Accountable Care Organization (ACO)
www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves for the Medicare program.

Patient Centered Medical Home: (PCMH): https://pcmh.ahrq.gov/

The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination. Instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.

Preventable Care Admissions Team: (PACT): A model of Transitional Care

An intensive, short-term transitional care program for patients at high risk for a 30-day readmission
Mission:

- Identify and address underlying areas of psychosocial strain increasing readmission risk;
- Ensure a connection to a medical home (for primary & specialty care);
- Improve patients' health outcomes

Health Home: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes

A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home."

Centers for Medicare and Medicaid: The Innovation Center:
https://innovation.cms.gov/initiatives/index.html#views=models

The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

American Academy of Home Care Medicine: AAHCM:
https://innovation.cms.gov/initiatives/index.html#views=models

National Organization of House Call Providers, including provider locater services.