



Message from the Director of the VHA Office of Rural Health



Dr. Mary Beth Skupien
ORH Director

In the Spring issue of 'The Rural Connection', we are highlighting National and local Geriatrics programs in the VA that enhance care for the rapidly growing elderly rural Veteran population. According to VHA data sources, 8% of enrolled rural Veterans are 85 or older and nearly half are over the age of 65. These numbers

are quite large in comparison to the general U.S. population in which 2% of Americans are 85 or older and 13% are over the age of 65. Older adults are more likely to suffer from chronic conditions such as heart disease, diabetes, dementia and stroke. They also seek medical care and services associated with the aging process more often, so it is essential that the VA improve access to care for this population.

The VHA Office of Rural Health (ORH) is partnering with the VHA Geriatrics and Extended Care (GEC) Office and has funded several initiatives addressing geriatrics-related issues. ORH is supporting the expansion of the successful home based primary care (HBPC) program into rural areas, including 50 HBPC sites currently serving 22,000 rural Veterans. To address the barrier to care caused by a shortage of Geriatricians and rural providers with expertise and training in geriatrics, ORH is supporting the Geriatric Scholars program. This National VHA in-service education program is leading the way to nationwide quality improvements for geriatric care in rural Community-Based Outreach Clinics (CBOCs). Since the program began there have been 239 participants.

Transportation remains an important access to care issue for rural Veterans, especially for those who are older and/or disabled. Since 2009, ORH has funded numerous transportation initiatives throughout the country. For Fiscal Year (FY) 2012, ORH is providing \$4.8 million to support transportation initiatives in nine different VA Service Networks (VISNs). In addition, ORH is providing \$2 million to help expand the Veterans Transportation Service (VTS). The goals of this new program are to improve coordination of transportation services, increase Veteran transportation options, and to utilize 21st Century technologies to improve the efficiency of existing transportation resources.

ORH also supports the expansion of home telehealth into rural areas by funding demonstration projects and equipment purchases. These telehealth initiatives target homebound Veterans with chronic conditions and those at risk for long term institutional care. The aim of these initiatives is to allow Veterans to remain at home while being monitored by a VA care coordinator. Along these lines, and because dementia is a significant cause of morbidity in the elderly population, ORH is supporting the VA Proactive Dementia Care Pilot program to rural areas. This program combines education of rural CBOC staff on how to screen for memory disorders; telehealth technology for extension of specialty care from a neuropsychologist; and coordination of provider activities to come up with a comprehensive management plan that can be implemented by patient aligned care teams (PACTs) in coordination with the Veteran and their family members.

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The Coming “Age Wave”

by Josea Kramer, PhD, Geriatric Research, Education, and Clinical Center (GRECC), Associate Director of Education
VA Greater Los Angeles Healthcare System

Starting in 2011, over 78 million Baby Boomers reached the age of 65 and the VA and other health care systems are preparing for this “age wave”. By 2030, Seniors will comprise 20% of the US population. Furthermore, the many successes in disease prevention and chronic disease management have allowed people to live longer. In April 2010, there were 53,354 people over 100 in the US, and that number is expected to increase over 10-fold by 2050. These statistics are mirrored in the VA with 1.24 million Veterans over age 75 actively enrolled in VA primary care clinics.

What defines geriatric care? Is there a specific age (such as 65, 75 or even 85) that a Veteran is appropriate for evidence and age-based interventions or guidelines? Who needs to be referred to a geriatrician and geriatric team? Unfortunately, chronological age alone is not the best marker for such a referral. Those within the field of geriatrics would argue that other characteristics, such as the medical and psychosocial complexity, the trajectory of a patient’s functional or cognitive status, the presence of “geriatric syndromes” (e.g. falls, dementia) and the needs for interdisciplinary team care to manage community supports are more relevant. The words that might best exemplify geriatric care include holistic, team-based, palliative and independence-preserving. Embracing these principles, many seniors are able to maintain their independence and enjoy a robust life in the best possible health. Others will receive evidence-based chronic care that emphasizes quality over quantity of life and preserves care preferences approaching the end-of-life.

Historically, the majority of care provided for older Veterans is delivered by clinicians in primary care and not in geriatrics. Since



the number of health care providers receiving formal training in geriatrics is small, this will likely remain the case. In 2008, the Institute of Medicine reviewed the health needs of older Americans and the healthcare workforce in its report, “Retooling for an aging America: Building the healthcare workforce”. Currently there is insufficient training in geriatrics across the healthcare professions, too few geriatricians and poor incentives to recruit and retain professionals who have developed competency skills in geriatrics. The report suggests that bold actions need to be taken to improve care for aging Americans.

The VA has long taken the lead in improve care for aging Veterans and Americans. The VA Geriatric Research Education and Clinical Centers (GRECC), which were established in the mid 1970’s, have been at the forefront of research and development of state-of-the-art care practices. For instance, the VA developed comprehensive geriatric assessment programs, termed Geriatric Evaluation and Management teams, and pioneered the V. Zoster vaccine. Another GRECC innovation is the Geriatric Scholars Program, which reaches out to clinicians in the rural Community-Based Outpatient Clinics to infuse principles of geriatrics into the primary care practice environment. This multi-modal educational program equips primary care providers and staff to deliver high-quality geriatric care and to use quality improvement to ensure that the VA is strategically positioned for the “age wave” ahead.

For more information about the VA Geriatric Research Education and Clinical Centers visit www.va.gov/grecc. ♦

ORH Director’s Message (Continued from page 1)

Finally, we highlight an effort to support family members of rural Veterans who have suffered a stroke by disseminating a guidebook for caregivers. The guide was developed by VA researchers and is a companion to the Resources and Education for Stroke Caregivers Understanding Empowerment (RESCUE) website. These resources are intended to help family members become skilled caregivers for their loved ones as well as to help them cope with the daily challenges and stress of doing so.

The Office of Rural Health is committed to ensuring that the health care needs of elderly rural Veterans are met. With a multi-pronged approach of home health care, telehealth, chronic disease management, transportation and caregiving initiatives, the VHA is making great strides in their mission to ‘honor America’s Veterans by providing exemplary services that are both patient centered and evidence based.’ ♦

Home Based Primary Care: – A Signature VA Program Targeting Veterans with Complex Chronic Conditions

by Nancy Maher, PhD, Program Analyst, VHA Office of Rural Health

The Home Based Primary Care (HBPC) program, an initiative begun by the VA Office of Geriatrics and Extended Care (GEC) in the late 1990s, provides comprehensive, longitudinal primary care by an interdisciplinary provider team in the homes of Veterans with complex, chronic, disabling conditions. The goal of the program is to reduce hospitalizations, control costs and to allow frail, medically complex, patients to continue to live at home. This program is available at 140 VA Medical Centers and at 53 Community-Based Outpatient Clinics (CBOCs). Nationally, there are just over 59,000 Veterans enrolled in this program. The average age of the HBPC enrollee is 76.5 years. Most enrollees have multiple chronic conditions such as heart disease, diabetes, and dementia, however, HBPC is not restricted by age as a substantial number of enrollees have an underlying neurological deficit such as multiple sclerosis.

The HBPC provider teams typically consist of a physician, nurse, mental health care provider, social worker, dietician, physical therapist and an occupational therapist who work together with Veterans, their family members and their caregivers to develop a plan tailored to the Veteran's health care needs. The goal is for the Veteran to achieve a higher quality of life, a higher level of functionality and independence, as well as to reduce hospitalizations, hospital stays, and outpatient visits, all while remaining in their home environment. A 2007 analysis of this program found that enrollment in HBPC was associated with a 59% reduction in hospital bed days of care, an 89% reduction in nursing home bed days of care, and a combined reduction of 78% in total inpatient days of

care. Enrollment in HBPC was also associated with a 21% reduction in 30-day hospital readmission rates.

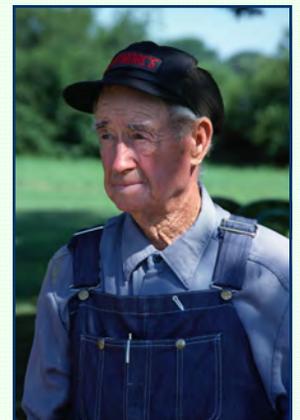
The HBPC program provides medication management, wound care, pain management, collection of specimens for laboratory analysis, monitoring of symptoms through telehealth, and care coordination between the VA and community providers. Veterans are eligible for this program if they are currently enrolled in the VA, and are either 1) confined to the home with chronic health problems that require ongoing care, 2) discharged from the hospital and require short-term follow-up care at home to become fully independent, 3) near the end-of-life and wish to remain at home, or 4) just unable to manage their own health care.

In order to address the needs of this aging population, the Office of Rural Health (ORH) has, for four years, supported the expansion of HBPC to serve rural Veterans. Typically operating out of rural CBOCs, HBPC teams provided primary care to nearly 22,000 rural Veterans in Fiscal Year (FY) 2011. In FY12, ORH will expend nearly \$43 million supporting this effort in an additional 50 rural areas of the country. In FY13, ORH will continue to support rural HBPC expansion.

Learn more about this program at the VA Home Based Primary Care website, www.va.gov/geriatrics/guide/LongTermCare/Home_Based_Primary_Care.asp. If you are a Veteran interested in enrolling in the Home Based Primary Care program, contact the social work office at your local VA Medical Center (www.va.gov/facilities) to find out if you are eligible. ♦

Did you know?

- Rural Veterans are, on average, older than their urban counterparts. Almost half of rural Veterans are between the ages of 55 and 74 and approximately 26% are over the age of 75.
- Geriatricians have expertise in treating conditions that older individuals experience, such as loss of mental sharpness, changes in mood, falls, sensitivity to medications, loss of vision and hearing, and incontinence.
- The American Geriatrics Society reports that today there is roughly one geriatrician for every 2,600 people 75 and older. This ratio is projected to fall to one geriatrician for every 3,800 older Americans by 2030.
- Just 56% of first-year medical school fellowship slots in geriatrics were filled last academic year. Only 56% of medical students had a clinical rotation in geriatrics in 2008.
- Primary care physicians do not have training or experience to manage complex, older adults with multiple chronic diseases.
- To improve provider training in geriatrics among rural VA providers, the VHA Office of Rural Health has supported the Geriatric Scholars program. This national VA in-service education program is leading the way to quality improvements in rural Community-Based Outpatient Clinics (CBOCs) across the U.S. The program offers state-of-the-art education in geriatrics to primary care providers, social workers and pharmacists and culminates with each Scholar initiating a quality improvement project in his or her clinic. ♦



Geriatrics Scholars Program – Keeping Rural Providers Up on the Latest in Geriatrics Management for Rural Vets

by *Janelle Brock LCSW, Marjie Heier MD, Marta Krissovich GCNS, ANP-BC, and Katrina Hansen-Schmitt, Members of the VA Geriatric Scholars Quality Improvement Team*

The Geriatrics Scholars Program, sponsored by the VHA Office of Rural Health (ORH), trains clinicians from rural Community-Based Outpatient Clinics (CBOCs) in the most current science in geriatric care and in the principals of implementation science. Each “Scholar” participates in an intensive course in geriatric care and a one-day team leadership and quality improvement workshop. The program culminates with each Scholar implementing a quality improvement project to improve healthcare for older Veterans within the rural CBOC clinical setting. Each Scholar receives personalized coaching from Tennessee Valley Geriatric Research Education and Clinical Center (GRECC) clinicians who have expertise in quality improvement. The Tennessee Valley Healthcare System Systems Redesign Committee provides an independent review of all projects prior to implementation. In addition, each Scholar is offered a tailored education program including distance learning, clinical mentorship and a clinical practicum at one of the GRECC sites.

Geriatric Scholars Janelle Brock, LCSW and Marjie Heier, MD formed a team at the Grand Island CBOC in Central Nebraska to improve access to dental care for the more than 10,000 older rural Veterans they serve. The oral health of older adults is often neglected due to low incomes; and Medicare does not cover routine dental services. The VA can provide dental care to a very limited group of qualified Veterans and an estimated 95% of Grand Island Veterans with comorbid conditions are currently ineligible for VA dental care. Travel distance to available community dental services in rural areas is another significant barrier for older Veterans.

Often, unmet dental needs can only be addressed through coordinated efforts of clinicians, public health professionals and local community networks. In order to provide Veterans with more effective access to dental care, the Grand Island CBOC Geriatric Team developed a collaborative relationship with local community agencies that provide dental care to low income people. Information about local dental care resources was disseminated to Veterans and a referral system established within the VA electronic medical record. The Grand Island CBOC staff collaborated with a local church and volunteers to assist patients with transportation. They also coordinated the provision of relevant medical records, such as medical imaging and medication lists so



Janelle Brock, LCSW and Marjie Heier, MD

that dental care could be provided efficiently within community dental clinics. Six months after implementation of this care coordination project, 151 Veterans have been referred to community resources for dental care. Eighty-one (56%) of those referred to a specific clinic were confirmed to have been treated at that clinic.

Dental hygiene is an essential part of health and well-being and has a significant impact on quality of life and systemic health. Poor dental hygiene has been associated with increased morbidity and mortality due to coronary artery disease and renal failure. There are known disparities in dental care for rural Veterans. This Grand Island Geriatric Scholars project has had a direct impact on the lives of at least 81 Veterans and has demonstrated the effectiveness of care coordination with non-VA community providers. The project is currently being expanded to other rural VA clinics within Nebraska.

Another VA Geriatric Scholar inspired by the intensive training course, Katrina Hansen-Schmitt, returned to the Home Based Primary Care Clinic (HBPC) in Maui, Hawaii and developed a program to increase the reporting of falls in the home and improve safety for patients enrolled in their HBPC program. VA HBPC programs use multi-discipline teams to provide long-term primary care in the patient’s home to a mostly geriatric population of home bound, chronically ill Veterans. Falls are the leading cause of injury deaths in older Americans as well as the most common cause of non-fatal injuries and of hospital admissions for trauma among older adults. Fall risk factors include age, functional abilities, chronic disease, vision difficulties and the use of multiple prescriptions drugs or psychoactive drugs.



Katrina Hansen-Schmitt, FNP-C, RN

In order to improve the rate of fall detection among HBPC patients and thus provide an intervention, a brochure entitled “Call If You Fall” was produced and distributed to patients. The brochure encourages Veterans and their caregivers to call within 24 hours if a fall occurs. The number of falls identified more than doubled after the brochure was disseminated. Patients were evaluated for fall risk factors and were provided additional education on fall prevention. Evaluation of these patients also identified additional needs for access to home equipment to reduce fall risk (stair railings, grab bars, poor lighting) and for locally available vision evaluation in this rural, island based population.

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“Bridging the Gap” for Veterans

by Patricia O’Neil, ARNP

The GAP Home Assessment Program is a pilot program in the North Florida/South Georgia Veterans Health Care System (NF/SGVHS) initiated last year by Nannette Hoffman, MD, the Associate Chief of Staff for Geriatrics and Extended Care (GEC). The GAP program is designed to better serve Veterans who are on the Homemaker/Home Health Aide Program (H/HHA) waiting list, or who are currently enrolled in the H/HHA program, but are experiencing an escalating need for various services.

The GAP Program provides services for a one-year period that interface with the patient aligned care teams (PACT) for ongoing care coordination and assistance with care transitions. The GAP team’s work provides the PACT team with an accurate assessment of the Veteran’s home environment and functional needs.

The GAP interdisciplinary team is comprised of two nurse practitioners, an occupational therapist, and a social worker. The team provides comprehensive in-home assessments to identify any unresolved medical, social, safety, and environmental needs. The team also performs medical screenings for dementia, administers additional cognitive screenings, reconciles medications in the home, conducts home safety evaluations, provides adaptive equipment, assesses caregiver burden, and provides support to decrease caregiver burden through education and by linking them to a variety of VA and community resources.



The NF/SGVHS GAP Home Assessment Program Team

At the end of the one-year enrollment period, Veterans will be discharged from the GAP Program, but will continue with their PACT team providers. During the one-year follow-up by GAP, telephone support and home visits will continue and will include interdisciplinary evaluations to determine what additional care or services, if any, the Veteran may need.

What is particularly unique about the GAP program is that it bridges the gap for Veterans between the care provided by their PACT team at the VA Medical Center and the variety of services provided to the Veterans in their home. This program is particularly beneficial to rural Veterans as this care is very often delivered in rural areas where traditional access to care can be limited.

The GAP Program delivers quality health care services to Veterans in their home, in a manner that is cost effective to the VA system, and al-

lows the Veteran to participate and manage their individual health care needs.

For more information about the GAP Home Assessment Program, please contact office at Pat.ONeil@va.gov or 352-374-6005/1-877-722-8387, ext. 6005.

For more information about VA Geriatrics and Extended Care (GEC), please visit www.va.gov/geriatrics. ♦

Geriatrics Scholars Program *(continued from page 4)*

After completing the Geriatrics Scholars Program, Marta Krissovich returned to Montana and formed a HBPC program serving rural Veterans in the vast area between Missoula to Bozeman and Great Falls to Butte. To best utilize resources, the HBPC team developed a screening tool to identify patients who would most benefit from urgent enrollment into the HBPC program, such as those who are at highest risk for permanent nursing home placement. This tool has been revised and improved and is now used to help identify the most vulnerable Veterans in this part of Montana.

Comparing the screening tool scores of patients that were admitted versus those that were not admitted to HBPC, the team determined

that the patients with the lower scores could be adequately served by other programs, such as Care Coordination via Telehealth, Hospice, or through Home Health Aide services delivered in the Veteran’s home. This allowed the Montana HBPC program to focus their resources on Veterans who could benefit most from their intensive, interdisciplinary approach. The Montana HBPC team continues to disseminate their HBPC admission process to other rural HBPC teams and they continue to utilize process improvement techniques learned as a result of the VA Geriatric Scholars program.

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A Lifeline for Stroke Caregivers in Rural Areas

by Kristen Wing, Communications Specialist, VHA Office of Rural Health

Family caregivers play critical roles in enabling Veterans with chronic diseases to remain in their homes and avoid institutionalization. Stroke caregiving is an important geriatric and rural health issue as the majority of stroke survivors are over the age of 65 years and there is a disproportionately high prevalence of strokes in rural areas. It has been well documented that strokes are disabling and require extensive involvement of family caregivers for successful rehabilitation of the stroke survivor.

Researchers have found that stroke caregivers often lack information and support to manage their challenges and those of their stroke survivors. Family members that are stroke caregivers, particularly those living in rural areas, often do not have the time and energy to travel and attend face-to-face educational meetings and support groups. Also, many caregivers living in rural areas do not have a broadband connection and thus are unable to access the Internet for information. In addition, much of the available health information about stroke is written in language that can be difficult to understand.

The Veterans Health Administration (VHA) is committed to enhancing the quality of caregiving and Veteran quality of care, while reducing caregiver burden across a range of populations. A current Office of Rural Health (ORH) funded project led by Constance R. Uphold, PhD, ARNP, an Investigator with the North Florida/South Georgia Veterans Health System (NF/SGVHS) Geriatric Research Education and Clinical Centers (GRECC), offers a low-cost strategy to improve stroke caregivers' access to information and support. This project will provide education and training for both healthcare providers and stroke caregivers and aims to support stroke caregiv-

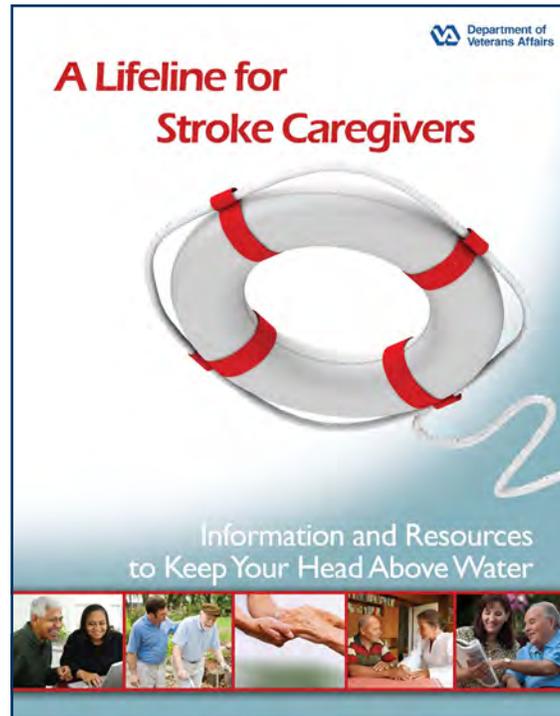
ers and improve the quality of care rural Veterans who have suffered a stroke receive once they are discharged to their home. This project addresses national clinical guidelines that urge healthcare providers to provide stroke caregivers with information and involve them in planning treatments and making healthcare decisions.

For this project, each rural Community-Based Outpatient Clinic (CBOC) will be given copies of "A Lifeline for Stroke Caregivers: Information and Resources to Keep Your Head Above Water", a 265-page guidebook developed by Dr. Uphold and her research team specifically for stroke caregivers of Veterans. The content of the guidebook is based on the RESCUE ("Resources and Education for Stroke Caregivers' Understanding and Empowerment") website, www.rorc.research.va.gov/rescue, also developed by Dr. Uphold and her team.

"A Lifeline for Caregivers" will inform both providers and caregivers about stroke caregiving and the challenges stroke caregivers face. It contains general stroke

information, tips for effective communication with the healthcare team, suggestions for reducing caregiver burden, and how to manage the physical and mental health needs of stroke survivors. In addition, the guidebook provides information about keeping stroke survivors safe, independent, and healthy; as well as guidance for finding community resources and managing financial and legal issues.

For more information about this project, contact Constance R. Uphold, PhD, ARNP at Connie.Uphold@va.gov or 352-376-1611 ext. 6912. ♦



Geriatrics Scholars Program (continued from page 5)

These projects highlight the important role that frontline clinical providers can take in improving care for elderly rural Veterans.

Since September 2009, 249 Scholars, including physicians, nurse practitioners, social workers, and clinical pharmacist have participated in the program. Other local improvement projects have addressed issues related to medication reconciliation, fall preven-

tion and osteoporosis, and screening for dementia. The program is based out of the VA Greater Los Angeles Healthcare System.

For more information about the Geriatric Scholars Program, please contact the Director, Josea Kramer, PhD at Josea.Kramer@va.gov or 818-895-9311. ♦

Educational Resources for Providers Caring for the Elderly

Portal of Geriatric Online Education

The Portal of Geriatric Online Education (POGOe) is a free public repository of a growing collection of geriatric educational materials in various e-learning formats, including lectures, exercises, virtual patients, case-based discussions, simulations, as well as links to other resources. New products are added every month. POGOe's mission is to promote geriatric education through the provision and encouragement of free exchange of teaching and assessment materials that support the fields of geriatrics and gerontology. Sponsors include the include the Donald W. Reynolds Foundation, the Association of Directors of Geriatric Academic Programs, American Geriatrics Society, the John A. Hartford Foundation, the Hartford Geriatric Nursing Initiative and the US Department of Veterans Affairs, Geriatric Research Education and Clinical Center.

Visit POGOe at www.pogoe.org for more information. ◆

VA Geriatric Research, Education and Clinical Centers (GRECCs)

There are twenty VA Geriatric Research Education and Clinical Centers (GRECC) across the country. Each has a research, educational and a clinical component. GRECC staff conduct basic research on the origins of aging and the diseases commonly associated with it. They also conduct research on health care delivery to the elderly and they disseminate knowledge of geriatrics through conferences, fellowship programs, peer reviewed papers, CD-ROMs and webinars.

Visit the GRECC educational events and products website, www.va.gov/GRECC/GRECC_Educational_Events_and_Products.asp, to learn more about training and educational opportunities in Geriatrics. ◆

In the News

New VA Outreach Clinic Opens in Decorah, Iowa



The Iowa City VA Health Care System conducted a ribbon-cutting ceremony, followed by an open house, for its new Outpatient Clinic on March 22, 2012. This new clinic, supported by the Office of Rural Health, will provide primary care services, chronic disease management, blood draw, care coordination home telehealth, diabetic education, nutrition group and individual sessions, weight loss/weight management classes and mental health services.

Veterans who are already enrolled in VA healthcare and wish to transfer their primary care to the Decorah VA Clinic, can call 319-338-0581, extension 7141. ◆

Green Cactus Project

The Green Cactus Project is an outreach home repair program for low income, elderly and disabled, veteran mobile homeowners living in the rural desert communities of Mohave County, Arizona; Needles, California; and Southern Nevada. The Home Depot Foundation, the Aquarius Resort Casino, the Wal-mart Foundation, and the Wells Fargo Housing Foundation joined together with local community volunteers to make home



repairs for rural veterans in the area. On March 17th the Green Cactus team of volunteers started work repairing, cleaning and upgrading the mobile homes of 8 local Veterans. In addition they installed handicapped-accessible shower stalls, applied thermal coating to roofs, and added visual appeal to the Veterans' homes by planting succulents in their yards.

If you would like to learn more about the Green Cactus Project or would like to volunteer, donate or nominate someone for services, contact the American Center for Educational Opportunities at <http://www.amceoinc.org>. ◆

MY HEALTHeVET SPOTLIGHT: VA Chemistry and Hematology Lab



VA patients with an upgraded* My Health eVet account are now able to see their VA Chemistry/Hematology laboratory test results in their My Health eVet Personal Health Record. This information comes directly from their VA health record. Chemistry lab tests can include hundreds of tests, but the most common tests include blood sugar, cholesterol, calcium, liver function, thyroid, and pancreatic tests. Hematology lab results include blood cell counts and clotting tests.

Viewing VA Chemistry and Hematology lab tests through My Health eVet requires that Veterans:

- be enrolled at a VA health care facility,
- be registered as a VA patient in My Health eVet,
- have completed the one-time **upgrade process*** called In-Person Authentication (IPA), which can be completed at a VA Medical Center or VA Community-Based Outpatient Clinic (CBOC).

VA Chemistry/Hematology lab results can be viewed by completing the secure log in and then navigating to the **Track Health** tab, then **Labs + Tests** tab. It is easy, convenient and free.



The VA Blue Button can be used to download, save and print **Labs + Tests** information. This can be information that was self-entered in My Health eVet or information from the VA health record. All My Health eVet registered users can access the VA Blue Button 24 hours a day/7 days a week.

These are wonderful features for rural Veterans and allow them to take an active role in managing their healthcare. These tools also make it simple for Veterans to share information from their VA Personal Health Record with non-VA providers they may receive care from in their community. For more information, contact the local VA facility My Health eVet Coordinator. ♦

Visit My Health eVet at www.myhealth.va.gov!

Upcoming Rural Health Events and Conferences

15th Annual Michigan Rural Health Conference, April 12-13, 2012, Mt. Pleasant, Michigan

This year's conference theme is "Pulling together During Times of Shrinking Resources". To view the conference brochure, visit http://www.mcrh.msu.edu/documents/conferences/15th_Annual_Conference/Brochureforweb.pdf. To view the conference agenda, visit: http://www.mcrh.msu.edu/documents/conferences/15th_Annual_Conference/2012ConferenceAgenda.pdf.

NRHA 35th Annual Rural Health Conference, April 17-20, 2012, Denver, Colorado

The National Rural Health Association's (NRHA) annual conference is the nation's largest rural health conference, created for all of those with an interest in rural health care, including rural health practitioners, hospital administrators, clinic directors, lay health workers, social workers, state and federal health employees, academics, community members and others. Learn more about the conference here: <http://www.ruralhealthweb.org/annual>.



NRHA Rural Medical Educators Conference, April 17, 2012, Denver, Colorado

The Rural Medical Educators (RME) group is a special interest group of NRHA committed to advancing the training of physicians for rural practice through network development and advocacy. Learn more about the conference at: <http://www.ruralhealthweb.org/go/left/programs-and-events/nrha-conferences/rural-medical-educators-conference>.



www.ruralhealth.va.gov

VHA Office of Rural Health

"Using Innovation and Technology to Improve Access and Quality"

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