CITY AND COUNTY OF SAN FRANCISCO
BOARD OF SUPERVISORS
BUDGET AND LEGISLATIVE ANALYST
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Policy Analysis Report

To: Supervisor Stefani
From: Budget and Legislative Analyst's Office
Re: Food Insecurity in San Francisco
Date: February 23, 2021

SUMMARY OF REQUESTED ACTION

Your office requested that the Budget and Legislative Analyst provide the following:

- An overview of the data currently being collected using validated measuring tools on food insecurity in San Francisco from both a population-level perspective and for vulnerable populations.
- How much is spent to address food insecurity in San Francisco.
- How the City is measuring how well and to what extent services are designed to address food needs.
- What transportation and delivery options are needed to address food insecurity.
- What food resources are available for non-citizens.
- What other jurisdictions are doing to measure and address food insecurity.

For further information about this report, contact Fred Brousseau, Director of Policy Analysis, at the Budget and Legislative Analyst's Office.

Notes on Impact of COVID-19

Research and field work on this report was conducted largely prior to the onset of the COVID-19 pandemic in March 2020. Following national trends, we conclude that food insecurity, already a problem in San Francisco, has likely increased since the onset of the pandemic and related spike in unemployment.

We found that at least 13.3 percent of San Franciscans, or 115,190 individuals, were identified as food insecure as of 2017 by Feeding America, a non-profit hunger relief organization, though other studies place the rate as higher than that and show that slightly less than half of the population in San Francisco living under 200 percent of the Federal Poverty Level are still food insecure, despite the fact that many of these individuals should be eligible for and possibly receiving food stamps.

National data show increases in food insecurity in 2020. Feeding America reports that more than 50 million Americans could be food insecure by the end of 2020, a 43 percent increase over 2019 levels.* The organization reported a 60 percent increase in the

number of people it serves through its food banks and pantries in 2020 and that a high percentage of people served are receiving food services for the first time.

Further, the Brookings Institution reports that 13.9 million children in the U.S. lived in households characterized by child food insecurity in the third week of June, 2020, 5.6 times as high as in all of 2018 and 2.7 times higher than at the peak of the Great Recession in 2008.** Rates were even higher for Black and Hispanic children, according to the Brookings Institution.

While the increase in food insecurity as a result of the pandemic may be temporary in nature, this report shows a persistent problem with food insecurity in San Francisco that needs to be addressed and has assumedly become even more critical due to the impact of the pandemic.

*FeedingAmerica.org

**About 14 million children in the U.S. are not getting enough to eat, Brookings Institution, July 9, 2020

Executive Summary

What is food insecurity?

A circumstance in which the ability to obtain and prepare nutritious food is uncertain or not possible.
San Francisco Food Security Task Force

- An estimated 115,190 San Franciscans, or 13.3 percent of the City's population, were identified as food insecure in 2017 by Feeding America, a non-profit hunger relief organization, in its annual Map the Meal Gap analysis.
- Other studies have shown that food insecurity rates in San Francisco are higher among certain segments of the population. Approximately half of low-income residents earning less than 200 percent of the Federal Poverty Level (FPL) in 2018, or 89,000 residents, were reported to be food insecure by the California Health Interview Survey administered by the University of California at Los Angeles.
- A San Francisco Food Security Task Force established by the Board of Supervisors in 2005 identified key groups as having high rates of food insecurity: (1) low-income families with children, and (2) low-income adults, such as people experiencing homelessness as well as older adults and people with disabilities.
- Specific groups more susceptible to food insecurity identified in various studies and surveys include:
    - Pregnant people who are low-Income and racial/ethnic minorities experience higher rates of food insecurity, with pregnant Latinx individuals reporting the highest rate at 26.5 percent (an estimated 434 individuals) according to the Food Security Task Force.

- A San Francisco Unified School District (SFUSD) survey found their high school students have a 16 percent rate of food insecurity.
- A City College of San Francisco (CCSF) survey found their students had a 41 percent rate of food insecurity.
- In a study of more than 600 adult residents of single room occupancy hotels, (SROs), 84 percent reported food insecurity.

Food assistance programs in San Francisco

- A total of $139 million was spent on City food assistance program benefits in FY 2018-19, of which approximately $26.2 million was local funding. The programs served an estimated 111,530 enrollees though the actual number of unique individuals receiving services is lower because this count of enrollees is not adjusted for individuals enrolled in multiple programs (such as a student receiving free school meals whose family also receives food stamps). It also doesn't include the number of individuals who receive the millions of meals provided annually in congregate settings and/or delivered to their homes or through Family Resource Centers and other programs. In addition to City- and School District-administered programs, food banks and free dining rooms also provide food assistance.
- Though major federal food assistance programs like food stamps (known as CalFresh in California), congregate and home-delivered nutrition programs provided by the Department of Disability and Aging Services (DAS), and free and reduced-price school meals have been proven effective, they do not appear to be fully addressing the food security needs of San Franciscans, as demonstrated by the high rate of food insecurity reported above, including 89,000 residents who may qualify for food stamps because they earn less than 200 percent of the Federal Poverty Level (FPL) but still report experiencing food insecurity.
- One reason CalFresh may not be resolving food insecurity for all San Franciscans is that the maximum income for households to qualify for food stamps is 200 percent of the Federal Poverty Level ($51,504 for a family of four), a threshold that leaves out many low-income households in high cost San Francisco. Worse, the Human Services Agency (HSA) reports that, due to current federal eligibility rules, only those earning up to 130 percent of FPL ($33,475 for a family of four) and meeting other eligibility criteria are most assured of qualifying for food stamps. HSA reports that some households earning between 130 and 200 percent of FPL qualify for food stamps, but their eligibility is less certain. These income thresholds are based on a single national standard, meaning it is not adjusted for the higher cost of living in San Francisco relative to other parts of the country.

Screening for food insecurity in San Francisco

- To ensure that food insecure San Franciscans obtain services from all food assistance programs to which they are entitled, an effective system of screening for food insecurity

and referral and access to relevant programs is needed. A number of validated (tested for accuracy) food insecurity screening tools have been developed by the U.S. Department of Agriculture and private physicians. They vary in length and complexity but one of them, known as the Hunger Vital Sign, has been proven to identify food insecurity in two steps, or questions. The advantage of this relatively shorter test is that it can be integrated into other screenings and processes such as eligibility assessments and medical screenings without undue burden on the screener.

- Research by the San Diego Hunger Coalition, a non-profit organization whose mission is combating hunger, found that the most effective screening and referral processes that result in new CalFresh enrollments is "On Demand On-Site Assistance," as shown in Exhibit A below. In this approach, an on-site resource coordinator assists individuals who screen positive for food insecurity in applying for CalFresh and other food assistance. The researchers found the least effective referral approach is "Referral to Local Community-Based Organization," in which the individual screened is simply provided with contact information about food assistance programs and is then expected to pursue them on their own.

Exhibit A: Types of Referrals for Food Assistance Programs, Ranked by Effectiveness

More Effective

	Model	Description
1	On-Demand On-Site Assistance	Patients are referred to a full-time, on-site resource coordinator to assist with applying for CalFresh and accessing additional food resources.
2	Intermittent On-Site Assistance	Patients are referred to an on-site partner organization to assist with applying.
3	Partner-Initiated Phone-Based Referral	After providing consent, patient receives a follow-up call from a partner organization to provide phone-based application assistance and additional food resource referrals.
4	Patient-Initiated Phone-Based Referral	Patients are provided with a phone number to call for assistance.
5	Information Referral to Local Community-Based Organization	Patients are provided with names, addresses and phone numbers of local community-based organizations for assistance.

- In San Francisco, the two-question Hunger Vital Sign food insecurity screening tool has been incorporated to varying extents and with varying degrees of success by a number of City and County programs and service providers: Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Department of Public Health's San Francisco Health Network (SFHN) of hospitals and clinics, In-Home Supportive Services (IHSS), and congregate and home-delivered nutrition programs administered by non-profit contractors of the San Francisco Department of Disability and Aging Services.
- While food insecurity screening processes have been adopted by some City-administered programs, they are not occurring in all settings, such as in HSA benefits eligibility offices, many SFHN clinics, and at SFUSD sites—all places where individuals susceptible to food insecurity are likely to be receiving or applying for food assistance programs.
- Referral processes used by City agencies are generally what is classified as "Information Referral to Local Community-Based Organization" and, as shown in Exhibit A, the least effective approach according to research conducted by the San Diego Hunger Coalition. In these types of referrals, screeners simply provide contact information for food assistance programs and services to individuals screening positive for food insecurity, but do not assist them in applying and do not follow up to see if they made contact and received services from programs to which they were referred. Most agencies reported that the results of food insecurity screenings and referrals are not reviewed to assess their effectiveness and to determine if improvements could be made to reduce the rate of food insecurity in San Francisco.

- Unlike most other City agencies, In-Home Supportive Services workers screen their clients for food insecurity *and* use a more effective referral process of assisting clients by telephone to access food assistance programs such as CalFresh and food pantry services.
- A summary of food insecurity screening and referral processes employed by City agencies is presented in Exhibit B.

Exhibit B: Food Insecurity Screening and Referrals Protocols at City Agencies

Program/ Agency	Screening Protocol	Referral Protocol
WIC/DPH	Two-question Hunger Vital Sign.	Provide clients with contact information for food assistance programs.
SFHN/DPH	Two-question Hunger Vital Sign adopted, but not fully implemented in many clinics.	At most, provide clients with contact information for food assistance programs.
DAS/HSA	Two-question Hunger Vital Sign required by DAS in its contracts with community-based organizations providing food assistance.	Depends on contracted community-based organization service provider. A standardized approach is not required by DAS.
SFUSD	None.	None, although a data match known as direct certification is required by federal law, which matches student enrollment data with enrollment data for health and social services programs in order to automatically enroll low-income students into the free and reduced-price school meals program.
IHSS	Two-question Hunger Vital Sign.	Assist clients by phone to support enrollment and access to CalFresh and food pantry services.
CalFresh	None.	None.
DCYF	None.	None.

Program/ Agency	Screening Protocol	Referral Protocol
Family Resource Centers (funded by First 5 SF, HSA, & DCYF)	Screening conducted for case management clients using an assessment form on multiple family challenges.	Case management clients receive individualized referrals based on need, including flyers (information and referral), phone follow-up (enhanced information and referral), or assistance with enrollment in food assistance programs.

- To better identify individuals experiencing food insecurity and refer them to food assistance programs, more robust screening and referral processes are needed, particularly by program administrators and service providers who interact with high-risk populations that may be eligible for one or more food assistance programs. For example, CalFresh clients who are pregnant or postpartum are categorically eligible for WIC. These two programs are beginning to collaborate, but face obstacles in sharing data about their clients due to federal data-sharing restrictions.

Access to transportation and food insecurity

- Research shows that the availability of public transportation impacts the level of food insecurity experienced by low-income populations. WIC program administrators reported that lack of transportation access is a significant barrier for San Francisco clients. Discount programs help low-income populations to be able to use public transit in order to access food assistance programs and healthy foods; however, a gap likely remains for low-income individuals who do not live in close proximity to public transit and/or those who may live in a food desert.

Lessons from other jurisdictions

- Other jurisdictions, including the Commonwealth of Massachusetts and the states of Oregon and Colorado provide insight on how California and San Francisco can ensure that a greater share of low-income individuals receive the food assistance resources they need. Massachusetts and Oregon are two examples of states that have aligned financial incentives using a Medicaid waiver that enables on-demand on-site assistance in accessing food resources.
- In Colorado, a non-profit organization, Hunger Free Colorado, has achieved significant results by establishing a navigation hub that provides phone-based assistance to patients who screen positive for food insecurity, connecting them to SNAP and/or WIC and helping them access other food assistance programs.

Policy Options

The Board of Supervisors could consider the policy options below to increase the number of food insecure people receiving food assistance.

1. Request reports from the Human Services Agency, Department of Public Health, and other relevant City agencies on what is blocking them from: a) implementing effective food insecurity screening and referral processes in all settings where program staff interact with populations at high risk of food insecurity, and b) regularly producing reports for management on results of their food screening and referral processes.

2. Request that the Human Services Agency, Department of Public Health, and other relevant City agencies report to the Board of Supervisors on opportunities and actions the departments can take to enable more frequent data-matching to better identify clients eligible for multiple major federal food assistance programs.

3. Request that the Human Services Agency and Department of Public Health regularly report back to the Board of Supervisors on their food screenings and referrals and the outcomes of these efforts.

4. Request that the Human Services Agency and Department of Public Health collaborate and report back on options for establishing a food resources navigation hub similar to what the non-profit Hunger Free Colorado created in Colorado.

5. Advocate for a flexible services program in the State's 1115 Medicaid waiver renewal with the federal government.

6. Explore additional transportation assistance for clients of food assistance programs such as subsidized rideshare services for pregnant and post-partum WIC clients.

Project staff: Rashi Kesarwani, Fred Brousseau

Table of Contents

Incidence of Food Insecurity in San Francisco

Food Insecurity is on the Rise among Low-Income Populations

Food insecurity is defined as a circumstance in which the ability to obtain and prepare nutritious food is uncertain or not possible, according to the San Francisco Food Security Task Force's 2018 Assessment of Food Security report. The Food Security Task Force was established by the Board of Supervisors in 2005 and charged with creating a Citywide plan for addressing food security.

A number of estimates have been prepared of the number of San Francisco residents who are food insecure in recent years. The non-profit organization Feeding America estimates the 2017 *overall* rate of food insecurity in San Francisco at 13.3 percent, or 115,190 people out of a total City population of approximately 866,090 in 2017[1]. This 13.3 percent estimated rate compares to 11.0 percent statewide and 12.5 percent nationally.

According to Feeding America, of the estimated 115,190 San Franciscans facing food insecurity, 58 percent (or, approximately 66,810) have an income at or below 200 percent of the Federal Poverty Level (FPL)—the gross income limit to qualify for some amount of Supplemental Nutrition Assistance Program (SNAP) food stamps benefits—and 42 percent (or, about 48,380) have an income that exceeds 200 percent of FPL. Feeding America estimates the prevalence of food insecurity in its annual Map the Meal Gap study using a regression model that includes variables known to influence the probability of someone being food insecure.[2] This estimate suggests that existing food assistance programs, given their caseloads detailed later in this report, may not be adequately addressing food insecurity in San Francisco.

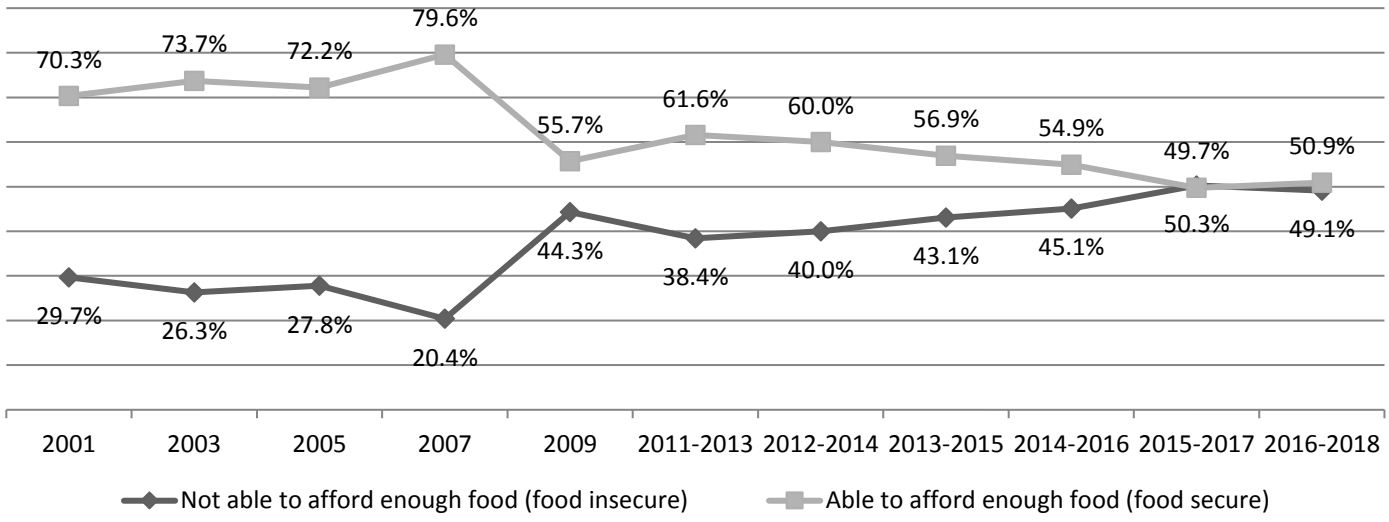
[1] The total population estimate is derived from Map the Meal Gap data generated by Feeding America. According to the United Census Bureau, the San Francisco population was estimated to be 883,305 as of July 1, 2018 (https://www.census.gov/quickfacts/fact/table/sanfranciscocountycalifornia/PST045218).

[2] Feeding America - Map the Meal Gap, 2019, https://www.feedingamerica.org/sites/default/files/2019-05/2017-map-the-meal-gap-full.pdf.

Other more limited estimates of the food insecure developed through the California Health Interview Survey (CHIS) administered by UCLA were reported by the Food Security Task Force in its 2018 Food Security Assessment.

The CHIS—the largest state health survey in the country—provides an understanding of the level of food insecurity experienced over time by San Franciscans earning less than 200 percent of FPL. The survey data show an upward trend since 2001, reaching a rolling average of about 50 percent from 2015 to 2018, as shown in Exhibit 1. If about 50 percent of survey respondents earning less than 200 percent of FPL reported an inability to afford enough food and a total of about 178,000 San Franciscans earn less than 200 percent of FPL (approximately 20 percent of the City's population), then this could be generalized to say that about 89,000 people earning less than 200 percent of FPL experience food insecurity.[3] We know that 89,000 is almost certainly an underestimate of the total level of food insecurity in San Francisco since the CHIS only screens for food insecurity among individuals earning 200 percent of FPL or less. For perspective, the regression model used in the Map the Meal Gap study estimated about 115,190 people experiencing food insecurity in San Francisco in 2017—an amount that is 26,190, or 29 percent, larger than the CHIS survey findings from 2018 which only covered those earning less than 200 percent of FPL.

Exhibit 1: Food security (ability to afford enough food) asked of San Francisco adults whose income is less than 200 percent of the Federal Poverty Level (FPL)



Note: Annual data was not collected until 2011. Data for 2014, 2016 & 2017 are statistically unstable, so rolling averages have been used.
Source: AskCHIS, 2001-2018,
http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography

[3] American Community Survey, Table "S1701 San Francisco," 2018, https://data.census.gov/cedsci/table?q=s1701%20san%20francisco&g=0500000US06075&lastDisplayedRow=67&table=S1701&tid=ACSST1Y2018.S1701&layer=county

How Food Insecurity Is Measured

There are a number of validated screening tools—that is, tools tested for reliability—that are used to assess food insecurity, including the 18-item food insecurity screening known as the U.S. Household Food Security Survey Module developed by the U.S. Department of Agriculture Economic Research Service as well as shorter 10-item and six-item versions of the survey.[4] The 18-item screening enables the assessor to determine an individual's level of food insecurity on a four-point scale:

1. High food security
2. Marginal food security
3. Low food security
4. Very low food security

Households with high or marginal food security are classified as food secure whereas those with low or very low food security are considered food insecure. While the 18-item, 10-item, or six-item food insecurity screenings are useful for research purposes (the CHIS uses the six-item food insecurity screening), it is not practical to use a multi-item screening in a health care setting. In 2010, doctors in Boston developed a validated two-item food insecurity screening based on the U.S. Household Food Security Survey—known as The Hunger Vital Sign—which is now used in many health care settings. Patients are asked just two questions, as shown in the nearby textbox. If they answer that either or both of the statements are "often true" or "sometimes true," then the household is considered food insecure. In our research for this report, we found that some entities have adapted the Hunger Vital Sign screening to only ask about the past three months in order to arrive at a more accurate assessment of a household's current hunger status.

The Hunger Vital Sign Two-Item Validated Food Insecurity Screening

1. "Within the past 12 months, we worried whether our food would run out before we got money to buy more." (Often, Sometimes, Never)
2. "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more." (Often, Sometimes, Never)

Major Food Assistance Programs Determine Eligibility Using Federal Poverty Guideline

This report focuses on the impact of three major food assistance programs for low-income individuals, children, and families administered and partially funded by the Food and Nutrition Service of the U.S. Department of Agriculture and which are intended to address food insecurity in San Francisco. For each of the three programs specified in the numbered list below, we assess: (a) what is known about the degree to which these programs address food insecurity in San Francisco, (b) the nature of food insecurity screening and referral to other food assistance programs conducted by these programs,

[4] The 18-item U.S. Household Food Security Survey Module is available in Appendix I.

(c) best practices on screening and referral from other jurisdictions, and (d) policy options for strengthening the social safety net to more effectively screen and refer San Franciscans to food assistance programs.

1. **CalFresh is California's food stamps program**. CalFresh provides benefits to eligible low-income households via an electronic benefit transfer (EBT) card; benefits can then be exchanged for food at authorized retailers.

2. **Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**. The WIC program provides federal grants to states for supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding post-partum people, and to infants and children up to age five who are found to be at nutritional risk. Families can use their WIC benefit to purchase authorized foods from local grocery stores. In San Francisco, a local food supplement program known as "EatSF – Vouchers 4 Veggies" provides pregnant and post-partum people an additional $40 monthly subsidy to purchase fresh fruit and vegetables at authorized retailers for up to nine months.

3. **School Meals Programs**. The School Breakfast and School Lunch programs provide federally-supported meals in public and non-profit private schools, including free or reduced-price meals to all eligible children.

There are a number of other food assistance programs available in San Francisco that do not screen for eligibility in the same way as CalFresh, WIC, and school meals programs and are funded from other sources, such as:

- Food programs for older adults and people with disabilities, such as congregate meals, home-delivered meals, and home-delivered groceries (some of these services are administered by the San Francisco Department of Disability and Aging Services (DAS));
- Food pantries;
- Free dining rooms;
- Food bag distribution to families through Family Resource Centers;
- Meals and snacks funded by the Department of Children, Youth and Their Families (DCYF); and
- the EatSF food voucher program.

The major federal food assistance programs administered at the local level: CalFresh, WIC, and the school meal program, all use the official federal poverty guideline to determine eligibility; however, the federal poverty guideline does not adequately reflect the cost of living in San Francisco because it does not take into account regional cost differences, such as higher housing and food prices.

Official Federal Poverty Threshold Developed in Mid-1960s

The official Federal Poverty Level (FPL) threshold used to determine eligibility for federal food assistance programs was developed in the mid-1960s, at a time when generally accepted standards of minimum need were not available for basic necessities, such as housing, medical care, clothing, and transportation. Instead, the official poverty measure is derived from the cost of a minimum food diet as determined by a 1955 Household Food Consumption Survey prepared by the Department of Agriculture, which found that for families of three or more, the average dollar value of all food used during a week accounted for about one-third of their total income.[5]

Because of the challenges inherent in developing a threshold for how much income is enough, the Social Security Administration economist who developed the official poverty measure noted, "If it is not possible to state unequivocally 'how much is enough,' it should be possible to assert with confidence how much, on an average, is too little."[6] In this sense, the Federal Poverty Level is a measure of not having enough. The poverty threshold is updated annually for inflation using the Consumer Price Index—a measure of the average change over time in the prices paid by urban consumers for goods and services based on a national survey of spending habits—but it does not vary geographically to account for regional cost-of-living differences.[7,8,9] The annual update to the FPL threshold amount is known as the poverty guideline. The federal poverty guideline for 2019 is shown in Exhibit 2 below; for a family of four, it is $25,750, as shown.

[5] "The Development of the Orshansky Poverty Thresholds and Their Subsequent History as the Official U.S. Poverty Measure," May 1991 – partially revised Sept. 1997, https://www.census.gov/content/dam/Census/library/working-papers/1997/demo/orshansky.pdf.
[6] "The Development of the Orshansky Poverty Thresholds and Their Subsequent History as the Official U.S. Poverty Measure," May 1991 – partially revised Sept. 1997, https://www.census.gov/content/dam/Census/library/working-papers/1997/demo/orshansky.pdf
[7] "How the Census Bureau Measures Poverty," Aug. 27, 2019, https://www.census.gov/topics/income-poverty/poverty/guidance/poverty-measures.html
[8] Consumer Price Index, U.S. Bureau of Labor Statistics, https://www.bls.gov/cpi/
[9] How is the CPI market basket determined?, Consumer Price Index Frequently Asked Questions, https://www.bls.gov/cpi/questions-and-answers.htm#Question_2

Exhibit 2: 2019 Federal Poverty Level (FPL) for San Francisco (applies to the 48 contiguous states and District of Columbia)

Household Size	Federal Poverty Level
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170

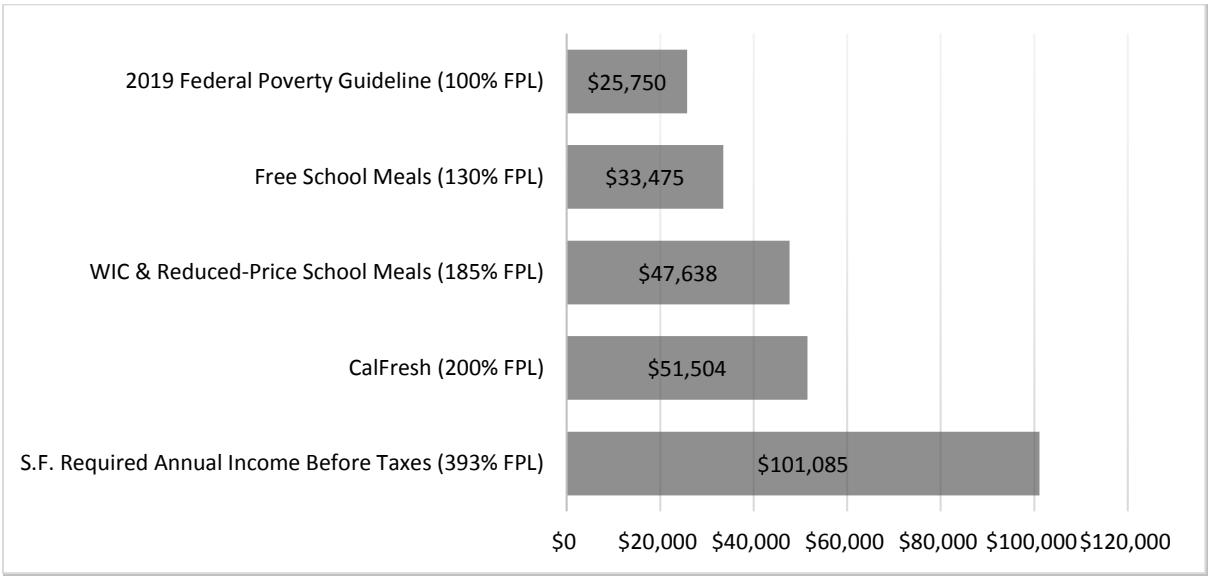
Source: U. S. Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, https://aspe.hhs.gov/2019-poverty-guidelines

A living wage calculator that considers minimum costs for food, child care, health, housing, transportation, other basic necessities, and taxes developed by the Massachusetts Institute of Technology puts into perspective the significant gap between the $101,085 minimum living wage income needed in San Francisco for a family of four (two adults and two children) compared to the income maximums above which applicants generally do not qualify for major federal food assistance programs, as displayed in Exhibit 3, such as the income maximum of $51,504 for a family of four to potentially qualify for some amount of CalFresh assistance.[10]

There is a gross income limit of 200% of FPL to be eligible for CalFresh. However, HSA reports that the federal eligibility rules are complex and that, in practice, only households earning up to 130 percent of FPL and meeting other eligibility criteria are assured of being determined to be eligible for food stamps. Households earning between 130 and 200 percent of FPL may be determined eligible for food stamps but are less assured that they will actually qualify. This means that many low-income households in San Francisco do not qualify for food stamps under federal eligibility rules, likely contributing to food insecurity.

[10] MIT Living Wage Calculator, 2019, https://livingwage.mit.edu/counties/06075

Exhibit 3: San Francisco Cost of Living for a Family of Four Relative to Income Maximum for Qualifying for Major Federal Food Assistance Programs



Sources: MIT Living Wage Calculator (https://livingwage.mit.edu/counties/06075), CalFresh eligibility (http://mycalfresh.org/the-basics/), WIC eligibility (https://fns-prod.azureedge.net/sites/default/files/resource-files/WPM-2019-4-WICIEGs_508.pdf), School Meals eligibility (https://frac.org/wp-content/uploads/fedrates.pdf).
Note: There is a gross income limit of 200% of the Federal Poverty Level (FPL) to be eligible for CalFresh; however, we note that the eligibility rules are complex and that HSA uses a rule of thumb of 130% of FPL as the income limit at which individuals are frequently eligible for CalFresh once eligibility rules are applied.

Populations Vulnerable to Food Insecurity

As noted earlier, an estimated 13 percent of San Franciscans (approximately 115,190 people) experienced food insecurity in 2017, according to the Map the Meal Gap estimate developed by Feeding America. However, other survey research collated in the 2018 Assessment of Food Security report prepared by the Food Security Task Force identifies populations that are particularly vulnerable to experiencing food insecurity. As detailed below, we have grouped these populations into two categories—(1) low-income families with children and (2) low-income adults.

1) **Low-income Families with Children**, including pregnant people, children, transitional-aged youth (16 to 24 years-old), and college students.
   - **Pregnant people who are low-income and racial/ethnic minorities have an 8.2 percent rate of food insecurity overall, with the highest rates among Latinx and black/African American individuals.** The San Francisco Community Health Needs Assessment of 2019 showed higher levels of food insecurity among surveyed pregnant people of color and almost no reported food insecurity among white women, as shown in Exhibit 4.

While the overall rate of food insecurity for pregnant people was 8.2 percent, higher rates were reported for certain races/ethnicities. The highest rate of food insecurity among the surveyed group was found among pregnant Latinx individuals at 26.5 percent (an estimated 434 individuals), followed by 19.4 percent among black/African American pregnant individuals (an estimated 83 people), and 6.6 percent among Asian, Pacific Islander, or pregnant individuals identifying as other (an estimated 214 people). We note that the San Francisco Community Health Needs Assessment 2019 only reported the percentage of food insecurity among pregnant people, but not the population from which the percentages were drawn. We arrived at actual numbers by applying data on the live births by race and ethnicity of mothers in San Francisco available from the Annie E. Casey Foundation.

Exhibit 4: Food Insecurity among Pregnant People in San Francisco, 2017

	Total	Food Insecure	% Total
White	3,631	0	0.0%
Asian, Pacific Islander, or Other	3,249	214	6.6%
Latinx	1,639	434	26.5%
Black or African American	428	83	19.4%
Total	8,947	731	8.2%

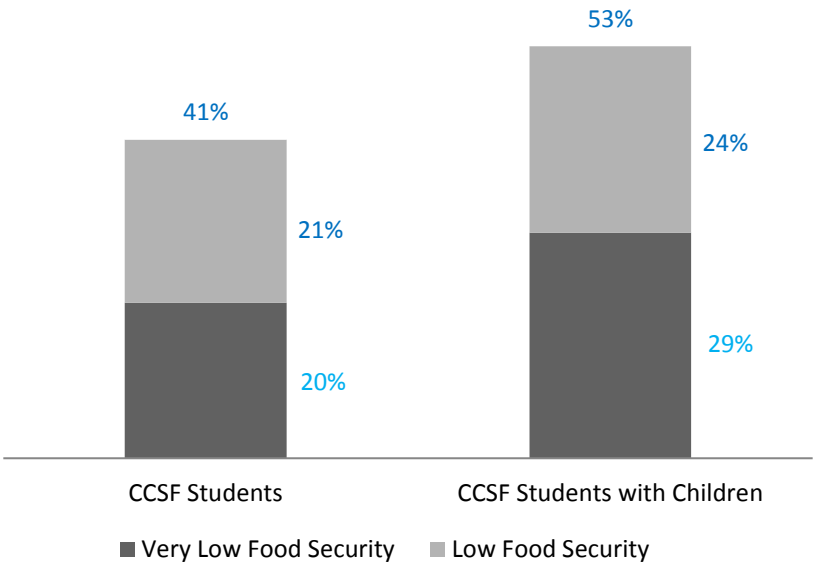
Source: San Francisco Community Health Needs Assessment, 2019, p. 18, https://www.sfdph.org/dph/hc/HCAgen/2019/May%207/CHNA_2019_Report_041819_Stage%204.pdf & Annie E. Casey Foundation Kids Count Data Center, Total Births by Race in San Francisco, 2017, https://datacenter.kidscount.org/data/tables/6038-total-births-by-race#detailed/3/91/false/871/3,2,1,4,13/12703,12704

- **A San Francisco Unified School District (SFUSD) survey found high school students have a 16 percent rate of food insecurity.** Every other year, the Youth Risk Behavior Surveillance System survey is conducted by the Centers for Disease Control and Prevention to monitor health-related behaviors among children. In 2018, a new question was added related to food insecurity: "During the past 30 days, how often did you go hungry because there was not enough food in your home?" Of the more than 2,000 SFUSD high school students surveyed, the preliminary results provided by the school district showed nearly 16 percent reporting some level of food insecurity: 63.6 percent answered "Never," 20.7 percent answered "Rarely," 12.1 percent answered "Sometimes," 2.5 percent answered "Most of the Time," and 1.1 percent answered "Always." It cannot be determined from available survey results how many of the surveyed students are

participating in SFUSD's school meals program or other food assistance programs such as CalFresh, which may result in less food insecurity reported by surveyed students.

- **A City College of San Francisco (CCSF) survey found students had a 53 percent rate of food insecurity.** Of the CCSF students surveyed, 41 percent were found to be food insecure among a sample of 1,088 students, and 53 percent of CCSF students with children were found to be food insecure among a sample of 188 students, as shown in Exhibit 5. The higher rate of food insecurity among these college students compared to high school students in the SFUSD survey referenced above may reflect the impact of the SFUSD school meals program on students' reported rate of food security.

Exhibit 5: Food Insecurity among City College of San Francisco Students



Source: City College Food Pantry Work Group CCFPWG Food Security Survey Results, November 2017.

2) **Segments of the low-income adult population have rates of food insecurity ranging from 56 to 84 percent.** People experiencing homelessness or residing in single-room occupancy housing (SROs) as well as older adults and people with disabilities have all been found to have high rates of food insecurity.
   - During the 2019 San Francisco homeless survey (conducted as part of the biannual point-in-time count), 56 percent of respondents indicated that they had experienced a food shortage in the past four weeks, which is a slight increase over

the 2017 survey when 52 percent of respondents reported experiencing a food shortage in the past four weeks.[11]

- In a study of more than 600 adult residents of SROs, 84 percent reported food insecurity.[12]
- An estimated one-third of low-income older adults in San Francisco are reportedly unable to afford enough food.[13] Program data from DAS indicates that 78 percent of adults with disabilities seeking home-delivered meals and/or congregate meals were food insecure.[14]

Effectiveness of Food Assistance Programs

Studies show that the food assistance programs CalFresh, WIC, and school meals are considered to be effective in reducing the level of food insecurity among enrollees. However, as the survey data in the previous section show, even with these programs available in San Francisco and tens of thousands of residents enrolled in them, tens of thousands of San Franciscans continue to experience food insecurity.

CalFresh

Nationally, an estimated 85 percent of people eligible to receive SNAP benefits—known as CalFresh in California—did so in fiscal year 2016.[15] In California, an estimated 72 percent of people eligible to receive CalFresh benefits did so in 2016.[16] However, in San Francisco, just two-thirds of eligible participants, or 66 percent, received CalFresh benefits in 2016.[17]

[11] San Francisco Homeless Count and Survey Comprehensive Report, 2019, http://hsh.sfgov.org/wp-content/uploads/FINAL-PIT-Report-2019-San-Francisco.pdf.
[12] Strategies to Improve Food Security among Single Residents of San Francisco's SROs: SRO Resident Food, Cooking and Nutrition Survey Results & Recommendations, 2018, Assessment of Food Security.
[13] San Francisco Department of Aging and Adult Services Assessment of the Needs of San Francisco Seniors and Adults with Disabilities: Part II: Analysis of Needs and Services. San Francisco, CA: San Francisco Human Services Agency Planning Unit, 2016.
[14] Program data from San Francisco Department of Aging and Adult Services, Fiscal Year 2017-18.
[15] "Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2016, United States Department of Agriculture, March 2019, https://fns-prod.azureedge.net/sites/default/files/resource-files/Reaching2016.pdf
[16] "Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2016, United States Department of Agriculture, March 2019, https://fns-prod.azureedge.net/sites/default/files/resource-files/Reaching2016.pdf
[17] CalFresh Data Dashboard, Program Reach Index by County and Year, 2016, https://public.tableau.com/profile/california.department.of.social.services#!/vizhome/CFdashboard-PUBLIC/Home

A number of studies show that participation in SNAP has the effect of reducing food insecurity. A 2013 study by the U.S. Department of Agriculture Food and Nutrition Service found that participating in SNAP for 6 months was associated with a decrease in the number of households experiencing food insecurity by about 5 to 10 percentage points, including households with food insecurity among children, based on interviews with nearly 10,000 households in 30 states.[18] Over the last 10 years, SNAP has been linked with improved nutritional outcomes and lower health care costs.[19]

Trump Administration Policies Reduce Enrollment in Food Assistance Programs among Immigrants

Both HSA and DPH reported a decline in enrollment in food assistance programs as a result of Trump administration policies like the so-called "public charge rule" for immigrants. In rare situations, this rule would make it more difficult for certain immigrants to receive a green card if they have benefitted from public assistance programs, such as Medicaid (known as Medi-Cal in California), food stamps (CalFresh), or housing subsidies. The HSA provides more information here: https://www.sfhsa.org/services/immigrants-benefits/understanding-public-charge

The HSA reported that in the two and a half years after President Trump's election in November 2016, the number of San Francisco households that had one or more non-citizen members and that participated in CalFresh declined by more than 25 percent. The WIC Program Director at DPH reported that the public charge rule has had a "huge chilling effect," even though WIC is not included in the final public charge rule and immigration information is not collected by the program.

More recently, the Trump administration finalized a new federal rule that would have had the effect of pushing more able-bodied adults with no dependents (ABAWDs) off of CalFresh for failure to meet work requirements. However, the rule was blocked by a federal judge in March 2020.

WIC

The 2018 Assessment of Food Security in San Francisco report noted high rates of food insecurity among low-income San Francisco families despite their participation in WIC. Among a sample of 170 low-income WIC families, 60 percent were found to be food insecure and among a sample of 633 low-income pregnant WIC participants, 53 percent were found to be food insecure.[20,21,22] Despite the high rates of food insecurity found among WIC clients in San

[18] Measuring the Effect of Supplemental Nutrition Assistance Program (SNAP) Participation on Food Security (Summary), United States Department of Agriculture, Aug. 2013, https://fns-prod.azureedge.net/sites/default/files/Measuring2013Sum.pdf

[19] SNAP Is Linked with Improved Nutritional Outcomes and Lower Health Care Costs, Center on Budget and Policy Priorities, Jan. 17, 2018, https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-nutritional-outcomes-and-lower-health-care

[20] Promoting Housing Security and Healthy Homes for Families Served by Maternal, Child and Adolescent Health Programs, 2017, SFDPH Children's Environmental Health Promotion Program

[21] Are food insecurity's health impacts underestimated in the U.S. population? Marginal food security also predicts adverse health outcomes in young U.S. children and mothers, 2013, Advances in Nutrition

[22] EATSF Healthy Food Voucher Program Fiscal Year 2017-18 Aggregate Survey Data

Francisco, extensive research finds WIC to be a cost-effective investment that improves the nutrition and health of low-income families.[23]

Over four decades, researchers have found WIC to provide the following health and wellness benefits:

- **Better Birth Outcomes and Lower Infant Mortality**. WIC participants give birth to healthier babies who are more likely to survive infancy.
- **More Nutritious Diets and Better Infant Feeding Practices**. WIC participants now buy and eat more fruits, vegetables, whole grains, and low-fat dairy products, following the introduction of revised WIC authorized foods that are more closely aligned to current dietary guidance. In California, the authorized food list was updated in April 2019.[24]
- **Healthier Children with Better Mental Development**. Low-income children participating in WIC are just as likely to be immunized as more affluent children, and are more likely to receive preventive medical care than other low-income children. Furthermore, children whose mothers participated in WIC while pregnant scored higher on assessments of mental development at age two than similar children whose mothers did not participate, and they later performed better on reading assessments while in school.

School Meals

Research has found that participation in a school lunch program reduces food insecurity, improves dietary intake, positively impacts health and obesity rates, and leads to a better learning environment. In terms of the impact on food insecurity, studies have shown an association between school meal programs and lower food insecurity:

- According to one estimate using national data, receiving free or reduced-price school lunches reduces the prevalence of food insecurity among children screened by at least 3.8 percent.[25]

- Among a sample of low-income children entering kindergarten, receiving a free or reduced-price school lunch reduces the probability of household food insecurity at school entry, whereas paying full price for school lunch is associated with a higher probability of household food insecurity.[26]

[23] WIC Works: Addressing the Nutrition and Health Needs of Low-Income Families for 40 Years, Center on Budget and Policy Priorities, March 29, 2017, https://www.cbpp.org/research/food-assistance/wic-works-addressing-the-nutrition-and-health-needs-of-low-income-families
[24] Women, Infants and Children (WIC), CA Dept. of Public Health, Aug. 30, 2019, https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/WICFoods.aspx
[25] U.S. National School Lunch Program improves health of children in low-income households, study suggests, ScienceDaily, Nov. 11, 2011, https://www.sciencedaily.com/releases/2011/11/111110142106.htm
[26] Benefits of School Lunch, Food Research & Action Center, https://www.frac.org/programs/national-school-lunch-program/benefits-school-lunch

- Rates of food insecurity among children are higher in the summer—a time when many do not have access to the good nutrition provided by the school meal programs available during the academic year.[27]

Higher Health Care Costs for Individuals who Experience Food Insecurity

Researchers have estimated the health care costs associated with food insecurity, finding in a nationwide study that food insecure adults have annual health care expenditures that are an average of $1,834 higher than food secure adults.[28] Using an analytical approach known as "targeted maximum likelihood estimation," these researchers linked the following three data sources: 1) 2011-13 National Health Interview Survey/Medical Expenditure Panel Survey data to estimate average health care costs associated with food insecurity, 2) Map the Meal Gap data to estimate state- and county-level food insecurity prevalence (through 2016), and 3) Dartmouth Atlas of Health Care data to account for local variation in health care prices and intensity of use.[29] The targeted maximum likelihood estimation approach estimates the excess health care costs associated with food insecurity and then updates the estimate using a secondary model that estimates the probability of being food insecure. This analysis found that $205 million is spent on additional health care costs associated with food insecurity in San Francisco. With the estimated $1,834 in additional health care costs per adult, the total food insecure population is 111,778, or close to the estimated 115,190 San Franciscans identified as food insecure by Map the Meal Gap, referenced above.[30]

Policies to better connect individuals to food assistance programs may be important mechanisms to contain health care expenditures associated with food insecurity. In the section that follows, we provide details on direct expenditures for major food assistance programs and briefly describe the level of food insecurity screening that occurs in San Francisco—a topic we return to in greater detail later in the report.

Profile of San Francisco's Food Assistance Programs

The four primary government programs aimed at improving food availability for San Franciscans are:

1) CalFresh (food stamps), administered through the Department of Human Services (DHS) of the Human Services Agency (HSA);

[27] Benefits of School Lunch, Food Research & Action Center, https://www.frac.org/programs/national-school-lunch-program/benefits-school-lunch
[28] State-Level and County-Level Estimates of Health Care Costs Associated with Food Insecurity, Centers for Disease Control and Prevention, July 11, 2019, https://www.cdc.gov/pcd/issues/2019/18_0549.htm
[29] State-Level and County-Level Estimates of Health Care Costs Associated with Food Insecurity, Centers for Disease Control and Prevention, July 11, 2019, https://www.cdc.gov/pcd/issues/2019/18_0549.htm
[30] State-Level and County-Level Estimates of Health Care Costs Associated with Food Insecurity, Centers for Disease Control and Prevention, July 11, 2019, https://www.cdc.gov/pcd/issues/2019/18_0549.htm

2) Food programs targeted to older adults and adults with disabilities including congregate and home-delivered meals administered by the Department of Disability and Aging Services (DAS) of HSA;

3) WIC, administered by the Department of Public Health (DPH); and

4) School meal programs providing free and reduced-price meals to eligible students attending SFUSD and some private schools.

The Department of Children Youth and Their Families and First 5 San Francisco provide food assistance services though with lower expenditures than the other programs. A summary of program expenditures and caseload data for these agencies is presented in Exhibit 6, followed by more detailed descriptions of the administering agencies and programs.

As shown in Exhibit 6, approximately $139 million was spent in FY 2018-19 on food assistance benefits (excluding administrative costs) for low-income San Franciscans, of which approximately $26.2 million was local funding. We note that DAS measures meal program caseload in terms of total meals served (or delivered) in a fiscal year while CalFresh, WIC, and SFUSD measure caseload by the number of unduplicated clients served in a fiscal year. There were a reported 115,530 enrollees in the CalFresh, WIC and school meals programs in FY 2018-19, excluding DAS congregate and home-delivered meals for which there is no estimate available of the number of clients served. However, there are likely to be duplicates in these numbers, such as SFUSD students enrolled in the school meals program whose families are also receiving CalFresh benefits. Recall that Feeding America estimated 115,190 San Franciscans experience food insecurity whereas the largest food assistance program—CalFresh—had a total of 78,358 unduplicated enrollees in FY 2018-19, suggesting that not everyone experiencing food insecurity is connected to a food assistance program. In addition, as discussed above, many of the enrollees in WIC and DAS food programs have been found to still experience food insecurity. It is unknown how many CalFresh enrollees continue to experience food insecurity.

Exhibit 6: Expenditures and Caseload for Major Government Food Assistance Programs in San Francisco, FY 2018-19

Program	FY 2018-19 Total Expenditures	Total Expenditures from General Fund/Local	FY 2018-19 Caseload or Meals Served
CalFresh (food stamps)	$72,562,536[1]	$0	78,358 unduplicated enrollees
DAS Congregate & Home-Delivered Meals	$31,709,235	$18,677,912	• 1,602,635 congregate meals • 2,234,069 meals delivered
WIC	$5,942,773	$0	• 12,972 unduplicated breastfeeding & postpartum individuals & children 0-5 • 1,200 unduplicated pregnant individuals enrolled
School Meal Program	$27,019,199	$7,249,898	• 19,000 students enrolled
DCYF	$1,336,212	$282,592	• 412,619 meals and snacks served
Family Resource Centers (funded by First 5 San Francisco, HSA and DCYF)	$500,000[31]	n.a.	• 2,000 bags of food distributed weekly through 10 FRCs
Total	**$139,069,955**	**$26,210,402**	• 111,530 enrollees (not adjusted for duplication between programs)[2] • 1.6 mill. congregate meals • 2.2. mill. meals delivered • 412,619 meals & snacks served to youth and families • 104,000 bags of food distributed through Family Resource Centers

Sources: Expenditure and caseload data provided by each agency.
[1] This amount reflects benefits only, not administrative expenses.
[2]The total caseload simply reflects the sum total of the unduplicated caseload count for all programs except DAS congregate and home-delivered meals for which there is no unduplicated case count.

Program descriptions and caseload information for each of the key food programs listed in Exhibit 6 are provided below. We also describe the degree to which each program is

[31] We note that this amount is an estimate of distribution costs absorbed by Family Resource Centers for which there is not a dedicated funding stream.

screening for food insecurity and referring individuals to other food assistance programs, an issue we address in greater detail later in the report.

Human Services Agency (HSA)

The Human Services Agency is San Francisco's county social services department, which determines eligibility for and administers large federal and state-funded social services programs serving low-income individuals and families. The HSA is comprised of three departments:

- Department of Human Services (DHS), which administers CalFresh, California Work Opportunities and Responsibility to Kids (CalWORKs)—California's Temporary Assistance to Needy Families (TANF) welfare program, General Assistance for indigent adults, and eligibility for Medi-Cal (California's Medicaid health program for low-income individuals and families), among other programs. Program administrators reported that program staff do not screen clients for food insecurity.
- The Department of Disability and Aging Services (DAS) administers: congregate and home-delivered nutrition programs by contracting with community-based service providers, In-Home Supportive Services (IHSS) for older adults and people with disabilities who need assistance in order to remain at home, as well as other programs and services to support older adults and people with disabilities. DAS program administrators reported that community-based providers of congregate and home-delivered nutrition as well as IHSS program social workers do screen clients for food insecurity; however, DAS does not track the results of food insecurity screenings conducted by community-based service providers in order to assess the degree to which clients accessed other food assistance programs. The IHSS program, on the other hand, has a more robust process in place to refer clients screening positive for food insecurity to food pantry services and/or CalFresh by connecting clients to telephonic assistance.
- The Office of Early Care and Education (OECE) administers childcare services and pre-school to children ages 0 to five. Child care providers do not universally screen children for food insecurity; however, these screenings are conducted by Head Start and Early Head Start providers.

Key HSA programs addressing food insecurity are:

1. **CalFresh Program.** CalFresh benefits are funded entirely with federal funds. DHS staff are responsible for initially enrolling and renewing eligibility for CalFresh recipients every six months (pursuant to federal requirements). CalFresh staff consisted of 204.2 full-time equivalent positions (FTEs) in FY 2018-19.

   A total of 78,358 unduplicated enrollees, or individuals, and 54,430 households received CalFresh at some point in FY 2018-19, as shown in Exhibit 7.

Exhibit 7: CalFresh Caseload in FY 2016-17 and FY 2018-19

	Total unduplicated clients served at any point in FY 2016-17	Total unduplicated clients served at any point in FY 2018-19	Percent Change
Households	50,978	54,430	6.8%
Children 0-17	23,506	19,592	-16.7%
Individuals 18-59	40,981	36,802	-10.2%
Older Adults +60	12,622	21,964	74.0%
Total	77,109	78,358	1.6%

Source: Human Services Agency and 2018 Assessment of Food Security, p. 32.

A comparison of FY 2016-17 to FY 2018-19 CalFresh caseload data in Exhibit 7 shows a significant growth in the number of older adults enrolling in CalFresh. This is due primarily to a state policy change known as the "SSI Cashout Reversal," which began in May 2019 and allows more older adults and people with disabilities to be eligible for CalFresh who were not previously. In the period from May through September 2019, a cumulative total of 18,304 individuals have enrolled in CalFresh as a result of the SSI Cashout Reversal. The 21,964 older adults enrolled in CalFresh in FY 2018-19 represents a 74% increase over two years earlier of 12,622 enrolled older adults in FY 2016-17. The double-digit declines in the number of children and adults enrolled in CalFresh are driven primarily by improved economic conditions, according to HSA.

The average monthly CalFresh benefit ranges from $139 for an individual to $503 for a family of five, as shown in Exhibit 8.

Exhibit 8: CalFresh Average Monthly Benefit Amount in FY 2018-19

Household Size	Maximum Monthly Benefit	Average Monthly Benefit
1	$192	$139
2	$353	$213
3	$505	$371
4	$642	$435
5	$762	$503

Source: Human Services Agency.

The U.S. Department of Agriculture reports bi-annual (January and July) benefit issuance data by county. We used the January and July total CalFresh benefit issuance for San Francisco to arrive at an annual estimate of benefits for the three

most recent fiscal years through FY 2018-19, as shown in Exhibit 9.[32] In FY 2018-19, the annual CalFresh expenditures were estimated to be $72.6 million, or about $6 million per month. Also presented in Exhibit 9 is the declining trend in these expenditures over the three fiscal years from FY 2016-17 through FY 2018-19 of 15.2 percent due to an improved economy. We note that the CalFresh benefit is fully funded by the federal government.

Exhibit 9: Estimated Annual CalFresh Benefit Expenditures, FY 2016-17 – FY 2018-19

FY 2016-17	FY 2017-18	FY 2018-19	% Change from FY 2016-17 to FY 2018-19
$85,614,528	$80,539,740	$72,562,536	-15.2%

Source: Human Services Agency.

Screening for food insecurity: Though the HSA programs primarily deal with lower income clients who are more likely to experience food insecurity, the agency does not conduct food insecurity screening as part of the eligibility processes for CalFresh, Medi-Cal, or CalWORKs. Even though research shows that CalFresh applicants and renewing enrollees experience lower levels of food insecurity than they otherwise would, the California Health Interview Survey, cited above, has shown that an estimated 89,000 San Francisco residents earning less than 200 percent of FPL experience food insecurity. This means that either some individuals receiving food stamps are still food insecure in spite of their enrollment in CalFresh, or that many individuals eligible for CalFresh are not participating in the program even though it could help reduce their level of food insecurity, or a combination of the two.

2. **Food Programs for Older Adults and People with Disabilities.** The HSA's Department of Disability and Aging Services (DAS) administers food programs to older adults and people with disabilities, consisting of congregate meals and home-delivered meals and groceries.

   In FY 2018-19, DAS spent a total of $31.7 million on congregate and home-delivered nutrition: $13 million on congregate nutrition, with 1,602,635 meals served, as shown in Exhibit 10, and $18.7 million on home-delivery of groceries and meals, with a total of 2,234,069 meals delivered and 277,662 grocery bags delivered, as shown in Exhibit 11.

[32] Food and Nutrition Service, SNAP Data Tables, Jan. 17, 2020, https://www.fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap

Exhibit 10: Congregate Nutrition Spending, FY 2016-17 to FY 2018-19

	FY16-17	FY17-18	FY18-19
Federal	$1,634,855	$1,559,854	$1,686,390
State	$137,949	$135,074	$97,556
Local Public	$6,271,899	$6,918,590	$7,064,200
Local Private[33]	$4,236,473	$2,242,366	$4,189,521
Total Dollars	**$12,281,176**	**$10,855,884**	**$13,037,667**
Total Meals	1,632,323	1,619,209	1,602,635
Cost per Meal	$7.52	$6.70	$8.14

Source: Human Services Agency.

Exhibit 11: Home-Delivered Nutrition Spending, FY 2016-17 to FY 2018-19

	FY16-17	FY17-18	FY18-19
Federal	$1,794,782	$1,696,609	$2,164,081
State	$338,006	$253,312	$121,246
Local Public	$8,841,652	$10,589,592	$11,613,712
Local Private[34]	$3,828,846	$4,268,138	$4,772,529
Total Dollars	**$14,803,286**	**$16,807,651**	**$18,671,568**
Total Home-Delivered Meals	2,017,947	2,236,297	2,234,069
Grocery Bags	140,021	215,043	277,662

Source: Human Services Agency.

Screening for food insecurity: As mentioned above, DAS's community-based organization contract food program providers do screen clients for food insecurity. However, there is no standard process for referring clients to food assistance programs and ensuring that clients receive the services they need. On the other hand, county social workers that conduct in-home assessments for the In-Home Supportive Services program screen program participants for food insecurity and refer clients screening positive to CalFresh and food pantry services using a mobile phone app developed by the HSA Information Technology unit.

Department of Public Health (DPH)

The DPH is divided into two divisions: (1) San Francisco Health Network of Zuckerberg San Francisco General Hospital (ZSFG) and clinics and (2) the Population Health Division. The Maternal, Child and Adolescent Health unit sits within the San Francisco Health Network division and administers the WIC program.

[33] Private non-matching contributions as self-reported by community-based organizations and included in the DAS Area Plan budget submitted to the California Dept. of Aging.
[34] Private non-matching contributions as self-reported by community-based organizations and included in the DAS Area Plan budget submitted to the California Dept. of Aging.

The WIC program received and expended approximately $8.9 million in FY 2018-19 for administrative and benefits costs—fully funded by the federal government, as shown in Exhibit 12. The total number of WIC clients served in FY 2018-19 was 14,172, as shown in Exhibit 13. DPH also reported that in 2016 the average benefit for a WIC participant in California was $61 per month, meaning that a family of four WIC-eligible members received about $244 worth of food. Infants who receive non-specialized formula have a higher average monthly benefit amount of about $160 to $175.

Exhibit 12: WIC Funding, Federal Fiscal Years 2016-17 to 2018-19

	FY16-17	FY17-18	FY18-19
Administrative Funding	$2,958,326	$2,981,646	$3,004,965
Benefit Funding	$7,537,238	$6,742,921	$5,942,773
Total	**$10,495,564**	**$9,724,567**	**$8,947,738**

Source: Department of Public Health.

Exhibit 13: WIC Caseload: Total unduplicated clients serviced at any point in FY 2018-19

Population	Caseload
Pregnant People	1,200
Breastfeeding & Postpartum People and Children 0-5	12,972
Total	**14,172**

Source: Department of Public Health.

Screening for food insecurity: WIC program administrators reported that, beginning in September 2019, the California WIC program introduced a statewide validated food insecurity screening tool into its assessment and electronic data system, creating new potential for referring WIC clients to additional food resources more effectively.

Physicians within the San Francisco Health Network also reported using the Hunger Vital Sign two-item food insecurity screening beginning in October 2019 on a pilot basis—to varying degrees of adoption depending on the clinical setting. However, they have also reported that implementation has not been comprehensive and that in many clinical settings, it is difficult for medical providers to incorporate this screening and referral process into their protocols.

San Francisco Unified School District (SFUSD)

The SFUSD provides school meals, including breakfast, morning snack, lunch, and—for afterschool programs—snack and supper, spending a total of $27 million and providing approximately 5.4 million meals in FY 2018-19, as shown in Exhibit 14. Students whose families earn 130 percent of FPL (in 2019, $33,475 for a family of four) or less are eligible

to receive free meals; and children in families earning between 130 to 185 percent of FPL (up to $47,638 for a family of four) are eligible for reduced-price meals.

In San Francisco, children eligible for reduced-price meals (paying 30 cents for breakfast and 40 cents for lunch) are provided free meals subsidized by the District's General Fund. Of the 124 public schools in SFUSD, 55 are subject to the "Community Eligibility Provision" (CEP), meaning that all children in the school are eligible to receive free meals because of the high percentage of low-income families at that school eligible for CalFresh, CalWORKs, and/or Medi-Cal.

As of August 2019, about 19,000 students were enrolled in CEP schools, according to the Executive Director of Student Nutrition Services for SFUSD.

Screening for food insecurity: The Executive Director of Student Nutrition Services reported that the school district does not screen students for food insecurity. However, monthly data matches occur (1) between SFUSD student enrollment data and HSA's data on CalFresh and CalWORKs enrollees and (2) between a state student enrollment database and state enrollment data on CalFresh, CalWORKs, and Medi-Cal in an effort known as "direct certification." Students whose families are found to be enrolled in CalFresh, CalWORKs, or Medi-Cal are "categorically" (or, automatically) eligible for the free and reduced-price school meal program and are automatically enrolled by the school district without the need to complete a separate school meal application.

Exhibit 14: School Meal Funding (Benefits Only), FY 2016-17 to FY 2018-19

	FY 2016-17	FY 2017-18	FY 2018-19
Federal	$17,743,693	$18,917,673	$18,665,116
State	$1,049,593	$1,155,857	$1,104,185
Local	$5,522,305	$7,063,344	$7,249,898
Total	**$24,315,591**	**$27,136,874**	**$27,019,199**

Source: San Francisco Unified School District.

Exhibit 15: Number of free and reduced-price meals served, San Francisco Unified School District

	FY 2016-17	FY 2017-18	FY 2018-19
Breakfast	1,200,269	1,358,535	1,192,184
Lunch	2,620,673	2,701,732	2,637,727
Afterschool Snack	552,112	408,475	419,802
Afterschool Supper	1,048,547	1,053,056	1,024,193
Summer Meals	40,465	79,953	87,155
Total	**5,462,066**	**5,601,751**	**5,361,061**

Source: San Francisco Unified School District.

Other Food Assistance

Department of Children, Youth and Their Families
The Department of Children, Youth and Their Families (DCYF) administers investments in children, youth (including transitional age youth), and their families, including a limited amount of funding for free meals and food assistance. Funding for this program totaled about $1.3 million in FY 2018-19, with more than 400,000 meals and/or snacks served in FY 2018-19, as displayed in Exhibits 16 and 17.

Exhibit 16: DCYF Meal Funding (Benefits Only), FY 2016-17 to FY 2018-19

	FY 2016-17	FY 2017-18	FY 2018-19
Federal/State	$526,276	$806,194	$1,053,620
Local	$179,931	$311,570	$282,592
Total	**$706,207**	**$1,117,764**	**$1,336,212**

Source: Department of Children, Youth and Their Families

Exhibit 17: DCYF Number of Meals and Snacks Served, FY 2016-17 to FY 2018-19

	FY 2016-17	FY 2017-18	FY 2018-19
Total	**244,267**	**333,952**	**412,619**

Source: Department of Children, Youth and Their Families

Family Resource Centers — First 5 San Francisco

Neighborhood-based Family Resource Centers (FRCs)—jointly funded by HSA and First 5 San Francisco—provide a range of services intended to strengthen families and improve child well-being. Pre-pandemic, 10 FRCs distributed 2,000 food bags weekly at an estimated cost of $500,000 annually, according to a First 5 Program Officer. The FRCs also provide snacks and meals with some programming.

Screening for food insecurity: DCYF reports that they do not have a screening protocol in place required of their contractors and subgrantees. Family Resource Centers funded by First 5 San Francisco, DCYF, and HSA do screen for food insecurity for certain clients.

Screening for Food Insecurity and Referral to Food Assistance Programs

To address the unmet needs of the tens of thousands of food insecure in San Francisco, it is critical that residents who are eligible for food assistance programs are aware of and able to enroll in those programs. One way this can be accomplished is through City departments screening residents for food insecurity, particularly populations that are more likely to be food insecure, and facilitating connections between these individuals

and food assistance programs. This is occurring to some extent in San Francisco but, as highlighted above and discussed further below, both the screening and referral processes could be improved to ensure a greater probability of the food insecure accessing available food assistance programs.

From 2014 to 2016, the San Diego Hunger Coalition, a non-profit organization that brings together San Diego organizations to combat hunger, piloted five models for screening for food insecurity in health care settings and referring patients to CalFresh and other food programs, as summarized in Exhibit 18. The five distinct pilot models provide a framework for understanding five different approaches to referring patients to food assistance programs, with on-demand on-site assistance through a resource coordinator found to be the most effective as compared to a referral that simply provides the name, address, and phone number of a local community-based organization, which was found to be the least effective.

In the section that follows, we provide greater detail on the nature of screening and referral to food assistance programs that is conducted by HSA, DPH, and SFUSD. While screening for food insecurity is taking place to varying degrees, we found the referral methods currently used in San Francisco such as partner-initiated phone-based referrals and the more passive information referral to a local community-based organization often lead to a high loss to follow-up.

Exhibit 18: Referral Models Piloted by San Diego Hunger Coalition

More Effective

Model	Description	Effectiveness
On-Demand On-Site Assistance	Patients are referred to a full-time, on-site resource coordinator to assist with applying for CalFresh and accessing additional food resources.	Little to no loss to follow-up.
Intermittent On-Site Assistance	Patients are referred to an on-site partner organization to assist with applying.	Limited loss to follow-up, if assistance is provided regularly.
Partner-Initiated Phone-Based Referral	After providing consent, patient receives a follow-up call from a partner organization to provide phone-based application assistance and additional food resource referrals.	Loss to follow-up is often high.
Patient-Initiated Phone-Based Referral	Patients are provided with a phone number to call for assistance.	Loss to follow-up is often high.
Information Referral to Local Community-Based Organization	Patients are provided with names, addresses and phone numbers of local community-based organizations for assistance.	Loss to follow-up can be extremely high, unless the community partner is located in close proximity.

Source: Launching Rx for CalFresh in San Diego: Integrating Food Security into Healthcare Settings, Oct. 2016, https://static1.squarespace.com/static/55130907e4b018f9300f3e63/t/5823d006f5e2312802b5fefc/1478742024280/Rx+for+CalFresh_FINAL-Oct+2016.pdf.

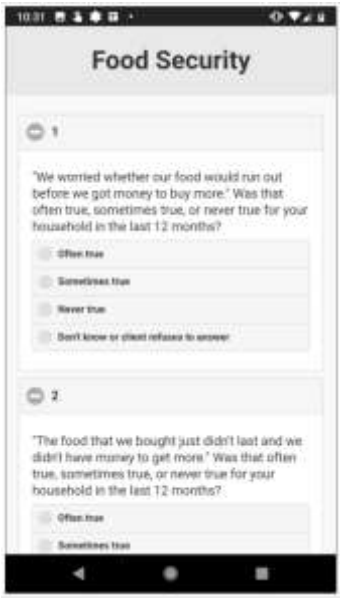
More details on some of the food security screening and referral processes in place by various City agencies and programs are now discussed.

HSA Screening and Referrals

In-Home Supportive Services (IHSS)

The IHSS program, administered by the Department of Disability and Aging Services (DAS) at the Human Services Agency (HSA), provides personal care as well as domestic and related services to low-income older adults and people with disabilities. Department social workers conduct an IHSS assessment in order to determine the number of hours of assistance that a client will receive for various activities of daily living, such as bathing, grooming, and grocery shopping. For the past several years, social workers have been screening clients for food insecurity and switched from using a six-item screening to using the Hunger Vital Sign two-item screening in June 2019. Social workers who assess clients for IHSS use a mobile phone app created by the HSA Information Technology department to assess for food insecurity and ask follow-up questions that lead to a partner-initiated phone-based referral. A screenshot of the mobile app is displayed in Exhibit 19 below.

Exhibit 19: Screenshot for IHSS Food Insecurity Screening



Source: Human Services Agency.

If an IHSS client expresses interest in food pantry services, then the SF-Marin Food Bank is notified and conducts phone outreach. If the client expresses interest in assistance to submit a CalFresh application, then HSA utilizes the services of 211 San Diego representatives under the terms of a contract with HSA to conduct phone outreach in order to support individuals in applying for CalFresh telephonically. The 211 San Diego customer service line is similar to SF311.

A total of 4,164 unduplicated IHSS clients were screened for food insecurity in the first quarter of FY 2019-20. Of those, a total of 702, or 16.9 percent, screened positive for food insecurity, as shown in Exhibit 20 below. The data on referrals from food insecurity screening of IHSS clients shows that there is a high loss to follow-up with partner-initiated phone-based referrals for food bank assistance, with only 17.5 percent of clients who screened positive for food insecurity, expressed interest in the food bank, and were referred to the food bank actually receiving food bank services. The results were much better for CalFresh, where a full 51 percent of clients were enrolled in CalFresh after screening positive, expressing an interest in the program, and being referred to 211 San Diego. However, even with these better results, it still means that about half of those interested in the program are not enrolling in CalFresh.

Exhibit 20: IHSS Clients Screening Positive for Food Insecurity in FY19-20 Quarter 1 (July 1 – September 30, 2019)

	Number	Percent
Number of screenings	4,164	
Number of unduplicated IHSS clients screening positive for food insecurity	702	16.9%
Of those screening positive, number of unduplicated clients expressing an interest in the food bank	439	62.5%
Of those screening positive and expressing an interest in the food bank, number of unduplicated clients referred to SF-Marin Food Bank[1]	332	75.6%
Of those screening positive, expressing an interest, and referred to SF-Marin Food Bank, number of clients receiving food bank assistance[2]	58	17.5%
Of those screening positive, number of unduplicated clients expressing an interest in CalFresh	473	67.4%
Of those screening positive and expressing an interest in CalFresh, number of clients enrolling in CalFresh	241	51.0%

Source: Human Services Agency.

[1]Note: Referrals are not sent to SF-Marin Food Bank for individuals found ineligible for IHSS, served through a contract with a non-profit home care provider, already enrolled in another home-delivered grocery model, or lacking a registered caregiver. Once a client has a caregiver in place, IHSS will send the referral to SF-Marin Food Bank.

[2]Note: There is a time lag between screening and referral to SF-Marin Food Bank, particularly for new clients in the process of determining IHSS eligibility and securing a caregiver.

Department of Disability and Aging Services (DAS) Food Programs

The Director for the DAS Office of Community Partnerships reports that community-based organizations under contract with the department screen for food insecurity using the Hunger Vital Sign two-item screening and record the results in CA-GetCare, a comprehensive web-based information management system for adult services administered by DAS, as shown in Exhibit 21 below. DAS reported that food insecurity screening began in FY 2016-17. Clients also undergo a nutrition risk assessment. If a client is found to screen for high nutritional risk, they are referred to a nutrition counseling program in which registered dietitians are given contact information for the client and attempt to engage them to discuss nutrition-related resources and concerns.

In addition, the Office of Community Partnerships Director reports that community-based organizations providing home-delivered nutrition and/or congregate nutrition services are expected to have some level of familiarity with local programs in order to provide information referrals to other programs and services. The DAS also notes that many nutrition program sites are co-located with other services, so a client who screens positive for food insecurity or with high nutrition risk may receive additional services in this way. At George Davis Senior Center, for example, where numerous services are

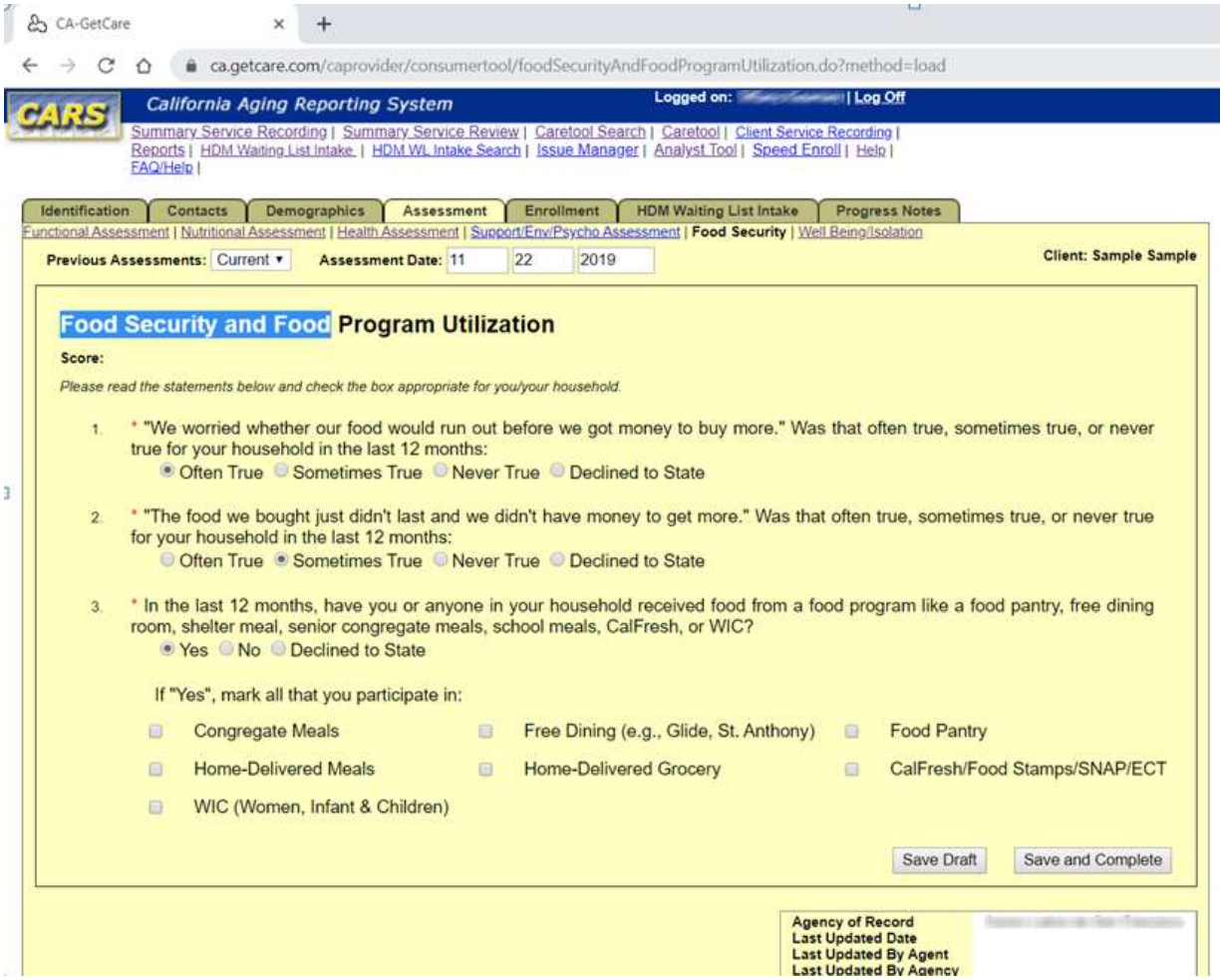
available, the Director for the DAS Office of Community Partnerships reported that there may be a higher level of referral assistance that takes place though the Department does not have specific data available to determine if this is the case.

Unlike the IHSS program where there is a standardized process for handling referrals, the community-based organizations that provide home-delivered and congregate nutrition services under contracts with DAS do not use a standardized referral process, meaning there is no guarantee of an effective referral process across all provider organizations. The DAS Office of Community Partnerships Director and Lead Nutritionist report that the type of referrals may depend upon the nature of the community-based organization and other services they provide and could take the form of providing a client with referral information—a method found by the San Diego Hunger Coalition study to be prone to a high loss to follow-up. A more effective referral process is in place at DAS's comprehensive benefits and resources hub at 2 Gough Street, which provides referrals to services for older adults and people with disabilities, including nutrition services, in person.

As of the writing of this report, DAS reported that they were unable to provide a data report from CA-GetCare on the number of home-delivered nutrition and congregate nutrition clients who screened positive for food insecurity. Producing such a report would require DAS to work with the CA-Get Care system vendor.

While DAS's implementation of a validated screening tool through its contracted community-based organizations represents an important step in addressing food insecurity among its clients, the absence of a standardized referral process or methods for determining the results of the referrals reduces the effectiveness of these efforts.

Exhibit 21: Screenshot of Hunger Vital Sign two-item food insecurity screening in the CA-GetCare database management system



Source: Human Services Agency.

CalFresh

HSA reported that CalFresh does not conduct a food insecurity screening of its clients. However, efforts have been made by CalFresh program administrators to support Medi-Cal recipients in applying for CalFresh telephonically through the contract organization 211 San Diego. HSA also out-stations CalFresh eligibility workers at all of its Navigation Centers serving homeless individuals, ZSFG, the Community Assessment and Service Center for justice-involved adults, and community-based organizations. HSA also reported funding the SF-Marin Food Bank to support an extensive network of community-based CalFresh application assisters. Among the other efforts highlighted by HSA are emergency food boxes offered to CalFresh applicants at the eligibility office at 1235 Mission Street and food pantry distributions to non-citizens who may be ineligible for CalFresh.

Significantly, HSA conducts a "direct certification" in which SFUSD students who are enrolled in CalFresh are automatically enrolled in the free and reduced-price school meal program without the need to complete a separate school meal application. Direct certification was first introduced at the federal level in 1986 and refers to an electronic data-match that streamlines the process for enrolling children who are categorically eligible—as a result of their enrollment in CalFresh—into the free or reduced-price school meals program. In 2010, the federal Healthy, Hunger-Free Kids Act required that 95 percent of all students receiving food stamps be directly certified beginning in the 2013-14 school year.[35]

DPH

WIC Program

The WIC program recently incorporated the Hunger Vital Sign two-item screening into the program's statewide eligibility assessment in September 2019 and data from the screening is supposed to become available in 2020. The WIC program is administered by DPH, but program administrators reported data limitations in that they do not share the Epic electronic medical record (EMR) system with DPH's network of hospitals and clinics nor do they share data with HSA-administered programs like CalFresh due to federal data privacy regulations.

In January 2020, a pilot was initiated to co-locate a WIC enrollment specialist at one of the HSA eligibility offices located at 1440 Harrison St. in order to facilitate the enrollment of individuals into WIC, CalFresh, and Medi-Cal at the same location. As part of the co-location pilot, WIC will be tracking cases that get referred from HSA. Data matches to identify likely WIC candidates will not occur due to the federal data privacy limitations, but HSA eligibility staff will send contact information for interested clients to WIC on a per-person basis.

Aside from the new collaboration between HSA and DPH to provide on-site assistance at 1440 Harrison St., WIC clients are generally provided an information referral and it is incumbent upon the client to access additional services, an approach deemed less effective by the assessment of screening and referral processes discussed above. WIC does not follow-up with all clients to ensure that they have accessed services after referrals are made.

San Francisco Health Network (SFHN)

The San Francisco Health Network, including ZSFG and public health clinics, report that the Hunger Vital Sign two-item food insecurity screening has been incorporated into their Epic EMR system but this does not mean screenings are being conducted

[35] Direct Certification Improves Low-Income Student Access to School Meals: An Updated Guide to Direct Certification, Nov. 2018, https://frac.org/wp-content/uploads/direct-cert-improves-low-income-school-meal-access.pdf

throughout the City's healthcare system. The Chief of Community Primary Care and the former Medical Director of Healthy Food Initiatives at ZSFG reported that a pilot screening for food insecurity program began in October 2019. They identified a number of challenges to wider adoption, including:

- **Information Technology Barrier**. The Epic modules are unique for each health care setting, such as the emergency department, inpatient setting, or outpatient setting. Within the Epic module for a particular health care setting, there is a spectrum of how easy the food insecurity screening questions are to access.
- **Training and Engagement of Workforce**. Wider adoption requires training of health care workers conducting the screening.
- **Operational Priority**. Health care workers need to feel invested that conducting the screening is an operational priority. In the primary care setting, this is particularly challenging due to competing mandates.
- **Lack of Financial Incentives**. Certain health-related activities, like screening, can be tied to incentive dollars for health systems that are paid for by insurers. Because there is no direct incentive dollars tied to food insecurity screening rates, this work is deprioritized relative to other work that is reimbursable or has incentives tied to it.
- **Lack of Navigable Referral Network.** The food safety net is complicated and fragmented so it is difficult to develop tools that make it easy for health care providers to identify the collection of optimal resources that best fit patients' needs once food insecurity is identified.
- **Lack of Feedback on Outcome.** Health care providers cite lack of a feedback loop to know whether referrals are leading to successful connections to food resources for their patients, causing lower motivation to screen and refer.

Though the program is new, with all of the challenges listed above, we found that food security screening and referrals have not been successfully implemented as of the writing of this report at the San Francisco Health Network.

SFUSD

The SFUSD did not report conducting any standardized screening of students for food insecurity.

The Executive Director of Student Nutrition Services reported that the school district faced technical issues in being able to ask families about their interest in CalFresh benefits. Even if these technical issues could be overcome, the State does not allow school districts to share data on families eligible for free and reduced-price school meals with HSA's CalFresh program without an opt-in release form. The school district is also barred from spending federal U.S. Department of Agriculture funding on helping to

connect these low-income families to CalFresh. However, a new state law—Chapter 461, Statutes of 2019 (AB 1377, Wicks)—specifically requires the State Department of Education, Department of Health Care Services, and Department of Social Services to develop a plan for better data-sharing in order to increase CalFresh enrollment, particularly among families with children enrolled in free- and reduced-price school meals.

One bright spot is the monthly data-match that occurs at the local and state level known as direct certification. Locally, SFUSD provides student enrollment data to HSA for the purposes of conducting a data-match in order to identify students whose families are enrolled in CalFresh and/or CalWORKs. These students are then automatically enrolled in the free and reduced-price school meals program without needing to complete an application.

At the state level, monthly data matches occur between the state student enrollment database known as the California Longitudinal Pupil Achievement Data System (CALPADS) and state enrollment data on CalFresh, CalWORKs, and Medi-Cal. Because the Medi-Cal health care program for low-income populations is larger than CalFresh, attempts to verify beneficiaries' information electronically is more likely when student data is compared to Medi-Cal enrollment data than with CalFresh enrollment data (CalFresh federal requirements involve enrollees reporting changes to their income every six months and undergoing an annual phone or in-person recertification), making it more likely that eligible families may be dis-enrolled.[36]

Transportation and Food Insecurity

Research shows that the availability of public transportation impacts the level of food insecurity experienced by low-income populations.[37] WIC program administrators reported that lack of transportation access is a significant barrier for San Francisco clients.

We note that the Medi-Cal health program for low-income individuals provides transportation coverage for certain eligible beneficiaries to get to and from medical appointments but not to access food services or resources.[38] Some Family Resource Centers—jointly supported by HSA, DCYF, and First 5 San Francisco—have funds available for transportation assistance for clients.[39] Additionally, local and regional transit agencies provide discounts for youth and seniors, and the Bay Area Rapid Transit (BART) District is piloting a low-income rider discount for individuals with incomes at or

[36] City and County of San Francisco Human Services Agency: Keeping CalFresh, https://www.sfhsa.org/services/health-food/calfresh/keeping-calfresh
[37] The Effect of Public Transportation Accessibility on Food Insecurity, 2016, Eastern Economic Journal
[38] Frequently Asked Questions for Medi-Cal Transportation Services, Jan. 29, 2020, https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation_General_FAQ.aspx
[39] We requested a breakout of how much is spent on transportation assistance by Family Resource Centers but this information was not available from First 5 San Francisco.

below 200 percent of FPL. The BART discount is proposed to be 20 percent per trip for BART, Caltrain, and Golden Gate Transit and 50 percent for the San Francisco Municipal Railway (Muni). Currently, seniors age 65 and older, people with disabilities, and Medicare cardholders are eligible for a 62.5 percent discount and youth ages 5 to 18 are eligible for a 50 percent discount on BART.[40] Muni offers free access for low- and moderate-income youth ages 5 to 18, seniors age 65 and older, and people with disabilities who live in San Francisco in households earning up to 100 percent of the Bay Area median income.[41] While these discount programs help low-income populations to be able to use public transit in order to access food assistance programs and healthy foods, a gap likely remains for low-income individuals who do not live in close proximity to public transit and/or those who may live in a food desert.

Best Practices from Other Jurisdictions

Massachusetts & Oregon: Aligning Financial Incentives through a Medicaid Waiver for On-Demand Onsite Assistance

Section 1115 of the Social Security Act allows states to waive certain federal Medicaid program requirements or obtain federal matching funds for costs or investments that would not otherwise be allowed under the Medicaid health program for low-income individuals and families. Some states have used these so-called "1115 waivers" to test the efficacy of funding screening and referral as well as the provision of food assistance programs.

In California, the current 1115 Medi-Cal waiver is effective through calendar year 2020 and includes a number of initiatives. However, California does not currently have a waiver program that provides an incentive for screening for food insecurity and referring patients to food assistance programs.[42] However, with waiver renewal negotiations underway between the state and federal government, medical societies and associations as well as community-based organizations are advocating for the inclusion of food and nutrition services.

Massachusetts: Flexible Services Program

In Massachusetts, the Centers for Medicare & Medicaid Services (CMS) approved a $149 million Flexible Services Program as part of the state's Delivery System Reform Incentive Payment (DSRIP) Program, an 1115 waiver initiative that ties federal Medicaid hospital payments to corresponding improvements in health outcomes for Medicaid enrollees and the remaining uninsured.[43] Massachusetts' Flexible Services Program tests whether a group of doctors, hospitals, and other health care providers that work together as an Accountable Care Organization (ACO) can improve members' health outcomes and

[40] Tickets and Clipper, https://www.bart.gov/tickets
[41] Free Muni, https://www.sfmta.com/getting-around/muni/fares/free-muni
[42] Medi-Cal 2020 Demonstration, Feb. 27, 2020, https://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx
[43] Medicaid and CHIP Payment and Access Commission, Delivery System Reform Incentive Payment (DSRIP) Programs, March 2015, https://www.macpac.gov/publication/delivery-system-reform-incentive-payment-dsrip-programs-2/

reduce the total cost of care through a targeted evidence-based program that addresses a certain subset of eligible members' health-related social needs—like homelessness and food insecurity.

In order to receive Flexible Services, members must meet at least one of three risk factors:

1) Experiencing homelessness;
2) At risk of experiencing homelessness; or
3) At risk of nutritional deficiency or imbalance due to food insecurity.

The Commonwealth of Massachusetts shifted to an ACO model for Medicaid beneficiaries in March 2018, which means that a network of physicians, hospitals and other community-based health care providers are now financially accountable for cost, quality, and member experience for over 850,000 Medicaid enrollees.[44] We spoke to the Director of Innovative Partnerships at Children's HealthWatch, a network of health professionals, researchers, and policy experts affiliated with the Boston Medical Center—one of the commonwealth's 17 ACOs—in order to better understand how the Flexible Services Program will be operationalized. Boston Medical Center screens every patient using a ten-item questionnaire known as Thrive to assess eight social determinants of health, which includes the Hunger Vital Sign two-item screening for food insecurity.[45] The Boston Medical Center ACO is approaching food insecurity as a set of four tiers (tiers zero to three) with progressively greater interventions for higher-risk populations, utilizing the model of on-demand on-site assistance. Tiers two and three will be funded through the Flexible Services Program.

- **Tier 0** involves connecting patients to federal food assistance programs, including food stamps, WIC, and free and reduced-price school meals. A co-located WIC office is available at the Boston Medical Center.
- **Tier 1** is considered an intervention for low-risk populations that involves connecting individuals to a preventive food pantry through a partnership with The Greater Boston Food Bank. Boston Medical Center's food pantry was started decades ago and has evolved to include a teaching kitchen and a rooftop farm.
- **Tier 2** is for an intermediate risk-level patient and will be funded through the Flexible Services Program. This intervention will involve the delivery of medically prescribed

[44] MassHealth Partners with 17 Health Care Organizations to Improve Health Care Outcomes for Members, Aug. 17, 2017, https://www.mass.gov/news/masshealth-partners-with-17-health-care-organizations-to-improve-health-care-outcomes-for

[45] Boston Medical Center develops EHR tool to screen for patients' social needs, Becker's Health IT & CIO Report, May 17, 2019, https://www.beckershospitalreview.com/ehrs/boston-medical-center-develops-ehr-tool-to-screen-for-patients-social-needs.html

meals and/or vouchers so patients can access fresh fruit and vegetables from a mobile truck.

- **Tier 3** is intended for the highest risk population, such as cancer or AIDS patients who are unable to cook for themselves. These patients will be provided medically-tailored meals by a community-based organization.

Prior to the establishment of the ACO model of care delivery, there were "islands of success" within the pediatric and senior populations, according to the Director of Innovative Partnerships at Children's HealthWatch, but the ACO model and Flexible Services Program has shifted financial incentives in order to enable a population-wide approach to address food insecurity.

Oregon: Coordinated Care Organizations Focus on Social Determinants of Health

A coordinated care organization (CCO) is a network of health care providers who work together in their local communities to serve Medicaid enrollees, similar to the Medicaid ACO model used in Massachusetts as described above. The Oregon 1115 waiver renewed in 2017 requires that the state's CCOs consider using alternative services, including "health-related" services.[46] A "health-related service" is intended to promote the efficient use of resources and, in many cases, target social determinants of health, such as a lack of adequate housing and nutrition. They include two types of services:

1. "Flexible services," which are cost-effective services offered in addition to covered benefits; and
2. "Community benefit initiatives," which are community-level interventions focused on improving population health and health care quality.

We spoke to the Statewide Health Care Liaison for the Oregon Food Bank, who described how CCOs have partnered with the food bank to screen and refer patients to food assistance programs. In Oregon, there is one food bank that serves the entire state through 1,400 pantries. Food insecurity screenings are conducted in more than 400 hospitals and clinics. The Statewide Health Care Liaison reported that the performance metrics specified in the waiver are giving CCOs a financial incentive to address social determinants of health, including screening for food insecurity and referring patients to food assistance programs. Although CCO expenditures for health-related services were initially not considered in setting the capitated rate that a CCO receives for enrollees, these costs are now factored into CCO funding and the CCO does retain any health care

[46] Centers for Medicare and Medicaid Services, Dept. of Health & Human Services, Jan. 12, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf

savings that result from food insecurity screening and referral.[47] High-performing CCOs are also rewarded in that they receive a higher percentage of profit than lower performing CCOs.[48]

The Statewide Health Care Liaison of the Oregon Food Bank trains health care workers, such as care coordinators, social workers, and nursing students, to screen patients for food insecurity and spend 10 minutes with them to review a resource list created by the Oregon Food Bank. The health care worker is trained to provide the patient with on-site assistance, such as assistance in completing a SNAP application, making an appointment to go to a WIC office, or receiving a localized resource list for congregate meals and food pantries.

Colorado: Partner-Initiated Phone-Based Referrals

In Colorado, the state has not used an 1115 Medicaid waiver to shift its delivery system, but the non-profit organization Hunger Free Colorado has established a navigation hub that provides phone-based assistance to patients who screen positive for food insecurity, connecting them to SNAP and/or WIC and helping them access other food assistance programs. As a non-profit organization, Hunger Free Colorado accepts donations from individuals and organizations.

We spoke to the Food Assistance Program Manager for Hunger Free Colorado, who shared that they launched their screening and referral system in 2012 with Kaiser Permanente Colorado and have since expanded to other hospitals and clinics. In the first year, Hunger Free Colorado found that providing patients who screened positive for food insecurity with a referral phone number was ineffective, with a high level of loss to follow-up. Evaluation efforts showed that fewer than five percent of Kaiser Permanente referrals were calling the hotline. In order to increase the number of patients receiving food assistance, program staff developed a referral form in the EMR, which patients could sign to authorize Hunger Free Colorado to contact them directly. The Hunger Vital Sign food insecurity screening was also adjusted to ask about the last three months, rather than the last 12 months (i.e., "In the past three months, have you worried whether your food would run out…?"), which helped staff to more accurately identify patients with immediate food assistance needs. These two changes to the process increased the proportion of referred patients receiving resources from 5 to 78 percent.[49] Since 2012, food insecurity screening and referral to Hunger Free Colorado has grown to 41 medical systems statewide.

[47] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations, Association for Community Affiliated Plans & Center for Health Care Strategies, Inc., Dec. 2018, https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf
[48] Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations, Association for Community Affiliated Plans & Center for Health Care Strategies, Inc., Dec. 2018, https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf
[49] Linking The Clinical Experience To Community Resources To Address Hunger in Colorado, Health Affairs, July 13, 2015, https://www.healthaffairs.org/do/10.1377/hblog20150713.049277/full/

In 2014, through November, the experience of Kaiser Permanente Colorado showed that 1,547 patients were referred to Hunger Free Colorado. Of that number, approximately 73 percent were contacted by Hunger Free Colorado and referred to food assistance programs, as shown below in Exhibit 22. In the case of SNAP, 65, or nearly 30 percent of the 222 patients referred, were enrolled in the program by a Hunger Free Colorado navigator. The Colorado case study shows that it is possible to connect low-income individuals and families to food assistance programs even in the absence of an 1115 Medicaid waiver that shifts financial incentives.

Exhibit 22: Kaiser Permanente Colorado (KPCO) Food Insecurity Screening and Referral Report, Nov. 2014

Performance Measures	2012	2013	2014 (through Nov.)	Total
Total number of members referred to Hunger Free Colorado by KPCO	60	232	1,547	1,839
Number of members referred to SNAP by Hunger Free Colorado	32	59	222	313
Number of SNAP applications submitted by Hunger Free Colorado online[1]	N/A	N/A	65	65
Number of members referred to food pantries by Hunger Free Colorado	Data unavailable	182	857	1,039
Number of members referred to WIC by Hunger Free Colorado	Data unavailable	42	48[2]	90
Number of members that could not be reached by Hunger Free Colorado	Data unavailable	6	400	406

Source: Linking The Clinical Experience to Community Resources to Address Hunger in Colorado, Health Affairs, July 13, 2015, https://www.healthaffairs.org/do/10.1377/hblog20150713.049277/full/

[1]Note: Submission of online application began in late summer 2014. An online application is completed by Hunger Free Colorado on behalf of the member once eligibility is determined via a phone conversation.

[2]Note: Current as of Nov. 2014.

Conclusion

This report has identified a growing rate of food insecurity in San Francisco in recent years, particularly among lower-income communities and other marginalized groups, such as racial/ethnic minorities, older adults, people with disabilities, and individuals experiencing homelessness. A study on the topic estimated 115,190 San Francisco residents as food insecure as of 2017. A more recent study estimated that 50 percent of

those with incomes less than 200 percent of the Federal Poverty Level (FPL), or about 89,000 residents, were food insecure as of 2018 and that this rate increased every year between 2012 and 2017. Since 200 percent of FPL is the threshold below which people can qualify for food stamps, it means that some individuals who would qualify for food stamps are not taking advantage of the program and/or some of those who are enrolled in the program are still experiencing food insecurity and need additional food assistance.

A key to ensuring that needed food support resources reach individuals in need is identifying those with food insecurity through screening and then assisting those identified as food insecure in obtaining all resources for which they are eligible, such as food stamps through the CalFresh program, food support services from the Department of Disability and Aging Services (DAS), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), school meals through the San Francisco Unified School District, food support services through programs funded by the Department of Children, Youth and Their Families and First 5 San Francisco, and access to food banks and pantries. All of these programs have been found to be effective in curbing food insecurity though any one may not be sufficient for certain individuals and households depending on their circumstances and in the context of the high cost of living in San Francisco.

We found that there is some level of food insecurity screening being conducted for WIC clients, recipients of DAS food programs, In-Home Supportive Services (IHSS) clients, and, in limited settings, San Francisco Health Network (SFHN) patients. San Francisco's CalFresh program has not implemented food insecurity screening as part of its standard food stamp enrollment and renewal processes though they have co-located CalFresh eligibility workers at selected sites, such as Navigation Centers. The Human Services Agency has not incorporated food insecurity screening into eligibility processes for other programs they administer such as TANF/CalWORKs, Medi-Cal, and General Assistance.

Potential benefits of data-sharing

We found that the major federal food assistance programs CalFresh, WIC, and free and reduced-price school meals do not "talk" to each other as robustly and as frequently as they could. To the extent that low-income individuals and families are eligible and enrolled in one of these programs, it is often the case that members of the household may be eligible for one or more of the other programs. We find that it is an efficient and effective use of the City's resources to focus on ensuring that more low-income individuals and families who are eligible for major federal food assistance programs are enrolled by streamlining the enrollment process through data-matches between programs. The monthly direct certification conducted by HSA that automatically enrolls youth on CalFresh into the free and reduced-price school meal program is an example of the type of streamlining that can and should occur.

Another opportunity exists to develop more robust data-sharing between CalFresh and WIC; however, there are significant barriers to doing so as a result of federal data privacy regulations. The Board of Supervisors may wish to request information from relevant City agencies to understand these limitations so that it may assess the degree to which federal lobbying may be worthwhile, or whether local work-arounds can be developed. For instance, in Colorado, the results of the Hunger Vital Sign two-item screening that occurs in clinical settings are shared with the food resources navigation hub Hunger Free Colorado by asking patients for permission to share their data.

Need for departments to enhance and track results of food insecurity screenings and referrals

Our analysis identified that DAS non-profit contractors who provide home-delivered and congregate meals to older adults and people with disabilities are required to screen for food insecurity using the Hunger Vital Sign two-item screening, but the results of such screenings are not collected in the Department's data management system nor are the outcomes of these screenings tracked by the Department.

We find that where food insecurity screening is occurring for vulnerable populations, every effort should be made by department management to evaluate the screening and referral data to better understand the populations that experience the highest rates of food insecurity and their ability to access additional food assistance. In addition to the DAS food programs, the programs known to be screening or piloting the screening of food insecurity include IHSS, WIC, and some SFHN hospitals and clinics.

Need for a food resources navigation hub

Physicians with the San Francisco Health Network (SFHN) report that one of the challenges they experience is not having a single point-of-entry to which patients in need of food assistance resources can be referred. The creation of a food resources navigation hub similar to one created in Colorado by the non-profit Hunger Free Colorado could address this need. We note that DAS operates a similar navigation hub concept for older adults and people with disabilities at its 2 Gough Street facility to connect these individuals to the range of services they may need—from CalFresh to IHSS. A prerequisite for success of a food navigation hub is consistent screening for food insecurity in the health care setting. As of the writing of this report, SFHN physician leaders are in the early stages of piloting food insecurity screening and report barriers to wider adoption such as training and lack of a financial incentive through insurance reimbursement for such screenings.

Provide more incentives to address food insecurity through the state's new 1115 Medicaid waiver

In order to fully transition the financial incentives of the health care setting, there is an opportunity for the Board of Supervisors to work with State elected officials and administrators so that a flexible services program is incorporated into the State's next 1115 Medicaid waiver with the federal government. This could enable funding of better food assistance referrals and better access to food assistance programs.

Subsidized or free transportation could help some City residents access food

BART and Muni already offer significant discounts for youth and seniors and BART was in the process before the pandemic onset of piloting a discount for all individuals with incomes at or below 200 percent of the Federal Poverty Level that would also apply to Muni riders. These efforts are likely to reduce the transportation barriers associated with accessing food for low-income populations who use public transit. If the Board of Supervisors is interested in providing additional support to households experiencing food insecurity, it may wish to consider the possibility of providing rideshare discounts targeted to recipients of WIC and/or CalFresh to assist clients who either (a) do not live close to public transit and/or (b) reside in a food desert.

Policy Options

The Board of Supervisors could consider the policy options below to increase the number of people receiving food assistance.

1. Request reports from the Human Services Agency, Department of Public Health, and other relevant City agencies on what is blocking them from: a) implementing effective food insecurity screening and referral processes in all settings where program staff interact with populations at high risk of food insecurity, and b) regularly producing reports for management on results of their food screening and referral processes.

2. Request that the Human Services Agency, Department of Public Health, and other relevant City agencies report to the Board of Supervisors on opportunities and actions the departments can take to enable more frequent data-matching to better identify clients eligible for multiple major federal food assistance programs.

3. Request that the Human Services Agency and Department of Public Health regularly report back to the Board of Supervisors on their food screenings and referrals and the outcomes of these efforts.

4. Request that the Human Services Agency and Department of Public Health collaborate and report back on options for establishing a food resources navigation hub similar to what the non-profit Hunger Free Colorado created in Colorado.

5. Advocate for a flexible services program in the state's 1115 Medicaid waiver renewal with the federal government.

6. Explore additional transportation assistance for clients of food assistance programs such as subsidized rideshare services for pregnant and post-partum WIC clients.

APPENDIX I

The 18-item U.S. Household Food Security Survey Module developed by the U.S. Department of Agriculture Economic Research Service is available below.

U.S. ADULT FOOD SECURITY SURVEY MODULE:
THREE-STAGE DESIGN, WITH SCREENERS
Economic Research Service, USDA
September 2012

Revision Notes: The food security questions in the U.S. Adult Food Security Survey Module are essentially unchanged from those in the original module first implemented in 1995.

September 2012:

- Corrected skip specifications in AD5
- Added coding specifications for "How many days" for 30-day version of AD1a and AD5a.

July 2008:

- Wording of resource constraint in AD2 was corrected to, "…because there wasn't enough money for food" to be consistent with the intention of the September 2006 revision.

September 2006:

- Minor changes were introduced to standardize wording of the resource constraint in most questions to read, "…because there wasn't enough money for food."
- Question numbers were changed to be consistent with those in the revised Household Food Security Survey Module.
- User notes following the questionnaire were revised to be consistent with current practice and with new labels for ranges of food security and food insecurity introduced by USDA in 2006.

Overview: The U.S. Adult Food Security Survey Module is the same set of questions that is administered as the U.S. Household Food Security Survey Module to households with no child present. For many measurement purposes, the adult module can be used both for households with and without children present.

The U.S. Adult Food Security Survey Module is the same set of questions that is administered as the U.S. Household Food Security Survey Module to households with no child present. For many measurement purposes, the adult module can be used both for households with and without children present.

- ***Advantages (compared with the 18-item household module):***
  - ***Less respondent burden.***
  - ***Improves comparability of food security statistics between households with and without children and among households with children in different age ranges.***
  - ***Avoids asking questions about children's food security, which can be sensitive in some survey contexts.***
- ***Limitations:***
  - ***Does not provide specific information on food security of children.***

Transition Into Module (administered to all households):
These next questions are about the food eaten in your household in the last 12 months, since (current month) of last year and whether you were able to afford the food you need.

Optional USDA Food Sufficiency Question/Screener: Question HH1 (This question is optional. It is not used to calculate the Adult Food Security Scale. It may be used in conjunction with income as a preliminary screener to reduce respondent burden for high income households).

HH1. [IF ONE PERSON IN HOUSEHOLD, USE "I" IN PARENTHETICALS, OTHERWISE, USE "WE."]

Which of these statements best describes the food eaten in your household in the last 12 months: —enough of the kinds of food (I/we) want to eat; —enough, but not always the kinds of food (I/we) want; —sometimes not enough to eat; or, —often not enough to eat?

[1] Enough of the kinds of food we want to eat
[2] Enough but not always the kinds of food we want
[3] Sometimes not enough to eat
[4] Often not enough to eat
[ ] DK or Refused

Household Stage 1: Questions HH2-HH4 (asked of all households; begin scale items).

[IF SINGLE ADULT IN HOUSEHOLD, USE "I," "MY," AND "YOU" IN PARENTHETICALS; OTHERWISE, USE "WE," "OUR," AND "YOUR HOUSEHOLD."]

HH2. Now I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months—that is, since last (name of current month).

The first statement is "(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more." Was that often true, sometimes true, or never true for (you/your household) in the last 12 months?

[ ] Often true
[ ] Sometimes true
[ ] Never true
[ ] DK or Refused

HH3. "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

[ ] Often true
[ ] Sometimes true
[ ] Never true
[ ] DK or Refused

HH4. "(I/we) couldn't afford to eat balanced meals." Was that <u>often</u>, <u>sometimes</u>, or <u>never</u> true for (you/your household) in the last 12 months?

[ ] Often true
[ ] Sometimes true
[ ] Never true
[ ] DK or Refused

<u>Screener for Stage 2 Adult-Referenced Questions:</u> If affirmative response (i.e., "often true" or "sometimes true") to one or more of Questions HH2-HH4, OR, response [3] or [4] to question HH1 (if administered), then continue to ***Adult Stage 2;*** otherwise skip to ***End of Adult Food Security Module.***

<u>NOTE:</u> In a sample similar to that of the general U.S. population, about 20 percent of households (45 percent of households with incomes less than 185 percent of poverty line) will pass this screen and continue to Adult Stage 2.

<u>Adult Stage 2: Questions AD1-AD4</u> (asked of households passing the screener for Stage 2 adult-referenced questions).

AD1. In the last 12 months, since last (name of current month), did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

[ ] Yes
[ ] No (Skip AD1a)
[ ] DK (Skip AD1a)

AD1a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

[ ] Almost every month
[ ] Some months but not every month
[ ] Only 1 or 2 months
[ ] DK

AD2. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

[ ] Yes
[ ] No
[ ] DK

AD3. In the last 12 months, were you every hungry but didn't eat because there wasn't enough money for food?

[ ] Yes
[ ] No
[ ] DK

AD4. In the last 12 months, did you lose weight because there wasn't enough money for food?

[ ] Yes
[ ] No
[ ] DK

Screener for Stage 3 Adult-Referenced Questions: If affirmative response to one or more of questions AD1 through AD4, then continue to ***Adult Stage 3;*** otherwise, skip to ***End of Adult Food Security Module.***

NOTE: In a sample similar to that of the general U.S. population, about 8 percent of households (20 percent of households with incomes less than 185 percent of poverty line) will pass this screen and continue to Adult Stage 3.

Adult Stage 3: Questions AD5-AD5a (asked of households passing screener for Stage 3 adult-referenced questions).

AD5. In the last 12 months, did (you/you or other adults in your household) ever not eat for a whole day because there wasn't enough money for food?

[ ] Yes
[ ] No (Skip AD5a)
[ ] DK (Skip AD5a)

AD5a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

[ ] Almost every month
[ ] Some months but not every month
[ ] Only 1 or 2 months
[ ] DK

END OF ADULT FOOD SECURITY MODULE
User Notes

(1) Coding Responses and Assessing Household Adult Food Security Status:
Following is a brief overview of how to code responses and assess household food security status based on the Adult Food Security Scale. For detailed information on these procedures, refer to the *Guide to Measuring Household Food Security, Revised 2000,* available through the ERS Food Security in the United States Briefing Room.

Responses of "yes," "often," "sometimes," "almost every month," and "some months but not every month" are coded as affirmative. The sum of affirmative responses to the 10 questions in the Adult Food Security Scale is the household's raw score on the scale.

Food security status is assigned as follows:

- Raw score zero—High food security among adults

- Raw score 1-2—Marginal food security among adults
- Raw score 3-5—Low food security among adults
- Raw score 6-10—Very low food security among adults

For some reporting purposes, the food security status of the first two categories in combination is described as food secure and the latter two as food insecure.

(2) Response Options: For interviewer-administered surveys, DK ("don't know") and "Refused" are blind responses—that is, they are not presented as response options but marked if volunteered. For self-administered surveys, "don't know" is presented as a response option.

(3) Screening: The two levels of screening for adult-referenced questions are provided for surveys in which it is considered important to reduce respondent burden. In pilot surveys intended to validate the module in a new cultural, linguistic, or survey context, screening should be avoided if possible and all questions should be administered to all respondents.

To further reduce burden for higher income respondents, a preliminary screener may be constructed using question HH1 along with a household income measure. Households with income above twice the poverty threshold AND who respond <1> to question HH1 may be skipped to the end of the module and classified as food secure. Using this preliminary screener reduces total burden in a survey with many higher income households, and the cost, in terms of accuracy in identifying food-insecure households, is not great. However, research has shown that a small proportion of the higher income households screened out by this procedure will register food insecurity if administered the full module. If question HH1 is not needed for research purposes, a preferred strategy is to omit HH1 and administer Adult Stage 1 of the module to all households.

(4) 30-Day Reference Period: The questionnaire items may be modified to a 30-day reference period by changing the "last 12-month" references to "last 30 days." In this case, items AD1a and AD5a must be changed to read as follows:

AD1a/AD5a. [IF YES ABOVE, ASK] In the last 30 days, how many days did this happen?

_____ days

[ ] DK

Responses of 3 days or more are coded as "affirmative" responses.