Date of Hearing: April 26, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2500 (Arambula) – As Amended April 7, 2022

SUBJECT: Farm to Hospital Grant Pilot Program.

SUMMARY: Establishes the Farm to Hospital Grant Pilot Program (Program), upon appropriation and until January 1, 2031, administered by the Department of Food and Agriculture (DFA) Office of Farm to Fork (Office), to award competitive grants to eligible applicants to provide hospital patients with meals prepared from California-sourced agricultural products and build direct relationships with California farmers and ranchers, as specified. Requires the Office, in consultation with the Department of Public Health (DPH), to develop grant criteria to evaluate proposals from eligible applicants. Authorizes grant recipients to use grant moneys only for specified purposes, and require them to report specified information to the Office and DPH. Requires the Office, in consultation with DPH, on or before January 1, 2027, to submit to the Legislature a report on the Program. Specifically, **this bill**:

1) Establishes the Program, upon appropriation for this purpose, and requires the Office to administer the Program.

2) Requires the Office to, in administering the Program, award competitive grants to eligible applicants to provide hospital patients with meals prepared from California-sourced agricultural products and build direct relationships with California farmers and ranchers.

3) Requires the Office, in consultation with DPH, to develop grant criteria to evaluate proposals from eligible applicants. Requires as part of each proposal, an eligible applicant to include all of the following:
   a) A proposal narrative;
   b) A proposal budget;
   c) The scope and estimated number of hospital patients to be served meals by California-sourced agricultural products through the proposal;
   d) A description of the eligible applicant's existing meal preparation facilities and food procurement practices;
   e) The proposed use of any grant moneys awarded, including how that use is consistent with the purposes as described; and,
   f) A plan for direct outreach to farms, ranches, and food hubs and for procurement, either directly or through a food distributor, from farms, ranches, and food hubs.

4) Allows a grantee to use grant moneys for only the following purposes:
   a) Improving or expanding hospital meal preparation facilities or infrastructure for the use, preparation, or storage of California-sourced agricultural products;
   b) Supporting the planning of menus and patient meals that use seasonal California-sourced agricultural products;
   c) Purchasing equipment for meal preparation or storage of California-sourced agricultural products;
   d) Staffing necessary to conduct outreach to farms, plan menus, and procure California-sourced agricultural products;

   e) Cost-share purchasing of California-sourced agricultural products, as specified; and,
   f) Conducting outreach to California farmers, ranchers, or food hubs to procure California-sourced agricultural products or connect farmers, ranchers, or food hubs with food distributors contracted by a hospital.

5) Requires the Office to set the percentage of a grantee's costs of purchasing California-sourced agricultural products that the Office will pay using grant moneys through cost-share purchasing.

6) Requires the Office to set a separate cost-share purchasing percentage, in addition to the percentage set in 5) above for purposes of cost-share purchasing, for each of the following conditions applicable to the entity from which the California-sourced agricultural products are purchased:
   a) The farm or ranch employs climate smart agricultural practices;
   b) The farm or ranch is owned by a socially disadvantaged farmer or rancher, woman farmer or rancher, or veteran farmer or rancher;
   c) The farm or ranch has gross incomes under $250,000; and,
   d) The entity is a food hub that serves a farm or ranch described in b) or c) above.

7) Authorizes the Office to set a different percentage for each condition in setting percentages pursuant to 5) above.

8) Requires the Office to provide technical assistance to, and leverage its relationships with community-based organizations, the California Farm Bureau Federation, and county farm bureaus to, assist grantees for purposes of identifying and communicating with California farmers, ranchers, and food hubs.

9) Requires each grantee to collect the following information, before and after each meal, from each hospital patient provided with a meal prepared from California-sourced agricultural products pursuant to the Program:
   a) The hospital patient's mood;
   b) The hospital patient's duration of hospitalization; and,
   c) The hospital patient's blood sugar level.

10) Requires each grantee to collect the following information:
   a) The grantee's average daily expenditures on food procurement and preparation;
   b) The grantee's average daily income from meal purchases;
   c) The grantee's method of outreach to farms and ranches; and,
   d) The grantee's procurement agreements with farms, ranches, food hubs, and food distributors.

11) Requires each grantee to, on or before January 1, 2026, report the information described in 9) and 10) above, with the information described in 9) above reported in aggregated and deidentified form consistent with the federal Health Insurance Portability and Accountability Act of 1996, to the Office and DPH.

12) Requires the Office to, in consultation with DPH, on or before January 1, 2027, submit to the Legislature a report on the Program that includes, but is not limited to, all of the following:
   a) The use of grant moneys by grantees;

b) The number of patients and meals served through the Program;
c) The pilot program's impact on patient outcomes; and,
d) Any recommendations for future revisions to the Program.

13) Authorizes the Office to contract with a private entity for the purpose of fulfilling the requirements of this bill.

14) Defines the following:
a) California-sourced agricultural products as agricultural products that have been produced in California or harvested in its surface or coastal waters;
b) Climate smart agricultural practices to include those practices defined as climate smart agricultural practices in the United States Department of Agriculture Natural Resources Conservation Service's conservation practice standards or by the DFA for purposes of the Cannella Environmental Farming Act of 1995;
c) Eligible applicant as the University of California, a research hospital, or a hospital capable of complying with this bill's requirements;
d) Food hub as a public-serving aggregation and distribution enterprise or community food hub for California-sourced agricultural products;
e) Grant moneys as moneys awarded to an eligible applicant through the Program;
f) Grantee as an eligible applicant awarded grant moneys through the Program;
g) Program as the Farm to Hospital Grant Pilot Program, as established;
h) Research hospital as a hospital that expends at least 10% of its operating budget in each fiscal year exclusively on medical research activities that are not directly related to the provision of services to patients; and,
i) Socially disadvantaged farmer or rancher as defined in existing law.

15) Sunsets the provisions of this bill on January 1, 2031.

EXISTING LAW:

1) Establishes the Farm to Fork Account in the DFA Fund that consist of money made available from federal, state, industry, philanthropic, and private sources. Specifies that all money deposited in the Farm to Fork Account is hereby continuously appropriated to the DFA without regard to fiscal years to carry out the purposes as specified.

2) Establishes DPH to protect and improve the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention.

3) Requires DPH, commencing July 1, 2017, to annually post on its internet website a summary of the amount and source of any funding directed to diabetes prevention and management and to expenditures by DPH for programs and activities aimed at preventing or managing diabetes.

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, good nutrition is critical in hospitals to reduce hospitalization lengths, improve recovery, and lower risks of complications.

Research shows that approximately one-third of patients in developed countries have some degree of malnourishment upon entering a hospital, with two-thirds worsening during their hospital stay. A key disconnect between the importance of nutrition and the presence of widespread malnutrition is centered on the meals offered in hospitals. In order to keep costs down, some hospitals sometimes offer meals that are unappealing to patients, worsening malnutrition. California has such diversity and availability of agricultural products that connecting hospitals with this bounty would have direct impact on patient health. Further, planning meals around seasonal availability can be cost competitive with traditionally sourced meals. This bill would establish a grant to support hospitals that need to improve their meal facilities, carry out the hard work of making relations with farmers and ranchers, and tracking the impact that fresh California agriculture has on patient wellbeing.

2) **BACKGROUND.** According to a study entitled, Hospital Malnutrition: Prevalence, Identification and Impact on Patients and the Healthcare System, malnutrition is a broad term that can be used to describe any imbalance in nutrition; from over-nutrition often seen in the developed world, to under-nutrition seen in many developing countries, but also in hospitals and residential care facilities in developed nations. Malnutrition can develop as a consequence of deficiency in dietary intake, increased requirements associated with a disease state, from complications of an underlying illness such as poor absorption and excessive nutrient losses, or from a combination of these aforementioned factors. Malnutrition is associated with negative outcomes for patients, including higher infection and complication rates, increased muscle loss, impaired wound healing, longer length of hospital stay and increased morbidity and mortality.

   a) **Hospital Malnutrition**. The prevention and treatment of hospital malnutrition offers a tremendous opportunity to optimize the overall quality of patient care, improve clinical outcomes, and reduce costs, according to an article entitled, "Critical Role of Nutrition in Improving Quality of Care: An Interdisciplinary Call to Action to Address Adult Hospital Malnutrition." Unfortunately, malnutrition continues to go unrecognized and untreated in many hospitalized patients. It is well recognized that malnutrition is associated with adverse clinical outcomes. Although data vary across studies, available evidence shows that early nutrition intervention can reduce complication rates, length of hospital stay, readmission rates, mortality, and cost of care. The key is to systematically identify patients who are malnourished or at risk and to promptly intervene. The article presents a novel care model to drive improvement, emphasizing the following six principles: i) create an institutional culture where all stakeholders value nutrition; ii) redefine clinicians' roles to include nutrition care; iii) recognize and diagnose all malnourished patients and those at risk; iv) rapidly implement comprehensive nutrition interventions and continued monitoring; v) communicate nutrition care plans; and, vi) develop a comprehensive discharge nutrition care and education plan.

      A more recent example, the Medically Tailored Meals (MTM) Pilot Program launched on April 1, 2018, in eight California counties. The Department of Health Care Services oversees the program and has contracted with Project Open Hand for the provision of services. The pilot will run for four years with a total budget of $6 million, and will be evaluated to determine the impact of the MTM program on hospital, emergency department, and skilled nursing facility admissions. The program will serve three medically tailored meals per day for 12 weeks to 1,413 eligible beneficiaries with congestive heart failure during the four-year period. At the conclusion of the pilot, the

State will submit a report to the Legislature identifying any positive health outcomes and reductions institutionalizations for these beneficiaries.

b) Farm to Hospital Initiatives. The U.S. Department of Agriculture notes that nationwide, tens of millions of people each day eat their meals outside of home at schools, colleges, hospitals, corporate cafeterias and government agencies. Each one of these institutions represents an opportunity for U.S. farmers, ranchers and food businesses to gain market share, earn a livelihood, forge ties with local residents, and improve community health and well-being through farm to institution efforts, in which local producers sell to institutions nearby. Connecting with local producers benefits the institutions, too. Hospitals are finding that farm to institution programs can increase access to healthy, fresh food for patients and staff; some, like in Maine, are prescribing fruits and vegetables to patients and helping them utilize nearby farmers' markets. And a slate of state and local governments are setting goals and developing strategies to use food purchasing policies to support their farmers and local economy. As institutional buyers purchase more local food, they create business opportunities for farmers and ranchers and keep a greater share of food dollars in the local economy.

The University of California Sustainable Agriculture Research & Education Program (UC SAREP) is a program committed to the success and continued growth of farm to hospital programs. UC SAREP has evaluated existing farm to hospital programs in California to provide insight to start-up programs to help navigate the farm to hospital landscape. According to UC SAREP, farm to hospital or other institutional initiatives advance hospitals' mission to promote and protect health, especially in light of widespread nutrition-related illnesses such as obesity, diabetes and cardiovascular disease. The success of these programs requires successful collaborations and sometimes restructuring of existing contracts. Local food purchasing at hospitals can be difficult to incorporate into hospital food supply chains, which are ties to many other food processing, distribution, and procurement systems.

According to the UC SAREP paper entitled, "Emerging Local Food Purchasing Initiatives in Northern California Hospitals," farm-to-hospital initiatives are intended to help hospital foodservice leaders plan and develop their own local food sourcing practices, and help those outside the hospital setting, e.g. farmers, public officials, nonprofit support agencies, better understand the hospital purchasing environment. The findings and analysis of this paper inform the process of addressing current institutional and industry barriers facing farm-to-hospital initiatives, and suggest some direction for facilitating them through further research, policy, education, and technical assistance efforts. Hospitals in California's San Francisco Bay Area are at the forefront of a small but growing national movement to incorporate fresh, local food into healthcare foodservice. By purchasing and serving local food, hospitals can improve the quality of their foodservice and encourage their patients, staff, and visitors to eat more healthfully. Serving better food advances hospitals' mission to promote and protect health, especially in light of widespread, chronic, nutrition related illness such as obesity, diabetes, and cardiovascular disease. By modeling local food consumption, hospitals can use their considerable influence to actively promote sustainable agriculture and support California's small and mid-scale farmers. In California, where agriculture is still a primary industry, these markets are needed to help farmers and rural communities withstand diminishing farm prices and the concentration of the agriculture and food

sectors. Buying local food is a complicated and challenging task for hospitals, due to a range of contractual obligations and financial constraints, as well as dependence on established and carefully regulated procedures for menu planning and meal production. Local food purchasing is difficult to incorporate into hospital food supply chains, which are tied to many other food processing, distribution, and procurement systems and institutions, including foodservice distributors and Group Purchasing Organizations. For these reasons, hospital efforts to purchase local food represent significant efforts to change institutional policies and practices as well as the wider healthcare foodservice industry.

3) **SUPPORT.** The California Farm Bureau states that this bill would facilitate new and enhancement of existing direct marketing opportunities for farmers of all sizes and production styles with state and private hospitals in California in a sustainable manner. Beyond the economic resiliency this bill will enable for California farmers, it will also provide an avenue for health insecure patients to consume fresh, healthy, California-grown agricultural products in a hospital setting. Poor diet is one of the leading causes of death in California, and contributes to obesity, heart disease, high blood pressure, and cancer. California-grown procurement and farm-to-fork policy action throughout this Program will result in positive changes in patient health outcomes and provide for lifelong healthy eating habits post-discharge.

4) **PREVIOUS LEGISLATION.**

   a) ACR 108 (Bonta), Chapter 166, Statutes of 2017, encourages local jurisdictions across California to create "Food as Medicine" programs to address the obesity and diabetes epidemics.

   b) AB 2696 (Gaines), Chapter 108, Statutes of 2016, requires DPH to submit a report to the Legislature on or before January 1, 2019, that includes a summary and compilation of recommendations on diabetes prevention and management from various sources, including the University of California and the federal Centers for Disease Control and Prevention. AB 2696 also requires DPH to annually post on its Website a summary of any funding directed to, and expenditures by, DPH to prevent and manage diabetes.

   c) AB 2413 (John A. Pérez), Statutes of 2014, Chapter 583, establishes the Office of Farm to Fork within DFA.

5) **DOUBLE REFERRA.** This bill is double referred; it passed the Assembly Agriculture Committee with a vote of 9-0 on April 6, 2022.

6) **AUTHOR'S AMENDMENTS.** The author proposes the following amendments to address DPH's technical assistance:

   a) Require eligible applicants to include a description of proposed nutrition standards, proposed hospital staff necessary to implement the Program, and a plan for collection data and evaluation;

   b) Require grantees to collect information of the hospital's patient's palatability and food or plate waste; and, the grantee's changes to the hospital's nutrition standards; and,

c) Include the proportion of grantees implementing improved standards and a description of improved standards as part of the report to the Legislature.

7) POLICY COMMENT. This bill allows a grantee to use grant moneys to improve or expand hospital meal preparation facilities or infrastructure for the use, preparation, or storage of California-sourced agricultural products and increase staffing. The hospitals that would be qualified to participate in this program, including the University of California hospitals, are presumed to have robust facilities and staffing. It is unclear whether these facilities are lacking such infrastructure and whether these moneys should instead be focused on the procurement of the California-sourced agriculture products.

REGISTERED SUPPORT / OPPOSITION:

Support

California Farm Bureau

Opposition

None on file.

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