**Sacramento Region Health Care Partnership
SWOT Analysis**

The following Strength, Weaknesses, Opportunities and Threats (SWOT) analysis has been prepared from data collected, stakeholder interviews, site visits, SRHCP convenings, advisory group and observation of the study's consulting team.

FUNDING
[Defined as: (1) reimbursement rates, (2) payor mix, and (3) Medi-Cal contract access]

Strengths
None identified

Weaknesses
- CHCs underfunded, reimbursement, grants, donations
- Insufficient direct reimbursement services and health education, no state/federal funding for teen pregnancy
- No technical assistance for CHCs, limited funding for care and strategic initiatives
- Reimbursement is a huge challenge for patient care. Prescriptions are a challenge.
- Some CHCs have large account receivables and slow payments
- Many CHCs do not have the staff to apply for MUA status or other grants
- Mental health reimbursement is much lower than primary care
- Current structure of GMC in region seen as barriers to progress
- Cost containment

Opportunities
- Important incentives that ties funds to "health" or outcome rather than service delivery
- Apply on federal and state designations (i.e., MUAs, HPSAs, etc.)
- Willingness to collaborate and come together with a united voice
- Willingness to map all safety net assets, where funding has been lost, key programs dropped, looking for gaps
- Move to value-based purchasing and purchasing cooperation between all CHCs (FQHC or not) and training.
- Incentive payments are available for certain MUAs/HPSAs. Need to determine if they are being drawn down.
- Expansion in newly insured under ACA

Threats
- Significant threat to key features of ACA
- State and federal budget cutbacks and funding and cash flow challenges as a result
- Healthcare safety net lacks a lead agency to coordinate financing conversations

COLLABORATION
[Defined as: (1) cooperation among CHCs, hospitals and clinicians (2) coordinated strategies from financing sources (i.e., county indigent care, Medi-Cal managed care, health systems, etc.) and (3) cooperative opportunities resulting in better care, lower costs and more leveraged coverage of care]

Strengths
- Some FQHCs meet and share regularly
- Network of clinic consortiums (i.e., Central Valley Cooperative, Capitol Community Health Network, Redwood Community Health Coalition, etc)
- Access El Dorado, Placer Collaborative Network, Future of the Safety Net Yolo County,
- Supportive local medical society
- Supportive health systems
- There are other good collaboration models in region that can be learn from (i.e., hospital and clinic collaboratives)

Weakness
- Very competitive health care market leads to lower collaboration and sharing of resources - discharging patient is like "walking the plank"
- No clear collective community clinic voice or vision
- Lack of culture of sharing
- Siloes mentality
- Less than optimal engagement by health care stakeholders

Opportunities
- Convening health care stakeholders for knowledge sharing
- Expand collaboration outside HC (healthcare) arena to include business community.
- Sighting of HC facilities are not by transportation or the transportation hours do not correspond with the facility.
- Collective desire to identify and implement strategies to reduce unnecessary ED visits
- Willingness to establish new partnerships and shared visions between hospitals and CHCs
- Shared services/group purchasing

Threats
- Proprietary view of information
- Sharing may be perceived as putting at risk some current collaborative
- Healthcare safety net lacks a lead agency strong enough to coordinate and integrate different interest.

EXPANSION, RETENTION OF WORKFORCE

[Defined as: (1) workforce for staffing CHCs, (2) strategies that are within the control of time and resources for this project and (3) cooperative opportunities which can be accomplished with limited resources]

Strengths

- Great training capabilities in this region capable of meeting a wide range of needs (i.e., physician, nurse practitioner, pharmacy, medical assistants, etc.) and the potential to bring some these experts to the CHC arena
- Lessons learned from application to CMMI proposal prep re: allied health, education and community health workers

Weakness

- Wide background for clinicians, expand regulations
- Retiring clinical workforce is going to mean a shortage
- Clinicians working with minority groups/cultural competency
- UC Davis stepping away from primary care training
- Little regional workforce training coordination

Opportunities

- Coordinate training resources in the region
- HRSA pushing pharmaceutical, use school of pharmacy to assist CHCs with meds
- Ability to leverage training resources at low cost
- Telemedicine presence is strong for leveraging skilled practitioners

Threats

- Significant primary care and specialty physician care shortage
- Need to increase workforce by 2014
- No residency program at the CHCs
- Potential challenge to future nursing capacity
- Lack of significant workforce alternatives (i.e., nurse practitioners, physician assistants)

PRIMARY CARE SAFETY NET & SPECIALTY CARE

[Defined as: (1) primary care physicians and providers (NPs and Pas) in sufficient capacity to meet or exceed safety net demand, (2) strategies for specialty carefully leveraged through best and promising practices (3) access to both categories in a timely manner is achieved]

Strengths

- CHCs have the ability to employ primary care providers
- Small but significant number of private practitioners willing to see safety-net patients
- Some CHCs have deployed best practices to obtain limited specialty care access
- Many national models for achieving "leveraged" specialty care coverage

Weakness

- Behavioral health is also a challenge particularly for hospital care. Need to improve efficiency of care coordination between systems
- Low number of specialists in the region. Reimbursement is low or nonexistent for their services
- Gap between optimal and actual visit, need to do process improvement region wide
- Care plans for defining appropriate specialty care services and screening for those services are not universally applied by CHCs throughout the region
- GMC definition of network and geographical assignments of patients has the impact of restricting access
- GMC has a "published" network of specialty-care physicians
- The region is not prepared for the concept of "medical home"

Opportunities
- Possibility of virtual "homes", creative thinking, and telehealth
- Include health care prevention
- Telehealth can address some specialty care access

Threats
- Limited actual or practical coverage
- Much competition from health groups and health systems for the retention of primary care practitioners
- Productivity from a regional sense in terms of encounters per provider is lower than the statewide average

CARE COORDINATON
[Defined as: (1) interface between care givers (i.e., CHCs, hospitals, etc.) is optimized, (2) strategies for case management and chronic disease is fully embraced between these entities and (3) metrics in place to measure outcomes and to adjust performance]

Strengths

- Hospitals and CHC "T^3" program
- Grant funding is available and has been utilized to a certain extent for this issue in the region

Weakness

- Does not exist to any significant degree
- Much in the way of episodic care and thus not the desired medical home model
- Extensive overuse of ED resources by those in the safety net that do not need to use that service and when they do receive episodic care

Opportunities

- Community Based Care Transition Program – CMS, prevent readmits w/in 30-days.
- Accountable Care Organizations
- Reduce unnecessary ED visits through education, promotores and partnering with faith based/community organizations

Threats

- Destined to a high-cost, less-than-ideal outcomes for health care
- Not properly using all the extensive capabilities that need coordination in the region

IT/COMMUNICATION INTEGRATION
[Defined as: (1) IT capability designed to inform and coordinate care amongst all regional care givers and other key providers, (2) IT systems that can access best and promising practices (i.e., CHCs, Stanford and Kaiser care management pathways, etc.) and (3) operational care coordination to assure the best care and case coordination practices are optimized]

Strengths

- All hospitals and most CHCs have made a substantial commitment to IT/EHR
- Federal and local support likely available
- Healthy Living Map
- Using telehealth in El Dorado County for complex chronic diseases

Weakness

- IT systems that are in place are unique for small community based orgs
- No real regional collaboration for interactivity/interoperability not achieved
- In real terms: "our EMRs cannot talk to each other"
- Big telehealth program (UCD) in region and it is underutilized locally
- Telehealth only works if specialists participate

Opportunities

- Included this in the recent community CMS Innovations grant
- Excellent IT development resource (CalHIPSO & Redwood Empire, etc.)
- Cloud technology
- Expand provider directory on healthy living map to all four counties
- Web or mobile technology

Threats

- Without full interoperability will not achieve and the "vision" for EMRs will not be achievable identified
- Like care will continue to be fragmented, unnecessarily repetitive and duplicative and the "medical home" model will not be fully achieved

BUILDING CAPACITY
[Defined as: sufficient physical, workforce and financial resources to meet all the needs of the safety net into the future particularly with regard to ACA]

Strengths

- Network of CHCs with nearly half that are FQHCs or look-alikes
- Engaged stakeholder group
- Hospitals that are supportive and are key funding sources to date
- Significant building and capital expansion plans in development for the CHC
- Many CHCs have additional physical capacity

Weakness

- There is a shortage of specialty care physicians
- The data shows capacity will be full 2014
- Sources of care are not always coordinated as to the selected sites for CHCs
- Competition between CHCs
- Silo mentality

Opportunities
- Identify building space/facilities to expand operations
- Funding for remodeling and renovations for building space/facilities
- Coordination with community clinics initiative
- ACA capacity grants

Threats

- Funding and expertise to plan expansion missing
- Silo mentality, no coordination in planning
- Not hitting the targeted need would be a critical failure of the region

LEADERSHIP
[Defined as: key organization(s) or person(s) that will facilitate goal setting, measures of success, recognition and adoption of best practices and funding sources that will bring mentoring and technical support to the region to assure the goals of the planned strategic plan and beyond are met and exceeded for the primary care safety net.]

Strengths

- Network of CHC consortiums in place
- Leadership shown by the Foundations that have underwritten this initiative
- Hospitals that are supportive
- Engaged stakeholder group
- Broad endorsement by most stakeholders during this project that this level of leadership is needed

Weakness

- Leadership as defined does not currently exist
- No current entity has been identified as fulfilling this role
- Current silo mentality makes this goal a challenge
- Many missed opportunities (i.e., funding, care coordination, IT, best practice recognition and adoption, etc.)
- Some funding sources "sprinkle" their funding without benefit of a community-based consensus of priorities

Opportunities

- No existing structure that would distract from a "zero-base" start to this topic
- Tremendous potential yield to meet all goals with an effective leadership structure
- Significant acceleration of capacity building goals could be achieved with such leadership

Threats

- Perceived risk of proprietary methods and data being exposed
- Competitive nature of some provider entities
- Silo mentality, no coordination within key areas (i.e., planning, sharing practices, shared risk, pilot studies, etc.)
- Without an effective leadership structure the goals of this study will not be achieved
- The current system's fragmentation is destined to continue