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Checking her pulse is one service that nurse Maryellen Keller, at left below, performs during a visit to Rose Salvucci. Salvucci is among patients whose care is coordinated by Health Quality Partners of Doylestown.

By Josh Goldstein

INQUIRER STAFF WRITER

Rose Salvucci, 89, would probably be stuck in a nursing home, a hospital, or worse if she weren't part of a program that coordinates care for chronically ill Medicare patients.

The Telford woman has a cavalcade of conditions that would daunt a per-

son half her age: heart failure, diabetes, and lupus.

But Salvucci is one of 810 chronically ill Medicare patients who have their care coordinated by a small Doylestown nonprofit, Health Quality Partners. Computers track Salvucci's care. A nurse looks in on her weekly

to monitor her progress, and her doctor is involved. The attention allows her to remain in her apartment, a big feat for her, and helps taxpayers funding the giant Medicare program.

A recent study in the *Journal of the American Medical Association* found that the nonprofit has succeeded where many other similar efforts have failed. The group has shown it can keep chronically ill Medicare patients healthy and reduce spending, especially among the sickest patients like Salvucci. Health Quality Partners was one of 15 programs that Medicare funded to see if coordination could improve quality and reduce costs. It was one of only two successful programs. Overall the nonprofit reduced health spending by 12 percent—or \$84 per person a month—compared with the control group. For the sickest patients, the number of hospital visits fell 29 percent, and spending dropped 20 percent, saving \$180 per month.

The program suggests how the United States might cut burgeoning health costs among a key group. The sickest 15 percent of Medicare patients account for almost 75 percent of program spending, said David B. Nash, dean of the Jefferson School of Population Health in Philadelphia.

Nash said that care coordination must be part of whatever health plan President Obama proposes. He thinks that Health Quality Partners has found a solid combination of interventions to hold down costs. But, he says, the group's patients are highly moti-

Fit to be tried

By keeping the sickest elderly people healthier, at reduced cost, a small Doylestown nonprofit is giving pointers to Medicare.





vated. So a key question remains: “Can such programs be scaled up to cover the hundreds of thousands of severely chronically ill patients in this country?” Ken Coburn, the group’s chief executive and medical director, says there is nothing magical about its approach.

“There is no shortcut to take aging, chronically ill people and suddenly make them not need health care,” he says.

The system, he notes, spends a lot of money after disease lands patients in the hospital. Why not invest in keeping those people healthy?

Coburn’s team uses lots of personal contact, group training, data tracking, and close partnerships with doctors and hospitals. Such care programs, known as disease management, have historically been losing efforts, failing to keep people healthier and save enough money to justify their expense, said Richard L. Snyder, senior vice president for health services at Independence Blue Cross, the region’s largest insurer. Patients typically get these services through their health plans, state Medicaid programs or Medicare managed-care plans. Traditional Medicare has not offered such assistance. “One of the things that was missing in a lot of those models was that the person who the patient considers their most trusted health adviser, their physician, was not doing the intervention,” Snyder says. The nonprofit emphasizes that, which probably accounts for its success, said Snyder, who is working with the Rendell administration on similar initiatives.

The nonprofit works closely with dozens of doctors in Bucks, Montgomery and nearby counties. Before it enrolls a patient, the person’s doctor must agree to collaborate with the group. Sicker patients get more attention, but all the participants have regular face-to-face contact with nurses that extends well beyond a routine checkup. On a recent weekly visit to Salvucci’s

apartment, nurse Maryellen Keller took along a “talking” scale. She hoped it would enable Salvucci, who has poor eyesight, to weigh herself daily to better guide medication dosages. Keller’s visit lasted more than an hour. The nurse examined her patient, chatted with Salvucci about her latest craft project, and got the latest family news. Together they reviewed a recent doctor’s appointment and discussed a coming one. The nurse ducked into the bedroom to make sure the mask for oxygen that Salvucci uses at night is reachable from the bed.

Then she steadied Salvucci on the new scale. It wasn’t loud enough for Salvucci to hear, so Keller took it back and would try something else. “Rose has a strong desire to be independent, so she tries very hard to stay healthy,” Keller said. That desire by patients appears to be another advantage that the nonprofit has over other care management programs, often paid by employers. A computerized system also tracks each patient’s care and alerts the group when someone’s blood pressure or cholesterol is out of whack.

Flu vaccination rates for participants rose from 54 percent in 2005-06 to 94 percent this season after the computer system started reminding nurses which patients had missed



shots. “This is a simple, but powerful way to manage” sick elderly patients, said Health Quality Partners’ vice president Sherry Marcantonio. Another area the program focuses on is “care transitions”—when a patient moves back home from the hospital or nursing home. Those are key moments when confusion over medications and care can easily send someone back to the hospital, especially a frail senior. In this program, the nurse calls the patient the day after discharge to review new medical orders and drugs. Within a week, the nurse conducts a home visit. Another technique the nonprofit uses

is group sessions for weight control, mobility, and self-management of asthma, diabetes and heart disease. The sessions equip patients with useful skills and provide more face time with nurses.

The groups seem to have a side benefit: using peer pressure to stay healthy.

Six men and four women were happily chatting on a recent weekday morning before the weight management and exercise class at the nonprofit’s offices on North Easton Road in Doylestown. Keller gently tried to get the raucous group of 70- to 84-year-olds to settle down. She handed out



homework, asking them to list their goals, barriers and possible solutions.

Keller has worked with the group for nearly four years. Most participants have lost weight and kept it off. After 30 minutes, Keller led the group down the hall to a larger room where they began video-guided exercises.

Afterward Keller took everyone’s blood pressure and chatted with each individually. For Joyce and Bob Ott of Dublin, Pa., the benefits extend well beyond the combined 56 pounds they have lost.

On April 14, 2007, Joyce insisted that her 71-year-old husband go to the hospital when he complained of indigestion that wouldn’t go away.

She recognized the signs of a heart attack that Keller had described in class. “I really feel that this has saved his life,” she said.

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