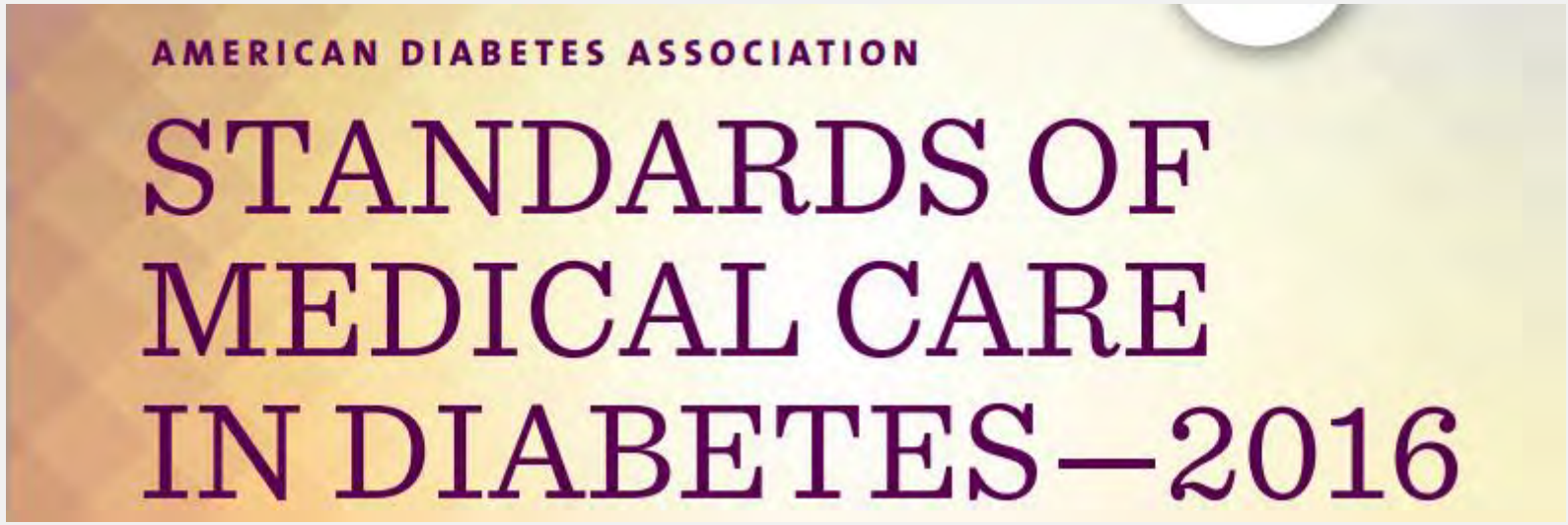
Source: Seligman H K et al. Health Aff 2014;33:116-123

SUMMARY OF THE WAVE WE ARE CRESTING

- Food insecurity is entering the mainstream of healthcare as a critical social determinant of health
- Financial interconnections between food insecurity and poor health are increasingly appreciated

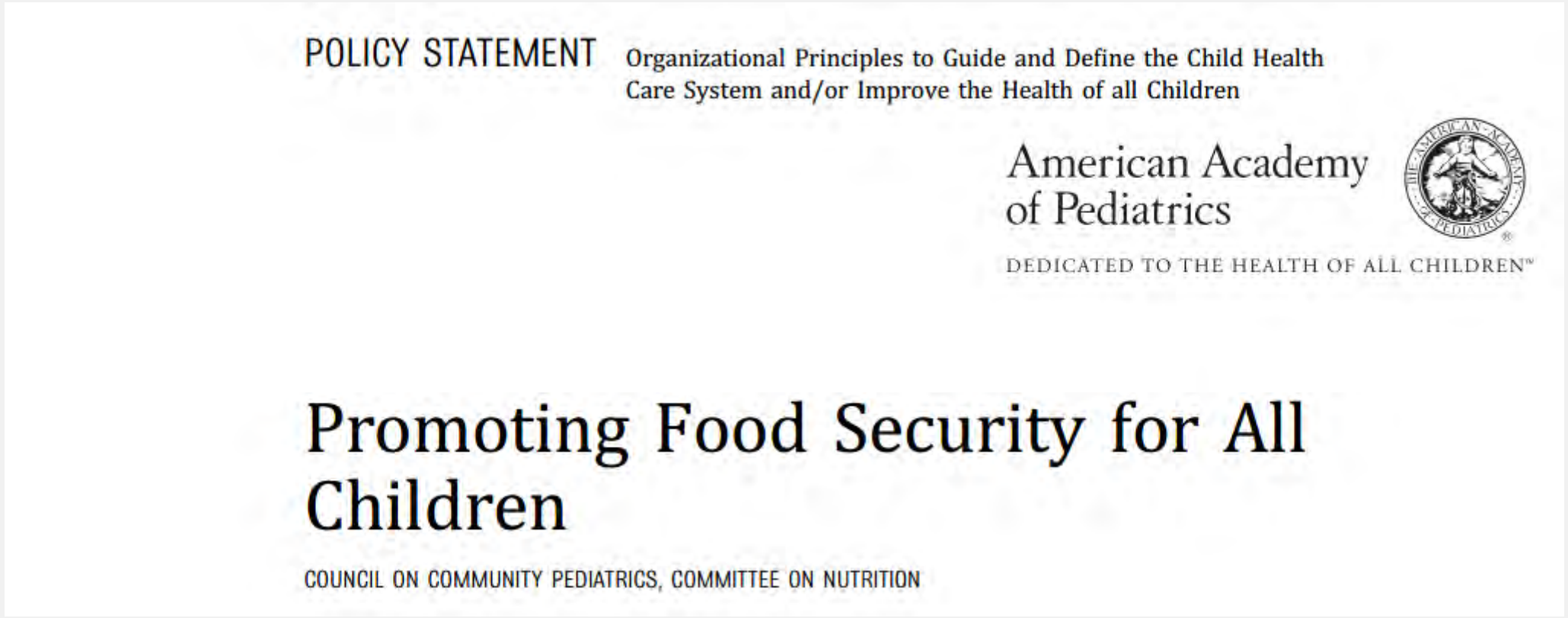
Implications:

- Professional organizations for physicians are recognizing importance of food insecurity
- Dozens of food insecurity interventions are being implemented in clinical settings
- Numerous *potential* funding mechanisms and models



- For the 1st time, advises providers to:
  - "Evaluate hyper and hypoglycemia in the context of food insecurity"
  - "Propose solutions accordingly"
- Offers suggestions for medication management
- Proposes linkage to community resources

American Academy of Pediatrics Recommends Universal Screening



POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Promoting Food Security for All Children

COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON NUTRITION

Available at: http://pediatrics.aappublications.org/content/pediatrics/136/5/e1431.full.pdf

Key Points in AAP Policy Statement

- Importance of food insecurity for children's physical and mental health, behavior, and developmental/academic outcomes
- Recommendations for pediatricians
  - Two-item screening tool "at scheduled health maintenance visits"
  - Learn how food insecurity impacts health outcomes
  - Familiarize yourself with community resources
  - Be advocates for increasing access to and funding for nutrition programs

Available at: http://pediatrics.aappublications.org/content/pediatrics/136/5/e1431.full.pdf

Hunger Vital Sign©

For each statement, please tell me whether the statement was "often true", "sometimes true", or "never true" for you or your household:

Within the past 12 months we worried whether our food would run out before we got money to buy more.

- ☑ Often True
- ☑ Sometimes True
- Never True

Within the past 12 months the food we bought just didn't last and we didn't have money to buy more.

- ☑ Often True
- ☑ Sometimes True
- Never True

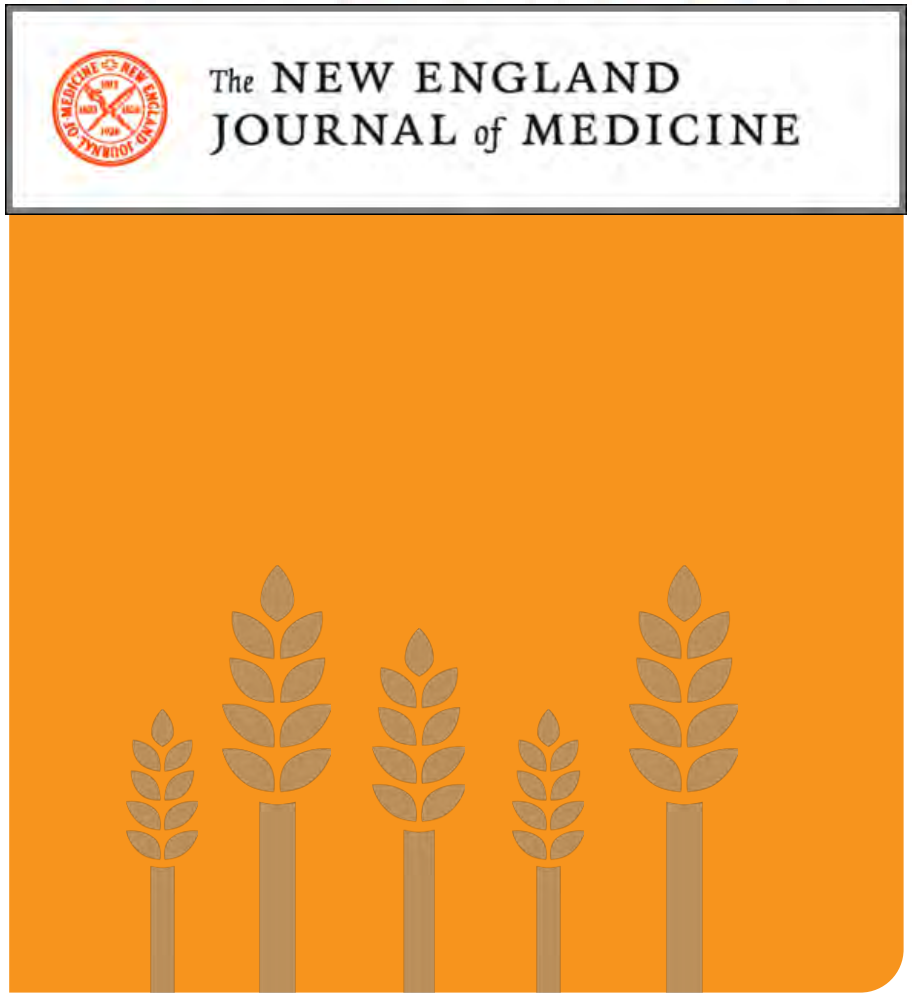
http://www.childrenshealthwatch.org/public-policy/hunger-vital-sign/

Early Data on Clinical Screening Programs Available: More Coming Soon!

- Kaiser Permanente of Colorado experience
- Passive referrals are much less efficient than active referrals

http://healthaffairs.org/blog/2015/07/13/linking-the-clinical-experience-to-community-resources-to-address-hunger-in-colorado/

Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid



- Major new CMS program for social needs screening in clinical settings
  - Food insecurity, housing instability, transportation needs, utility needs, intimate partner violence
- Grants ongoing; evaluation to begin 2017
- 3 specified tracks

Screening for needs + info about resources
Screening for needs + navigation into resources
Screening for needs + 'alignment of healthcare systems and community organizations'

So what is a health partner to do?

1. *Implementing on-site initiatives*
2. Clinical initiatives – Screening for food insecurity and referring to community based partners
3. Engaging actively in community advocacy and policy development
   - Participating in community coalitions, like your local food policy council
4. Financing community initiatives that your patients are using to address their dietary needs, either through community benefits or operating funds
5. Modelling the importance of food security and health for the community – attractive, healthy foods in cafeteria are affordable
6. Intentionally hiring from neighborhoods at highest risk and supporting career growth and leadership opportunities

Partners in Health and Nutrition

Feeding America's national reach makes it possible to create overarching partnerships that can support health and nutrition throughout the network.

- **Enroll America**: The nation's largest health insurance enrollment coalition and Feeding America are training food banks to provide affordable health care information, referrals and/or enrollment assistance

- **Pathways to Health Promotion**: Feeding America is developing a standardized framework to empower food banks to implement evidence-driven health care partnership activities in their communities

On-Site Initiatives: A Spectrum

- Educating clinicians and health care staff about screening
- Onsite food distribution
  - Food Pharmacy (“Farmacy”) permanently located at hospital or clinic, stocked and/or staffed by Food Bank
  - Mobile food distributions at hospital or clinic
  - Take-home meals provided at discharge
- Meal programs onsite
  - Summer Food Service Program
  - Congregate Meal Site
- On-site SNAP enrollment assistance during clinic visit or hospitalization

PREPARING YOUR FOOD BANK FOR HEALTH CARE PARTNERSHIPS

- Have a staff person familiar with use of the Hunger Vital Sign, clinical interventions, and public health impact of food insecurity
- Prepare yourself with important issues that arise in intervention implementation
  - Universal screening may yield more demand than you can handle
  - Increased demand to provide highly nutritious foods
  - Sustainability: encouraging health care partners to develop shared financial models
  - Matching intervention with stage of readiness of partner
  - HIPAA compliance

Partners in Health and Nutrition

Food banks are embedded in local communities, making them powerful partners in educating food-insecure people.

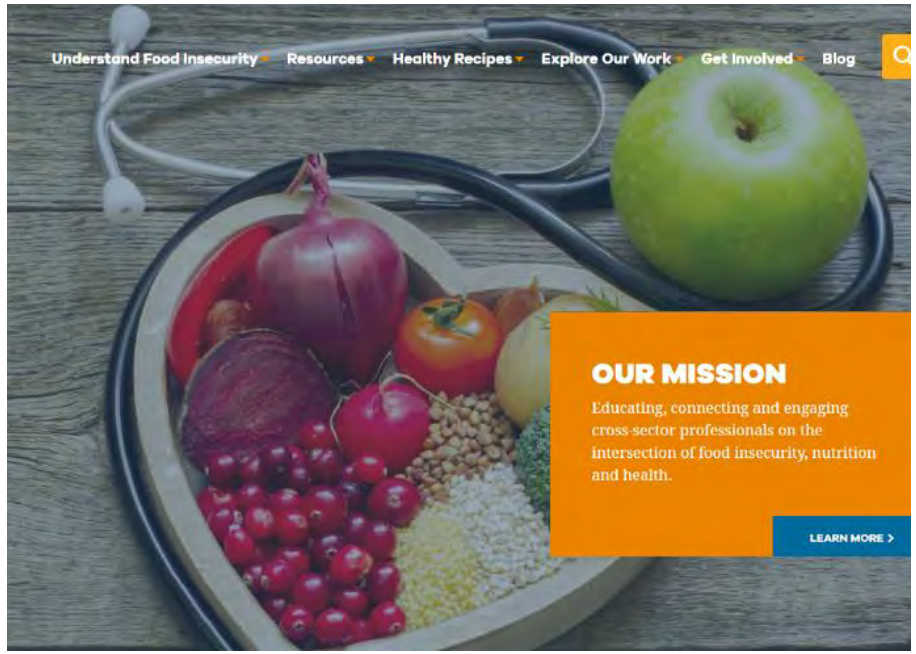
- Food banks reach people who are more likely to be dealing with nutrition-related illnesses and may have less access to health care than the average population
- Recent changes in health care delivery may enable food banks to play a more formal role in health promotion
- To help food banks in this work, we have launched a technical assistance series with the publication of ***"Food Banks as Partners in Health Promotion"***

HungerandHealth.org

Educate. Connect. Engage.

- Launched in February 2017
- Public Feeding America platform
- Provides expanded information, resources and engagement opportunities
  - Healthy recipe and resource libraries
  - Peer-sharing blog platform
  - Customizable widgets for external websites

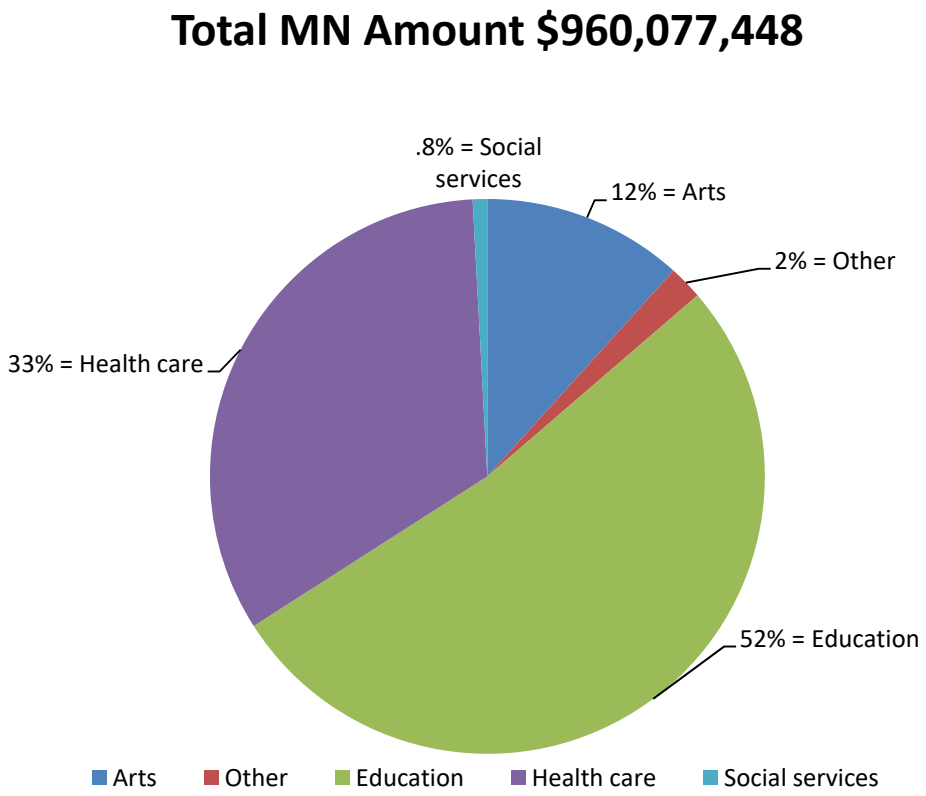
HUNGER + HEALTH | FEEDING AMERICA



Partner with Us

Subscribe to Our Digest

Philanthropy to Minnesota Nonprofits: Where Do the Dollars Go?



Notes:

- From *Chronicle of Philanthropy*
- 2007-2016
- Gifts $1M and greater, from individuals/their foundations
- To nonprofits in MN
- Data may not be complete; the *Chronicle* uses publicly announced data and welcomes new information

second harvest HEARTLAND

BCG

second harvest HEARTLAND

Preparing for the future: Scenario modeling the meal gap

Steering committee meeting #2

July 26, 2017

THE BOSTON CONSULTING GROUP

Executive Summary (I of II)

Recall, in Minnesota the rate of *Food Insecurity* is at lowest since 2009; However proposed changes to federal welfare programs threaten to reverse this momentum

- Currently, over 540,000 Minnesotans miss ~100 million meals *after* federal programs & Emergency Food System (EFS)
- Now, the federal administration is proposing funding reductions to select nutrition and welfare programs that could exceed $700 million in Minnesota on an annual basis

The social and economic effects of hunger are far-reaching

- Hunger predisposes people to health problems and social dysfunction
- Providing an answer to hunger can be a critical gate in avoiding further economic and social hardship

We are engaged to help SHH understand the impact of these proposed changes and how the organization can position itself to lead over the future months and years

- This analysis seeks to identify how demand on the local EFS could increase given the range of potential changes to public assistance programs
- The findings can be used to advocate with key stakeholders for needed changes and support (i.e. state legislatures)

We are approaching this work in three phases

- Last time, we reviewed the preliminary input variables, assumptions and output from the meal gap model
- Today, we will review a refined estimate and discuss what it means for SHH in terms of program funding and growth
- In the final phase of work, we will provide a set of advocacy materials for use by SHH

Executive Summary (II of II)

Our refined model predicts with 80% confidence that the meal gap in Minnesota will increase by at least 35 million meals and could double from ~100 million today to ~200 million total by 2022

- SNAP is the largest and most sensitive variable; It is imperative for the state to fully fund what the federal government ceases to in order to contain the incremental meal gap
- Cuts to non-food programs also prompt heavier reliance on the EFS, contributing to the incremental meal gap

Changes to these programs would put tremendous strain on low income households and the EFS

- Minnesota's EFS would need to increase its output by ~70% to meet the incremental need
- With 75% share of MN's EFS, this burden would fall primarily on the shoulders of Second Harvest Heartland

To meet the incremental need in its service area, SHH would need to double its current growth projection for 2025; Funding this growth would require an additional $24M in annual operating revenue

- Before operations can grow, SHH needs to secure the capital campaign funds to execute its planned investments & buildout
- However, the facility alone is not enough; Growing output substantially would require SHH to unlock new levels of resourcing across food, funds and volunteers

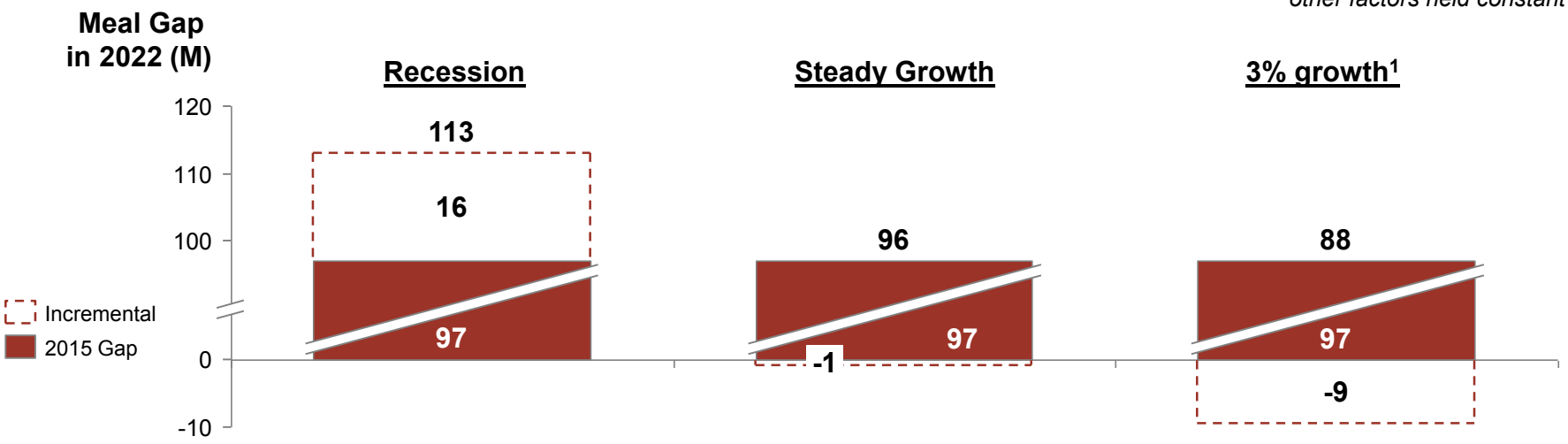
The final phase of work will produce three things:

- Set of advocacy materials
- Agile tool to support strategic planning
- Preliminary list of opportunities for growth

Added GDP scenarios to Monte Carlo model

GDP scenarios added to account for potential variance in baseline meal gap

Illustrative - assumes all other factors held constant



	Recession	Steady Growth	3% growth[1]
Unemployment %	5.9%	3.9%	2.5%
Poverty %	10.9%	8.1%	7.8%
Median Income	$66k	$79k	$92k
Home ownership	68.5%	68.5%	69.1%
Probability in MC	**20%**	**60%**	**20%**
Methodology[2]	• Identified lowest level since 2000 for each metric • Modeled linear change over 10 years	• Calced '11–'16 CAGR for each metric • Modeled steady growth using calculated CAGR values	• GDP Grew 3.03% in 2005 • Calced 2005 CAGR for each metric • Modeled steady growth w/ CAGR

GDP growth or contraction could swing baseline meal gap estimate between 88M and 113M by 2022

1. Trump budget proposal assumed 3% GDP growth to balance budget 2. Projected over time, point represents 2022 for each scenario
Source: Oxford Economics, FRED Economic Data, Minnesota Compass, Kaiser Family Foundation

Recall, Federal budget proposal targets several welfare programs with both direct & indirect impact to EFS

We assessed Federal nutrition programs that *directly impact* meal gap

Major nutrition programs

1. Supplemental Nutrition **(SNAP)**
2. Women, Infant, Children **(WIC)**
3. School meals **(NSLP)**
4. Summer meals **(SFSP)**
5. Afterschool meals **(CACFP)**

No significant changes to child nutrition programs in budget proposal

Attention was also paid to programs that *indirectly impact* the meal gap

Major assistance programs

2. Medicaid & American Health Care Act **(AHCA)**
3. Temporary Assistance for Needy Families **(TANF)**
4. Low Income Home Energy Assistance **(LIHEAP)**
5. Earned Income & Child Tax Credit **(EITC) / (CTC)**

The degree to which these indirect variables impact the meal gap is estimated in the next section using an approach of the household budget

Prioritized five key programs for further analysis

Refined population estimates

Five key programs face potential funding cuts up to ~$700M per year in Minnesota

	Program	2016 Federal funds to MN	Key changes in current budget proposal	Max funds at risk in MN ($)
Direct	1 SNAP	$600M	• Federal restrictions on eligibility • States required to match up to 25%	($60M) ($300M)
Indirect	2 AHCA	$6,400M[1]	• Restrict eligibility via Medicaid expansion phase-out and cap funding	($83M)
Indirect	3 TANF	$270M	• Reduce TANF by 10%	($27M)
Indirect	4 LIHEAP	$114M	• Eliminate LIHEAP	($114M)
Indirect	5 EITC CTC	$3,600M	• Require SSN for tax credits	($120M)
TOTAL				**($704M)**

Assumes MN meets at halfway point because full dismantling of SNAP highly unlikely

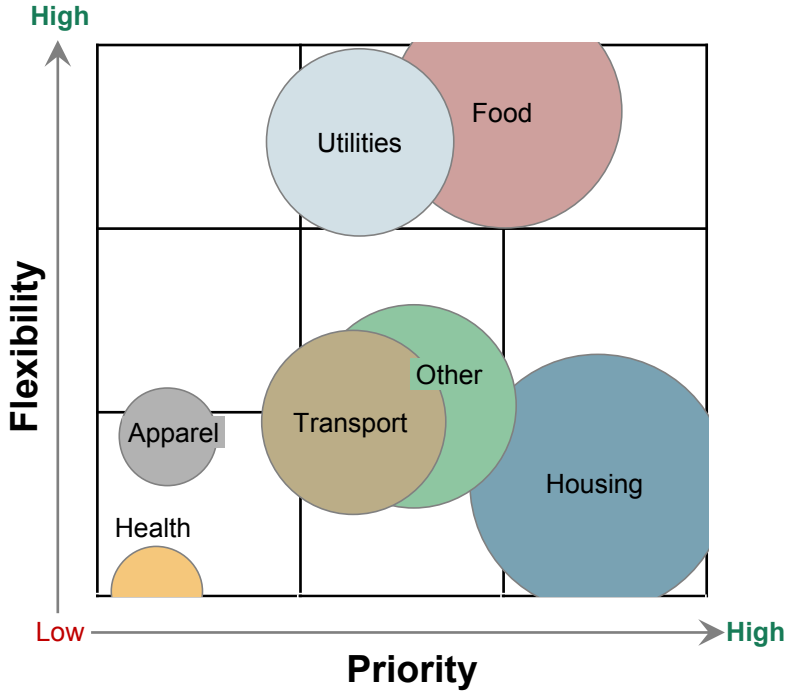
It is possible the state of MN could respond to any of the proposed cuts with funding from state budget; However, as the budget is currently written, SNAP is the only program that explicitly shifts cost burden to states

1. Reflects only federal share of Medicaid funding; MN State funds nearly 43% of program total (FY total = $11.2B in MN)
Source: U.S. Government Major Savings and Reforms, BCG Analysis

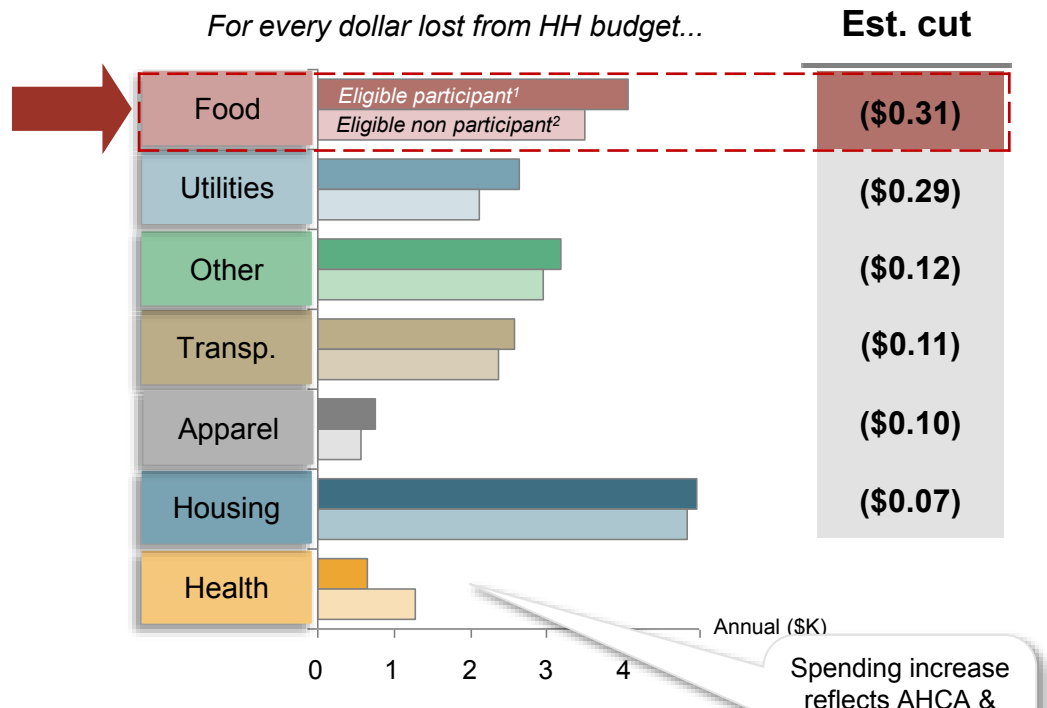
Updated degree of tradeoffs based on new data source

Refined estimate: For every dollar lost in non-food welfare benefits, $0.31 cut from food budget

Low income HH's make trade-offs based on perceived flexibility & priority of expense



Food spending is highly flexible because of substitutes & alternate sources like EFS



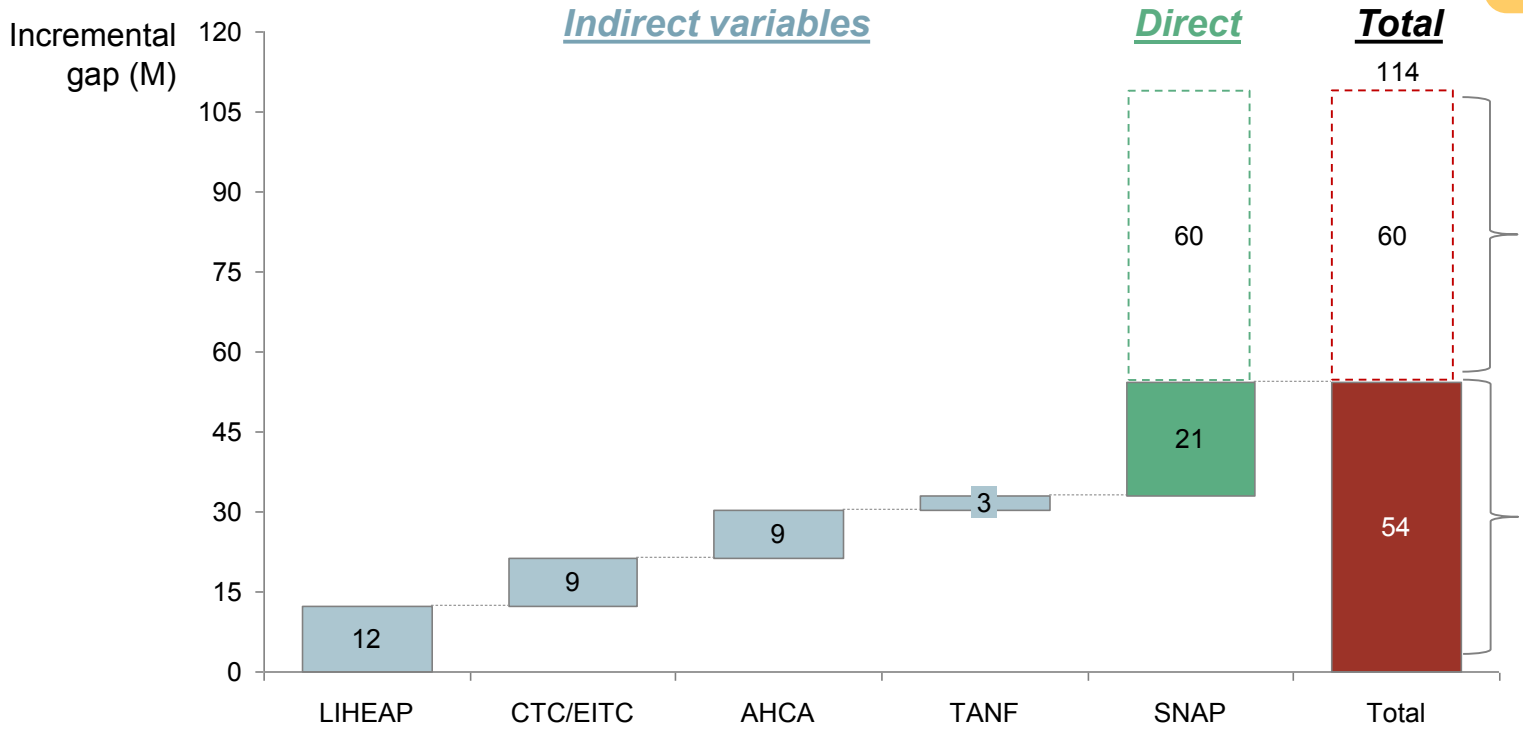
When low income families experience a financial shock, food spending is often hit first and hardest

1. Consumers <=130% FPL and receiving SNAP Benefits 2. Consumers <=130% FPL not identified as SNAP participants
Source: Mathematica Policy Research based on Consumer Expenditure Survey (pre-recession 2005), BCG analysis
Note: *Flexibility* reflects degree of change between participants & non participants by category; *Priority* reflects relative variance in absolute spend among participants; *Other* includes categories such as entertainment, savings, etc.

Cuts to indirect programs also prompt heavier reliance on EFS, pushing up incremental meal gap

Illustrative scenarios demonstrate the sensitivity of state's SNAP funding to total incremental gap

This is *in addition to* an already-missing 100M meals in MN



If MN funds only $100M of $150M SNAP, incremental gap jumps to 114M

If MN funds full 25% SNAP share, incremental gap contained at 54M (assumes only Fed-level changes occur across all variables)

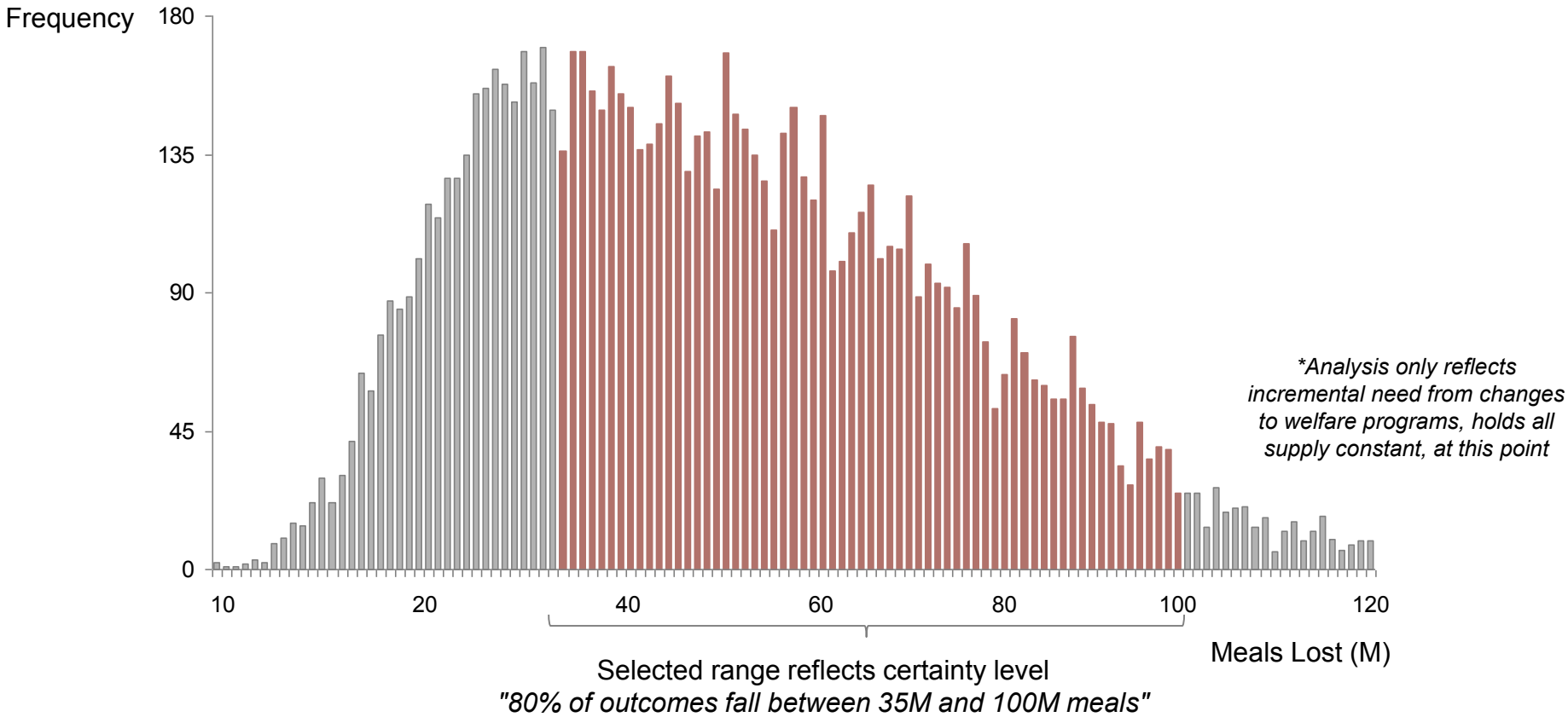
It is imperative for state legislatures to step in and match Federal SNAP funds to control incremental meal gap

Monte Carlo predicts with 80% confidence MN meal gap will increase by at least 35M and could double by 2022

This is *in addition to* an already-missing 100M meals in MN

Incremental meal gap: Frequency view

Simulation runs 10,000 random trials; each bar reflects potential outcome



**Analysis only reflects incremental need from changes to welfare programs, holds all supply constant, at this point*

Note: Probability that meal gap increases by *more than* 100M meals is 6.41%
Source: BCG analysis