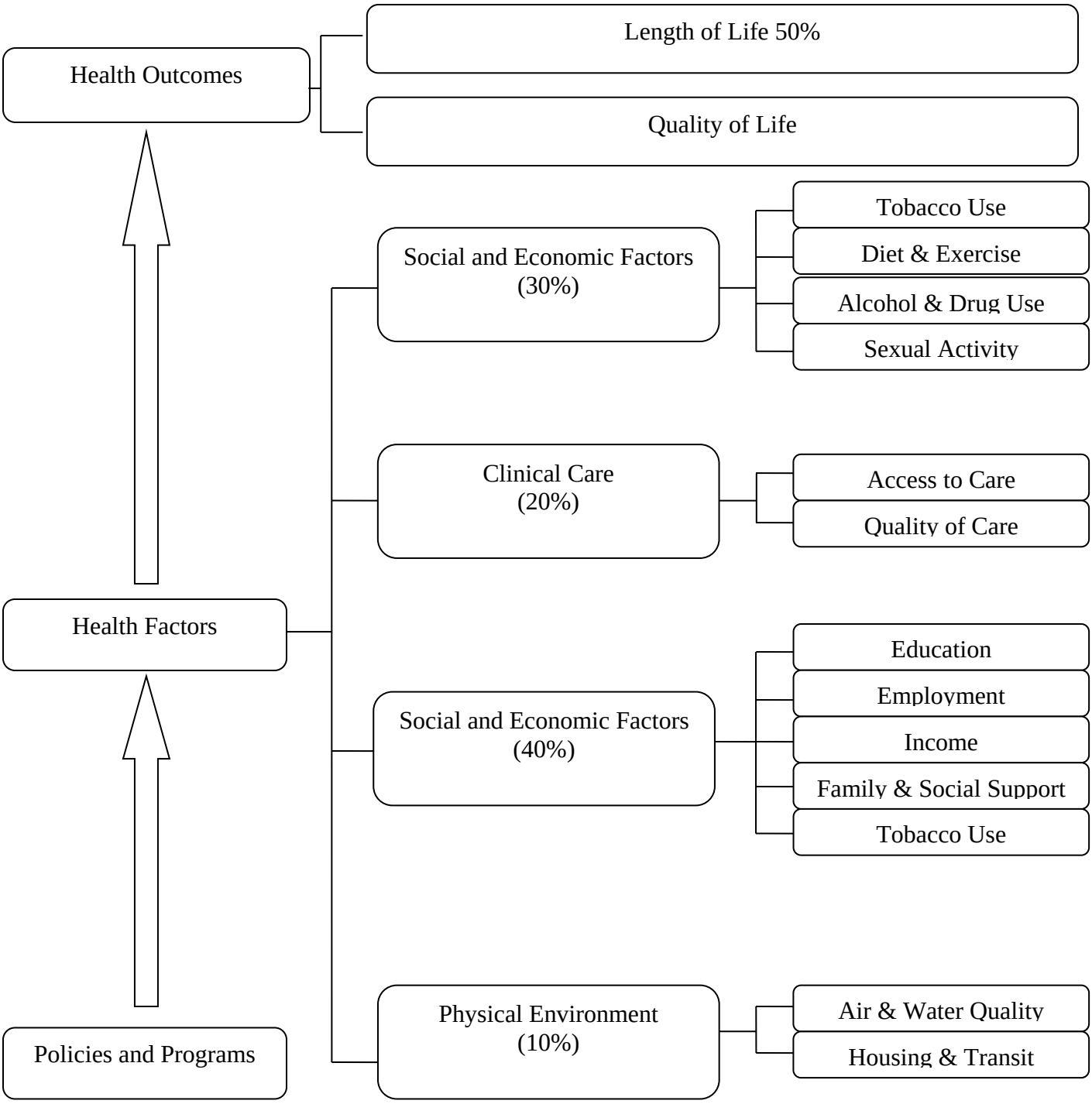
Figure 1.1. Factors Effecting Health Outcomes



Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2015. www.countyhealthrankings.org. Used with permission.

Figure 1.2. PCMH Principles

2007 Joint Principles	2014 Expanded Principles with Behavioral Health Integration
Personal Physician	Each patient has a personal physician who knows that patient's situation and biography.
Physician Directed Medical Practice	The health care team focuses on the physical, mental, emotional and social aspects of the patient's health care. Behavioral health providers may be part of the primary care practice, or may be connected to the primary care practice as part of the medical neighborhood.
Whole Person Orientation	To achieve a whole person orientation, care must focus on both the behavioral and physical aspects of the patient.
Care is coordinated and/or integrated	Behavioral and physical health care must be coordinated and integrated via shared registries, medical records (especially shared problem and medication lists), shared decision making, shared revenue streams and shared responsibility for patient care plans
Quality and safety are hallmarks	Care plans are developed in partnership by the patient, family, physician and behavioral health provider. Electronic health records must incorporate the behavioral health provider's notes, mental health screening and case finding tools, and behavioral health outcomes must be tracked.
Enhanced access to care	This includes access for patients, families, and physicians to behavioral health care resources

	through systems of collaboration, shared problem solving, flexible team leadership, and enhanced communication.
Payment recognizes the added value of the PCMH	Payment recognizes the added value of behavioral health care as part of the PCMH, and the value of behavioral health clinicians as members of the team. Funding streams should be pooled and applied flexibly such that fragmented care ends.

Adapted from: Advancing behavioral health integration within NCQA recognized patient-centered medical homes (p. 4), SAMHSA-HRSA Center for Integrated Health Solutions, 2014. http://www.integration.samhsa.gov/integrated-care-models/Behavioral_Health_Integration_and_the_Patient_Centered_Medical_Home_FINAL.pdf

Figure 1.3. 2014 NCQA PCMH Standards Specific to Behavioral Health Integration

NCQA recognition standards are categorized into six standards, each of which includes several elements and factors. The following table, directly from NCQA standards, highlights the four standards which include elements and factors *specific* to behavioral health integration.

Standard	Element	Description
Standard 2: Team-based Care	• Element 2B: Medical Home Responsibilities • Element 2D: The Practice Team*	• Documenting and communicating to patients is the process by which practices address the behavioral health needs of patients/families • Training and assigning members of the care team to support patients/ families/caregivers in self-management, self-efficacy and behavior change
Standard 3: Population Health Management	• Element 3B: Clinical Data+ • Element 3C: Comprehensive Health Assessment and • Element 3E: Implement Evidence Base Decision	• Capturing status of tobacco use for patients 13 years and older in the electronic record in structured fields. • Performing comprehensive health assessments that include: (1) attention to an individual's behaviors that affect health, (2) history and family history of behavioral health conditions and (3) an understanding of social and cultural factors that impact the individual's health • Screening for depression using a standardized tool for practices with

	Support *	access to relevant services when results are positive • Implementing clinical decision support following evidence-based guide-lines for a mental health or substance use disorder+ and a condition related to unhealthy behaviors
Standard 4: Care Management Support	• Element 4A: Identify Patients for Care Management **	• Identifying through a systematic process, patients who benefit from clinical care management by using criteria that consider (1) behavioral health conditions, (2) certain social determinants of health and (3) high use/ high costs of healthcare services. Populations serviced by care management have a high prevalence of behavioral health conditions/issues
Standard 5: Care Coordination and Transitions	• Element 5B: Referral Tracking and Follow-up++	• Maintaining agreements with behavioral health providers to enhance access, communication and coordination across the two disciplines • Describing the approach to integrate behavioral health providers within the practice site

* 3E, Factor 1, a critical factor that must be met for practices to receive a 75% or 100% score

+ A Stage 2 core meaningful use requirement

** 4A includes a critical factor (Factor 6) that must be met for practices to receive a score above 0% on this element.

++ 5B is a must pass element and a stage 2 core meaningful use requirement: Practices that do not score above 50% will not receive recognition. In addition 5B, Factor 8 is a critical factor.

Adapted from: Advancing behavioral health integration within NCQA recognized patient-centered medical homes (p. 4), SAMHSA-HRSA Center for Integrated Health Solutions, 2014. http://www.integration.samhsa.gov/integrated-care-models/Behavioral_Health_Integration_and_the_Patient_Centered_Medical_Home_FINAL.pdf