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Changes in Need, Changes in Infrastructure: A Comparative Assessment of Rural Nonprofits Responding to COVID-19

Margaret F. Sloan [1,*], Tina Switzer [2], Laura Hunt Trull [3], Claire Switzer [4], Melody Eaton [2], Kelly Atwood [5] and Emily Akerson [6]

[1] College of Business, James Madison University, Harrisonburg, VA 22801, USA
[2] College of Health and Behavioral Sciences, James Madison University, Harrisonburg, VA 22807, USA
[3] Center for Rural Health Research, East Tennessee State University, Harrisonburg, VA 22807, USA
[4] Blue Ridge Hospice, Winchester, VA 22601, USA
[5] Graduate Psychology, James Madison University, Harrisonburg, VA 22807, USA
[6] Institute for Innovation in Health and Human Services, Harrisonburg, VA 22807, USA
* Correspondence: sloanmf@jmu.edu

Abstract: Due to the variance in community infrastructure and resources, COVID-19 impacted rural communities differently than their urban counterparts. This study examines two waves of data from a survey of rural residents in the Shenandoah Valley of Virginia regarding how community organizations responded to the pandemic, what strategies were most successful, and where needs shifted. The findings demonstrate that organizations with deeply embedded community leaders achieve higher levels of collaborative change in a timely manner. Additionally, mental health services have become a more pronounced need as a result of the pandemic. The interdependence of community needs, recognized by community members, calls for collaborative strategies for the future.

Keywords: rural; COVID-19; rural nonprofit; pandemic; nonprofit leadership; rural leadership; qualitative

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1. Introduction

Globally, the response to the COVID-19 pandemic impacted the economy negatively, widened inequalities, and affected various sectors such as agriculture, food security, nutrition, education, tourism, trade, and transportation [1]. In the United States, the decentralized response allowed local authorities to interpret regulations and develop policies. Although rural areas have experienced significant trauma as a result of COVID-19, the focus of pandemic discussions has largely been on urban areas with higher case numbers. Pollard and Mare', and later KaKan, define a geographic community as inclusive of its people and culture, sharing its resources and institutions [2]. Rural populations and their nonprofit organizations face specific community challenges that are often overlooked in discussions of the pandemic [3].

Throughout the pandemic, nonprofit organizations have adapted significantly to provide uninterrupted services for low-income, vulnerable, and disadvantaged individuals [4–10]. Even prior to the pandemic, nonprofits played a vital role in aiding communities to mitigate and resolve problems across various social setups and sectors [6,11], yet along with their work addressing immediate issues, nonprofits excel at adapting and exhibiting resilience to assist communities in navigating change [12]. Faced with rising demands during the pandemic, rural nonprofit organizations considerably expanded their capacity while adhering to safety guidelines and adjusting strategies in response to dynamic government directives [10]. Van Fenema and Romme [13] characterize this adaptive response to unpredictable emergencies as "latent organizing,"

wherein organizational employees promptly and efficiently address a crisis without expecting immediate economic returns [14,15]. Numerous instances of latent organizing have been observed within the human services industry during the COVID-19 pandemic, with many workers sacrificing their well-being to provide life-saving services for vulnerable individuals [16].

In early-stage pandemic research, Sloan et al. [17] explored the impacts of COVID-19 on rural communities and the responses of nonprofit communities and other community infrastructure within the Shenandoah Valley. The study conducted in June 2020 utilized survey research along with four interviews with key informants. Building on Sloan et al.'s work, this paper examines changes in community needs and themes within nonprofit organizations due to the pandemic by comparing survey responses collected in 2020 with those gathered in 2022.

Conceptual Background

Approximately 60 million people, or around 19 percent of the U.S. population, reside in rural areas, according to the U.S. Census [18]. Additionally, 12.4 percent of Virginia's population lives in non-metropolitan areas, making the rural effects of COVID-19 impact over one million residents [18]. While rural life offers advantages such as easier maintenance of social distance and the ability to enjoy outdoor spaces, rural areas faced significant challenges and disparities during the COVID-19 pandemic, including health literacy, accessible testing [19], and increased mortality [2]. The fragile infrastructure in rural communities can exacerbate long-term negative effects, including unemployment and limited access to healthcare [10]. COVID-19 testing in rural America was notably slower than in urban centers, resulting in less documented viral spread and fewer cases [2]. Anzalone et al. [20] found that rural residents were about 36% more likely than urban residents to die within 90 days after being hospitalized with COVID-19. Health disparities that existed in rural areas before the pandemic in the U.S. were amplified by the lack of preparedness in these areas [21]. Souch and Cossman [19] pointed out that individuals over 65, those with obesity, and those who smoke or use e-cigarettes face higher COVID-19 risks, factors that manifest differentially in rural communities [22]. Moreover, rural residents often encounter challenges related to reduced access and capacity in their healthcare facilities [19].

Beyond the elevated risk of COVID-19 mortality, the rural population is particularly vulnerable to disruptions in the economic infrastructure of their communities. If one business fails, there may not be another readily available to employ its workforce. While rural employment and population have been on the rise from 2010 to 2019 [23], the growth rates are slower compared to metropolitan areas. Rural areas have both strengths and challenges when it comes to meeting the health, social, and economic needs of their residents, and this has been clearly demonstrated during the pandemic.

The unique context for this study is the rural areas of three Virginia U.S. counties, including Page, Shenandoah, and Rockingham. According to the Center for Rural Innovation, the demographic, socioeconomic, physical capacity, and human resources data indicated that Shenandoah County was categorized as low, Rockingham County as very low, and Page County as extremely low preparedness for COVID-19 [24]. Two of the three counties hold a rural designation from the US Health Resources and Services Administration (HRSA) and exhibit a poverty level ranging from 9% to 17% [25]. Furthermore, 6% to 12% of the residents in these counties experience food insecurity and/or live in food deserts, highlighting challenges related to distance from or lack of resources [26]. All three counties are designated as health professional shortage areas for medical, dental, or mental health care [27]. Notably, an average of 20.5% of the population in these counties is over the age of 65, placing them in a high-risk category for COVID-19 mortality [27].

The Rural Health Information Hub discusses healthcare access barriers in rural communities and how overall physical, social, and mental health status, disease

prevention, detection, diagnosis, and treatment of illness, quality of life, avoiding preventable deaths, and life expectancy are all rooted in these access challenges. The Robert Wood Johnson Foundation [28] lists important rural challenges and barriers to resources, which include geographic distance and transportation, workforce shortages, health insurance coverage, broadband access, poor health literacy, and social stigma/privacy. Specific healthcare resources that rural communities find difficult to access include home health, hospice and palliative care services, mental health services, substance use disorder care, and reproductive, obstetric, and maternal health services [29].

Healthy People 2030 defines social determinants of health (SDOH) as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" [30]. Examples of the SDOH are safe housing, transportation, and neighborhoods; education and literacy skills; job opportunities and income; access to nutritious foods and physical activity opportunities; and safe air and water quality. These SDOH clearly intersect with community resources, or lack thereof, in both urban and rural areas. Additionally, Walters [31] found that frail infrastructure in rural communities may have compounded longer-term negative effects such as unemployment and access to care. When a community's infrastructure is unable to meet the SDOH, especially the health-related social needs (HRSNs) of its residents, outcomes are likely to be negatively impacted [32].

Rural nonprofits have historically faced funding, organization, and strategic challenges and are familiar with gaps in services, doing more for less. There are several challenges related to funding: receiving on average USD 401–648 less per capita in federal funds, 1.4 percent less in corporate giving, and 6.8 percent of overall foundation funding. Even given these challenges, rural nonprofits' remain financially healthier than their urban counterparts due to cash reserves and the avoidance of deficit operating. Successful rural nonprofit organizations develop strategic relational partnerships, tailor their programs to meet their specific community needs, and maintain nimble program design to align with funding opportunities [33,34].

Sloan et al. [17] surmised that rural communities experienced "unique challenges and were forced to demonstrate resiliencies during the COVID-19 public health crisis," and furthermore, "the rural barriers to health, work, and education experienced on an ongoing basis were exacerbated by the pandemic" (p. 63). Their original study, conducted in 2020, explored community perceptions of local resource needs (including SDOH) and perceived strengths and asked participants to rank areas of concern in their communities, followed by a series of questions regarding what was helpful during the pandemic. This research seeks to explore and compare responses from the same communities two years into the national emergency from a strength's perspective [35], acknowledging the unique context of these communities. The strengths perspective recognizes that rural communities possess many resources and assets they can bring to bear on their community challenges, rather than being devoid or lacking in resources.

2. Methods

The sample for this study was drawn from three rural counties in Virginia (see Figure 1). Participants were excluded if they did not reside in one of the counties and if they did not identify as living in a rural area. Residents and other stakeholders from these three counties participated in the original 2020 survey, and an identical survey was distributed in 2022 with the addition of one question asking how needs had changed as a result of COVID-19. All participants who participated in the 2020 survey were directly contacted for the 2022 version, as well as all the original contacts for the first wave. Because the team again sought to gain as much information as possible without leading the participants, most of the survey questions were open-ended. Previous local community conversations informed the list of needs presented on the survey. After the first wave of the survey, the research team conducted selected stakeholder interviews with leaders whose organizations were noted by survey respondents as particularly helpful during the

pandemic to further contextualize the survey responses. These nonprofit leaders represent four organizations that provide essential and extended services: Page One, Elkton Area United Services, Living Legacy Community Center, and The Counseling and Psychological Services (CAPS). Page One and Elkton Area United Services are both social service organizations with a broad base of programs such as food and housing assistance. Living Legacy Community Center provides tutoring, food service, meeting space, sports, and games to the local youth. The Counseling and Psychological Services (CAPS) program is a mental health organization affiliated with a regional university that provides one-on-one and group mental health counseling services to the area. Interviews included four semi-structured interview questions, lasted approximately one hour, and were conducted via web conferencing.

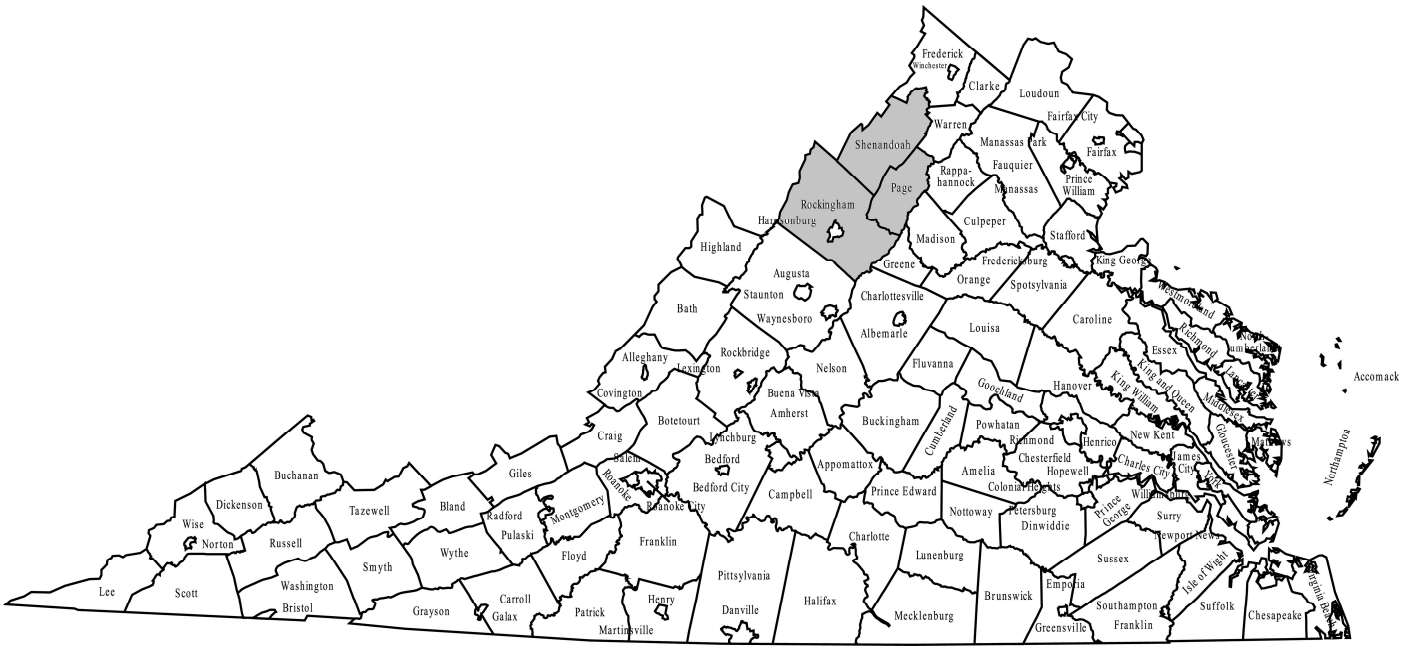

Figure 1. Map of counties (source: Adobe Stock image).

To reach these rural populations, the research team initiated the exploratory survey (see Appendix A), employing a snowball sampling technique based on community networks. The research team elected to keep surveys anonymous to encourage participation. The survey was distributed throughout the leadership team's professional networks via email, with requests to share the survey among their contacts residing within the three-county area. The first question of the survey asked if respondents reside in an urban or rural area; those responding "rural" were included in the data analysis. Wave 1 of the survey was administered from 12 June to 29 June 2020 at the beginning of the COVID-19 pandemic, and Wave 2 collected data two years later, from 6 July to 11 September 2022, after pandemic restrictions were lifted. Both waves utilized Qualtrics for electronic survey distribution. During Wave 1, respondents could register for a USD 10 cash card, but the funding was not available to support that incentive during Wave 2. The average survey completion time was 13 min. The purpose of this study is to compare the results of the two waves of data.

The survey contained both qualitative and quantitative questions for responses. Surveys requested participants rank areas of concern in their communities, followed by a series of open-ended questions regarding helpful measures during the pandemic. Researchers may contact the publication team to obtain a copy of the survey. The survey was intentionally designed to be largely open-ended, aiming to gather information without imposing expectations or leading the participants. Moreover, the research team adopted an asset-based approach and employed a strengths-based perspective [22] to

comprehensively explore the support and response landscape within the community rather than just the deficits.

To develop coding for the data analysis, the research team initially identified a priori codes related to problem areas highlighted in previous community listening sessions held by the research team prior to the pandemic in these counties and considered challenges and opportunities outlined in the emerging literature on pandemic responses in rural settings. Subsequently, the data underwent examination for additional subthemes within the a priori codes as well as emergent themes not initially anticipated. After independently coding by three teams of two researchers, the whole team convened to review individual coding, practice reflexivity [3], and address any disparities to achieve consensus. The integration of both strands of qualitative data involved multiple interactions among the research team. Themes across the two waves of data were collectively discussed to refine and synthesize the findings.

3. Results and Discussion

Demographics for respondents differed slightly between the waves, as noted in Table 1. For Wave 1, two hundred forty-eight (248) rural adults responded to the survey. Survey respondents identified as predominantly white (93.6%), female (82.84%), and married (78.98%). Ages varied, with 9.64% between 18 and 29, 33.13% between 30 and 49, 45.58% between 50 and 65, and 11.45% over 65. Approximately 10% of the group had a high school degree or less, with 30.68% having some college or an associate degree, 27.27% with a bachelor's degree, and 31.82% with a graduate degree. For Wave 2, out of a pool of 127 people who accessed the survey in Wave 2, 75 respondents fully completed the survey. The reduction in respondents from Wave 1 to Wave 2 may be attributed to "survey fatigue" reported by numerous researchers throughout the COVID-19 pandemic and the lack of incentive payments in Wave 2. [12]

Table 1. Comparison of respondents.

	Wave 1	**Wave 2**
N=	248	127
% white	93.60	90.67
% female	82.84	91.00
% married on in domestic partnership	78.98	77.63
% Bachelors degree or higher	59.09	63.00
Median age	49.85	49.50

In examining demographic data, most respondents, 90.7%, identified themselves as white, followed by 5.3% identifying as black. 1.3% of respondents identified as Hispanic/Latino, Native American/American Indian, or other race not specified. Of the 68 that disclosed gender, 91% of respondents identified themselves as female, with the remaining 9% identifying as male. Most respondents (77.6%) were married or in a domestic partnership. Respondents tended to be diverse in terms of age, ranging from 21 to 86, with a median age of 54. Survey respondents tended to be highly educated, with 63% having obtained a bachelor's degree or higher. No respondents reported having below a high school diploma or GED. 96.4% described their community as "rural," and 3.6% perceived theirs to be "urban."

On average, survey respondents from both waves of data collection tended to be older and more educated than the general population. The median age of respondents was 54, approximately ten years older than that of both Page (45.3) and Shenandoah (44.5). The greatest limitation of this survey beyond sampling may be the educational disparity between respondents and that of the general population of these communities, with 63% of respondents reporting having a bachelor's degree or higher, compared to only 14.6%

and 20.4% of Page and Shenandoah residents, respectively. The sample's skew toward white females may not fully represent the perspectives of these counties' full population, which, although predominantly white (92%), also has an employment rate averaging 58% with only approximately 30% having a degree higher than high school. This misalignment may be an indication that this data overlooks the needs of the broader, and potentially more vulnerable, populations in each county. However, the samples are derived from networks of those well connected with support networks in these communities by nature of the snowball technique and, as such, can provide valuable information and perspectives on the needs and resources within these counties.

3.1. Community Needs

As indicated in Table 2, survey respondents were asked to rank the following community needs: transportation, healthcare, mental health, substance abuse, housing, childcare, food/grocery access, business support technology access, infrastructure, and employment, with values ranging from 1 (most important) to 11 (least important). During Wave 1, collected early in the pandemic, employment was identified as the greatest need with a mean of 4.08, followed by healthcare (4.62). In descending order of need, the other categories included: substance abuse, mental health, food/grocery access, housing, technology access, transportation, childcare, infrastructure, and business support. In Wave 2, the priorities shifted so that mental health was ranked number one most often (20), followed by employment (17), and healthcare (16). Although housing was not ranked the number one need as often, the importance of housing within the rankings experienced the largest gain from Wave 1 to Wave 2, rising almost a full point (−0.98); mental health has the second highest gain in importance with a −0.64 difference. Food access, employment, and transportation experienced the widest decreases in importance, respectively.

Table 2. Comparative a priori mean needs rankings from Wave 1 and Wave 2 data.

Need area	Wave 1	Wave 2	Difference	Avg rank over time
Business support	8.22	8.48	+0.26	8.35
Childcare	5.82	5.45	−0.37	5.64
Employment	4.03	4.60	+0.57 **(0.092)	4.35
Food/groceries access	5.76	6.63	+0.87 *(0.021)	6.20
Healthcare	4.60	4.79	+0.19	4.695
Housing	5.54	4.56	−0.98 * (0.009)	5.05
Infrastructure	8.35	8.20	−0.15	8.275
Mental Health	4.90	4.26	−0.64 **(0.063)	4.58
Substance abuse	5.20	4.82	−0.38	5.01
Technology access	7.19	7.38	+0.19	7.285
Transportation	6.39	6.83	+0.44	6.61

* Indicates a statistically significant difference (Welch's test < 0.05); ** indicates a statistically significant difference (Welch's test < 0.10).

In 2022, 71% of respondents selected yes in the answer to "Have the needs in your community changed as a result of COVID 19?" While pre-test respondents determined that employment was the greatest local need, followed by healthcare, substance abuse, mental health, food/grocery access, housing, technology access, transportation, childcare, infrastructure, and business support, the 2022 ranking reflected a shift toward more health care, particularly mental health needs. While all needs rankings shifted somewhat, food access and housing demonstrated a statistically significant difference in means between Waves 1 and 2 as indicated by ANOVA (Welch's test <0.05), and employment and mental health had weaker statistically significant differences at 0.10.

On average, the highest-ranked needs were "mental health", "housing,", and "employment", respectively. The lowest ranked needs were "business support", "infrastructure", and "technology access". However, "technology access" had the highest variance and standard deviation, followed closely by "food/groceries access," and "transportation", indicating that though these areas were not highly ranked, the significant variation may warrant closer examination.

Nuances within the rankings shifts across community needs were invested more deeply through the qualitative data where participants were asked to explain their rankings. Respondents were asked multiple open-ended questions regarding community needs, assets, the ways in which the COVID-19 pandemic impacted the community, suggestions for interventions, and any innovations or collaborations that emerged in the community during the pandemic (a new question not on the 2020 survey). Respondents indicated that existing needs were exacerbated by the COVID-19 pandemic stating that "these issues that already existed have significantly increased" and "[a]ll of the items of need have been emphasized". One respondent provided a comprehensive answer that underscores the interconnectedness of needs, writing, "healthcare delivery has changed dramatically. Businesses have closed and employment is down. Fuel is outrageous and transportation is difficult. Technology is slow in this area. Drugs are in the rise. Children are suffering. It all seems intertwined with a negative trickle a down effect. the local government has limited resources". Overall, the open-ended responses from both waves of data reflected the importance of mental health, healthcare, employment, and housing resources, as well as the challenges in accessing these resources two years into the pandemic.

Several individuals also expressed difficulty ranking these needs, as they felt they all needed to be addressed and were very closely related ("It was difficult to rank some because of which came first? The chicken or the egg"). One individual even stated that if their first five ranked needs are addressed, "the rest falls into place". This interdependence of needs was also a theme in the 2020 responses. The SDOH were clearly referenced in the open-ended responses with employment (financial resources), food insecurity, housing, and education listed by many of those surveyed. Many responses mentioned "lack of services,", "limited resources", "basic needs,", and lack of housing and employment opportunities. When asked to "describe how the needs in your community have changed as a result of COVID-19", the responses were reflective of the ranked needs and expressed that already existing challenges were greatly exacerbated by the pandemic, especially with healthcare resource access and housing, as well as business stability and employment. Many responded that mental health and substance use issues increased during the pandemic, and again, technology infrastructure as related to increased need was discussed by many. Respondents also shared frustrations with access to healthcare resources. Responses to the "greatest difficulties encountered by your community in light of COVID-19" aligned with the ranked challenges, but additionally, the word "isolation" was used by eight different respondents along with other descriptors for limited social connections listed as challenges. As previously described, "technology access" had the widest variance and deviation; however, in the short answer responses, multiple respondents mentioned technical or internet access challenges related to virtual school, education, or healthcare. Table 3 enumerates the significant community challenges noted by respondents.

Table 3. Key themes: greatest community challenges.

Theme	Elaboration
Increased need for internet access	The demand for faster and more reliable internet service is consistently highlighted, particularly for online learning, telehealth, and virtual communication.
Escalation of mental health Challenges	A significant increase in mental health problems is noted, with greater stress, anxiety, and depression observed. The strain on local healthcare facilities and community services is emphasized.
Impact on education	The lack of internet access and resources has created challenges for students, leading to stress in households and a greater need for technology. Educational disparities and the digital divide are evident.
Elevated healthcare needs	There is a perceived greater need for healthcare services, with emphasis on the challenges in accessing prompt appointments, wellness visits, and telehealth services.
Economic struggles	Unemployment, homelessness, and economic hardships have increased, with implications for housing affordability and overall cost of living. Business closures and supply shortages are mentioned as contributing factors.
Substance abuse issues	Substance abuse problems are reported to have risen, potentially linked to increased stress, unemployment, and disruptions in daily life.
Challenges in accessing housing	Decreased access to housing is identified as a concern, exacerbated by rising prices and changes in housing programs during the pandemic.
Governmental impact on the economy	Criticisms are expressed regarding the governmental response to the pandemic, with claims that decisions have negatively affected the ability to work and live.
Limited mental health resources	Mental health support and access are reported to be challenging, with long waiting lists and temporary closures of mental health facilities due to staff shortages.
Changes in employment landscape	Layoffs, changes in employment opportunities, and mistrust in workplaces are highlighted as economic challenges faced by the community.
Disparities in healthcare access	Issues related to access to physicians, appointments, and healthcare needs are reported, with concerns about disparities and changes in healthcare delivery.
Challenges in housing programs	Changes or stoppages in housing programs during the pandemic are noted as impacting the availability and affordability of housing.
Impacts on the older population	The older population, in particular, is reported to be still isolated, with changes in employment opportunities and neglect of healthcare needs due to fear of contracting COVID-19.
Transportation and healthcare access	Transportation needs are mentioned, particularly in relation to accessing healthcare services, indicating challenges in mobility and health-related travel.

3.2. Community Assets

In terms of assets, organizations that were frequently identified as "effective" within the community for Wave 1 continued to be noted as significant in Wave 2. Such organizations included Page Alliance for Community Action (a youth outreach organization), Choices (a women's shelter), Valley Health System (the regional health system), the local free clinic, Page One (a resource assistance center), the Chamber of Commerce, and the public school system. Several respondents also indicated the value of faith-based organizations as well as other informal supports within the community. One participant identified "churches, nonprofit organizations, neighbors, and families looking

out for one another" as assets. Another participant stated, "Faith-based food and assistance programs really stepped up during COVID. Also, our Department of Social Services.". Other key assets mentioned included other civic organizations (Ruritans), local law enforcement and emergency medical services, libraries, local food and shelter resources, and volunteers in the community. Resources identified as helpful in light of COVID-19 included vaccine clinics and testing access, telemedicine (as well as other virtual options), Wi-Fi access at community access points, meal/grocery deliveries, and support provided by Valley Health System. Many respondents said federal and state policies such as tax credits, grants, and free school lunches had a positive impact within the community.

When asked for suggestions for interventions within the community, respondents placed an emphasis on the need for greater access to healthcare and mental health services. A participant reported, "The hospital works well with [the] free clinic and [the] rural health clinic… However, we have a long way to go to make sure all receive healthcare, especially mental health.". Along these lines, several suggested that some access challenges and disparities may be mitigated by an urgent care facility,after-hours care, or provider recruitment and incentives. Increased access options for healthy foods, transportation, and broadband. Many also indicated a need for raising awareness and more effectively connecting individuals to existing resources within the community. Furthermore, respondents placed emphasis on the importance of building interpersonal and interorganizational connections through outreach and community meetings.

Innovations or collaborative partnerships identified included a local community center, the town, churches, and other organizations working together to support youth, online church services, expansions on local services including porch visits (food delivery and outreach) and local peer recovery resources, and community gardens as innovations or partnerships. This may be an unrevealed result of latent organizing [13], as nonprofit organizations were nimble and ready to address and respond to community needs without the community members explicitly recognizing their out-of-sight efforts.

4. Conclusions

4.1. Community Recommendations

Themes identified across the two waves of data collectively reflect a complex web of challenges faced by these communities, underscoring the interconnectedness of various factors such as technology, healthcare, employment, and housing in shaping the overall well-being of individuals. A breech or lack of strength within any area of this web negatively impacts social determinants of health, both physical and mental. Because essential economic and healthcare infrastructures are lacking within these communities, the impacts of COVID-19 that are being experienced across both rural and urban communities are more difficult to rectify through appropriate treatment.

In keeping with a strengths-based approach, this research provides evidence of the ingenuity and resourcefulness of rural communities to identify and consider solutions given their needs. There is also the unstated impact of latent organizing [13], which allows collaborating nonprofit organizations to have a nimble and adaptive response to crises in rural areas. When asked what might be beneficial for their community moving forward, respondents provided a wide array of ideas for interventions that bear consideration, including:

4.1.1. Infrastructure

Although infrastructure as a stand-alone category was consistently ranked the least important in the list of community needs across both waves of the survey data, many of the recommendations from community members moving forward advocated for the development of community infrastructure for technology, business, healthcare, food supplies, and housing. Although in some cases, these resources already exist, affordability

was a barrier for residents. Respondents also recommended the allocation of funding to address aging infrastructure in the community.

The interconnectedness of infrastructure issues was noted by respondents with comments encouraging: primary care providers to work in rural areas through incentivization; the promotion of preventive education and awareness programs to address healthcare challenges; prioritization of economic development and higher-paying job opportunities to elevate income and assets, addressing various community issues; efforts to provide broadband internet services to rural areas to prevent the loss of potential talent and opportunities; the benefits of broadband access for citizens, particularly in aiding access to education and telehealth services; people's ability to return to work and stay employed and support for start-up businesses; the establishment of public transportation to support businesses and access to healthcare services; and recognition of the need for an urgent care facility in Page County for general healthcare access.

4.1.2. Funding and Capacity Building for Nonprofits

It is important to advocate for initiatives that invest in the growth and sustainability of nonprofits while addressing community needs. Examples of services that would provide community support include the following: the development of a YMCA within the community; the establishment of a rescue mission for men with drug and alcohol abuse; and the development of a community college or adult education center, particularly along a specified bus route. Some respondents suggested funding directed toward organizations supporting existing community needs was more important than further developing infrastructure.

4.1.3. Mental Health Resources and Connection Building

Advocacy for increased funding for mental health resources and initiatives to connect people and build relationships within the community. Respondents recognize the linkage between substance abuse and mental health, encouraging the establishment of local substance abuse treatment facilities to address this rising priority. Particularly seeking the increased impacts of COVID-19 on depression, respondents recommended the integration of classes in the school system addressing drugs and depression, with a focus on both older and younger populations.

4.1.4. Public Communication Strategies

While distress with public communication was a thread in Wave 1 data early in the pandemic, this theme continued in the second data collection, particularly regarding ideas to increase effective communication within rural areas. Consistent with the findings of Fuller and Rice (2022), nonprofits within this study sought both perseverance and innovation within their COVID-19 communications strategies [36]. Suggestions included the development of easily accessible information targeted for seniors, the undereducated, and those with English as a second language. Such communications should focus on healthcare and educational services, particularly regarding available local, state, or federal programs. Respondents also advocated for conducting more community meetings that focus on shared concerns, promote unity, and advocate for practical solutions to the issues faced by the community through collaboration across the public, private, and nonprofit sectors.

Nonprofit organizations have adapted to the pandemic, expanding their capacity to meet increasing demand while adhering to safety guidelines and adjusting strategies based on dynamic government directives [37]. The concept of latent organizing has emerged, where organizations respond promptly and efficiently to crises without anticipating immediate economic value [13]. Many workers in the human services industry have taken risks to provide essential services during COVID-19 [16]. This research underscores the essential function of the nonprofit sector in providing a safety

net for rural communities where government and business resources are slim and infrastructure is constrained.

4.2. Limitations

While this study provides valuable insight into community needs and assets, some limitations exist in sampling and generalizability. First and foremost, this convenience sample data depicts the needs of several communities across geographically broad counties. Thus, these data are not necessarily accurately representative of the needs of any one community in particular and are biased due to the nature of the sampling method. Convenience sampling does not allow for response rate calculation. While the results are not generalizable, they can help inform policy and practice. Additionally, the previously described demographic data is incongruent with that of Page and Shenandoah Counties as a whole.

4.3. Future Research Considerations

The research team intends to continue sampling this rural population's perspectives through community meetings and working with researchers and community leaders to identify practical solutions that can improve the quality of life for these populations. Moving forward, this survey data may provide a helpful starting point in terms of identifying broad community needs and interventions; however, future data collection efforts should aim to address a more diverse population, with special attention taken to ensure those frequently underrepresented are included. Additionally, survey data should be divided and analyzed by county and possibly even by individual locality in order to obtain a more accurate picture of individual communities, as there is significant disparity, particularly in the resources available. It will be crucial to consider creative and perhaps unorthodox means of obtaining data conducive to the unique culture of this rural area.

In conclusion, this research illuminates the intricate tapestry of challenges faced by communities, emphasizing the interplay of technology, healthcare, employment, and housing in shaping individual well-being. The vulnerabilities exposed by the COVID-19 pandemic underscore the profound impact of weak links within this interconnected web, echoing throughout both rural and urban settings. Despite these challenges, a strengths-based approach reveals the remarkable resilience and resourcefulness of rural communities. Latent organizing [13] facilitates nimble responses by collaborative nonprofit organizations, indicative of the capacity for innovative solutions in times of crisis. As we consider the multifaceted interventions proposed by community members—ranging from infrastructure development and funding for nonprofits to enhanced mental health resources and improved public communication strategies—we recognize the potential for transformative change. By addressing the affordability barriers, incentivizing healthcare providers, and prioritizing preventive education, we can fortify these communities against the persisting challenges and pave the way for holistic well-being. The future lies in recognizing the agency of these communities, advocating for strategic investments, and fostering collaborative efforts across sectors to build a resilient foundation for enduring change.

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Appendix A. Survey Instrument

My community is best described as (choose one): Rural/Urban
My gender is _____ (open text box)
My age is _____ (open text box)
Which race/ethnicity best describes you? (Please check only one.)
American Indian or Alaskan native (1)
Asian/Pacific Islander (2)
Black or African American (3)
Hispanic American (4)
White/Caucasian (5)
Multiple ethnicity (6)
What is the highest degree or level of school you have completed?
Some high school, no diploma (1)
High school graduate, diploma or the equivalent (for example: GED) (2)
Some college credit, no degree (3)
Trade/technical/vocational training (4)
Associate degree (5)
Bachelor's degree (6)
Master's degree (7)
Professional degree (8)
Doctorate degree (9)
Question 1
Please rank the needs of your community with one being the most important and 5 being the least important.
Transportation
Child care
Healthcare
Mental health
Infrastructure
Business needs
Employment
Food/groceries access
Housing
Technology access
Substance abuse
Question 1a (open text box)
Please explain your choices from the previous question.
Question 2 (open text box)

What else, if anything, is not on this list of needs that should be?

Question 3

Have the needs in your community changed as a result of COVID-19? YES/NO

If yes, go to Question 4

Please describe how the needs in your community have changed a result of COVID-19?

Question 5 (open text box)

Please list the key assets of your community. In other words, please list the most effective organizations that get things done in your community.

Question 6 (open text box)

What have been the greatest difficulties encountered by your community in light of COVID-19?

Question 7 (open text box)

What are some things that have been helpful to your community in light of COVID-19?

Question 8 (open text box)

What do you think would be helpful for your community and/or other rural areas during this time that has not already been mentioned?

Question 9 (open text box—this question was only asked during Wave 2)

Please describe any innovations or collaborative partnerships that have emerged in your community due to COVID-19.

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