

# **Analysis of Strengths, Weaknesses, Opportunities and Strengths**

prepared for the

**Maryland Rural Health Planning Consortium**

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## *MRHPC SWOT - Executive Summary*

This report is based upon a review of written responses to a SWOT worksheet as well as follow-up interviews with representatives from all six member organizations of the Maryland Rural Health Planning Consortium. In the categories of Strengths and Weaknesses, feedback was organized according to whether it was related to the strengths/weakness of the Rural Health Plan itself or the organizations comprising the Rural Health Planning Consortium. Opportunities and Threats were organized at federal, state, and local levels.

### Strengths

Nearly all participants had positive regard for the Plan itself. The plan was praised for its foundation of in real-world issues, and its utility as a communication tool for the advocacy efforts of member organizations such as MRHA and MHA. As a Consortium, MRHPC member organizations possess key strengths pertinent to the implementation of the plan, including communication and advocacy skills, practical experience with some of the more innovative aspects of the plan (e.g., telehealth, care coordination), and a strong history of collaboration and social capital with other local healthcare organizations.

### Weaknesses

The lack of concrete milestones to assess the progress in implementing the recommendations from the RHP was one of the most prominent weaknesses identified by MRHPC members. More specificity is needed in order to chart progress and determine next steps for implementing each recommendation. In terms of the consortium, a significant weaknesses was that its membership did not include a prominent local health care organization (e.g., Mid-Shore Behavioral Health). Furthermore, some MRHPC organizations do not have staff positions dedicated to necessary tasks such as grant-writing and fundraising.

### Opportunities

The most frequently cited opportunity at the local level was the participation in Local Health Improvement Coalitions. At the state level, the legislative session was identified as the most promising occasion to further the implementation of the plan. At the federal level, the availability of grant money was identified as an opportunity to fund implementation of some RHP recommendations. Multiple MRHPC members pointed out that Telehealth Expansion and Reimbursement has risen to prominence as a result of the COVID-19 pandemic. These members suggested capitalizing on the momentum of these changes to secure the long-term implementation of telehealth expansion.

### Threats

The most frequently cited threat at the local level was the competition for limited resources. Furthermore, many local health organizations with which the MRHPC could partner are small non-profits with limited organizational capacity to seek larger state or federal grants. At the state level, several members cited the lack of legislative buy-in as a contributing factor to the local shortage of financial and human capital. At the federal level, the unpredictable availability of funding opportunities was labeled as a threat. Furthermore, re-prioritization of resources due to the COVID-19 pandemic affects all levels of public health.

## **S.W.O.T. REPORT**

### **Data Collection Notes**

The data presented in this report is a synthesis of feedback from both written and verbal feedback supplied to the external evaluator. A total of six organizations participated in the SWOT analysis, providing written and/or verbal feedback to the evaluator. Written feedback was analyzed based on participants' responses to SWOT worksheets, and verbal feedback was gathered via virtual interviews. Quotes from interviews and worksheets are incorporated into the summary to help contextualize the individual points of feedback. Quotes are de-identified in the Weaknesses and Threats sections.

### **Strengths**

Nearly all participants had positive regard for the Plan itself. The plan was praised for its foundation of in real-world issues and its utility as a communication tool. As a communication tool, it has the potential to unify messaging related to rural health in Maryland. Unity in messaging facilitates the advocacy efforts of member organizations such as MRHA and MHA. As a Consortium, MRHPC member organizations possess key strengths pertinent to the implementation of the plan, including communication and advocacy skills, practical experience with some of the more innovative aspects of the plan (e.g., telehealth, care coordination), and a strong history of collaboration and social capital with other local healthcare organizations. A synthesis of MRHPC members' perceptions of strengths follows:

#### **Plan-based**

- Plan is multi-level, including policy, systems, and individual recommendations
- Plan identifies real needs in the targeted communities (e.g., lack of specialists, need for collaboration, transportation / technology infrastructure, etc.)
  - Plan is based on focus group data that gives real world feedback on what is working / not working
- The plan is a communication tool that can be used when conducting advocacy
  - *"Our reach grew as a result of publishing the Rural Health Plan"* (MHRA)

#### **Consortium-based**

- SRH, CCHS, and Horowitz have direct experience (and in some cases, outcome data) providing services that are related to the Systems- and Individual-level RHP Recommendations:
  - Telemedicine (\*CCHS reports having patient outcome data related to diabetes)
  - Mobile Health & Crisis Services
  - School-based Health Centers
  - Care Coordination (\*CCHS reports having patient outcome data related to diabetes)
  - Community Trust Building
  - Stigma Reduction
  - Social Media and Marketing Services
  - Health Insurance Literacy Education
  - Healthy Lifestyle Education
- MHRA and MHA have experience with advocacy on policy-level recommendations

- Strength of communication skills of member agencies (e.g., MHRA; MHA; Horowitz)
- Ability to collaborate within and outside of MRHPC
- Community has high level of trust in member agencies
  - *“A key strength for our organization was the support we received from local health departments and other community-based organizations”(CCHS)*
- Designation of some RHPC members as FQHCs grants unique access to funding

## Weaknesses

The lack of concrete milestones to assess the progress in implementing the recommendations from the RHP was one of the most prominent weaknesses identified by MRHPC members. More specificity is needed in order to chart progress and determine next steps for implementing each recommendation. Furthermore, MRHPC members pointed out that some recommendations included in the Plan (e.g., Telehealth Expansion) do not acknowledge the infrastructure weaknesses inherent to rural areas in Maryland. In terms of the consortium, a significant weaknesses was that its membership did not include a prominent local health care organization (e.g., Mid-Shore Behavioral Health). Furthermore, some MRHPC organizations do not have staff positions dedicated to necessary tasks such as grant-writing and fundraising. A synthesis of MRHPC members’ perceptions of weaknesses follows:

### Plan-based

- Plan lacks specificity in how to evaluate progress- need milestones or definition of the next phase of goals for big issues
- Plan does not address the changes that have occurred as a result of COVID
  - Telehealth recommendation *“should be updated with lessons learned from COVID so the biggest pain points can be worked out.”*
- There is not an acknowledgement or process developed to raise the funds or address infrastructure needs that precede the ability to implement certain recommendations
  - Especially **technological** barriers to healthcare access
  - *“Trying to build out a more robust technology infrastructure could just have so many benefits to a rural health strategy”*
  - *“The recommendations to address [rural health needs] I think are a little vague, because you would have to attach resources to them...there is no power of a budget here”*
- Plan may need reprioritization for areas outside of the Mid-Shore due to differences in what rural looks like across Maryland.
- The plan does not specify how to oversee its implementation
  - *“Without having an organization identified as the lead to implement the Rural Health Plan, the work will have to be driven through collaboration. Member organizations have demonstrated that in their respective areas, but I believe there is challenges to take that to scale for statewide implementation.”*

### Consortium-based

- People who are running LHIC’s may need to think more strategically about expanding partnerships
  - What other sectors or organizations need to be at the table, and how do we get them here?

- SWOT is a misplaced priority for the MRHPC.
  - *“When we look at the Rural Health Plan, now that we see the recommendations- What we could do is say, ‘OK, let's all just agree these are good recommendations.’ What we need to get to next is probably some prioritization and not this analysis of the strengths and weaknesses. But prioritization based on what we know our organizations can do or networks that are already in place”*
- Human resources related to certain vital tasks such as fundraising are limited
  - *“The grants seems to be something that is an opportunity. But when you move in that direction, it's never anybody's real job. So it kind of falls by the wayside.”*
- The consortium has not done enough to continue promoting the existence of the RHP
  - *“We have to find a way that these recommendations see the light of day more often than just once or twice a year.”*

## Opportunities

Partnership development was generally the theme of local opportunities. The most frequently cited opportunity at the local level was participation in Local Health Improvement Coalitions. These coalitions provide the chance for the relevant players in the healthcare landscape to share information and unify their public health efforts.

At the state level, MRHPC members saw opportunities to gain access to funding for public health initiatives. At this level, the legislative session was identified as the most promising occasion to further the implementation of the plan. Furthermore, multiple MRHPC members discussed the alignment of the RHP with efforts related to Maryland’s Total Cost of Care Model as an opportunity to see the Plan’s recommendations put into action.

At the federal level, the availability of grant money was identified as an opportunity to fund implementation of some RHP recommendations. Multiple MRHPC members pointed out that Telehealth Expansion and Reimbursement has risen to prominence as a result of the COVID-19 pandemic. These members suggested capitalizing on the momentum of these changes to secure the long-term implementation of telehealth expansion. A synthesis of MRHPC members’ perceptions of opportunities at the local, state, and federal levels of the healthcare landscape follows:

- **LOCAL:**
  - Uncontacted partners
    - Midshore Behavioral Health
    - MASBHC
    - MCHRC
    - MSDE
    - Core Service Agencies for crisis services
    - Maryland Association of MCO’s
    - Care Transformation Organizaitons
  - Mid-Shore Local Health Improvement Coalition
    - *“Every dollar has to be maximized... So, if you've got a group already sort of spending the time and the resources to [address a specific public health priority], take full advantage of that and direct your attention over here*

*where maybe there's fewer people... This is why I think for me, the local health improvement coalitions have become such an important part of our strategy” (Horowitz)*

- Educational institutions
  - Colleges/Universities may provide a supply of skilled student workers to assist with things like public health communication efforts
  - Presence of educational leaders on LHICs
    - *“And in that case, I think it's just going to the top. It's going to the superintendent or going to the school board members or going to whoever heads up the library system for the county. And I think it's just inviting them to come be part of the coalition.” (Horowitz)*
- New partnerships that occurred as a result of COVID should be sustained, given limited local resources (e.g., collaborate with primary care and hospitals to help move care coordination forward)
  - *“We don't have to do everything, and we're not going to be the best at everything if we do it all. So, what organizations are doing some of those things really well? And we'll probably refer patients...” (CCHS)*
- Collaborate with Health Departments on Loan Repayment Plans – to address the shortage of providers
- **STATE:**
  - *“To move the needle... I would recommend a **state rural health consortium** that MRHA could lead that would be supported by the state to drive benchmark goals, provide data to inform plan efforts and determine outcomes.” (MHA)*
  - Align elements of RHP (such as care coordination, behavioral health, and telehealth expansion) with Total Cost of Care efforts at state level
  - Legislative session identified as opportunity to implement policy changes
    - Telehealth rules already relaxed due to COVID – this is an opportunity to advocate for *“long term solutions for funding this important component of health care. Focus needs to include both video and audio only visits to address the lack of broadband access” (CCHS)*
    - Advocacy at federal and state levels to maintain the telehealth expansion and reimbursement that were enacted during pandemic (MHA)
  - The Community Health Resource Commission will oversee a new Health Equity Community Program leveraging over \$45 million dollars starting in FY22-25 to address health disparities. This is an excellent opportunity for MRHA along with the partners to unify a request or leverage those dollars to support the RHP. (MHA)
- **FEDERAL:**
  - Grants from federal orgs like SAMHSA focusing on opioid crisis
  - **National Health Service Corps** – federal program that offers loan repayment

### Threats

The most frequently cited threat at the local level was the competition for limited resources. Furthermore, many local health organizations with which the MRHPC could partner are small non-profits with limited organizational capacity to seek larger state or federal grants. At the state

level, several members cited the lack of legislative buy-in as a contributing factor to the local shortage of financial and human capital. At the federal level, the unpredictable availability of funding opportunities was labeled as a threat. Furthermore, re-prioritization of resources due to the COVID-19 pandemic affects all levels of public health. As such, COVID-19 was characterized as both a threat and an opportunity to the implementation of the plan. A synthesis of MRHPC members' perceptions of threats at the local, state, and federal levels of the healthcare landscape follows:

- **LOCAL:**

- Competition for resources among local non-profits
  - *“When we do look at going after grants, we find out... we have other people right in our backyard going after the same grant money... Maybe something that hasn't necessarily been addressed yet is...you all are a consortium, but yet there are still other public and private entities that are that share your mission and that may be competing with you on some of the same stuff.”*
- Ensuring that the RHP itself is not a competing set of directives for other plans
  - *“[Many healthcare entities] in Maryland all have community health implementation plans as part of their health needs assessment...So you have Maryland, every hospital... you've got the state, you've got Maryland Rural Health. You have Mid-Shore Behavioral Health.”*
- Culture of certain communities may be driven by the “been here” vs. the “come here” people – complacency / resistance to change
  - *“The ‘come heres’ .... They're more accustomed to X, Y, and Z, and they're more demanding. The locals, the ‘been heres’ are far more forgiving and accepting of what is... That's an attitude...”*
- First responders are not fully funded in all counties (may hinder collaboration)
- Technological / internet access for citizens

- **STATE:**

- Lack of buy in from appropriate state offices
  - Infrastructure funding / funding for transportation is lacking
  - Misperception of rural area as a “land bridge” on the way to the beach
- Sustainability of funding streams
- Climate change will further impact healthcare access (e.g., islands in the Bay)

- **FEDERAL**

- Federal resources were directed toward COVID efforts/other public health initiatives in 2020-2021
- Federal funding opportunities may cater to public health needs of urban rather than rural areas
- Medicare and Medicaid reimbursement policies interacting with state policy
- Administration changes impact the leadership and contacts at many levels which makes continuity of advocacy work challenging

## TOOLS

### SWOT Analysis Grid

The purpose of this grid is to aid the MRHPC in prioritizing activities related to the opportunities and threats identified in the SWOT Analysis. Brief summaries from the SWOT are included to facilitate action planning utilizing the grid. Definitions of each intersection are as follows:

**INVEST:** Clear matches of strengths and opportunities for implementing Plan elements

**DEFEND:** Areas of threat matched by areas of strength indicate a need to mobilize resources either as a consortium or with others

**DECIDE:** Areas of opportunity matched by areas of weakness require a judgment call: invest or divest; collaborate

**DIVEST:** Areas of threat matched by areas of weakness indicate need for damage control

	<b>Opportunities</b> <i>Grants, legislative sessions, Expanding collaboration with uncontacted partners, LHICs, educational institutions, policy changes due to COVID</i>	<b>Threats</b> <i>Local competition for resources, existence of other local / regional health plans, lack of state legislative buy-in, complacency among citizens, policy / funding changes due to COVID</i>
<b>Strengths</b> <i>Plan Based Communication tool – opportunity for unified, consistent messaging Reflective of real world issues</i>  <i>Consortium Advocacy Collaboration Communication Reputation Experience with implementing specific recommendations – e.g., telehealth, health literacy, health communications</i>	<b>INVEST</b> <ul style="list-style-type: none"> <li>Plan provides for unified messaging (<b>plan strength</b>) + mid-shore LHIC revitalizing (<b>opportunity</b>) = <ul style="list-style-type: none"> <li>Utilize LHIC meetings to expand visibility of Plan</li> </ul> </li> <li>Telehealth policies relaxed due to COVID (<b>opportunity</b>) + MRHPC experience with telehealth expansion + MRHPC experience with advocacy = (<b>consortium strengths</b>) <ul style="list-style-type: none"> <li>Prioritize Telehealth Expansion advocacy efforts; include relevant outcome data from MRHPC members</li> </ul> </li> </ul>	<b>DEFEND</b> <ul style="list-style-type: none"> <li>Advocacy, Communication (<b>consortium strengths</b>) + lack of legislative buy-in (<b>threat</b>) = <ul style="list-style-type: none"> <li>MRHPC could organize “legislative day” / consortium member visits to 2022 session</li> </ul> </li> <li>Collaboration, Reputation (<b>consortium strengths</b>) + presence of other agencies’ health plans (<b>threat</b>) + competition for limited resources (<b>threat</b>) = <ul style="list-style-type: none"> <li>Share information on organizational priorities at LHIC meetings to reduce unnecessary duplication of Plan efforts</li> </ul> </li> </ul>



	<b>Opportunities</b> <i>Grants, legislative sessions, Expanding collaboration with uncontacted partners, LHICs, educational institutions, policy changes due to COVID</i>	<b>Threats</b> <i>Local competition for resources, existence of other local / regional health plans, lack of state legislative buy-in, complacency among citizens, policy / funding changes due to COVID</i>
<b>Weaknesses</b> <i>Plan Based</i> <i>Lacking specificity</i> <i>Lacking metrics for evaluation</i>  <i>Consortium</i> <i>Missing certain partners (MSBH)</i>  <i>Lack of publicity of the Plan</i>  <i>Limited capacity to seek funding given multiple priorities of member orgs</i>	<b>DECIDE</b> <ul style="list-style-type: none"> <li>Limited organization capacity for grant-seeking (<b>consortium weakness</b>) + many grants at state &amp; federal levels; expanded collaboration with uncontacted partners (<b>opportunities</b>) = <ul style="list-style-type: none"> <li>Choose grants that multiple orgs will be excited about to reduce the burden of completing the application</li> </ul> </li> </ul>	<b>DIVEST / Damage Control</b> <ul style="list-style-type: none"> <li>Limited capacity to seek funding (<b>weakness</b>) + local competition for resources (<b>threat</b>) = <ul style="list-style-type: none"> <li>Utilize the services of professional grant writers; put a larger or more well-resourced institution (e.g., a college / university) in charge of grant management</li> </ul> </li> </ul>

After utilizing the grid to generate a list of potential strategic actions, the rating tool below will facilitate prioritization of effort and resource allocation. Group discussion can be facilitated using these dimensions to analyze the ratio of impact to ease of doing. Generally speaking, actions with a favorable impact-to-ease ratio would be taken first.

**STRATEGIC ACTION:** \_\_\_\_\_

Likely Impact:	<b>Low</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>High</b>
Ease of Doing:	<b>Low</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>High</b>

*Example (based on group feedback): A “Mid Shore Healthcare Legislative Day” might get a 4 / 5 for likely impact, but also a 2 / 5 for ease. If there were other activities with a higher impact or similar impact with greater ease, these should be done first.*