Grantee Sustainability in the Rural Health Outreach Grant Program

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ABSTRACT

Since 1991, the Federal Office of Rural Health Policy (ORHP), Health Resources and Services Administration (HRSA) has made grant awards available to rural health consortia through the Rural Health Outreach Grant Program (RHOGP) to enhance the availability and quality of essential health care services for rural areas. This study looks beyond the accomplishments of program grantees during their period of grant support to several years following the expiration of RHOGP funding. Organizational and operational characteristics of 99 rural consortia supported by the RHOGP are analyzed to assess the degree to which participation in the RHOGP contributes to the strengthening and stabilization of local health care capacities. These consortia represent 95 percent of the RHOGP projects funded during the 1994 and 1996 grant cycles and have between four and seven years post-grant operational experiences. Data for the analyses were collected by a telephone survey of former grantees and from documentation provided by the ORHP. Successful post-grant consortia were defined as those that were able to:

- continue their initial efforts to address unmet local needs (breadth of activities and services),
- build on these efforts and resource commitments to address other existing and emerging unmet needs (depth of activities and services), and
- create a self-sustaining capacity to support ongoing operations (stability of funding).

After an average of almost six years of post-grant operations, 86 percent of the RHOGP consortia were still operational. Approximately 60 percent of the surviving consortia exhibited at least two out of the three criteria described above including the use of client revenues and third party reimbursement to support operations. Participation in the RHOGP can result in significant contributions to the strengthening and stabilization of local health care capacities. The vast majority of initial consortia activities and services (88%) were still available up to four years later, a variety of new and expanded efforts have been initiated and stable funding was developed for 46 percent of surviving consortia.

INTRODUCTION

This report summarizes the post-grant experiences of ninety-nine Rural Health Outreach Grant Program (RHOGP) consortia initially supported by the federal Office of Rural Health Policy (ORHP). The purpose of the study is to explore the extent to which these former grantees have been successful in developing a capacity for sustaining post-grant operations to meet local health care needs. The period of consortia operations that are of the most interest to the investigation encompass the transition period from RHOGP funding to alternative sources of operational support and operational experiences.

During their tenure in the RHOGP, these consortia contributed to the improvement in the availability of health care services for millions of rural residents that would not otherwise have had access to such services and activities.[1] Until this study little information was available about these rural consortia beyond their final grant period reports. It was not known how many were still in operation and were continuing to meet the critical service needs that initiated their efforts under the RHOGP.

Since the initial RHOGP awards were made in 1991 over 600 projects have been funded. Each of these program participants were required to identify and implement a post-grant strategy for project self-sustainability. Although there were no specified benchmarks for the nature and degree of self-sustained operations that should be achieved by the grantees, the general expectation was that a sufficient proportion of important services and activities would continue after the grant period ended. The RHOGP was intended to be a seed program that could jump-

[1] The Office of Rural Health Policy, Health Resources and Services Administration, publishes a summary document "The Outreach Sourcebook" that describes the composition and accomplishments of funded rural consortia for each grant cycle of the RHOGP. Baseline data for the current study were collected from Volume 4 (1994-97) and Volume 6 (1996-99) of the series.

start local efforts that would eventually support themselves, thus allowing program resources to target other areas of the country.

The requirement for the development and implementation of a post-grant plan of self-sustainability serves as the core focus of the study. The study extends the traditional assessment process beyond the determination of effective action plan implementation and product/outcome delivery to years past the expiration of grant support. Interest is focused on the degree to which program participants achieve broader program goals (i.e., independence from RHOGP funding and remain responsive to local needs). It asks more fundamental questions on whether participation in the grant program contributed to the strengthening of local health care delivery and provided ongoing access to needed services? The answers to this and other program/policy questions provide important insights that will help the ORHP better understand what their program design is accomplishing, the implications that design modifications may have on the long-term impact of program participation for rural communities and useful guidance to other rural consortia working to meet the needs of their rural communities.

BACKGROUND

Many rural populations, especially those in remote and isolated communities, have long struggled to overcome gaps in the availability of needed health care services. A variety of state, federal and private sector initiatives have emerged to provide direction and resources to help rural communities find solutions to barriers to health care services. The RHOGP encourages the creation of collaborative relationships and innovative strategies to meet these needs. One of its more popular and valuable hallmarks is its flexible approach toward the inter-organizational relationships of program participants.

It requires that grant funds target activities that directly contribute to the provision of new or expanded health care services and allows minimal use of the funds for participant organizational needs. In many ways, through the flexible approach to organizing and the avoidance of internal struggles over the resource needs of participating organizations the RHOGP provides a clearly focused strategy for providing services to rural populations. The express terms of the authorizing legislation frame the program purpose as follows:

> *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.* [2]

The RHOGP made its first cycle of grant awards in the fall of 1991. In its press release, the U.S. Department of Health and Human Services (DHHS) described the program as an important step in closing severe health care gaps in rural America (DHHS, 1991). The response to the first request for applications from the RHOGP was overwhelming with over 500 applications received. One hundred grantees were selected with awards totaling $18.3 million. With steady appropriations and two subsequent re-authorizations in 1996 and 2002 the program has provided a significant amount of assistance to rural areas that might not otherwise have had access to the needed resources. [3] The current number of active grantees is 107 including 13 in 2001, 39 in 2002, and 55 in 2003. Over the tenure of the program the RHOGP has awarded over three hundred million dollars and supported more than 600 consortia projects.

Funding awards are capped at $200,000 annually and are limited to a maximum of three consecutive years of support, with provisions for no-cost extensions that could potentially carry

[2] Section 330A subsection (b) of Article 42 of the Public Health Service Act (42 U.S.C. 254c).

[3] The program is currently authorized by Section 330A, Title III of the Public Health Service Act as amended by the Health Care Safety Net amendments of 2002.

over funds for another year. Grant applications are publicly requested and accepted on an annual basis depending upon the availability of public funding. The value of the RHOGP for rural areas has been recognized by its reauthorizations in 1996 and in the fall of 2002. The current authorization is in effect through the end of the 2008 Federal fiscal year.

As policy priorities are reviewed and amended to adapt to current events the processes of acquiring authorization/re-authorization and appropriations to support rural health initiatives will likely become more heavily influenced by evidence-based criteria for success. What is the return on investment of public dollars that could be used to support other efforts? We are moving beyond traditional criteria specifically tied to successful execution of grant award contract conditions (e.g. meeting product deadlines, work plan objectives, expenditure guidelines) to embrace broader system goals such as self-sustainability. Lessons learned from RHOGP consortia experiences can help develop a clearer picture of the criteria programs want to emphasize to their grant recipients

CONCEPTUAL MODEL AND APPROACH

The analytic approach used in this study is based on a model of collaborative behavior developed from over a decade of research and observations into the development of rural health networks, rural hospital consortia, systems and other alliances, confederations and cooperative ventures (D'Aunno and Zuckerman, 1987; Gregg and Moscovice, 2003; Luke and Begun, 1988; Moscovice, Christianson, Johnson, Kralewski and Manning, 1995; Weiner, Alexander and Zuckerman, 2000).

Our model focuses on four areas that can influence the ultimate success of consortia operations:

- project design (i.e., the identification and development of program components),

- project implementation (i.e., the commitment and support of the membership to activate the project's design),
- on-going operations (i.e., the value placed on the activities and services provided by local residents and area providers), and
- monitoring and operational support (i.e., the awareness of local needs, project effectiveness in meeting the need, changing environmental circumstances and the resources to respond to such information).

The effective identification and development of project activities and services requires an understanding of local needs and singling out those needs that are within the scope and capacity of consortia members to address. Doing so minimizes the opportunities for overextending consortium expertise and resources and maximizes opportunities for building political and organizational capital necessary for continued operational success. Successful project design implementation depends largely on the degree to which consortia members holding the necessary resources and expertise are committed to the project's success and are willing to invest the resources needed to succeed. Successful post-grant operations over the long-term depend on the degree to which the local population and area stakeholders value a consortium's activities and services and use them in the manner to which they were intended. Maintaining member and local population buy-in is, in part, a reflection of the degree to which consortia members are able to remain responsive to their needs and expectations (i.e., monitor project operations, environmental developments and maintain access to sufficient resources to respond as necessary).

The glue molding these areas of consortia operations is comprised of a series of important consortia, community, and environment relations. These relations undergo constant re-definition and re-negotiation to remain current with changing economic, demographic, organizational, and personal circumstances. Factors originally contributing to the development and implementation

of grant-supported efforts, over time, shape the *breadth or scope* of post-grant activities and services. Those contributing to consortia abilities to monitor local needs and develop appropriate responses to those identified needs while shifting with environmental changes shape the *depth or refinement* of post-grant activities and services. Maintaining the access to the resources needed to continue the *breadth* and *depth* of post-grant consortia operations is impossible without adequate access to the development of *stable funding streams*.

Breadth of activities and services is determined by the successes achieved in the areas of project development and implementation. Rural health consortia that continue to provide a majority of the activities and services originally supported by the RHOGP grant do so because the participating providers and the target populations continue to see a need or rationale for their continued provision. The benefits to participating providers and the community are seen to extend beyond the grant award period.

Depth of activities and services is determined by the degree to which consortia are successful in providing additional or expanded services to the same or a growing target population. These types of consortia are considered to exhibit a robust infrastructure and suggest a growing provider and consumer acceptance of the services provided as well as project flexibility to address additional needs and opportunities.

Stability of funding streams to support activities and services is determined by the ability of consortia to identify and secure sufficient resources to maintain on-going operations. These types of consortia often have targeted activities and services that traditionally have been included in existing state and/or federal reimbursement policy.

Success can be measured by the degree to which former grantees have made their initial grant supported activities and services available to surrounding communities, attained added

capacities for responding to new and emerging community needs, and secured a stable and predictable source of operational support to continue operations into the near future. Survey data were used to operationalize each of the criteria and include:

- The degree to which a consortia continued to provide a majority (i.e., more than 50 percent) of the activities and services originally supported under the RHOGP, excluding cases where it was demonstrated that the need was no longer critical.
- The degree to which consortia were able to enlarge their post-grant scope of services either through the addition of new services or the expansion of existing services (e.g., increased staffing, hours of operation, locations for accessing the health care system).
- The degree to which consortia were able to develop a stable post-grant source of operational support (i.e., operational revenue accruing to the consortium by virtue of the value it brings to its members and the surrounding rural communities).

These criteria were used to define four categories of post-grant sustainability:

Robust capacity – those former RHOGP grantees that meet all three criteria including continuing to provide the activities and services originally funded under the RHOGP grant, expanding their post-grant scope of service and developing a stable source for supporting consortia operations.

Moderate capacity – those former grantees that meet two out of the three capacity criteria.

Minimum capacity – those former grantees that only meet one of the three capacity criteria or that have at least maintained post-grant operations and continued to provide some of the originally supported activities and services.

No Capacity – those former grantees that could not maintain post-grant operations and were closed at the time of the RHOGP consortia survey.

It should be noted that our definition of expanded project scope relates only to the post-grant expansion or addition of services and does not necessarily imply that the number of

individuals served by a consortium have increased. Increased project scope was selected as a measure for post-grant capacity because it was assumed to include the reallocation of existing consortia resources or the expenditure of political or organizational capital. The decision to expand an existing service or to offer a new service involves some decision-making about resource allocation and involves opportunity costs that could delay or prevent other courses of action. An expansion in scope of service most often requires additional operation and set-up costs (e.g. new staff, reassigned staff, new or rented equipment, or the establishment of new points of access such as satellite and mobile clinics).

DATA COLLECTION AND ANALYSIS

Analysis of the post-grant operations of RHOGP rural consortia required primary data collection efforts. With over 600 projects funded over the past decade, it was necessary to identify a sample of the 600 rural consortia for participation in a phone survey.

Based on the desire to maximize the length of post-grant operational history for analysis and the likelihood of locating former grantees with knowledge of the project grant and post-grant operational experiences, two separate funding cycle cohorts were selected — those initially funded in 1994 and in 1996. A total of 104 former grantees were included in the sample with post-grant operational histories ranging from four to seven years (79 from 1994 and 25 from 1996). Data for analysis were collected from the project summaries available in the RHOGP's *"Outreach Sourcebook"*, financial information provided by the ORHP, and the primary data collected through a structured telephone survey.

Survey Design

The telephone survey lasted approximately 45 minutes depending on the amount of information provided by the respondent. Ninety-nine of the 104 grantees in our sample

responded to the survey, yielding a response rate of 95 percent. Respondents were asked to describe major project design components, the project's impact in terms of meeting program and project expectations, and those activities and services that were still being made available to local area populations. In the event that some of the services were no longer provided by the original consortia membership, respondents were asked to identify what organization was currently providing the activity or service. Respondents were also asked to identify their project's most important component, discuss why it was selected for inclusion in the project, and to identify any facilitating or obfuscating factors in the implementation of the component.

The major focus of the survey questions was on the post-grant operations and the transition period prior to the end of Outreach grant support. Financial information included data on the project's most recent annual budget, identification of the two most important sources of operational support, and plans for supporting future activities. Specific questions were asked to identify changes in the size and diversity of consortia memberships, form of governance and leadership, scope of effort, as well as target population changes (e.g., demographic and clinical priorities). Finally, respondents were asked to describe key lessons learned that would be useful for rural providers facing similar issues and if information about consortia activities had been disseminated to other rural areas.

Analysis

The analytic approach employs both qualitative and quantitative techniques to explore relationships contributing to the development of consortia post-grant capacity to sustain operations meeting local health care needs. Descriptive statistics were used to document the relationships and statistical tests were used to assess the strength of the relationships. The framework used to guide both the descriptive and bivariate analyses was based on the four

categories of consortia capacity as defined in the conceptual model (i.e., robust, moderate, minimal and no capacity).

CONSORTIA CHARACTERISTICS

The consortia in this study are widely distributed across the country and represent virtually every state (Figure 1). They vary considerably in terms of project focus and the number and diversity of participating organizations. Consortia members include providers of medical care (e.g., hospitals, clinics and solo practitioners), health and human service providers (e.g., county departments of health, social services and mental health and substance abuse agencies), social and economic development agencies (e.g., cooperative extension services, economic development agencies and job training services) and highly enmeshed community entities such as schools, churches, ministerial groups, and community action agencies.

Consortia characteristics provided in the Outreach Sourcebooks, their core activity or service as indicated in the survey and their target population and service area were used to separate consortia into one of two service settings. Approximately 44 percent of the consortia shared characteristics of clinic-based settings while 56 percent operated in a community-based setting (Table 1). The clinic-based consortia focused heavily on the delivery of direct health care services while the community-based consortia were more likely to target health education, screening and risk reduction, and mental health and substance abuse needs. In addition, clinic-based consortia were more likely to initiate a larger number of projects than the community-based consortia.

The overall distribution of the sample consortia according to our measure of capacity was 14 percent with robust capacity, 35 percent with moderate capacity, 37 percent with minimal

FIGURE 1
Outreach Grantee Project by State, 1994 and 1996

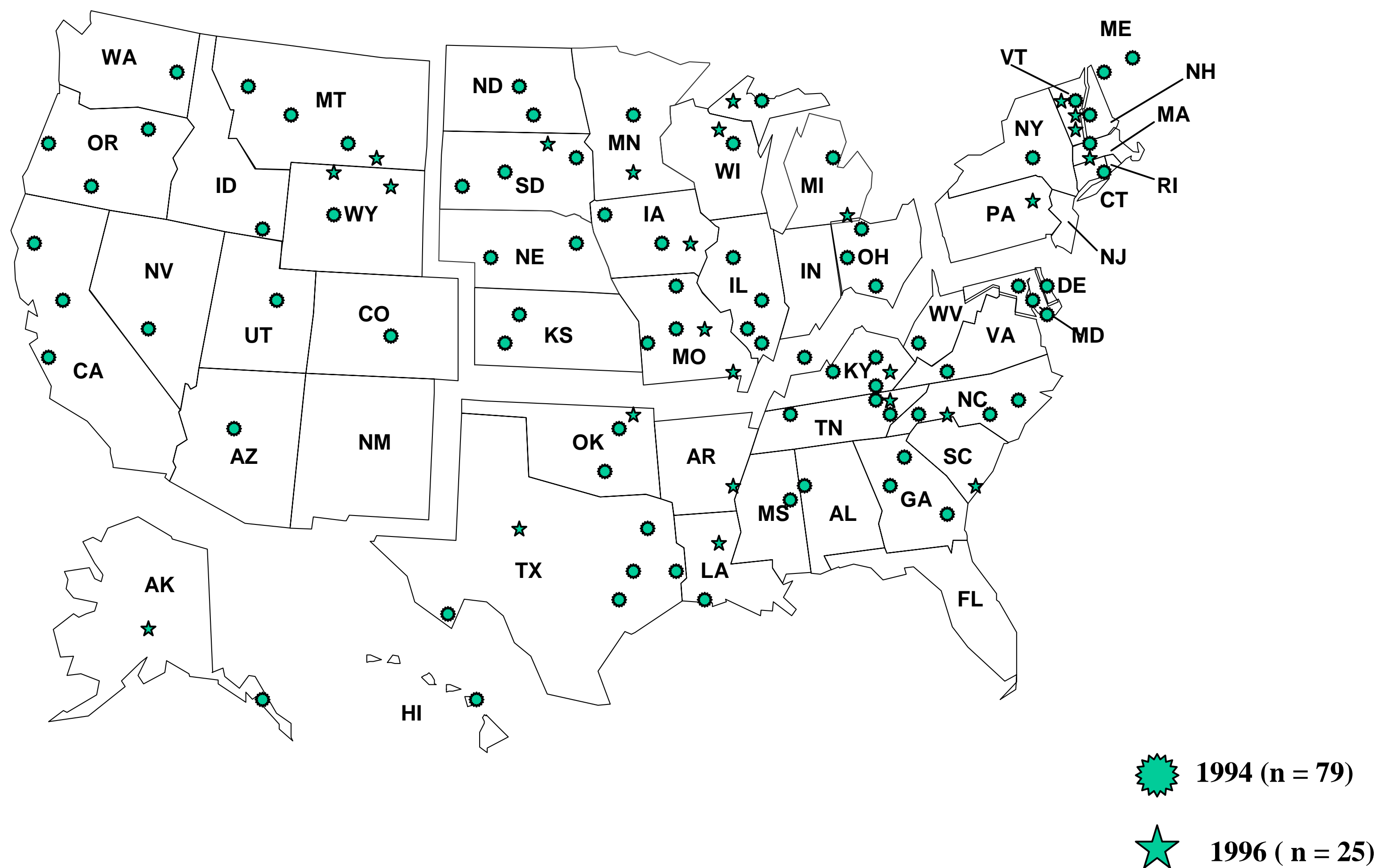


TABLE 1

Consortia Service Setting and Focus
(n=99)

Service Setting		**Service Focus**	
Clinic-based Setting	44%	Vulnerable Populations	57%
		Clinical Services (e.g. Primary Care)	32%
		Member Needs	7%
		Infrastructure Needs	4%
Community-based Setting	56%	Vulnerable Populations	60%
		Risk Reduction	18%
		Substance Abuse/Mental Health	9%
		Infrastructure Needs	7%
		Member Needs	6%

capacity, and 14 percent with no capacity (Figure 2). Clinic-based settings were more likely to include robust or moderate capacity consortia than community-based efforts (66% versus 44%, $p<.05$). This is likely a reflection of the post-grant funding source of the consortia (i.e., clinic-based projects may rely on fees or other continuous and service-related funding not available to community-based projects focusing on outreach and health education projects). Clinic-based consortia also were more likely to expand their post-grant efforts than community-based consortia ($p=.05$).

Forty-six percent of surviving consortia identified some form of self-sustaining revenue stream (e.g. fee-for-service including Medicare and Medicaid reimbursement) that would likely remain available to support the services they provided. There is a strong relationship between existing reimbursement policies, the activities and services offered by consortia and their ability to survive following the expiration of grant support. Even if many of the common barriers to rural health care were addressed (e.g., availability of trained and qualified practitioners and physical access by rural populations in need) it is difficult to maintain the availability of needed services if there is no means of sustaining the resources necessary to meeting those needs. This raises some concern over the long-term impact of providing non-subsidized services since almost 60 percent of all consortia devoted resources to meeting the needs of vulnerable populations.

Size

The average consortia membership size was five organizations with the largest consortia having 45 members (Figure 3). The seven largest consortia had more than one fourth of all consortia members. The size of the largest consortia reflects the nature and scope of issues addressed. In the case of the largest consortium (45 members), the issue addressed was the coordination of trauma care training for ambulance and emergency room personnel. Given the

FIGURE 2

Consortia Capacity to Meet Community Health Needs

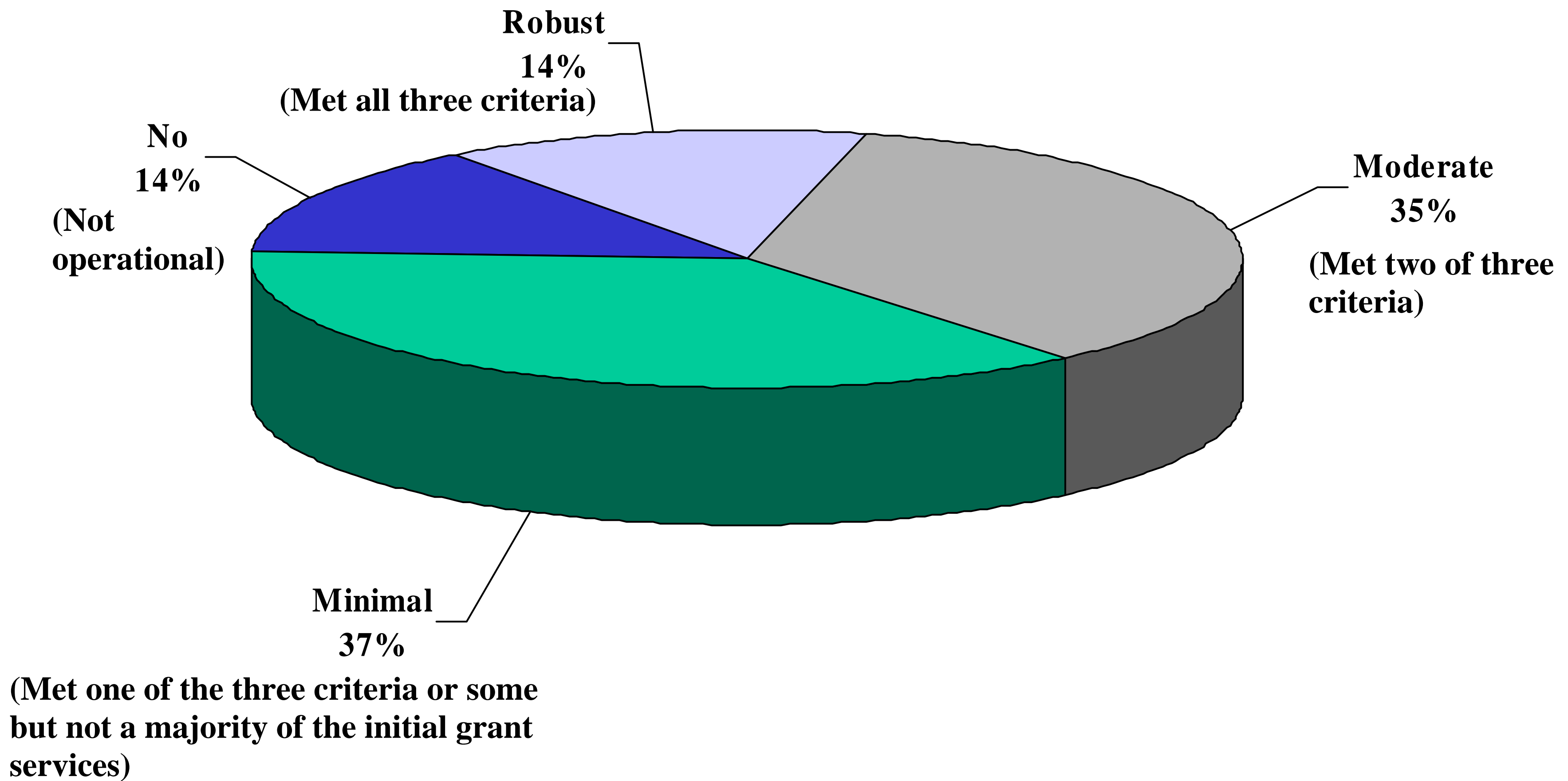
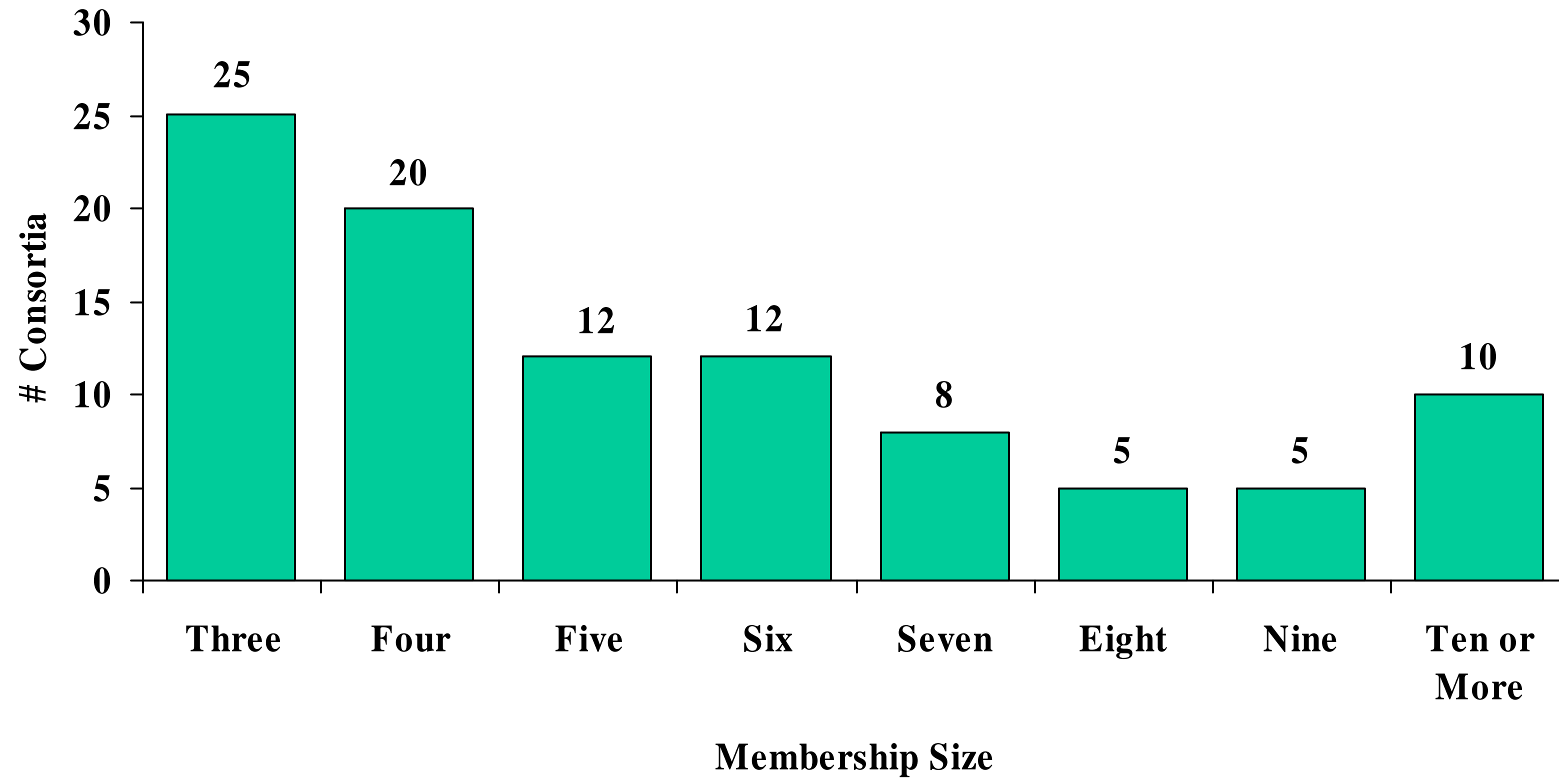


FIGURE 3

**Consortia Membership Size
(n=97)**



expertise required and the lack of a traditional source of reimbursement, neither the small rural hospitals involved nor the EMS agencies could afford to accomplish the task independent of each other. In an effort to achieve economies of coordination and scale, eight hospitals and thirty-six ambulance squads covering five rural counties joined with a Community College to accomplish the needed upgrade in training.

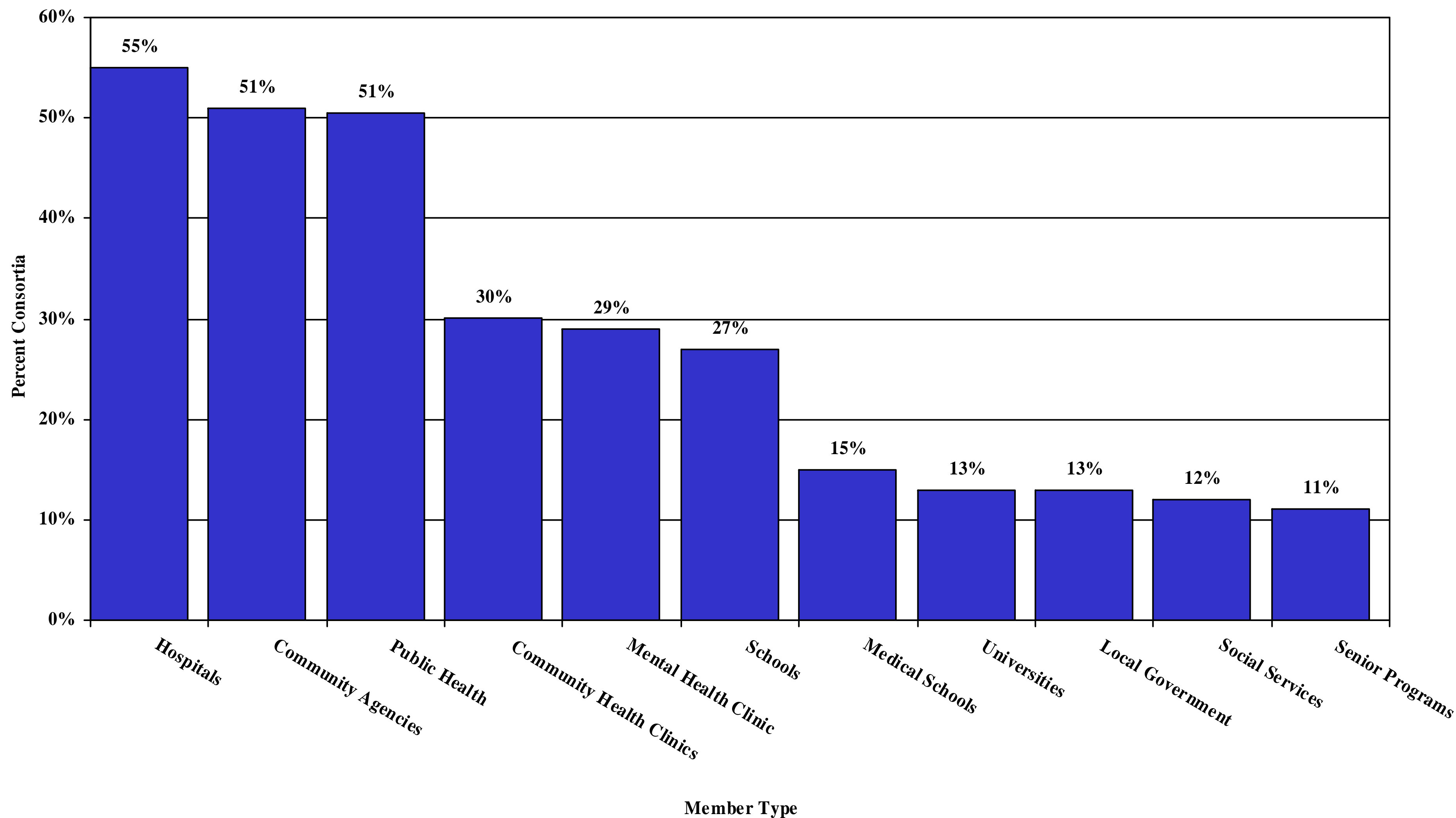
Similar relationships were observed in the remaining six largest consortia. For example, the next largest consortium targeting adolescent alcohol and substance abuse covered an eight county area and included one mental health agency, one substance abuse agency and one county court from each county to implement a strategy to break the cycle of juvenile addiction and criminal recidivism. The complex relationships between substance abuse, poverty and criminal acts as well as the absence of any significant reimbursement source for these efforts reduced the ability of the project to continue once grant funds expired. Although some activities continue, the project has lost half its staff and downsized many activities. It appears that the largest consortia encounter substantial difficulties in maintaining sufficient post-grant capacity.

Member Diversity

The diverse nature of organizations participating in RHOGP consortia is evident in Figure 4. The high proportion of consortia with hospitals was expected given the central role hospitals play in the delivery of rural health care. The fact that they are participating in only a little over half of all consortia likely is due to the nature of consortia projects. Many projects address access issues (e.g. transportation, social and mental health related support services) that are normally not reimbursable through existing funding streams. Community-based non-clinical providers are more likely to be involved in these projects. The large number of county health departments and not-for-profit community agencies and charities underscore the atypical nature

FIGURE 4

Types of Organizations Participating in Consortia (n=99)



of some of the access issues being addressed by RHOGP projects. In this respect a number of RHOGP projects were reminiscent of the grass-roots efforts that marked the earlier farm coop movement during the last century.

Hospitals were the most common participant to act as the lead grantee agency followed closely by county public health agencies and community-based agencies. Together these three provider types represent the leadership agencies for almost two thirds of all the consortia (Table 2). Community-based agencies were as prevalent in consortia as hospitals and clearly are a significant stakeholder in the operations and outcomes of grant projects.

Mental health and substance abuse agencies represent another significant player in consortia development and operation (Table 2). This may be due to the need to marshal resources more than usual for inter-related issues such as substance abuse, poverty and violence or the need to expand provider involvement to achieve economies normally unavailable when addressing issues not funded through the existing reimbursement structure.

Prior Member Collaboration

Three out of four grantees had at least two consortium members that had collaborated in the past and over half of the rural consortia reported that all members had a history of collaboration (Figure 5). We expected that prior collaboration would have a positive impact on the ability of consortia to establish a post-grant capacity for meeting local health care needs. Half or more of the robust, moderate and minimal capacity consortia have a 100 percent history of prior collaboration among their members while only 36 percent of the failed consortia have 100 percent histories of member collaboration prior to engaging in the RHOGP grant ($p=.09$) (Figure 6).

TABLE 2

Distribution of Providers by Consortia

Provider Type	Consortia With This Provider	Lead Agency For RHOGP Grant	Average Number Of This Provider In Consortia With This Provider
Hospital	55%	27%	1.7
County Public Health	51%	19%	1.2
Community-Based Agencies	51%	15%	1.7
Community Health Clinic	30%	10%	1.8
Mental Health and Substance Abuse	29%	7%	2.5
Public Schools (Districts and Individual)	27%	4%	NA*
Higher Education – Medical Training	15%	2%	1.2
Local Government	13%	3%	1.3
Higher Education – General Training	13%	5%	1.2
Social Services	12%	1%	1.0
Home Health Services	12%	1%	1.1
Senior Programs	11%	0%	1.0
Emergency Medical Services	8%	0%	1.1
Individual Practitioners	8%	0%	2.0
Cooperative Extension	7%	1%	1.2
Health Care Systems	5%	1%	1.0
Migrant Health	4%	2%	2.0
Tribal/Native American	4%	1%	7.3

*Calculation of average number per consortia was not possible as many respondents reported by districts without specifying the number of schools in the district.

FIGURE 5

Proportion of Members with a History of Collaboration
(n=99)

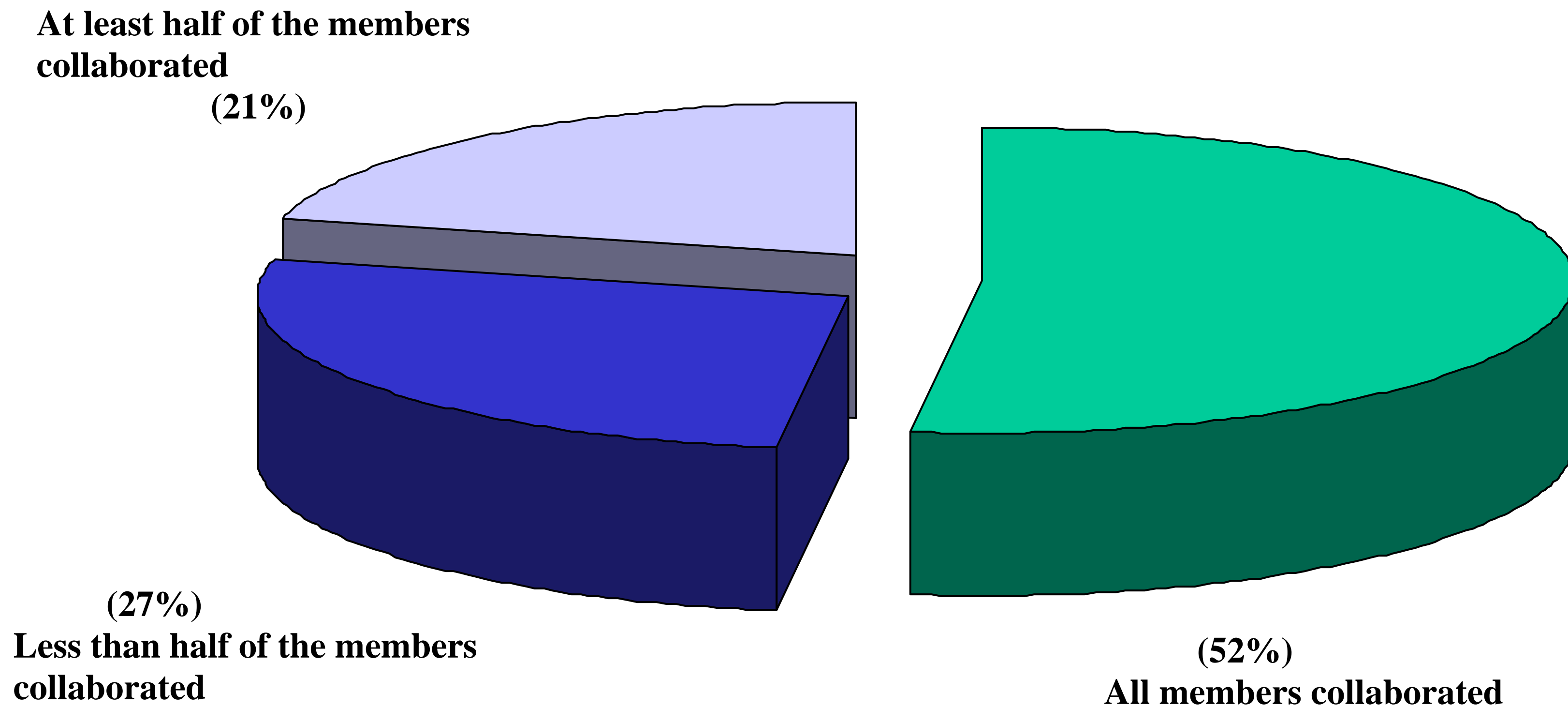
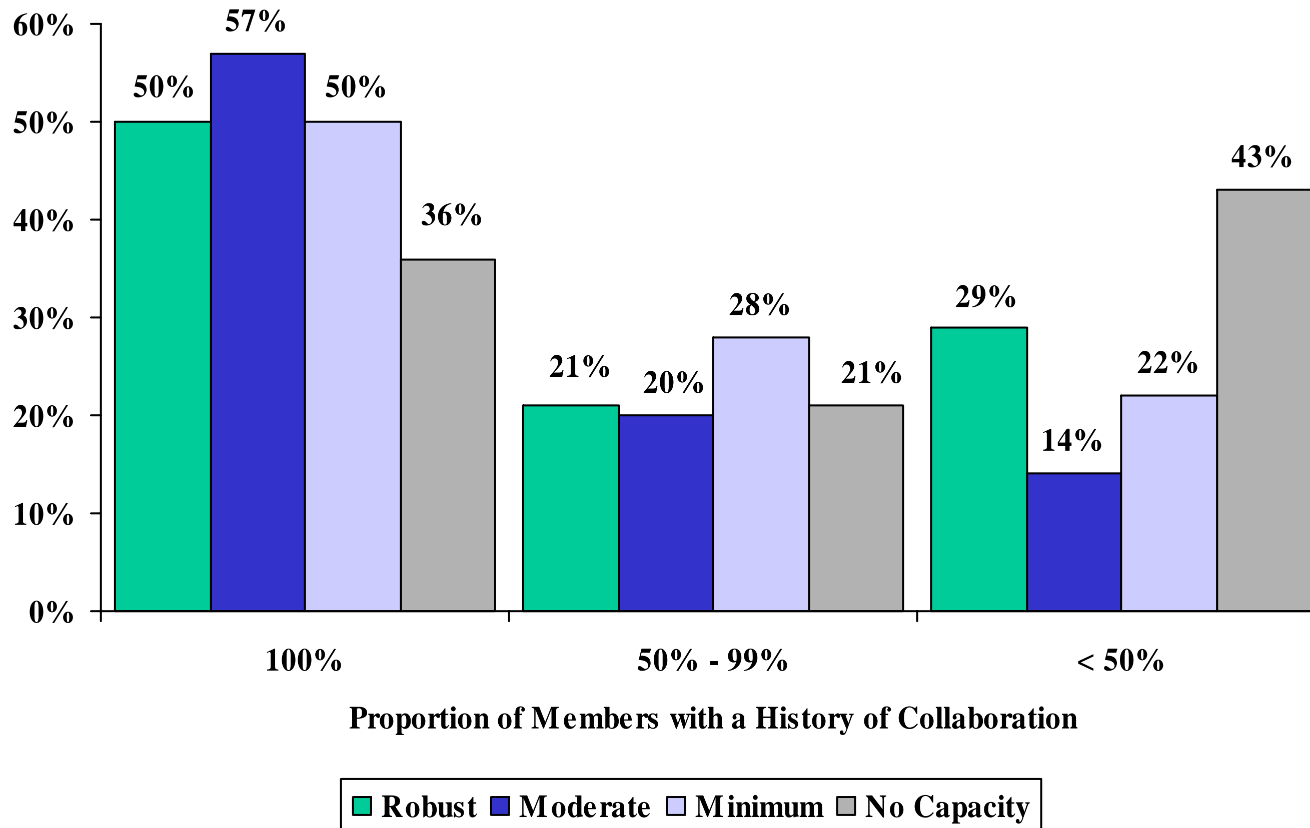


FIGURE 6

Collaborative History by Sustainable Capacity
(n=97)



Project Focus and Operational Support

Given the benefits of providing services that link with existing methods of reimbursement, it is not at all surprising that the most prominent activity of consortia was in the areas of primary and preventive care services. However, activities related to health education, wellness and health promotion were the second most prominent category followed by mental health and substance abuse prevention efforts. This may be evidence of pent-up need for services traditionally not reimbursed. On average consortia initiated more than five activities and services as part of their RHOGP project. Consortia funded during the 1994 grant cycle had fewer members, initiated fewer grant supported activities and services and had fewer surviving activities and services than the later grantees (Table 3).

POST-GRANT OPERATIONS

Fourteen percent of the rural consortia failed to continue operations following the expiration of their RHOGP grant support. While some consortia identified a range of issues related to implementing their most important activity/service, the overwhelming reason given for closure was loss of funding. Typical responses included … "funding ended and we could not replace it" … "the population being served was too small to sustain the program" … "the clinic could not survive with a population of 920 people. When the grant was written, PAs were not making what they are now. Liability insurance for doctors increased. These clinics have to be 100 percent subsidized."

Just over one half (58%) of all consortia experienced an expansion in project scope following the termination of their RHOGP grant support (Figure 7). Three out of every five of the 92 grantees reporting a change in project scope following the end of their ORHP grant experienced an expansion in services and activities. Almost 40 percent of grantees that

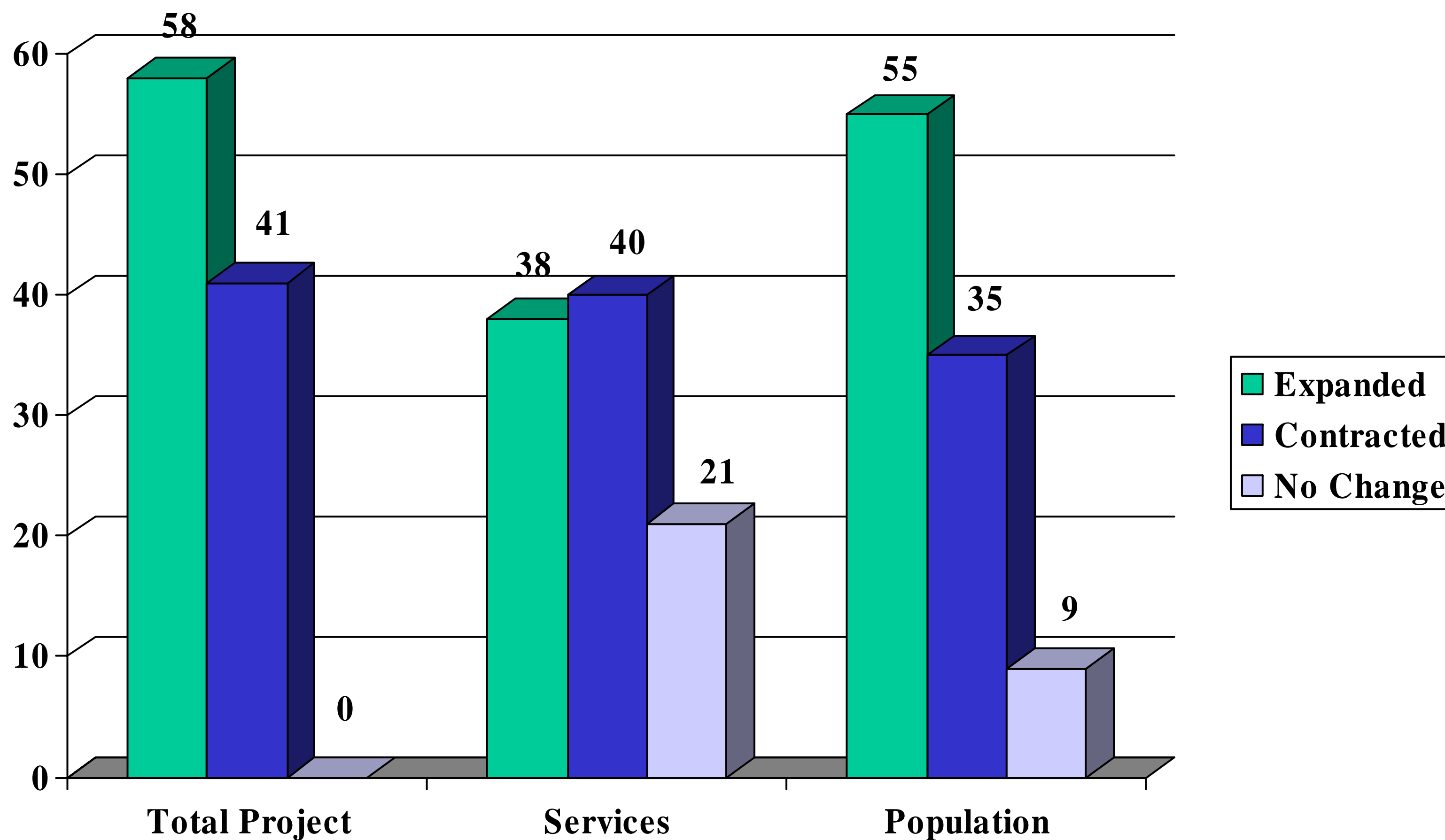
TABLE 3

Consortia Membership and Project Size by Cohort
(n=99)

Cohort	Membership Size	Number of Initial Activities/ Services	Net Surviving Activities/ Services	Post-Grant Activities/ Services Provided by Non-Consortia
1994	6.2	4.8	4.1	0.7
1996	7.2	5.6	5.1	1.1

FIGURE 7

Major Post-Grant Changes in Project Scope
(n= 99)



experienced a reduction in scope ceased operations at the end of the grant period. Not surprisingly, the most common reason given for a reduction in scope was funding; however, funding accounted for only few of the expansions (Table 4). The most significant factors affecting non-financial expansion in scope were organizational cooperation (28%) followed closely by the demonstrated need for the activity or service (21%). Effective working relationships make expansion of effort less problematic. Access issues are a primary factor in committing consortia resources to their "most important" activity since 65 percent of the most important activities evolved from difficulties in access for local populations (Table 5).

The majority of surviving grantees managed some increase in either services or populations served during post-grant operations. About one half of the grantees reporting an expansion in service availability expanded their depth of coverage with new services (e.g. transportation, screening, dental, Ob/Gyn, migrant health, physical therapy, and mental health services). The remaining grantees were evenly split between the expansion of personnel available to provide services (e.g. paraprofessionals, physicians, bilingual psychiatrist, and technical staff) and the availability of additional access points (e.g. new clinic sites, mobile vans, expansion of existing community health clinic).

ACTIVITIES AND SERVICES

The survey identified more than three hundred activities and services offered by surviving consortia (Table 6). Given the on-going issues with access to basic health care services in many rural areas, it was not surprising to find that almost one quarter of all consortia identified primary care services as their most important activity. Four out of five consortia with primary care as their most important activity identified area need as the most compelling reason

TABLE 4

Major Reason for Post-Grant Change in Scope of Project
(n=92)

Reason for Change in Scope	Increased Scope (61%)	Decreased Scope (39%)
Funding Related Factors	11%	35%
Organizational Cooperation	28%	2%
Effective Working Partnership	(14%)	(2%)
Project Acceptance	(8%)	(0%)
Leadership	(6%)	(0%)
Need for Activity/Service	21%	0%
Other	1%	2%

TABLE 5

Rationale for Selection of Most Important Activity or Service
(n=97)

Rationale	Percent
Targeted Service Needs (e.g. specific services needed but not available in community)	35%
Financial Barriers to Care (e.g. free immunizations, reduced or free primary care, services for children in poverty, free or reduced cost pharmaceuticals)	9%
Non-Financial Access Issues (e.g. lack of transportation, cultural and language barriers, workforce shortages)	21%
Consumer and Patient Education (e.g. healthy lifestyle and wellness, farm safety, violence prevention, screening and risk reduction, education about nursing home care for the elderly, heart disease screening)	23%
Delivery System Improvements (e.g. training for staff, acquire equipment, staff retention)	12%

TABLE 6

Post-Grant Activities and Services Available in Surviving Consortia, 2003 (n=85)

Activity/Service	Percent of Most Important Activity	If Have Activity, Percent It Is Most Important Activity	Percent of All Activities/ Services
Primary Care	22.4	63.3	9.2
Health Education	12.9	33.3	10.1
Screening and Follow-up	8.2	21.9	9.8
Member Services	7.1	35.3	5.2
Case Management	5.9	31.3	4.9
Coordinate System Services	4.7	16.0	7.7
Home Health	4.7	100.0	1.2
Mental Health	4.7	22.2	5.5
Medication Assistance	3.5	50.0	1.8
Senior Services	3.5	42.9	2.1
Transportation	3.5	21.4	4.3
Family Services	2.4	13.3	4.6
Immunizations	2.4	13.3	4.6
Infrastructure Support	2.4	16.7	3.7
Public Safety	2.4	40.0	1.5
School Health	2.4	15.4	4.0
Dental Services	1.2	25.0	1.2
Home Visits – for Projects	1.2	7.7	4.0
Physical Therapy	1.2	50.0	0.6
Social Services	1.2	9.1	3.4
Substance Abuse Services	1.2	11.1	2.8
Wellness Programs	1.2	14.3	2.1
Preventive Care	0.0	0.0	5.5

for the ranking of these services. Primary care was almost twice as likely to be the most important activity of consortia compared to health education services which was the second most important activity.

When asked what non-financial factor helped the most in implementing their "most important service/activity," four of five consortia identified either the level of member cooperation (42%) (e.g., a willingness to collaborate, pool resources and commit to the project) or administrative effectiveness (38%) (e.g., staff, leadership and program planning and implementation) (Table 7). The biggest challenge to implementing their most important activity was related to specific aspects of project infrastructure including poor operational effectiveness, planning and implementation, marketing strategies and ability to access needed financial support. Issues specific to either project personnel or target population characteristics also presented significant challenges (Table 8).

Three quarters of all grantees experienced a major organizational change since the termination of RHOGP support (Table 9). The greatest source of post-grant organizational change resulted from gains or losses of consortia members. The second most significant source of organizational change was either a shift in governance and leadership or in the nature of project operations. Half of the governance and leadership changes occurred at the executive level while more than half of the project changes were caused by changes in the project's service area. In some instances changes in governance and leadership were very positive (e.g., merger with a health system permitting the pooling of resources to expand service capacity).

LESSONS LEARNED

Survey respondents provided a variety of comments about the lessons they had learned. Three general areas emerged:

TABLE 7

Non-Financial Factors that Facilitate Implementation of Most Important Activity (n=92)

Factor	Subcategory	Category
Intra-Consortium Cooperation		42%
Willingness to Collaborate	24%	
Pooling of Resources	12%	
Commitment to Project	6%	
Effectiveness of Consortium Administration		38%
Visionary/Effective Leadership	11%	
Staff Effectiveness and Support	17%	
Program Planning and Implementation	10%	
Community Cooperation/Support		15%
Recognition of Project Value	9%	
General Acceptance	4%	
Municipal Help and Support	2%	
External Assistance		5%
Technical Assistance	3%	
Legitimacy of Efforts by Local Community/Providers	2%	

TABLE 8

Biggest Challenge in Implementing the Most Important Activity/Service (n=95)

Challenge	Percent
Project Infrastructure (e.g. Operational effectiveness, planning and implementation, marketing project in local community, obtaining financial and non-financial resources to support operations)	42%
Project Personnel (e.g. Staff burn-out, recruitment and retention problems, insufficient staff expertise, low levels of staff acceptance or satisfaction with project design/efforts)	21%
Hostile Operating Environment (e.g. Local providers either threatened or resistant to project efforts and goals, insufficient reimbursement to provide necessary and stable staffing)	12%
Target Population and Service Area Issues (e.g. Target population mistrust about program, engagement issues, mobility, distribution and physical barriers)	21%
Other	4%

TABLE 9

Major Post-Grant Organizational Changes
(n=74)

Change	Percent
Changes in the number of organizational members	28%
Changes in organization structure (e.g. Administration, Formalization, Ownership and Linkages)	22%
Changes in project operations (e.g. Scope of Effort, Area Capacity)	22%
Dissolved Partnership	19%
Other (e.g. Time Limited Effort, Merger, Transformation into New Entity)	9%

- the negotiation and management of the collaborative relationships needed to reach consortia goals,
- the importance of thorough, informed planning and preparation to pursue specific objectives, and
- the recognition of the unique factors that influence a rural consortium's likelihood of achieving self-sustaining operations.

The Complexities of Collaboration

Many respondents pointed out that organizational self-interest will always be present and that the safest and most healthy approach is to expect it and work with it rather than to allow it to drive a wedge of mistrust and inefficiencies among consortium members (i.e., don't see it as a necessary evil but more as an opportunity to forge bridges between partners by directly recognizing their true interests and incentives for action). In general, newer organizational relationships will prove more challenging than more mature ones because there has not been time for issues to be brought out into the open and addressed. "Working with other partners for the first time is extremely challenging. Everyone didn't know what their part was. They [would] do their own thing and we [would] do ours."

In a worst case scenario the relationship can gravitate to a financial tug-of-war … "as long as there are funds people are committed [but] as soon as they look in their own pocket, they lose commitment." In a best case scenario, issues are aired and links are found … "the [state] told us, 'you think you have problems now, wait until you get the money' – we got the money and people came right away and said, 'our slice isn't big enough.' We had to make sure that everyone felt their needs were being taken into consideration to move forward successfully – we all agreed to go with our original plan and it worked really easy."

Many respondents felt that the involvement of community members in their projects and particularly the creation and use of on-going open communications and assessment of need and

capacity was important for the success of their efforts. “Building an effective bridge to the community can be as important for the project as the development of a delivery system model. It takes time and is not necessarily a mistake to ‘let a project grow at its own rate’. It’s more important to focus on relationship building in the community.” Most considered the level of understanding that providers have about the language and culture of the communities and populations they intend to serve to be very important in achieving project success. However, this is not necessarily an easy task. Self-perceptions and tacit biases can be a handicap that is hard to see. “I found that regardless of how I feel about a particular course of action, I couldn’t just go with my ideas about what I think the community needs. I need to listen to what they say to best devise a strategy for addressing key needs.”

Planning, Staging and Stockpiling

Not surprisingly, many placed a high level of importance on planning and resource management as integral steps in achieving project success. Effective planning means obtaining a through understanding of the issues at hand; not overreaching the member capacities to address them; keeping the approach as flexible as is prudent given prevailing conditions; the exercise of strong leadership with a clear vision of purpose and responsibilities; a recognition of the importance of good staff and an awareness of member limitations and resource priorities.

> “You need to continually assess the nature and needs of the community in order to provide timely and acceptable service – you constantly need to look at the community and who you serve – be aware that populations change over time.”

Project size and scope may be related to successful capacity development but the wide range of local circumstances and provider characteristics defies standardization. However, one common approach that appears effective is to develop slowly and incrementally … “start with a small but committed group of partners and have the same group monitor what is happening” …

"there is a tremendous amount of management involved in any project; we thought about project size and decided to think smaller because of the management it would need." Many found that self-sustainability is just not possible in certain situations, unfortunately situations that are all too common for many remote rural areas, … "the population was too small to sustain the program."

Many felt that strong leadership with a clear vision of purpose and method was critical for making the most of member strengths and weaknesses. As one respondent noted, "[You] don't need a lot of money to achieve good things for the community but [you] do need the right project director – it is the key to success." Visionary leadership can be one of the prime factors in achieving the type of project flexibility so many respondents recommend. Having seasoned staff can make this goal all the more achievable. However, you need to bring key staff in early in the project … "need to get the agreement with physicians at the frond end of the project" … it is very important to use seasoned staff in critical project positions whenever possible even if it is only 50 percent of their time … much time can be lost by using new staff with a steep learning curve to overcome."

Project flexibility and thorough planning also becomes more likely as member limitations and resource availability are clearly known. To insure against immediate financial calamities respondents note the best plan is to … "diversify your funding sources [as soon as possible] so that the end of any one source will not mean you close down your project … [for] lack of money." Others cautioned that long careers in health care can blind one's ability to see alternative paths linked with non-health care entities noting that one shouldn't … "write off a potential source of support because it does not come from the health care industry – people outside the health care community are very interested in improving the health of the community." Still others recommended a diversity of approaches as a safe strategy … "use

multiple approaches and remain flexible in how you prioritize project activities and be ready to shift to take advantage of timing and opportunities." Despite the finite nature of grant funding, a number of respondents stressed that providers need to take their time (i.e., don't push your products and approaches too hard; maintaining steady engagement rather than short-term high bursts of effort can mean the difference between long-term success and short-term gains that are hard to repeat). "You can't change and fix everything…. You need to pick and choose your battles for linking people to the [needed] services."

The Rural Environment and Issues of Sustainability

One clear message from the former grantees was that in most rural operating environments, unless the services and activities already have an established revenue stream it will be very hard to make them self-sustaining. Achieving self-sustainability and addressing the needs of rural communities are not always complementary. A number of respondents noted that their project was … "successful because it was reimbursed." Many of the activities and services provided by RHOGP consortia do not have identified sources of reimbursement. This presented a difficult dilemma for many providers … "unless a project is sustainable, it is difficult to offer the activities and services to the community knowing that they will disappear once the funding ends." Many of the respondents shared their views on this…. "you need to be sure you can provide services when funding is done," … "a grant [project] does need to transition to something else," … it is very important to carefully control your cash flow and build towards a strategy that permits sustained efforts after the grant." However, one respondent noted that "funding streams for health care services follow acute occurrences of medical conditions … there is very little funding for preventive activities, especially in the elderly."

CONCLUSIONS

The consortia included in the two RHOGP cohorts are as diverse in membership and as varied in focus as the populations and community health issues they were organized to address. The vast majority of RHOGP grantees in these two cohorts have remained in place and continue to address critical access issues in their rural service areas. More than half of the surviving consortia have continued to make essential health care services available, develop additional capacities to meet emerging needs, and with the securing of more stable methods for supporting operations, continue to evolve into mature, effective, delivery system partnerships. Participation in the RHOGP has clearly had a demonstrable impact on strengthening local health care delivery in many rural areas across the country.

Almost one third of the surviving consortia reported efforts had been made to replicate their successes in other parts of the country. Nine out of ten of these efforts were the direct consequence of the active dissemination of information or the provision of on-site project assistance by former grantees.

To facilitate the further dissemination of the experiences of the grantees and to foster healthy consortia with the capacity to address rural health care needs, the RHOGP should consider the following recommendations:

- One of the hallmarks of the RHOGP has been its flexible approach to consortia organizational structure and the ability to amend action plans and timetables to accommodate emerging opportunities and barriers. The RHOGP should continue in this flexible approach.

- Where possible, consortia should be encouraged to provide a blend of services to balance those that lack traditional funding streams (e.g. transportation, mental health services, wellness) with those (e.g. primary care, rehabilitation and diagnostic services) that are reimbursed by third party payers.

- Unless consortia projects and memberships are homogeneous, large memberships should be actively discouraged to minimize the disruptive effects of competing organizational agendas.

- Evidence of past collaborative relationships among the prospective consortia members should continue to be required. It may help to expand the requirement to include a majority of proposed consortia members as well as to require a greater demonstration of the types of projects that were involved and the degree of effort provided and outcome achieved.

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