Rural Health SWOT Analysis Results

Survey by Tim Size at RWHC with eleven "rural health expert respondents" as of 12/3/03

Respondents were asked to reflect on the **S**trengths and **W**eaknesses of providers in their community and the **O**pportunities and **T**hreats faced by these providers.

The "focus organization" for the SWOT analysis was a "virtual organization" made up of the local health care "system"—the hospital, physicians, long-term care providers, public health, etc. in the community even though they are likely part of multiple corporations.

The context requested was that of the local system's ability to meet the need of the community for local access, high quality care and reasonable costs.

For each part of the SWOT, in bold there is a summary statement along with those bullets which seem to be part of an overall theme (both very subjective attempts at synthesis by the surveyor).

Strengths: Local Knowledge & Creative Problem Solving

- **Rural people know rural issues and are creative in solving their problems i.e. regional collaboration, cross training of staff etc**
- **Committed primary care physicians**
- **Employees dedicated to their community's needs**
- **Strong commitment by hospital board to rural health**
- **Small-scale providers with greater ability to adapt/respond**
- Quality of life
- We have most of the pieces in place and most of these providers (mental health, social services, etc) are very willing to work together toward common goals. We have recently organized a quarterly meeting of the leadership of all of these entities to make sure we aren't working at cross-purposes or duplicating efforts
- Nine doctors provide OB services, two of which are OB/GYN's
- Three nursing homes and four assisted living facilities limits outmigration
- Strong component of specialists (18 different disciplines) from Madison and surrounding area
- Good transportation
- Hospital has strong affiliation with tertiary care facility
- Strong and many groups of EMT's
- Strong school systems
- Committed workforce; willing to sacrifice higher compensation for opportunity to serve local community and have direct contact with patients
- Leeway to focus on areas of strength, niche services, etc
- Ability to exert *some* control over one's destiny (less influenced by regional trends/competition)
- Commitment to providing quality care
- Employees knowledgeable regarding quality improvement strategies

- Smaller staff having to reach consensus expedites implementation of improvement strategies
- Collaborative relationships among providers
- Accountability to the community accountability and access of board and admin.

Weaknesses: <u>Fighting Alligators Rather Than Draining The Swamp</u>

- **We CEOs have a tendency to view the world from the perspective of our offices and the immediate challenges of staffing, quality, medical staff, finances etc. vs. the community as a whole and all of the things that impact health.**
- **Lack of capital/reserves**
- **Transportation barriers: getting to appointments and transfers to other facilities**
- **Need to modernize our information systems technologies**
- **Lack of team or collaborative approach among community providers.**
- In some situations, limited/no local access to primary and specialty care removes the individual from the local system
- Mental health is one of the weak links: limited resources to pay for this large, unmet need
- Difficulty in changing life-styles/health habits that lead to obesity, diabetes, etc
- <u>Information systems</u> Rural hospitals and their subsidiary operations need a massive capital infusion, like that of the Hill-Burton program decades ago. This would address patient safety (Computerized Physician Order Entry or CPOE, for example) all the way to information being available on a real time basis across a large geographic area and among multiple agencies
- Low numbers of physician specialists live in our county
- Physician admitting/active staff is two small for great peer review
- Some experienced managers are hard to find
- Some people, professional and staff, are “plain stubborn”
- Lack of psychiatrist
- Infighting/lack of trust between providers; turf issues
- Vague understanding of what collaboration/cooperation really means
- Business/marketing plans too limited - rarely willing to explore new ventures/opportunities
- Overwhelmed by the "business" demands of health care
- The current system is fragmented so some services may be duplicated or not be provided
- Competing systems or lack of local resources often removes patient from local system
- Lack of implementation and maintained of quality strategies resulting from low staffing ratios and automated data collection processes, small sample size difficult to interpret data\
- Workforce shortages and inability to keep nurses in the profession
- Information technology that needs to be supported by multiple health systems
- Negotiating strength, mental health resources, capital resources

Opportunities: <u>Organizational &Technological Innovation</u>

- **The leadership role of rural communities coming together to address population health issues**. (The trick will be in transitioning to a system that will reward success with this activity)
- **There is an opportunity to better organize, in a more formal way, how we coordinate the services that the various organizations provide in our county.** Through better coordination maybe we could start to get a handle on costs associated with health.
- **Improve safety through standard info systems or products that allow for seamless / paperless records. Make use of telemedicine technology for areas lacking certain medical specialties.**
- **Technology evens the playing field to some degree; particularly in the areas of training/continuing education and recruitment**
- Collaborative/cooperative efforts to assess and address local needs could lead to a more comprehensive approach by system players
- Elderly apartments
- Dialysis
- Increased market share
- Mobile PET Scanner
- The building of Centers of Excellence
- Increased outpatient services
- Need to be paid "cost" through R E A C H legislation for more than 25 beds
- Legislation designed to even the playing field
- Increasing awareness of rural America
- RWHC!!!
- Revised measures/indicators are becoming more useful to rural providers, data has improved thus easier to use for baseline and to verify improvements after improvement implementation , case study approach such as JCAHO's process to follow a patient through the hospital as part of a on-site survey, acceptance of benchmark data as valid comparison for quality improvement
- Collaborative health improvement efforts addressing cardiovascular risk factors in youth, ie obesity & physical inactivity

Threats: <u>Rising Costs & Falling Revenue</u>

- **Increasing health care costs and fall off in employer-sponsored health insurance** shows up first in smaller groups which will disproportionately impact rural providers who by and large already have a disproportionate number of lower paying publicly insured.
- **Reduced funding** (or not keeping up with inflation) is certainly a threat at this time given governmental budgets and rapidly increasing costs of services
- **Workforce** issues are going to be particularly unkind to rural communities in the area of dentistry and pharmacy. Dentists because we're not training enough and pharmacists because we are extending educational requirements and reducing the likelihood of rural practice.
- **Misinformation (or lack of credible data) that rural healthcare is not as safe as urban.**

- **Competitive models of healthcare delivery that force rural patients to leave the local facility** to receive care in the more urban setting; same issues that the urbans face with specialty hospitals.
- **Integrated health systems' fights spilling over into rural areas**
- Lack of technology viewed as inability to achieve high quality levels
- Growing numbers of un/underinsured
- People not taking responsibility for their health status – looking for external, quick fixes
- Potential scale backs in public insurance could aggravate things further and privatizing some portion of Medicare is not going to create a kinder gentler environment for rural providers (In the Reinhardt/Scully interview in Health Affairs, Scully seemed to think that by allowing only bids from insurers for large multi-state regions the averaging out at the insurer level would solve the geographic equity problem at the provider level)
- To much government intervention
- Insurance company's limiting access to care
- Too limited reimbursement for home health, nursing homes, dialysis, hospice, etc.
- Compliance with numerous/redundant regulations
- Obvious stuff: lower reimbursement, older/sicker populations, urbans/suburban competition, etc
- Local economy typically dependent on 1-3 major employers - struggling to provide health benefits
- Lower volumes
- Spiraling health care costs (particularly pharmaceuticals)
- Patients demanding choice/quick fixes, but not as willing to be accountable for their own health/wellness
- Information overload
- The increase in charity care, primarily it appears to be due to the increase in foreign labor, either associated with the tourism business or with agriculture
- The lack of specialists and our ability to support their life style in terms of on call time
- Change in reimbursement for long term care, it is getting more and more difficult to break-even in the long term care business
- Some hospitals with long term care are saying if it was not part of their mission they would jettison that part of their business
- Future employees: Young people are not wanting to stay or return to their home communities, they want to flee to the more urban areas that can give them a richer life style (in their eyes)
- If it doesn't happen locally, it will happen regionally (needs will be met outside of the local area)
- Lack of technology viewed as inability to achieve high quality levels
- Statements that measures are not applicable to rural health may imply poor quality can't be improved
- Small sample size limits proof of improvement may be difficult for consumers to interpret—big will look better because data is available
- Increasing # of uninsured/underinsured and declining reimbursements from state, federal and private payers