FINDINGS + ANALYSES

# Farm-to-Hospital Procurement

## Understanding Institutional Purchasing of Local Food in North Carolina

FIG
FOOD INSIGHT GROUP

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GILLINGS SCHOOL OF
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# Findings and Analyses

PARTS 3 AND 4

The following two sections present the results and analysis of our qualitative research. Part 3 details our findings in the context of stakeholder relationships, including how these groups perceive and interact with each other. Part 4 presents our team's analysis of the NC FTH system as a whole.

## PART 3

# Key Stakeholder Interviews

This section outlines the gaps to a sustainable farm-to-hospital (FTH) system in North Carolina based on interviews with stakeholders in the FTH system. We start by contextualizing our work and continue by detailing our team's approach to conducting key interviews with those in the state's FTH system. We highlight the most salient themes from our interviews and provide recommendations for future engagement with this system. In completing this report, our goals are to summarize what we have found and provide direction for future research aimed at increasing FTH procurement.

## KEY THEMES

**BARRIERS**
**to accessing the FTH system and increasing local food procurement in hospitals**

**VALUES**
**of different stakeholders that influence decision-making**

**PERCEIVED POWER**
**of stakeholders to make changes within the FTH system**

**LEVERAGE POINTS**
**within the FTH system to increase local food procurement in hospitals**

## Approach

From September 2018 to January 2019, our team conducted 20 key stakeholder interviews, including researchers and nonprofits (n=9), hospitals (n=6), distributors/aggregators (n=3), and producers (n=2). We triangulated responses to create a holistic understanding of the FTH system from multiple perspectives. Not all stakeholders interviewed were involved with farm-to-institution initiatives, but nearly all stakeholders worked within North Carolina's food system.

To analyze the interviews, we created memos summarizing the key findings from each interview, identified patterns and emerging themes, explored those themes through matrices, and interpreted the findings.

## Findings

This section presents the findings from key stakeholder interviews in four overarching themes: barriers, values, perceived power, and leverage points. These four themes contextualize the practices and beliefs around FTH procurement (or the absence of FTH procurement) in North Carolina. They illuminate restrictions on certain stakeholders' ability to enter the FTH supply-chain, the complexity of the system, uncertainty around stakeholders' values of local food, and informational withholding that inhibits sharing knowledge, forging connections, and developing partnerships within and across stakeholder groups.

### BARRIERS

The first theme that we identified in the interviews encompasses the barriers that producers, distributors, and hospitals face in the FTH system. These barriers impact stakeholders' ability to start or increase local food procurement and sales in hospitals.

First, producers are unsure about hospitals' demand for local food or even their process for obtaining local food. One farmer, who does not work with hospitals, shared that in order to enter the system or sell directly to hospitals, they would need to know what hospitals are currently paying and by how much, if at all, a hospital is willing to change its current price point (Jimenez-Magdaleno and Salomon 2018). Producers in general do not know if hospitals can be flexible with purchasing price and decision-making. Similarly, distributors often will not share information with producers about where their products are going for fear that the producer will instead sell directly to the purchaser. This, however, seems like an unfounded fear given the difficulty in selling directly to hospitals, particularly for small farms. Consequently, when distributors withhold information, producers cannot project demand for their products.

When making food purchasing decisions, hospitals we spoke with cited food safety and storage as an important consideration, along with price and availability. Distributors streamline this process, completing food safety inspections and ensuring Good Agricultural Practice (GAP) certification of the farms with which they work. Therefore, hospitals do not see any incentive to work directly with farmers. It is easier for hospitals to work with a distributor who already has connections to many farms rather than connecting with individual farms. Other barriers to purchasing local produce mentioned by hospital interviewees include price, seasonality, volume, and lack of patient demand.

Generally, hospitals with food service providers tend to be more focused on price than self-run hospitals. Food service providers have existing negotiated contracts with food purveyors, so it is more efficient for hospitals to purchase within that contract. Further, hospitals' Group Purchasing Organizations (GPOs) require purchasing compliance up to a certain percentage, which limits the hospitals' flexibility in local purchasing. The rigidity of GPO purchasing as well as food service provider contracts are


both barriers to purchasing local.

Lastly, distributors recognize GAP certification and insurance as the primary barrier for producers trying to sell to hospitals. Multiple distributors we spoke with saw this as an issue of scale; smaller farmers do not have the time or resources to pursue and maintain GAP certification. Food hubs can help farmers with GAP certification, which minimizes the barrier to entry to the market.

Just like how hospitals saw their food service provider contracts as a barrier to new purchasing, distributors understood the complexity of those relationships in preventing new FTH sales and cited price as a reason why hospitals do not purchase locally. One distributor told us that if a farmer is trying to sell to a food service provider, like Aramark, they need to first become an approved vendor, which is often prohibitively time-consuming and much harder for small farms (Plaugic and Salomon 2018). Food service providers might also be a barrier to entry for distributors. Food service providers tend to work with one distributor per market, so if one or two food service providers are serving the majority of hospitals in a market, this limits the number of distributors who are selling to hospitals.

## VALUES

Our interviews reveal that stakeholders' values have the potential to influence their decisions around local food procurement. Here we define values as the ideals or standards held by stakeholders related to their organization's function and mission. The ability to recognize and capitalize on hospitals' values influencing their food procurement practices is key for producers looking to enter the FTH system. While producers we interviewed spoke of having incomplete knowledge about hospitals' values, they expressed interest in fostering sustainable relationships between their farms and hospitals. Most often, producers are interested in fostering a relationship with a single individual or organization to help them navigate these barriers to sales, such as with an individual food service director at a single hospital. However, this differs greatly from hospitals' interest in working with distributors in order to avoid having to manage multiple relationships


with individual vendors. Hospitals trust their distributors to have a reliable food quality and safety standard - a standard that they perceive is not guaranteed with individual producers. Therefore, rather than purchasing directly from farmers, hospitals can write in requirements or incentives in their purchasing contracts to encourage their distributors to procure more local products.

In their role as an intermediary between producers and hospitals, distributors we spoke with value both the social and economic impact of purchasing local produce on local farmers and the marketability of local food to hospitals. These values of local, social, and economic impact and marketability of local foods have motivated some distributors to increase their capacity to purchase and sell local foods. For example, some distributors support farmers in becoming GAP certified or have detailed tracking systems for local foods so they can better promote these products to their purchasers and can increasingly divert purchasing of non-local products by their organization. Distributors understand that securing competitive price is a primary value that informs hospitals' decisions, in that they are unlikely to purchase locally produced foods if the price is too high. However, distributors also recognize that some hospitals value being able to promote purchasing from local vendors. In general, self-run hospitals value local food procurement more than hospitals on contract with food service providers; this is especially true when there is a chef with a vision that has received support from their administration (Pollan and Holbrook 2018). However, distributors expressed that there are many chefs who have been resistant to purchasing local foods. Distributors we spoke with cited the difficulty in translating the value of local food to some hospital chefs.

Hospitals, both self-run and contract-run, have three main values when making food purchasing decisions: safety, quality and financials. Food safety is a central value to hospitals because they are feeding immunocompromised populations, and therefore will not purchase any products where food safety is a concern. Their values of quality and having a healthy "bottom-line" are interdependent in procurement decisions.

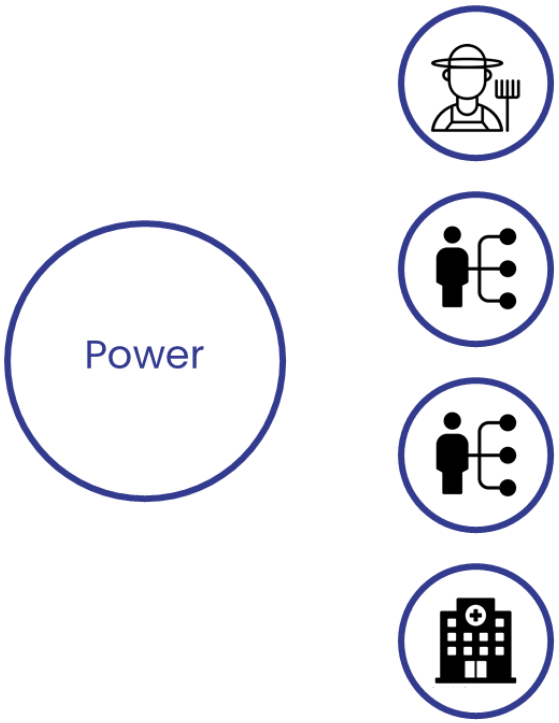
For example, having high quality food, which may include local products, is important to hospitals because it improves customer/patient choice and satisfaction, and patient satisfaction is tied to funding through the Hospital Consumer Assessment of Healthcare Providers and Systems (Pollan and Salomon 2018). At the same time, their ability to purchase high quality food is based on their budgets, which are often perceived as being too rigid to pay for locally produced products.

Different actors within hospitals may also have differing values around local food procurement. Unlike other institutions where consumers may drive demand for local foods, we heard from hospital interviewees that hospital patients have not expressed concern about consuming locally produced food. However, since one hospital interviewee noted that local food could be tied to patient satisfaction, this may be more related to the lack of hospital marketing around their local food procurement practices, which in turn could increase patients' perception of food quality and satisfaction. Often, it is hospital administrators and chefs that express value for procuring local foods. For example, administrators value how local food procurement aligns with the hospital's mission (or brand) of investing in local communities and like being able to promote this investment, and chefs value the flavor and higher quality of local foods. Both administrators and chefs have the ability to push initiatives to increase the purchasing of local food based on these values.

## PERCEIVED POWER

Our interviews revealed discrepancies in how certain stakeholders perceived their level of power in the promotion of FTH procurement, and confirmed limited powers of producers in particular. Producers believe distributors and hospitals have the resources to change the system, as their own power is limited by regulatory requirements to enter the FTH system, like GAP certification. Even if the producers have GAP certification or meet other regulations, they rarely have informational power in terms of hospitals' price points for particular produce, hospitals' demands for particular products, or flexibility to purchase new produce (Jimenez-Magdaleno and Salomon 2018). This idea of producers having limited information was corroborated by distributors, where one interviewee noted that farmers technically have the power to negotiate, but they need access to information to have influence over other stakeholders. Meanwhile, our interviews with hospitals suggest that producers are often not invited to conversations around FTH procurement, but given the structure of the FTH supply chain, a direct connection between farmers and hospitals may not be the most efficient route. These power discrepancies set producers back in their ability to negotiate and advocate for FTH procurement.

The level of perceived power that distributors have varies by type of distributor: broadline or produce (see Part 2 of this report). Most purchasers have contracts with both broadline and produce distributors, or a distributor that provides both produce and broadline items. Broadline distributors--like Sysco and US Foods--source produce, food service supplies, paper products, etc., to hospitals. We were not able to get in touch with any broadline distributors for interviews; however, in interviews with produce distributors, they shared that broadline distributors' connection to GPOs grants them power in promoting or dampening FTH procurement efforts. One produce distributor estimates that 95% of hospitals are on contract with a GPO (Pollan and Plaugic 2018), and because GPOs are able to create sole-source contracts with broadline distributors (Klein 2015), the broadline distributors have internal control over the sourcing of the products that go to most hospitals in the state. Those products are ultimately not local because distributors believe their sole role is to provide the hospital with the demanded products at the lowest price, meaning that distributors defer to the purchasing power of institutions.

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hospital with the demanded products at the lowest price, meaning that distributors defer to the purchasing power of institutions.

In general, hospitals reported believing that their power for increasing FTH procurement is limited, whereas all other stakeholders interviewed believed hospitals hold the purchasing power to initiate change. To understand the purchasing power of hospitals, it is imperative to know how the hospital handles its food management services, either as self-operated or contracted through food service providers (see Part 2 of this report). Both self-operated as well as contracted hospitals can be members of GPOs. It is crucial to note that the hospital's GPO sets up purchasing thresholds for produce and broadline items, and these purchases must be made through a specific broadline distributor identified by the GPO. If the hospital does not fulfill the purchasing requirements--which is usually 80% from the in-house broadline distributor--then the hospital is penalized (Pollan and Salomon 2018). Naturally, hospitals feel limited in their ability to demand much change because of the perceived rigidity of the GPO structure and their inclination to avoid penalties.

For hospitals that operate with contracted food service providers, several of the stakeholders believe hospitals often diminish their purchasing power and defer to the sourcing from broadline distributors. One hospital stakeholder noted that food service providers send recipes to hospitals that dictate the exact food items to purchase, and the expectation is that hospitals will follow those recipes and, therefore, purchase those specific products (Pollan 2018). Yet, one researcher believes hospitals have the ability to force changes in the standards for local food purchasing since these contractors are just responding to the demands of the ultimate purchaser, stating that:

> *"Food service [providers] will do whatever [hospitals] want to keep their business... it's up to [the hospital] to say, 'we want you to buy 10% from [this company] or 5% of our meat from [this producer].' You don't need to cajole them into doing something. The hospitals and the universities have the power - they just need to demand it"* (Salomon 2018a).


Producers can **obtain GAP certification and utilize existing relationships with distributors and hospitals**

Distributors can **assist small-scale producers with obtaining GAP certification**

Leadership groups within hospitals can **exert pressure on business operations**

Hospital funders can **advocate for local food purchasing**

This perspective reflects what a produce distributor shared with us about hospitals' commitment to local food procurement, noting that distributors have the ability to supply more local food but purchasers continue "to not make the final decision to purchase local," even when local food prices are competitive (Pollan and Plaugic 2018). Working with a produce distributor that likes the marketability of "local" makes it easier for hospitals to expand their local food purchasing, but some produce distributors we interviewed were more focused on promoting local food than others.

The relationship among hospital administrators, in-house food service managers and chefs, contracted food service providers, and the hospitals' GPOs further illuminates this complex perception of power in institutional change. Hospital administrators who manage the procurement of all products within the hospital view food procurement as a miniscule decision that makes up a minor percentage of the hospital budget, and these administrators are in charge of creating GPO contracts and dictating what food to purchase (Pollan and Salomon 2018). In one case, a chef from a hospital system with a contracted food service provider noted that even though the chef is in charge of the daily food operations in the hospital kitchen, the larger hospital system negotiates the food service contract on behalf of all hospitals. If the hospital wanted to increase purchases from local food vendors not chosen by the food service provider, they would need to go through a bureaucratic process to obtain approval from the provider, "which basically means that [new local vendor approval] doesn't happen" (Plaugic 2018). But looking at the hierarchy of the food service contractors, administrators, and GPOs reveals that the decision-making power ultimately falls in the hands of hospitals to demand the terms of contracts.

One of the major gaps identified in our research was a lack of understanding of GPOs and the power they hold over hospitals, distributors, and the market for FTH procurement. Only produce distributors and hospitals were able to comment on the power (or even existence) of GPOs. These stakeholders view GPOs as gatekeepers of the market by approving the procurement of new or local items, which echoes the findings from work by Klein (Klein 2012). Because one GPO contract is shared with other hospitals in the same system, the ability to modify the contract regionally becomes even more difficult. However, even amongst distributors and hospitals, there was vast variation in their understanding of how GPOs are set up or how they operate. It is unclear who exactly is invited to make the decisions for procurement and who makes up the GPOs.

## LEVERAGE POINTS

Excepting GAP certification, producers view most leverage points in the system as being outside of their control. Multiple producers stated that GAP certification was necessary to enter the market, a sentiment echoed by others in the system (purchasers, distributors) as well as those outside of it (researchers). The existence of personal and open relationships between producers and hospitals was another means that some suggested could alter the system. Producers expressed no knowledge of GPOs and were unaware of how, or if, GPOs could be leveraged to their advantage.

As with producers, hospitals viewed leverage points in the system as being external to themselves. However, all other stakeholders and observers interviewed (producers, distributors, and researchers) viewed the main leverage points in the system as squarely within hospitals' jurisdiction. As one interviewee said, "The hospitals are the customer. I can talk all day long to a distributor, but if the hospital isn't asking for it, the distributor isn't going to go to the trouble of finding local product and sourcing more" (Holbrook and Salomon 2018). Likewise, a distributor noted, "we have the ability to supply more local food, but purchasers continue not to make the final decision to move to local products" (Pollan and Plaugic 2018).

In terms of the specific zones of decision-making and influence within hospitals, interviewees most aware of hospitals' institutional structure pointed to leadership groups (e.g., "the Diversity Team," "the C-Suite," and "the Board") (Salomon 2018b; Pollan and Salomon 2018; Pollan and Holbrook 2018). These leaders can exert pressure on hospitals' business operations to ensure that the organization is adhering to its vision and mission. Several interviewees also mentioned funders as a key means of applying pressure to these leadership groups (Salomon 2018a; Salomon and Jimenez-Magdaleno 2018).

## Matrices

Our matrices are found in **Appendix B** of this report.

## Knowledge Gaps and Discrepancies

From our qualitative analysis, there are a number of gaps and discrepancies in our understanding of the FTH supply chain. First, because we were unable to interview any GPOs, our understanding of the structure and function of the GPO is limited to hospitals' experiences and existing research, which is minimal. Similarly, we did not interview any broadline distributors, who likely have different goals and interests than smaller, regional produce distributors.

Next, there is a consistent discrepancy between the power that hospital purchasers perceive they have to influence their GPO and the functional relationship between hospitals and GPOs. While we heard from hospitals that GPOs hold all of the purchasing power because of their contract structure, we heard from researchers that hospitals in fact are the ones with the power to make final purchasing decisions. The GPO works for the hospital, but hospitals still view their negotiating power as constrained.

Another discrepancy relates to the lack of acknowledgment of the hospitals as anchor institutions and the value add in FTH procurement. None of the stakeholders along the supply chain mentioned any value in investing in local food. Stakeholders also did not discuss the potential influence that hospitals have on broader economic and community development if there was an increased movement to support local farmers at the institutional level. This suggests an opportunity for future conversations around FTH procurement to intentionally highlight the connection between local food procurement and economic benefit, encouraging the discussion to move from the bottom line towards a more sophisticated social return on investment.

Lastly, there is a discrepancy between producers' perception of the distributor's role and the functional role of distributors. One producer told us that their distributor would not share information about purchasers and price points for fear that the producer would sell directly to the purchaser. From our research and other discussions, it is clear that distributors play a key role in connecting farmers to hospitals and that direct sales to hospitals are prohibitively difficult. Additionally, because GAP certification for producers is a critical component to entering institutional purchasing, some distributors and aggregators assist small farms in becoming GAP certified. While these relationships may vary by distributor, the role of the distributor in the FTH system is significant; thus, distributors' perceived threat of producers selling directly to hospitals appears unwarranted.

### LIMITATIONS

There were several limitations with our qualitative efforts, including time constraints, difficulty finding stakeholders available for interviews, and inability to reach saturation in responses with various stakeholders. It was difficult to find stakeholders and obtain saturation for two reasons: (1) many of the non-hospital stakeholder groups were unfamiliar with FTH procurement

even if they had existing procurement relationships with other anchor institutions, such as schools; but (2) those who did know about FTH procurement were either hesitant to open up about hospital-based decision-making and operations or financial implications.

To address some of these gaps and limitations, we developed a survey to collect primary data from producers, distributors, and purchasers about the FTH system in North Carolina. See Part 4 of this report for more details about the survey.

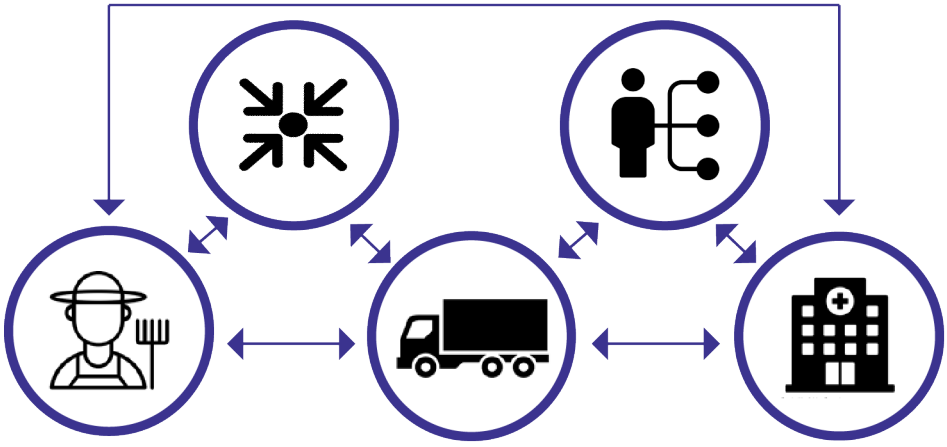
## PART 4

# Systems-Level Analysis

In Part 3, we explored themes related to the relationship between stakeholders based on the qualitative interviews. In this section, we extrapolated those themes along with gaps from the literature review to create a systems-level strengths, weaknesses, opportunities, and threats (SWOT) analysis.

By applying the SWOT framework to the North Carolina Farm-to-Hospital Supply Chain (below), we were able to highlight aspects of the system that advance Farm-to-Hospital (FTH) initiatives and those that hinder FTH in the state. In this analysis, internal attributes of the system that are helpful to achieving FTH are considered strengths, while those attributes that are harmful to achieving FTH are described as weaknesses. Similarly, external attributes that could advance FTH are called opportunities, whereas external attributes that could limit FTH are referred to as threats.

## FARM-TO-HOSPITAL STAKEHOLDERS



## SWOT MATRIX

Thirty-five unique elements are included in the SWOT matrix: 10 strengths, 9 weaknesses, 7 opportunities, and 9 threats. Each of these was drawn directly from qualitative interviews and/or the grey literature review.

| | **Helpful** to promoting FTH | **Harmful** to promoting FTH |
|---|---|---|
| **Internal** Attributes | **STRENGTHS**<br>1. Availability of local food<br>2. Champions across the system<br>3. Existing capacity to support FTH<br>4. Existing demand for local food<br>5. Existing FTH initiatives<br>6. Flexibility of supply chain infrastructure<br>7. Stakeholder values align with FTH<br>8. Stakeholders have market knowledge<br>9. Stakeholders have purchasing flexibility<br>10. Stakeholders have purchasing power | **WEAKNESSES**<br>1. Hospitals and GPOs have a disproportionate amount of power<br>2. Hospitals deny their power to change the system<br>3. Individually-led FTH initiatives are unsustainable<br>4. Lack of transparency<br>5. Negative perceptions of local producers<br>6. Stakeholders are disconnected<br>7. Status quo incentive<br>8. System complexity<br>9. There is no consistent definition for "local food" |
| **External** Attributes | **OPPORTUNITIES**<br>1. A new generation of champions is emerging<br>2. Abundance of relationships, resources, and expertise in local foods and healthcare systems in NC<br>3. External stakeholders want FTH initiatives to succeed<br>4. Hospitals are connected to local communities and regional economies<br>5. Land is well-suited for agricultural production<br>6. Local foods movement is growing<br>7. The NC General Assembly supports agriculture and economic growth | **THREATS**<br>1. Aging farmer population<br>2. Budgetary priorities and constraints<br>3. Climate change<br>4. External systems influencing stakeholder behaviors<br>5. Hospital consumers/patients may not value FTH<br>6. Negative perceptions of local food<br>7. Power of multinational corporations<br>8. Regulations limiting FTH participation<br>9. Technological limitations and reliance |

The SWOT analysis can be interpreted by considering each quadrant in isolation, but a richer understanding occurs by assessing the matrix through the lens of several key findings found on the next page.

## KEY FINDINGS

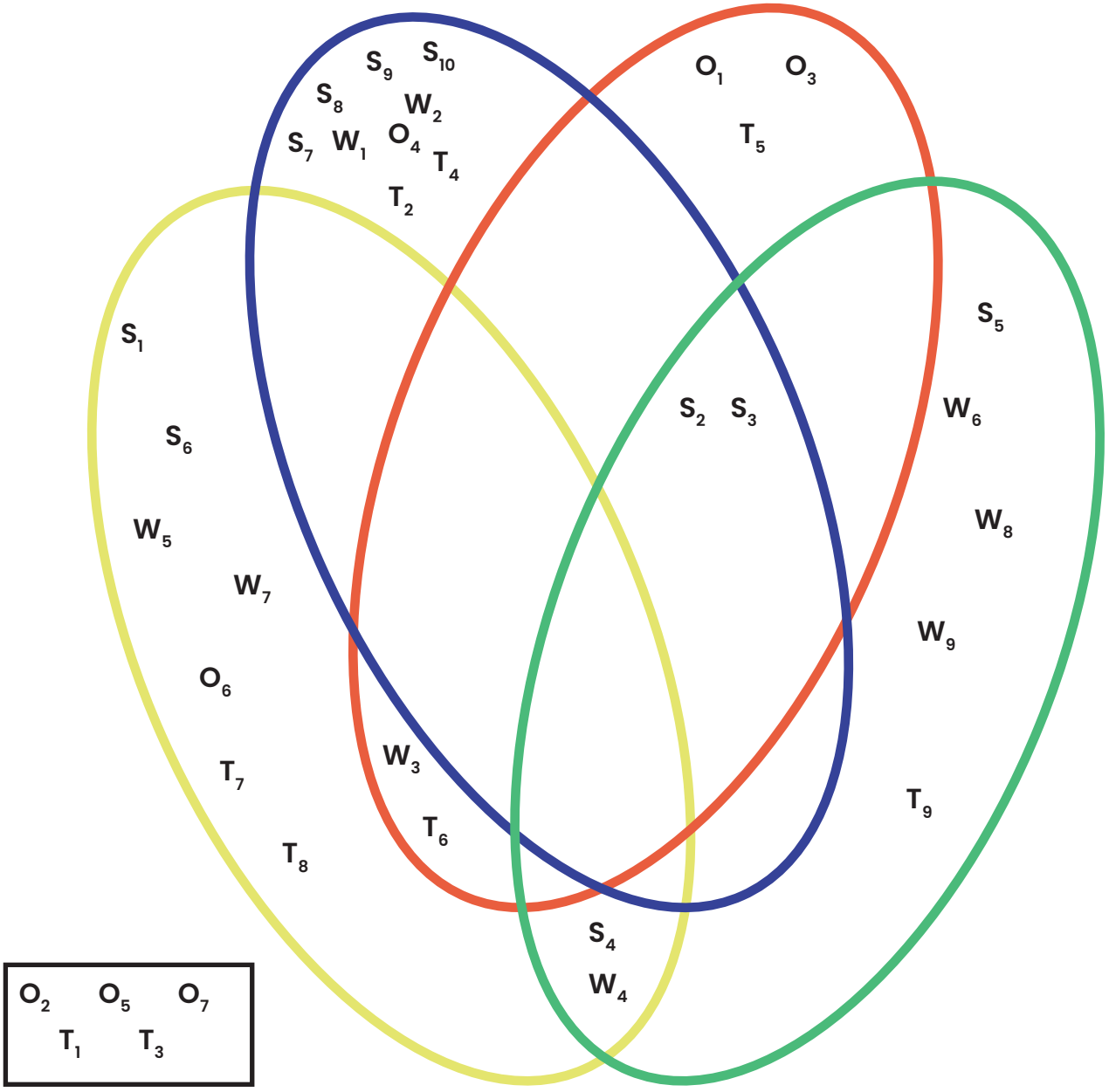
**INDIVIDUAL CHANGE MAKERS** across the system rely on limited, non-institutionalized efforts to implement FTH

**STRUCTURAL FEATURES** of the FTH system make it difficult for stakeholders to transform the system

**STAKEHOLDER ATTRIBUTES** such as knowledge and values influence power dynamics within the system

**MARKET FORCES** are powerful and can either promote or hamper community-driven FTH initiatives

**NORTH CAROLINA FACTORS** related to the environment and politics can influence the FTH system



## Individual Change Makers

### STRENGTHS

Our team identified a number of strengths related to the individuals working within the FTH system. Primarily, **visible champions exist across the system** in each role. Through our work, we were able to locate and connect with farmers, distributors, and purchasers who were interested in our mutual cause. These **champions are creative and resourceful people**, and their passion and optimism for FTH procurement was highly visible. By serving as a beacon for FTH, these individuals are easily identifiable as a point of contact for enacting change in this system. Stemming from these individuals' values, another strength is shown as a **demonstrated capacity to support increased FTH procurement**. In many cases, these champions' passions for healthier communities and food systems provide solid points of contact for efforts to increase FTH procurement. In fact, our team found several instances where pathways to local FTH procurement systems had already been established, either organically or through partnerships between these champions and other invested groups.

### WEAKNESSES

In relation to individual change-makers and their attempts to lead FTH initiatives, our team observed a key weakness in the system. **Individually-led FTH initiatives are unsustainable.** When these passionate individuals push for increased FTH procurement, they develop successful relationships. Developing and maintaining these relationships is a difficult and resource-intensive process, which can then lead to burnout. Unfortunately, **these relationshipsexist within the individual and not within the institution;** as champions leave their position of influence, they often take the relationships with them. Because the institution does not require staff to dedicate efforts towards FTH initiatives, those individuals replacing the champions may or may not support FTH initiatives on their own. Recreating or continuing these relationships is often difficult, as the **champions in this system lack a network.** Second, these individuals often appear "randomly" and there is no known method of driving support for FTH within the current system. Individuals who are sympathetic to the cause may have **limited power within their institution to express and act on their wishes**. Even if this is not a problem, it is often the case that individual initiatives cannot be expressed within the actions of the larger system.

### OPPORTUNITIES

The first opportunity our team perceived is that there are **external stakeholders who want FTH initiatives to succeed.** In North Carolina, there are many food, farming, and economic development advocates who want FTH initiatives and will support them as they are able. This amounts to groups of people who are willing to learn and teach others about the power and value of local movements. Second, we noticed **a new generation of champions emerging** in places where they may not have existed in years past. These distributors, chefs, and producers voiced a willingness to address the need for sustainable food systems and were willing to act on their beliefs.

### THREATS

The largest threat our team identified at the level of individual change-makers within the system was seen through the eyes of the end consumer. **Hospital eaters may not value the FTH system or local food.** In fact, they may even have negative opinions of local food.

## Structural Features

### STRENGTHS

There are some existing attributes within the FTH system that are helpful to achieving local food procurement in hospitals. The first is that **FTH initiatives are happening.** We have examples of FTH initiatives within North Carolina and nationally that could be modeled or replicated by other hospitals. However, these initiatives are often small-scale efforts that may not translate well to larger, standardized replication. Another strength is that **demand for local food exists**. We have heard from producers, distributors, and hospitals that there is some existing demand to move local product through the system, but demand is not consistent across stakeholders. We know that at least some of this demand can be met because distributors already carry local alternatives that hospitals could swap with their regular product purchases. Next, the **capacity to support FTH initiatives exists.** The distributors are positioned to act as intermediaries; they have relationships with both hospitals and producers and can communicate across the supply chain. Some distributors that focus on supporting local products are already acting as intermediaries, assisting farmers with GAP certification and encouraging local purchasing at hospitals. Lastly, some stakeholders, particularly self-run hospitals, or hospitals not working with a food service provider, have **flexibility around their food purchasing decisions**, and thus can be adaptable to changes in supply and demand. Depending on seasonality and menu changes, hospital purchasers can make requests for certain products from their distributor.

### WEAKNESSES

Weaknesses within the FTH system can be harmful to achieving local FTH initiatives. First, there is **no consistent definition for "local food."** This lack of a standardized, universal definition of "local" makes it difficult to track, measure, and highlight local food across stakeholders. Next, across this complex system, **stakeholders are disconnected**. Producers have unequal access to institutional markets requiring wholesale volume, like hospitals. Additionally, little demand for aggregation results in a dearth of aggregators and processors who manage small-scale volumes of local food product. Further, distributors are not incentivized to promote local food. This disconnect among stakeholders makes it difficult to collaborate on FTH procurement changes. **Lack of transparency** in the FTH system similarly hinders collaboration among stakeholders. Stakeholder groups do not share knowledge around purchasing decisions and patterns. For example, some distributors will not share price points or product demand with their producers; thus, producers cannot anticipate demand. On the purchasing side, hospitals perceive that there is little room for negotiation within their GPO contract. The hospital-GPO relationship tends to be discussed as if the GPO holds all the power, when in actuality, the GPO works for the hospital; thus, the hospital should have more power to make changes. The **complexity of the system** is also a weakness. Producers have difficulty navigating the system and meeting requirements to sell to hospitals (e.g. liability insurance). For hospitals using contracted food service providers, the vendor approval process is time-consuming and resource intensive, so hospitals rarely seek vendors that are not already approved through their food service provider.

### THREATS

T**echnological limitations** could threaten FTH intiatives. Sufficient supply-chain infrastructure is needed to physically connect farmers, distributors, and hospitals. The system must be efficient if it is to be successful.

## Stakeholder Attributes

### STRENGTHS

The team identified a number of stakeholder attributes that are strengths. First, there are **champions across the system**, meaning that individuals who value FTH exist within all five stakeholder groups. A second strength is that those stakeholders who purchase food in the system (e.g., hospitals, distributors, aggregators, and GPOs) have **purchasing flexibility**. In particular, self-run hospitals can make independent decisions regarding what types of food to buy – a strength because they have the ability to purchase more locally grown food if they so choose. These same **stakeholders possess market knowledge**, meaning they recognize supply and demand trends and will respond to demand for local food. Relatedly, hospitals and GPOs have enormous **purchasing power**, which is a strength when leveraged to support a more robust regional food system and increase FTH. Another strength is that some **stakeholders' values naturally align with FTH.** Hospitals' mission to serve their communities, producers' desire to sell institutionally, and the quality that distributors and hospitals associate with local food are all examples of this strength. A final boon is that many of these **stakeholders have the capacity to support FTH.** Producers possess or can access the credentials needed to enter the market; distributors have the internal capacity to source more local food, given demand; and hospitals and GPOs can use champions to participate in FTH.

### WEAKNESSES

There are some attributes which manifest as weaknesses. First, **hospitals and GPOs have a disproportionately large amount of power,** which weakens the system's overall ability to support FTH procurement. This power imbalance actually derives from several aforementioned strengths, including purchasing power and complete knowledge. This makes the system unstable because it disadvantages producers, aggregators, and (to a lesser degree) distributors. In particular, the power hospitals naturally hold within this system means they have a nearly exclusive ability to change the sytem. If they embrace FTH, it will undoubtedly occur. Unfortunately, most **hospitals do not acknowledge their power to change the FTH system**, which is a significant weakness. At present, hospitals appear unwilling to accept the responsibility and power they have within this system. Many have stated GPO rules restrict their ability to demand local products – an argument which denies their position as GPOs' customers.

### OPPORTUNITIES

In terms of external opportunities, there are several related to stakeholder attributes. The fact that **hospitals are connected to local communities and regional economies** is a substantial opportunity. Hospitals' involvement with, influence in, and responsibility to the communities in which they are situated present a clear rationale for advancing FTH sourcing. FTH sourcing is a clear way for hospitals, as anchor institutions, to support local economies and invest in the communities in which they are located.

### THREATS

**Budgetary priorities and constraints** (i.e., that the bottom line outweighs the value of "social good") impact stakeholders across the system, but the biggest threat comes from hospitals, given their position as system driver. A final threat stems from the fact that all of these stakeholders operate in **external systems that influence their behavior**. A shift in any one of those external systems (e.g., a distributor's parent company moving offshore) could change a stakeholder's behavior within this system and threaten existing or future FTH procurement.

## Market Forces

### STRENGTHS

North Carolina has a large number of agricultural producers, meaning potential **access to a large supply of local food** for distributors and their customers (e.g., hospitals). Another strength is **demand for local food does exist** and, in some areas, increases in FTH procurement occurred because hospitals were responding to the community's vocal requests. This indicates a third strength of market forces: the **supply chain infrastructure is flexible** in that there are variations in the ways hospitals set up contracts, how distributors partner with producers and/or purchasers, and how local food could enter institutions. For example, some hospitals might choose to work directly with a local producer to set up a weekly CSA for visitors, staff, and community members that leads to room for expansion in local producers establishing new economic relationships with hospitals.

### WEAKNESSES

Despite these strengths, market forces create various weaknesses in FTH procurement. Primarily, **producer price, seasonality and scale do not always match hospital demand.** Hospitals have expectations and a history of purchasing cheap and abundant products, and there is a belief that local food producers might not be able to meet such expectations based on concerns like a producer's lack of labor capacity, land capacity, GAP certification, liability insurance, and year-round availability of seasonal products. Another weakness is that the **hospital procurement system lacks transparency.** If producers are unaware of the demand for local products from hospitals or their willingness to change price points, then it is difficult for local food producers to enter the market. Economic factors contribute to this lack of transparency, as broadline distributors and vendors protect their proprietary information for fear of losing market share, and hospitals do not share product price information, likely due to privacy restrictions related to GPO contracts Finally, there exists a **status quo incentive** in which stakeholders are encouraged to continue operating as usual rather than expand local procurement because it avoids potential short-term revenue loss (from startup costs associated with establishing new FTH partnerships). The perception that market shareholders see changes to the supply chain system as inefficient furthers this status quo incentive.

### OPPORTUNITIES

We identified one key market forces opportunity: **the local food movement is growing.** There is an increasing demand for local food by the public that improves the position of producers to leverage their ability to supply that demand; this increase may also incentivize distributors to push local, or hospitals to demand local food in their contracts. Based on our interviews and grey literature, hospitals are marketing local food as a value-add,

### THREATS

Four major market force threats exist in FTH procurement. First, the **power of multinational corporations** favors centralized food operations. This increases the role of large-scale, consolidated national/international food service providers and distributors in providing hospitals with all the supplies they demand year round. There is also a cultural **belief that local food is expensive.** This might inhibit hospitals from attempting to increase FTH procurement because of assumptions about the cost of local food. Likewise, there are **regulations limiting FTH participation** and standards that limit entrance of either producers or distributors to the market.

# North Carolina Factors

## OPPORTUNITIES

The team identified a number of opportunities for the FTH system in North Carolina, including environmental, social, and political opportunities. North Carolina is **well suited for agricultural production**, with an abundance of fertile land ripe for agricultural investments that could provide a highly accessible supply for the FTH system. North Carolina also has an abundance of **valuable relationships, resources, and expertise in local foods and healthcare systems.** For example, there are strong university-hospital relationships, as well as relationships between hospitals and farms that have built local food infrastructure. Nonprofits and researchers in North Carolina have a wealth of knowledge and have also built systems to increase transparency of FTI procurement, and these data are publicly available. Finally, the **NC General Assembly supports agriculture, economic growth, and public health,** which can translate to support of FTH systems.

## THREATS

The major threats to FTH procurement in North Carolina are threats that affect agriculture across the US. The first major threat is **climate change,** which will affect the entire food supply chain; however, there is concern of a disproportionate effect on smaller-scale producers who already experience significant barriers to institutional markets. The second major threat is that North Carolina **farmers are aging,** with the average farmer age in North Carolina in 2012 rising to 58.9 years. This raises concerns about having enough farmers to continue to produce for the state.

FIG

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