



# THE VAHHA VOICE

*The Newsletter of the Vermont Assembly of Home Health Agencies*

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## Two Rural Vermont Agencies Automate Their Patient Records

The Lamoille Home Health Agency, based in Morrisville, and the Orleans Essex VNA and Hospice, based in Newport, two of the more rural home care agencies in Vermont, have jumped feet first into the high tech world of automated records. The two agencies, which share an information director, now have fully automated records, including laptops for the nursing staff.

"Our leap to laptops for visiting staff was almost accidental," said Ann Mallett, Executive Director of the Lamoille agency. "Originally intending to work with new software for billing and scheduling only, we added the clinical documentation piece to maximize our new system and the fun began!"

"Through our transition we've learned a lot: in-house staff with a passion for computers and computer programs is a must; individualized teaching with

clinicians is needed in order to span the wide variety of skill sets; intensive and sustained support for field staff cannot be overdone; a creative trainer from the software company makes a big difference; and a sense of fun and good humor throughout the process doesn't hurt!"

Mallett said that the switch to laptops has resulted in some unexpected secondary gains - patients are excited and accepting of the new technology, clinicians have a renewed sense of camaraderie as they help each other problem solve, and nurses and therapists are better able to see how 485s, OASIS documentation (Medicare forms) and visit plans fit together.

"Total confidence in our new system is still being built, but we're pleased with the beginning foundation," Mallett said.

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*"Through our transition we've learned a lot: in-house staff with a passion for computers and computer programs is a must... and a sense of fun and good humor throughout the process doesn't hurt!" Ann Mallett, Executive Director Lamoille Home Health Agency*

## On Any Given Day...

On any given day, there are more patients served by Vermont's 12 home care agencies than there are inpatients in Vermont's 14 hospitals. On any given day, the Visiting Nurse Association of Chittenden, Grand Isle Counties provides home care service to more Vermonters needing nursing-home level care than live in any of the state's 44 nursing homes. Most Vermonters know something about home care, few know about the size and scope of home care services.

In 2001, Vermont's 12 Medicare-certified home care agencies made 864,575 home visits to 21,754 people. One in every 36 Vermonters received home care, possibly the highest service penetration rate in the nation. Services include nursing, therapies, respite care, hospice, home health aide, and homemaker. Some patients today receive high tech care, such as ventilator care, IV therapy, and chemotherapy treatments, that twenty years ago was limited to in-hospital service only.

Home care is not just for the elderly. Forty-two percent of the home care patients in 2001 were under 65. That

number has grown steadily over the past decade. Ten years before, only 29 percent of home care patients were under 65. Part of the increase is due to more high tech services to children and expanded service to the Maternal Child Health and Healthy Babies programs.

Total Revenues in Fiscal Year 2001 were \$73,520,327. Medicare payments, the largest revenue source, were \$35,516,949, 48.3% of the total. Medicaid revenues, the second largest payer, were \$21,024,138, or 28.6%. Over the past seven years the Medicare percentage of the total revenues has steadily declined while the Medicaid percentage has increased. In 1996, Medicare comprised 62.3% of the total home care revenues while Medicaid was 18.3%. The shift is due mostly to the rise of the Medicare Home and Community-based Waiver program. This program, which was established in 1987, provides services to nursing-home eligible patients who live at home rather than in a nursing home. Currently, there are 945 "slots" available. Another 100 are expected to

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## VNA and Fletcher Allen Team Working Together on Palliative Care

*The following article was submitted by Larisa Pazmino, of the VNA of Chittenden, Grand Isle Counties, to the Vermont Program for Quality Health Care, for inclusion in the VPQHC annual report on quality improvement.*

**P**alliative care, that care which is considered comfort care as opposed to life-extending care, is vital for individuals who have chronic illnesses or who may be living their final days, weeks or months of life. The VNA is developing three exciting new palliative care initiatives, thanks in part to funding from the Fletcher Allen Community Health Foundation. These three initiatives are designed to improve palliative care practices in the agency, and increase understanding of palliative care in the greater community we serve.

### **Advance Care Planning/Palliative Care Education**

The Advanced Care Planning/Palliative Care Education project is designed to educate clinical staff about the importance of advanced care planning, the basics of palliative care practice, and ways of communicating with clients about these important topics. The need for the project became clear both from the results of a national study that showed nurses did not feel prepared to talk to patients about end-of-life care issues, and concerns expressed by VNA clinical staff. All nurses, not just Hospice nurses, need to understand what palliative care is, how it can improve patients' quality of life, and how to talk to patients about how they want to travel life's final journey. Communicating the importance of clear advanced care planning is also critical to patients and their families to ensure that patients' wishes are carried out.

Funding from the Fletcher Allen Community Health Foundation has helped the VNA, in collaboration with the Vermont Ethics Network, to develop a course which will over time be offered to all clinical staff. Arnold Golodetz, MD, has been instrumental in developing and teaching the class, along with Zail Barry, MD and Barb Seigel, RN, from Fletcher Allen Health Care, John Campbell from the Vermont Ethics Network, Cate Nicholas and Alan Rubin, MD, from the University of Vermont College of Medicine, and Pat Donehower, MSN, Roz Grossman, and Angel Collins, MSN from the VNA. Currently, nine home care staff members are taking the course for four hours each Friday for four weeks. They are learning about patient assessment for advanced care planning, educating patients about Palliative Care and Hospice, the law and advanced directives, and symptom management.

### **Pediatric Palliative Care**

Keven Ericksen and Angel Collins are heading the Pediatric Palliative Care Initiative. This is a very timely project, as the health care community is recognizing the importance of palliative care and symptom management in critically ill children. The American Academy of Pediatrics recently issued a statement calling for the establishment of Pediatric Palliative Care centers to ensure that children with life limiting illnesses receive appropriate treatment, and that their families receive needed support. For this project the VNA is collaborating with Parent to Parent, an important community resource for parents of ill or disabled children, and Fletcher Allen Health Care.

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## **And the Winners Are...**

**H**ealth and Human Services (HHS) has announced the eight states that will be the test markets for the new OASIS-based (Medicare assessment tool) home care report card. The eight selected for the pilot are: Florida, Massachusetts, Missouri, New Mexico, Oregon, South Carolina, West Virginia, and Wisconsin. Vermont, and the other 41 states, will be added later in the year. The criteria for review include:

- Four measures related to improvement in moving around the house (getting better at walking and moving using less equipment, getting in and out of bed without help, getting to and from the toilet without help, and having less pain when moving around);
- Four measures related to improvement in meeting basic daily needs (getting better at bathing, taking

medicines, dressing the upper part of the the body without help, and bathing without help);

- Two measures related to medical emergencies (patient had to be admitted to the hospital and needed emergency medical care); and
- One measure related to improvement in mental health (being confused less often).

CMS intends to buy ads in several newspapers to inform Medicare beneficiaries of this project. The data will be evaluated and reports published on the CMS website for all the Medicare participating home care agencies. The criteria will be "risk adjusted" to allow for the fact that patients are admitted to home care with different needs.

## Bad News From Medicare - VAHHA Opposes Cuts

On April 1, 10 of the 12 Medicare-certified home care agencies in Vermont were hit with a 10% cut in their Medicare rates. This decrease followed the 5% rate reduction of last October. Rates paid to the other two agencies, Chittenden and Franklin, were lowered 11% last October. In addition, Medicare plans to freeze the Medicare home care rates for four years and wants participants to pay a 10% copayment. The October cuts cost Vermont agencies more than \$2 million and the reduction this April will cut payments by \$3 to \$4 million more. VAHHA staff and representatives from the 12 agencies have been active with Vermont's Congressional delegation in opposing these cuts. VAHHA representatives will be meeting with Vermont's Washington delegation this spring. In the meantime, the following letter was sent to Vermont's three-person Congressional delegation by VAHHA Executive Director Peter Cobb.

"It is my understanding that the Congressional Budget Office (CBO) and the Medicare Payment Advisory Commission (MedPAC) have presented Congress with several options to further reduce expenditures of the Medicare home health benefit, some of which are very bad for home care in Vermont. Among the options that would greatly hurt home care here are the addition of copayments, a freeze on the base payments through 2007, and a reduction in the home care payments.

"The budget option presented by CBO to impose home health copays will not work and will result in significant cost shifts to the agencies. The CBO plan would impose a 10%

MedPAC suggested that home health agencies can handle these proposed cuts by further reducing services to patients.

copayment on the home care benefit. This option makes no sense for several reasons. First, point-of-service collections are not feasible for home health. Home care services in Vermont are provided by more than 3000 nurses, therapists and home care aides. To make each of them also a bill collector is ludicrous. With point-of-service collection not an option, the only other option is to bill the patient. We believe the cost to collect these payments would add, unnecessarily, thousands of dollars to our costs and could exceed the payments themselves. More importantly, adding deductibles would restrict access to home care because many patients, who would need home health services but who would not be able to afford the copayments, would not get the help they need. This would result in worse health outcomes, would increase institutionalization in hospitals and nursing homes, and would prove costlier for the Medicare program.

"The proposed freeze on base payments for Medicare home health through 2007 and a reduction in the payments for each Home Health Resource Group (HHRG) would threaten the financial viability of the 12 Vermont agencies and could force agencies to reduce services to high cost, high need patients.

"In its March, 2003 report to Congress, MedPAC used average profit margins for home health agencies that it had computed to justify proposals for major additional cuts in home health payments. There are several problems regarding MedPAC's home health margin calculations including: 1) while MedPAC calculated average profit margins (from somewhat limited data), it does not discuss actual ranges in margins; 2) MedPAC estimated average profit margins by weighting more heavily high volume Medicare providers; 3) the data used to calculate home health margins does not include pending retroactive adjustments that will significantly reduce profit margins; 4) MedPAC fails to consider foreseeable increased

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### Given Day - (from page 1)

be added this year.

All 12 home care agencies are not-for-profit, visiting nurse associations. This system provides a unique public, private partnership that guarantees all Vermonters access to a full range of high quality, low cost home health and hospice services. Another important feature of the not-for-profit system is the effort to coordinate and collaborate in the organization and delivery of services, rather than compete for patients, territory, and funding. Because the 12 VAHHA members collaborate rather than compete, they can work together on

statewide quality improvement initiatives including patient satisfaction measurements, high tech training and standards, and agency accreditation statewide. Currently, the member agencies are measuring 41 clinical outcomes and bench marking with federal data to assure that Vermont quality is high.

In addition, the 12 home health home care agencies in Vermont are committed to universal access to medically necessary, cost-effective, home health services; local community governance, involvement and accountability; and promotion of client self-determination and independence.

## Home Care Agencies Improve Quality with Consumer Councils

*The article below, written by VAHHA Director Peter Cobb, is featured in the April issue of Caring Magazine, the monthly publication of the National Association for Home Care.*

One of the most difficult tasks for any home care agency is to meet the needs of people with disabilities, especially the needs of young disabled who often need help everyday, sometimes two and three times a day and frequently during the hardest hours to staff - early mornings, late evenings and weekends. In addition, the independent living philosophy, with its emphasis on consumer choice and control, has forced Vermont agency staff to rethink how they do business. Though most Vermont agencies work hard to assure that their patients are active participants in directing their own care, the problem often is in the details, especially over issues of staff liability and staff availability.

In an attempt to deal with the growing need for long term care services and to incorporate the independent living philosophy that says the patient is the boss, into the everyday world of home care services, the Vermont Assembly of Home Health Agencies (VAHHA), the professional association for 12 non-for-profit home care agencies, hired, through contract, a Director of Long Term Care Services, whose job is to help the agencies determine whether their programs meet the needs of people with disabilities. In addition, she works with representatives and advocates for the disabled and with the state to assure that Vermont home care agencies understand what is expected of them and that those with disabilities understand the strengths and limitations of home health.

The first job in providing better services to people with disabilities was establishing consumer advisory councils at several of the home care agencies in the state. These councils are comprised of consumers of home care services. They advise, from the prospective of people with disabilities and others who receive care, on what should be done. Before the establishment of the councils, most agency staff were confident that their services met the needs of those with disabilities. Often, however, the home care staff discovered that they were wrong, that what was wanted was not necessarily what was being delivered.

“Engaging consumers in advisory committees or groups pushes us all towards a much more collaborative approach to the service delivery system,” said Judy Peterson, VAHHA Director of Long Term Care Services and the Vice President of the Central Vermont Home Health & Hospice,

based in Berlin, Vermont. “Collaboration is not easy. It is hard work. It requires receptiveness and openness. It takes time and commitment. Consequently, the payoff is enormous. Consumers bring a fresh perspective to old issues and problems the agency has struggled with for years. They provide creative solutions and boundless energy.”

Brenda Smith, VAHHA President and Executive Director of the Caledonia Home Health and Hospice, agrees. “The Consumer Advisory Committee of Caledonia Home Health Care has been highly effective in planning for community education, improving communications with clients and families and exploring service delivery options. The efforts of this committee have assisted the agency in enhancing our efforts to promote independence and increase client satisfaction with the services offered,” she said.

The councils usually meet either monthly or quarterly and review the agency services. Recommendations made have been as simple as making changes to the office to make it more disability friendly, to a serious rethinking of the culture of the agency.

“When providers and consumers work side-by-side to design programs or processes or solve service delivery problems, both are enriched. Both develop an expanded view of the other and gain an appreciation of the expertise and experience that each brings

to the table. Agencies who are willing to involve consumers in such an open and meaningful way are making a profound statement. They are saying they are willing to change,” Peterson said.

VAHHA also has established a Medicaid Waiver Advisory Group. The Medicaid Home and Community-based Waiver is the state program that provides services to nursing home eligible patients who live at home rather than in a nursing home. The Medicaid Waiver coordinators from all 12 agencies meet frequently with the VAHHA Long Term Care Director to assure that the goals of the program are met and to work out any problems with the state. According to Peterson, this group makes sure that the services of this program are consistent from one agency to the next.

Last October, at the VAHHA annual meeting, a panel of advocates for people with disabilities explained to the VAHHA board of directors their view of the problems and strengths with home care services. The panel was the result of information learned through the consumer councils - agency staff needed to hear first-hand what was needed. Many of the concerns expressed not only were surprises to the home care agency staff, but also counter to some of what home

*“Engaging consumers in advisory committees or groups pushes us all towards a much more collaborative approach to the service delivery system,” Judy Peterson, VAHHA Director of Long Term Care Services*

care had considered conventional wisdom on dealing with people with disabilities.

The most consistent problem, and one of the most difficult to resolve, deals with staffing. People with disabilities who need help getting up in the morning and going to bed at night want their lives to be as normal as possible. They want to get up when they want to get up and go to bed when they are tired, just like everyone else but meeting that need is not simple, especially with short staffing a growing problem.

"I don't want to go to bed early, at eight-thirty at night, just because that is convenient for the nurse," Hector Racine, one of the four panelist at the VAHHA meeting, told the Assembly. Racine, who uses a wheelchair, said he is sympathetic to the staffing problems but home care needs to understand his problem. "How would you like to lie in bed awake in the morning waiting for your attendant to show up?" he said.

Significant staffing shortages for nurses and attendant care staff, in Vermont and elsewhere, plus the growing number of people who need daily care, have made it nearly impossible for home care agencies to staff all the hours requested. Despite staffing problems and greater demand for services, Vermont agencies have provided service for most of the hours requested.

Since 1999, the Vermont agencies have provided services for an average of 94 percent of the hours requested in the Medicaid Waiver program. But to the those few who lay in bed waiting for home health aide to show up, statistics are meaningless, Racine told the group.

Added to the staffing problem is the fact that often what the staff wants runs counter to what the patient needs. In the highly competitive staff recruitment market, one powerful recruitment incentive is flexible hours. On paper, flexible hours plays well, especially since most home care agencies cannot match the pay at their local hospital. But the hours the staff want frequently do not match what the patients need. The greatest demand for services is in the 6am to 8am hours, very difficult hours for parents with children. Evenings and weekends, also high needs times, likewise present huge staffing problems.

Adding to the difficulty in meeting the needs of those with disabilities, are conflicts between what the patients want and what the agency believes the patients and their families need. This has been especially difficult in the Vermont Medicaid High Tech program for children. This program was established about 15 years ago to provide extensive services to families

with children who are technology dependent. The goal of the program is to assure that any child who can live at home has that opportunity and is not forced to live in a hospital or nursing home. Many of these children need help everyday, some require many hours of home health service each day, and some require nearly 24-hour, round-the-clock care. When the program was first established, the theory was that home care would provide extensive services the first few months or through the first few years after the child had left the hospital, but eventually the family would assume most of the care burden. In many cases, however, that has not worked as the care burden on the families, especially the emotional burden, is

much greater than anticipated. Agency staff and the family often disagree on what role the family should assume.

Another problem is dealing with what the agency staff thinks is appropriate behavior both for them and for the patient, compared to what the person with a disability thinks is appropriate. Over the past five years, VAHHA and its members have worked hard to establish suitable professional boundaries between the staff and the patient. Racine thinks the agencies have gone too far. One home health aide, he said, who has worked with him for more than 10 years and is both his caregiver and friend, told him she could not visit

him at his home in her spare time because that is against agency policy.

"Be realistic," Racine said, "bounds of friendship are made regardless of agency policies" (that try draw a clear line between the professional and personal behavior). That line, he said, is not clearly defined and never will be.

Don Lambert, who also uses a wheelchair, agreed. He told the VAHHA members that too often home health aides look at their jobs as just a job and forget that they are dealing with a person whose needs go beyond physical. Sometimes when he gets a bath, he said, he feels as though he is treated not much differently than if he were a car getting a car wash, the quicker the better.

There also can be conflict between what the patient wants and the safety of the staff. In one case, a patient who needs assistance in getting up in the morning, asked her personal care attendant to change the way she lifted her out of bed because the method used by the attendant was uncomfortable to her. The method she suggested, however, which requires the staff members to lift her onto their shoulders, has resulted in several back injuries. She prefers the lift

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***"The purpose of the partnership is to shape new approaches to how home health services are provided that bring together the best of both home care principal and the independent living movement," Deborah Lisi-Baker, Executive Director, Vermont Center for Independent Living***

## ***VNA and FAHC Team - (from page 2)***

A Steering Committee has been established and has met several times. A focus group including members of the community will be held mid-winter. The focus group will help the organizations managing the work to do an “up-to-date” community assessment and involve a number of people in the planning process. The next step will be to provide education to the care providers. A team from the Jason Program, a pediatric palliative care program in Maine, will come in the spring to help provide advanced training in Pediatric Palliative Care. The goal is to provide a solid education base to build sustainable community systems to care for children with life threatening illnesses.

**Madison-Deane Initiative: Resources for End-of-Life Care**  
Finally, the Madison-Deane Initiative, a program of the VNA, in partnership with Vermont Ethics Network and Fletcher Allen Community Resource Center, received a grant to expand educational outreach about end-of-life care throughout our community. The grant is partially funding the development of a resource guide which will include information about local,

state, and national resources. The resource guide will contain educational information about palliative care, as well as a listing of organizations and services. The grant is also helping to produce an educational video about palliative care. The video will introduce the topic of end-of-life care and serve as a companion to the resource guide.

Other organizations serving this population are showing interest and excitement about this project. Currently, Cindy Bruzzese, Project Coordinator, is gathering information and inviting organizations to list their information in the guide.

Through the support of Fletcher Allen Community Health Foundation, and collaboration with like-minded organization, the VNA is working to improve palliative care, and educate the community about their options when faced with serious illness. These three very different initiatives are clear examples of VNA’s commitment to providing excellent care to people at all stages of life.

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## ***Quality Councils - (from page 5)***

performed her way, does not want a mechanical lift in her house, and would like the agency to figure out a system that meets her needs. Like so much of home care services, balancing the desires of the patients and the needs of the staff is not simple.

Deborah Lisi-Baker, Executive Director of the Vermont Center for Independent Living (VCIL), an advocacy and service provider for people with disabilities, said the independent living philosophy is not intended to put home care staff in unsafe working situations.

“Sometimes the design of the home, the size and design of assistive technology and the size, strength and physical abilities of both the people with the disability and the home care provider make it difficult to do transfers without injury. When more universal design and accommodation features are planned for, in housing and furniture design, and even in assistive technology design, hopefully both the individual needing help and the individual helping will both experience less strain and the potential for injury will be lessened. That is why universal design principal is so much a part of the independent living movement,” she said.

VAHHA members are working more closely with the VCIL to assure that the independent living philosophy is clearly understood.

“The purpose of the partnership is to shape new approaches to how home health services are provided that bring together the best of both home care principal and the independent living movement,” Lisi-Baker, said. “In a sense we are looking for a new kind of medical model, one that is shaped by what users have to tell us about how home health services can support independence and self determination but that also allows the provider to bring specific expertise to bear on the health and rehabilitative needs of individuals with disabilities. Both the user and the provider have expertise to offer, but we won’t benefit from either perspective if we can’t listen to one another and take action”

No one, home care staff or the patients, believes that home health services are perfect but most agree that home care in Vermont is moving in the right direction and the consumer councils can take much of the credit.

Ben Wimett, a third member of the VAHHA annual meeting panel, said without his parents, his friends, his peer counselor (Hector Racine), and the home health staff, he could not have completed high school and become the man he is today. Hector Racine and Don Lambert agreed that their home care services, if occasionally flawed, are invaluable.

## **Automated Records - (from page 1)**

The Orleans agency made the switch when their business systems vendor sold to another company.

“When Picker Business Systems (PBS) informed us that they were selling out to CareFacts, our initial reaction was disappointment. The PBS system was the first computerized documentation system we had used. However, once the shock wore off, we realized that this transition would be an opportunity to streamline our documentation process, our communication efficiency, and our paperwork load,” said Nancy Warner, Executive Director of the Orleans, Essex agency.

“Our first step was to learn as much about the CareFacts system as we possibly could. In an effort to do this, agency administrators attended presentations discussing the operational aspects, and we sent two of our field nurses to Pennsylvania to observe an agency that had been on the system for a few years. One nurse was very familiar with computers, the other not so. We figured that sending these two nurses would give us an indication of software capability and ease of use. The consensus was that the CareFacts system offered a chance to integrate our clinical, financial and client data information, enabling us to have a point-of-care system which could enhance our services,” Warner said.

According to Warner, once the decision was made to go automated, the agency hired an Information Technology (IT) Systems Director in conjunction with Lamoille Home Health. Since both organizations are small and neither could justify a full-time IT director, an agreement was made to share time for this position. Mark Draper was hired to alternate his time between the two organizations. Once he and the administrative staff reviewed the needs of the agency, they determined that the best course of action was to outfit the professional field staff with Toshiba’s Satellite laptop computers. This six-pound lightweight unit would enable

field staff to complete documentation in the home, without overburdening the staff.

As Draper was filling out requisition forms for equipment and related supplies, the rest of the staff was attending Boot Camp on computers. Since the range of computer knowledge was wide among staff, including some staff with little computer experience, training included basic computer use, as well as CareFacts software training. One-on-one sessions were held with those whose anxiety levels were high. Paula Ducharme, RN, was selected as the Orleans,

Essex computer “guru” to assist the clinical staff to learn and transition from a paper documentation system to a computerized one.

“Since our ‘go live’ date in December, 2002, we have encountered huge successes and minor frustrations,” Warner said. “We have overcome software glitches and personal fears. Communication has improved because each nurse has the entire client record at their fingertips for each visit.

*“Since our ‘go live’ date in December, 2002, we have encountered huge successes and minor frustrations,” Nancy Warner, Executive Director, Orleans Essex VNA and Hospice.*

One of the surprises we have encountered is the acceptance of the computers by clients. They have been receptive and even curious about this new way of communicating.”

The experience at the Orleans agency mirrors the Lamoille experience. “The transition from a paper system to the CareFacts program has been interesting and, although we still encounter problems now and then, we are happy to report that we are progressing,” Warner said.

## **Bad News from Medicare - (from page 3)**

home health costs in estimating profit margins and projecting future costs; and 5) MedPAC did not evaluate the overall financial status of home health agencies.

“MedPAC also suggests that home health agencies can handle these proposed cuts by further reducing services to patients. This a very bad idea from a health care quality perspective. Since 1997, the average visits provided over a 60-day episode has already dropped nationwide from 36 to 20 (also 1.3 million fewer Medicare beneficiaries got home

health services in 2002 than in 1997).

“We believe Congress should provide much-needed stability in the Medicare home health benefit by rejecting proposals to increase home health beneficiary cost sharing and rejecting further cuts in payments and access to care. Further, serious consideration should be given to restoring home health care funding and extending the 10% rural add which expires April 1 of this year.”

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