Environmental Scan of Rural Health Equity-Focused, Multi-Sector SORH Collaboratives

Environmental Scan Project Overview

The National Organization for State Offices of Rural Health (NOSORH), in partnership from the Association of State and Territorial Health Officials (ASTHO) and support from CDC, performed an Environmental Scan of rural health equity-focused, multi-sector networks/collaboratives funded by the Federal Office of Rural Health Policy (FORPH) to identify potential alignment with CDC 2103 COVID-19 Disparities Grant efforts. NOSORH identified how rural networks have utilized federal funding to support rural networks and provide tactical recommendations on how CDC 2103 grantees can engage these existing partnerships to advance shared goals.

Methodology

The project consisted of a data analysis based upon data retrieved from the Health Resources & Services Administration (HRSA) Data Warehouse, key informant interviews with State Offices of Rural Health (SORHs), to create an Excel workbook with data provided by SORHs and HRSA.

- NOSORH retrieved baseline-level data from the HRSA Data Warehouse in December 2022, with the following selected parameters: *Program Areas, Program Name, Year, State, County,* and *Grantee Class*. NOSORH selected a seven-year period to allow for three years pre-pandemic, the initial year of the COVID pandemic, and three years following that initial pandemic year (FY 16-22).

- The following 18 grants were chosen from “All HRSA Program Areas” and “Rural Health” as network collaboration is listed as a requirement for application: *Rural Health Care Services Outreach Grant Program (D04), Rural Health Network Development Program (D06), Delta State Rural Development Network Grant Program (DELTA) (D60), Rural Health Care Coordination Network Program (D78), Rural Network Allied Health Training Program (G04), Rural Health Care Coordination Network Partnership (G07), Rural Communities Opioid Response (Planning) (G25), Rural Communities Opioid Response Program – Neonatal Abstinence Syndrome (G26), Rural Communities Opioid Response Program – Mental and Behavioral Health (G28), Rural Communities Opioid Response-Implementation (GA1), Rural Communities Opioid Response Program - MAT Expansion (GA3), Rural Health Opioid Program (H1U), Rural Communities Opioid Response Program-Psychostimulant Support (H7N), Rural Communities Opioid Response Program - Medication Assisted Treatment Access (HB1), Rural Health Network Development Planning Grant Program (P10), Rural Public Health Workforce Training Network Program (TR1), Rural Communities Opioid Response Program-Evaluation (U3C), and Rural Communities Opioid Response Technical Assistance (U6B)*.

The timeline of the project, beginning in fall 2022, allowed for the cleaning of the raw data from the HRSA data pull, followed by five months of virtual meetings with all 50 SORHs and additional data requests to HRSA for any additional information or analysis that they may have in relation to this project. Two HRSA Regions are contacted each month by NOSORH starting in December 2022 to schedule meetings from January to May. By June and July of 2023, NOSORH finalized the Environmental Scan and design for distribution to 2103 grantees and a final version for both internal planning purposes and current programming under the CDC 2103 project.

Following the cleaning of the data pull information and first five meetings with SORHs to discuss organizations for their state, NOSORH decided to expand the partnership list beyond those receiving federal funding. This allowed for representation of states not represented in the data pull (Rhode Island, Wyoming, New Jersey, and Pennsylvania) and states not involved in the selected grants in the data pull.

SORH Partnership EScan 2103 Data

After analysis of the data collected from the data pull and meetings with SORHs, NOSORH identified certain data points presented as potentially the most useful. To allow for faster sorting abilities, slowed in the initial data pull, organizations are split between HRSA Regions 1 through 5 and Regions 6 through 10. The SORH Partnership EScan 2103 has four sheets in the workbook: Organizations_Regions 1-5, Organizations_Regions 6-10, States, Additional Data.

Data in the Excel workbook is sorted from information provided during the individual SORH and NOSORH meetings, HRSA data pull, and data provided by SORH through emails or provided non-compete continuation (NCC) or Performance Improvement and Measurement System (PIMS) reports from their SORH grant. Data from SORH depended on each office's employee work bandwidth, so not all data columns were addressed or represented for each jurisdiction. Additionally, 11 states had not met with NOSORH at the time of this report. Due to these reasons, if a state did not note if they were familiar with an organization, the column was left blank. NOSORH determined the best course of action to include the organization in the workbook.

In the ‘Organization_Regions’ sheets, FY2019-FY2022 organizations were pulled from the full HRSA data pull and used in the SORH Partnership EScan. The HRSA Region of the organization, the HRSA grant they received and the year they were awarded were included in each example when possible. Notes from SORH on their familiarity or involvement with the organization, any existing relationship, or outcome notes are included on this sheet as well. Additionally, organizations provided by a SORH in response to the follow-up question “Are there any other organizations not listed that your SORH partners with for additional grants or programs“ or added from individual meetings, partnership focus(es) were included. Rounding out the information on the ‘Organization_Regions’ sheets, organizations’ contact email address and the grant funds awarded to the organization are included.

With further analysis of the SORH, some relationships with the HRSA data became apparent, NOSORH included an informational sheet with details of each SORH included within this EScan. On the ‘States’ sheet within the workbook, you will find each state, their office’s staff size, what entity is the SORH a part of (state government, non-profit, or university-based), number of Critical Access Hospitals (CAHs), number of Rural Health Clinics (RHCs), if they stated that they work with their state Rural Health Association or State Hospital Association, the SORH Region under FORHP, and if the state of the SORH has their own definition of rural or if another definition is used.

The final sheet of the workbook is “Additional Data”. Within this sheet, the responses primarily derive from conversations had with SORHs during the interview process. To ensure accurate responses and protect the identity of those who participated, the information identified under this sheet is not attributed to the state who provided the information. There are two columns on this sheet, they include: “Additional Information” and “Possible Reasons Given by SORHs that Organizations that they work with are not able to get a grant.” Additionally, NOSORH prompted states to answer the following information regarding the nature of their relationships with non-funded organizations: “If your SORH does not work with an organization listed in the spreadsheet, are you aware of their outcomes/initiatives?” Only three responses were provided: “no” and “no, because we stay out of their way,” to this question from SORH.

For simplification of the workbook, NOSORH excluded grant numbers, duplicate organizations, abstracts, congressional districts, addresses, grant contacts, and grantee classes.

Additional Outcomes

When looking at the SORH data and Organization data, unique similarities and differences generated patterns in SORH, themselves. For example, over half (26 of 39) of the SORHs with CAHs or RHCs work with their Rural Health Association or State Hospital Association, and often if they work with one, they work with both (13 of 26). Similarly, many SORH work with the same kinds of organizations as SORH in another state. Universities and local colleges, Medical Schools, Broadband organizations, libraries, other state departments and divisions, EMS coalitions, and hospital networks, were mentioned by many SORH or listed in the HRSA data pull. This highlights one of the SORH grant objectives and the sentiment shared by many SORHs. SORHs want to collaborate and network with as many partners as possible and provide resources to those looking to improve rural health.

Tracking similar organizations in each state can lead to new partnership opportunities in other states. In 2020 and 2021 when multiple webinars were presented to SORH in collaboration with rural libraries, it opened avenues for many SORH to create new partnerships and launch innovative programs. The SORH Partnership EScan 2103, with additional research, brings to light a new type of organization that could be useful to other SORHs.

A different aspect noticed during the SORH meetings was the ‘modesty’ of SORH staff. Many partnerships mentioned during conversations with SORHs could have been submitted when asked to name organizations they work with, yet when asked to share partners, SORH often said they didn’t have any partnerships to add. SORH only sometimes recognizes their work as a partnership or a network, this created some difficulties in adding additional partner organizations to the workbook.

Issues in Collecting Data

During the data-gathering process, a few difficulties emerged that could affect the project data or highlight something that should be addressed. One of these issues is the division of work at the state level limited SORHs’ familiarity with grants and organizations. While some SORH may work with Opioid efforts, a focus in many of the grants in the data pull, for other SORH, Opioid-focused grants and programs are housed in other bureaus, or even departments.

As mentioned previously, the SORH office itself can unwillingly be a roadblock to the information that was being collected. Consequently, small SORH Offices were often limited in the data that they could gather and share simply because of the workload compared to the staffing capabilities they experience. Comparing SORH with larger staffs and the number of organizations from the HRSA data pull that they are familiar with, NOSORH finds that often larger SORH are more cognizant of these grant awardees, and they often had more organizations and information to share with NOSORH.

Additionally, new SORH staff are often unaware of historical partnerships that might be seen in the HRSA data pull and so share that they are not familiar with an organization that the SORH may have previously done projects. New SORH staff are still getting settled into their roles and learning; they are unaware of all the partnerships and networks that the SORH is or could join. The exact number of new SORH staff is not available for this report because of ongoing turnover and the hiring process throughout the 50 SORH. During the SORH interview process, however, there were at minimum four new SORH Directors. Beyond the SORH directors, there is no additional insight into other staff positions in the SORH offices that have experienced turnover.

The formerly mentioned concerns of small or new SORH offices compound the difficulty in compiling and maintaining partnership and network lists. This is especially true if there was not a comprehensive list prior to fresh staff arriving. Accordingly, SORHs with a staff of five or fewer in 16 of the 39 SORHs interviewed were less likely than their larger staffed peers to be able to provide or confirm the number of partners they have or details regarding their partnership.

With no precise method of SORH to identify all stakeholders in their state who receive Federal funding, they could not address whether their partners fell in this category. As such, a list of current partners, both funded and non-funded, was provided by SORHs

during the 5-month interview period. Moreover, some SORH would mention that they knew an organization had received a grant because they provided grant writing assistance, but they were not aware of what grant(s) and if they were federal, state, or non-profit grants.

While many Rural Health grants require a Letter of Support from the SORH office, even when a letter of support is given, no follow-up is provided to the SORH on who received (or didn't receive) a grant. For many SORH, the list of grantees provided in their state from the HRSA data pull was a surprise; and one of the reasons many were not familiar with the organizations listed. Additionally, while the grants require a letter of support from the SORH, not all organizations that apply for a Rural Health grant reach out to their SORH, and currently, they are not denied for lack of a letter of support. The number of HRSA grants available and the various grant cycles make it difficult for many SORH to keep up with awardees and applicants.

Unforeseen Outcomes

As part of the interview and follow-up with SORH, NOSORH asked SORH for possible reasons that organizations that they work with were not able to get a grant. The question was posed to see if SORH are aware of issues with organizations getting grants, preventing them from being a part of the original intent of the environmental scan. This question provided strong responses from many SORH. Responses varied, but one repeated reason was the competitive nature the grant application process has taken. The sentiment is that professional grant writers are often needed to be awarded a grant. This is something the smaller, rural organizations cannot afford to do.

Many responses also involved the application period and the notifications from HRSA as both a hindrance and if addressed, could assist in applicants being awarded. There is currently no feedback for the applicants on why an application was denied funding, so there is no way to know what the deciding factors were and how to address the concerns identified by the reviewers to be approved for future funding.

Two states, Rhode Island and New Jersey, had no organizations with grants from the data pull. This was due to two main reasons. First, neither state has CAHs or RHCs in their jurisdictions. But even more noteworthy, no areas in their state fit the federal definitions of rural. The frustration with the many federal definitions of rural is not limited to the two eastern states.

When SORH were asked how many counties in their state were rural, nearly all asked, "Based on what definition." With over 80 definitions of rural available from Federal Government departments, the process can be confusing, and yet there can still be an inequity felt from state to state. States, such as Wyoming and Montana have many of their counties in the frontier classification. Conversely, Rhode Island and New Jersey don't have any frontier counties, but they do have areas in their state that they feel should classify as rural. However, using Federal definitions, they are not rural, which has led to many of these communities and the organizations working within them denied

from receiving rural specific resources. Due to numerous federal rural definitions, many of which are exclusive for communities within their jurisdictions, many state governments utilize their own rural definitions or health jurisdictions. Nineteen of the interviewed states mentioned a different rural definition, state process for looking at healthcare districts, or “rural development definition”.

Another unforeseen outcome from this research is finding the lack of accountability by grant applicants to contact SORHs and update them on activities. As mentioned, applicants, while told to contact the SORH, are not denied if they don’t contact them. Neither the applicant nor HRSA is required to contact the SORH if the grant is, or is not, awarded. Not only does that make tracking rural health grantees in their state difficult, but it also means many activities and projects that grantees perform go unnoticed and unsupported by the SORHs, inhibiting an opportunity for collaboration and partnership that could benefit the rural communities they both serve.

Continuing Data Collection

SORH partnerships are being created every week. The continuing grant cycles and with more grants requiring collaborations or creating a network, establish more opportunities for SORH to connect with new partners. And while the official data collection for this project has ended, NOSORH continues to receive word from SORHs wishing to share their partnerships or SORH that did not schedule an interview. Notwithstanding, the collection of data and a deeper understanding of these partnerships will continue to grow.

Although the project direction and data collected changed slightly from the initial launch, this spreadsheet gives a large overview of the partnerships and the work some of those partnerships are accomplishing, and areas that show areas that can build upon or support state 2103 efforts.