
Capacity Building in Rural Communities Through Community-Based Collaborative Partnerships

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Overview

The importance of collaboration in human service systems cannot be underemphasized for persons with disabilities, particularly within the current economic context in which budgets are more constrained and smaller numbers of personnel are responsible for larger scopes of work. When taking a holistic view of a person, it is also important to recognize that a situation may not require only one intervention, but a variety of techniques to positively influence outcomes. Collaboration is defined as working together to create or accomplish something. Collaborative partnerships are essential in rural service delivery. In this chapter, we will explore the benefits and challenges to rural collaboration and explore a variety of rural partnerships that maximize outcomes for rural residents with disabilities.

Learning Objectives

Upon completion of this chapter, the reader should be able to:

1. Identify collaboration and interagency collaboration
2. Recognize why collaboration is important in rural settings
3. Identify elements of good collaborative partnerships in rural rehabilitation
4. Recognize barriers to collaboration in rural partnerships
5. Describe models of successful collaborative relationships for people in rural areas
6. Develop strategies to identify and develop collaborative efforts for rural residents

Rural Communities

Rural communities have served as the foundation of our country. Through our nation's history, the rural life has nourished and sustained the nation. Rural communities offer unique assets and strengths as diverse as the people who reside within them. However, rehabilitation professionals recognize that there are challenges associated with providing quality services to rural community members with disabilities. It is well recognized that people residing in rural areas may experience greater economic, social, and health disparities while having access to fewer local resources (Kuipers, Kendall, & Hancock, 2001). Rural community members living with any kind of disability can be faced with multiple problems that make the

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disability harder to manage and live with. The nature of rural communities, and lack of access to specialized care and resources, can result in this population being underserved. This can negatively impact quality of life, health outcomes, and full participation in life. A thorough understanding of how to collaborate with formal and informal entities can aid in positive outcomes at the individual level and build capacity across systems. In this chapter, we will first define collaboration and describe the importance of establishing and sustaining community partnerships. We will discuss some of the barriers that may exist when serving those in rural areas. We will also explore mechanisms for developing collaborative opportunities and show an example of multi-stakeholder collaborative in Appalachian Kentucky that has engaged interdisciplinary professionals, community members, people with disabilities, and their family members. Finally, we will offer suggested ways for rehabilitation professionals and administrators to navigate the rural landscape, across agencies, across community-based assets, and across disciplines to enhance outcomes for consumers of rehabilitation services.

Collaboration

Collaboration occurs when two or more people work together to accomplish a task. More formal collaborations between people from different organizations who are working toward a shared goal are referred to as *interagency collaborations*. Collaborations in which “two or more stakeholders pool together resources in order to meet objectives that neither could meet individually” (Graham & Barter, 1999, p. 7) have the potential to greatly improve outcomes for rural populations. In times when budgets are shrinking and job tasks expanding, the opportunity to pool knowledge, ideas, and workloads can enhance efficiency and lead to better resolution for people who are utilizing rural rehabilitation services and supports.

Some examples of potential professional collaborators in rural rehabilitation are:

- State vocational rehabilitation agencies
- Centers for Independent Living (CIL)
- Public health departments
- Community mental health centers/social services
- School districts
- Cooperative Extension Systems
- Local colleges or technical schools

Within each of the above are a cadre of professionals who can provide particular expertise. However, it is also important to remember that collaborative partners do not only consist of professional providers of rehabilitation services. Powerful collaborators can also include:

- Community leaders
- Church leaders
- Community members with a variety of backgrounds who are connected to the individual with a disability

Community Partnerships

In rural communities, *community partnerships* are essential in service provision. Community partners assume shared responsibility for agreed upon goals. The partners consist of collaborators who work together positively and productively. The inherent benefits of collaboration include using the strengths of cross-disciplinary knowledge to better solve complex problems, utilizing group ideas, and brainstorming to propose solutions that may not have been thought of (or possible) when approached by a single rehabilitation professional, providing services more efficiently and with less redundancy, and by bringing together more resources that can improve outcomes.

Rehabilitation professionals can use person-centered planning tools when collaborative partnerships are being established to work with individual cases. One example of such a tool is the relationship map. Relationship maps are important resources that can identify people who serve as informal or formal supports to the person with a disability. The identified people may be family, friends, and service providers or represent other community organizations. This effort as defined by O'Brien (1992) will help to determine the community opportunities that may already exist to assist the person with a disability in achieving his or her goals and pursue interests. In rural communities, an understanding of the existing community entities can vastly improve collaborative possibilities. Below are descriptions of some potential community partners.

Potential Community Partners

Faith-Based Organizations These are churches, synagogues, mosques, and other organized religious or spiritual groups. In rural communities where resources can be scarce, a person's religious community can provide a variety of supports. While these organizations are grouped together based on faith, they also bring the respective networks of their collective members, thus potentially opening up previously untapped possible vocational or independent living options available within the immediate community.

Cooperative Extension System The Cooperative Extension System has a presence in every state in the nation. While every county no longer has an extension office, regional offices support rural communities, providing research-based information to community members and professionals around family and home, agriculture and food, community economic development, and youth. Of particular interest to the rehabilitation field is Extension's focus on reduction of poverty and youth transition. As will be detailed later in this

chapter, Cooperative Extension is also connected with the AgrAbility program. Further exploration of this collaboration will be discussed later in this chapter.

Positive collaborative relationships do not happen by accident. They involve people who are:

- Good communicators
- Proactive
- Persistent with follow through
- Respectful to all parties
- Able to learn from setbacks as well as from successes

These characteristics are true for all collaborating parties, whether they be considered a professional or a person of significance to the individual who is receiving services. Each person must be willing to balance power and control and to use the overall goals of the collaboration to drive the work that is being done.

Barriers to Collaboration

Unfortunately, a variety of disincentives to collaboration exist. Inherent barriers to collaboration can happen when organizations have differing:

- Missions
- Structures
- Priorities
- Funding sources
- Levels of support from leadership
- Schedules
- Professional disciplines

There is no real benefit to including an organization as a collaborative partner if that participation is not real and meaningful. To simply include Agency X for the sake of being able to say that entity is involved brings nothing to the collaboration. In fact, it can damage professional relationships by disenfranchising Agency X who is not genuinely needed or included. This can lead to even bigger problems down the road, when a situ-

ation arises in which the expertise of Agency X would be beneficial. Determining who the right people are to have at the table is critical. This is also why it is good to recognize that collaborative partnerships may evolve over time. Contacts that did not develop initially may evolve over a longer period of time into a strong collaborative partnership. It may be discovered that a Center for Independent Living has valuable money management training and referrals for home modifications for a particular case and that they are subsequently “on call” for future needs of a consumer.

Capacity Building

In order to maximize positive working relationships across organizations and ensure the focus of efforts is centered on the person with a disability and the family, Walter and Petr (2000) outlined the elements for success as including:

- Missions that recognize family-centered principles
- Involvement of community members and families
- Accountability
- Emphasis on person-centered decision-making
- Emphasis on linkages of informal supports

In all communities, but rural in particular, capacity building is one method to help fill potential gaps in services through community-based collaborative partnerships. Capacity building is a conceptual approach to development that focuses on understanding the obstacles that inhibit people, governments, international organizations, and nongovernmental organizations from realizing their developmental goals while enhancing the abilities that will allow them to achieve measurable and sustainable results.

The steps for capacity building include:

1. Engaging stakeholders on capacity development
2. Assessing capacity needs and assets

3. Formulating a capacity development response
4. Implementing a capacity development response
5. Evaluating capacity development

There are multiple levels of capacity from the individual to societal level. The individual level requires the development of conditions that allow individual participants to build and enhance existing knowledge and skills. It also calls for the establishment of conditions that will allow individuals to engage in the process of learning and adapting to change. The institutional level involves aiding preexisting institutions. It should not involve creating new institutions, but rather modernizing existing institutions and supporting them in forming sound policies, organizational structures, and effective methods of management and revenue control. Finally, the societal level should support the establishment of a more interactive public administration that learns equally from its actions and from feedback it receives from the population at large.

There are two ways to quickly build capacity: (a) develop a new program or service based on the prioritized needs of the collaborative group, or (b) connect with existing resources. In this chapter, we will give examples of these two types of capacity building partnerships. AgrAbility represents an effective capacity building mechanism that has existed since 1990 in many states around the country. The Kentucky Appalachian Rural Rehabilitation Network (KARRN) is a unique rural collaborative that grew from research to address the needs of constituents in rural Appalachia.

The National AgrAbility Project

One example of long-standing collaborative partnerships in rural communities can be found in the AgrAbility program. AgrAbility is a program administered by the National Institute of Food and Agriculture (NIFA) and sponsored by the US Department of Agriculture (USDA) to serve

The National AgrAbility Project (NAP), with an annual budget of 4.2 million dollars, consists of a national network of state AgrAbility programs. NAP provides services and information to farmers with disabilities and their families including educational training to increase the professional development of AgrAbility staff and promote the autonomy of AgrAbility clients, networking to facilitate the efficacy and capacity building of agricultural disability networks, and direct service provision through individual assessments to agricultural workers with disabilities.

The state-level AgrAbility projects, also funded by the USDA, are administered through a collaborative partnership. The partners must, at a minimum, include a land-grant university who works in concert with a nonprofit organization in the state, such as Easterseals, Goodwill Industries International, an Arthritis Foundation affiliate, or Center for Independent Living (CIL). The state programs have their own professional staff who work to support the goals of the program (Mathew et al., 2011). Each statewide program provides a core set of services that include identifying assistive technology for agricultural equipment, modifying agricultural operations, assessing agricultural work sites, and distributing information on safe farming practices to farmers with disabilities. AgrAbility projects also work to connect farm families with disabilities to each other, recognizing the importance of peer support and networking in providing ongoing support for farmers.

Although not intended to provide direct payment or equipment to help farmers, the state AgrAbility programs function as an intermediary to work with other sources of funding, such as Vocational Rehabilitation (VR) Services, to assist farmers who want to continue agricultural work after the onset of a disability (Haire, 2007). A recent evaluation of the impact of the National AgrAbility Project from one study demonstrates the overwhelming majority (88%) of AgrAbility clients are able to continue to engage in full-time or part-time farming after the onset of their disability (Meyer & Fetsch, 2006).

Approximately 500,000 persons working in agriculture have physical disabilities that inter-

fere with their performance of essential tasks. For this target audience, “success” may be defined by many parameters, including gainful employment in production agriculture or a related occupation, access to appropriate assistive technology needed for work and daily living activities, evidence-based information related to the treatment and rehabilitation of disabling conditions, and targeted support for family caregivers of AgrAbility customers. AgrAbility addresses a wide variety of disabilities. AgrAbility represents unique partnership opportunities via Cooperative Extension and state disability organizations. This collaborative partnership shows the power of harnessing entities with very differing areas of expertise, allowing both to maximize efforts and improve outcomes for the consumer. It is important to note that AgrAbility projects do not provide funding to farmers. However, this program provides an opportunity to develop additional collaborations, depending on the needs of the individual. For example, state rehabilitation agencies may work in tandem with AgrAbility to provide needed assistive technology to maintain employment and independent living. Other organizations can be sought out for nonemployment-related needs to maintain way of life.

Kentucky AgrAbility Case Study

As with the National Project, Kentucky AgrAbility has a threefold mission: professional training, technical assistance, and information dissemination. Kentucky AgrAbility has a long tradition of providing extensive direct on-farm technical assistance. In this capacity, they make recommendations related to modifying/adapting tools, equipment, machinery, and farm tasks. They also help educate on how to make the home and farm building more accessible. Kentucky AgrAbility has a strong partnership with the State Office of Vocational Rehabilitation. For appropriate farmers, vocational rehabilitation can join the process and provide training and equipment that help keep these farmers farming.

Background

Jack is a 65-year-old male with a left below-the-knee amputation as of February 4, 2011, as a result of diabetes. He has his second prosthesis that he says is fitting “pretty well.” Jack has a cardiac history and has had stents placed. Jack also has arthritis with back pain. Jack and his wife Gina are directors of Internet sales for a local stockyard. Jack and his wife live in a two-story home on 5 acres where they manage 2 horses, a donkey, 18 lambs, and 10 ewes that they feed twice a day. The county extension agent recommended Jack contact someone regarding the AgrAbility program.

Challenges Identified During Visit

When asking Jack what he felt he needed help with in the operation of his farm activities, he said “nothing that I know of right now but that I may need something I am not even aware of.” He was very pleasant and willing to share information on the activities and operation of his farm. He was open to suggestions that could assist him in the daily activities on the farm.

Functional Assessment

Jack walks from the house to his barn, pasture, and utility shed with a cane, but he did not use a cane on the date of visit. The distance to each of these areas is approximately 150–300 feet of grass and gravel terrain with slope and uneven terrain. Jack walked with a slow labored gait, having to laterally weight shift further to advance prosthesis. Jack showed shortness of breath after walking from house to the pasture beside house, then to the barn and utility shed. Jack demonstrated his path through the barn where he opened metal gates to enter stalls where the sheep are sheered and access to back pasture where the sheep reside. To feed his animals, he fills a bucket from the barn and carries it approximately 30 ft where he lifts it over the fence to pour it in the trough. The buckets weigh approximately 5–10

pounds. When walking from barn to utility shed, Jack showed slight imbalance on two occasions with uneven terrain but was able to self-correct. He showed shortness of breath with each distance. When asked if he experienced any pain with his activities, he stated that after 30–40 min of walking, he has pain in the lower back and left residual limb. He has a garden tractor with a garden cart attachment and a zero-turn mower. The garden tractor is located in the barn, and the zero-turn mower is located in the utility shed. Jack had not been on his mower since his amputation but did so with contact guard from this occupational therapist. This transition would not be safe for him without someone to assist as he appeared slightly unsteady when stepping on to mower.

Inside Home

When asked if he had difficulty accessing areas inside his home, he said no not really. After offering to look over areas in his home to give suggestions for ease and safety, Jack took us through his home while describing his adaptations and modifications already made. There were several areas that could improve his mobility and safety in the home that were discussed during the visit:

Stairway – Four steps to a landing then long stairway to second floor where there is only one railing. Recommended railing on both sides since it was narrow enough to reach both sides simultaneously. Rail on both sides will provide improved muscle power, energy conservation, weight shift, joint protection, and safety while ambulating stairs which he does several times a day.

Bathroom – The door way is narrow making it difficult for access via wheelchair which he uses to transition to shower chair. He has wheelchair on both levels of home. Shower stall is narrow where he has a small shower chair that he transitions to after removing prosthesis. Recommended transitioning to shower chair with prosthesis on for increased stability then removing once seated on shower chair. His commode is standard height with small grab

bar on one side. Recommended elevated commode with bilateral grab bars on each side to improve muscle power, joint protection, and body mechanics and conserve energy.

Safety Implications

Safety concerns include uneven terrain that can create potential for falls when walking from house to barn and utility shed. Carrying feed buckets to trough on uneven terrain 30 plus feet poses a potential to increase back pain and compromise right leg and hips due to increased demand. Lack of railing on stairs inside home puts Jack at risk for increased back pain and joint compromise with muscle imbalance with postural compensation to manage steps several times a day. His compensation requires increased energy which creates increased shortness of breath. Standard height commode and small shower stall increase risk of accelerated joint wear and pain with potential for falls with transitions.

Action Plan

Share findings with AgrAbility team to determine recommendations for modifications and resources that will increase Jack's safety and accessibility while managing his farm activities. Provide Jack with joint protection, energy conservation, and work simplification strategies to assist in self-care and farm management. Provide Jack with contact information for resources to assist with modifications.

Questions:

1. Who should be members of Jack's rehabilitation team?
2. What other needs can you identify that should be included in an action plan?
3. Are any of these needs related to community participation or quality of life?

Kentucky AgrAbility's involvement as a collaborative partner and member of Kentucky

Appalachian Rural Rehabilitation Network, described below, is an example of building capacity by connecting two existing collaborative resources. The services provided by AgrAbility benefit KARRN and the community members who access the resources KARRN provides, and KARRN provided a way for Kentucky AgrAbility to expand services in the underserved region of Appalachian Kentucky. This was a win-win partnership and a sound example of building capacity to serve communities. It also shows that collaborative partnerships, even among groups with strong internal collaborations, are better together.

Kentucky Appalachian Rural Rehabilitation Network (KARRN)

Of the 420 counties that comprise Appalachia, those located in eastern Kentucky are among the poorest. Approximately 80% of these Kentucky counties have a shortage of designated health professionals and healthcare resources to address life changing injuries/illnesses. The Kentucky Appalachian Rural Rehabilitation Network (KARRN) has been established as a collaborative team including individuals with spinal cord injury (SCI), stroke, and traumatic brain injury (TBI), providers who serve them, members of communities in which they live, advocates, educators, and researchers who investigate these impairments. The goal of KARRN is to identify, develop and disseminate information and strategies, and maximize resources to improve health outcomes and quality of life for individuals with neurologic conditions living in rural Kentucky Appalachian counties.

Initial funding for KARRN was through a research grant by the Experimental Program to Stimulate Competitive Research (EPSCoR; funded through the National Science Foundation). The initial study examined the health and quality-of-life-related supports and challenges from the perspective of individuals with spinal cord injury (SCI) and their families and from the healthcare providers who treat these individuals. Additional funding was provided by the National Institutes of Health and National Center on Minority Health

and Health Disparities. The additional funding allowed for the broadening of focus from SCI to include stroke and TBI. It also provided the funding to develop infrastructure to help solidify the network through a telehealth system and annual conferences.

KARRN was developed as an outcome of the community-based participatory research (CBPR) approach. CBPR is a collaborative research process involving researchers and community representatives; it engages community members, employs local knowledge in the understanding of health problems and the design of interventions, and invests community members in the processes and products of research (Cornwall & Jewkes, 1995). In addition, community members are invested in the dissemination and use of research findings and ultimately in the reduction of health disparities. Community-based research (CBR) is rapidly gaining recognitions as an important tool in addressing complex environmental, health, and social problems (Israel, Schulz, Parker, & Becker, 1998; Lustig, Weems, & Strauser, 2004). “Outside expert”-driven research approaches have been proven ineffective, and communities across North America are demanding that they be given greater decision-making power over studies that take place in their midst. Therefore, CBR is not a method, but an approach to research (Wallerstein & Duran, 2003), that emphasizes the importance of collaboration, participation, and social justice agendas over positivist notions of objectivity and the idea that science is apolitical (Minkler, Blackwell, Thompson, & Tamir, 2003).

In the KARRN projects, the approach was adapted from the participatory rural appraisal (PRA) strategy as described by Kuipers et al. (2001). PRA is a research and development approach for shared learning between local people and outsiders. It is based upon the World Health Organization’s model of community-based rehabilitation. Using qualitative methods, volunteers and key informants were recruited to participate in the study. In-depth interviews and discussions were conducted, with the long-term goal of creating an ongoing community-based group interested in issues related to rehabilitation in rural Appalachian Kentucky.

The development of KARRN was a natural extension of the community-based project. Through developing partnerships with the “participants,” the group had the conduit for keeping them connected and having the group come together. After the completion of data collection, all participants were invited to take part in a 1 day retreat to discuss the findings from the study and to explore a potential formalization of the group.

The creation of KARRN included multiple steps: initial data collection, partnership development, asset mapping, and developing a group consensus of priorities for KARRN. The group was intentional in approaching group development from a positive point of view by conducting an asset mapping session versus a needs assessment. This framed a strength-based approach, in recognizing the benefits, talents, and gifts that were present in the community. This is in contrast to a needs assessment approach, in which gaps, missing elements, and areas of want or need are highlighted. In addition to the community asset mapping, a formalized shared mission for the network was developed. Results from the study and the asset mapping meeting were used to develop short-term and long-term goals for the group.

KARRN has been active since 2005. It includes people living with neurologic disorders, healthcare providers who work with people with neurologic disorders, university researchers, related local nonprofit programs, vendors, and hospital administrators among others. As a group, the KARRN members meet monthly via a telehealth system which provides a mechanism for people to meet face to face in regional groups and use videoconferencing technology to connect all of the sites together with audio and video. The main focus areas of KARRN that were established and agreed upon by its members include:

- Education: for healthcare providers, clients, and caregivers and communities
- Advocacy: for clients and caregivers and community
- Share information: help to match persons with state and community resources

- Research: to improve long-term healthcare and quality of life
- Increase quality of life and community participation: of persons with disabilities in rural Kentucky
- Sustainability: set up so the group does not have to rely solely on grant funding for continued existence

With these areas of focus in mind, KARRN has hosted an annual conference and developed educational video series available through the KARRN website and brochures related to travel tips and to accessibility of state parks, thus enhancing community access.

In terms of research, KARRN has resulted in the establishment of the Kentucky Stroke Surveillance database that is being used to impact research and service provision. Currently, a study is in progress looking at the impact of a community lay health navigator for people in Appalachian Kentucky who have had a stroke. As a community-based organization, any research that takes place with the support of KARRN must in fact provide something tangible to the participants and the community. It is not the intent of this collaborative to partner with people who want to stop by and collect data and subsequently move on. There must be a benefit to the KARRN members in some way to partner with researchers. In essence, the research must be translated into some meaningful form that has practical applications for the research participants.

With regard to advocacy, an offshoot group, the Kentucky Congress on Spinal Cord Injury, has developed out of KARRN. KARRN group members with shared life experience of spinal cord injury sought additional avenues to promote needed social and legislative changes based upon barriers they faced in their communities. The group recognized the powerful voices that could be used to create positive changes for people with SCI and all people with mobility limitations. This further highlights the reach and new directions that can result when capacity is built in rural communities through meaningful collaborations.

The Role of Rehabilitation Professionals

There is an important opportunity for rehabilitation professionals in capacity building in rural rehabilitation. Rehabilitation counselors and administrators recognize their roles within a collaborative environment and work effectively as part of a collaborative effort. The importance of collaboration to the profession is highlighted in the Code of Professional Ethics for Rehabilitation Counselors (Commission on Rehabilitation Counselor Certification [CRCC], 2017, Section E.2.a.):

Rehabilitation counselors who are members of interdisciplinary teams delivering multifaceted services to clients must keep the focus on how to serve clients best. They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of their profession and those of colleagues from other disciplines.

Rehabilitation counselors and administrators can positively impact capacity building opportunities in rural populations through team building. The knowledge base of rehabilitation counselors can be used to help identify beneficial collaborations at the local level. Also, rehabilitation counselors can help collaborators express shared values and vision. Rehabilitation administrators can assist in initial communications across agencies to help identify commonalities across missions, even when it may not be immediately apparent. The following case study provides an example of how this can work.

Case Study

One area of need for a consumer in a rural area of the state was around mobility. The driveway ended approximately 100 feet from the entrance of her home. To get to the front door, there was a substantial incline, with a narrow dirt path filled with various obstructions (exposed tree roots, protruding

rocks, etc.). The consumer was a manual wheelchair user and could not independently get from her vehicle to the house or enjoy any of the areas outside the house. When putting together a team for this case, her vocational rehabilitation counselor immediately thought about the rehabilitation assistive technologists (who were overwhelmed with referrals) and about the expertise at a local university. She spoke with her supervisor, who contacted the school. Initially, the school staff attempted to connect them with disability support services. However, as the administrator and university employees continued the conversation, she was put in touch with both the engineering and landscape departments. An interested faculty member became involved who subsequently saw this as a student research project. The consumer outcome included improved access to the exterior of the home. The outcomes at a capacity building level included new connections between the state VR agency and the university, as rehabilitation technologists were added as guest lecturers in both engineering and landscape. More students had preprofessional projects to include rehabilitation and community building efforts and, subsequently, gained a better understanding of rural rehabilitation.

Summary

Ultimately, the goals of collaboration in rural settings will result in improved outcomes for people with disabilities. But that is just the beginning. Bringing together the right collaborators to address issues in rural rehabilitation can lead to mentorship, enhancement of natural supports from within the community, and additional resources. Availability of federal funding can also help to foster collaboration across agencies. One example is Partnerships in Employment Systems Change grants, through the US Department of Health and

Human Services' Administration for Community Living. These grants, funding states, establish consortia of various state agencies to work toward improving employment opportunities for those with disabilities. While this represents a very formal approach to collaborative efforts, it further highlights the need for collaboration to take place at all levels in order to effect real change.

As demonstrated in the example of the Kentucky AgrAbility case study described in this chapter, the action plan shows the opportunity for a collaborative partnership between Kentucky AgrAbility and disability providers in the state. Based upon the approach of community-based participatory research (CBPR), the Kentucky Appalachian Rural Rehabilitation Network (KARRN) provides a powerful rural example of a collaborative that was intentionally developed to improve the quality of life of individuals with disabilities in Kentucky and ultimately improve the systems around supporting people with disabilities. Additionally, the capacity building of KARRN created an advocacy group called the Kentucky Congress on Spinal Cord Injury. The final case study in the chapter documents the important contributions rehabilitation professionals can make through developing collaborative partnerships and increasing capacity building. In turn, this can lead to better outcomes and improved quality of life for rural residents. As shown in the case studies in this chapter, creative collaborations can build capacity within rural communities and also build capacity for the field of rehabilitation.

Ultimately, rehabilitation professionals can play an important part in building and sustaining meaningful collaborations. Successful collaborations include knowledgeable and engaged partners, willing to share time and expertise around a common goal. Though barriers to collaboration exist, it is ultimately in the best interest of everyone involved to work together to support success in rural communities.

Web Resources

Extension: nifa.usda.gov/extension

KARRN: www.karrn.org

National AgrAbility: www.agrability.org

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