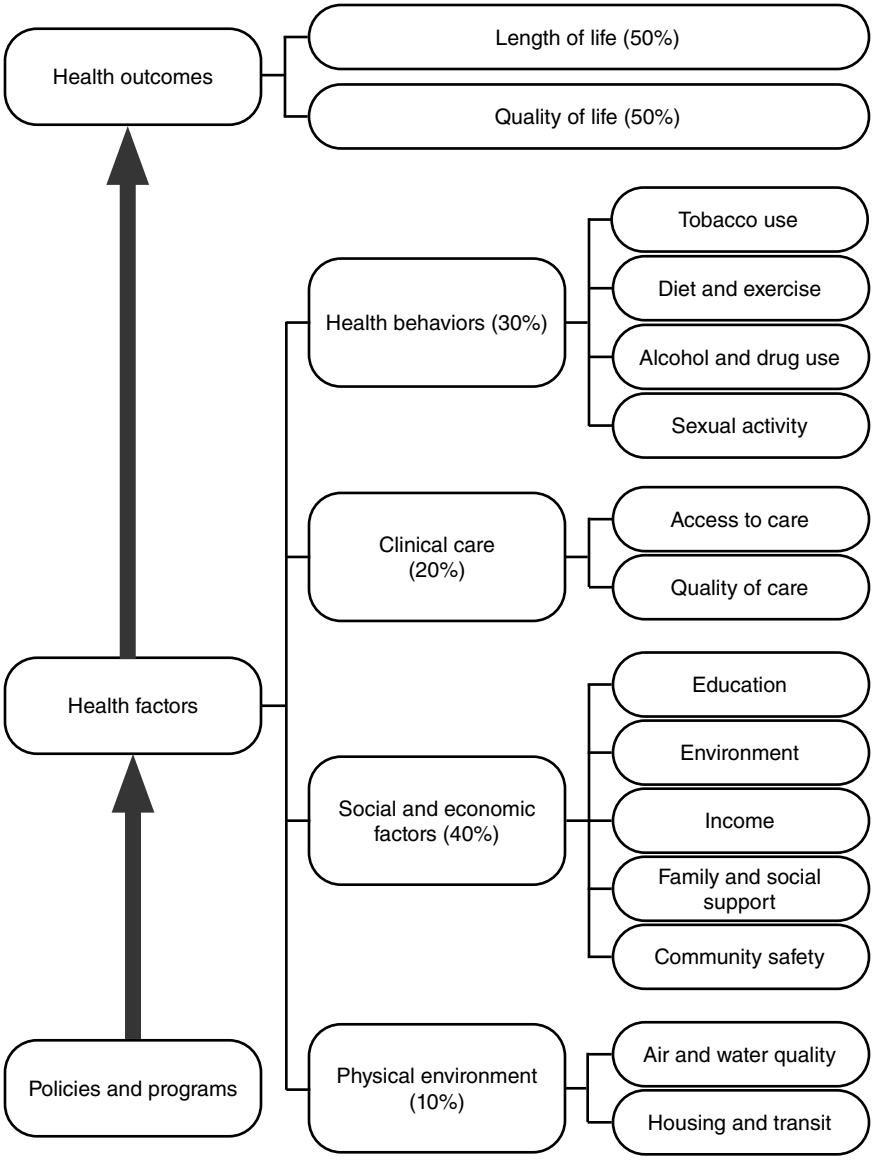
FIGURE 1.1. Factors Affecting Health Outcomes



Note. From *County Health Rankings Model*, by University of Wisconsin Population Health Institute, 2014, County Health Rankings & Roadmaps (https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model). Copyright 2014 by UWPHI. Reprinted with permission.

FIGURE 1.2. Patient-Centered Medical Home 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 with 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. 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.

Note. PCMH = patient-centered medical home. Adapted from *Advancing Behavioral Health Integration Within NCQA Recognized Patient-Centered Medical Homes* (p. 3), by SAMHSA-HRSA Center for Integrated Health Solutions, 2014 (https://brsstacs.center4si.com/Behavioral_Health_Integration.pdf). In the public domain.