

COMMUNITY BENEFITS PLAN – REPORTING FORM
Pursuant to RSA 7:32-c – I

FOR FISCAL YEAR BEGINNING 1/1/2006

to be filed with:

**Office of the Attorney General
Charitable Trusts Unit
33 Capitol Street, Concord, NH 03301-6397
603-271-3591**

www.state.nh.us/nhdoj/CHARITABLE/char.html

| | | |
|---|----------------------------------|-----------------------|
| <u>Visiting Nurse Association and Hospice of VT & NH, Inc. (VNAH)</u> | | <u>03-6006494</u> |
| Organization Name | | Federal Tax ID |
| <u>331 Olcott Drive, Suite 1</u> | <u>4508</u> | |
| Street Address | State Registration Number | |
| <u>White River Jct.</u> | <u>VT</u> | <u>05001</u> |
| City | State | Zip |

Has the organization filed its Community Benefits Plan Initial Filing Information form?

Yes X No _____

If No, please complete and attach the Initial Filing Information form.

If Yes, has any of the initial filing information changed since the date of submission?

Yes X No _____

If Yes, please attach the updated information.

Attached are:

- Revised By-Laws
- Current Board List
- Current Organizational Chart

Section 1 – Community Benefits Contact Person:

- Name and Title: Brenda Bryer, Controller
- Address: Visiting Nurse Association and Hospice of VT & NH, Inc.
331 Olcott Drive, Unit 1
White River Junction, VT 05001
- Telephone Number: 802-295-2604

Section 2 – Mission Statement:

1. What is your mission statement?

“Our hearts, skill, 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 and families we serve.”

2. When was it last reaffirmed?

January 2003

Section 3 – Miscellaneous:

Is this plan available on your web site? Yes No

If yes, may we include a link to the plan on the CTU web site?

Yes No Web Address: www.vnavnh.org

Please check here if you are an area agency that reports to the Department of Health and Human Services

Please check here if this report is filed for two or more healthcare charitable trusts.

Section 4 – Definition of Community and Population Served

The VNAH serves an area in southeastern Vermont and west central New Hampshire that consists of 86 communities and is bigger than the State of Rhode Island. Services are provided through three branch offices, one of which is located in New Hampshire as well as multiply drop sites. The drop sites enable agency services to be community based. As a multi-service agency, the VNAH provides care to a diverse group of individuals of all ages who have a wide variety of health care needs.

Section 5 – Community Needs Assessment Information

1. Did you conduct your own community needs assessment or did you conduct the needs assessment in conjunction with other healthcare charitable trusts in your community?

The VNAH has gathered assessment data from a variety of sources. These sources include:

- o Board discussions, participation in United Way of the Upper Valley meetings and surveys and assessment process, the results of which were used in Agency planning.
- o Participation in the District V Community Benefit Coalition (now called the Bistate Coalition for Community Health Improvement- BCCHI) generated information. This Coalition was formed in the summer of 2002 following the passage of the NH Community Benefits legislation. The initial goal of the Coalition was to do a collaborative Community Needs Assessment and work together to identify community health problems. One such problem was the access to affordable medications. The coalition members worked together to initiate Access Rx in the fall of 2004. This program has served more than 50 clients. Current membership in the Coalition is listed at the end of this report.
- o Consideration was also given to the goals established in Healthy People 2010 which include:
 - Promote physical activity and fitness
 - Prevent injuries
 - Improve access to quality long-term care
 - Prevent and reduce diseases and disorders
 - o Mental health
 - Depression
 - Violent/abusive behavior
 - o Other
 - Falls
 - Burns

- o If you conducted your own assessment, please answer the following questions:

Not applicable to VNAH

- a. When was the assessment last conducted updated? (Following the development of the initial Community Needs Assessment, the assessment must be updated every three years.)
- b. Describe how community input was solicited and used in conducting the community needs assessment. (The needs assessment process shall include consultation with members of the public, community organizations, service providers, and local government officials in the trust's service area.)
- c. If your assessment was conducted or updated this year, please attach a copy.

Section 6 – Community Benefits Plan/Report

Program Focuses

The VNAH offers the following programs:

- Home Health Services which includes the Home Care Program, Hospice, Wellness Clinics, Safe Steps Program and Long Term Care, (Vermont/New Hampshire Medicaid Waiver programs)
- Family Health Services which includes Family Support Services, Fatherhood program, Maternal-Child Health

Most programs receive funding from multiple sources, which include federal, state, county and local governments as well as grants and contributions from individuals, foundations and other organizations. Whether funded by “per unit contract” or annual appropriation, amounts funded from government sources are capped. Growing community health and social-welfare needs that must be addressed by VNAH have increased the need for additional fundraising and grant writing. The support of individuals, foundations and other organizations has been essential in our efforts to serve our communities.

Summary of Community Benefits

| | 2004 | 2005 | 2006 |
|-------------------------|------------|--------------|---------------|
| | Loss | Loss | Estimate Loss |
| Home Health Services | \$ 421,000 | \$ 733,493 | \$ 460,114 |
| Family Health Services | \$ 121,000 | \$ 411,713 | \$ 295,886 |
| Total Community Benefit | \$ 542,000 | \$ 1,145,206 | \$ 756,000 |

Home Health Services

Category: Home Health Care, Wellness clinics, Safe Steps program, Long Term Care, Hospice

Target Population: Individuals in need of physician ordered, home-based, skilled care provided by nurses, physical therapists, occupational therapists, speech therapists, nursing assistants and social workers, individuals who are at the end of life, patients who require ongoing supportive care to stay in their homes and those seeking preventive care in the community

Objective: Maintain people in their homes with quality care
minimize admissions to area nursing homes and expedite hospital discharges to home
provide supportive, comfort care at the end of life

Measurement: Outcome Based Quality Improvement (OBQI)
Patient Satisfaction
Numbers of patients served (meeting community needs)

| | | |
|-------------------------|--------------------------|--------------------------|
| FY2005 Numbers | Individuals Served: 5519 | Unfunded Cost: \$733,493 |
| FY2006 Estimates | Individuals Served: 5600 | Unfunded Cost: \$460,114 |

Home Health Care Program

The Home Care program is designed to deliver intermittent health care services in the home to individuals with who have been recently discharged from a hospital or nursing home or who have been referred by a community MD or a family member. These services are provided by nurses, licensed nursing assistants, social workers and therapists. Service include but are not limited to: infusion therapy, gait training, wound care, cardiopulmonary assessment and patient education, assistance with activities of daily living and end of life decision making. Common diagnoses include: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Joint Replacements, Neurological Disorders, Vascular Disease, and Diabetes. Home care is the core program of the VNAH and hence this is our largest community benefit. Services are provided to individuals regardless of their ability to pay for the care. Some individuals are under-insured or have no insurance and no funds to pay privately for services.

Wellness Clinics

The VNAH provides community clinics in 18 communities in Vermont and New Hampshire. Clinics include foot and blood-pressure checks, flu vaccinations, medication management, nutrition and general health education. These clinics are funded from the general operating reserves of the VNAH as well as through contributions from cities and towns. Donations are accepted from clients as well.

Two unique programs in this category are located at the Quail Hollow Retirement Community in West Lebanon, NH and at the Woodstock Wellness Center in Woodstock, VT.

Wellness Center

The Woodstock Wellness center continues to operate two days per week, three hours per day and offers patients appointments varying in length between 15 and 30 minutes. The wellness nurse works with senior volunteers to provide care that focuses on prevention and education services. Services include blood pressure screening, health education, flu clinics and medication teaching. The target population is seniors living within a five to 10-mile radius of the Center.

Long Term Care

The Medicaid programs in both Vermont and New Hampshire have served as a very important alternative to more expensive nursing home care. In the state of Vermont, care at home is supportive in nature such as that provided by a personal care attendant (PCA). PCA's assist with shopping, errands, cooking, cleaning and other household tasks as well as provide companionship and direct care when necessary. These services often are the difference between staying at home and being admitted to a nursing home. PCA's improve the quality of life for those we serve, while at the same time meeting their patient's needs in a cost-effective manner. New Hampshire has a similar program which is entitled the Home and Community Based Care Program (HCBC). Both the Vermont and the New Hampshire programs are under intense scrutiny in the state legislative arena and are threatened by the cut back in federal Medicaid funding.

VNAH is projecting that the Medicaid dollars will be shrinking again in both states during 2006. There is great concern about how long the agency can sustain these programs with decreasing resources. It is anticipated that there will be more patients with more complex medical problems who will need services at home as the states tighten the criteria for nursing home admission.

Hospice

Hospice serves patients throughout the VNAH service area. Hospice is a concept of care that focuses on a holistic approach to comfort care for patients and their support persons, facing a life limiting illness. Since Hospice is a philosophy and not a place, home is wherever the patient is.

Services are individualized depending on the patient/family goals and within the scope of services that hospice provides. Our team of skilled medical professionals, counselors and trained volunteers, offer the following services: nursing, medical director consultations, social services, spiritual care services, licensed nursing assistants, volunteer services and bereavement services for up to 13 months following a patient's death.

Bereavement support groups are offered in all regional office locations for bereaved family, friends and community members. Other consultation services that are available as determined by the plan of care are for assessment, care planning and education include physical occupational, nutritional and speech therapists.

Medicare, Medicaid and many private insurance plans cover eligible patients. Our program is available to all who meet eligibility requirements without regard of ability to pay.

Reimbursement from insurance companies and federal and state programs do not meet the costs of VNA & Hospice services. Hospice depends on community financial support including gifts from individuals corporate and foundation grants, towns we serve, memorials gifts, bequests and fundraising events.

The increased need for community financial support for the Hospice program results from more acutely ill patients being admitted, for a shorter period of time. The patients that are referred to hospice are more clinically complex than ever before, have shorter, more critical stays and require a greater intensity of medical/technical/emotional interventions. The reimbursement from insurers has not kept pace with the escalating costs of hospice care.

Uncompensated Care

The VNAH assures access to medically necessary services for all persons regardless of their ability to pay within the limits of the agency’s resources. The agency uses a means test and sliding fee scale in deciding the amount of uncompensated care that will be extended to a particular patient.

Family Health Services

Category: Family Support Services, WIC (end 6/30/05), Fatherhood program, Maternal-Child Health services
Target Population: Families at risk (single parents and/or those suffering from addictions and/or those at risk for abuse and neglect)
Objective: To empower and strengthen families
Measurement: Number of individuals served
 Indicators that are required by funding sources that demonstrate the ability of a program to meet outcomes

| | | |
|-------------------------|--------------------------|--------------------------|
| FY2005 Numbers | Individuals Served: 1194 | Unfunded Cost: \$411,713 |
| FY2006 Estimates | Individuals Served: 1250 | Unfunded Cost: \$295,886 |

Family Support Services

Family Support Services comprises a team of professionally trained Social Service Assistants and two paraprofessional Family Service Aides. These team members work with families in their homes and in support groups with the goal of enhancing constructive social behavior and parenting skills. Services are open to anyone, but the majority of families served are the poor and working poor who have serious and/or chronic medical, mental or cognitive challenges.

NH Fatherhood Project

The Fatherhood Project provides individual and group support services to all interested fathers. Staff provides guidance and skills training specifically geared to them. The program is intended to help fathers establish, re-establish and/or strengthen their vital role in successful parenting.

Maternal and Child Health

Maternal and Child Health services are delivered in the home primarily by nurses who work in partnership with the social service assistants who are experienced in pediatrics and family health. Clinical staff works to insure positive birth outcomes through the New Hampshire Home Visiting Program.

Primary prevention services are focused on wellness. Program professionals teach families about anticipatory guidance, growth and development, and appropriate utilization of community resources. They also strive to insure access to health care through the NH Healthy Kids program.

Secondary prevention services address the needs of children who may have acute or chronic illnesses. Children with a variety of illnesses, such as diabetes or asthma, benefit from this program. Families are better able to monitor and manage illnesses.

The provision of Maternal Child Health services provides significant operating challenges for the Visiting Nurse Association. MCH visits frequently include the provision of services to both the mother and the child during the course of a visit, thereby extending the duration and frequency of visits.

This population is also one that frequently does not have insurance to cover the cost of the services provided, resulting in a significant financial burden for the agency to provide this uncompensated service to the community.

Update from the 2005 Community Benefits Report

Clinical Case Management

- Clinical staff in-serviced on case management basics and use of care conference notes to enhance inter-disciplinary communication
- Implemented weekly interdisciplinary care team meetings in all branches
- Al Howard program on case management held in June of 2005 featuring expert speaker on case management role

Telemedicine - Minimize rehospitalization

The agency has been working diligently to identify best clinical practices to reduce the number of patients who return to the hospital while under our services. 2005 saw a reduction of 2% in this rate, from 32% to 30%. We are confident that the telemonitors had a significant impact in our ability to reduce this number. A patient teaching tool that clearly outlines the correct person to contact for symptom management was developed. This tool is in the patient admission packet and customized for each patient on admission.

The telemedicine program involves the placement of a monitor in a patient's home which records their pulse, blood pressure, weight and blood oxygen levels. This data is delivered via satellite to a central monitoring station in our Lebanon New Hampshire Office and is reviewed by a nurse who responds if the vital signs are outside of established parameters. Consistent monitoring has enabled agency staff to visit patients in a timely fashion when the monitor indicates a cause for concern. The monitors have also enabled the agency to make decisions about utilization of nursing resources. This contact may prevent a trip to the emergency room or hospital. Our quarterly hospitalization rate is lower for monitored patients than for non-monitored patients.

The VNAH received support from various sources for this initiative including the United States Department of Agriculture (USDA) and the Ottauquechee Health Foundation. At the end of 2005, slightly over 50 monitors were being used throughout the agency in patient's homes. The agency has purchased cables that will enable the monitoring of blood glucose readings in the home. The annual cost of this program is estimated to be \$30k for which there is no reimbursement from any public or private healthcare insurance. This amount is an unfunded cost and is over and above any dollars that are contributed for the purchase of telemedicine units. Agency personnel think that Telemedicine is a glimpse into the future of health care.

Collaborative Congestive Heart Failure program

Members of Dartmouth Hitchcock Alliance and the VNA investigated potential areas for joint improvement for mutual patients. A decision was made to start a task force to look at all heart failure education materials used with inpatients at Dartmouth Hitchcock Medical Center.

Reduce patient falls

An interdisciplinary team investigated the patients who fell while on services of the agency. The population of agency patients makes them prone to falls but the objective of the committees work was to prevent as many falls as possible. The committee investigated fall prevention teaching programs utilized by other facilities.

Plans for 2006

Case Management

- Further develop case management model to include education on payors and disease management
- OASIS training, including OBQI education to be conducted by the Clinical Documentation Team/Quality Department

Point of care

- MCH laptop implementation
- Disease management care protocols on laptop

Telemedicine

- Begin utilization of Med partners in home to improve patient compliance with medication management
- Increase number of monitors in patient homes

Congestive Heart Failure

- Joint inpatient/outpatient project team to begin work in 2006
- Goals of project team include improved collaboration between two institutions
- Additional goals include reduction in emergent care and rehospitalization for heart failure patients

Reduce patient falls in the home

- Expand falls prevention program to all branches
- Encourage telemedicine usage for all patients experiencing a fall

Strategies to reduce Hospitalization

- Increase number of telemonitors in patient's homes
- Develop a hospitalization risk assessment to be done on admission for all patients
- Investigate feasibility of implementing telephone visits for those not being telemonitored
- Implement best clinical practices identified as successful in other agencies to reduce hospitalization

Section 7 – Public Notice

How is your plan/report made known and available to the public?

Currently the plan/report is posted on the Web site, and is also available in print to anyone who requests it.

Section 8 – Additional Information

The Visiting Nurse Association did not hire an outside firm to prepare our needs assessment, nor did we hire an outside firm to prepare our plan/report.

The cost of the plan/report in personnel hours for 2005 was approximately 100 hours.

The services the VNA delivers did not change in any way as a result of this assessment and reporting process.