SECTION 1:   **INTERNAL & CURRENT STATE**

Strengths and weaknesses should address your community, your systems of care and your Network in its current state (not as you wish it to be). Strengths and weaknesses are relative comparisons to other, similar communities, systems and Networks.

SWOT Domain	Population Health*	Systems of Care in Your Service Area	Network's Organizational Capacity
Strengths	What are the relative strengths of population health in our communities? 1. Age-adjusted morality rates for chronic lung disease lower in rural areas vs urban areas (39.5 vs 44.3) 2. Ever told they had depression in lower rural areas vs urban areas (15.8% vs 18.0%) 3. Food insecurity in the past year was lower in rural areas vs urban areas *16.5% vs 19.4%)	What are the relative strengths of systems of care in the area serviced by our Network? 1. There are several clinics that are members of an ACO (e.g. York, Crete, Falls City, David City, Seward, Geneva, West Point, and Fairbury) 2. Some other clinics are recognized as a Patient-Centered Medical Home (e.g. Crete) 3. Two clinics (Falls City and Wahoo) are operating a CMS funded Chronic Disease Management Program. 4. All of the local health departments are involved in some kind of care coordination activities with their primary care clinics (e.g. diabetes prevention	What are the relative strengths of our Network? 1. The network consists of a diverse group of stakeholders (e.g., local health departments, critical access hospitals, physician clinics, an FQHC, academic medical center, and a community action agency). 2. The network has excellent leadership and a vision for care coordination. 3. Several members of the network have worked together and collaborated for several years. 4. The communication between network staff, leadership, and members has been very good.

		programs, worksite wellness programs, community health workers, and cancer screening and awareness programs. 5. The service area includes in FQHC and one satellite clinic. 6. Most of the hospitals in the service area have above average financial margins. 7. Several local health departments are working with hospitals in their district to prepare the Community Health Needs Assessment (CHNA) and Implementation Plan.	
Weaknesses	What are the relative weaknesses of population health in our communities? 1. Age-adjusted mortality rates for heart disease higher in rural vs urban areas (168.5 vs 150.2) 2. Age-adjusted unintentional injury overall rates higher in rural areas vs. urban areas (48.9 vs 29.9) 3. Age-adjusted rates for motor vehicle crashes higher in rural areas vs urban areas (24.0 vs 8.7) 4. Current smokeless tobacco use in rural areas higher than urban areas (8.4% vs 3.8%)	What are the relative weaknesses of systems of care in the area serviced by our Network? 1. Several communities are classified as state or federal health professional shortage areas and have a shortage of physicians and other health professionals (e.g., dentists and mental health professionals). 2. The health care system is often fragmented and operates in silos, making coordination difficult. 3. In a few communities, there is not a close working relationship between physician clinics and the hospital.	What are the relative weaknesses of our Network? 1. The relatively large geographic area serves 21 counties and many communities which range from less than 500 people to over 20,000 people. 2. At times, it has been difficult to reach a consensus on all issues because of the variation in needs and the readiness of the communities to undertake care coordination activities. 3. The capacity and ability of the organizational members to commit financial resources also varies across the service area.

	5. Up-to-date on colon cancer screening lower in rural areas vs urban areas (56.1% vs 67.0%) 6. Obese (BMI=30+) higher in rural areas vs urban areas (31.6% vs 27.5%) 7. Always wear a seatbelt when driving or riding in a car lower in rural areas vs urban areas (55.3% vs 80.0%)	4. There seems to be a fairly wide variability in care coordination activities across the service area. 5. There is some variability in the training and the skills and competencies of community health workers. 6. Once the CHNA is completed, many hospitals are relying on the local health department to implement the intervention strategies and provide little or no funding.	

What conclusions can we draw from these responses that should inform our strategic planning efforts?

*The data were averaged using the years 2011-2014.

Source: Division of Public Health, Health Status Assessment: Nebraska 2016, September, 2016

RHND Planning Grant: SWOT Analysis

A Sense Making Tool for Development of a Network Strategic Plan

SECTION 2:   **EXTERNAL & POTENTIAL**

Opportunities and Threats should address those factors and conditions external to your community, your systems of care, and your Network that have the most potential to influence your future efforts. When considering factors your group should judge both the potential to materialize (e.g., what is the likelihood this will happen?) and the potential impact (e.g., will this cause a meaningful change?).

SWOT Domain	Population Health	Systems of Care in Your Service Area	Network's Organizational Capacity
Opportunities	What external factors are most likely to favorably impact population health in our communities? 1. State and national studies have highlighted and heightened awareness of the disparities in mortality rates between urban and rural areas. 2. There are new funding opportunities to address the opioid crisis. 3. The ability to analyze EHR data provides enhances the ability to identify health needs. 4. There is a better understanding of how to use collective impact techniques to address complex health issues.	What external factors are most likely to favorably impact systems of care in the area serviced by our Network? 1. The new models of care provide strong incentives to move from volume to value. 2. New technological advances such as telehealth and electronic patient monitoring will help to offset shortages of health professionals. 3. New types of health workers such as community health workers and community paramedics have the potential to improve access to care and health outcomes.	What external factors are most likely to favorably impact our Network? 1. The potential to use new modes of communication (e.g., teleconferencing and social media) provides more input and feedback from more people. 2. New technology provides opportunities to analyze data more rapidly. 3. The evidence-based policies and practices from outside sources (e.g., the Community Guide) are used by network partners.

	5. The ability of local health departments to develop flexible intervention strategies the address major issues (e.g., opioid crisis).	4. The growth of the Nebraska health information exchange (NEHII) has the potential to provide near real time health information to networks of care. 5. The provision in the Medicaid managed care contracts to promote care coordination and patient-centered medical homes should improve care coordination opportunities. 6. In the past, it has been difficult to close the loop on care coordination for high risk patients, but this project provides an opportunity to reduce these gaps (e.g., a larger number of and expanded use of Community Health Workers). 7. The use of new technology (e.g., electric health record, electronic patient monitoring, etc.) provide great opportunities to track and better assure that high risk patients are receiving the care that they need.	
Threats	What external factors are most likely to have a negative impact on population health in our communities? 1. The lack of Medicaid expansion and the potential repeal of the Affordable Care Act create possible barriers to access to care. 2. A failure of health care providers to understand the major factors (e.g., the	What external factors are most likely to have a negative impact on systems of care in the area serviced by our Network? 1. A slowdown may occur in the implementation of MACRA and other value-based reimbursement systems.	What external factors are most likely to have a negative impact on our Network? 1. Funding cuts reduce the number of members and their commitment to care coordination. 2. Some nonprofit hospital network members may not be willing to allocate community benefit funds to the category of community health initiatives.

	social determinants of health, behavioral risk factors, environmental hazards, etc.) that influence health outcomes. 3. An inability of health care providers to distinguish between population health and population health management. 4. The potential funding cuts at the state and federal level could reduce the capacity of the state and local health departments. 5. The downturn in the agricultural economy will have a negative effect on the Nebraska economy and unemployment rates. 6. Although it is not as severe as some other states, the opioid crisis is expanding. 7. The Nebraska Legislature failed to pass the tobacco tax bill which would have provided additional funding for local health departments.	2. New funding is needed to test new care coordination models of care and train community health workers. 3. The inability to replace aging physicians, dentists, and other health professionals is a major problem. 4. The failure of a few large hospitals to join the Nebraska health information exchange will limit the exchange of health information. 5. The potential closure of some small hospitals is a distinct possibility. 6. The presence of urgent care clinics in small communities may interrupt the continuity of care between patients who are seen at both the urgent care clinic and the primary care clinic. 7. With no or limited health insurance coverage, some people are turning to the internet and social media (e.g., Facebook) to get their information about appropriate health care.	

Although the network has some weaknesses such as significant health problems, some areas without an adequate supply of health professionals, a fragmented health care system, and wide variation in care coordination activities, and the large geographic area, there are many strengths and opportunities to build effective care coordination models. However, our network meetings and key informant interviews revealed a strong commitment from both health care providers and local health departments to develop a cohesive care coordination system across the network. Some of the critical strengths to build care coordination systems include: (1) several physician clinics are already a patient-centered medical home and/or a member of an ACO so they have an incentive to work with local health departments to improve population health outcomes, (2) all of the

local health departments in the network are already working on care coordination activities with some physician clinics (e.g., the National Diabetes Prevention Program, work site wellness programs, cancer screening awareness programs, and the use of community health workers), (3) the adoption of new technology such as telehealth, electronic patient monitoring, and electronic health records, and (4) the ability to analyze local data and implement evidence-based intervention strategies that best target patient and population health needs.