The Internal Revenue Service (IRS) requires nonprofit healthcare organizations to demonstrate community benefit activities that promote health. To meet this requirement, community benefit departments develop a community benefit implementation strategy[1] in response to health needs that are identified via a community health needs assessment (CHNA). While an assessment and planning process is considered a best practice for addressing population health, these processes may overwhelm a department that is fully committed to implementing and reporting on its current portfolio of services. Adding to this challenge, implementation strategy documents have a short, three-year lifespan — per the IRS guidelines — during a time of rapid evolution in the health ecosystem. This three-year cycle can feel burdensome and perpetuate a "check the box" phenomenon, since often strategy implementation is barely underway before the next community health needs assessment is launched. However, over years of facilitating implementation strategy processes, HRiA has found that the IRS requirement actually presents a [illegible] **a ab e f a q e a e ec be e e a a e f ea e a a e a d ac .** The efforts invested in the assessment and planning processes can be more effective by ensuring that they advance both population health improvement and community benefit/hospital priorities.

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l c ca, e a q e, de a e e (ROI) f a ea a e.

As the political landscape shifts in unpredictable ways, and various reforms are considered and implemented, accountability for improving quality, health outcomes, and the cost of care is expected to continue. Health care is in a transitional period of trying to meet these challenges while re-aligning current care delivery with new reimbursement models (e.g., alternative quality contracts, accountable care organizations, or other value-based payments). One way to meet the "triple aim"[2] of cost, outcomes, and quality is to align hospital care delivery with community benefit strategies — an efficient and effective way to improve health indicators through community-based prevention and health promotion initiatives.

N a eed c ea e c d a f eff , q e a e a e , a d a ef ce c a d a e c a e , a d ac , de ee e c e a d f ec a e affec ea ca e de e a d e b e e e .

There is wide consensus that no institution can do it alone, and that all institutions need to address persistent health issues from a social determinants of health framework.[3] Formal, strategic partnerships across healthcare delivery, community, government, public health, and philanthropic sectors in this work will be an important way to meet the challenges of the triple aim.

Moving beyond IRS requirements — **f c a ce a e c a e** — allows health care institutions to improve population health and demonstrate return on investment for community benefit activities by maintaining efforts to address persistent community health issues, and in so doing, ensure continuity from one community benefit implementation strategy to the next. HRiA has developed a structured and inclusive plan, called the **a e c e e a a** (SIP), TJ.2 (e)Tj( )Tj (52eed. a.2 (2 ( ), Tdel 5

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HRiA's facilitated SIP-LINE process allows participants to e a e ıe b ead ıa d de ı f c eed / e ce , de f c d ı ıe ı a e , a d e ec a ac ıe ıa f e c ab a ac ı ę e e . The SIP-LINE process focuses on four major planning elements to:

- **D ę e a a d ea ab e b ec ı e** for current and future initiatives that align with community needs;
- **Se ec a e e** consistent with the institution's aims and develop performance measures;
- **O e _a c a e ce** for each of the strategies;
- **De _e a d ę a a a ac ıe ;** and

C ea e a ıa ed a a e that encourages a broad definition of health.

Ma _e e ı e e in community benefit initiatives and approaches by articulating and promoting shared population health outcomes.

E ıa ce ı a e f a ce relative to its strategic plan, particularly through improvement in metrics that are sensitive to the social determinants of health.

P ı de a f a e to strengthen existing partnerships and form new partnerships across hospital, community, and philanthropic sectors.

L ę e a e e ce and guide funding decisions in alignment with institutional strategic plans that

Convening

- Hospital leadership
- Subject matter experts (SMEs)

Data gathering and review

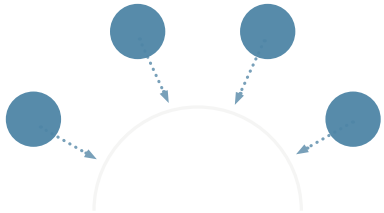
- Assess existing resources
- Review internal hospital strategic plan/priorities
- Identify community health needs

Mapping priorities

- Identify areas of strategic overlap
- Identify gaps

Planning

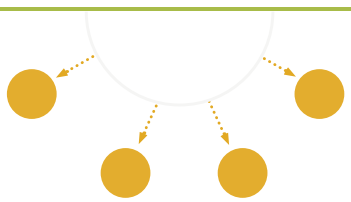
- Identify priority issues for SIP
- Align SIP with



HRiA works to guide the formation of an inclusive steering committee to oversee the process, consult key subject matter experts, and select and mobilize a designated work group to define and implement the

Data gathering and review informs the creation of an **a e a** that identifies areas of synergy between the CHNA and institution-wide priorities. For each priority area, key issues are determined based on data from the CHNA and areas of overlap are noted. Examples of institutional alignment could be an institutional priority on oral health across the lifespan and an identified community need for oral health preventive care in children, or an institutional strategic goal on enhancing access and an identified community need for transportation services. (See **SIP a a e .**)

The SIP is created "live" with work group members through **e e , fac a ed a e** . Identified community health needs are consolidated into three to five priority areas that synchronize with the institution's strategic plan. Specific SIP components are developed, as depicted in the sample SIP template in **F e 2.** (See the **S a e c e e a a e a e**).



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Community benefit and hospital system efforts to impact and improve population health are enhanced when strategic planning processes include c -de a e a eade within a hospital or across a hospital system. The SIP-LINE process engages leadership from various functions and content areas, depending on the priorities selected for the SIP. Developing the SIP is an interactive, cooperative planning process among these key leaders, who then — as a result of rigorous assessment, clear goals, metrics, and financial data — can articulate the business case for community benefit investments to executive leadership and thereby demonstrate the value of community benefit initiatives.

The SIP-LINE process builds on past approaches, strategies, and successes and c de c e a e a d a e e when developing the SIP. The internal alignment mapping process ensures that the hospital's mission and goals are well integrated with those of community benefit.

As part of the planning process, internal collaboration grows while external partnerships are cultivated with key stakeholders to effectively implement specific programs and approaches. The SIP-LINE process helps b d ea c -ba ed a a e e c - ba ed e a d ea a ac e a d a e e. These steps, including exploring funding opportunities, expand both the hospital's and partners' capacities to address community needs.

Collective engagement to identify shared priorities and actions yields strategies that can have the greatest impact on population health and opportunity for scalability and replication. In many cases, community-based organizations within the hospital's catchment area offer e ce add e c a de e a f ea — including access to food, housing, transportation, or job training and placement. In those cases, ea e a de e ce e a d a d e a ce e e ce as a cost-effective and collaborative mechanism for strategic implementation activities aimed at improving population health outcomes.

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C - a c ab a

Integrate hospital leadership in cooperative planning to improve population health.

Ta aec

Share quantitative and qualitative community health data and indicators.

S ae ca e

Map areas of potential alignment between community health needs and the institution's strategic priorities.

Ef ce c

Produce a detailed strategic plan through an intensive and interactive process — in just one or two sessions totaling eight hours!

E e fac a

Engage a trusted, experienced leader to manage group process, offer templates and tools, and provide guidelines.

The context for care is changing rapidly. Insurers are requiring healthcare providers to shift from volume-based care (fee for service) to a value-based reimbursement structure (fee for value) with a population health approach.[4] Value-based reimbursement has prompted large healthcare delivery organizations to manage costs and improve population health outcomes through innovative strategies including strategic partnerships, mergers, acquisitions, and other arrangements.[5] In particular, it has encouraged a number of institutions to explore creative, collaborative partnerships with community-based organizations that can offer preventive services outside the clinical setting. L
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in today's healthcare and public health sectors where external pressures demand clear demonstration of ongoing efficiencies and effectiveness.

HRiA developed the SIP-LINE process to maximize strategic impact in response to the fast-changing healthcare environment, increasing mandates, and diminishing resources. A c ab a e, - de SIP ce f e c e , e , a e , a d e ce e , e f c ead f de ce-ba ed, - ac a e e e a ea .

SIP-LINE TOOLS FOLLOW OR CAN BE DOWNLOADED:

- SIP e- a
- SIP a a e
- SIP e a e

Pre-planning tool for strategic implementation plan (SIP)

Fill in this tool based on the SIP elements de nitions below. Current initiatives/strategies can be pulled from Community Bene t Inventory for Social Accountability (CBISA) data. Identify workgroup members and deadline

Workgroup member(s):

Deadline for completing this tool:

Priority 1:

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PRIORITY 1:	
CURRENT INITIATIVES/STRATEGIES (List one per line; include those from previous SIP that you anticipate continuing over next 1-3 years)	POPULATION ADDRESSED

PRIORITY 1:	
FUTURE/ANTICIPATED INITIATIVES/ STRATEGIES (Next 3 years)	POPULATION ADDRESSED

Priority 2:

E\\[j1

KXi^\k gfglcXk`fe j kf Y\ X[[i\jj\[ Yp `e`k`Xk`m\j&jkiXk\^`\

PRIORITY 2:	
CURRENT INITIATIVES/STRATEGIES (List one per line; include those from previous SIP that you anticipate continuing over next 1-3 years)	POPULATION ADDRESSED

PRIORITY 2:	
FUTURE/ANTICIPATED INITIATIVES/ STRATEGIES (Next 3 years)	POPULATION ADDRESSED

Priority 3:

PRIORITY 3:	
CURRENT INITIATIVES/STRATEGIES	

Strategic implementation plan (SIP) mapping alignment tool

Complete the alignment mapping process prior to the Strategic implementation plan template. Identify workgroup members and deadline for completing this tool.

Workgroup member(s):

Deadline for completing this tool:

SIP TERM	DEFINITION/DESCRIPTION
Priority	A category of focus.
Needs	Subcategory of topics to be addressed under priority area.
Target population	Those high-needs populations addressed by a community bene t strategy.
Goal	A goal describes in broad, strategic terms the desired outcome of the planning priority.
Objective	Objectives articulate goal-related outcomes in speci c and measurable terms. Objectives are SMART (speci c, measurable, achievable, relevant, time-phased).
Outcome indicators	Data-driven measure(s) of a change in status. These indicators ultimately let your team know if the plan was successful in impacting the priority. This may help you identify activities that are useful in meeting your objective(s), and those that are not. Outcome indicators are NOT how you will know that the strategy has been implemented. Baseline is the current value; target is the year 3 value.
Strategy	A strategy describes an approach to achieving the objective. It is less speci c than action steps but tries broadly to answer the question, “How can we get from where we are now to where we want to be?” In SIP terms, these are speci c programs or initiatives to address a priority area or objective.
Timeline	The methods you will use to track and capture data on strategies and activities (e.g., quarterly reports, participant evaluations from training).
Hospital (and other) contribution(s)	The allocation of staff salaries, physical space, or other contributions provided by the hospital to implement the strategy.
Monitoring/evaluation approaches	The methods used to track and capture data on strategies and activities (e.g., quarterly reports, participant evaluations from training).
Potential partners	Those individuals or organizations who are key to achieving the objective. Potential partners could also be organizations who already have initiatives underway in the objective area.

:fddle`kp Y\e\Ñk [\Ñe`k`fe1

Per the IRS guidelines, community bene t is programs or activities that provide treatment and/or promote health and healing as a response to identi ed community needs, especially for those community members who are most vulnerable/highest need. Community bene t generates a low or negative nancial return. Such programs or activities include:

- Financial assistance
- Government-sponsored means-tested programs — unpaid costs of public programs
- Other community bene t services (e.g., initiatives offered to the broader community designed to improve community health)
- Community health improvement services
- Health professions education
- Subsidized health services
- Research
- Cash and in-kind contributions (e.g., use of facility space for community group meetings)
- Community-building activities
- Community bene t operations

Alignment map

Strategic implementation plan (SIP) template

Fill in this template based on the SIP elements de nitions below. Identify workgroup members and deadline for completing the template.

Workgroup member(s):

Deadline for completing this template:

SIP TERM	DEFINITION/DESCRIPTION
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- Community health improvement services
- Health professions education
- Subsidized health services
- Research
- Cash and in-kind contributions (e.g., use of facility space for community group meetings)
- Community-building activities
- Community bene t operations

Priority 1

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OBJECTIVE 1.1

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
1.1.1						
1.1.2						
1.1.3						
1.1.4						
1.1.5						
1.1.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 1

OBJECTIVE 1.2

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
1.2.1						
1.2.2						
1.2.3						
1.2.4						
1.2.5						
1.2.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 1

OBJECTIVE 1.3

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
1.3.1						
1.3.2						
1.3.3						
1.3.4						
1.3.5						
1.3.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 2

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OBJECTIVE 2.1

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
2.1.1						
2.1.2						
2.1.3						
2.1.4						
2.1.5						
2.1.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 2

OBJECTIVE 2.2

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
2.2.1						
2.2.2						
2.2.3						
2.2.4						
2.2.5						
2.2.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 2

Priority 3

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OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
3.1.1						
3.1.2						
3.1.3						
3.1.4						
3.1.5						
3.1.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 3 | OBJECTIVE 3.2

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
3.2.1						
3.2.2						
3.2.3						
3.2.4						
3.2.5						
3.2.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 3 | OBJECTIVE 3.3

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
3.3.1						
3.3.2						
3.3.3						
3.3.4						
3.3.5						
3.3.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 4

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> f X c + 1

OBJECTIVE 4.1

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
4.1.1						
4.1.2						
4.1.3						
4.1.4						
4.1.5						
4.1.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 4

Priority 4

OBJECTIVE 4.3

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
4.3.1						
4.3.2						
4.3.3						
4.3.4						
4.3.5						
4.3.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 5

G i ` f i ` k p ,1

> f X c ,1

OBJECTIVE 5.1

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
5.1.1						
5.1.2						
5.1.3						
5.1.4						
5.1.5						
5.1.6						

Monitoring/evaluation approaches:

Potential partners:

Priority 5

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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Priority 5

OBJECTIVE 5.3

OUTCOME INDICATORS (be sure to address specific populations):	BASELINE	TARGET AT END OF YEAR 3
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STRATEGIES	TIMELINE			HOSPITAL $$ CONTRIBUTION	OTHER SOURCE A	OTHER SOURCE B
	Y1	Y2	Y3			
5.3.1						
5.3.2						
5.3.3						
5.3.4						
5.3.5						
5.3.6						

Monitoring/evaluation approaches:

Potential partners: