A History of the Rural Health Care Services Outreach Grant Program

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In recent years, concern for rural populations has emerged in Congress and in other upper levels of government. The creation of the Federal Office of Rural Health Policy (ORHP) exemplified this new recognition of the significant challenges and difficulties facing rural residents in a rapidly urbanizing Nation. Although there are multiple definitions of "rurality," the U.S. Bureau of the Census and the U.S. Office of Management and Budget (OMB) provide the most common measurements of rurality. The Census Bureau describes all territories, populations and residential spaces in urbanized areas or in locations of 2,500 or more people outside of urbanized locations as "urban." By default, "rural" areas are all areas not defined as urban. The OMB's definition uses the urban/ rural definitions formulated by the Census Bureau to classify counties as either "metropolitan" or "non-metropolitan."1 According to the 1990 census, there were 61,648,330 people living in rural areas, constituting a population greater than that of the UK, Spain, France or Italy in 1996.1 Rural America touches almost every State and the majority of the land is defined as rural for a number of Western States.

Research has found that the rural population of the U.S. differs significantly from the urban population in ways such as age, income, education and health status. The rural population tends to be older than the urban population. According to Rural Health in the U.S., in 1996, the median age of the U.S. non-metropolitan population was 35.6 years in contrast to the median age of 33.8 for the metropolitan population.1 Generally, non-metropolitan populations have higher rates of poverty and unemployment and have less years of education than their metropolitan counterparts.2 Rural residents also experience poorer health status. There are higher rates of chronic disease, infant mortality, accidental injuries related to farming activities, occupational hazards and trauma mortality in rural areas as compared to metropolitan areas.3 A compounding factor affecting these already poor indicators is the significant lack of access to health care in rural communities. Research has found that there are serious barriers preventing residents from obtaining health care. Data from studies reveals that rural families have less insurance coverage and pay a higher proportion of their income for insurance premiums than urban families.4 Rural residents are more likely to cite a lack of local resources and transportation difficulties as reasons for their inability to receive care.4 Long distances between rural and urban communities and inadequate rural public transportation systems further worsen these conditions.4 There is also a shortage of specialists and primary care providers in rural America. In 1996, there were 54.6 patient care specialists per 100,000 people in non-metropolitan communities compared to 190 specialists per 100,000 people in metropolitan areas.4 Subsequently, all of these factors prevent rural residents, who statistically are already disadvantaged regarding age, poverty and health status, from obtaining adequate health care services.

Rural access issues have recently secured a wider visibility since the creation of the Department of Health and Human Services (HHS) Rural Task Force by Secretary Tommy Thompson. The HHS Rural Task Force, a workgroup dedicated to addressing rural concerns and problems,

identified three areas that inhibit the expansion of services to rural areas: statutory barriers, regulatory barriers and resource barriers. Statutory barriers refer to legislative requirements that indirectly disadvantage rural communities. Programs that require substantial State matching funds often are inaccessible to States with larger rural constituencies and limited population bases.[5] Similarly, programs that allocate funds using formulas based on costs and the numbers of people served may hurt rural communities that have smaller populations and cannot easily minimize costs.[5] Another example is that funds are often funneled to populations through the State in such forms as "block grants." However, some States are not as concerned with rural interests and the funds may be allocated in such a manner that they ultimately only benefit urban populations.[5] Regulatory barriers include inadequate definitions of "rurality" that often result in the exclusion of certain communities from access to funding opportunities even if they actually do have rural needs.[6] [7] Collection and evaluation of data can be difficult for rural communities because of the diversity of rural areas and the smaller sample sizes.[6] In addition, regulations often do not consider the varied and unique needs of rural areas that may require alternative means of service and resource development.[6] Limited resources can also be insufficient for the extent of rural residents' needs. Improvements in infrastructure would relieve such problems as the lack of public transportation, workforce shortage, inadequate technology to support higher levels of services and lack of equipment for distance-based education.[8]

All of these barriers inhibiting the improvement of services for rural residents stem in part from the area-specific, highly localized needs of rural communities. The HHS Rural Task Force Report to the Secretary acknowledges that the "regional nature of rural America makes it hard to serve rural residents."[9] Specifically, strong regional and State identities, different ethnicities and diverse health needs across large areas can make it difficult for residents to obtain services in locations outside of their community. The report says, "Frontier areas, populated largely by white Americans, differ greatly in their health needs from Southeastern rural communities, populated largely by African Americans."[9] Because of these regionalized health needs, most current HHS programs and resources are not always applicable to particular rural communities. According to the report, there are 225 HHS programs that currently serve rural areas. However, the report admits, "rural communities struggle to access resources because individual programs have unique application, implementation and evaluation requirements."[10] Essentially, Federal programs are not sufficiently flexible to meet the unique and diverse needs of rural populations. Subsequently, rural residents are often unable to benefit from available resources and services.

Negative rural implications of current Federal policies are most apparent in the widespread prevalence of the categorical funding methodology. Categorically funded programs require organizations to fulfill certain requirements and identify specific needs before they can qualify for funding. However, many rural proponents say that "categories of funding begin to define the need rather than the need defining the response."[9] Such funding methodologies require rural communities to reframe their needs according to the eligibility provisions. Often these communities do not have the available resources to locate particular programs that could potentially benefit their community out of a wide and confusing range of Federal services. The categorical methodology then requires these communities to narrow their services according to required program specifications and to generate comprehensive reports. This arduous process and the restrictive qualifications of categorically funded programs often prevent rural organizations from applying for the needed resources and services. Twenty years ago, all that existed for rural communities were categorically funded grant programs. In recent years, policy changes regarding rural health and services have resulted in the emergence of more rural-friendly programs. The Rural Health Care Services Outreach Grant Program is one Federal program that employs a non-categorical funding methodology. This program considers the

diversity of rural America and has provided rural communities with a more flexible mechanism of receiving Federal funds for specific health care needs.

The Outreach program began in the late 1980s. The Senate Appropriations Committee allocated funds in the 1991 budget for "Health Services Outreach Grants in ruralareas."11 The Appropriations Committee intended for these grants to "outreach to populations in rural areas [that] do not normally seek health or mental health services… the forgotten populations in rural America" and "enable services to be provided to rural populations that are not receiving them… to enhance service capacity or expand service area… increasing the number of individuals and families receiving services."11 In addition to the expansion of services to rural communities, these grants were intended to promote community health service collaboration. The Committee believed that "community and migrant health centers, local health departments and private medicine by and large do not cooperate and coordinate." Subsequently, the report emphasized the need to "facilitate integration and coordination of services in or among rural communities… enhance linkages, integration and cooperation" among organizations that are eligible to receive grants.11

The creation of the Outreach program was originally due to the efforts of several constituencies. Rural advocates had long complained that the categorical nature of discretionary grants and limitations in block grants created a need for a dedicated grant funding source for rural communities. Those concerns were echoed by the National Advisory Committee on Rural Health, and were heard by Congressional staff working on the Senate Rural Health Caucus and the House Rural Health Coalition.

With the support of the Appropriations Committee and several key Congressmen, legislation was passed between 1990 and 1991 to allocate funds for the Outreach program. The new program was received in the 1991 budget with an allocation of $19, 518, 000.11 Although these funds had been formally allocated, there was no authorization or law behind the allocation. Essentially, the program was the creation of the Senate Appropriations Committee, which cited Section 301 of the Public Health Services Act as its legislative basis.11 The actual authorizing legislation did not emerge until the mid 1990s. The formal authorization for the Rural Health Care Services Outreach Grant Program was through Section 330A of the Public Health Services Act as amended by the Health Centers Consolidation Act of 1996, Public Law 104-299. The law indicated that the purpose of the Rural Health Care Services Outreach Grant Program is to "expand access to, coordinate, restrain the cost of, and improve the quality of essential health care services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions."12

Initially, the Senate Appropriations Committee required the Health Resources and Services Administration (HRSA) to manage the program through the Office of the Administrator. The Office of the Administrator would seek the advice of the ORHP and other HRSA bureaus in the operation of the program.11 By November of 1990 the program was placed under the direct jurisdiction of ORHP in recognition of the need to designate a specific entity within HRSA to direct and operate the program. A HRSA-directed task force was also established for the purposes of designing a grant program with content that would meet the needs of all populations and interests. The initial schedule specified that the program would be completed by the end of the year. The application process was to start in January and continue until awards were posted in September of 1991.

The identification of priorities and preferences within the selection process was based on careful research that determined specific areas of critical rural health need. The implementation

workgroup in ORHP identified several review criteria. Reviewers were instructed to favor applications from communities with higher poverty, greater medical under-service and isolation that proposed projects specifically designed to respond to these needs. Projects that contained substantial community-based strategic planning and community involvement in the application process were also favored. Reviewers were instructed to adhere to the larger goals important to rural communities such as the improvement of pregnancy outcomes, increasing the number of people receiving primary care services and the provision of information and referral services to isolated populations.13 Such priorities were meant to guide applicants as well as reviewers. The workgroup hoped that these priorities would send a signal to rural communities of ORHP's recognition of these problems and needs, and would also serve to encourage those in certain fields to apply. For example, there is a tremendous stigma attached to mental illness, particularly in small, localized rural communities. Rural residents are reluctant to seek help and mental health professionals are reluctant to practice in rural areas. A mental health priority could potentially encourage the development of programs designed to meet this need in ways that overcome these rural barriers. Although a factor for the reviewers to consider, priorities are primarily used to guide applicants and are not used as a screen to eliminate applicants.

While the Outreach program has developed and changed over the last decade from the initial model, the guiding principles and goals remain the same. It is still primarily a program that seeks to address barriers to health care access within rural communities. The non-categorical funding mechanism enables communities to take advantage of government resources in the design and implementation of projects that are specifically tailored toward their populations' unique health needs. Projects are therefore expected to be responsive to any "unique cultural [or] linguistic needs" of the targeted population.14 At the same time, an underlying goal of the Outreach program is to identify successful models and strategies of service to rural communities and facilitate exportation of these ideas to communities with similar needs. In order to accomplish this goal, the program seeks to encourage "creative or effective" models of outreach and service delivery, or alternatively, the use of existing models in innovative ways, to address the specific needs of a community.14 To promote effective dissemination of such "best practices," applicants are required to submit a Dissemination Plan describing their strategy to distribute information about the project on a local, State and national level.15 ORHP facilitates the dissemination process through the publication of summarized descriptions of completed Outreach projects.

To truly enhance access, grantees are required to develop sustainability plans, with the understanding that grant funding is meant as "seed money" only. Projects are expected to use grant funds as the basis for instituting a long-standing health service delivery mechanism in their community that will grow and develop long after Federal funding has ended. Sustainability plans must indicate funding options that will enable projects to transfer easily from Federal to non-Federal funding sources.15 A related goal of the Outreach program is the improvement of rural health care services through the promotion of coordination and collaboration between providers. Projects must have the significant participation of at least three different health care organizations, such as hospitals, health departments, Community Health Centers, Rural Health Clinics and private practitioners. Each member must have a meaningful role in the planning and implementation of the proposed project.16

Throughout the years, Outreach program staff have realized that community involvement in these projects is crucial their successful continuation. In instances where the community is not engaged in the project, residents usually will not take advantage of the services. It is necessary to give the community ownership over the project by allowing them to identify and prioritize local needs. Applicants are currently advised to seek "significant community involvement in the project" from the very beginning. A consensus regarding community needs and goals highlights

the projects' potential to secure support from all levels of the community that persists after grant support ends.16

Since the creation of the Outreach program, a variety of projects have been funded in various States. From 1991 to 2004, funding has been provided to 561 grantees in 48 States and 3 Territories.17 The Outreach program grants have been awarded to local governments, rural hospitals and a wide variety of community health and social service organizations. Projects tailored toward the promotion of mental health, substance abuse treatment, and physical health, are encouraged. Emerging technologies such as recent advances in telehealth and telemedicine have provided a new avenue for the improvement of access to health care services. To promote the development of these new technologies and services, the Outreach program encourages using these services to address the needs of target populations.

Most projects are tailored to the unique demographic characteristics of particular communities' population. For instance, one Outreach program grantee, The Rural Health Outreach Program for Children in Polk County, Arkansas (1998-2001), focused on providing services to young parents and expectant mothers. This project responded to the high levels of poverty in Polk County where over 60 percent of its population is classified as "working poor." This poverty particularly affects young families. Ninety-two percent of single mothers in this county live below the Federal poverty level.18 The Arkansas project improved the health of children in these families by enabling young parents and single mothers to overcome transportation barriers to health care services, refer them to appropriate health care facilities, and provide education on parenting.19 In another example, in Pike County, Kentucky over 80 percent of children from ages 7-13 years are mildly or severely obese. This figure far exceeds the national average. The Kid Power Program (1998-2001) established a medically supervised program for weight-management that targeted children of this county.19

Other projects are designed to respond to geographic factors that result in poorer health outcomes for rural populations. For example, the State of Alaska has more lakes, rivers and waterways than any other State, resulting in a high incidence of drowning. As the second leading cause of death in the State, Alaska's drowning rate for recreational boaters exceeded the national average by 10 percent between 1987 and 1999. The Cold Water Safety in the Schools Program (1998-2001) was created in response to this public health problem. This program was able to use the Outreach program funds to train a network of teachers to deliver cold-water safety and survival training to teachers, pool staff and children in rural areas on a State-wide level.20

The Outreach program has had a significant impact on the health and welfare of many rural communities. By providing base funds for the initiation of health care services, it has facilitated the permanent institutionalization of many programs within rural communities. In February 2003, Ira Moskovich of the University of Minnesota's Rural Health Research Center completed the study, "The Impact and Sustainability of Past Grantees." He found that during a post-grant operating period of 2 to 5 years (1994-1996) in a sample size of 104 grantees, there was an 86 percent grantee survival rate. Fifty-three percent of grantees had "robust" or "moderate" post-grant capacity. 21 Eighty-eight percent of initial services of surviving grantees still remain available. He also found that 38 percent of surviving grantees had either expanded initial services (22 percent) or launched new services (16 percent) after grant funds had ended.21 Overall, most projects continued after the termination of funds, with only a small number of unsustainable projects.

Grantees have expressed their appreciation for the "rural friendly" application process. Marian Allen of the Cold Water Safety in the Schools Program (1998-2001) said, "This grant was a joy to

work with because of its flexibility - all grants should be like this one." Steven Ironhill of the Callam Country Hospital District # 1 Program (1998-2001) agreed that the Outreach program's easily adaptable requirements were a key incentive for initiating the process of application. He said, "I know that the non-categorical funding nature of the Outreach program actually made it possible for us to pursue this project." Grantees also praised the program's focus on rural needs and populations. Sandra Reckard of the SCORE-5 for the Heart Health Program (1998-2001) expressed, "A lot of grants only fund urban areas-it is fantastic that this program is geared toward rural people. As a small hospital, we wouldn't have been able to do this program without these funds." Ironhill added, "For rural communities, this is one of the best uses of Federal resources that I can think of." The most exciting results from the Outreach program are successful outcomes and concrete results from the projects. Reckard believes, "We have gone way beyond our expectations. The success of the project has been the materialization of a vision that allows us to actually see tangible benefits and an increasing amount of excitement from the community. I've been recommending this program to other people as well."

Although the Rural Health Care Services Outreach Grant Program started out as simply a General Appropriations program to test new and innovative ways of serving rural communities, it has now grown into a formally authorized and well-known program with a successful record of reaching hundreds of rural communities throughout America. Through the provision of Federal funds over the last decade, the program has been able to support improvements in access to health care services for rural communities. Since the first allocation in FY91 of $19.5 million, funding has increased to $23 million in FY02. Since the creation of the program, $271.9 million in Federal funds have been awarded.

Despite this assistance, the need continues to significantly outweigh available support. From 1991-2004, ORHP received 3,588 Rural Health Outreach Grant Program applications, representing nearly all States and Territories; however the Outreach program was only able to award 628 grants to these applicants (See Table 1 and 2 for more detailed descriptions of applicants and awardees).

Table 1
Office of Rural Health Policy

Funding History of the Outreach Program

Fiscal Year	Funding (in millions)
FY87	
FY88	
FY89	
FY90	
FY91	17.8
FY92	20.7
FY93	24.9
FY94	25.7
FY95	26.1

FY96	25.5
FY97	19
FY98	26.5
FY99	16.8
FY00	23.3
FY01	22.5
FY02	23.1
FY03	20.7
Total	292.6

Table 2
Office of Rural Health Policy

Outreach Program Applicant Statistics

Total Applications Received 1991-2004	Total Number of Awards 1991-2004	Percent Awarded
3588	628	17 percent

Notes

1. Thomas C. Ricketts, III, ed., Rural Health in the United States (New York: Oxford University Press, 1999), p. 7.

2. Thomas C. Ricketts, III, ed., Rural Health in the United States (New York: Oxford University Press,
1999), p. 17.

3. Thomas C. Ricketts, III, ed., Rural Health in the United States (New York: Oxford University Press, 1999), p. 19.

4. Thomas C. Ricketts, III, ed., Rural Health in the United States (New York: Oxford University Press,
1999), p. 26.

5. United States Department of Health and Human Services. HHS Rural Task Force Report to the Secretary, July 2002 (Washington, D.C.: 2002), p. 17.

6. United States Department of Health and Human Services. HHS Rural Task Force Report to the Secretary, July 2002 (Washington, D.C.: 2002), p. 19.

7. For example, the OMB definition of rurality classifies San Bernardino County, CA, as rural because it includes the City of San Bernardino, near the Pacific Coast. The county also includes most of Death Valley, making it an urban area under this definition.

8. United States Department of Health and Human Services. HHS Rural Task Force Report to the Secretary, July 2002 (Washington, D.C.: 2002), p. 21.

9. United States Department of Health and Human Services. HHS Rural Task Force Report to the Secretary, July 2002 (Washington, D.C.: 2002), p. 20.

10. United States Department of Health and Human Services. HHS Rural Task Force Report to the Secretary, July 2002 (Washington, D.C.: 2002), p. 16.

11. United States Congress. Senate Appropriations Committee Conference Report, Senate Appropriations Committee Report. 1990.

12. United States Department of Health and Human Services, Health Resources and Services Administration. Rural Health Outreach Grant Program: Program Guide and Application Instructions, 2003. p. 5.

13. Outreach Grant Program Implementation Workgroup, Federal Office of Rural Health Policy, 1990.

14. United States Department of Health and Human Services, Health Resources and Services Administration. Rural Health Outreach Grant Program: Program Guide and Application Instructions, 2003. p. 6.

15. United States Department of Health and Human Services, Health Resources and Services Administration. Rural Health Outreach Grant Program: Program Guide and Application Instructions, 2003. p. 31.

16. United States Department of Health and Human Services, Health Resources and Services Administration. Rural Health Outreach Grant Program: Program Guide and Application Instructions, 2003. p. 15.

17. United States Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy. Outreach Grant Program Management.

18. United States Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy, The Outreach Sourcebook, Volume 8, 1998-2001 (Rockville, M.D.: HRSA, 2002), p. 5.

19. United States Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy, The Outreach Sourcebook, Volume 8, 1998-2001 (Rockville, M.D.: HRSA, 2002), p. 25.

20. United States Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy, The Outreach Sourcebook, Volume 8, 1998-2001 (Rockville, M.D.: HRSA, 2002), p. 1.

21. Rural Health Research Center, University of Minnesota. Presentation on the Rural Health Outreach Grant Program: The Impact and Sustainability of Past Grantees by Ira Moscovice. February 2003.