Organizational Dynamics (2019) xxx, xxx–xxx

Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/orgdyn

Feeding Collective Impact: How to Foster Cross-Sector Partnerships that Build Innovative Solutions for Social Change

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INTRODUCTION

As Dave Krepcho, CEO of Second Harvest Food Bank (SHFB) of Central Florida, stared at the numbers, he realized they were not going to food bank their way out of the meal gap—the representative number of the meals missing for those whose food budget falls short in securing adequate, nutritious food year round. It remained at approximately 110 million meals. Every year SHFB has increased food distribution playing a vital role in alleviating hunger— '*feeding the line*'; however, the meal gap persisted. SHFB's vision is to inspire and engage the community to end hunger— '*shortening the line*'. Given the complexity, causes, and effects of food insecurity—a household's inability to provide consistent access to sufficient food for every person to live an active healthy life—the answer to how to shorten the line remained elusive.

Increasingly, Dave and his executive team felt the solution would require SHFB to disentangle the social determinants of health—the conditions in which people are born, grow, live, work and age, which include employment, housing, socioeconomic status, education, neighborhood and physical environment, and social support networks, as well as access to health care. Dave wondered: Where and how should SHFB start? He knew they could not do it alone and they would need cross-sector partnerships to co-create innovative solutions together. But, what organizations would be willing, motivated, and able to collaborate?

In Central Florida one in six people are food insecure with one in three children going to bed hungry every night. One challenging month for a household with an unexpected event such as car maintenance, an accident, health crisis, or layoffs at work can result in food insecurity. The unexpected event can create a snowball effect as it collides with other events and a scarcity of resources. Frequently, food insecure households make trade-offs between paying for food or paying for rent, utilities, transportation, medicine, or medical care. Food insecurity impacts health by increasing risk of chronic disease: cardiovascular disease (hypertension = 25% more common), diabetes (type 2 Diabetes Mellitus rates = 25% higher), kidney disease (= 50% higher), and osteoporosis (4x increased risk). In 2018, the healthcare costs for food insecurity in the U.S. equated to $52.9 billion dollars annually.

Food can either promote health by nourishing, healing, and protecting the body or hinder health by contributing to disease. In 2010 Dave hired a licensed nutritionist and started the process of exploring how SHFB could play a role in community health. At the time Dave did not know where or how to fit the nutritionist into SHFB as it was a new role within the organization. The nutritionist began working with the Vice President (VP) of Agency Relations and Programs (ARP), which supports the 550 plus feeding partners, such as food pantries, soup kitchens, shelters, senior centers, day cares, and afterschool programs, in six Florida counties. Together they began to help build the capacity of the feeding partners to meet the nutrition and health needs of those they serve. Concurrently a national conversation on healthcare was occurring as the Affordable Care Act (ACA) passed in 2010. As experts in food, the executive team became more and more convinced they could play a vital role within the community by connecting health and hunger. They made a strategic commitment to advocate for the concept of using 'Food as Medicine' to inspire and encourage community leaders from different sectors to work together.

Despite the well-studied and proven connection between health and hunger, numerous nonprofits, for-profits, and government organizations working to address food insecurity

https://doi.org/10.1016/j.orgdyn.2020.100803
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within the community did not facilitate the connection. Historically, the organizations operate in silos with their own processes, systems, departments, key metrics, data collection, data management, and provide services independently, usually without coordination between organizations. For example, a food bank collects and distributes food to feeding partners who provide food. A community medical center provides medical care. Each of these organizations serve an overlapping target population; however, their services were not connected in a systematic manner. In the absence of coordination, when a community healthcare provider recommends a nutrition and exercise plan to a food insecure patient, he or she will have to overcome a multitude of barriers, such as access to adequate nutritious food, a walkable neighbor, the transportation to pick up the food at a food pantry, and the time off work to do so. The patient must disentangle and navigate the silos while overcoming his or her lack of information, scarcity of resources, and absence of social support to make the connections. Due to this siloed approach, the potential for improving population health through access to nutritious food is largely unrealized.

Dave and his executive team began to reach out to healthcare industry leaders asking: what if we worked alongside each other instead of separately? Guiding their conversations was a goal of fostering collective impact, which was first defined by Kania and Kramer (2011) in their article published *Stanford Social Innovation Review* as "the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem" (p. 36). With each conversation they intentionally used the word 'we', emphasized the shared value of "Food as Medicine', and encouraged collaborative exploration. The open-ended nature of the conversations focused on listening and ideation. As champions of collective impact, SHFB invested in values, focused on facilitating rather than owning the process, and embraced continuous iterative learning.

The assumption is institutional change, which refers to changes in the general constitution of an entire class of organizations, is best led by governments and corporations as they have the infrastructure and resources to enact change, whereas nonprofits have limited bandwidth and capacity to expand their business operations. Nevertheless, SHFB—an established community nonprofit with a strong financial foundation and an entrepreneurial organizational culture focused on innovating for tomorrow—began to play the vital role of fostering cross-sector partnerships to build innovative solutions for social change.

SHFB: AN INNOVATIVE ANCHOR INSTITUTION

This SHFB case example serves as a model for how an organization can foster cross-sector partners to build innovative solutions for social change. The case illustrates how an anchor institution—an established organization in the community with long term orientation towards creating social change—fostered collective impact, and how this process was facilitated.

Whether it is a nonprofit, corporation, foundation, or government agency seeking to build a better tomorrow, a fundamental requirement is bringing together enough stakeholders from cross-sector organizations who will make the change happen. SHFB knew cross-sector stakeholders must align on whether, why, and how existing systems can be adapted, as well as practice collaborative innovation—a process of sharing ideas, information, and work to develop new ideas, values, products, services, processes, and business models—to create social change. Aligned with stakeholder theory, management's purpose in the process of fostering cross-sector partnerships is to find the most advantageous balance among stakeholders. For an organization to lead social change they must identify and create stakeholders from their own organization, as well as other organizations who recognize the need to address the social problem, which are also willing and able to commit resources to collectively act. Collective impact is the process of multiple organizations from distinct sectors co-creating and co-investing in building innovative social solutions. Organizations seeking to lead collective impact need models for understanding how to foster, structure, and support cross-sector partnerships from concept, launch, implementation, and through to sustainability.

History of SHFB

SHFB is a private nonprofit based in Orlando, Florida, that has worked to end hunger since 1983. In 2020, including the SHFB response to COVID-related community need, the organization will distribute 92 million meals, a 97% increase from 2019, of donated food to more than 550 feeding partners. Throughout its history, and especially in the last 15 years, SHFB has continuously invested in improving their organizational capacity to create social change, which has expanded their operations beyond traditional food banks.

Additionally, SHFB transforms the lives of economically challenged adults through their Culinary and Distribution Training Programs that focus on technical, life, employability skills, as well as job placement. To generate revenue to support the Training Programs and overall mission, SHFB has developed social enterprises—businesses that sell goods and services to reinvest the money back into achieving the social mission. The social enterprises include: Food Purchase Program, Community Event Space, Catering for Good, Meals for Good, and a signature food product program, Soup for Good.

In the past 15 years, SHFB has grown from 3 programs to over 16, which include the five social enterprises. Several programs focus on strengthening the capacity of their feeding partner network, helping with applications for the Supplemental Nutrition Assistance Program (SNAP), and investing in a collaborative approach to improve community health. Today, SHFB's operational budget is $17 million dollars, with an additional $18 million in highly restricted COVID relief funds, plus in-kind donations of food valued at $155 million. The operating revenue consists of government grants and fees accounting for 27%, contributions from individual and institutional donors accounting for 43%, and social enterprise income accounting for 34%. Overall, 85% of total funds are unrestricted, which includes agency fees, non-restricted contribution support, social enterprise revenue, and assorted interest/investment income. Unrestricted income provides the organization flexibility to invest in the future.

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"Innovating today to create our tomorrow" is central to the SHFB culture which embraces collaboration. Unlike the norm of isolated interventions which are often predetermined solutions executed by one organization, Dave and his team believe that building innovative solutions for social change requires a broad range of cross-sector partnerships to co-create and co-invest in new more effective solutions. The collective impact framework is especially valuable for organizations seeking to be leaders of social change through collaboration instead of the traditional siloed approach. The case study describes the organizational investment that enabled SHFB to convene key stakeholders from health systems, government, foundations, and other civic society organizations by utilizing and adapting the collective impact framework.

COLLECTIVE IMPACT: ORGANIZING FOR S CHANGE

Collective impact provides a framework to organize and achieve systems-level changes in a community, such as improving the health of Central Florida's most vulnerable populations, through coordinated cross-sector partnerships. Collective impact has quickly gained traction with organizations, communities, and perhaps more importantly, funders. For example, The Robert Wood Johnson Foundation (RWJF), which is the U.S.'s largest health philanthropy with an endowment of more than $10 billion, now advocates for collective impact. Instead of supporting siloed interventions by one organization which further facilitate gaps in addressing the complexity of social issues, funders now expect solutions to fill multiple social gaps through the application and employment of collective impact.

The collective impact framework provides a way of organizing cross-sector partners (i.e., collective coalitions) to jointly tackle complex social issues. To foster collective impact requires overcoming many obstacles, such as: the challenge of bringing together stakeholders who have never worked together, the struggle to let go of perceived competition among each other for funding and grantees, the historic lack of trust and communication, the effort of agreeing on shared metrics when each organization has different incentives, the risk of ownership and controlling behaviors overriding a shared agenda, and navigating politics and buy-in at the local level as well as with each participating organization. Collective impact contrasts with siloed approaches where funders and grantees seek to identify a single organization's solution to a social problem with the hope the intervention is effective and that it can be replicated by others. A flaw with isolated approaches is the assumption that a single organization is responsible and can fix a major social problem, which underestimates the complexity of social problems. In contrast to siloed approaches which fund predetermined interventions and view others working in the same space as competition, the collective impact framework helps change agents embrace a collective approach, foster co-creation and co-investment in new solutions, and views others as potential partners and collaborators. The framework consists of three pre-conditions and five conditions, as depicted in Fig. 1. To overcome the resistance to collaboration, Dave and executive team first focused on ensuring the pre-conditions of collective impact were met. Next, we provide an overview of the conditions of collective impact, and then we share how SHFB applied them.

Pre-conditions of Collective Impact

To foster collective impact requires three pre-conditions which include:1) *an influential champion or champions*, 2) *an overall sense that change is needed*, and 3) *enough resources to support the change*. The pre-conditions set the stage for creating the opportunity for stakeholder cooperation by fostering the motivation and enough momentum to encourage and enable distinct stakeholders, who often have never worked together, to form a collective coalition.

The most critical pre-condition is an influential champion, which in this case is SHFB. The influential champion is a credible, trusted, and respected leader that can engage and solicit participation from cross-sector leaders. The champion organization finds and helps gain support from other trusted leaders to form a small group of organizations that can contribute their strategic assets to support the collaborative effort. Each stakeholder contributes access to a broader network, understanding of their industry and the greater landscape of the business environment, and provides additional resources—financial, human, educational, emotional and physical. Effectively engaging influential leaders and their spheres of influence can improve the efficiency and effectiveness of a collaborative effort.

The second pre-condition requires that the social issue being addressed is perceived as important to the stake-

The Foundational Three-Preconditions	
An influential champion or champion(s)	A respected and trusted organization that can encourage and enable participation of cross-sector organizations.
An overall sense that change is needed	The social issue is important to all stakeholders.
Enough resources to support the change	Sufficient resources are provided to support the administrative function to support the effort.

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The Five Conditions for Shared Success	
A common agenda	All stakeholders have a common understanding of the problem and a vision for change that they believe can be solved by working together on an agreed upon action plan.
Shared measurement	Alignment and accountability for participating stakeholders requires collecting and measuring results consistently.
Mutually reinforcing activities	The plan of action must break down activities that are clearly defined and distinct for each stakeholder while coordinating all actions into a mutually reinforcing whole.
Continuous communication	Participating stakeholders must build trust in each other to execute and remain motivated to act jointly through maintaining consistent and open communication.
Backbone support	Creating and managing the action plan requires an organization to have the staff with the necessary skills and a willingness to invest organizational resources into coordinating all the stakeholders and the execution of the action plan.

Fig. 1 Collective impact conditions R1

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holders and the overall greater community so that enough traction for the collective effort can be achieved. Given there are numerous important social issues that impact our communities, it can be a challenge to identify a social issue that attracts and retains enough attention. Identifying leverage points in the complex web of causes which can be clearly understood and described by multiple stakeholders helps to create momentum.

If the small group of champions gains buy-in for action, the last pre-condition is adequate financial resources to support the collaborative effort. Given that a requirement for collective impact is the engagement of multiple partners, multiple strategies, and creating multiple interconnections where before stakeholders mostly acted independently, it is critical that enough resources exist to provide the administrative functions to support the collaboration. Often one funder, which often is the influential champion, provides the infrastructure and planning process to mobilize stakeholder participation and additional financial support. To advance collective impact enough resources must be in place to be successful. Meeting the pre-conditions establishes buy-in from enough distinct stakeholders who are willing to explore how to work together and do things differently from their traditional siloed and isolated impact approaches.

Five Conditions of Collective Impact

Once enough stakeholders are invested in the co-creation and co-investment of building innovative social solutions to address a complex social problem, the next phase is organizing for the collective effort. According to the collective impact framework, there are five conditions that must be present to achieve system-level change and build the momentum for others to adapt and replicate. The five conditions, as depicted in Fig. 1 above, include: 1) *a common agenda*, 2) *shared measurement*, 3) *mutually reinforcing activities*, 4) *continuous communication*, and 5) *backbone support*. The five conditions serve as guidelines for cross-sector collaboration to facilitate synchronized and evolving results.

The collective impact conditions define the process that encourages and enables the emergence of solutions toward the intended outcomes for creating social change. The process of collective collaboration is part of the solution itself. The collective impact effort, if efficient, fosters a heightened awareness by stakeholders which fosters innovation and further collaboration.

HOW SECOND HARVEST FOSTERED COLLECTIVE IMPACT

To provide a model of how to feed collective impact, this case study illustrates how SHFB convened cross sector stakeholders to build innovative solutions for social change. Aligned with the collective impact framework, we describe how SHFB met the pre-conditions of collective impact which enabled them to convene cross-sector partners. Next, we provide an overview of processes that fostered six cross-sector collective pilots and their payment models which highlight how each partner plays an integrated role creating, investing, and delivering an integrated solution. A concluding discussion highlights the lessons learned. While the case is told in a linear form it is important for leaders and managers to realize that many activities are occurring simultaneously with continuous feedback loops that often result in reorganizing and co-creating new solutions to address identified gaps in the delivery of the collective impact action plan.

Establishing Pre-conditions of Collective Impact

Along with SHFB's mission "to create hope and nourish lives through a powerful hunger relief network, while multiplying the generosity of a caring community", the executive team made the strategic decision to invest in making 'Food as Medicine' a shared value. Dave and his team knew to build innovative solutions for social change would require support and engagement from a patchwork of cross-sector stakeholders. Thus, SHFB began to actively engage its network of 550 plus partner agencies, its own Board and staff, members of the community, and colleagues throughout the nation in exploring innovative ideas to support access to healthy food and nutrition education for a population limited in their choices and significantly affected by chronic disease.

Addressing food insecurity provides a common leverage point (i.e., a starting place) for stakeholders to gain a deeper understanding of social determinates of health. The term stakeholder includes everyone with an interest (or "stake") in what the entity does and considers the interests of any group or individuals who can affect or be affected by an organization. Our workplaces, communities, neighborhoods, schools, and homes all play a role in the overall population health. Organizations play a vital role in developing new and more effective processes for social change.

SHFB leadership team and board realized that making 'Food as Medicine' a shared value throughout the community and identifying enough cross-sector partners who would be willing to collectively act would take time and investment. Collective impact is not business as usual, but rather a new way of working and being that requires time and effort. Organizational commitment is impacted by historical organizational practices, the perceived value placed on the objective, and measured by an organization's willingness to dedicate resources and staff to foster innovation. Historically, SHFB has invested in building an entrepreneurial mindset and practice, also known as effectuation, to foster collaborative innovation and facilitate their transition from a traditional charity to a social enterprise model. See Parris et al. 2018 published in *Organizational Dynamics*. Internally, SHFB's stakeholders understood and valued entrepreneurial thinking and action through collaboration; however, they knew this is not the cultural norm in most organizations. In the traditional model of social change each organization independently finds its own solutions which results in isolated impact. Organizations operate within their status quo; thus, to foster change, SHFB knew it would take time to identify and produce enough external stakeholders from distinct cross-sector partners to buy-in to being a part of collaborative effort and for them to adopt an entrepreneurial mindset and practice.

Fundamental for leading social change is the champion's reputation for trust and transparency, as well as the reputation of their internal stakeholders to gain buy-in from exter-

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nal stakeholders. In the case of SHFB, the VP of ARP had established credibility over the course of a twenty five-year career in social work and had cultivated relationships within the community to facilitate informal conversations. Furthermore, having SHFB recognized as a trusted top human-services nonprofit by the nation's leading charity watchdog (Charity Navigator) and a known and respected change agent in the community as an institutional champion of the effort, opened doors for additional conversations. Subsequently, the VP of ARP facilitated numerous informal conversations that were guided by informed research from Feeding America, a nationwide network of more than 200 food banks, which added additional credibility and played a vital role in creating awareness and exposing key stakeholders to new ideas. For over a year, the VP of ARP had informal conversations that provided an opportunity to gain an understanding of the problem from distinct perspectives, as well as to begin to identify key cross-sector stakeholders that had or were likely to develop a desire to jointly act.

However, through listening and asking questions it became apparent political and competitive sensitivities within the healthcare sector could hinder building a sense of community and would impede the collective impact effort if not addressed. Overcoming these potential barriers required a neutral party with deep understanding of the healthcare perspective and institutional knowledge of community stakeholders. For SHFB, this was the University of Central Florida (UCF) College of Medicine, a research-based medical school with a pioneering spirt and culture focused on community partnerships and collaborations. UCF College of Medicine played a critical role in helping SHFB understand and learn about the healthcare sector, from how it works, what the organizational incentives and motivations are, and who the key stakeholders are within the community. More specifically, they greatly helped the VP of APR learn how each cross-sector stakeholder in the health sector viewed their organizational position, perceived consequences of non-action, and the degree of opportunity with action. The team at UCF, like SHFB, understood the potential of connecting food and hunger to improve population health and began alongside championing the shared value of 'Food as Medicine'. Together, as well as independently, UCF and SHFB leaders sought to facilitate formal and informal conversations within the community. Over time they were able to make stakeholders aware of the problem, then sparking their interest to keep them engaged, followed by kindling their desire to jointly solve the problem, and finally persuading them to act. For an influential champion to be successful he or she needs to gain the support and buy-in from other organizations who also have the respect to bring together CEO-level-sector leaders and encourage active engagement over time. Making 'Food as Medicine' a shared value provided a way for internal and external stakeholders throughout the community to define the problem in mutual terms and generated an overall sense that change is needed.

Establishing the second pre-condition of collective impact—an overall sense that change is needed—by making 'Food as Medicine' a shared value was accomplished by three focal activities over several years from 2012-2015: 1) seeking out opportunities for informal conversations with key stakeholders throughout the community, region, and nation to build a collective mindset and set of expectations; 2) finding and producing enough stakeholders that could help navigate the political and competitive sensitivities across health systems to help establish a sense of community; and, 3) hosting events that helped to encourage civic engagement. The events provided a space for internal and cross-sector stakeholders to develop a deeper understanding of 'healthcare perspective', as well as created safe and open spaces to encourage innovation. These actions facilitated information sharing, created a sense of intimacy, and decreased psychological distance between stakeholders. Making it easy for stakeholders to ask questions and learn, which served to increase perceptions of transparency and trust across the stakeholder groups.

Additional support for the urgency for change was further supported by the health sector exploring new ways to adapt their business model and services to meet the new requirements of the ACA which was passed in 2010 with implementation on-going. The law was designed to increase access, improve quality, and lower costs which were implemented through multiple polices at the federal and state level. Health institutions' organizational situation was fundamentally altered with new severe consequences for non-action plus significant incentives for improving health outcomes. For example, an ACA value-based program like the Hospital Readmission Reduction Program (HRRP), created significant incentives for hospitals to reduce readmissions, and a new ACA-added Internal Revenue Code for nonprofit hospitals mandated improved transparency and accountability to prove these hospitals were providing community benefits sufficient to justify their favored tax status. The changes in healthcare laws incentivized healthcare providers to seek new opportunities that would provide solutions for patients at risk or challenged by chronic health issues.

Simultaneously, SHFB further invested in civic engagement by participating in national, regional, and local conferences with a focus on sharing, learning, and encouraging meaningful conversations to promote the connection between health and hunger. In 2014, SHFB hosted a two-day conference that was attended by over 90 leaders from the Feeding America network, healthcare systems, public health institutions, education, government, and foundations from around the nation asking, "What could the role of a food bank be in addressing community health?" The event had two main outcomes: 1) encouraged and enabled additional internal and external stakeholder buy-in to embrace the shared value of 'Food as Medicine', and 2) fostered listening, ideation, and sparked further conversations from cross-sector partners to explore collaboration. Making a shared value ensures all stakeholders have a mutual understanding of the problem which feeds a belief that by working together social change can be achieved.

As the champion for 'Food as Medicine' with a long-term strategic vision of fostering cross-sector collaboration to build innovative solutions, SHFB also committed to helping meet the third precondition of collective impact: providing an appropriate level of resources required to effectively do the work. For instance, in 2014, SHFB made a significant and ongoing investment into feeding collective impact starting at about $50,000 annually for internal organizational restructuring. SHFB hired a new Director of ARP that would manage the day-to-day oversight of all ARP programs besides Health and Hunger Programs (HHP), which would be led by

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the VP of ARP. Investing in additional staff resources enabled the VP of ARP to ensure all the preconditions for collective impact were met.

Once the three-preconditions were met it was time to launch the collective impact initiative. Together the preconditions provide the opportunity and motivation for cross-sector stakeholders who have never worked together to be actively engaged and maintain momentum for the collective effort to be launched. Meeting all the preconditions for collective impact took approximately five years: from 2010 when SHFB made the strategic decision to play a larger role in community health and hired a licensed nutritionist, to 2015 when they convened the Health and Hunger (HH) Task Force, an organizing body for the collective effort. The HH Task Force consists of key stakeholders and decision-makers from major local hospital systems, health insurance companies, and those members of Central Florida agencies, academia, foundations, and consortia with a vested interest in the health and wellness of Central Florida citizens.

Organizing to Achieve Collective Impact: Defining the Common Agenda

Now that the preconditions were met, it was time to begin organizing to achieve collective impact by employing the five conditions: common agenda; shared measurement; mutually reinforcing activities; continuous communications; and a backbone infrastructure. The priority was first defining the common agenda. For distinct organizations to break down the traditional silos where each organization works on a different piece of the problem requires new models for organizing to achieve collective impact. Making 'Food as Medicine' a shared value provided a lever point where key stakeholders from distinct sectors interested in addressing the problem could convene to explore the possibilities of jointly co-creating and co-investing in solutions. Change is often inhibited by not having a shared value as a starting place and pushing predetermined solutions without discovery of mutually reinforcing opportunity identification from key cross-sector stakeholders.

Unlike traditional nonprofits seeking support for predetermined programs, SHFB, as an innovative anchor institution, let solutions emerge by facilitating conversations. Whereas food banks are viewed as providers of commodities with a mission, SHFB expanded its role to be a convener with a mission. To support forging productive working partnerships with the healthcare sector to improve population health and based upon community-expressed interest gained through making 'Food as Medicine' a shared value, SHFB formed the HH Task Force in December 2015.

According to key stakeholders from the hospital systems and observations by SHFB staff at the first meeting, many attended as an exploratory opportunity. However, when the slide in Fig. 2 was shown comparing the costs of a health care visit versus healthy food for a blood sugar crisis, the conversations began to shift from expressing interest in the information provided to most attendees becoming convinced collective impact was the answer to the problem. Addressing food insecurity served as a starting place for the HH Task Force to jointly co-create and co-invest in solutions that address the social determinants of health.

SHFB convening key stakeholders from cross sector organizations as the HH Task Force formalized the shared value 'Food as Medicine' and created a space for organizing collective impact. The meetings serve as a time and space for co-creation where individuals and organizations can learn, listen, and share, which then enables progress through alignment, discovery, and emergence of innovative solutions. Furthermore, the development of the HH Task Force provides a method of identifying leverage points to create a healthier, more equitable community.

The HH Task Force meets every two months with additional workgroup meetings and has over 40 engaged cross sector members. The Task Force has three main objectives:

1 Share information on existing food bank-healthcare partnerships, related research, emerging perspectives, successful strategies, and pertinent state and federal policies for the purpose of identifying promising and best practices.
2 Identify prospective opportunities for merging priorities through actionable pilots/projects.
3 Develop strategies that will enable productive and effective collaboration to improve the health of the vulnerable population of Central Florida.

Cross-sector collaborations and partnerships are an essential component of collective impact. The HH Task Force focuses on three drivers for concerted action to feed cross-sector partnerships: the number, breadth, and quality of successful cross-sector partnerships; the adequacy of investment in these partnerships; and the adoption of policies needed to support them. The over 40 engaged members are key stakeholders that both in their own institutions, as well as within the greater community, have made a commitment to jointly engage, persist in encouraging community buy-in, and advocate for the shared value at the local, regional, and national levels.

Unlike the traditional partnerships where leadership is highly centralized, SHFB plays the role of convener, maximizing contributions and engagement through distributed decision making that ensures each stakeholder and sector benefits from meaningful participation in the collaborative effort. Leadership commitment and stakeholder buy-in are non-fiscal investments by the HH Task Force members which are supported with SHFB's serving as administrative back-

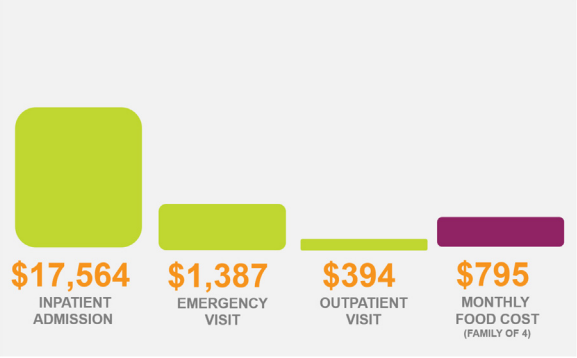

Fig. 2 Slide comparison R1

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bone support. The scheduling and implementation of meetings every two months in addition to work group meetings and active management of coordinating all stakeholders and the execution of the action plan ensures continuous communication—one of the five conditions of collective impact. While the slide discussed above that highlighted the relative cost of food versus healthcare served to gain stakeholder buy-in, the passing of the ACA which mandated and incentivized the healthcare sector further supported the formation of the HH Task Force. After organizing for impact, the next challenge was co-creating solutions to jointly act.

Creating Processes to Facilitate the Collective Action

Inextricably linked to developing a common agenda is meeting the next three conditions of collective impact: shared measurement, mutually reinforcing activities, and continuous feedback. The HH Task Force focuses on creating processes to support the collective impact effort. Often barriers to collaborating across traditional silos result in conflicts with existing operations, patterns of specialization, and the complexity of joint action. For a diverse group of stakeholders to jointly act, it is critical to identify or create mutually reinforcing activities where each participant is responsible for a specific set of activities within their specialization that supports the effort.

Mutually reinforcing activities, shared measurement, and continuous feedback ensure that each stakeholder's efforts must fit into a defined component(s) of the solution and fill systems gaps to form coordinated actions with other participating stakeholders. All stakeholders need support from their institutions to participate. Thus, every participating institution needs an internal champion that supports the common agenda (i.e., shared value), and that also has ability to ensure the resources for their internal stakeholders to participate and act.

The initial HH Task Force meetings and follow-up conversations encouraged members to share their unique expertise and identify gaps in their current service offerings in order to begin to piece together what each stakeholder had to offer to the larger solution and explore how together they could create a coordinated service offering that would address multiple causes of poor health. The process facilitated emergent rather than predetermined solutions and supported the creation of multiple solutions. When key stakeholders began to form a vision of how they could work together, they would go through multiple iterations of a logic model, which highlighted the inputs, outputs, outcomes and impacts, as well as define key assumptions for the success of the collective actions.

Each collective effort is uniquely designed to help answer questions related to clinical, behavioral, and/or healthcare cost outcomes. The measured outcomes of each pilot are also aligned with the objectives of the funders. Logic models are constructed to help provide clear and usable representations that outline the structure of each pilot and defines each stakeholders' role in relation to the larger coordinated effort. In addition, logic models outline how to track the progress of the pilot and provide a framework for continuous feedback loops. An assumption for all pilots is continuous communication across all funders and participants to further build trust, assure the activities by each stakeholder are mutually reinforcing, and strengthen the shared value of Food as Medicine. The logic models are one of the key tools for keeping the complexities of the pilots on track.

Through the collective process of iterating on the logic models it became evident that collecting data and measuring results consistently across all participants would be a challenge. First, there was a lack of data connecting food insecure individuals that are also patients within the greater

Pilot name	Funders and amount	Executing organizations	Funding distribution model	Payment periods	Precentage utilization by category
West Orange Healthcare District (WOHD)	WOHD = 267,000 & Aetna Foundation = $25,000 for Healthy Food Boxes	Community Health Centers & SHFB	Yr. 1 $25,201; Yr. 2 124,309; Yr. 3 62,387; Yr. 4 55,437	6/17 $44,900; 2/18 $43,350; 12/18 $43,350; 6/19 $45,327; Expect remainder in FY 2019/20.	58% Personnel; 21% Equipment; 8% Education; 13% Admin/Indirect costs
Orlando Health (OH)	OH Benefit = $20,000 for Healthy Food Boxes	"same as funder" & SHFB	FY 2018 $2,150; FY 2019 $6,250; Expect to distribute balance in FY 2020	Received all $20,000 in July 2017	90% Food Boxes & 10% recipe cards
Florida Hospital Community Care (FHCC)	Florida Hospital Systems = $10,000 for Healthy Food Boxes	Florida Hospital Community Care & SHFB	FY 2018 $0; FY 2019 $5,287; Expect to spend balance in FY 2020	Received all $10,000 in Jan 2018	100% Food Boxes
Florida Hospital Community Health Impact Council (CHIC)	Advent Health CHIC = $480,000 & Aetna Foundation = $25,000 Healthy Food Boxes	Advent Health CHIC & SHFB	Getting Started. Plan is to spend $105k in year 1, $207k in year 2, and $168k in year 3.	No payments received yet. This is a reimbursement based grant.	Personnel 28%; Training 2%; Equip/Supplies 8%; Advent Health Nutritionist 5%; Advent Health Supplies 2%; Food 53%; Transportation 3%.
Orlando Magic Youth Foundation (OMYF)	OMYF = $300,000	GMH, 3 Health Pantry Partners, & SHFB	Yr1 $100,000; Yr. 2 $100,000; Yr. 3 $100,000	Yr1 $100,000; Yr. 2 $100,000; Yr. 3 $100,000	Grace Medical Nutritionist 50%; SHFB Personnel 14%; Mileage 1%; Food 27%; Supplies 3%; Indirect Costs/Admin 3%; Equipment 2%.
Diabetes Prevention Program with Food Integration	Feeding America and Americares = $23,000	GMH, a certified Diabetes Prevention Program (DDP) Provider & SHFB	FY 18 $9,109; FY 19 $15,731	Received $21,840 April 2017 and $3,000 in June 2017.	90% Food Boxes & 10% Transportation

Fig. 3 Pilots and payment models R1

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health system. Thus, HH Task Force asked its stakeholders: How might we address the potential barriers in collecting food insecurity information through healthcare providers' many different patient tracking methods? In response, the Task Force has committed to expanding the utilization of a two-question food insecurity screen, also called the Hunger Vital Sign©, across nonprofit healthcare providers and other organizations that serve low-income populations with a range of effective solutions for people screening positive. To this end, the HH Task Force held multiple training sessions and sought best practices from across the nation on how to collect the data. Improved data will help identify and understand patients/clients who may be most vulnerable and enable the Task Force to continue to invest in co-creating solutions that improve health equity for those most at risk.

The HH Task Force, with members from medical care, public health, and social services, is collectively producing a more equitable, effective, and efficient coordinated effort to improve population health. Since the first task force meeting nearly five years ago, a coalition of more than 40 healthcare providers, affiliates, third party payers, academic institutions, community organizations and public health offices have established strategic goals that are in various stages of activation. The regular meeting process has also generated more than $1.2 million to support six pilots to provide proofs of concept that increasing access to affordable nutritious foods and healthy eating education for chronically ill food insecure people improves their health and reduces healthcare costs. Additionally, more than one public health office has established a food pantry onsite, as has a free and charitable clinic, and one of the large hospital systems, with others coming online soon. Fig. 3 provides an overview how the execution and funding of the six pilots are shared across organizations.

Each of the pilots generated through the collective work of the HH Task Force is unique in its details while still contributing to a greater community understanding of Food as Medicine. In finalizing the details of each pilot, stakeholders asked: How does this improve access for the most vulnerable while improving their experience and the quality of care received?

In all cases, food is the most expensive program element over the course of each pilot. There are moderate costs for nutrition education since it is primarily conducted by SHFB's in-house nutrition team. Over time, some funding has been reallocated to provide transportation for participants to access food at pantries. In addition, funders granted permission to shift funds for materials and supplies participating stakeholders identified would be beneficial for pilot participants, e.g., recipe books. Thus, the HH Task Force has learned it is imperative for funders and participants to be willing to adapt as lessons are learned through implementation.

The pilots' successes to date have fed community interest leading to additional stakeholders participating and the investments have followed. Together the pilots are generating evidence and building a knowledge base for understanding the issue of food insecurity and its integral relationship to health equity. The pilots serve as models for how traditionally siloed systems can be transformed through the integration of health systems, social services, and community nonprofits to improve health for low-income chronically ill patients.

Providing Backbone Support

To sustain an integrated systems approach requires backbone support. Often this is where collective impact efforts fail. It takes an organization with a strong commitment to see its values go from ideas to reality, and then to continue finding ways to ensure sustainability by dedicating staff with specific skill sets to lead, manage, and coordinate participating organizations. SHFB's commitment to foster collective impact has resulted in dedicating additional staff and redefining job roles to support the objectives of the HH Task Force. The onboarding of a Director of ARP in 2014 enabled the VP of ARP dedicated time to feed collective impact. Since 2019, the VP spends 70% of her time leading the Task Force, which has increased 10% every year since 2015.

In addition, the payment models for the pilots, as described in Fig. 3, supported SHFB's management of the collective pilots by enabling staff hires to serve as the operational backbone coordinating the collective efforts. The West Orange Healthcare District (WOHD) pilot's funding allowed SHFB to create the Healthy Pantry Program Coordinator position and provided funding to purchase upgraded equipment for those pantries involved. Next, the Advent Health grant for the Florida Hospital Community Health Impact Council (CHIC) enabled SHFB to promote the Healthy Pantry Program Coordinator to the Health & Hunger Programs Manager and hire her replacement to help manage capacity-building and nutrition education for the growing Healthy Pantry Network. The Orlando Magic Youth Foundation (OMYF) pilot's payment model covers the cost of food and a dietician on Grace Medical Home's staff who works one-on-one with each of the clients and their families. Overall, the pilots have grown the community capacity for meeting the needs of chronically ill food insecure patients.

During the first four months of COVID, the VP of ARP and staff that helped support the HH Task Force shifted their focus to navigating SHFB's immediate response to the sharply increased need for emergency and supplemental food brought on by the pandemic. For instance, the executive team at SHFB mobilized resources to roughly double their daily food distribution. As SHFB has begun to stabilize its response, the VP of ARP is again devoting time and focus to the HH Task Force, with new attention directed at Food as Medicine in the context of COVID and its impact on both historically vulnerable populations and newly stressed community members. The parallel epidemics, one communicable (COVID), and one non-communicable (poor diet and diet-related disease) are synergistic and are being further aggravated by the economic disruption and the impacts of climate change. Together these are leading to significant increases in food insecurity and hunger which further intensifies the susceptibility to both infections and diet-related diseases. Starting with food insecurity, the HH Task Force continues to address the social determinants of health by practicing and advocating collective impact. COVID accelerated the need for organizations to create and identify innovative social solutions that fulfill institutional, economic, and societal voids faced by the most vulnerable population, along with a growing number who have lost their jobs as a result of the pandemic and can no longer afford groceries. The scale of the social need has deepened the HH

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Task Force's commitment to improving population health through the value of Food as Medicine and collective impact.

LESSONS LEARNED

There are three main takeaways leaders of organizations seeking to be champions of collective impact should consider before fostering cross-sector partnerships to build new innovative solutions for social change: 1) invest in values, 2) focus on facilitating rather than owning the process, and 3) embrace continuous iterative learning.

Invest in Values

As an organization, SHFB relies heavily on a values-driven culture to define all aspects of its work, including strategy. Innovation, collaboration and a commitment to service steer all SHFB's work and provide the fundamental confidence required to embark on a project like creating a shared value of 'Food as Medicine' and starting the HH Task Force. Investing in values first instead of a predetermined solution to achieve a specific goal facilitates collaboration and increases the potential for the emergence of new possibilities and solutions.

Focus on Facilitating not Owning the Process

From its inception, SHFB recognized that it was only one piece of the puzzle needed to develop strategies and practices for effectively using 'Food as Medicine'. The process would require knowledge and expertise from multiple sectors, especially healthcare. As part of its mission, armed with knowledge and new research from Feeding America, and consistent with its values, SHFB was willing to raise awareness locally and then host convenings around the idea of collaboratively creating solutions to food insecurity within the healthcare sector. The Food Bank never intended to own the process but continues to facilitate and administer the work of the HH Task Force. In each meeting, SHFB leadership reinforces the message that they are the convener, not the owner, of the collective process and asks for continued partnership and shared leadership in finding ways to innovate for tomorrow.

Embrace Continuous Iterative Learning

A key learning of the HH Task Force has been that they are navigating uncharted waters and learning each step of the way. Key to fostering stakeholder commitment, engagement, and advocacy is creating a learning environment that encourages deep listening and embraces a "Yes. . . and" mindset that suspends judgment and allows different ideas and solutions to emerge over time. A learning environment further creates a space where members are sharing, learning, and listening together which enables members to share their expertise while gaining new knowledge. Each conversation and every pilot provide learning opportunities.

Unexpected challenges on multiple levels have created opportunities. For instance, addressing the most significant challenge to the successful implementation of the pilot programs, which was the lack of patient compliance due to lack of transportation, created a new opportunity. Due to transportation challenges many patients were not showing up to their appointments, nor could they pick up their diet specific food that could contribute to their overall health improvement. To mitigate the transportation barrier, SHFB began recruiting volunteers to act as delivery drivers to the program participants facing a transportation barrier. SHFB leverages the Healthy Pantry Network by having them act as food pick-up sites for the volunteers delivering the food. When a patient calls SHFB and identifies which program they are participating in, they are matched with a volunteer driver whose location and availability is similar to the patient's. Once the patient is put on the delivery schedule, they can receive deliveries bimonthly for the duration of their program participation. The goals of the new delivery program are to 1) improve patient compliance by removing the transportation barrier, 2) impact the patient's health and access to healthy food in a positive way and 3) reduce unnecessary ER/ED visits.

Since the onset of COVID, the discovery of the need for transportation assistance for pilot participants allowed SHFB, with financial resources from community funders, to expand on the volunteer driver solution to provide home delivery. In response to an unprecedented high demand of home-delivered food due to the pandemic, as well as stewardship of the community funders, SHFB was able to use the pilot program as a template to launch its newest program called Bring Hope Home. The program utilizes delivery partners and voluntary drivers to transport food to targeted groups unable to travel: homebound seniors, disabled, and others at high risk for COVID infection. To date, the Bring Home program has provided 262,000 nutritious meals to over 16,000 individuals.

CONCLUSION

The case study highlights the role of an anchor institution plays as a convener, a vital role in forming a collective coalition around a shared value of 'Food as Medicine' and how being a catalyst for change is only the beginning. To achieve collective impact requires long term investment, as well as an organizational willingness of all participants to go beyond traditional siloed roles. If medical care, public health, and social services always do what they have always done, they will always be what they always have been, maintaining a limiting and unnecessary gap in population health, equity, and well-being. SHFB's investment in innovating for tomorrow by feeding collective impact provides an example of how organizations need to be willing to challenge who they are and be open to who they can become.

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