POLICY BRIEF
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Rural Health Network Development Planning Grants Awarded to Entities in Counties with Majority Black, Indigenous, and People of Color Populations, 2003-2020

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Key Findings

- **Of the 430 HRSA-funded Rural Health Network Development Planning Grants awarded between the years 2003-2020, a total of 10% (n=44) went to counties and U.S. territories where the population was majority Black, Indigenous, and people of color.**
- **The most frequent focus area of these 44 grantees was systems improvement (n=15, 34%) – or work related to increasing access to and quality of care, care coordination, and integration of care.**

Purpose

The purpose of this policy brief is to describe the prevalence of Rural Health Network Development Planning Grants awarded to organizations located in counties where the population is majority Black, Indigenous, or people of color. We also identify the primary focus areas of work for these grantees, and how that focus has changed over time.

Background and Policy Context

The Rural Health Network Development Planning Grant ("Network Planning Grant") is a program funded through the federal Health Resources and Services Administration (HRSA), and administered by the Federal Office of Rural Health Policy's (FORHP) Community-Based Division.[1] The purpose of the Network Planning Grant is to assist in the development of an integrated health network, specifically for network participants who do not have a history of formal collaborative efforts. The one-year Network Planning Grant offers rural health care organizations the opportunity to better address community needs and respond to challenges while achieving efficiencies, expanding access to, coordinating, and improving the quality of essential health care services and strengthening the rural health care system as a whole. Each year, the Network Planning program awards an average of 20 grants, with a maximum award amount of $100,000 per grantee.

Rural areas of the U.S. have always been racially and ethnically diverse, and are increasingly so in recent decades.[2,3] Currently, more than one in ten (11%) of all rural U.S. counties are majority Black, Indigenous, or People of Color (BIPOC).[4] As such, and given the impact of structural racism on health outcomes and access to resources, it is critically important to assess the distribution of funding programs like the Network Planning Grant by race and ethnicity.[5] In this brief, we do that by identifying the proportion of grants from 2003-2020

that have gone to U.S. counties and territories where the majority of the population is BIPOC.

Approach

Data for this study came a review of funded proposals for the FORHP Network Planning Grant program, which providers financial support and technical assistance to assist in the planning of integrated rural health networks. We reviewed 430 funded proposals from 2003-2020, with the exception of 2004, for which proposals were not available for review. We used the primary county/territory of the organizations that applied for the Network Planning Grants, as identified in grant application materials, to determine the prevalence of grantees from counties with a majority BIPOC population. This included majority non-Hispanic Black, majority Hispanic, majority Indigenous, and grantees with no majority group. These locations were checked and validated for consistency by two members of the research team.

Next, primary counties were cross-referenced through Microsoft Excel's V-Lookup function with 2013 Urban Influence Codes, the most recent version available. These codes classify counties into twelve groups, two being metro (urban) and the rest being rural (including both noncore and micropolitan counties).[6] We used data from the American Community Survey to classify counties as majority non-Hispanic Black, majority Hispanic, majority Indigenous, and no majority racial or ethnic group. (There is no county in the U.S. that is majority Asian.) From the 430 grant awardees, 41 awardees emerged as located in counties with majority BIPOC populations. Three awardees were identified by hand as located in U.S. territories after being flagged as errors through the V-Lookup function. Therefore, a total of 44 awardees were determined to be located in counties with majority BIPOC populations. Many other grantees operating in majority white counties may also serve predominantly BIPOC populations; the results from this brief provide one way of looking at the distribution of grants by race and ethnicity among rural areas.

We then reviewed the 44 grantees identified to categorize the areas of focus for each grantee's work. Work focus areas were coded by a research assistant, who then met with another member of the research team to discuss differences. Focus areas were categorized into the following seven different themes: *systems improvement, population health, behavioral health, workforce, health information technology, emergency medical services,* and *social determinants of health*. See Table 1 (below) for detailed descriptions of what focus areas include. Results highlight different numbers of awardees in majority non-Hispanic Black, majority Hispanic, majority Indigenous, no majority group, and U.S. territories over time and changing areas of focus.

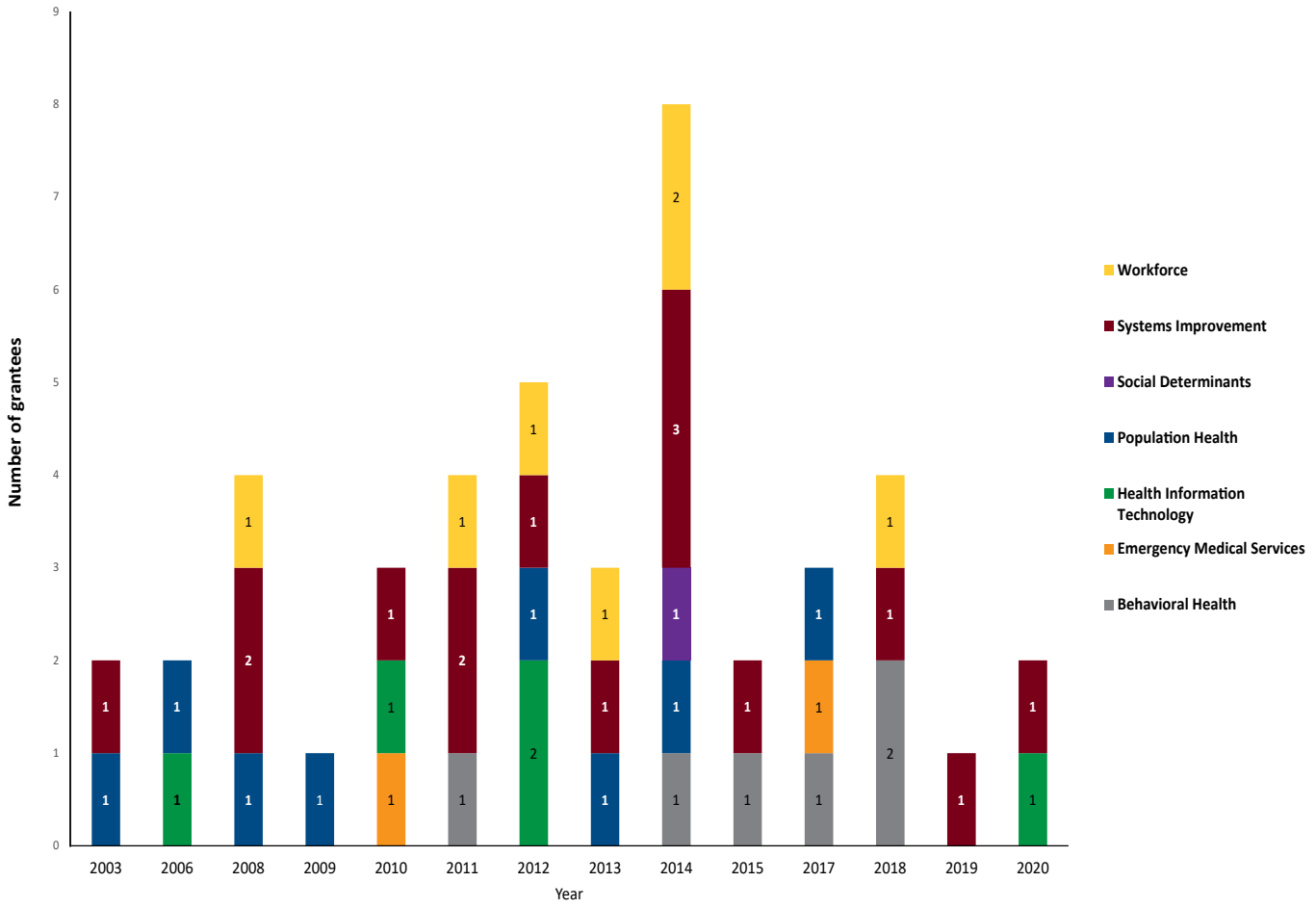
Results

Of the 430 grants awarded between the years 2003-2020, 10% (n=44) went to counties with majority BIPOC populations. A majority of these awardees were

Table 1. Focus of Grantees' Work

Focus Area	*Description*
Systems Improvement	Work related to increasing access to and quality of care, care coordination, and integration of care
Population Health	Work related to specific populations such as uninsured, low income, elderly, children, or populations who live with specific diseases such as diabetes, HIV, etc.
Behavioral Health	Work specific to improving mental health outcomes, reducing substance use disorder, or increasing access to these services
Workforce	Work that aimed to recruit, retain, develop or train clinical and health care workforce
Health Information Technology	Work that focused on developing, implementing, or sharing telemedicine, electronic records across health care providers to increase communication and share resources
Emergency Medical Services	Work to increase, streamline and share emergency medical services across geographic regions
Social Determinants of Health	Work that focused on factors that are outside of the traditional health care space such as transportation, education, justice-involved etc.

Figure 1. Number of Grantees by Year and Focus of Work, 2003-2020*



**Note that the year 2004 was unavailable for review and inclusion in this analysis. The years 2005, 2007 and 2016 are not included in this graph as there were no grantees awarded to applicants located in majority BIPOC counties in those years.*

located in a rural county (n=34, 77%). Seven grantees (15%) were in urban counties, and three grantees (6%) were located in a U.S. territory. It is important to note that in cases where the grant awardees were located in an urban county, the service area still focused on providing services to rural communities. Additionally, this finding reflects the variability inherent in defining rurality; a grantee may be classified as "urban" by county, but rural by their census tract or other level of geography for the purposes of this grant program.

Figure 1 displays the breakout of these 44 grantees over time, with an average of three awardees per year located in a primary county/territory with a majority BIPOC population, and their respective focus of work. The graph shows that systems improvement work is present in nearly every year, making it the most frequent focus of work (as seen in Figure 1). In the past six years, however, grantees' work has begun to focus more on behavioral health outcomes.

Across all years, the most frequent focus of the grant awardees was systems improvement (n=15, 34%), or work related to increasing access to and quality of care, care coordination, and integration of care. Eight grantees (18%) work focused on population health, seven grantees (16%) focused on improving and enhancing workforce, six grantees (14%) focused on behavioral health outcomes, five grantees (11%) focused on health information technology improvement, two grantees (5%) focused on increasing emergency medical services, and one grantee (2%) focused on identifying and addressing social determinants of health.

Table 2 (next page) describes the percentage of grant awardees located in majority BIPOC counties and territories. Across all years, 10% of grantees were located in

Table 2. Percentage of Grantees in Minority BIPOC Counties by Year

Year	*Grant Awardees in Majority BIPOC Counties and Territories*	*Total Grant Awardees*	*Percentage Awarded to Applicants in Majority BIPOC Counties and Territories*
2003	2	13	15%
2005	0	19	0%
2006	2	14	14%
2007	0	10	0%
2008	4	33	12%
2009	1	20	5%
2010	3	30	10%
2011	4	20	20%
2012	5	26	19%
2013	3	20	15%
2014	8	67	12%
2015	2	23	9%
2016	0	22	0%
2017	3	23	13%
2018	4	36	11%
2019	1	26	4%
2020	2	28	7%
Total	44	430	Average 10%

majority BIPOC counties, with individual years ranging from 0-20%. While 2014 was an outlier with the highest number of awardees in a single year (n=8), 2011 had the highest percentage of BIPOC awardees based on the total number of awards allocated that year (n=4, 20%).

Discussion

This analysis identified 44 (10%) of the 430 Network Planning Grant awardees as located in counties/territories with majority non-Hispanic Black, majority Hispanic, majority Indigenous, or no majority racial or ethnic group. This represents a slightly lower percentage than the 11% of all rural counties that are majority BIPOC. The impact of structural racism on health for BIPOC individuals is well-documented,[7] and there is growing evidence for dual disparity caused by the intersection of racism and rurality.[4,8–10] As we seek health equity for all people in rural America, it is important to pay attention to the distribution of resources allotted by race and ethnicity. In the case of the Rural Health Network Development Planning Grant, it is worth exploring how opportunities could be expanded to attract a more diverse pool of applicants.

Limitations

This analysis is subject to two overall limitations. First, the primary county for these grantees is not the only impacted county by their proposed work. Grant application materials included a broader service area that listed counties, which would be included within their scope of work. Grant awardees whose primary county was not located in a majority non-Hispanic Black, majority Hispanic, majority Indigenous or no racial or ethnic majority county were not included in this analysis. However, grantees could have had a majority white primary county, but theoretically had a service area that included a county with a majority BIPOC population. This indicates that there are potentially more counties with majority BIPOC populations who benefitted through this grant program than the 44 included in this analysis. Second, looking at counties by the majority racial or ethnic group is a blunt measure; there is often considerable racial or ethnic diversity even in counties that are majority white. However, this analysis

provided is an important first step in understanding the distribution of this grant program to the rural places where BIPOC individuals are more heavily concentrated. Future evaluations of this, and other rural-focused federal grant programs should take into account both community racial and ethnic composition as well as the composition of specific individuals served. Doing will require use of existing data sources (e.g., Census data and FORHP's Performance Improvement and Measurement System), but may also require additional data collection and more reporting on grant distribution by race and ethnicity.

Conclusion

The federal government aims to support rural organizations in addressing the unique health needs of their communities through grant programs such as the Rural Health Network Development Planning Grant. To ensure that communities who need these grant funds the most receive them, and to address integrated, whole-person care, we recommend that HRSA consider racial and ethnic composition of a grantee's service area in funding decisions. HRSA could accomplish this by continuing to ensure that funding opportunities are dispersed through a broad range of mechanisms to attract a diverse pool of applicants. Additionally, HRSA could review those applications for a focus on health disparities and racial equity. Further, HRSA could review its grant application process to reduce barriers for communities with fewer resources. Especially in light of the systemic racism exacerbated by the COVID-19 pandemic, it is integral that communities who are disproportionately burdened with adverse health outcomes are provided with tools to support the health of their populations as individual communities determine necessary.[11]

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