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# The Rural Monitor

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## Community Colleges: Critical Training

By Thomas D. Rowley

Community colleges are at the forefront of health care workforce training across the nation, particularly in rural areas.

According to Dr. Stephen G. Katsinas, the vast majority of nurses in rural areas came out of community colleges (which grant two-year Associate's degrees as their highest degree).

Katsinas, Director of the Bill J. Priest Center for Community College Education at the University of North Texas, says, "It wouldn't surprise me if anywhere from 60 to 85 percent of all nurses in more sparsely populated areas of the country are trained by rural community colleges."

University of North Texas doctoral student Mary Beth Reid is writing her dissertation on the impact that community colleges have on the nursing shortage in severely distressed counties. Reid says that community colleges supplied 60 percent of the nation's registered nurses in 2000, and most rural health care facilities are staffed by nurses trained at nearby community colleges of nursing.

Judith Miller is proof of that. Miller, 28, came to North Arkansas College from Indiana to become a certified nursing assistant (CNA). She now works as a CNA at a local nursing home where her duties include taking patients' vital signs, assisting in patient feeding and administering hygienic care. At the same time, she is continuing her studies at the college to earn her degree as a registered nurse.

*Judith Miller works as an aide at a nursing home in Arkansas while pursuing her RN degree at a local community college.*

Miller says that she is pleased with North Arkansas. Her only frustration with the college was wresting one of the 40 available enrollment slots from the 140 applicants. She attributes the demand to the fact that it has such a good program.

"They are very community oriented. I love the interest that the professors take in the students. They take a personal interest in our success. It's a very personal college."

Personal though the college may be, it's also the hub of an ever-expanding set of programs aimed at helping the region train its own health care workforce

*(continued on next page)*

while at the same time helping the region foster economic development. Both are critical for a region that is attracting retirees at the same time it is suffering from economic setbacks.

"The thing that makes it all work is partnership," says Rick Hinterthuer, Ed.D., Executive Director of the North Arkansas Partnership for Health Education (NAPHE) located in Harrison, Arkansas.

Since its start in 1996 as a partnership between the college and North Arkansas Regional Medical Center, NAPHE has been training students in allied health careers and providing continuing education for those already in the field. It also has eliminated duplication of programs, reduced expenses and made it easier for both people seeking to enter the health care field and providers seeking qualified employees.

To date, NAPHE has graduated some 1,200 CNAs, successfully placing 98 percent of them in jobs. Many, like Miller, go on to more advanced medical degrees.

"We're reaching all kinds of health care professionals to help them stay up on the latest information," Hinterthuer says. "We are generating a lot of the hospital's employees through what we do and impacting the number of health care professionals available to all providers in this area."

The partnership, which has 501(c)(3) nonprofit status, has been growing all the while, adding new partners (26 and counting) and programs (from myriad health care training classes to family skill building to tobacco cessation).

According to Hinterthuer, NAPHE's successes illustrate the role that community colleges can play in fostering partnerships that benefit the communities they serve. By bringing structure and credibility, they attract others, and serve as a catalyst.

"The facilities at the college made a lot of this possible," he says. "The college is the engine that's driving it in this community."

## Training for the Business Side of Health Care

To the southeast, another partnership provides training in the business side of the medical field—medical coding and billing procedures.

Sally Harrison, Director of Practice Management for the Mississippi Hospital Association, had been working with rural hospitals on billing issues. Just when a hospital would start making headway, she says, the person handling the billing would leave. The hospital then had to bring in a new person with little or no experience and teach them how to do billing, sometimes incorrectly. As a result, Harrison estimates that rural providers in the state were losing some $3 million a year in unpaid claims.

Then one day at a meeting of interested parties, Harrison found the answer: community colleges.

According to Harrison, a representative of the state's community colleges spoke up at the meeting and said 'we can fix this if we get some funding.'

That was October 2002. One year later, a pilot program in medical coding and billing had been developed and classes had begun at Copiah-Lincoln Community College (CO-LIN), which has its main branch in Wesson, MS. The program's launch was achieved with help from the Mississippi Department of Education, the Research and Curriculum Unit at Mississippi State, and consultants as well as funding from the Robert Wood Johnson Foundation, the Enterprise Corporation of the Delta, and the Bower Foundation.

Harrison chose to start the new program at CO-LIN because it already had a program in medical office technology. Plus the college had Angela Garrett, a 20-year veteran in the field with a degree in regulatory health information management and nine years of teaching experience, on its faculty.

When fully implemented, the program will have three components: an eight-week course updating skills of people already in the workforce; a one-year certificate program for people interested in the field; and a two-year associate's degree in applied science. Only the one-year program remains to be implemented. Eventually, Garrett hopes, the program will be offered at community colleges around the state.

In the eight-week course (three hours per class), students are taught what curriculum consultant Bridgette Lowe calls the "golden nuggets," the elements every employer wants employees to know. Those nuggets include such generic things as professionalism and customer service, but also more specific things like medical terminology, familiarity with the different types of coding and the biggest item of all: how to fill out CMS 450 and CMS 1500, the billing

forms used by providers across the nation to get Medicare reimbursement for hospital and outpatient services.

According to Lowe, students absorb the material quite well. "I feel good about it. I hope that it will improve the continuity, or the uniformity of the way billing is done in hospitals and doctors' offices…and eventually create trained job seekers, potential employees, so the hospitals will get people who know what they're doing."

The program—unique in the state and perhaps the country—fills a dual need, as do so many rural community college programs. It helps supply trained workers needed by the region's employers and helps workers qualify for jobs in regions that often are lacking jobs.

On the first count, as Garrett puts it, people in the industry burn out from all the changes in regulations and the need to train themselves. All of which, she says, is made worse in rural areas, because "people move on to make more money."

On the second count, the Mississippi Delta has a long history of economic woe, made worse by the recent closing of several textile and apparel plants.

As one measure of its success, demand for the eight-week course far outstrips its supply. All sections are full and a waiting list has been started, even though the only advertising is by word of mouth. Garrett, the only person certified to teach the coding classes, says she just cannot teach any more sections and hopes to hire more teachers. But, she says, that's tough to do. People who are qualified can make more money in the field than in teaching.

As for Harrison, she sees the program as "a huge, huge leap. For the first time in rural areas, hospitals and doctors have a pool of people to go to who have the knowledge and experience needed to get a bill paid." In addition, she says, "The Delta is so depressed economically. This is the prime time for this curriculum to be offered. This really can be a second career for someone who has had their job taken away from them."

## Keeping It Local

"Community colleges were designed to grow their own," according to Mary Beth Reid.

Betty Davis, Assistant Dean of Nursing at Meridian Community College in Meridian, Mississippi offers corroborating analysis. "I can't give you exact numbers, but I believe that probably well over 70-75 percent of our nursing students are here because going to a university is not an option for them."

They are, says Davis, "place-bound" because of a lack of transportation, the need for daycare for their children, or some other reason.

"Without community colleges, many rural people would not have career options, hospitals would not have the workforce and rural residents would not be getting the health care they need."

The Institute of Medicine's Committee on the Future of Rural Health Care recognizes the importance of community colleges as key institutions in the training of rural health workers in its just-released report, *Quality Through Collaboration: The Future of Rural Health Care*. The report calls on medical programs in universities and four-year colleges to collaborate with rural community colleges "to extend the array of rural-based education options while encouraging students to pursue higher levels of education." Such collaborations can allow for baccalaureate and specialty degree programs to be offered in rural communities, which allows rural healthcare workers to further move up the career ladder.

According to Bill Scaggs, Executive Director of the Rural Community College Alliance, rural community colleges help meet all sorts of community needs because they "are place-focused, community-connected institutions.…The only means we've got of maintaining a workforce is to train the folks who will be the primary caregivers. Virtually every rural community college has some type of programming in health care."

And, Scaggs says, that includes not just nursing but a whole host of allied health professions—dental hygienists, respiratory therapists, x-ray technicians, medical laboratory technicians and surgical technicians.

## Struggling to Meet the Demand

Despite the job that rural community colleges do in supplying nurses and other allied health professionals, severe shortages exist. According to an August 2002 report by the Joint Commission on Accreditation of Health Care Organizations, a nonprofit that sets standards in health care quality, more than 126,000 nursing positions were unfilled in 2002 in hospitals across the nation. Even worse shortages exist in long-

term care and home health agencies, with some 90 percent of long-term facilities lacking adequate nursing staff to administer basic care.

According to Reid, rural areas suffer most from the shortage of nurses and other health care providers. And poor rural areas, including most Native American reservations, are hit hardest. Citing a 1999 survey by the American Organization of Nurse Executives, she says rural facilities routinely take significantly longer to fill nursing vacancies in 15 of 22 nursing specialties than do urban facilities—sometimes up to 60 percent longer.

As good as rural community colleges are at training health care workers, they face limitations, particularly in the financial arena, which limit their ability to address these shortages as well as fulfill their other vital roles.

"We're not where we need to be in terms of funding these colleges," Katsinas says. "We're in a really tough ballgame. I believe we're going to have to do more than we've done."

Indeed, in a survey of state directors of community colleges conducted by Katsinas and colleagues, which was published October 2004, 74 percent believed that rural community colleges would experience the greatest fiscal strain of any community colleges during the 2004-2005 fiscal year.

That lack of funding, Katsinas says, limits the ability of rural community colleges to provide service. And it could result in reducing the availability of education in parts of the country.

"Geographic access to education is taken for granted. If you cut these colleges' funding, you don't have that anymore."

## GET CONNECTED

*For more information on the organizations and sources described in the previous article, see the following web sites:*

Bill J. Priest Center for Community College Education
http://www.unt.edu/highered/Priest/

Rural Community College Alliance
http://www.ruralcommunitycolleges.org/

Health Care at the Crossroads, JCAHO, August 2002.
http://www.jcaho.org/

To make up for budget cuts, Katsinas says, community colleges—like universities—are raising tuition rates, making education more expensive for students. At the same time, he says, the financial aid system is moving more and more toward loans and away from scholarships. In addition, the non-tuition costs (gas to drive to and from campus, daycare, etc.) are often higher for students attending a rural community college, something that student aid formulas do not take into account. On top of all that, rural workers, who typically earn lower wages than their urban counterparts, have a tougher time paying off their school debt. The end result, Katsinas says, is that rural students may be less likely to either go to school or, if they do, to return home to work after graduation.

Another challenge specific to training health care workers, according to Reid, is the aging of community college nursing faculty, with the average age of nursing faculty nationwide at 52. (The average age of all nurses is 49, she says.)

"We're not getting enough young blood," Reid says.

Yet despite all the challenges, Reid is pleased with what she sees. "Community colleges are doing an awesome job for what they have, especially in rural areas. They do a tremendous job."

Indeed, NAPHE's Hinterthuer says, the work that community colleges do "is what legislatures should love to hear. Everybody wins."

# Rethinking Human Services

by Tom Corbett, Ph.D.

## Ways of Envisioning a Different Future

In prior columns, I suggested several reasons for the need to rethink the way we organize and deliver human services in rural communities. For example, resources typically are scarce. Service infrastructures are poorly developed. Distances are great. And the needs are no less compelling than in urban areas. Even the private sector appears to fail rural communities. One study recently showed that minority workers in rural communities were less likely to have access to on-the-job training opportunities.

Increasingly, I argued, policy makers and community leaders are turning to what we call integrated service models. In these models, normally distinct programs work together in ways that deliver blended services and assistance to families that need more than one kind of help.

One recent experiment in service integration is emerging in Whatcom County in northern Washington State. Geof Morgan, the executive director of the Whatcom County Commission on Children and Families, expressed the need for rethinking services in their community as follows:

> "A major focus has been on relieving the difficulties that a family can face going from place to place to get the services they need. One of our goals is to work with a family at a specific 'access point,' and help them receive all the services they need without ever realizing they are being served by possibly many different providers."

As emphasized in the last column, there is no single vision or model of service integration.

The Whatcom County version is a variant of the no wrong-door strategy to achieving one of the key attributes that underlie successful efforts—that families would have easier access to a broader range of services and assistance than are available under existing service delivery methods. Whatcom County's program has four access points, including a Family Resource Team and a school readiness program.

Many communities, however, find it difficult to pursue a vision of reform that is difficult to define. This is immediately problematic—how can we advance a policy agenda without a clear concept of what is to be done? Moreover, they balk at the demands and challenges associated with fully blending existing systems into something brand new. In search of a workable solution, one might consider the following framework for envisioning what is feasible and workable.

A widely used conceptual approach to service integration has been developed in El Paso County in Colorado, which has implemented a much-discussed model. Their vision formulates integration along a continuum from better interagency communications to outright consolidation of staff, budgets and operations.

As a pedagogic device, I have modified their original continuum so that the key word denoting each step in the continuum starts with the letter C. As such, this might be described as the "Six Cs" continuum:

*Communication*—Clear, consistent and nonjudgmental discussions among several programs; giving or exchanging information in order to maintain meaningful relationships.

*Cooperation*—Assisting each other with respective activities, giving general support, information and/or endorsement for each other's programs, services or objectives.

*Coordination*—Joint activities and communications are more intense and far-reaching. Agencies or individuals engage in joint planning and synchronization of schedules, activities, goals, objectives and events.

*Collaboration*—Agencies, individuals, or groups willingly relinquish some of their autonomy in the interest of mutual gains or outcomes. True collaboration involves actual changes in agency, group or individual behavior to support collective goals or ideals.

*Convergence*—Relationships evolve from collaboration to actual restructuring of services, programs, memberships, budgets, missions, objectives and staff.

*Consolidation*—Agency, group or individual behavior, operations, policies, budgets, staff and power are united and harmonized. Individual autonomy or gains have been fully relinquished. Common outcomes and identity are adopted.

This framework focuses on the character and quality of the relationships among participating agencies and programs. Moving down this

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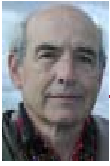

# Look What's Coming

by Wayne Myers, M.D.

## Institute of Medicine Comes to Rural: Now Read the Book!

The Institute of Medicine has turned its attention to the rural sector of American health care. The latest report in its series on quality of care is "Quality Through Collaboration: The Future of Rural Health." Coming as I do from the tradition of whining about rural issues being ignored, I was surprised and pleased to see this effort come together.

Like preceding reports it calls for convergence of individual care and population-based care, aka public health. It reaffirms that our health care should become **safe**, **timely**, **effective**, **efficient**, **equal** across groups and **patient**-centered. (My own mnemonic for this is "STEEEP.")

Most exciting to me is the report's first recommendation. It calls for development of health care system reform models in five rural communities. The underlying idea is that achievement of the six aims requires that care be organized and managed differently than it is today. If the clinic, health department, hospital, pharmacy, mental health facility and home health agency can come together under coordinated management with a common information system and billing office, care could be made safer, more timely, more efficient and so on. The report calls for support for the development of the model community-wide systems with support for comparison and evaluation of the approaches used and dissemination of the results. Note that this proposal is to create organizational models which might be applied in communities large and small as our current fragmented approach to health care continues to deteriorate.

A second truly new recommendation supports a Rural Quality Initiative, with efforts to measure and improve the quality of personal and public health care in rural communities. Measuring the quality of care, in terms of the six aims, is tough under any circumstances. Small sample sizes, lack of information, confidentiality concerns, a shortage of quality measurement specialists, as well as other factors, make quality measurement especially challenging in rural settings. This recommendation is complemented by a later recommendation for a national technical assistance center to help small towns manage problems with information and communications systems.

A major section on health workforce training repeats many of the ideas we've heard since the 1960's, but updates them. Training should instill certain core competencies beyond discipline-specific technowizardry. Schools should recruit rurally oriented faculty and students and get their students out of the medical center and into rural, multidisciplinary working health care. A relatively new point recognizes the potential for distance education to help train health personnel in smaller towns, capitalizing on the strengths of place-committed local students.

Other important recommendations call for strengthening the financial stability of rural providers including our beleaguered behavioral health colleagues. Another would assess the cumulative impact on rural providers of parallel changes in Medicare, Medicaid and private insurance, i.e. the three-way squeeze.

Perhaps the richest section of the report calls for strengthening rural information and communication resources. Strategies include a variety of carrots and sticks for federally subsidized providers and communications companies, recommendations to regulators and the creation of new technical assistance resources. These would lead to expanded use of telehealth and electronic medical records, better coordination of patient care and stronger quality measurement and improvement.

Much of the report is new. Some is not. It is, though, the first attempt I can recall to pull into a single document all the things that need to be done to upgrade rural care. Rural hospitals and clinics will survive and prosper to the extent that local people believe they give good care. Rural health managers should take this report to heart and work to make these recommendations happen.

Though many people and several organizations pooled their efforts to develop this document, special thanks are in order to Mary Wakefield (Committee Chair, and Director of the University of North Dakota Center for Rural Health), Forrest Calico (Federal Office of Rural Health Policy) and Janet Corrigan (IOM Staff) for their vision, energy and leadership.

The report is available from the National Academies Press: http://www.nap.edu

*Continued on page 7*

*(Corbett, continued from page 5)*

continuum places greater demands on policy makers and program managers. To achieve full consolidation, all aspects of program design and management must be addressed, creating demands far exceeding the requirements for merely putting programs in the same building.

A critical attribute of this continuum is its implicit flexibility. A community, for example, may choose to work on better communication or cooperation without attempting to advance further along the continuum. As better relationships are fostered and nurtured, a more ambitious vision of reform might be entertained. By taking it one step at a time, what might have appeared overly daunting is suddenly manageable.

In the next article, we will begin to explore the all-important dimension of institutional or program cultures.

*Tom Corbett has emeritus status at the University of Wisconsin-Madison and is an active affiliate with the Institute for Research on Poverty where he served as Associate Director. He has worked on welfare reform issues at all levels of government and continues to work with a number of states on issues of program and systems integration.*

*(Myers, continued from page 6)*

*Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.*

# Around the Country

by Thomas D. Rowley

## Hawaii

### Chemotherapy Via Telemedicine

The island of Moloka'i, Hawaii, home to just 7,000 people, has no elevators, no stoplights and no buildings taller than its coconut trees. But thanks to the efforts of the dedicated staff at its local hospital, it now has chemotherapy treatment.

In the past, with no oncologists or chemotherapy pharmacists on Moloka'i, cancer patients had to go "off island" for consultations and treatment, according to Desiree Puhi, Director of the Medical Office Building at Moloka'i General Hospital. Doing so was expensive and time-consuming, Puhi says, requiring hundreds if not thousands of dollars for airfare, taxis and hotels, and several days for each treatment.

"Seeing the suffering from the families all those years, it just starts wearing on you," Puhi says. "It's just not right."

Now, however, patients can "see" their doctors via telemedicine link-ups and receive the drug therapy they need without leaving the island.

The hospital, a critical access hospital and part of the Queens Health System, has hired two primary care physicians to work with Honolulu-based oncologists and chemotherapy pharmacists. Coordinating the procedure at such distances can be tricky, but extra safety measures have been built in.

First, the oncologist faxes over the prescription to a registered nurse who checks it to ensure that the hospital can handle it. Then, the nurse gives the prescription to one of the primary care doctors for review. In the meantime, the drugs are sent unmixed to the hospital where Puhi, a specially trained nurse, mixes them. Finally, and before being administered, the mixture orders are faxed to a chemotherapy pharmacist for review and the primary care doctor reviews the drugs themselves.

The service, begun in March, has already been used to treat 20 patients and has provided some 60 treatments.

Getting it up and running, Puhi says, took "a lot of sweat, tears, and hours…and dedicated personnel"—namely herself, Dr. Emmett Aluli, the hospital's Medical Executive Director, and Janice Kalanihuia, Chief Administrator.

And the trick now, Puhi says, will be to maintain the service, which requires expensive transmission lines paid for by a small population base. But, she says, it's all well worth it.

*For more information, contact Desiree Puhi at: dpuhi@queens.org*

## Montana

### Rural Emergency Management System Center (EMS)

The Rural EMS and Trauma Technical Assistance Center (REMSTTAC), a national focal point for information on rural emergency medical services and trauma care, is now fully operational.

The Center, located in Bozeman, Montana, helps support rural policymakers, as well as rural communities and organizations that are working to improve the quality and effectiveness of their emergency medical care. The center offers timely, accessible and effective information and assistance in overcoming obstacles like limited financial capital, human resources, training and technical knowledge. Its goal is to assist the Health Resources and Services Administration (HRSA) in preserving and improving EMS and trauma care in rural and frontier areas by developing innovative systems and tools that enhance systems change at national, state and local levels.

In October the Rural EMS and Trauma Technical Assistance Center held its first "town hall" meeting to solicit input from rural EMS providers across the nation on emerging challenges in providing essential emergency care in rural areas. The meeting, held in Park City, Utah on October 4, 2004, was attended by nearly 100 participants from more than forty states. Extended opportunities for discussion and dialogue were interspersed with presentations by nationally recognized experts in topics such as rural trauma care and quality improvement activities in small volunteer ambulance services. The participants expressed strong support for the need for a center such as REMSTTAC and see it as a vital focal point.

"Even though our first town hall meeting was an unqualified success, we learned a lot about how to make it an even stronger forum in the future," says REMSTTAC Director Nels Sanddal. "It took a while for the participants to get warmed up and we will restructure the next town hall meetings to allow more time for discussion and input."

The next series of town hall meetings will be scheduled for the New England area in the fall of 2005.

Sanddal says that REMSTTAC is a highly collaborative organization and relies heavily on strong working relationships between EMS and rural health policy makers as well as existing technical assistance centers such as the Rural Assistance Center. The recently published report, *Rural and Frontier EMS Agenda for the Future,* will serve as a guidepost for the center's future activities, Sanddal says. REMSTTAC, which is funded by the Health Resources and Services Administration, Office of Rural Health Policy (ORHP), is currently working with ORHP and other collaborators to promote an agenda that, Sanddal says, "has the potential to impact the very core of how emergency care is provided in remote and rural areas of the country."

*The Center's web site is available at: http://www.ruralhealth.hrsa.gov/ruralems*

*The Rural and Frontier EMS Agenda for the Future report is available at: http://www.nrharural.org/EMSagenda/EMS_Book_9_17A.pdf*

*For more information, contact Nels Sanddal, Director, at (866) 587-6370 or email at nels.sanddal@remsttac.org*

## Nebraska

### University and Indian Nations Form Interdisciplinary Health Care Project

The School of Pharmacy and Health Professions at Creighton University in Omaha, Nebraska, has received a $562,000 federal grant for a cooperative program between the university and the Omaha and Winnebago nations.

The Quentin N. Burdick grant, given by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), will fund "Circles of Learning: Clinic As Interdisciplinary Classroom," a three-year interdisciplinary training project.

The project builds upon a 10-year health care partnership between the Indian Nations and the university in which students in pharmacy, nursing, medicine, occupational therapy and physical therapy go to the reservations some 80 miles away to work in interdisciplinary teams. Students in the teams get hands-on training, experience rural life and learn about a different culture. Students also are provided with reading material on the cultural context of the tribes and are regularly assessed on measures relating to cultural understanding and bias. Assignments range from three to twelve weeks, with five or more students in residence at any one time. Supervision is provided by full-time medical personnel employed by the tribes (some of whom are graduates of the program).

The hope is that students will want to practice in rural areas once they have finished training, says the university's Joy Voltz.

On the other side of the partnership, members of the tribes get health care that might not be available otherwise in an impoverished, rural community. Indeed, the two tribes share a hospital.

The partnership, which has been awarded nearly two million dollars in federal health grants since 1997, began when representatives of the Omaha tribe came to the university seeking help in getting physical therapy services. Creighton—a Jesuit institution committed to social justice and service to others—agreed and things grew from there.

The "Circles of Learning" project will include health care services for diabetes, geriatrics and mental health services, areas of need identified by the reservation communities.

*For more information on the Creighton-Indian Nations partnership, see http://oisse.creighton.edu or contact Joy Voltz at joyvoltz@creighton.edu*

# Spotlight on Rural Research

by Thomas D. Rowley

*Hope in the Face of Challenge: Innovations in Rural Health Care,* by Thomas D. Rowley with photographs by D. Brent Miller, National Rural Health Association, 2004.

As the National Rural Health Association (NRHA) Executive Director Stephen Wilhide writes in the book's forward:

"Many are concerned about the state of rural health care in this country, and rightly so. There is great cause for concern. There is also, however, great cause for celebration. Around the country, rural communities are working to meet their health care needs. Unfortunately, their efforts all too often go unnoticed and unheralded."

Consequently NRHA commissioned the work to correct that one-sided view by chronicling in text and photographs 16 innovative rural health efforts from around the country. The ultimate goal: to inspire others, to learn from these efforts and to multiply them.

More journalism than research, the book tells the stories of the people who provide care as well as those who receive it.

On the giving end are people like Sabrina Feltner, a family health navigator for the University of Kentucky Center for Rural Health's Southeast Kentucky Community Access Program. This young woman helps low-income, uninsured rural residents navigate the complex health care system and avoid the potholes. To do that, Feltner arranges doctor's appointments, fills out forms, gets prescriptions and even helps obtain housing repairs—in short, whatever it takes to ensure her clients' health and well-being. Her efforts are all the more effective for having grown up in the community she serves and having been on assistance herself.

On the receiving end are folks like Nina Sperandeo, who battles the isolation that comes from living both in remote, rural Montana, and living with multiple sclerosis. Far from the doctors and hospitals she needs for treatment, as well as other women who share her illness and experience and whom she needs for support, Sperandeo was on the brink of despair. Then came Women to Women—an Internet-based support group for women with chronic illness living in remote rural areas run by the Center for Research on Chronic Health Conditions in Rural Dwellers at Montana State University-Bozeman.

In addition to these accounts are stories of health care and sexual and domestic abuse counseling for Mexican immigrants in Iowa, clinical care on the Oregon frontier made possible by residents creating a health care tax district, comprehensive social services under one roof for the elderly in Illinois, and more. Throughout each story run several themes:

- The efforts are innovative, bringing fresh ideas to bear on long-standing problems.
- They are locally grown, taking advantage of the fact that the best ideas often come from within the community.
- The people behind the efforts are passionate, whether from religious conviction or personal knowledge of what it means to be in need.
- Partnerships are essential in rural America, where resources are scarce.
- The best approaches are holistic, caring for the physical, emotional, social, economic and even spiritual needs of the patients.
- The efforts empower people, helping them to serve others.
- The people in the stories have gumption. They wouldn't take 'no' for an answer.
- Dignity pervades the efforts. Providers give not only care, but mercy and respect.
- Everyone involved—those who receive care and those who give it—is grateful.

The book is available for purchase at: http://www.nrharural.org