



## From the President & CEO

### William F. Aikman

I am delighted to be sharing this page with four team members from the Harvard Vanguard Medical Associates Complex Chronic Care (CCC) Program who have co-authored this issue's Guest Column. The CCC Program is taking the lead in monitoring patients with congestive heart failure for the Atrius Health Foundation's Home Telehealth Demonstration Project.

In addition to the column below, which gives us a candid glimpse into the daily lives of CCC nurse practitioners and nurses, the article on Page 4 describes more fully the work of this important program and its centrality to the Telehealth Project.

## Guest Column: A Day in the Life of the Complex Chronic Care Team

By Ken Comeiro, NP and Teen Perron, RN, Patricia Blazewicz, NP and Laura Coons, RN



*Pictured Left to Right: Laura Coons, RN, Patricia Blazewicz, NP, Ken Comeiro, NP, Teen Perron, RN*

It's 7:30 AM and the beeper has already started chirping. The Visiting Nurse Association is calling to report a 6-pound weight gain by one of your patients. As you are talking to the nurse, you order your coffee and by the time you reach the office it is still left untouched, as you have spent the entire 15-minute ride on the phone with the patient advising her how to avoid a hospitalization. Thankfully, your interventions are successful this time.

The first office patient of the day is a 53 year-old female heart failure patient and diabetic who has had poor control of her weight, blood pressure and blood sugars for the last several months. The first thing she says to you is, "I hate needles and I am afraid of insulin." One hour later you have a plan in place to manage all of her chronic conditions and have developed a new relationship built on trust.

It is only 9:30 AM and there are 7 more patients like this scheduled for the day. This is in addition to the 15-25 patient calls that will be triaged through your nurse partner. We answer e-mails; send staff messages to primary care physicians and specialists, make phone calls and by the end of the day have the day's documentation completed. As we prepare to leave the office, we heat up the remaining coffee from this morning and answer any pages we have missed. The clinicians in this group wouldn't have it any other way.

The 53-year-old patient mentioned above had been hospitalized for congestive heart failure in the past year and for that reason agreed to be part of the Atrius Health Foundation Home Telehealth study for heart failure patients. Now, two months later, her blood pressure and weight are under control, and her sugars are better controlled than at any other time in the recent past. She is managing all of her symptoms and is happy with all the attention and teaching she is receiving as a Telehealth study participant. Daily weight, blood pressure, oxygen saturation, and pulse readings are all measured with her home Telehealth monitoring system, and transmitted wirelessly to the Complex Chronic Care team. The Telehealth study has given her the satisfaction of being part of the decision-making process for her care, as well as the motivation to continue with healthy living choices.

*(For more about the Complex Chronic Care team, see article on page 4)*

## Innovative Medicine With a Human Touch: The Complex Chronic Care Team Leads Telehealth Project

The Complex Chronic Care (CCC) Program is a dedicated group of nurse practitioner (NP)/registered nurse (RN) teams that deliver personalized, patient-centered care to patients with multiple medical issues. Each two-person team is responsible for approximately 250 patients, many of whom are elderly, with conditions that include cardiovascular disease, diabetes, congestive heart failure, coronary artery disease, high blood pressure, arrhythmias, and high cholesterol. “We bring patients into our ‘family’ with the hope of using our expertise in the management of chronic conditions to improve their well-being and quality of life,” says Ken Comeiro, NP.

“We develop relationships with our patients as individuals, making them feel a part of the medical team, and we tailor our programs to their lifestyles with small gains they can see. We use the human touch to peel back the layers of uncertainty and skepticism by listening first and always looking for ways to educate about healthy lifestyle choices.”

Among its many roles, the CCC Program now has primary responsibility for the recently-launched Home Telehealth Demonstration Project, co-sponsored by the Atrius Health Foundation in partnership with NEHI (a national network for health innovation), and the Massachusetts Technology Collaborative. The Demonstration Project is designed to determine the clinical value and cost effectiveness of home telehealth technology.

Name	Nurse	Site	Weight	BP-PR	SpO2-PR	ECG	Survey
"	"	"					AlcoholCon. HypLife HTN
Aronson, Gr...	Bogart, ...	Alexandria, VA	164.4	134/89-86			Reflexive CHF Assess1 Reflexive
Cao, Lea	Bogart, ...	Del Mar, COU	265.6	118/86-79			
"	"	"					
Pacheco, Op...	Thomps...	Savannah, GA	118.8	115/67-79	93-83		
Doe, Mary	Thomps...	Alexandria, VA	345	124/83-75	96-87		
Jones, Jane		Del Mar, COU	N/R	N/R			
Ryan, Chris	Thomps...	Alexandria, VA					
Kaufman, Alice	Georgila...	Home Health...					
Tahmisian, G...	Bogart, ...	Savannah, GA	164.6				
Aldo, Harry	Bogart, ...	Alexandria, VA	237	127/84-77	95-81		
Waller, Rebe...	Bogart, ...	Savannah, GA	115.1	140/94-86			
Atlas, Ralph	Bogart, ...	Portland, OR	156	118/82-76	96-79		
Rem, Ronald	Thomps...	Alexandria, VA	254.7	127/84-72	97-75		
Empire, Emma		Portland, OR	104	121/87-77	99-99		

Color-coded “flags” alert CCC nurses of potential concerns (patient names and data are fictitious).

The technology used in the Foundation’s study allows patients with congestive heart failure to measure and wirelessly transmit daily readings of their weight, blood pressure, pulse, oxygen saturation, and other data to the CCC teams for monitoring. Any measurements that require intervention are “red flagged” by a computer and a CCC nurse calls the patient to follow up with suggested preventive interventions. “We know our patients so well that we can detect even subtle changes and act on them early enough to prevent more serious problems and hospitalization,” says Teen Peron, RN. “A weight change of as little as 2 pounds can put someone in the hospital. So a red flag is important, but we love the color green, which means everything is OK!”

*The voices of care:  
CCC nurses monitor and respond to patients participating in the Home Telehealth Program*



(Bottom row, left to right): Maureen Briggette, RN Lois White, Administrative Assistant, Laura Coons, RN (Second row, left to right): Ann Fruth, RN, Regis Petrozziello, RN, Teen Perron, RN. Missing from the photo: Christine Roddy, RN, and Cheryl Bovell, RN

This “management of minutiae” is part of the personalized medical care delivered by the CCC, says Patricia Blazewicz, NP, who has worked in the program since it began 14 years ago. “We go above and beyond patient care,” she says. “They even call us from the hospital. They say, ‘I’m not going to take the medicine the hospital gave me until I talk to my nurse.’”

The Home Telehealth Demonstration Project, with its “telestation” technology, is the latest tool in the CCC program to keep heart failure patients healthy and out of the hospital. “The right medications, the right technological devices, and the right follow-up will help our patients stay alive and healthy longer,” says CCC Administrator Linda Oliver, PA.