

# Medical Home NEWS

## Medical Homes in Residential Care: Challenges and Solutions from a Medical Home Serving Senior and Disabled Populations

By Sarah Keenan, RN, BSN

**T**his is an exciting time to be in healthcare. Legislation and reimbursement are beginning to align, allowing innovative practices to create new models of care. The recognition that the models getting the best results are often the least expensive has opened new doors. This article offers an example of a small medical home clinic that has created such a model for of a small, but costly, segment of the population.

Bluestone Physician Services in Stillwater, MN has built on the tenants of the patient centered medical home to create a unique model of facility based medicine which serves assisted living and group home facilities in the Twin Cities. Bluestone Physician Services is a “clinic without walls” that employs teams of Physicians, Nurse Practitioners, Physician Assistants, and RN Care Coordinators who provide on-site primary care in the homes of assisted living and group home patients. While on-site care is gaining popularity, particularly in the Minnesota marketplace, Bluestone Physician Services is one of the few practices in the country that is solely focused on this population.

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## Casting an A-team to Deliver Results: Embedding and Sustaining the Role of Community Health Workers in Medical Homes

By Jacqueline Martinez Garcel, MPH

**T**he results are out. The 34 programs supported by the Medicare Demonstration Projects on Disease Management and Care Coordination did not meet their target. Over the course of ten years, the 34 programs had no effect on hospital admissions or regular Medicare expenditures. Though there were variations in the results across programs -- care managers who had substantial direct interaction with physicians and in-person interaction with patients were more likely to reduce hospital admissions -- none of the programs brought about any significant cost savings.

The results are troubling. However, they are not too surprising. After all, attempting to layer care coordination and disease management atop a broken and fragmented system can only lead to so much change in outcome. The promised successes of the Patient Centered Medical Home (PCMH) lie on the premise that to achieve the standards of a medical home an entire system needs to be transformed. The transformation requires an entire paradigm and culture shift in western medicine. If done right, the new system will deliver coordinated, seamless care to an engaged and empowered patient using health information technology (HIT) and a high functioning team. The expectations are that these teams, coupled with HIT, will better manage care, deliver high quality services, coordinate tests and referrals, and track performance measures so that the quality of care as experienced by the patient enjoys continuous improvement.

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