Health Information & the Law

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MYTH: All integrated care models, such as Accountable Care Organizations, Patient-Centered Medical Homes, and Health Homes, are the same.

FACT: While all integrated care models share certain characteristics, they vary depending on the care setting and the providers and payers involved.

Integrated models of health care delivery create aligned, person-centered, primary care-focused health care that both increases care quality and reduces cost (or build upon existing quality, community health, and health prevention collaboratives to achieve these goals). Designed to break-through the barriers that define the current fragmented and siloed nature of the health care delivery system, integrated models rely on the sharing of information related to patient care among team members and establishing a comprehensive treatment plan to address the patient's biological, psychological, and social needs.

Several integrated care models have begun to take hold, including Accountable Care Organizations, Patient-Centered Medical Homes and Health Homes, each with distinct features but all with the same goal of better care coordination at lower overall cost.

Accountable Care Organizations: An Accountable Care Organization (ACO) is a specific type of Medicare provider consisting of physicians, hospitals, and other health care providers who align legally to provide coordinated and high quality care to Medicare patients. When an ACO succeeds in both delivering high-quality care and spending less, it will share in the savings it achieves for the Medicare program.

Patient-Centered Medical Home (also called Primary Care Medical Home): A Patient-Centered Medical Home is a team-based model of care led by a primary-care provider (usually a physician but sometimes a nurse practitioner) that provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. PCMHs are not tied to a federal program like Medicare or Medicaid and can exist in a commercial insurance setting. The main idea is to have a centralized setting that facilitates partnerships between individual patients, their health care providers, and the patient's family. Care is facilitated by registries, information technology, and health information exchange, and provided in a culturally and linguistically appropriate manner.

Health Homes: A Health Home is a specific type of optional Medicaid provider authorized by the ACA. Health Homes coordinate care for people with Medicaid who have chronic conditions and operate under a "whole-person" philosophy. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

For More Information:

- See our resources on Care Coordination.
- Learn about state and federal laws related to Health Information Technology.

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