



THE VAHHA VOICE

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Bear Creek Retreat Held At Lake Morey Roshi Joan Halifax Presents Buddhist Thinking on Death

“Life is a sexually transmitted terminal disease,” Roshi Joan Halifax, PhD told the participants at the 5th Annual Bear Creek Retreat, that was held in Vermont and New Hampshire for this first time this past October. Speaking at the Dartmouth Hitchcock Medical Center, Halifax began her comments by declaring that hospice professionals are “lightening rods for fear and rage for families facing death,” which she had just experienced the previous day in Chicago, while sitting with a dying friend.

The Bear Creek Retreats are dedicated to providing restorative, creative care for professional caregivers, according to Virginia Fry, Executive Director of the Hospice and Palliative Care Council of Vermont (HPCCV) and a participant in the retreat. “The retreats explore innovative, multi-cultural approaches to end-of-life care. Participants share their talents,

“Love and Death are the greatest gifts that are given to us, mostly they are passed on unopened”

challenges, dilemmas and dreams in a variety of media, while focusing on death and dying and changing care in the American medical system and our culture at large,” Fry said.

The 5th Bear Creek Retreat was held this year at the Lake Morey Inn in Fairlee and at the Dartmouth Hitchcock Medical Center and in Portsmouth, New Hampshire. For the past twelve years Lake Morey has

hosted the HPCCV annual conference. The growing interest in Buddhism and its views on death and dying led the retreat planning committee to New England because Roshi Joan Halifax, a medical anthropologist and one of only 12 women in the world ordained as a Buddhist monk, was coming to

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Talks on End-of-Life Issues Dominate First Two Months

Debate on a variety of end-of-life issues has dominated much of the discussion in the House Health and Welfare Committee this January and February. The Committee is trying to draft legislation that would encourage the use of durable power of attorney, advanced directives, and living wills (use of these end-of-life documents in Vermont is low) and legislation that would encourage better education on pain management.

The Committee considered but rejected allowing oral advanced directives where an agent for a patient could make decisions, if the patients could not, without written instruction but based on an oral agreement between the patient and the agent. Although there is considerable interest in expanding Vermont law to include oral advanced directives, the Committee decided that this move is too drastic for now and could be discussed in the future, possibly later this year or next year.

The Committee also is considering legislation on pain management. Diana Peirce, of Central Vermont Home Health and Hospice and Angel Collins, of the VNA of Chittenden, represented their agencies and the Hospice and Palliative Council Care of Vermont (HPCCV). They explained palliative care to the Committee, which included a very effective 17-

minute video from the VNA and the Madison-Deane Initiative. The Committee wants to change the rules dealing with end-of-life documents but is finding every aspect of this issue complicated and controversial (several hundred people attended a standing-room-only hearing on this issue).

The 60-member End of Life Coalition (both VAHHA and HPCCV are represented), organized from the Attorney General’s office, is leading the charge for change. The EOL wants the use of end-of-life documents increased and wants all doctors and nurses in Vermont to be required to take courses on how to treat pain.

In addition, the Committee is debating the pros and cons of passing legislation on assisted suicide. The Hospice and Palliative Care Council of Vermont and the Vermont Medical Society oppose legislation either for or against assisted suicide. Opponents and supporters are watching very closely. Supporting legislation that would permit physician-assisted suicide are Death with Dignity and End of Life Choices. Groups opposed are American Cancer Association, Vermont State Nurses’ Association, the Vermont Alliance for Ethical Healthcare, Roman Catholic Diocese, Vermont Center for Independent Living, and the VT Coalition for Disability Rights.

DNA Benefit: Willem Lange On Stage in Dorset

Story teller, raconteur and Vermont Public Radio commentator, Willem Lange is coming to Dorset on Saturday, March 27 to present his one-man show in a benefit for Dorset Nursing Association. Lange will present only one show at 7:30pm at the Dorset Playhouse, tickets will go quickly and should be purchased early. Tickets are available at Dorset Nursing Association, 867-5922.

Lange, born in 1935, is the child of deaf parents. He grew up speaking sign language and first came to New England for prep school in 1950. Prep school (which was offered to him as an option to reform school) was followed by college, which he breezed through in nine short years. In a series of scattered semesters, Lange worked as a ranch hand,

Adirondack guide, preacher, construction laborer, cab driver, bobsled run announcer, bar tender and many other occupations, all of which have informed his warm, heartfelt and humorous stories.

In addition, Lange directed the Dartmouth Outward Bound Center and, in 1973, founded the Geriatric Adventure Society, a group of outdoor enthusiasts who take on serious challenges in the wild. They have skied the 200-mile Alaska marathon, climbed in the Andes and Himalayas, and paddled rivers north of the Arctic Circle.

For information about Dorset Nursing Association or about the Benefit Night with Willem Lange, call (802) 867-5922.

Halifax (From page 1)

Dartmouth to teach “Being With Dying.”

Halifax, her head shorn nearly bald, clad in black robes and a purple vestment in the Japanese Soto tradition, said “my hairdo is a hair DON’T in some places. In prisons where I work, I get eyed for being a gang member. In hospitals, like this one, I get unwarranted sympathy from those assuming I am in cancer treatment. So I let my bald Buddhist head grow a quarter inch for you!”

Halifax said when she was in medical school death was seen as an aberration and a defeat. After conversion to Buddhism she found that “Love and Death are the greatest gifts that are given to us but mostly they are passed on unopened.” She recommends “relationship-centered care,” rather than patient-centered care, which she said leaves out too many people who are intimately involved in the dying process.

The nature of suffering is a major tenet of Buddhism. “Suffering is the story around the pain,” she said. “Are we afraid? Are we trying to escape? Do we make a big deal of the suffering?”

Halifax led the group in a brief guided imagery. “May I offer my caring, my presence, even though it may be met with love, indifference, anger or anguish?” she said. Then she told the story of an AIDS patient who said, “I don’t want to be judged on how I die.” Death can be seen as a karmic accelerator, she said. And though his dying was turbulent and ugly, she said, “I saw the shape of the wind as it lifted his ashes from my hand.”

“May I be peaceful and let go of all expectations,” is the prayer she uses with both the dying and caregivers. Equanimity and compassion are the keys, and can be developed by maintaining a “strong back and a soft belly.” Rather than seeking to diminish our emotional pain, she recommends growing it BIG. “The bigger it becomes, the more inclusive the pain can be until it encompasses all suffering in the world

and transforms into compassion for all.” She uses the Native American tradition of “council meetings” to support those caring for the dying person. She asks each caregiver, “How are you feeling?” And there is no cross-talking allowed. Everyone is heard so that they may share the in the caring - the key to surviving the care of the dying.

Halifax also gave several recommendations for supporting the dying person. Let the dying person take the lead. Prioritize the interventions. Encourage verbalization. Encourage time with family and community. Meet the person’s basic needs. During the vigil - sitting with an actively dying person - be in a place of not knowing, be open. Bear witness and be totally present. Accept all by being inclusive. Presence and respite are necessary and at least six people are needed to share this care.

Halifax reviewed the basic tenets of Buddhism including being in a place of not knowing, or Beginner’s Mind, which provides tolerance for the inconceivable. Bearing witness to suffering with a state of mind that recognizes the reality of impermanence and the source of all suffering. Healing comes with the “making of a whole cloth of one’s life,” which produces a non-exclusive relationship with the world. Buddhism is an ethical life of Do No Harm and supported by the Three treasures - the Buddha (all are Buddha), the Dharma (teachings), and the Sangha (a spiritual community).

Meditation provides mind-training leading to stability, not a process of focusing, but rather one of always returning to the center, to the breath, and the awareness of reality as impermanent. Meditation is medicine—a hand on the rudder that brings us back on course and provides mindfulness in all we do.

For more information on the Bear Creek Retreats, check the HPCCV webpage at: www.hpccv.org or check the VAHHA webpage at: www.vnavt.com.

If it ain't broke, don't fix it

John McClaughry, President of the Ethan Allen Institute, wrote an editorial this January that was printed in several Vermont newspapers entitled: "A Choice for Housebound Vermonters". The editorial was followed by a report with the same title. The premise of both the editorial and the report is that the home care system in Vermont (Medicare and traditional Medicare services are provided only by the

12 VNAs) should change and that for-profit agencies should be allowed to provide service to Medicare and Medicaid patients in Vermont. Among the newspapers which printed McClaughry's editorial was Caledonia Record in St. Johnsbury. Below is the response from the Board of Directors of the Caledonia Home Health Agency.

IN OUR OPINION . . .

In the words of that popular adage: "If it ain't broke, don't fix it." But fixing what isn't broken is exactly what John McClaughry wants to do. In his recent opinion piece in this newspaper, Mr. McClaughry suggests that the community-based, community-run system of home care services, that has assured Vermonters of universal access to this vital service, should be changed to allow competition from for-profit companies.

Mr. McClaughry is right that Vermont's system of regionalized not-for-profit agencies is unique – uniquely good. Historically, according to Medicare, the 12 Visiting Nurse Associations (VNAs) of Vermont have ranked in the top three nationally in two important categories: serving a higher percentage of those eligible for home care and at the lowest cost. Vermonters know a value when they see one. Thus, they have supported this system annually with generous town appropriations. They have also indicated their satisfaction with this system in independent and confidentially-obtained surveys which have consistently rated the services and staff of VNAs as being between very good and excellent. Furthermore, as a mark of the quality of care available in Vermont, all the VNAs have passed rigorous standards to become nationally-accredited by objective review programs.

Before we tamper with this system in the name of granting greater choice to consumers, we should look at the facts. Vermonters do have choices in obtaining home care services. If an individual or family is unhappy with the care they are receiving from a staff member, the agency providing the service will, no questions asked, assign another staff member. If an individual or family member is unhappy with the care they are receiving from an agency, arrangements are in place so that they may transfer their care to a neighboring agency. In the case of a Medicaid client in Vermont's Home and Community-based Waiver Program, there is the opportunity to bypass the home care system entirely and hire their own personal

care attendant, paid for by the state.

In addition to these cases, choice becomes important only if the current VNA system is unable to deliver needed services. Need is the important word here; Vermont's VNAs have been especially effective over the years in providing medically necessary care. Admittedly, sometimes this cannot always accommodate client's wants and convenience, but every effort is made to adjust care and visits to satisfy clients. It is insulting to our dedicated staff that Mr. McClaughry claims that clients are "stuck" in a system that puts "providers' interests first, consumers' interests later." Our client satisfaction results indicate something different.

Mr. McClaughry favors a system that would regulate home care providers and set up quality survey and reporting systems. He should be aware that such systems are in place and that the VNAs' performance under them and adherence to them are the major reasons that, over the past 30 years, state policy makers and all of Vermont's governors (Republicans and Democrats) have advocated maintaining the VNA network. The state's Department of Aging and Disabilities (DAD) conducts annual site visits to assess VNA performance under Medicare's conditions of participation. The results of these assessments are available to the public. Under the Home and Community-based Waiver Program, managed by DAD, the department annually surveys the recipients of services. In the most recent survey, our agency, Caledonia Home Health Care & Hospice received a 100% overall satisfaction rating by those we serve. The VNAs voluntarily submit their own client satisfaction survey results to the state as well.

So, if the current home care system in Vermont is so good, what would be the problem if there were competition? Wouldn't the current VNAs continue to do well given their track record? The experience in other states indicates otherwise. By their nature, for-profit agencies exist to make

a profit. Thus, it is to their benefit to target wealthier and insured clients. Because of their charitable mission, non-profit VNAs cannot and will not do so. Thus, the risk of competition is that VNAs may end up serving a disproportionate share of those who are unable to pay, who are sicker, and who are located in more remote locations – situations that can threaten the VNAs' economic viability. Furthermore, with a limited patient base and often scarce staff, competition drives up the cost of care as agencies vie for resources.

Mr. McClaughry states that Maine allowed competition in 1991 “with very positive results.” Yet, Medicare data shows something different. Prior to competition, Maine and Vermont had similar statistics in terms of charges per person and number of visits per person. Nine years after the introduction of competition in Maine, home care charges were \$368 more per person in Maine than Vermont and Maine provided 6 fewer visits per person than Vermont. In short, Maine now has higher costs and provides less service. In addition, according to the Home Care Alliance of Maine, agencies have gone out of business and there are now areas of the state that are no longer served by home care agencies.

Vermont has a tradition of supporting not-for-profit health care. Like home care, the hospital system in our state is also not-for-profit and non-competitive. If competition is good for home care, why doesn't Mr. McClaughry also advocate having a choice of hospitals in the towns that have a hospital? It's because such duplication would be costly and unnecessary. Home care is no different.

No, the VNA system is not perfect, but it strives to be. And yes, there will be some who are not satisfied. But, in an era of constrained resources for health care, dramatic policy shifts should be made based on fixing real systemic problems, not on the basis of anecdotal evidence or a few

incidents. To do otherwise puts in jeopardy a system that has served the vast majority of Vermonters well and at much less cost than other states. We maintain that the health care system in this country would be better if more care was provided by not-for-profit entities who put the community's needs first instead of by organizations that are profit-motivated for the benefit of their owners and shareholders.

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Vermont Home Care Serves More for Less

A review of the data from the Centers for Medicare and Medicaid Services (CMS) from 1990 to 2002 shows that Vermont always served more Medicare recipients than either the New England average or the US average and just about every year served more people per thousand than any other state. In 2002, Vermont home care agencies served 108 per

1,000 Medicare recipients, well above the national average of 61/1,000 and the New England average of 86/1,000. At the same time the Vermont agencies cost per visits was the lowest in the nation for every year from 1990 to 2002 and was almost always among the lowest cost per person.

Medicaid Budget 7.8% Higher but Most Programs Level Funded

Commissioner John Michael Hall of the Department of Prevention, Assistance, Transition and Health Access (PATH) has proposed a \$580 million FY 05 Medicaid budget. The proposed budget is \$42 million (7.8%) higher than the current \$538 million budget but most programs are level funded. The budget includes an extra \$1.6 million for more slots for the community-based waiver program (this is independent of the new 1115 waiver application). The number of people listed for waiver services in the current budget is 1525. That number jumps to 1640 in the FY05 budget. There is also an extra \$129,240 for two additional waiver slots for

the Traumatic Brain Injury (TBI) program. The budget includes an extra \$993,508 for home care rate adjustments but this listing is a bit deceiving as it is extra Medicaid payments paid from the Medicaid tax, at no cost to the state.

In the Department of Aging & Disabilities budget, the Homemaker program is level funded. The Health Department budget jumps to \$93.3 million from \$76.9 million. This does not include any money for mental health services which, under the proposed Agency of Human Services reorganization, would be under the Health Department. The Healthy, Babies, Kids and Families program is level funded.

Feds to Target Payment Transfers

The Bush administration says “payments transfers” (Medicaid tax and other programs) are costing the federal government billions of dollars and should be stopped. The Bush administration wants to crack down on arrangements used by many states to shift costs to the federal government. Federal officials contend that states use creative bookkeeping and other ploys to obtain large amounts of federal Medicaid money without paying their fair share.

The “Medicaid program integrity,” section of the recently passed Medicare legislation is an attempt to crack down. The section reads: “Throughout the life of the Medicaid program, States have used intergovernmental transfers (IGT) as a means of inappropriately drawing down inordinate amounts of Federal Medicaid funding. Past State funding mechanisms that manipulated the Medicaid Upper Payment Limit, Disproportionate Share Hospital Payments, and provider taxes and donations would have been impossible without the use of intergovernmental transfers. The FY 2005 President’s Budget proposes to further improve the fiscal

integrity of Medicaid by curbing IGTs that are in place solely to undermine the statutorily determined Federal matching rate. The budget proposes to cap Medicaid payments to individual State and local government providers at the cost of providing services to Medicaid beneficiaries and restrict the use of certain intergovernmental transfers.”

The Bush administration says some states have paid their share with “phantom dollars,” instead of state or local tax revenues. President Bush says he could save \$1.5 billion next year and \$23.6 billion in the coming decade by restoring the “fiscal integrity” of Medicaid. Federal and state Medicaid spending shot up nearly 60 percent in the last five years, to more than \$265 billion in 2003, and federal officials say it will double in the coming decade as the population ages.

So many states use Medicaid taxes and are so dependent on them that change anytime soon is unlikely. In Vermont, the total federal money earned from the tax is over \$50 million between hospital, nursing homes, and home health.

Governor Douglas Wants Insurance Credits for Small Business

Governor James Douglas wants to give small business tax breaks if they offer health insurance. To qualify for the governor’s tax credit plan, a small business would have to offer a specific type of health coverage to its workers - one of the high deductible plans that allow employers and employees to contribute pre-tax dollars to health savings accounts. Workers could use the money in these accounts to pay for a variety of medical expenses until they reached the level of their deductible. To be eligible for the tax credits, small-business owners would have to pay at least half of the annual cost of the insurance premiums for their workers and make annual contribution to each workers’ health savings account equal to

50% or more of the deductible. In return, an employer would receive a refundable credit to apply against business taxes due to the state. The amount would be no greater than \$40 per month per employee.

The Governor also wants to have the state pay a portion of the claims submitted by people in a small-group insurance market (business with fewer than 50 employees). Under the plan the state would pay claims between \$60,000 and \$100,000 and the insurance companies would lower their rates to small businesses. The state would pay for this scheme by using money from a 2% tax on health insurance premiums.

RAVNAH Capital Campaign Moves Forward

With a strong show of support from the Board of Directors and the RAVNAH staff, the "Caregiver Campaign" is nearing the half way point of the million dollar campaign goal. The Caregiver Campaign plans to raise \$1.15 million for RAVNAH services and facilities through generous donations made by friends and supporters in the Rutland area and beyond. \$500,000 of the funds raised will be used to create a lasting endowment, allowing RAVNAH to maintain and grow vital services, despite increasing financial pressures. The remaining funds will allow major growth and change in RAVNAH's current office facilities, which have not kept pace with growing staff and capacity for providing home health care services.

The office building renovation and construction will create additional meeting and planning space, better working conditions and more comfortable consultation rooms for patients, families and caseworkers. The redesigned, expanded building will allow RAVNAH to adhere to strict new patient privacy guidelines mandated by the U.S. Department of Health & Human Services.

Wilcox Pharmacy recently pledged \$10,000 and the Chittenden Bank pledged \$20,000 to benefit the RAVNAH campaign.

"Wilcox Pharmacy is pleased to help fund this wonderful project," said Dick Wilcox, owner of Wilcox Pharmacy. "The services provided by RAVNAH are essential

to its mission of providing vital home health and hospice care to many in the Rutland community. We also wish to recognize the hard work and dedication of all RAVNAH employees and especially the indomitable Executive Director, Ron Cioffi."

Chris Herriman, Vice President and Manager of Chittenden Bank's West Street Branch in Rutland and Harold Weissman, Vice President and a Private Banker for Chittenden's Wealth Management, presented the check and pledge to Campaign Chairman, Bill Bannerman, RAVNAH Board President Russ Gates, and Executive Director Ron Cioffi. "We are honored to have the support of such an important institution in the Rutland banking community," said Bannerman. "The generosity of Chittenden Bank will greatly assist us in reaching our total campaign goal."

"Chittenden Bank is pleased to help fund this wonderful project," stated Cynthia Gubb, Director of Community Development. "The services provided by RAVNAH are so essential and supporting their efforts to meet the growing health care needs in the Rutland area is crucial. We know that with the help of our pledge, many will benefit from the expanded services that will be offered at the their facility." Gubb concluded, "We hope that other businesses and private individuals will also support this capital campaign and help RAVNAH continue to provide quality home health services in the Rutland community."

Rutland Health Foundation Hosts Grand Parada

The Rutland Health Foundation will host the second annual Grand Parada, community health awards and celebration on Friday, April 23, 2004 at the Holiday Inn of Rutland. Vicky Young, will chair the gala event.

The Grand Parada will feature dinner, dancing to the Rutland High School Jazz Ensemble and the Stafford Technical Center All Stars, and presentation of the distinguished Emelie Munson Perkins Awards. A highlight of the evening will be an auction of the Grand Parada's annual signature art piece painted by renowned local artist, Judith Carbine.

"The Grand Parada celebrates those who excel in their commitment to the health of the Rutland community and recognizes the significant impact our Physicians, Staff and Volunteers have on the quality of care provided to the residents of the greater Rutland community," said Young. "Those nominated, as well as those receiving awards, represent the care that is delivered everyday by dedicated professionals."

The Emelie Munson Perkins awards were created to recognize the outstanding efforts of health care workers in the Rutland community. Named in honor of Dr. Emelie Munson Perkins, (1890-1986) whose outstanding career touched all

three of the Rutland Health Foundation's member organizations, one individual from each organization will be honored as the Volunteer of the Year and Employee of the Year and one Physician of the Year. Each awardee was chosen by their peers for their outstanding efforts, achievements and commitment to the good health of the Rutland community.

Established in 2001, Rutland Health Foundation exists to improve the health of people and communities in the greater Rutland community by building financial support for Rutland Regional Medical Center, Rutland Mental Health Services, and Rutland Area Visiting Nurse Association & Hospice. The Foundation has provided vital support for collaborative initiatives such as: Kids on the Move, a pediatric rehabilitation program; Bridges and Beyond, volunteer training program and the Maternal Child health program.

"Each member organization has a proud commitment of caring for the people in our community and providing them with a wide range of services," said Dom Serino, Vice President and Executive Director of Rutland Health Foundation. "The generous support reinforces the importance of providing Rutland County residents with good health care."

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