

Visiting Nurse Association & Hospice  
of Vermont and New Hampshire

2006/2007 CENTENNIAL EDITION ANNUAL REPORT



*Medicine can treat the body.  
Only people with compassion can treat the spirit.*





Jeanne A. McLaughlin  
*President and CEO*



Anne Page  
*Chair, Board of Trustees*

For over 100 years, the Visiting Nursing Association & Hospice of Vermont and New Hampshire, Inc. (VNAH) has focused on serving the health needs of people in our communities – our families, friends and neighbors. This historic year in the life of the VNAH has been commemorated in many ways. This expanded annual report, full of stories and history, is one of the ways we have chosen to remember and celebrate our past, and to demonstrate that we are poised for the challenges of the future.

We are proud of our legacy of providing quality healthcare to individuals in the comfort of their own homes, regardless of age or ability to pay. As a non-profit, we have always depended on the generous support of our donors to fulfill our mission. Many of our donors are grateful patients and hospice families. Many gifts come as a result of memorials. Other gifts are from people who simply appreciate that we will be there for them and their families, if and when the need arises. We appreciate all of you and all you do for the VNA and Hospice. You make it possible for us to provide many of our important services and to care for all those who need us. We are fortunate that thousands of individuals, businesses, foundations and municipalities have included us in their annual and targeted giving plans throughout the years; those outright gifts, appropriations, gifts-in-kind, planned gifts and bequests – of all sizes – mean so much to our continued existence and success.

The VNA & Hospice has seen a tremendous improvement in economic efficiency and clinical quality during the past several years. Our most recent state survey found absolutely no deficiencies. Our finances have also improved, and we are, indeed, an excellent place to invest your philanthropic dollars! With our team of compassionate and skilled staff and volunteers, we are poised for even greater success in our second century. Despite the ever-increasing state and national quandaries that surround healthcare, our mission is very simple and unchanged – to provide outstanding home and community-based healthcare and hospice services that enrich the lives of our neighbors, in all of our 86 communities. We live that mission every day.

Thank you again for your support. Please enjoy a look back through history, and join us as we plan for the future.

Best wishes,

A handwritten signature in blue ink that reads "Jeanne A. McLaughlin". The signature is written in a cursive style.

Jeanne A. McLaughlin  
*President and CEO*

A handwritten signature in blue ink that reads "Anne Page". The signature is written in a cursive style.

Anne Page  
*Chair, Board of Trustees*

## A Special Note of Thanks....

**SANDY DICKAU** *Vice President, Patient Care,  
Dartmouth-Hitchcock Medical Center*

### *Retiring from VNAH Board of Trustees*

From 1982 through 2007, Sandy Dickau's energy and vision have guided this agency through periods of growth and challenge. Sandy's commitment to homecare began when she was vice president of Mary Hitchcock Memorial Hospital (MHMH) and responsible for that department. June 2007 marked her retirement as chair of our Assembly of Overseers, a volunteer position of significant importance in the governance of the VNAH.

"While my entire professional career has been spent in hospitals, I know that hospital care is only a small stop in the health care continuum," Sandy explains. "Patients need to recover at home, surrounded by those who love them in a unique healing environment. That is why my involvement in home care has been so important to me."

While Sandy was overseeing home care at MHMH, she co-chaired the steering committee that took on the weighty effort of merging seven home health agencies. Called the Home Care Regional Consortium, its work culminated in the formation of the Visiting Nurse Alliance, now this agency. In the same role, she helped steer the merger of Hospice of the Upper Valley with the VNA.

"It has been an absolute privilege and honor to have been a part of this VNAH journey through times of growth, change and tough challenges," Sandy says. "I am proud to see the continued focus on quality services, which improve the lives of people every day, in so many ways."

Bruce Schwaegler, co-chair of the merger steering committee, past board chair and trustee, notes this about Sandy's contributions. "It's hard to visualize the agency without Sandy in a key governance role. Her service in numerous board leadership posts, including chair and vice chair and key board committees, has been outstanding. We all have a deep admiration for her commitment and her leadership."

Effective leadership comes from setting a tone and style that fosters results. Posey Fowler notes, "I had the pleasure of serving on the Board of Trustees with Sandy for six years. Her calm, confident and optimistic demeanor has been the backbone and strength of the VNAH. Her commitment and dedication to the mission of the agency and the patients it serves has been steadfast."

Dave Munro, with his long-term service to home care and VNAH, summarizes what Sandy Dickau has meant to us. "Sandy's efforts on the board have ensured that the agency will continue to deliver the highest quality homecare and hospice services to everyone we serve, in every town we serve. She will be missed."



IT IS WITH  
GREAT PRIDE  
AND RESPECT  
THAT WE  
HONOR AND  
RECOGNIZE THE  
EXTRAORDINARY  
COMMITMENT  
THAT SANDY  
DICKAU HAS  
MADE TO THE  
VISITING NURSE  
ASSOCIATION  
& HOSPICE  
OF VERMONT  
AND NEW  
HAMPSHIRE.

*Words fail me when I try to express my gratitude for your services. The nurses and aides rate five stars. They made possible mother's stay in her own home these last several years, and my caring for her.*

*It meant so much to me to know that we could call on someone for help at any time, day or night. It gave me a feeling of support during a hard and often frightening time. I will never forget how much you did for both of us.*



CARING FOR **100**  
YEARS



For one hundred years words like these, spoken and written, have conveyed what the Visiting Nurse Association & Hospice of Vermont and New Hampshire (VNAH) has meant to the people we serve.

Recognizing the importance of serving people in the comfort and warmth of home and providing services to all, our founders began to organize home-based nursing services in 1907. Financial support came from individuals and community organizations.

The oldest of the 15 home care and hospice organizations that would later combine to form the VNA & Hospice began in Windsor, Brattleboro and Woodstock, Vermont. The common focus of these district and town nursing services was to care for people who were unable to access health care because of their rural location and/or their inability to pay.

The **Brattleboro** Mutual Aid Society provided "household" nursing services to poor women and children—the seamstresses, needlewomen and shop girls of the town.

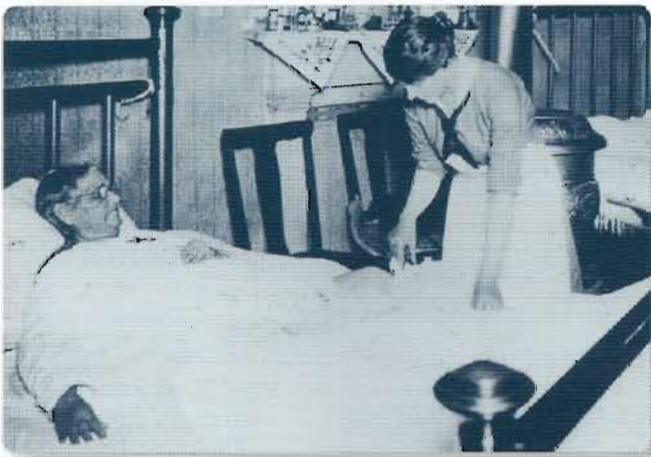
Richard Merry Bradley, a summer resident of the Brattleboro area, organized the society and secured support from the Thomas Thompson Charitable Trust of Boston. "We need to restore that old spirit of neighborly helpfulness which still exists in our town," he explained. He had the foresight to know that if a person's health needs were resolved in a timely manner, the cost of community health care would be reduced. Providing trained nurses was an economical and practical approach to helping people lead healthier lives. This awareness would spread.

In **Windsor**, the local Woman's Club was the first to support a nursing service. The town soon then appropriated funds, \$100 in 1907, and churches, clubs and the Red Cross raised money to cover the cost of "patients who do not need or cannot afford the whole time of a nurse or who cannot pay at all." Beginning in the early 1900s, a town nurse provided home care for the sick in Woodstock, VT.

### The Very Beginning

In the United States organized home care for the sick and infirm can be traced as far back as 1813 in Charleston, South Carolina. The effort was focused on the poor, and was supported by wealthy women in the community. By the end of the 19th century, urbanization and immigration brought constant danger of infectious illness. Inspired by Florence Nightingale, visiting nurse services emerged in this country. In 1860, Florence Nightingale wrote the following:

*My view is that the ultimate destination of nursing is the nursing of the sick in their own homes. I look at the abolition of all hospitals and work infirmaries. But it is of no use to talk about the year 2000.*



In urban areas, the earliest visiting nurses were based in social settlement houses that were set up by women of means to meet the needs of the urban poor who could not afford health care. Common ailments were pneumonia, typhoid and meningitis. Minor surgeries were performed and new mothers were taught how to care for their infants. As a result of home visits, nurses were the first to bring public attention to child labor in factories

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## FACTS THROUGH THE YEARS

- 1907** WAGES FOR BRATTLEBORO NURSES AND NURSES' AIDES -\$1.25/DAY
- 1920** WAGES FOR WINDSOR DISTRICT NURSES:-\$.75/HOUR  
-\$\$.60 FOR EACH ADDITIONAL HOUR  
-\$2.00 FOR OBSTETRICAL OR SURGICAL CASES  
-\$1.00 FOR A MASSAGE
- 1928** WAGES FOR A WINDSOR NURSE AND HER ASSISTANT FOR 2,649 PATIENT VISITS -\$3,872
- 1968** FIRST APPROPRIATION BY THE TOWN OF LYME FOR ITS HOME HEALTH SERVICE -\$1,700  
REIMBURSEMENT FOR LYME VISITING NURSES -\$.10/MILE  
WAGES FOR LYME VISITING NURSES -\$1.00/HOUR
- 1975** COST OF NURSING VISIT IN RANDOLPH -\$14  
COST OF PHYSICAL THERAPY VISIT IN RANDOLPH -\$16
- 1994** TOTAL VNAH OPERATING REVENUES -\$9.7 MILLION
- 2005** AVERAGE AGGREGATE COST PER VISIT -\$127
- 2006** VNAH OPERATING REVENUES -\$16.3 MILLION
- 2007** CELEBRATED OUR 100TH ANNIVERSARY BY EARNING A PERFECT SCORE ON THE STATE SURVEY, CREATING A FINANCIAL TURN-AROUND TO A POSITIVE BOTTOM LINE, AND THROWING A HUGE PARTY IN WINDSOR, VT!

## LUCILLE WALDO, Woodstock

**B**ack in 1938, I was the district nurse for Woodstock, Pomfret, and Bridgewater, Vermont. I boarded in a home in Woodstock when I was on duty. Wherever I went, everyone had a big kitchen. Of course the mother didn't work out of the house in those days so she was always at home. There would be a rocking chair, padded with quilts near the stove and many times also a cot. That's where the aunt and uncle or grandparent would be.

Every year we had a tonsil clinic in the town hall. Sometimes there were four or five children from one home. They were on low cots and I went around and gave them the cone ether and one of the doctors came along behind me with a scalpel and yanked out the tonsils and adenoids. The next morning I visited every home. It scares the heck out of me now to think about how this was done but we never had any casualties and never sent anyone to the hospital.

There was one Christmas day when I was home with my three kids and husband. The hospital in Hanover called and said they had a mother who was terminally ill with cancer. She could come home for the day to be with her five-year-old daughter if I would come to the house every four hours and give her shots for the pain. That's how I spent Christmas.

Another time in the spring, I got a call from a doctor about a woman who didn't have a telephone or electricity. When her kids came to school they said their mother was going to have another baby. The doctor couldn't come and he asked me if I would go. So I parked my car at the foot of the hill near a big field. I began to cross the field, picking mayflowers as I walked, and this robust man with red hair came down in a horse-drawn wagon and told me his wife was in labor. "Come on up," he said. So up I went in the wagon and sat with her.

They had kept their 10-year-old girl at home to get the meal, I guess. She'd made a cake with a lot of chocolate junk over the top—the flies were abundant—and she made boiled potatoes and salt pork that barely touched the stove. I couldn't say I had already eaten since I was there a long time. But I don't think I touched another boiled potato after that. The doctor said he'd stop by but I didn't think he would and he didn't. The baby came out fine.

—As told to Nancy Serrell for 'An Oral History of Nursing in Rural New England'

and the impact it had on health and development. Visiting nurses were advocates for school nursing. Many, if not all, of the visiting nurse agencies at some point in their histories ran clinics to insure that school age children were healthy and received appropriate immunizations. Community health education also became a foundation of the earliest work of visiting nurses.

A significant event in the development and demand for home nursing occurred in 1909. Lillian Wald, a nurse in New York City, convinced the Metropolitan Life Insurance Company to offer home visits to their policy holders. By 1952, one billion visits were made to policy holders. While insurance increased the availability of this important health service, it also initiated the paperwork tradition that became such a challenge for home care later in its history.

## Growth and Expansion of Home Nursing in the First 50 Years

Community support continued to be the principle source of funding for home health programs. By 1909, there were 600 community-sponsored visiting nurses services in the United States. In **Springfield**, Vermont in 1912, the King's Daughters, a church group, organized this service and supported it for 54 years until it became independently incorporated.

In 1919, the Woman's Club of Windsor raised enough money (\$499) to purchase an automobile for the district nurse. She had the distinction of being one of the few women to have four-wheeled as opposed to four-legged transportation, which had quite an impact on the number of patients visited. That district nurse, Catherine Flynn, was able to make over 3,000 visits in two years.

Governance of nursing services was, from the beginning, a volunteer activity. Often, oversight came from health committees formed by the towns. These volunteers, in addition to providing their time, would give financial support and serve as a source of referrals for residents needing services.

In the 1930s and '40s in Windsor, the service picture changed significantly. The impact of group health insurance was a key factor in the reduced demand for home care nursing. Factory workers were now able to visit doctors and use hospital services. In Windsor in 1947, only 335 home visits were made



and the town voted to drop the free nursing service from its budget. Other community fundraising ceased as well.

In 1930, the Town of Brattleboro took over the funding and management of the community's home health care agency.

## The Second Fifty Years

After the Second World War, developments in health care rapidly increased the need for nurses. Medical research resulted in significant changes in treatment of illness, the number of hospital beds was growing and the field of industrial health was emerging. Health insurance programs covered more of the cost of home nursing which began to have an impact on the demand for services.

In the 1950s, the number of people with chronic illnesses such as heart disease, diabetes, arthritis and cancer increased. National data showed that almost one in four home nursing visits were to elderly people with these diagnoses. The percentage continued to grow with people over 65 receiving a far higher proportion of services than in the past. By the end of the decade, they accounted for half of all home care recipients. This percentage would continue to grow.

At mid-century, visiting nurse services were also significantly affected by the development of the Salk vaccine for polio and by drugs and other treatments for tuberculosis and with diabetes.

All of these factors resulted in the re-emergence of visiting nurse services in Windsor.

In 1954, Mrs. Alice Beal, prompted by local doctors including Bob Ballantyne, began to re-establish the VNA service. The town and the Women's Club again contributed, as did the Cone Charitable Foundation, which continues to support the VNAH today. In 1955, Lucille Waldo, RN, who had served as the district nurse in Woodstock, was hired. Mrs. Waldo covered many miles not only for home visits but also to provide health education to the community. The VNA collaborated with Vermont's Department of Health and broadened its work to include children, cancer patients, school nursing and mental health services.

In that same decade, the Upper Valley towns of **Lyme** and **Hanover** established visiting nurse services. In 1957, the Lyme Utility Club, a women's group that supported community services, organized a visiting nurse committee. Miss Hattie Wise had the idea for the service and stored nurses' supplies in her home on the town's green. The initial charge for an hour visit was \$1.00. The club paid for the nurses' supplies and provided transportation to patients' homes. Two club members agreed to be "call bureaus," the early version of referral services, and listed

their phone numbers in all publicity. Every family in Lyme was visited by a club member who could answer their questions about the program, a true outreach effort.

A town resident noted that home nursing "was too new an idea to receive immediate acceptance. The rugged individualism which we admire often proves difficult when a new service is proposed and people prefer to get on as they have always done rather than trying a new thing." This person was unaware that the idea was not so new.

Of course regulations were not new to home nursing either. In Lyme, these were prepared by Dr. William Putnam and included:

- *The nurse's hat, coat and bag should not be taken into the patient's room. If absolutely unavoidable they should be placed as far away from the patient as possible.*
- *A gown should be worn when caring for patients suffering from scarlet fever, diphtheria, typhoid, dysentery. This may be left in the patient's home between visits. When the case is closed the gown should be taken back to the office in a separate bag and soaked in solution of Clorox. If a paper gown is used, it should be burned.*

In 1968, the Lyme Home Health Agency was created at the town meeting and care was available to all, regardless of ability to pay. The Utility Club paid the nurses when a family was unable to. "The fee wasn't the important purpose," as an article in the local paper noted. "It was the feeling of helping out a neighbor in time of trouble."

The first town budget for the nursing service was \$1,687 for salary, transportation and office supplies.

In Hanover, the town agency began with one nurse and expanded to three nurses by the late '60s in order to meet the growing need for home care. With the advent of Medicare certification for the agency, a physical therapist was added. By 1975, the Board of Selectmen appointed a health council to provide overall supervision.

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In 1980, Hanover's service became hospital-based, and changed its name to Mary Hitchcock Memorial Hospital Home Health Agency. Services included nursing, physical therapy, occupational therapy, speech therapy, social work, personal care, laboratory services, community clinics and health education programs. The agency employed 30 people by 1991.

## The Federal Government Steps In

In 1965, the most significant health care legislation in history was enacted by the United States Congress. Title 18 of the Social Security Amendments created the Medicare Act to provide health care benefits to everyone over the age of 65, regardless of income or need. Thanks to the efforts of leaders of national nursing organizations, a home health benefit was included. The federal government was now the single largest provider of health insurance.

Medicare was followed by Medicaid, which expanded health care coverage to low-income people. By 1970, Medicaid required states to include home care coverage.

Initially, both of these programs had a very positive impact on the visiting nurse agencies. Services expanded to include physical, occupational and speech therapy. Home health aides and medical social workers were also added to the care team. Nurses were trained as case managers; they were now helping to develop plans of care and coordinate with other members of the care team.

Government reimbursements closed the gap between income and expenditures, and many agencies were able to have positive bottom lines. Unfortunately, this would not continue. Town funding, private contributions and grants from the United Way and other sources, while always important, would become critical to the agencies' ability to provide services and to stay true to their charitable mission.

In order for a visiting nurse service to treat Medicare patients, an agency had to be certified. Once this certification was received, agencies recognized a growing demand for services and expanded to serve surrounding



towns. This was especially true of Woodstock, Windsor and Brattleboro. This growth strained existing resources and necessitated moves to new office space and the hiring of more nurses and homemaker-home health aides, physical therapists and nutritionists.

In the Bold region of New Hampshire, the Mascoma Area Health Council was established in 1969 to serve Canaan, Enfield, Grafton, Orange and Dorchester. Area residents who lacked financial resources and transportation were in great need of medical services. While the towns had run clinics and developed a volunteer system of aiding neighbors, a more formal structure was required to meet the health care needs of these small communities.

## More Changes in the 1970s.

Before the 1970s, medical costs were reimbursed through a "fee for service" model...what was billed was paid. As costs quickly rose, the need for improved control became evident. Hospitals and home care services became more standardized and regulated by government and private funding sources

During that decade, cost containment came to the forefront in health care insurance and health maintenance organization (HMO) programs evolved. Regulation of reimbursement rates increased the need for and volume of documentation; mandated service options, including home health care, became a condition for certification. Despite the efforts to control costs while assuring quality, the Federal government was unable to sustain its programs without additional drastic reform.

Further legislative changes created the prospective payment system (PPS). Payments for health care would be based on 467 home health related groups (HHRG). When Congress noted that the PPS Medicare changes resulted in a 37% increase in home health referrals from hospitals, it cut coverage for these services. So while hospitals were discharging patients quicker and in more fragile condition, Medicare was denying them the more intensive care they would need post-discharge by tightening definitions of what was considered *skilled care* and what was considered *medically necessary*.

During this period, visiting nurse agencies were involved in increased community-based health services such as clinics and maternal child health programs that

provided medical care and guidance on early child development and parenting challenges.

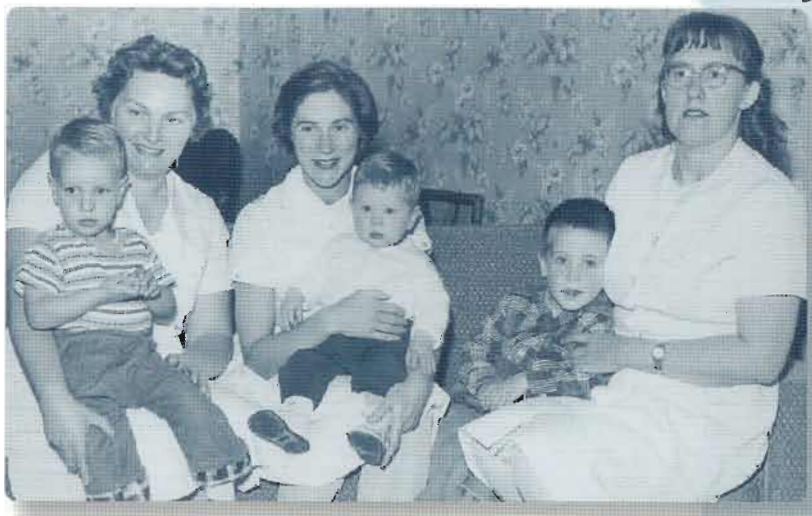
The **Lebanon** Area Health Council was incorporated as a non-profit organization in 1972 for the purpose of promoting and coordinating health care in the Lebanon area. The earliest services included well child and dental clinics as well as home nursing. Referrals came from doctors, welfare workers, social agencies and Mary Hitchcock Memorial Hospital.

By 1976, regional coordination of homemaker and home health aide services expanded to include Hanover and Lyme. Programs grew to include maternal child health and the WIC supplemental food program for mothers and children. In the early '80s, the organization's name was changed to Home and Community Health Care of the Upper Valley, to better reflect the expanded scope of its programs.

In 1973, Gifford Memorial Hospital in **Randolph** and two community-based organizations, Orange County Mental Health Services and Faith, Hope and Charity, joined efforts to establish a home health agency. A more limited version of this service had been provided by Faith, Hope and charity. Through a Vermont Department of Health grant, the Community Human Service (CHS) Agency was initiated and headed by Father Rouelle and Edith Kent, RN. In 1975, the program was certified for Medicare, Medicaid and private insurance coverage.

In addition to home health services, CHS, through its affiliation with Gifford Hospital, provided well child and adult screening clinics, pre-natal classes, and education on the care of newborns. Physical therapy, communicable disease control and community health education were also offered. All services, with the exception of home visits, were free. Nursing visits cost \$14 and physical therapy, \$16. Towns served included Chelsea, Brookfield, Hancock, Granville, Rochester, Pittsfield, Bethel, Randolph, Royalton and Braintree.

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## RUTH JENKS, Lyme

I began working for the Lyme Home Health Agency in the mid-1960s. We had four nurses. All of us worked part-time because we had children to care for. We often brought our children with us on patient visits because there was no child care available at that time. The patients enjoyed seeing the children and it brought joy to their days.

One memorable patient was Elsie. She was a very talented and interesting woman. In New York City she was a legal secretary who wrote articles for the newspapers. She moved up here because she wanted to live on a farm. As she grew older, her health deteriorated but she was proud and stubborn and insisted on doing much of the work on the farm herself. At that time, as a nurse for the Lyme agency, I made sure to call on our elderly neighbors at least once a month. My visits to Elsie's were always interesting. It was not unusual to go to her home in the middle of winter and find a new calf in her kitchen, warming near the wood stove. Her house was filled with beautiful pieces she collected on her travels around the world and her conversations were always fascinating. Seeing her deteriorate and struggle to do what she had to do to stay in her home had a deep impact on me.

Caring for Elsie was a community effort. My son, Peter, and his Boy Scout troop would carry firewood into her house so she would always have enough to keep her home warm. The farmer down the road would cut her hay, check in on her and call me if she needed my attention.

One day he found her outside on the ground. He recognized that she'd had a stroke and called the ambulance. Elsie wouldn't budge, insisting, "I'm not going!" The only way we could get her to the hospital was by police car, with me at her side.

Because she was partially paralyzed, she was sent to a nursing home after discharge. After she eventually came home, I did what I could to make her comfortable. She was better for awhile and happy to be back in her home. It was a special place for her, no matter what it looked like to the rest of us.

I loved nursing, especially taking care of older people. There were a lot of nights when I couldn't sleep wondering, "Could I have done more?" I felt so blessed to be able to do this work.

—Ruth Jenks, RN  
Lyme Home Health Agency  
1966–1978

## DOREEN SCHWEITZER

**A**s cancer patients, in the late 70s, we saw that there were significant gaps in the care given to people who were dying. So we began offering supportive services. In a sense, we served as the precursors to hospice volunteers—working with families, providing emotional support. We focused on caring, not curing; we were creating “a community of care” to flesh out the medical focus on cure.

Before the official formation of Hospice of the Upper Valley, I would visit patients in the hospital and at home. Soon after, the early Hospice workers did the same. We were an “all volunteer” hospice; as such, we were not bound by government regulations. It was an amazing time.

We were often seen as “knights in shining armor” by the patient and family. We would get involved and their stress levels would ease. They would be so grateful. It was surprising really. We couldn’t fix anything; but we could provide a listening ear. In that simple way we validated their emotional and physical suffering. First by understanding their pain and then by providing help with the tasks of daily life and clarifying communications with health care professionals, we changed their situation dramatically!

I know this now as compassion in action. The power of that compassion was extraordinary. It’s about kindness and connection. I learned that, in a very short period of time, with a sincere interest and a willingness to be present, you can change a person’s life, especially at the end of their life.

—Doreen Schweitzer,  
A founder of Hospice of  
the Upper Valley and  
former executive director

## Continuing Changes in Home Nursing

With the passage of the Medicare Act and the increasing complexity of home health services, agencies needed more formal management structures. In the '70s and '80s, agencies expanded their geographic coverage and consolidated their management and administrative functions. The **Norwich-Thetford** agency became Community Health Services and covered, in addition to Norwich and Thetford, Hartford, Fairlee, Corinth, Newbury and Bradford.

Town agencies such as those in Brattleboro and Hanover were consolidated under hospitals and other health providers to achieve operational efficiencies. The Ellsworth Home Health Agency in Chester combined with the Schoff Agency in Springfield to form the Visiting Nurse Association of Southeastern Vermont.

In 1987, Community Health Services joined with Home and Community Health Care of the Upper Valley to become the first bi-state home care agency. This improved coordination of care in both states and also helped secure Blue Cross insurance coverage for the New Hampshire towns.

Multi-agency coordination of billing and quality improvement efforts and hospice services were taking place across the Lebanon, Windsor, Springfield and Woodstock agencies by the late 1980s. The time came for this cooperation to be formally recognized.



## The Visiting Nurse Alliance is Formed

On December 17, 1991, at the Juniper Hill Inn in Windsor, Vermont, the heads of seven visiting nurse agencies signed an agreement to merge—the single most important event in the one hundred year history of the VNA & Hospice. The foresight and boldness of this move meant that, for tens of thousands of people along the Connecticut River Valley in New Hampshire and Vermont, home health care would continue to grow and strengthen to meet increased need.

The seven agencies were as follows:

- Gifford Memorial Hospital Community Health Services (Randolph)
- Home and Community Health Care of the Upper Valley (Lebanon, Hartford, Norwich, Bradford)
- Mary Hitchcock Memorial Hospital Home Health Agency (Hanover)
- Mascoma Home Health Agency (Canaan, Enfield, Dorchester)
- VNA of Southeastern Vermont (Springfield)
- Windsor Regional Home Health Agency (Windsor)
- Woodstock Visiting Nurse Association (Woodstock)

Changes in Medicare regulations and reimbursements were one factor contributing to this action. In 1991, a 41% increase in home visits was fueled by shorter hospital stays, more complex patient needs, an aging and more frail population and an increased awareness about the benefits of hospice care. Demand for maternal child health services also increased due to the impact of the recession on family incomes.

Betsy Davis, who arrived in 1987 to run the Gifford, Woodstock, and Springfield/Chester VNAs, was chosen to lead the Alliance. In speaking about the impetus for the merger, Betsy said, "The primary goal was to improve the ability of the visiting nurse organizations to respond to the complex needs of people in our service area and to be proactive in meeting the current and future demands of an ever-changing health care system."

"Combining these seven organizations was a huge challenge," Betsy explained. "Each one had its own administrative and clinical policies and procedures. Some 390 employees would be affected. Job descriptions and pay grades varied significantly. Everyone worked very hard to make the changes happen."

Bruce Schwaegler of Orford, NH, who became the chair of the Board of Trustees of the Alliance, was a member of the steering committee which included a board member and executive director from each agency.

He explained, "Changes in Medicare coverage for hospitalizations meant that people were being released sooner, with greater medical needs. The small agencies just couldn't meet this need alone. The merger meant that they would share resources and cover for each other, so patients could be seen 24/7."

Getting the legal and regulatory approval involved reviews and investigations by Vermont and New Hampshire state agencies, as well as by Medicare and the Department of Justice.

Community perception was also a factor in the success of the merger. "It was crucial that each of the 70 towns in the combined service area understand and accept what was happening—that services would not be diminished, but in fact would be improved because of efficiencies of the merger," Betsy Davis noted. "Our efforts were highly successful as each town continued to provide annual support to the new agency. We also met with other funding sources, including the United Ways, to ensure their understanding and ongoing involvement."

"We had a wonderful, collaborative team," Betsy recalled. "The work was daunting but exciting."

Bruce Schwaegler concluded, "I am so proud of what we did to bring this together. It really took a lot of foresight and energy to achieve this merger, and Betsy Davis gave us exactly the kind of strong leadership we needed."

## After the Merger— the Challenge Grows

In the first years after the merger, the Visiting Nurse Alliance experienced a remarkable growth in demand for services. The number of home visits more than doubled early in the decade. By the mid-90s, visits for all programs totaled over 250,000 and revenues reached close to \$16 million. Changes in Medicare and private

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insurance limited hospital reimbursements and resulted in increased demand for home care. More high tech services evolved. The need for family health services increased the number of home visits and well-child clinics, and the agency became involved with the *Healthy Babies* initiative in the State of Vermont. Community health screenings and flu clinics continued to provide important health education and prevention programs.

In the '90s, the agency's homemaker services, which provide longer term care enabling frail elders and persons with disabilities to live at home, faced funding cuts in Vermont and multiple years of level funding in New Hampshire. As a result, these services were curtailed and a waiting list was needed.

By 1994, the Visiting Nurse Alliance experienced an increase in the number of patients with inadequate or no health insurance and no ability to pay for care. At the same time, federal government programs began to reduce support for home care, and state reimbursements continued to remain unchanged while inflation increased the cost of home care.

Community support continued to be an important factor in agency operations. Voters in all 70 towns in the service area approved funds at their town meetings in support of care for individuals unable to pay, continuing a tradition that started in the earliest days. Funding from the United Ways of the Upper Valley and of Windham County supported homemaker and family health services. Private grant money began to flow to the agency. Realizing the need for increased community support, the Alliance launched its first annual appeal fundraising campaign in 1994.

## Focus on Efficiency and Cost-Effectiveness

As a result of the financial and operating challenges faced by the agency and the belief that these challenges would continue in our rural environment, the Board of Trustees and agency leadership evaluated processes and outcomes to determine where service delivery improvements might be made. Productivity standards were increased to meet growing patient needs. Embracing the philosophy of Total Quality Management resulted in ongoing monitoring of service quality, efficiency and patient satisfaction.

The financial health of the organization improved after the introduction of a medical record system that focused on patient outcomes, and the agency's billing processes were centralized. Collaboration with other health providers and the development of services for nursing homes also contributed positively to agency operations. Programs were assessed to reduce or eliminate losses.

With the operating changes, the agency was able to respond to the growing need for services and the number of visits provided continued to increase annually. In addition, the VNA was running the Good Neighbor Health Clinic in White River Junction, providing WIC (Women Infant and Children) nutrition programs to qualified NH residents, and offering psychiatric nursing and a Help At Home private duty program; these all were eventually eliminated, as home care and hospice services required a greater concentration of resources.

## Medicare Strikes Again

In 1997, Congress passed the Balanced Budget Act that focused on eliminating federal deficits. As a result, Medicare implemented the Interim Payment System (IPS) in an effort to decrease the rate of growth of home health care expenditures. Over a two-year period following this implementation, Medicare funding for home care declined by 45%.

All agencies were treated the same regardless of the differences in the cost of their care. In Vermont, the impact of the decline in reimbursement was particularly severe. With Medicare significantly reducing the number of individuals and services covered, average utilization by Medicare beneficiaries decreased from 74 visits per year to 30. Once again, the agency began to incur operating losses. Across the country, one-third of all home health agencies went out of business or merged.

The Visiting Nurse Alliance's visit volume dropped by 62%, from a peak of 275,000 in 1997, to 120,000 in 2000. Financial performance declined significantly and aggressive financial improvement plans were put in place. The agency was forced to borrow \$500,000 from hospital partners and to secure lines of credit. Revenues declined over a two-year period from \$15 million to \$13 million.

As an example of the cuts in human terms, this meant that a 96-year old woman with severe arthritis was no longer eligible to receive Medicare services through the VNA. Services continued to be provided without reimbursement. Home care provided to hundreds of patients with chronic illness was challenged by a growing gap between Medicare and Medicaid funding and the cost of their care.

In 2000, Medicare implemented yet another change in the form of the Prospective Payment System (PPS). This set a predetermined dollar amount for every 60-day episode of care. Reimbursement amounts varied, based on a scoring system that considers clinical diagnosis, functional ability and other factors, to arrive at a case weight. This weight is applied to an average reimbursement rate of \$2500 per episode. The more complex the case and the care plan, the higher the reimbursement. While more complicated to administer than IPS, this change resulted in improved reimbursement for the VNA.



## The Twenty First Century

The geographic service of the agency as we know it today was completed with the merger of the Southern Vermont Home Health care, the Brattleboro regional agency in 2001. The next year, Betsy Davis retired as president and chief executive officer, Susan Larman was named as her successor. With her experience as a home care nurse and a master's degree in business administration, Sue was chosen to lead the agency into the new

*Continued on next page*

## CAROL HEAVISIDES

Harry was one of the first patients I cared for as a staff nurse for the Lebanon area's home health agency in the mid-1980s. Harry taught me a lot! With his stunning blue eyes, he was legally blind and hearing impaired. He was under our care for seven years, through his early eighties, when he died.

Visiting Harry was always an adventure. He lived alone in a house that was beyond repair. That didn't matter to him. His one source of water was frozen for most of the winter. Heat came from a single wood stove with so many cracks I'm surprised it never ignited his home.

I came two to three times a week to care for a chronic draining wound on his shin. He refused to see a doctor. With no family or friends to care for him, the VNA was his lifeline. A home health aide and a social worker would also visit him, so someone was there every day.

Harry called each of us "Girlie," and since he could only see shapes, he would know which one was visiting by our size and smell. You could never visit him without bringing a treat and my treat was an egg and cheese sandwich. He knew it was me the minute I walked in the house!

We certainly had to do things for Harry that we didn't have to do for other patients. When he asked, "Had your exercise yet today?" you knew he needed firewood. Shaving him in the winter meant heating water on his wood stove. In addition to his groceries, we brought in kerosene for his lamps.

Harry's favorite place in the summertime was his blueberry patch up a steep hill behind his house. The first few times I came, I would panic when I couldn't find him. Then I knew to take my bag and hike up to the berries where Harry would be sitting in the sun. He loved it there—napping on the grass, smelling the flowers, relishing those berries. That was his joy.

When I first began to care for Harry, I wanted him to live by my standards and I tried hard to "fix" things for him. He wanted no part of that. He was feisty and independent and wanted to be left alone. No hospital, no nursing home. His doctors knew that and respected his wishes. The more I saw that he was happy with what he had, the more I came to understand that you have to accept how people want to lead their lives. It was a lesson well-learned for me and one that guided me through thirteen years of homecare visits.

—Carole Heavisides  
VNAH Quality Improvement Staff

century with a goal to improve systems and the use of technology.

At the end of 2003, the Board of Trustees completed a strategic plan to focus on priorities in program quality and responsiveness, community awareness and collaboration, hiring and retention of staff and fund development. In recognition of the geographic expansion and the agency's integration of hospice services, the organization's name was officially changed from the visiting Nurse Alliance to the Visiting Nurse Association & Hospice of Vermont and New Hampshire.

The agency's mission statement was revised:

*Our hearts, skills and resources are dedicated to delivering outstanding home and community-based health and hospice services that enrich the lives of people who live throughout our region. We do this in active partnership with other organizations and with the individuals we serve.*

The core elements of the agency's operations were distilled to six guiding values, which have become much more than just words on a page:

- Accountability
- Excellence
- Innovation
- Integrity
- Respect
- Team Work

As the reimbursement challenges continue and the demand for services grow with the rapidly aging population, the VNA & Hospice of VT and NH (VNAH) is positioning itself to achieve the highest level of effective, compassionate services through the following key strategies.



## Being an Employer of Choice

Unlike a hospital, the VNAH does not have a large facility or expensive medical equipment to support its services. Instead, the quality of our services depends on clinicians who visit patient homes, and on the staff that supports these clinicians. The population most likely to use home care (those 80 years of age and older) is expected to double in the next decade, while the shortage of caregivers becomes more severe.

Recognizing this, we continually strive to create a work environment that is responsive to the personal and professional needs of our highly valued staff by ensuring that salaries and benefits are competitive, that staffing is adequate for our caseloads, and that ongoing training enhances employee competency.

## Using Electronic Patient Records

Over one and a half million dollars was raised through the Technology Capital Campaign in 2002 to equip nurses and other clinical staff with laptop computers in order to switch from a paper system to an electronic patient record. The introduction of this technology has made a significant difference in the quality of service delivered and the management of financial resources.

In the past, nurses admitting a patient to home care had to complete a paper form which asked more than 100 health-related questions. Each time the patient's care plan changed, the form had to be updated. Every contact with the patient or the patient's doctor had to be documented in the paper file. Now, the nurses use an electronic patient record and data entry can be completed at the point of care. Errors are flagged and corrected on the spot, avoiding payment delays. Records are stored in a central electronic data file accessible to all staff who visit the patient. Records are readily updated on the laptops, administrative time is saved and face-to-face patient care time is increased.

## Telemonitors

A telemonitor is the size of a small clock radio and can be equipped with a digital thermometer, blood pressure meter, glucose meter, digital scale, pulse oximeter and other peripheral devices. The monitor's voice and text on an LCD screen leads the patient through a sequence of measurements and questions. This data

is transmitted to a central computer at a VNAH office. If any of the measurements are outside of the patient's normal parameters, a VNAH nurse will confer with the patient's physician and decide how to treat the problem before it requires a visit to a doctor's office or hospital.

Patients most likely to benefit from a telemonitor are those with heart disease, pulmonary and circulatory disorders or diabetes. Use of this machine results in fewer adverse reactions to medications, increased independence and fewer trips to the hospital.

For recent VNAH patients using telemonitors, only 11% were re-hospitalized compared to 30% of those without machines. This program enhances quality of care and improves outcomes for our patients. For VNAH, telemonitoring helps to direct nursing visits more appropriately to need, increases efficiency of patient care and results in timelier communications with doctors.

In addition, clients learn more about medication management, the disease process, home safety, nutrition, and the signs and symptoms related to their illness that require immediate attention. Patients get in the habit of self-monitoring, learn cause and effect and how to manage their disease.

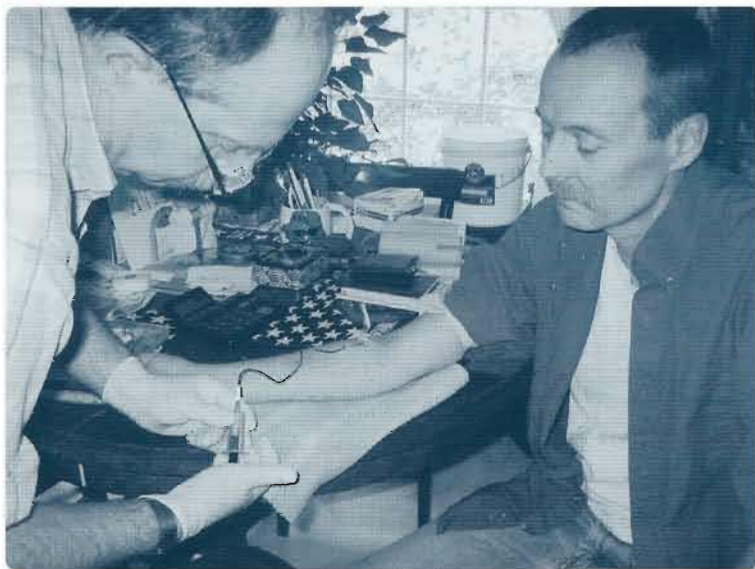
Using a telemonitor is also very cost-effective for patients and for the agency. One day in the hospital averages \$3,608. One day of telemonitoring averages \$10, and even as little as \$6.47 a day if a patient is monitored for an entire year.

## High Tech In-home Treatments

VNAH nurses are able to administer complex treatments that once were only available in hospitals, thereby reducing, if not eliminating, hospital visits and allowing patients to be cared for in the comfort of their homes.

Infusion therapy involves the administration of medication and fluids directly into the bloodstream. Until recently, patients needing the treatment remained in the hospital. Stays were costly and kept people from resuming normal activities of daily living. Now, this therapy can be delivered in the home for infections, cancer and cancer-related pain, gastrointestinal diseases, congestive heart failure and other disorders.

Wound care is a nursing specialty that requires VNAH employees to complete a nine-week training program and pass a certification exam. Wounds can be caused by many factors including pressure on a body part, poor circulation, trauma or surgery. Preventing infection is the key to healing a wound and keeping people out of hospitals and nursing homes. Patient comfort is enhanced and the cost of health care reduced.



One of the newest treatment techniques administered by VNAH nurses involves the use of a Pleurex™ machine with a chest tube to remove fluid from the chest cavity. The most common side effects of severe illnesses like cancer, lung disease or a traumatic injury to the chest is the build-up of fluids. Keeping a patient stable used to require regular hospital visits, some lasting as long as two weeks, to properly drain the fluids that surrounded the lungs. Patients are now able to stay at home and caregivers no longer have the added stress of frequent trips to the hospital. The impact on quality of life for both is significant.

For people with kidney disease, those without kidneys or patients with end-stage heart disease, cleansing of blood through a treatment called peritoneal dialysis is necessary to remove excess fluids from the abdomen. The VNAH is now able to provide this treatment in the home and eliminate hospital visits, some of which totaled 16 hours a week.

## Enhanced Focus on Quality

To ensure that we are fulfilling our mission and achieving our goals, the VNAH has established three patient outcome goals by which to measure the quality and efficiency of our care. Our performance in each area is measured against appropriate state and national benchmarks that we strive to exceed. Additionally, we measure patient satisfaction with our services.

For each goal, we measure our performance against other agencies in New Hampshire and Vermont because of the similarities in the demographics of the population, the regional health care practices, and the higher rates of access to home care services.

*Continued on next page*

## Our Quality Goals

- *Reduce acute care hospitalization*
- *Increase the number of patients discharged to the community*
- *Reduce emergent, or unscheduled, care*
- *Maintain optimum level of patient satisfaction*

## Charitable Contributions

From our earliest days—when individuals and community organizations recognized the need to provide health care at home to their neighbors—to the present, we have relied on charitable contributions to support our work. In 2006, gifts from individuals, businesses, towns, the United Ways and other community organizations totaled over \$1.8 million, representing ten percent of our operating budget. This support helps us to serve those who are uninsured or underinsured and helps us cover annual shortfalls in reimbursements. Since 1994, when the agency organized its first annual appeal, we have focused our development efforts on finding more effective ways to increase philanthropy to the VNAH. Our



costs, as well as the demand for our services, will continue to rise; government funding at the Federal and state levels will undoubtedly continue to be challenged. The need for private support of our services will also continue to increase. Memorial donations, bequests, gifts of all sizes, and volunteer time—all will be needed to preserve the ability to fulfill our mission and achieve our goals.

## A View Ahead

Many of the challenges the VNA & Hospice of VT and NH faced in its recent history will continue: shortages of clinical staff, especially nurses and physical therapists; rising costs that outpace the growth in reimbursement; an aging population and hospitals releasing patients in more fragile conditions.

As the agency continues to improve its quality and efficiencies, the positive results are evident. Patient satisfaction improves; employee satisfaction increases; our 86 communities become more aware of our role as an important community resource; private financial support continues to increase; and the caring which has been our hallmark for 100 years continues, supported at every level in the agency.

Enhanced communications with clinical and administrative staff has increased understanding of the important role each and every employee plays in achieving these positive results. Our patients and their families remind us daily of their gratitude for our exceptional dedication to caring.

Firmly focused on the challenges of a second century of care, we are grateful for all who have invested their passion, energy and resources to provide 100 years of community care. We are proud of this history and committed to honoring our legacy.



## GREG MORNEAU

As an occupational therapist (OT), I work a lot with people who have joint replacements to help them gain back as much of their mobility as possible in the shortest time possible. People really want to function as they did before surgery, and in many cases that can happen.

Ruth is 78 years old and she is a dairy farmer in Vermont. In the early '70s, she was named "Farm Woman of the Year," an award she proudly displays. A gentle and independent woman, working in the barn and milking and feeding 70 cows—each with a name—is as important to her as breathing. Every day she walks out to her picture-perfect landscape and begins her "job."

I started working with Ruth early in 2007, after her second knee replacement. The first thing she said to me when I visited was, "When can I go and take care of my cows?" My reply was, "Well, let's go out and see." She grabbed her cane and slipped on her rubber boots. I watched carefully and noted that she was walking well enough for me to be confident with her moving about in the house. As we went out her front door and confronted steps that were sturdy enough but slippery from the snow, my first thought was, "Have to get a railing."

Then Ruth began to navigate the 50-foot path to the barn that was thick with mud. I knew she needed something more than a cane. In the barn, I saw the cattle, penned on both sides, and each weighing well over a thousand pounds. The floor was hardly flat and smooth. There were grates and multiple trip hazards. Ruth was moving between the animals; "Oh, I'm fine," she exclaimed. "Well," I think, "I'm not! She needs something more stable than that cane."

As an OT, I often see people, especially the elderly; struggle to regain their independence after surgery or an accident that affects their activities of daily living. The simplest solution is to encourage them to give



up the activities that present the most risk. That thought never occurs to me. Instead, the better solution is in restoring people's independence as quickly as possible.

The solution for Ruth was pretty simple. After making recommendations for safety features inside her home, two walkers were obtained—one without wheels to use on the walk from the house to the barn, giving her stability in moving through the mud. Inside the barn, she uses a rolling walker provided by the Cooperative Extension in Vermont; it has a seat, large wheels, a basket and a set of brakes.

Now she can move with stability. She places the milking equipment on the walker and, with her son's help, rolls down the center of the barn. Ruth can maneuver into position to milk the cows and use the seat to give her support. She knows she must have something to hold onto as she moves in the barn, even if it's a cow's tail! That worries me a bit, but it works. Ruth knows.

I am amazed at her energy, her persistence. I see it in her face, in the sparkle and teasing in her eyes. The "Farm Woman of the Year" is back! She's back in her daily routine. What she enjoys. What I love.

—Greg Morneau  
Occupational Therapist

## SHERRI LORETTE

**M**eeting the patients and their families is the bright spot in my day. They always amaze me.

Often those who start out being somewhat prickly are the ones I end up enjoying the most. I had a patient whose husband kept saying to me, "Why should we have hospice? I can have an ambulance here and my wife to the hospital in 15 minutes."

I know it can be difficult for a family to get through to a doctor. When I call and say I'm the hospice nurse, I can get through very quickly. I told him that when his wife is having problems, instead of taking 15 minutes just to get to the hospital, you can call our hotline and a VNAH nurse will tell you how to make her more comfortable and, if necessary, how to adjust her more medication. You will know exactly how much to give and how soon you should expect to see a change in her symptoms. This will very likely mean she can stay at home without the hustle and bustle of going to the hospital. "Wouldn't that be better?" I asked.

He was skeptical, but agreed to have his wife in hospice for 30 days. She had had a stroke and was unable to speak. I would visit twice a week, listen to her lungs and make sure the fluid was draining from the tube in her chest. I really took the time to talk to her. I'd sit next to her chair, ask her questions. She would nod her replies. In the beginning, her husband would insist on giving the answers. I told him it was important for her to be able to respond. She was feeling helpless enough as it was.

The turning point for him came when I made a joint home visit with her doctor. The husband saw that a hospice nurse can be a liaison, a facilitator... not just another layer to work through in his wife's health care.

It didn't take long before he was asking me, "When's your next visit? I really love it when you come and see my wife." He was comforted by the attention she received.

I am tired at the end of every day but I feel very satisfied. The feedback that I get from my co-workers and my patients helps me appreciate that I am doing a very important job. It is a job that I feel called to. I know that I'm doing what I was meant to do and I'm making a difference in people's lives every day.

—*Sherri Lorette, RN*  
Certified Hospice Nurse

# HOSPICE

*You matter because you are you. You matter to the last moment of your life. We will do all we can, not only to help you die peacefully, but also to help you live until you die.*

—*Dr. Cicely Saunders*  
Founder, Hospice Movement

**O**ur present hospice program evolved from three volunteer organizations: Hospice of the Upper Valley, Springfield Area Hospice and Randolph Area Hospice.

The earliest effort to organize hospice care developed in the Upper Valley of Vermont and New Hampshire. In 1977 a group of cancer patients, concerned professionals and community members met to address the quality of care available to people with life-threatening illnesses. The goal was to develop improved systems for emotional and social support as well as to improve pain and symptom management. In 1979, **Hospice of the Upper Valley** was incorporated. Volunteers, as they are today, were the heart of the early hospice program. The first volunteer training program was conducted in 1980 with 58 people participating. That same year, the first staff members were recruited—Dee Dee Monica as volunteer coordinator and Doreen Schweitzer as program coordinator and later, executive director. After setting up its first "office" in Fran Field's living room, space was rented in Lebanon and secretarial staff was hired.

In the following years, a bereavement program was established, an annual community education program was initiated and an interdisciplinary advisory team was organized to help the program grow. The team consisted of physicians, home health nurses, clergy and hospice staff.

In 1986, the hospice's board of directors agreed to continue to offer the services free of charge. At the same time, a contract was signed with Home and Community Health Care of the Upper Valley, the visiting nurse agency based in Lebanon, so reimbursement could be received from private insurance companies. The first computer was donated to hospice for use in keeping financial and fund raising records. The program cared for 78 patients that year.

To meet increased demand in the late '80s, services were expanded to six additional towns in Vermont. The patient census continued to grow. A strategic plan was created for a three year period, more staff was hired and fundraising activity increased. In 1989 the **Hospice Regional Network** was organized to make the hospice Medicare benefit available to patients. The network consisted of seven home health agencies and five volunteer hospice organizations. A bereavement program was started for children.

One of these agencies in the network was the **Springfield Area Hospice**. It was founded in 1980 by a group of ten local citizens and Dr. John Hughes, who noted the need for support of his dying patients. This program was a volunteer-only service, supporting families facing life-threatening illnesses as well as those close to death. Volunteers visited people in the hospital as well as at home, provided transportation to medical appointments as well as bereavement support.

In 1991, in further recognition of the growing demand for hospice services, the Hospice Regional Network contracted with the Visiting Nurse Alliance for managerial support. Hospice offices were relocated to the VNA office in Lebanon. With the VNA as the lead agency, all hospice services also became Medicare certified, enabling greater coordination of referrals, assessments and patient care. In 1995, Hospice formally merged with the Alliance and its name was changed to Hospice of Vermont and New Hampshire. Marie Kim was hired as the executive director.

Also in the early '90s, Hospice of Vermont and New Hampshire became involved in the development of the Regional Palliative Care Institute at the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center.

The **Randolph Area Hospice (RAH)** was another volunteer organization that joined the regional network. Started by clergy and local residents in 1980, meetings were held in a house across from Gifford Hospital. RAH began coordinating with physicians and raising funds to support the work. In 1988, six patients were being cared for and fundraising was bolstered by bake sales, family dances and a quilt raffle.



In 1989, RAH and Gifford Hospital began working together to provide a registered nurse-coordinator of patient and family care. In 1996, the RAH merged with Hospice of Vermont and New Hampshire. To the present day, original RAH volunteers continue to support and promote awareness of hospice in the Randolph area.

By 2003, the VNA and the Hospice programs were fully integrated, and the name was changed to the Visiting Nurse Association & Hospice of Vermont and New Hampshire to reflect the importance of hospice services in the organization.

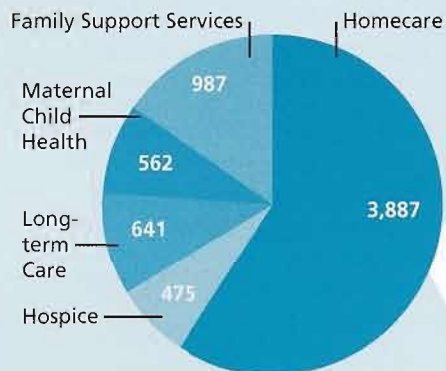
## Hospice Today

The VNAH now serves about 400 hospice patients each year, plus innumerable family members and caregivers. The hospice program offers a full range of services by physicians, nurses, therapists, social workers, aides, chaplains and volunteers. Bereavement support programs, volunteer trainings and annual community education events continue to be important elements of this vital program.

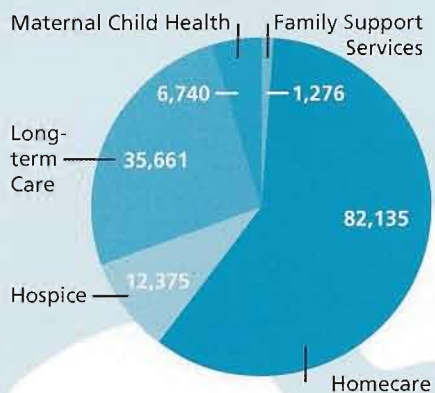


## FINANCIAL REPORTS

### Patients Served (Total 6,552)



### Home Visits (Total 138,187)



### Community Healthcare Clinics Held—603

### For the year ending December 31, 2006

#### Income

Federal and state government payers limit reimbursement for services. Third party payers contract for services at rates below cost, so the VNAH has billing adjustments that represent shortfalls in covering the actual cost of care. The VNAH serves all who qualify, regardless of their ability to pay.

Charges for Care Provided	\$ 19,862,655
Non-Reimbursed Charges	
Medicare and Medicaid	2,979,454
Third-party payers	385,015
Uninsured patients	244,896
<b>Total</b>	<b>3,609,365</b>
<b>Net Revenue from Patient Care</b>	<b>\$ 16,253,290</b>

#### Expenses

Salaries and Benefits	\$ 12,490,339
Direct Care Cost	2,095,094
Mileage Reimbursement	791,652
Operating expenses	2,801,472
<b>Total Expenses</b>	<b>\$ 18,178,557</b>
<b>Patient Care Operating Loss</b>	<b>(\$ 1,925,267)</b>

#### Charitable Contributions, Grants and Investments

Private and public support helps to cover the cost of uncompensated care and enables VNAH to serve all who qualify.

Charitable Contributions & Memorial Gifts	494,007
Bequests	58,824
Grants (Foundations, United Way, Town, County, State)	1,280,525
Investments	60,733
<b>Total Contributions, Grants and Investments</b>	<b>\$ 1,894,089</b>

## OUR MISSION

**O**ur hearts, skills and resources are dedicated to delivering outstanding home and community-based health and hospice services that enrich the lives of people who live throughout our region. We do this in active partnership with other organizations and the individuals we serve.

**For the year ending December 31, 2007**

**Income**

Federal and state government payers limit reimbursement for services. Third party payers contract for services at rates below cost, so the VNAH has billing adjustments that represent shortfalls in covering the actual cost of care. The VNAH serves all who qualify, regardless of their ability to pay.

Charges for Care Provided	\$ 20,387,759
Non-Reimbursed Charges	
Medicare and Medicaid	3,106,941
Third-party payers	487,207
Uninsured patients	16,982
<b>Total</b>	<b>3,611,130</b>
<b>Net Revenue from Patient Care</b>	<b>\$ 16,77,629</b>

**Expenses**

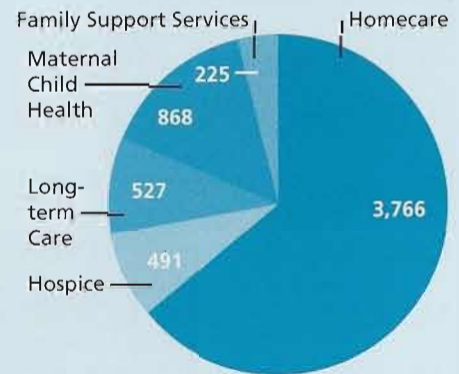
Salaries and Benefits	\$ 12,511,711
Direct Care Cost	2,200,676
Mileage Reimbursement	784,595
Operating expenses	2,995,690
<b>Total Expenses</b>	<b>\$ 18,492,672</b>
<b>Patient Care Operating Loss</b>	<b>(\$ 1,716,043)</b>

**Charitable Contributions, Grants and Investments**

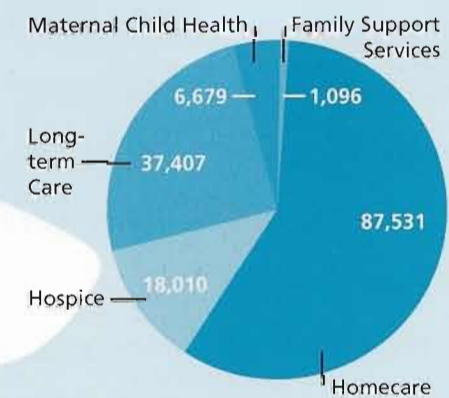
Private and public support helps to cover the cost of uncompensated care and enables VNAH to serve all who qualify.

Charitable Contributions & Memorial Gifts	506,783
Bequests	100,000
Grants (Foundations, United Way, Town, County, State)	1,213,751
Investments	111,631
<b>Total Contributions, Grants and Investments</b>	<b>\$ 1,932,165</b>

**Patients Served (Total 5,877)**



**Home Visits (Total 150,723)**



**Community Healthcare Clinics Held—451**

Increased efficiency and productivity coupled with improved processes have contributed to both clinical and financial successes. Between the years 2005 and 2007, our bottom line has improved, from a loss of \$680,000 in 2005 to an increase of \$224,616 in unrestricted net assets in 2007. The agency received a perfect score on a 2007 state clinical audit.

## HOW YOU CAN HELP

### Annual Appeal

By responding to our annual appeal mailing, individuals, businesses, service clubs and foundations help close the gap between our costs and reimbursements.

### Circle of Caring

In 2006, the agency initiated a leadership giving program for donors contributing more than \$500 per year.

### Stock Contributions

Contributions of stock may be made to the Visiting Nurse Association and Hospice.

### Planned Giving and Bequests

We are honored to receive financial support from people who name the Visiting Nurse Association and Hospice in their wills. These gifts become part of our endowment fund, where they are invested under the oversight of the Board of Trustees. By producing current and future income, each bequest makes a lasting contribution in support of our programs.

### Memorial Donations

Each year we receive more than 1,000 memorial gifts from friends and families of loved ones who died during the year. These important legacy gifts provide current and future support for the agency.

### Gifts in Tribute "Honoring People by Helping Others"

When someone celebrates a special occasion or achieves an important goal in his/her life, people may honor them by making a Tribute Gift. Contributions are made to mark birthdays, weddings, graduations, anniversaries or other occasions.

### Contribute On Line

Visit our Website at: [vnahospicevtnh.org](http://vnahospicevtnh.org) Click on the link named "Make a Contribution" and look for the links to securely donate online.

For further information on contributing to the VNA & Hospice, please visit our website at [vnahospicevtnh.org](http://vnahospicevtnh.org) or call the Development and Community Relations Office at **892-296-2838, ext. 1057.**



CARING FOR **100**  
YEARS



# VISITING NURSE ASSOCIATION & HOSPICE OF VERMONT AND NEW HAMPSHIRE

## ADMINISTRATIVE OFFICES

White River Junction, VT  
Phone: 800-858-1696  
Admissions/Referrals: 800-575-5162  
TDD: 800-735-2964  
Internet/Web: [www.vnavnh.org](http://www.vnavnh.org)

## NORTH REGION

(Serving VT & NH)  
West Lebanon, NH  
Phone: 888-300-8853

## CENTRAL REGION

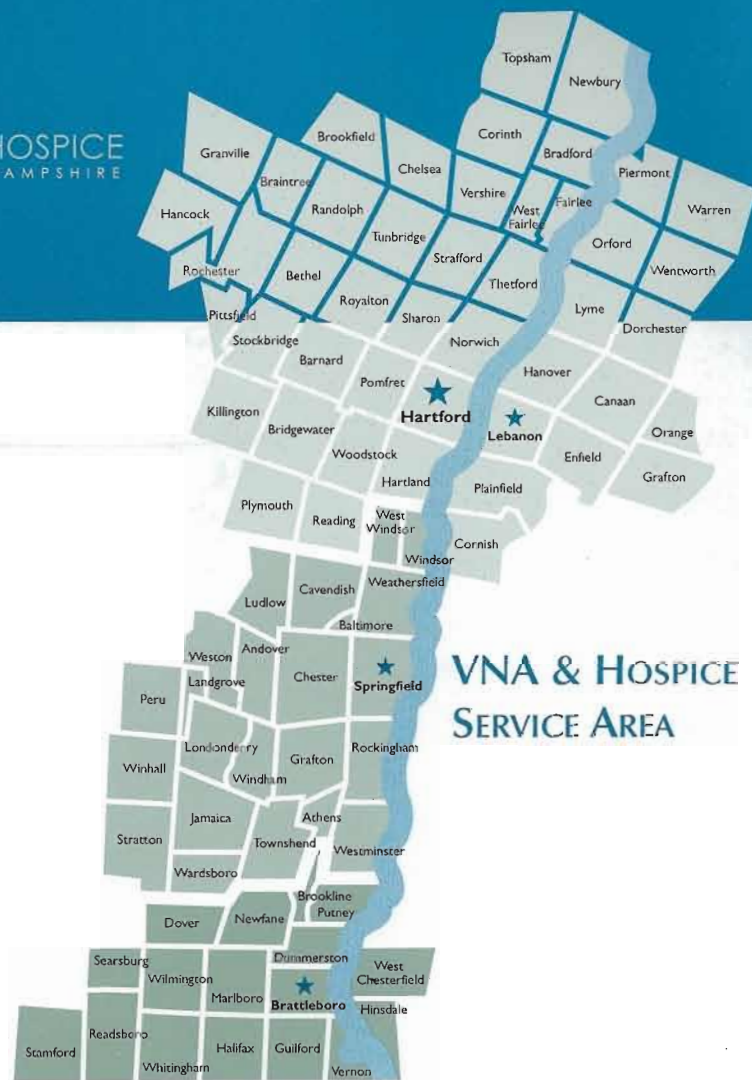
Springfield, VT  
Phone: 888-886-2501

## SOUTH REGION

(Serving VT & NH)  
Brattleboro, VT  
Phone: 800-997-7790

## DONATION ADDRESS

VNA & Hospice of VT and NH  
PO Box 976  
White River Junction, VT 05001



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