Chapter 2
Integrated Behavioral Health and Primary Care: A Common Language

C.J. Peek

Abstract The field of integrated behavioral health has been around for decades, but until recently in the hands of pioneers in their own particular settings, using their own distinctive language and concepts. That work was generally successful and gathered around it considerable energy in this era of patient-centered medical home and primary care transformation. Mainstream application requires the field to coalesce enough in language and concept to be consistently understood by implementers, health systems, researchers, policymakers, purchasers—and of course patients themselves. Unifying a field with consistently understood concepts and definitions is a normal stage in the development of emerging fields. Inconsistently understood concepts and definitions—including what constitutes the essential functions of integrated behavioral health—have been a practical concern and source of confusion in the field. Even authors writing about different topics in the same book have encountered such ambiguities and confusions. The response to this practical problem was to employ published methods from the field of Descriptive Psychology to create a consensus lexicon or operational definition for behavioral health integrated in primary care. This work sponsored by the Agency for Healthcare Research and Quality—on behalf of the field—resulted in a lexicon described here and employed by chapter authors to move toward using consistently understood terms and functional descriptions of integrated behavioral health.

C.J. Peek, Ph.D. (✉)
Department of Family Medicine and Community Health, University of Minnesota
Medical School, 6-240 Phillips-Wangensteen Building, MMC 381, 420 Delaware Street SE,
Minneapolis, MN 55455, USA
e-mail: cjpeek@unm.edu

Introduction: "Why Should I Read a Lexicon?"

The purpose of this book is to provide a detailed snapshot of the state of integrated behavioral health initiatives (also known as collaborative care) and a "consumer's report" for stakeholders on the evidence and foundations and essential ingredients of integrated behavioral health. While the mission and vision for integrating physical and behavioral health propel the field forward, this book provides a critical analysis of risks, resources, and challenges of different models.

The field has evolved from a few isolated initiatives to many approaches spearheaded by diverse groups of professionals and organizations. The availability of descriptive information on the various models has not kept pace with the growth of this field, and few resources exist that compare and contrast integrated care models. The book is meant to provide a comprehensive digest for stakeholders who are new to these initiatives and a resource for those planners, administrators, researchers, and clinicians that are already invested.

This chapter aims to provide an overarching definitional template language for clinician implementers, patients, health care system administrators, researchers, and policymakers—a common language that chapter authors could use to describe and assess strengths and weaknesses of various integrated behavioral health models. Note the various phrases in the preceding paragraphs—*foundational components… essential ingredients…compare and contrast models*. These reveal an ambitious goal of making it possible for a broad range of audiences to orient themselves and navigate this emerging field by creating a framework of both its defining functions and its many legitimate variations.

But having a common definitional framework is a recent development. The field of integrated behavioral health has often not been clear about what is foundational, or even the meanings of commonly used terms. This chapter offers a standard language to discuss the essential elements of integrated care, the different forms it may take, and common definitions for the many terms used to describe its basics. Identifying the need to clarify concepts in use within the subject matter is a normal developmental stage of emerging fields (Miller, Kessler, Peek, & Kallenberg, 2011; Peek, 2011).

The rest of this chapter (1) tells the story of the practical need for development of this lexicon; (2) describes the method for reaching a consensus lexicon or operational definition of behavioral health integrated in primary care; (3) outlines the resulting lexicon; and (4) describes current and potential applications for such a lexicon.

The Story: The Practical Need for a Lexicon in Integrated Behavioral Health

This section is adapted, paraphrased, or quoted from similar sections in Peek (2011).

The Field Requires More Consistent Language Today Than in Earlier Times

Exploding interest in the concepts of "patient-centered medical home" (PCMH), "health care home," or "advanced primary care" (all synonyms) have brought increased attention to the 40 year-old subfield of improved integration of behavioral health and medical care. The field of integrated behavioral health at this stage of development is aiming for implementation on a meaningful scale, not just in pockets created by pioneers. But the subject matter called "integrated behavioral health and medical care" also goes by "collaborative care", "mental health integration," "integrated care," "shared care," "co-located care," "primary care behavioral health," "integrated primary care," or sometimes "behavioral medicine"—and this is just a start. Each of these terms encompasses a similar core of subject matter for implementation and study. But each of the names for that subject matter has emerged from different practice, intellectual, geographical or disciplinary traditions—as if dialects of a more general language loosely understood by insiders or "native speakers" in that field. To find a meaningful place in PCMH—broad implementation on a meaningful scale—the field of integrated behavioral health must not only show its effectiveness empirically, but must become a field more consistently and widely understood in language and practice by the public and by the practitioners themselves.

Such language must help everyone navigate the subject matter in a consistent and precise enough way to enable the practical work of (1) practice redesign—shaped by (2) performance evaluation and research—leading to (3) patient engagement, demand, and purchasing decisions—and sustained by (4) policy and business model change.

Consistent Understanding of Core Concepts Is Far from a Theoretical Concern

In planning an AHRQ-funded research development conference for the Collaborative Care Research Network (CCRN), in 2009 (Miller, Kessler, Peek, & Kallenberg, 2011), very practical concerns pointed to the need for a common language or lexicon. Research funders, policymakers, and those trying to redesign health care had become interested in integrated behavioral health (then referred to as "collaborative care") as a means of accomplishing the larger goals of primary care or of PCMH.

However, during conference planning, it became apparent that integrated behavioral health care clinicians and advocates seemed to stumble over language, even naming their field inconsistently. It was more like individual voices without a structure of shared concepts, rather than an organized group using a consistent framework of concepts and language for their subject matter. While policymakers and research funders remained persuaded by the *potential* value of integrated behavioral health care, they felt handicapped in advocating for it publicly or behind the scenes because of the perceived lack of consistency or rigor of the concepts in use. The composite message received leading up the conference was clear: "It would help if you all talked about the components and terms of your field in a much more consistent way than you do now."

Conference planners stumbled over language, with conference calls slowed down by observations such as, "I'm not sure we mean the same thing by that," or "I thought I understood where you were going five minutes ago, but now I don't think we meant the same thing by X," and "I wonder if what I call Y, you call Z, and if there is really any difference." In a starter list of research questions brainstormed by the committee, the terms "continuum of integration", "extent of collaborative care components," and "degree of collaborative care" appeared—along with a conversation about whether these are the same or not and whether anyone would know how to measure them. It became very difficult for the program committee to formulate an initial series of unambiguously understood integrated behavioral health care research questions that could be examined, refined, or replaced by the broad audience invited to the research conference. The following questions arose:

> Do we have a good enough *shared* vocabulary (set of concepts and distinctions) for asking research questions together across many practices? Do we mean similar enough things by the words we use or how we distinguish one form of practice from another, for purposes of investigating their effects? Do we have a shared view of the edges of the concepts we are investigating—the boundaries of the genuine article or the scope of our subject matter? If we don't share enough of that vocabulary, we will *think* we are asking the same research questions, using the same distinctions, doing the same interventions, or measuring the same things, but we won't be and we will confuse our network practices and our funding organizations…

Confusion over Language and Definitions Typically Takes Two Forms

Meaning of commonly used terms. What are the differences between mental health care and behavioral health care? What are the differences between collaborative care, integrated care, integrated primary care, integrated behavioral health, shared care, coordinated care, co-located care, and consultation/liaison? These and other common terms frequently stopped conversations while the group verified what each other meant by these. As a result of these conversations, a literature-based "family tree of common terms" was created (See Fig. 2.1—reproduced from Peek and the National Integration Academy Council (2013).
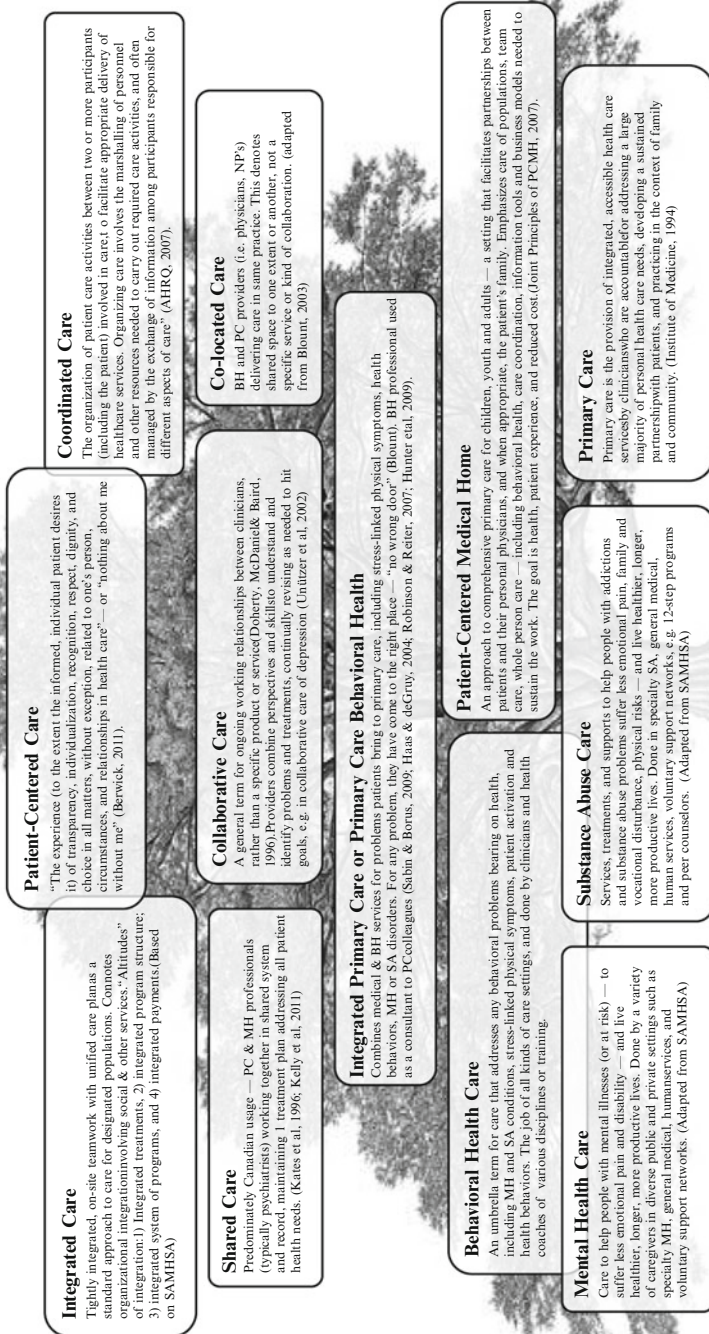
Patient-Centered Care

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"— or "nothing about me without me" (Berwick, 2011).

Coordinated Care

The organization of patient care activities between two or more participants (including the patient) involved in care, t o facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care". (AHRQ, 2007).

Co-located Care

BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Collaborative Care

A general term for ongoing working relationships between clinicians, rather than a specific product or service(Doherty, McDaniel& Baird, 1996).Providers combine perspectives and skillsto understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

Integrated Primary Care or Primary Care Behavioral Health

Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place — "no wrong door" (Blount). BH professional used as a consultant to PCcolleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter etal, 2009).

Patient-Centered Medical Home

An approach to comprehensive primary care for children, youth and adults — a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care — including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost.(Joint Principles of PCMH, 2007).

Primary Care

Primary care is the provision of integrated, accessible health care servicesby clinicianswho are accountablefor addressing a large majority of personal health care needs, developing a sustained partnershipwith patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Integrated Care

Tightly integrated, on-site teamwork with unified care planas a standard approach to care for designated populations. Connotes organizational integrationinvolving social & other services. "Attitudes" of integration:1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments.(Based on SAMHSA)

Shared Care

Predominantly Canadian usage — PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Behavioral Health Care

An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Substance Abuse Care

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks — and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Mental Health Care

Care to help people with mental illnesses (or at risk) — to suffer less emotional pain and disability — and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, humanservices, and voluntary support networks. (Adapted from SAMHSA)

Fig. 2.1 A family tree of terms encountered in integrated behavioral health or collaborative care

Necessary components of integrated behavioral health. What actually has to be in place for a particular practice to be regarded as doing integrated behavioral health? This question posed the more difficult challenge, and is not fulfilled by the "family tree of terms." It is all too easy for a practice or clinician to say, "Integrated behavioral health—yes we already do that. We have a social worker in the hospital and a psychiatrist across town on our referral list." But for many, this would not count as a genuine instance of integrated behavioral health care. But on what basis? Who says? What is the package of functional components we all agree is necessary for a particular practice to be doing integrated behavioral health? This was important for many reasons—identifying genuine instances of integrated care in practice, enrolling practices in research, identifying differences between them—and of course knowing what you are buying and what functions you want to support if you are designing a system, payment model, or public policy.

Without common language for the subject matter and what counts as the genuine article, creating a national research agenda and other developmental tasks for the field would be difficult to accomplish. One of the conference tasks was to create a usable "lexicon" or system of concepts for this new (or newly rediscovered) field.

The 2009 conference experience led to a two-stage process to develop a lexicon or functional definition for behavioral health integrated in primary care. The first stage was to convene a subset of the planning committee to use a systematic lexicon development method to create a product for use only at that conference (Peek, 2011). The second stage was an AHRQ funded conference in 2012 to broaden and deepen that starter lexicon among members of the AHRQ National Academy Integration Council, a steering group for the Academy for Integration of Behavioral Health and Primary Care. Patient representatives were also included in this process.

Conceptual Confusion Is a Normal Stage of Development for Emerging Fields

The research conference committee decided it had to sharpen concepts and language if it was to successfully create a research agenda—the "deliverable" of the funded conference. And later, the AHRQ Integration Academy broadened and deepened the lexicon for its purposes—which included measures of integration (AHRQ, 2013), and workforce competencies—as well as to have a consistent way to portray the field via its website (http://integrationacademy.ahrq.gov).

All this was done without apology or sheepishness. All mature scientific or technical fields have lexicons (systems of terms and concepts) developed well enough to allow collaborative and geographically distributed scientific, engineering, or applications work to take place. Systematically related concepts have an esteemed place in the history of mature fields, such as electrical engineering, physics, and computer science, and have enabled them to become mature sciences or technologies with

associated empirical triumphs. In many cases the definitional, conceptual or pre-empirical development of these fields was done so long ago that we take it for granted and now see only the concrete or empirical achievements. But it takes a generally understood system of concepts and distinctions to do good science. Here is one example of lexicon development from nineteenth century science:

> At the time of the first International Electrical Congress in Paris in 1881, "complete confusion had reigned in this field; each country had its own units". Multiple different units were in use across researchers and countries for electromotive force, electric current and resistance. At this first Congress, agreements were reached on the ohm and the volt—with ampere, coulomb and farad also defined, all done as one conceptual system. Governments saw that it had become necessary for commercial transactions to create an international system of definitions and to provide a forum of scientists, manufacturers, and learned societies to establish terminology for the whole field of scientific and technical concepts (du Couëdic, 1981).

Without this system of electrical concepts becoming community property with standing across all electrical researchers, the field could not have developed into the mature form of empirical science that we now witness. The effect was immediate:

> The first Congress of 1881 has borne good fruit. It has not only brought about a rapprochement between electricians of all countries, but it has led to the adoption of an international system of measurement which will be in universal use. (The Electrical Congress of Paris, 1884)

Conceptual Clarification Is Especially Important for Anything "Behavioral"

Historically, subject matters that include the terms "behavior," "mental health," "psychosocial" or "collaborative" in their names have stereotypically been seen as soft, subjective, or not as conducive to scientific investigation, despite the existence of extensive literature and research. Different published papers often employ disparate conceptual and language systems, and this can lead to a sense (especially as seen by those outside the field) that the field is "not quite worked out" or seems to be re-created anew by each author. As important as "behavior" is to contemporary health care and the PCMH, an impression remains that it is a fuzzy concept compared to traditional medical areas. The behavioral dimensions of health and health care not only entail studying immensely complex phenomena, but also may be earlier in their development as fields compared to their biomedical cousins. Creating a lexicon for integrated behavioral health puts at least a few things "behavioral" or "collaborative" as they relate to primary care on a more systematic and consistent conceptual consensus-based foundation that is accessible to anyone, including the authors of the chapters of this book. More on the need for widely accepted conceptual systems for use in behavioral fields and psychology appears in Peek (2011), Bergner (2006), and Ossorio (2006).

A Consensus-Based Method for Creating a Lexicon for Integrated Behavioral Health

This section is adapted or paraphrased from Peek (2011) and Peek and National Integration Academy Council (2013).

Requirements for a Lexicon Development Method

For a lexicon to become more than one person's invention for one limited study or application, it would have to serve the practical purposes of a broad range of people over a broad range of applications. This could not be created and published as an opinion by one person or small group in isolation, which is a common to proposing definitions and gives rise to the sense of cacophony that policymakers and researchers had noticed. Instead, a method for creating a lexicon with standing in the field should:

- Be consensual but analytic (a disciplined transparent process—not a political campaign)
- Involve actual implementers and users ("native speakers" of the field—those actually doing the work—not only observers, consultants and commentators)
- Focus on what functionalities look like in practice (not just on principles, values, goals, or visible "anatomical features")
- Portray both similarities and differences (specify both theme and legitimate variations)
- Refine and employ existing familiar concepts that are serviceable to the extent possible
- Be amenable to gathering around it an expanding circle of "owners" and contributors (not just an elite group with a declaration)

Fortunately methods for defining complex subject matters that meet these requirements exist in the published literature—"paradigm case formulation" and "parametric analysis"—as described by Ossorio (2006). The product, a lexicon for posing integrated behavioral health care research and practice development questions, is described in later sections.

About Definitions, Paradigm Case Formulation, and Parametric Analysis

Before describing the lexicon itself, we'll step back and contrast paradigm case formulation and parametric analysis with the usual approach to creating definitions. The usual approach is to create one or two sentences, such as "integrated behavioral health care is X, Y, and Z," often done pragmatically for the purposes of just one study or project. If done to structure the concepts for an entire field, a standard definition would

1. *Paradigm case:* A husband and his wife living with their natural children, who are a seventeen-year-old son and a ten-year-old daughter.

2. *Transformations:*

   T1. Eliminate one parent but not both.

   T2. Change the number of children to N, N > 0.

   T3. Change the sex distribution of children to any distribution other than zero boys and zero girls

   T4. Change the ages of the children to any values compatible with the ages of the parents.

   T5. Any combination from T1, T2, T3, and T4.

   T6. Add any number of additional parents.

   T7. Add adopted and other legally defined sons and/or daughters.

   T8. Eliminate the requirement of living together.

   T9. Change the number of children to zero if husband and wife are living together.

Fig. 2.2 Example—paradigm case formulation of "family" (Quoted from Ossorio, 2006; pp. 26–27)

attempt to identify genuine instances on the basis of uniformities in common across all instances. But integrated behavioral health care is characterized not only by uniformities (a common core), but also by many legitimate differences between instances of integrated behavioral health. The definitional challenge is to develop a consistent shared language for both commonalities and differences without devolving into either "a cookie cutter" or "anything counts." A simple one-sentence definition such as "integrated behavioral health care is X, Y, and Z" would likely be oversimplified, full of qualifications and exceptions, or considered wrong or incomplete by many.

Paradigm case formulation. For complex subject matters such as integrated behavioral health care, a paradigm case formulation is an improved device for creating a definition because it maps both similarities and differences at any level of detail desired. For example, the concept of "family" is a complex subject matter and would be very difficult to define in a single sentence that would satisfy everyone. The paradigm case formulation approach to "family" starts with one archetypal statement (the paradigm case) that no one could possibly disagree with—and then goes on to systematically describe what could be changed (transformations of the paradigm case) and still be "family" (see Fig. 2.2).

Note that constructing a paradigm case formulation calls for careful decisions and the exercise of judgment in regard to which cases to include or exclude. Disagreement may arise among different persons. For example, T6-T9 seem much more likely to elicit objections ("I wouldn't call that a family!") than T1-T5.

In this example, the paradigm case and its transformations *becomes* the "definition" of family. One can distill a one-sentence summary definition of the usual sort found in great diversity and abundance in dictionaries, in professional publications, and on the web. But the limitations of one-sentence definitions are why the paradigm case formulation method was employed for the integrated behavioral health lexicon.

If you go to the lumberyard and ask for a 2x4, the person behind the counter will ask three questions:

> A) How long?
> B) What grade?
> C) What species?

If you say, "I need an 8-foot, #2, fir", they will go back into the stacks and get one. There is little more to say to specify a 2 x 4. These three parameters are the finite ways 2x4's can differ from one another. The parameters and some of the possible values for each parameter are illustrated below.

Parameters Possible "settings" for each parameter

1. Length	4'	8'	12'	16'
2. Grade	# 1	#2	# 3	C Select
3. Species	Fir	Pine	Maple	Oak

Fig. 2.3 Example—parameters of 2 × 4's

Parametric analysis. A complementary device, parametric analysis, goes on to create a specific vocabulary for how one instance of integrated behavioral health in action might be the same or different from another instance across town. In the "family" example, two of the parameters would be "number of children" and "number of parents." Parametric analysis (understanding the dimensions of something) sounds exotic, but is commonplace in other fields. One extremely simple illustration is shown in Fig. 2.3—parameters of number 2 × 4's.

A scientific example of parametric analysis is in the specification and comparison of different colors employing the three parameters of color: brightness, hue, and saturation. Any color can be specified through supplying a "setting" (formally called a "value") on each of these parameters as expressed in the Munsell color chart (Ossorio, 2006; pp. 35–36). Parametric analysis is used routinely to fine tune product design and market competitiveness for industrial products and software because it allows the designer to measure the influence of all parameters (or design features) on the outcomes desired and the trade-offs between them (Thieffry, 2008).

Parametric analysis sets the stage for comparative effectiveness research in integrated behavioral health care, where one set of arrangements is tested against a different set of arrangements. The "arrangements" are expressed through the parameters.

Overview of the Consensus Process to Reach Paradigm Case and Parameters

The lexicon process began with a core group of CCRN program committee members in 2009 that consisted of Benjamin F. Miller, Gene Kallenberg, and Rodger Kessler

and this author. A larger circle of contributors included research conference participants and those attending a Collaborative Family Healthcare Association presentation soon after. With this wisdom incorporated, the lexicon became the organizing system for integrated behavioral health care research questions submitted to AHRQ (Miller, Kessler, Peek, & Kallenberg, 2011). The lexicon shown here is a condensation of the updated version (Peek and the National Integration Academy Council, 2013).

About the discussion process for creating a consensus definition. *(Adapted from Peek,* 2011*).* An functional definition to serve practical purposes for a broad range of people interested in integration of behavioral health and primary care could not be created by one person or perspective alone. Doing so would increase the sense of ambiguity or multiplying compatible but different definitions (usually without much functional specificity) that implementers and patients had noticed, sometimes as cacophony.

As described earlier, a "paradigm case formulation" is a vehicle for creating a definition that maps both similarities and differences. A "parametric analysis" builds on the paradigm case to create a specific vocabulary for how one instance of integrated behavioral health practice might differ from another instance across town.

The paradigm case and parameters amount to a set of interrelated concepts (like an extended definition) that can be used in comparing practices, setting standards, or asking research questions using a common vocabulary.

The consensus process is facilitated in two stages. (1) A core group draft was done in this case by four people, followed by (2) a "second ring" review/contributor group in this case of 20 people.

In each stage, the product contains parts A to C—progressively refined until good enough to use:

A. *Create a* paradigm case *of integrated behavioral health in action:* "Here's a case of integrated behavioral health in action if ever there was one". One indisputable example—that is deliberately aspirational—not necessarily representative of what you find out there but would like to find. *This step maps out the uniformities in what we mean by integrated behavioral health.*

B. *Introduce* transformations *of this paradigm case.* The purpose of *transformations* is to identify additional cases that we as a group also believe qualify as integrated behavioral health—*"You could change X or delete Y and it would still be integrated behavioral health."* This step maps the differences. The paradigm case and transformations, when taken together is our "definition" of behavioral health integrated in primary care.

C. *Parameters: Dimensions for legitimate differences between practices.* This is a vocabulary for how one integrated behavioral health practice might be different from the one next door.

Facilitation details for this group consensus process were devised by CJ Peek, and are beyond the scope of this chapter. Facilitation included individual feedback via emailed documents and worksheets, a daylong intensive meeting, plus rounds of follow-up input and editorial work.

The Product: A Lexicon for Integrated Behavioral Health Care

This section is a condensed version of the full lexicon that appears in Peek and National Integration Academy Council (2013)*, a project of Agency for Healthcare Research and Quality*

Structure of this Lexicon

The summary (Fig. 2.4) starts with a general definition ("what"), followed by defining clauses ("how" and "supported by") and named parameters. The *defining clauses* are declarative statements of what genuine behavioral health integrated in primary care looks like in action—an extended definition—uniformities to be expected. *Read these numbered clauses as if one long run-on sentence.* The *parameters* are a vocabulary for how one instance of how one integrated care practice might legitimately differ from another one across town. *Read these as a typology of differences.*

The defining clauses and sub-clauses are spelled out, often with bullet points. Some defining clauses also include "transformations"—legitimate variations on the defining clause, e.g., "you can delete X, modify Y, or substitute Z and it's still a genuine case of integrated behavioral health". Where no transformations appear, the defining clause is required as stated. Defining clauses are a set of required functions, not specific ways of carrying them out. They represent fidelity to the definition of behavioral health integrated in primary care, but leave room (and require) a great deal of local adaptation such as specific workflows. *Read this as a pattern, not a "cookie cutter."*

The parameters are spelled out as a vocabulary for legitimate differences. Each parameter has a set of categories (in boxes) that represent legitimate differences between integrated behavioral health practices. Some parameters articulate *types*—different legitimate approaches or methods. Other parameters outline *levels* that might be regarded as developmental stages toward full aspiration. But there is no presumption that one of these variations is empirically proven best. Some parameters show grayed-in categories. These are not acceptable variations, shown only as context for the others.

In the lexicon, many fine-print annotations appear that define terms, refer to literature, or clarify concepts and balances. For simplicity, these details are omitted here in favor of figures (2.5, 2.6, 2.7, 2.8 and 2.9) that are excerpted from the Executive Summary of Peek and the National Academy Council (2013).

Applications for the Lexicon: What Good Can It Do for Whom?

As said at the outset of this chapter, a lexicon is not just an academic exercise. It is a response to practical problems for stakeholders in this field who often have an inconsistent understanding of the vocabulary for core functionalities of integrated

Lexicon for Behavioral Health and Primary Care Integration
At a Glance

What
The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.
This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Defining Clauses	Corresponding Parameters
What integrated behavioral health needs to look like in action	*Calibrated differences between practices*
How	
1. A practice team tailored to the needs of each patient and situation	1. Range of care team function and expertise that can be mobilized
A. With a suitable range of behavioral health and primary care expertise and role functions available to draw from	2. Type of spatial arrangement employed for behavioral health and primary care clinicians
B. With shared operations, workflows and practice culture	3. Type of collaboration employed
C. Having had formal or on-the-job training	4. Method for identifying individuals who need integrated behavioral health and primary care
2. With a shared population and mission	
A panel of patients in common for total health outcomes	5. Protocols
3. Using a systematic clinical approach (and a system that enables the clinical approach to function)	A. Whether protocols are in place or not for engaging patients in integrated care
A. Employing methods to identify those members of the population who need or may benefit	B. Level that protocols are followed for initiating integrated care
B. Engaging patients and families in identifying their needs for care and the particular clinicians to provide it	6. Care plans
C. Involving both patients and clinicians in decision-making	A. Proportion of patients in target groups with shared care plans
D. Using an explicit, unified, and shared care plan	B. Degree to which care plans are implemented and followed
E. With the unified care plan and manner of support to patient and family in a shared electronic health record	7. Level of systematic follow-up
F. With systematic follow-up and adjustment of treatment plans if patients are not improving as expected	
Supported by	
4. A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care.	8. Level of community expectation for integrated behavioral health as a standard of care
5. Supported by office practice, leadership alignment, and business model	9. Level of office practice reliability and consistency
A. Clinic operational systems and processes	10. Level of leadership/administrative alignment and priorities
B. Alignment of purposes, incentives, leadership	11. Level of business model support for integrated behavioral health
C. A sustainable business model	12. Extent that practice data is collected and used to improve the practice
6. And continuous quality improvement and measurement of effectiveness	
A. Routinely collecting and using practice-based data	
B. Periodically examining and reporting outcomes	(Plus three auxiliary parameters)

Fig. 2.4 Summary

behavioral health. A consistent understanding and vocabulary can be especially difficult to establish across different stakeholder communities such as clinicians, purchasers, health plans, policymakers, and patients themselves. This lexicon is intended to provide a common language and functional definition across the communities listed below—and was created with representation from most of them.

The following sections list stakeholders, their basic need for a lexicon—or a sample of their applications for a lexicon. This is a list of what the lexicon can do for whom.

"How" Defining Clauses (1-3)

(Those functions that define what integrated behavioral health care looks like in action)

1. A practice team tailored to the needs of each patient and situation

A. *With a suitable range of behavioral health and primary care expertise and role functions available to draw from* — so team can be defined at the level of each patient, and in general for targeted populations. Patients and families are considered part of the team.

B. *With shared operations, workflows, and practice culture* that support behavioral health and medical clinicians and staff in providing patient-centered care

- Shared physical space — co-location

    Alternative (what could change): Change "shared physical space—co-location" to "a set of working relationships and workflows between clinicians in separate spaces that achieves communication, collaboration, patient-centered operations, and practice culture requirements."

- Shared workflows, protocols, and office processes that enable and ensure collaboration — including one accessible shared treatment plan for each patient.
- A shared practice culture rather than separate and conflicting behavioral health and medical cultures.

C. *Having had formal or on-the-job training* for the clinical roles and relationships of integrated behavioral healthcare, including culture and teamwork (for both medical and behavioral clinicians).

2. With a shared population and mission

With a panel of clinic patients in common, behavioral health and medical team members together take responsibility for the same shared mission and accountability for total health outcomes.

Alternative: Change "a panel of clinic patients in common" to "any identifiable subset of the panel of clinic patients for whom collaborative, integrated behavioral health is made available."

3. Using a systematic clinical approach (and system that enables it to function)

A. *Employing methods to identify those members of a population who need or may benefit* from integrated behavioral and medical care, and at what level of severity or priority.

B. *Engaging patients and families in identifying their needs for care,* the kinds of services or clinicians to provide it, and a specific group of health care professionals that will work together to deliver those services.

C. *Involving both patients and clinicians in decision-making* to create an integrated care plan appropriate to patient needs, values, and preferences.

D. *Caring for patients using an explicit, unified, and shared care plan* that contains assessments and plans for biological/physical, psychological, cultural, social, and organization of care aspects of the patient's health and health care. Scope includes prevention, acute, and chronic/complex care. (See full lexicon for elements)

E. *With unified care plan, treatment, referral activity, and manner of support to patient and family contained in a shared electronic health record* or registry, with ongoing communication among team members

    Alternatives:
    Change "unified care plan in shared medical record" to "problem list and shared plans are contained in provider notes or other records in same organization medical record which everyone reads and acts upon," Delete "electronic" in "shared electronic medical record" (interim, not desired final state).

F. *With systematic follow-up and adjustment of treatment plans* if patients are not improving as expected. This is the "back-end" management of patients from "front-end" identification. (See full lexicon for specifics)

Fig. 2.5 The "How" defining clauses spelled out

Patients and Families

Questions:

"What should I expect from integrated behavioral health in my own doctor's office? How would I recognize the genuine article if I encountered it? How would I know whether the integrated care my family received was up to standard? Is there a standard?"

"Supported by" Defining Clauses (4-6)

(Functions necessary for the "how" clauses to become sustainable on a meaningful scale)

4. **A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care** so that clinicians, staff, and their patients achieve patient-centered, effective care.

5. **Supported by office practice, leadership alignment, and a business model**

   A. *Clinic operational systems, office processes, and office management* that consistently and reliably support communication, collaboration, tracking of an identified population, a shared care plan, making joint follow-up appointments or other collaborative care functions

      Alternative: Delete "consistently and reliably" (an interim state, not adesired final state).

   B. *Alignment of purposes, incentives, leadership, and program supervision within the practice.*

      Alternative: Substitute "Intention and process underway to align... " for "alignment of."

   C. *A sustainable business model* (financial model) that supports the consistent delivery of collaborative, coordinated behavioral and medical services in a single setting or practice relationship. .

      Alternative: Substitue "working toward sustainable business model" for "sustainable business model,"

6. **And continuous quality improvement and measurement of effectiveness**

   A. *Routinely collecting and using measured practice-based data* to improve patient outcomes—to change what the practice is doing and quickly learn from experience. Include clinical, operational, demographic and financial/cost data.

   B. *Periodically examining and internally reporting outcomes*—at the provider and program level—for care, patient experience, and affordability (The "Triple Aim") and engaging the practice in making program design changes accordingly.

Fig. 2.6 The "Supported by" defining clauses spelled out—those necessary for the clinical "how" to become sustainable on a meaningful scale

Applications:

One of the "supported by" defining clauses points to the need for patients to understand and expect better integrated care as a standard of practice. The functional definition of the lexicon can serve as the basis for simple orientations or conversations that help patients and families understand the potential value to them for integrated behavioral health.

For example, the author and a patient who participated in the lexicon development process used the lexicon to query a patient advisory council at the Institute for Clinical Systems Improvement in 2012. When these patients said they didn't know what "behavioral health" or "integrated behavioral health" was, the defining clauses clarified it. Then the conversation could quickly move to whether the group thought that patients would expect or demand it as a standard of practice.

Purchasers of Health Care Plans

Questions:

"What exactly am I buying if I add integrated behavioral health care to the benefits? What do I tell my employees (or other constituents) they can expect to encounter in this benefit—especially for any change in service or employee cost?"

Parameters 1-7 Related to the "How" Clauses
How one integrated practice might differ from another

Types of practice arrangements

1. Range of care team function and expertise that can be mobilized	Foundational functions for target population • Triage/identification for need for integrated BH • Behavioral activation/self management, community res. • Basic MH-SApsychological and pharmacologic interventions; psychological support/crisis intervention • Common chronic/complex illness care • Follow-up, monitoring for timely adjustment of care		Foundational plus others • Registry tracking & coordination • Specialized MH or pharmacologic therapies	Extended functions, add Specialized expertise in • Conditions, populations • School, vocational, spiritual, community

2. Type of spatial arrangement employed for BH and PC clinicians	Mostly separate space • Little time in same space • Patient sees providers in at least twobuildings	Co-located space • Different parts of same building; some but not all time in same space • Patient movesfrom PC to BH	Fully shared space • Share rooms in shared space • Typically, the clinicians see the patient in same exam room.

3. Type of collaboration employed	Referral-triggered periodic exchange--Minimally shared care plans or workflows	Regular communic. /coordination Separate systems and workflows, but significant care plan coordination	Full collaboration/ integration Treatment plans,documentation, communication,workflows

4. Method for identifying individuals for integrated BH	Patient or clinician Patient or clinician identification done in a non-systematic fashion	Health system indicators Demographic, registry, claims, or other system data	Universal screening or identification processes All or most patients identified or screened for being part of a target population

Levels of implementation of practice arrangements — from getting started to full implementation

5A. Protocols in place for engaging patients in integrated BH?	Protocols not in place Undefined or informal (*Not acceptable*)	Protocols in place Protocols and workflows for integrated BH are built into clinical system as a standard part of care process	

5B. Level that protocols followed for initiating integrated BH	Protocols followed less than 50% (*Not acceptable*)	Protocols followed more than 50% but less than 100% (an interim state)	Protocols followed nearly 100% (Standard work)

6A. Proportion of patients in target groups with shared care plans	Less than 40% (*Not acceptable*)	40% to nearly 100% (Meaningful proportion but less than full-scale)	Nearly 100% (Standard work)

6B. Degree care plans are implemented & followed	Less than 50% (*Not acceptable*)	More than 50%, less than 100% (An interim state, not final state)	Care plans followed nearly 100% (Standard work)

7. Level of systematic follow up*	Less than 40 % (*Not acceptable*)	40% to 75% (Significant but incomplete)	76% to 100% (Standard work)
*Follow upelements: A) At least one follow-up for those engaged in care; B) At least one follow-up in initial 4 weeks of care; C) Cases reviewed for progress on a regular basis (e.g., every 6-12 weeks); D) Receive treatment adjustments if not improving.			

Fig. 2.7 Parameters corresponding to the "how" defining clauses—how one genuine integrated practice might differ from another one

Applications

When employers or other purchasers change the "product" or benefits for health care, they must also explain and set expectations—and what they expect the value to become. A clear functional description of a particular purchase of integrated behavioral health using language of the lexicon can help be more specific about what is being purchased and what the patients should expect for their own premium contributions.

Health Plans

Important questions:

"What specifically do I require clinical systems to provide to health plan members—and what will I specifically look at to see if they are providing it or not?"

Parameters 8-12 Related to the "Supported by" Clauses

Conditions needed for success of clinical action in the real world on ameaningful scale

8. Level of community expectation for integrated BH as standard of care	**Little or no understanding & expectation** *(Not acceptable)* Insufficient reach of understanding and expectation to enable integrated BHto start andfunction	**Expected as standard of care only in pockets** Partial but substantially incomplete community understanding and expectation	**Widely expected as standard of care** Community understanding & expectation for integrated BH health as a standard of care

9. Level of office practice reliability and consistency	**Non-systematic** *(Not acceptable)* Office processes are non-standard with unwarranted variation across clinicians and situations	**Substantially routinized** Standards set for most processes, but unwarranted variability and clinician preference still operate —not yet standard work	**Standard work** Whole team operates each part of the system in a standard expected way that improves reliability and prevents errors.

10. Level of leadership / administrative alignment and priorities	**Misaligned** *(Not acceptable)* Conflicts apparent with other priorities, resource allocations, incentives, habits, standards	**Partially aligned** Some alignment achieved, but unresolved tensions evident	**Fully aligned** Constructive balance achieved between priorities, incentives, and standards. Emerging conflicts routinely addressed

11. Level of business model support for integrated BH	**Behavior health integration not fully supported** The business model has not yet found ways to fully support the integrated behavioral health functions selected and built for this practice.		**Behavioral health integration fully supported** The business model has found ways to fully support the integrated behavioral health functions selected and built for this practice.

12. Scale of practice data collected & used For the integrated BH aspect of the practice	**Minimum:** **(less than 40% of patients)** *(A startup state—not desired final state)* Very limited system for collecting and using practice data to improve quality and effectiveness (of integrated BH)	**Partial:** **(40%-75% of patients)** *(An interim state, not a desired final state)* Significant but less than full collection and use of practice-based data for decision-making	**Full / standard work:** **76% -100% of patients** Routine data collection on most patients with integrated BH to improve effectiveness at the system, unit, population level

Fig. 2.8 Parameters corresponding to the "supported by" defining clauses—conditions needed for success of clinical action in the real world on a meaningful scale

Applications:

Health plans are not only insurance companies, but administrators of health care insurance across provider groups. Health plans set rules, policies, and are in a position to confirm that particular practices are providing the benefits described. A common functional framework for integrated behavioral health can help give structure to those administrative functions.

Clinicians and Medical Groups

Questions:

"What exactly do I need to implement—to count as genuine behavioral health integrated in primary care—and to advertise myself as doing integrated behavioral health? What are the core functions, and what is up to me to locally adapt?"

Applications:

First of all, sufficient shared language and definition for the field increases clinician confidence in talking with each other and other stakeholders. Clinicians do not like to stumble over basic terms or language that distinguishes the components and

Auxiliary Parameters

These may be useful for specific purposes, though not considered central to the full lexicon.

Target sub-population for integrated BH	**A. Setting**	Primary medical care		Specialty medical care		Specialty mental health care	
	B. Life stage	Children	Adolescents	Adults/young adults		Geriatrics	End of life
	C. Type of symptoms targeted	Severe mental illness	Mental health or substance abuse conditions	Stress-linked or "medically unexplained" physical symptoms	Medical conditions; chronic illnesses, self-management	Complex blend, including social factors interfering with health and care	
	D. Type of situations targeted	Patients with no health system contacts for problems or prevention	Diseases and conditions	Prevention, wellness	Acute life stresses	Health disparities	High risk and/or high cost cases

Degree that program is targeted to specific population or situation *(Blount, 2003)*	**Targeted** Program designed for specific populations such as disease, prevention, at-risk, age, racial and ethnic minorities, social complexity, pregnancy or other	**Non-targeted** Program designed generically for any patient deemed to need collaborative care for any reason— "all comers"

Breadth of outcomes expected depending on program scale or maturity *(From Davis, 2001)*	**Pilot scale** Limited expectations for a limited set of outcomes for a limited group of patients	**Project scale** Significant, but not full-scale outcomes expected, e.g., multiple pilots gathered together	**Full-scale** Full-scale and broad-based outcomes expected for the entire population; no longer a project within a mainstream that hasn't changed

Fig. 2.9 Auxiliary parameters: These were used by chapter authors and may be useful to readers for specific purposes, though not considered central to the published lexicon

variations for integrated behavioral health. This is especially frustrating when communicating with policymakers, patients, or researchers. If clinicians talk with each other and those outside the field using common language they are likely to be more confident engaging others.

Second, the defining clauses and parameters of the lexicon can be translated into simple "checklists" with which a practice can inventory what it does or does not do by way of integrated behavioral health—and set development or improvement agendas. Multiple different practices can compare notes with each other on what they do and learn from others who are better at some parts of this than others. The field has lacked such a shared framework for self-description or self-evaluation—with each practice typically inventing its own. This makes it more difficult for practices to compare and collaborate on practice improvement or create local or regional shared improvement agendas. If the field is to develop as whole rather than in pockets, such a common framework for self-description and self-assessment is needed.

Policymakers and Business Modelers

Questions:
"If I am being asked to change the rules or business models to support integrated behavioral health, exactly what functions need to be supported?"

Applications:
Common language and functional description for integrated behavioral health in its various forms makes it easier for policymakers to answer important questions such as what exactly are people getting from "X" form of integrated behavioral health care—the product and benefits? What policies are needed to sustain the functions leading to those benefits? How much will people pay for that benefit (and those functions)? How do I justify that cost as a return on investment?

These are only basic questions, but if the lexicon is used across policymakers and longitudinally over time, it may bring more respectability to the field as seen through policymaker eyes.

Researchers and Program Evaluators

Questions:
"What functions need to be the subject of research questions on effectiveness? What functions require and form the basis for metrics? What terms will I use to ask consistently understood research questions across geographically distributed research networks?"

Applications:
The functional description of the lexicon can help researchers identify practices that qualify as doing integrated behavioral health for purposes of recruitment to a practice-based research network such as the Collaborative Care Research Network (Sieber et al., 2012). Moreover, the lexicon can help researchers (and the practices themselves) articulate (with sufficient definition) the comparisons to be made. For example, a research design might call for comparing different approaches to team composition and function, or look at which of the functions described in the lexicon account for what proportion of positive outcomes. Comparative effectiveness research requires clearly articulated comparisons to be made in real-world settings.

The papers resulting from the AHRQ-supported research conference framed the research questions using the vocabulary of the lexicon (Miller, Kessler, Peek, & Kallenberg, 2011). The lexicon can function as a consensus-based definitional reference for the terms and components listed in the research questions.

The lexicon provides distinctions for asking consistently understood practice development and research questions. But measurable indices (metrics) are also needed to serve as quantitative measures, or approximations of otherwise qualitative descriptions of integrated behavioral health care practice contained in the lexicon. Such data elements are needed for comparative effectiveness research (Kessler & Miller, 2011). Because of the variations in integrated behavioral health care practice, specific data elements and what should be expected to count as a successful outcome will vary. For example, what is reasonable to expect or measure depends in part on the target population under study. Exactly what data elements to include depends on whether the integrated behavioral health practice is aimed at

children or adults, whether aimed at mental health conditions or chronic medical conditions or both, and whether it is aimed at a specific disease or subpopulation of some kind.

In addition, what is reasonable to expect or compare from practice to practice also depends on level of practice development (Davis, 2001). Some implementations may be limited startups or pilots, others are larger scale projects, and a few may be mainstream implementations within a larger organization or community. It would not be appropriate to compare results of limited pilots with mature large-scale projects or mainstream implementations because reasonable performance expectations for these will be different and the specific data elements available may be different.

The lexicon functional descriptions can also be converted to process measures—evaluation of processes that drive the performance that people ultimately care about. Each of the six defining clauses could become the basis for an internal process measure for practice self-evaluation and quality improvement.

Conclusion

A Vision for a Unified Set of Concepts and Language for Emerging Fields in Health Care

Other emerging fields are also important to PCMH. Program and planning committees also encounter definitional confusions and quibbles over the concepts in their subject matter. The examples below illustrate other examples where clarifying systems of definitions and functions were needed to build a foundation of support and understanding for patients, clinicians, health plans, policymakers, and researchers.

Palliative care. The Institute for Clinical Systems Improvement (ICSI) in Minnesota embarked on a community effort in 2009 to improve the availability and quality of palliative care among groups in the state. Similar patterns of confusion over language emerged. This author facilitated development of a consensus palliative care lexicon or operational definition—a joint product of the Institute for Clinical Systems Improvement (ICSI) and the University of Minnesota (2012). This lexicon is in use in Minnesota to give definition to palliative care in practice, along with derivative self-evaluation checklists.

Patient-centered medical home. The Institute for Clinical Systems Improvement (ICSI) has facilitated extensive Minnesota work on PCMH (called "health care home" in Minnesota) since 2007. Again, confusion over terms and "what is the genuine article" arose on phone calls. A consensus operational definition of health care home was developed first with a core group from four state systems and four private medical groups across the country, with contributions by a larger national review group of PCMH implementers—a joint product of the University of

Minnesota and Institute for Clinical Systems Improvement (Peek & Oftedahl, 2010). Observations about inconsistent understanding of PCMH for purposes of implementation and policymaking have been made by Stenger and Devoe (2010) and Stange et al. (2010).

Shared decision-making. In shared decision-making, patients and providers become active partners in clarifying acceptable options and helping the patient choose a course of care consistent with patient values and preferences and best available medical evidence. The Minnesota Shared Decision-Making Collaborative steering committee encountered similar definitional confusions and embarked on lexicon creation facilitated by the present author. This consensus lexicon or operational definition is a joint product of the Minnesota Shared Decision Making Collaborative, Institute for Clinical Systems Improvement, and the University of Minnesota (2012).

These lexicons are interlocking in some respects. For example, the health care home lexicon calls for integrated behavioral health. When someone asks, "what is integrated behavioral health?" it is now possible to go to the integrated behavioral health lexicon for specifics. The palliative care lexicon calls for shared decision making. Similarly, when someone asks, "what is shared decision making?" it is now possible to go to the shared decision making lexicon for specifics. And the health care home lexicon also calls for what amounts to palliative care functionality. Again, when a person asks, "What is palliative care exactly?" it is now possible to go to the palliative care lexicon for those specifics. Taken together these begin to clarify the conceptual and functional structure for these important emerging fields in health care.

A Generalized Need for Consistently Understood Concepts and Vocabulary in Emerging Fields

Steering groups in all these emerging fields experienced similar reasons to go through the painstaking process of developing a lexicon—a conceptual framework or operational definition. It became apparent when clearer and more consistent concepts and definitions for a field are needed:

1. Enough people are stumbling over language and what things mean—especially as encountered in practice, not only in theory or at the level of principles and values.
2. Enough people need clearer boundaries for an area X—what counts as "this is an example of X" for describing to the public, setting expectations, assigning insurance benefits, certifications, or saying how something is different than "usual" care.
3. People are asking, "What components are necessary for a given practice to really be X? What are the dimensions and milestones for practice improvement?"

4. Researchers want to ask quality or research questions more consistently and clearly—especially in geographically distributed research or QI networks
5. There is a felt need to improve the consistency or reputation of an area with "outsiders", e.g., policy-shapers, legislators, funders, and others not "native speakers" of the field.
6. When your field is being distorted or misunderstood by the public (or a vocal subset).
7. When practitioners themselves are unhappily inconsistent in the way they present their field to the outside world.

Lexicons are for practical communication across stakeholders who want to collaborate—to build the field while they improve their own implementations. Shared language is needed to ask questions and aggregate results or lessons learned. In one's own setting of course "we know what we mean by X". But the challenge of the field is to create enough [italicized] shared language for collaboration.

A journey has been underway to articulate and answer empirical research questions in integrated behavioral health and to help practices achieve the performance that everyone needs them to achieve. The necessary pre-empirical development of a basic conceptual system for this important subfield is being done—something that enables researchers, clinicians, and policymakers to talk to each other using a common vocabulary and an organized way of specifying the required components of integrated behavioral health care. The consensus-based approach described here avoids the debates and lack of uptake typically associated with a single author or elite group devising a conceptual system or vocabulary for one isolated purpose and proposing it in a journal article. Yet the lexicon described in this chapter is an evolving document to be shaped by succeeding groups as collective wisdom emerges on just what functions are required and the best ways to articulate them.

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