FSTF Special Meeting Minutes

10/25/2023

Present: Rebeca Flores (OARE/SFDPH); Tommy McClain (SFHSA); Eric Chan (OARE/ SFDPH); Kaela Plank (SFDPH); Raegan Sales (Children's Council SF); Lura Jones (Leah's Pantry); Cindy Lin (SFHSA); Fiona McBride (SFHSA); Cathy Huang (SFHSA); Ellen Garcia (Vouchers4Veggies/EatSF); Pilar Marin (Leah's Pantry); Marchon Tatmon (SFMFB); Jade Quizon (API Council); Guillermo Reece (SFAAFBC); Reese Isbell (OHE); Chester Williams (Community Living Center); Jade Siphomsay (SFHSA); Isaiah Coston (Leah's Pantry); Kim Wong (SFDPH); Ana Ayala (POH); Cissie Bonini (Vouchers4Veggies/EatSF); Paula Jones (OARE/SFDPH); Veronica Shepard (OARE/ SFDPH)

Agenda Item	Discussion
1. Call to order 9:00 a.m.	Paula Jones, Vice Chair/SFDPH called the meeting to order at 9:08 a.m.
2. Land Acknowledgement 9:00 a.m.	Eric Chan recited the Land Acknowledgement.
3. Welcome and Introductions, Paula Jones (OARE/SFDPH) 9:05 a.m.	Paula asked everyone to present themselves and introduced the agenda.
4. General Public Comment 9:15 a.m.	None.
5. Overview and Update on Biennial Food Security & Equity Report (BFSER), DPH BSFSER Project Team 9:20 a.m.	Reese Isbell (SFDPH – Office of Health Equity) gave an overview of logistics for the meeting. Paula Jones provided an overview of the purpose and requirements of the contents of the Biennial Food Security and Equity report as defined in Ord 103-21 June 30, 2021 (handout) Overarching questions required to be answered by the ordinance: • Do city related services address health, racial, geographic, age or other inequities? • What barriers exist? • Recommendations

	• Improvements The full presentation for this is available on the Task Force website: See presentation [FSTF Special Meeting 10.25.23 Presentation]
6. Review selected data from Reporting Agencies, DPH BFSER Project Team 9:30 a.m.	Attendees divided themselves into 3 breakout groups, with: • Group 1 focusing on the health disparities data • Group 2 focusing on poverty and income data • Group 3 focusing on programs serving priority populations. Each group was provided with data tables to help them answer the following questions: *Questions* ▪ How many programs serve these groups? ▪ How many people are being served? ▪ How much funding is going to the programs serving these groups? ▪ Are there gaps? ▪ What are the barriers? ▪ Other insights? ▪ Recommendations? Please see the breakout group notes at the end of this document for all three groups.
7. Next Steps and Feedback, DPH BFSER Project Team 11:30 a.m.	Each breakout group shared what they discussed in response to the guiding questions. After each group reported out, general feedback and comments were provided by attendees. The DPH BFSER project team clarified next steps and thanked everyone who participated in the meeting. The next steps will be to compile the notes, and add the remaining data mentioned.

	Also prepare to review the remaining data from Reporting Agencies at the meeting on 11/6/23 (1:30 pm – 4:30 pm). Veronica Shepard – Thanked the DPH team and especially Paula and Kaela for pulling together the data. Fiona McBride – Include population counts with rates/percentages so that we can see actual number of people being served/not served. It would be helpful to have initial summary data tables that are a bit more digestible so that we can start analyzing the data. Chester Williams – Thank you for the work, it's important to get community voices involved in the programs that are serving and impacting them. They need to have a say in how the programs are structured and developed to best meet their needs. Shali - Thanked all of the people who came to the meeting and contributed to looking at the data, giving their insights and recommendations.
8. Adjournment 12:00 p.m.	Meeting adjourned at 12:00 p.m.

Breakout group notes from 10/25/23 Special Meeting of the Food Security Task Force

Group 1 – Focused on health inequities and health disparities

Used data presented at: 10/4/23 FSTF data presentation

- ❑ Slides 28-31 show hospitalizations due to diabetes, hypertension and heart failure
  - Highest rates: Native Hawaiian or Pacific Islander, Black/African American, Native Americans

How many programs serve these groups and areas? Where are the gaps?

- Groups with highest health disparities are receiving least amount food access. Not adequate amounts of food resources for groups with the highest needs.
- The groups with the highest health disparities need services in different ways than other groups may need.
- CalFresh is the easiest to join you can go online or via phone.
- WIC, Cal FRESH, Afterschool meals and Homeless Services reach the African American and Latinx populations the most.
- Programs serving the groups with the highest health disparities: programs from HSH and DCYF. Gap – programs serving adults that aren't homeless
- The following programs are not serving the groups with the highest health disparities as much:
  - Grocery access, meal support, Home Delivered Meals, food pantries.
- Programs providing financial resources are more accessible than food access programs, because one of the barriers are location.

The group looked at zip codes: 94130, 94102, 94124 because these zip codes had high rates of hospitalization for diet sensitive diseases.

- 94130/Treasure Island high rates of Health Disparities issues.
- 94130 has highest poverty rate 42%. Do we know the age? (Data not available at this time)
  - Not a lot of programs are reaching this zip code
  - Lacking in resources for adults
  - Most people aren't eligible for programs from Department of Disability and Aging Services
  - No Permanent Supportive Housing on Treasure Island, so there aren't programs from HSH
  - There are residential stepdown programs operated by DPH. Do they have food programs?
- Positive - Grocery vouchers funded by HSA are available as a result of feedback from organizations and people on Treasure Island.

94102 – This zip code has more support than 94130

- 94124 – There are a lot of programs but they're not meeting the need
  - Total units of service are high but individuals served are not, showing that the programs that exist are serving the same people a lot.

- People rely on the programs, so they're critical for the people accessing them.
- Existing programs are not enough.

How many people are being served?

There are different programs DAS does the most - home delivery program. They contract with non-profits to provide weekly boxes to people.

Food access – Asian population receiving the highest % of these services

How much funding is going to the programs serving these?

How do we bring knowledge of CBO funding if it is not found on the spreadsheet?

Funding the programs that are actually serving these groups? Do they have funding?

What are the barriers? Why are some groups not accessing programs (especially food access programs)

- Diet specific needs, culture and religious needs.
- Time is a barrier
- People must go to many programs.
- Locations of programs can be a barrier. Just because there's a program doesn't mean that people can access it. Resources need to come to people.
- May not have kitchen, refrigerator.
- Not enough food with the programs. Not enough food resources to sustain these populations, the dehumanization of this is having to go for food to many places.
- Lots of waste in programs - quality matters.

Other insights (more questions)?

- Programs need to be intentional about people accessing food, especially people with health disparities.
- We are creating situations that increase the health disparities because of the way programs are funded. They're not intentionally addressing health disparities.
- Programs in silos – Not interrupting but perpetuating and exacerbating health disparities. The barriers and programmatic silos are not interrupting the food disparities.
- Need to look comprehensive around households.
- Consult with key leaders from highest need communities. Use existing community groups that are trusted
- Why don't we all come together (meaning all providers)

- There are waitlists but organizations may not have city $ so their wait lists aren't visible
- Information needed to make decision – need to know what programs are running out?
- What shapes program structures or resident's ability to access?
    - How are people getting food involved in shaping programs?
    - What does the community need? Prepared food or groceries?

- What is the plan to get people out of relying on food programs?
- Need more upstream investment and comprehensive approach:
    - Workforce training
    - Financial Empowerment
    - Education
    - Childcare

Recommendations? Group 1

1. Data:
    a. Would like more analysis.
    b. Want to know what direction the public facing report going to take so we can provide comment on that.
    c. Need to add CBO Data.
    d. Data points are established – now need to ensure programs are planning to collect that data.
2. We need to address root causes of food insecurity including work force development, economic opportunity, education, child care.
3. We need stories from the community, what is it that people need?
4. Community should be involved in designing and running their own programs
5. Departments need to work more collaboratively to plan for food allocation – Mayors Office can help.

Group 2 – Focused on poverty and income

Used data 10/4/23 FSTF data presentation

- ❑ Slides 9-16 show poverty and income levels by race/age/zip code
  - Populations with highest rates of poverty (<100% FPL): Black/African, American Indian, or Alaskan Native, Native Hawaiian or Other Pacific Islander
  - Zip codes with highest rates of poverty (slide 9 last bullet)
  - Median income by race (slide 13) lowest Black/African American, American Indian or Alaska Native

How many programs serve these groups and areas?

Number of programs that serve each high priority zip code (quick calculation based off tables)

94102	17
94103	17
94108	18
94111	14
94124	18
94130	12
94133	14

Programs that serve groups/areas

- All 19 serve African Americans
- 14 that serve American Indian/Alaska Native
- 15 for Native Hawaiian/Pacific Islander

How much funding is going to the programs serving these groups?

How much $ is going to programs (these have poverty eligibility regulations)

- WIC? 2022-23, $10.84 million 2023-24
- CalFresh $79.5 million 2022-23, $71.3 million 2023-24
- SDDT $1.5 million 2022-23, $1.3 million 2023-24

This question was not a good use of the group's time. It's easier to calculate this information on an Excel spreadsheet.

Federal programs are under-enrolled due to thresholds.

Note: 94104 & MOE – need to check margin of errors for zip codes and other data, 94104 (financial district) has a small population and if the MOE is just as large as the population, then we should exclude this zip code

- Understanding more in depth of each zip code, neighborhood, demographic makeup
- Clustering zip codes by neighborhoods
- Identifying programs based on tiers – difficult to determine as different programs serve different levels (individual level, family, household)
    1. Full service
    2. Moderate
    3. Supplemental

Question on HSA's funding of food security farms – why was theirs' not included as food access but SF Recreation and Park's funding for Alemany Food Security Farm was included as Food Access?

Is there data on:

- Low -income families
- Seniors living alone

Wanted to note that children's poverty decreased with increased funding during COVID. Now that emergency funding is over, what will happen?

Are there gaps?

Should we be looking at other identifiers of low- income populations, such as:

- SSI recipients
- CalFresh recipients (we did receive this data)
- MediCal recipients – San Francisco has a high enrollment rate, almost perfect
- Data on recipients impacted by ending of emergency allotment funds
- Data/analysis on the people that are in between programs eligibility requirements
- Data on 200%, 300 % FPL
- Demographics: e.g., immigrants

CBO data needed:

- St. Anthony's (we do have this data)
- DKI funding is important as their budget hasn't been impacted. They will be larger players and knowing what their funding is going to look like is important
- MTA hasn't given us any data, but we do know they run some programs related to food, such as a shuttle that takes seniors to supermarkets. DAS might have data on this.

What are the barriers?

- Food insecurity in terms of funding cycles of food programs – not guaranteed/ impermanence. Programs are always not 100% sure of where funding will come from next
- Federal programs do not meet SF needs, benefits eligibility vs. true cost of living in San Francisco
- Using actual counts and combine zip codes based on neighborhood to guide funding
    - Can potentially serve whole population if numbers are small enough
- There are biases in perception of need, e.g., Chinatown may seem like a neighborhood that is low need, but a significant population is very low-income

- Barriers in access based on travel and transportation, and safety related to getting to resources
- Sometimes there's limited choice in food options within food access programs
- Language access

Other insights?

- MediCal well enrolled – effective avenue for reaching people
    - MediCal/Medicaid Medically supportive food - expand/ Go Big
- Targeted food support to highest need through organizations serving those populations
    - What is success? Set targets (i.e., increase access to xx by 20%)
- Tables don't stratify by program, so it's hard to compare/ tally programs that prioritize different populations or eligibility criteria
- What happens w/ entities that didn't provide data?
- CBO data needs to be considered in the data sets to get a better sense of services and gaps
- Federal programs don't make sense given the income and poverty data
- DKI budget not getting cut – becomes a larger more significant role in food security –
    - need them at the table
    - Importance of DKI funding populations being served need to make sure we understand that data

Recommendations

- Local supplement to WIC/SNAP CACFP
- Having interventions/programs that specifically serve target populations based on age, behaviors, lifestyle, culture, and highest needs
- Medically supportive interventions
- SF's high cost of living (tied to housing)
    - UBI / Supplemental income
    - Link food funding and support to housing costs - if housing goes up food funding needs to go up
- Do not cut or restrict access to cash benefits
- Have BFSER recommendations not be restrictive to allow departments the independence and flexibility to set targets/create programs and not restrict funding
- Recommendations to do some more data analysis
    - Want to break out this data, putting aggregate numbers to see how these programs might look

Group 3 Focused on programs focusing on priority populations

Used data presented on Table 5 – Zip code & Table 7 – Racial Health Disparities

- ❑ Which programs are serving areas with highest need (color coded zip)

How many programs serve these groups and areas?

Priority Populations:

- Family with Children/Dependents – with larger households with Children and /or Dependents
- People living under 200% FPL
- Populations with Chronic disease
- *Brown and Black communities (Black/ AA, Latinx, Asian Pacific Islander, Native American)
- Unhoused individuals
- Older adults
- TAY (18 – 24 year-olds)
- Homebound/ People with limited mobility
- Foster age youth
- Emancipated youth
- Monolingual speakers
- People losing access to food due to budget cuts

Number of programs serving

- * 94102 – 17
- * 94103 – 18
- 94104 – 6
- * 94108 – 16
- 94109 – 19
- 94111 – 9
- 94112–14 – 94112 – CFAT Community-centered groceries – funding is going down for this program. People currently served will lose out/
- * 94115 – 16
- * 94121 – 13
- * 94124 – 18
- * 94130 – 9
- 94132 – 16
- 94133 – 17
- * 94134–17

- 94158 – 12
- Other – 15

94102 – Tenderloin and SOMA

94112 – Excelsior and Parts of Outer Mission

94121 – The Richmond

94124 – Bayview Hunters Point

94130 – Treasure Island

94134 – Visitacion Valley, Portola

94108 – Chinatown / North Beach

And 94133,94109, 94111

94115 – Western Addition / Filmore

How much funding is going to the programs serving these groups?

- Priority zip codes will be losing a ton of funding
- How do these cuts impact certain populations
- Look really hard at cuts happening in priority zip codes
    - cuts on funding table?

Are there gaps?

FY22-–23 vs FY 23–24 – COVID Funding scaled back and will not be captured in this data

- Gap that leaves these populations even more vulnerable
- Are these programs still operating in these zip codes?

Missing data about school is a gap.

What are the barriers?

Lack of continued funding

Other insights?

Landscape is shifting so drastically

Questions:

- Funding contract or actual monies spent?

Want to be able to compare across years direct service in programs?

To do:

Map with layers for all priority populations – layers

Ex.: 1. Layer FPL

2. Layer Diabetes rates etc.

Next time:

- Funding by zip code. | Effectiveness of different models
- Race/Ethnicity by zip code

Community Supports

- Focus on people with chronic disease
- Time limited
- Scaling will be slow
- Food Markets

Recommendations:

People with incomes

Economic opportunity

Recommendations? Priority populations Focus

- People with different disabilities
- TAY
- Asking for narratives – asking people for their stories!