

Lexicon for Behavioral Health and Primary Care Integration

Concepts and Definitions Developed by
Expert Consensus



Agency for Healthcare Research and Quality
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The information in this report is intended to help clinicians, employers, policymakers, and others make informed decisions about the provision of health care services. This report is intended as a reference and not as a substitute for clinical judgment.

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The Academy
Integrating Behavioral Health and Primary Care

Foreword

The Lexicon for Behavioral Health and Primary Care Integration was funded by AHRQ through the Center for Primary Care, Prevention, and Clinical Partnerships (CP3) as part of a programmatic focus on developing and promoting the field of integrating behavioral health primary care. The original version of the Lexicon was developed through an AHRQ small conference grant to the University of Colorado in 2009. Throughout the planning process for that meeting, it became clear that the experts involved were struggling to find common language and concepts related to integration that would allow them to communicate effectively. After the pilot work at the meeting to develop a shared understanding, all participants agreed that the Lexicon was an important, even critical, advancement for the field that needed further refinement.

To date, the *Lexicon* has been used with another important effort underway with funding by AHRQ – the *Atlas of Integrated Behavioral Health Care Quality Measures (IQM)* (expected to be released in 2013). The *Lexicon* will continue to be part of ongoing efforts of AHRQ’s Academy for Integrating Behavioral Health and Primary Care (<http://integrationacademy.ahrq.gov>).

AHRQ expects the *Lexicon* will inform stakeholders such as providers, practices, health plans, purchasers, governments, researchers and others, by providing a common definitional framework for building behavioral health integration as one important way to improve health care quality. For example, implementers could use the lexicon to describe basic functions to put in place, differences in options for fulfilling those functions, and milestones for reaching full functionality.

Others have also recognized the need for shared language, e.g., the SAMHSA-HRSA Center for Integrated Health Solutions (2013), University of Washington AIMS Center, Milbank Memorial Fund (2010), and others. The creators hope that stakeholders will use the lexicon in their own ways in their own work as they converse with others who are developing this field as a whole.

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About the Academy for Integrating Behavioral Health in Primary Care

This Lexicon was developed under the auspices of **AHRQ’s Academy for Integrating Behavioral Health in Primary Care** (the Academy; <http://integrationacademy.ahrq.gov>). AHRQ created the Academy to advance the field of integration by serving as a national resource and coordinating center for those interested in behavioral health and primary care integration. The Academy’s vision is to support the collection, analysis, synthesis, and dissemination of actionable information that is useful to providers, policymakers, investigators, and consumers.

The National Integration Academy Council (<http://integrationacademy.ahrq.gov/bios>) advises the Academy operational team on strategic issues, helping to improve the sharing of knowledge, experience, and ideas as the field moves forward. The NIAC comprised most of the expert panel that created this Lexicon. By reflecting the diversity in the field and providing a forum for outstanding leaders to share perspectives and tools, the NIAC will also help to expand the common ground and enrich the discussion about what methods work in which contexts.

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Executive Summary

This lexicon is a set of concepts and definitions developed by expert consensus for what we mean by behavioral health and primary care integration—a functional definition—what things look like in practice. A consensus lexicon enables effective communication and concerted action among clinicians, care systems, health plans, payers, researchers, policymakers, business modelers and patients working for effective, widespread implementation on a meaningful scale.

The Problem

The field of behavioral health integration is only beginning to develop a standardized vocabulary, with different vocabularies emerging from different intellectual, geographical, organizational, or disciplinary traditions. Definitions in the field have emphasized values, principles, and goals rather than functional specifics required for a particular implementation to count as “the genuine article. Definitions have not supplied a vocabulary for acceptable alternatives—to prevent behavioral health integration from being seen as a field in which “anything goes.”

Benefits of a Shared Lexicon

For patients and families. “What should I expect from integrated behavioral health?”

For purchasers. “What exactly am I buying if I add integrated behavioral health care to the benefits?”

For health plans. “What specifically do I require clinic systems to provide to health plan members?”

For clinicians and medical groups. “What exactly do I need to implement—to count as genuine behavioral health integrated in primary care?”

For policymakers and business modelers. “If I am being asked to change the rules or business models to support integrated behavioral health, exactly what functions need to be supported?”

For researchers. “What functions need to be the subject of research questions on effectiveness? What functions need to be measured? What terms will I use to ask research questions?”

Methods for Creating a Consensus Lexicon

Methods exist for defining complex subject matters (Ossorio, 2006). These methods led to:

1. Six paradigm case *defining clauses* that map similarities and differences in genuine integrated behavioral health.
2. Twelve *parameters*, a vocabulary for how one instance of integrated behavioral health might differ from another one across town.

Requirements for a Method

- Be consensual but analytic (a disciplined transparent process).
- Involve actual implementers and users—“native speakers”.
- Bring out functionalities in practice (not only principles, values, or ‘anatomical’ features).
- Specify acceptable variations on the required pattern—not a rigid prescription.
- Be amenable to gathering an expanding circle of contributors.

Lexicon Overview

The outline on the next five pages helps the reader quickly see the basic lexicon structure and content. However, the full lexicon contains denser clarifying detail that the creators found necessary to resolve ambiguities and get beyond, “What do you mean by that?” The full lexicon backs up the summary.

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

Three auxiliary parameters appear on page 8 of this Executive Summary.

“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

Goal: To create a patient-centered care experience and a broad range of outcomes (clinical, functional, quality of life, and fiscal), patient-by-patient, that no one provider and patient are likely to achieve on their own.

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 with specific roles.

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 practice cultures.

C. *Having had formal or on-the-job training* for the clinical roles and relationships of integrated behavioral health care, including culture and team-building (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, e.g., age group, disease cluster, gender, culture, ethnicity, or other population.”

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/medical care, 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 of care plans and markers for their implementation.)

- E. *With the unified care plan, treatment, referral activity, and manner of support to patient and family contained in a shared electronic health record or registry, with regular 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 the 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 specific markers of such follow-up and care plan adjustment.)*

The “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 a desired 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: Substitute “*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.

Parameters 1-7 Related to the “How” Defining Clauses

How one genuine integrated practice might differ from another

1. Range of care team function and expertise that can be mobilized to address needs of particular patients and target populations	Foundational functions for target population <ul style="list-style-type: none"> • Triage/identification • Behavioral activation/self management • Psychological support/crisis intervention • Straightforward community resource connection • Straightforward mental health/substance abuse psychological interventions • Straightforward mental health pharmaceutical interventions • Common chronic/complex illness care • Follow-up, outcome monitoring for timely adjustment of care and coordination • Cultural and linguistic competency 		Foundational plus others for population <ul style="list-style-type: none"> • Triage/identification with registry and tracking/coordinating functions • Complex or specialized mental health therapies needed for population • Complex or more specialized pharmacologic interventions 	Extended functions, add <ul style="list-style-type: none"> • Specialized disease experts • Specialized population experts • Experts from cultural, school, vocational, spiritual, corrections, other areas of intersection with health care or specialized care managers
2. Type of spatial arrangement employed	Mostly separate space <ul style="list-style-type: none"> • Behavioral health and medical clinicians spend little time with each other practicing in same clinic space. • Patient has to see providers in at least two buildings 	Co-located space <ul style="list-style-type: none"> • Behavioral health and medical clinicians in different parts of the same building, spending some but not all their time in same medical clinic space. • Patient typically has to move from primary care to behavioral health space 	Fully shared space <ul style="list-style-type: none"> • Behavioral health and medical clinicians share the same provider rooms, spending all or most of their time seeing patients in that shared space. • Typically, the clinicians see the patient in same exam room. 	
3. Type of collaboration employed	Referral-triggered periodic exchange Information exchanged periodically with minimally shared care plans or workflows	Regular communication/coordination Regular communication and coordination, usually via separate systems and workflows, but with care plans coordinated to a significant extent	Full collaboration/integration Fully shared treatment plans and documentation, regular communication facilitated and/or clinical workflows that ensure effective communication and coordination.	
4. Method for identifying individuals (who need integrated behavioral health and medical care)	Patient or clinician Patient or clinician identification done in a non-systematic fashion	Health system indicators <i>(Other than patient screening)</i> Demographic, registry, claims, or other system data, at risk for complex needs or special needs	Universal screening or identification processes All or most patients or members of clinic panel are screened or otherwise identified for being part of a target population	
5A. Protocols in place or not for engaging patients in integrated care	Protocols not in place <i>(Not acceptable—described here only for context)</i> Undefined or informal: Up to individual clinician and patient whether or not and how to initiate/engage with integrated behavioral health care, e.g., whose care should be integrated, goals, appropriate team and roles, main contact person		Protocols in place Protocols and workflows for initiation and engagement in collaborative care are built into clinical system as a standard part of care process	
5B. Level that protocols are followed for initiating integrated care	Protocols followed less than 50% <i>(Not acceptable)</i>	Protocols followed more than 50% but less than 100% <i>(an interim state)</i> Protocols for initiating integrated behavioral health care are followed for 75% to 100% of patients identified in priority group.	Protocols followed nearly 100% Protocols for initiating integrated behavioral health care are followed for nearly 100% of patients identified in priority group. Goal is 100%--as in “standard work”.	

6A. Proportion of patients in target groups with shared care plans	Less than 40% <i>(Not acceptable)</i> Most patients in targeted groups for integrated behavioral health without written care plans	40% to nearly 100% A meaningful proportion but less than full-scale integrated behavioral health care plans for targeted groups—an interim state—not a desired final state	Nearly 100% Nearly 100% of patients in targeted groups with care plans—as “standard work”
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6B. Degree that care plans are implemented and followed	Less than 50%. <i>(Not acceptable)</i> Care plans implemented and followed for less than 50% of patients.	More than 50%, less than 100% <i>(An interim state, not final state)</i> Significant but incomplete implementation of care plans	Care plans followed nearly 100% Care plans implemented and followed for nearly 100% of patients in priority group. Goal is 100%--as in “standard work”.
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7. Level of systematic follow up* (Percent of patients in the practice population or target sub-population)	Less than 40 % <i>(Not acceptable—shown here only for context)</i>	40% to 75% Significant but incomplete follow-up being done	76% to 100% Goal is 100%--“standard work”
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*Follow up elements that may be tracked in parameter 7 include: A) Patients with at least one follow-up (those engaged in care); B) Patients with at least one follow-up in initial 4 weeks of care; C) Patients who have their cases reviewed for progress on a regular basis (e.g., every 6-12 weeks); D) Patients who receive treatment adjustments if not improving.

Parameters 8-12 Related to the “Supported by” Defining Clauses

Calibrated conditions needed for success of clinical action in the real world on a meaningful scale

8. Level of community expectation for integrated behavioral health as a standard of care	Little or no understanding and expectation <i>(Not acceptable—shown here for context)</i> Insufficient reach of understanding and expectation to enable integrated behavioral health programming to start and function in this community or practice	Expected as standard of care only in pockets Partial but substantially incomplete community understanding and expectation for integrated behavioral health as a standard of care; need for continuing education, consciousness-raising, clarification	Widely expected as standard of care Almost universal community understanding and expectation for integrated behavioral health as a standard of care
9. Level of office practice reliability and consistency	Non-systematic <i>(Not acceptable—shown here only for context)</i> Referral, communication, and other processes are non-standard and vary with clinician and clinical situation	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 <i>Inspired by Schein (2004), Collins (1996)</i>	Misaligned <i>(Not acceptable—shown here only for context)</i> Integrated behavioral health care is one among several strategic initiatives, but practical conflicts with other organizational priorities, resource allocations, incentives, and habits are apparent. Such tensions may or may not be articulated openly	Partially aligned Some alignment achieved but with constructive ongoing work to bring to the surface and resolve unresolved tensions between purposes, incentives, habits, and standards.	Fully aligned Constructive balance achieved between priorities, incentives, and standards. Integrated behavioral health functions are fully designed into priorities and incentives. Emerging conflicts are routinely addressed and respected as part of what the organization does to improve
11. Level of business model support for integrated behavioral health	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. If these functions are maintained, it is by diverting resources not designated for these purposes or through unsustainable sources of funding such as grants or gifts.	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. No diversion of funds marked for other purposes nor unsustainable sources of funding are required.	
12. Scale of practice data collected and used on at least the integrated medical/behavioral health aspect of the practice	Minimum: (less than 40% of patients) <i>(A startup state only—not a desired final state)</i> A system for collecting and using practice data from a limited number of patients or situations—to improve quality and effectiveness (of integrated behavioral health), especially at the individual patient level	Partial: (40%-75% of patients) <i>(An interim state, not a desired final state)</i> Significant but less than full collection and use of practice-based data for decision-making—to improve quality and effectiveness and reporting at the system or unit level	Full/standard work: 76% -100% of patients Routine data collection on most patients with integrated behavioral health—with internal reporting of “triple aim” outcomes and their use in decision-making to improve effectiveness at the system, unit, or community/population level

Auxiliary Parameters

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

Target sub-population for integrated behavioral health	A. Locus of care		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 High risk and often high stress for clinics	Mental health or substance abuse conditions Patients with one or more typical mental health or substance abuse conditions; family, partner, and relationship problems affecting health	Stress-linked physical symptoms Patients with stress-linked or “psycho-physiological” symptoms, e.g., headache, fatigue, insomnia, other	Medical conditions Patients with one or more medical diseases or conditions, e.g., diabetes, asthma, cardiovascular disease, lung disease	Complex cases Complex blend of symptoms, problems, conditions, diseases or personal situations, social determinants of health		
	D. Type of situations targeted	No contact Patients with no presenting problems or no contact with health system, even for prevention	Diseases, conditions	Prevention, wellness	Acute life stress Unsafe environment, social risks, isolation, financial, other	Culture, race, ethnicity and language or other special populations linked to disparities	High risk and/or high cost cases	

Degree that program is targeted to specific population or situation (Blount, 2003)	Targeted	Non-targeted
	Integrated behavioral health program designed for specific populations such as disease, prevention, at-risk, age, racial and ethnic minorities, social complexity, pregnancy or other specific situation.	Integrated behavioral health 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	Project scale	Full-scale
	Limited expectations for a limited set of outcomes for a limited group of patients: A “pilot” is a demonstration of feasibility or starter “test of change” with limited number of patients or clinical scope	Significant, but not full-scale outcomes expected: Multiple promising pilots gathered together with a larger, but still not full scale population, but led visibly as a project aiming toward the mainstream.	Full-scale and broad-based outcomes expected: Full scale way of life in the organization for the entire population of patients—the way things are done, no longer a project attached to the mainstream that hasn’t changed

Illustration: A family tree of related terms used in behavioral health and primary care integration

See glossary for details and additional definitions

Integrated Care

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

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, to 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).

Shared Care

Predominately 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)

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 skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

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)

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 PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

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.

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).

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, human services, and voluntary support networks. (Adapted from SAMHSA)

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)

Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

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Introduction

The Aim for this Lexicon for Integrating Behavioral Health and Primary Care

This lexicon--or *operational definition*--is a set of concepts and definitions developed by expert consensus for what we mean by “behavioral health and primary care integration” in practice. A consensus lexicon enables effective communication and concerted action among clinicians, care systems, health plans, payers, researchers, policymakers, business modelers and patients working for effective, widespread implementation on a meaningful scale.

Annotations:

The term “behavioral health” is employed as a broader concept than “mental health”—although “mental health” is probably better understood by the general public. Every term becomes a problem for someone, but “behavioral health” is reasonably accurate for the scope of this lexicon.

The scope of this lexicon is integration of behavioral health and primary care. Other worthy contexts for behavioral health integration, e.g., integration of behavioral health with specialty medical or tertiary care settings, are beyond the scope of this report.

The Problem

The field of behavioral health integration is only beginning to develop a standardized vocabulary. Behavioral health integration also is referred to as “integrated care,” “shared care,” “primary care behavioral health,” or “integrated primary care”—and this is just a start. Each term encompasses a similar core subject matter, but each has emerged from different intellectual, geographical, or disciplinary traditions.

To date, definitions in the field have emphasized values, principles, and goals rather than functional specifics required for a particular implementation to count as “the genuine article.” Definitions have not supplied a vocabulary for acceptable alternatives—to prevent behavioral health integration from being seen as a field in which “anything goes.”

The field not only must show its effectiveness empirically, but also must clarify its concepts and definitions enough to become consistently and widely understood by the public and health care practitioners.

Context—the Patient-Centered Medical Home

Pressure for transformation in health care has intensified in response to unsustainable costs and escalating concerns with quality and patient experience. Thanks in large part to these pressures, interest in successfully implementing the patient-centered medical home (PCMH) has been exploding (Cutler, 2010; PCPCC 2012, Crabtree et al 2011).

In turn, this has led to widespread interest in integration of behavioral health and primary care, widely viewed as a critical component or function of PCMH (PCPCC 2012; deGruy 2010), and required if primary care is to do its part in achieving “The Triple Aim” of health, affordability, and enhanced patient experience (IHI, 2010).

Benefits of a Shared Lexicon

For patients and families. “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?”

For purchasers. “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 any change in service or employee cost?”

For health plans. “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? How will I understand the functions well enough that I am able to price it?”

For clinicians and medical groups. “What exactly do I need to implement—to count as genuine behavioral health integrated in primary care—and to advertise myself as practicing integrated behavioral health? What are the core functions, and what is up to me to locally adapt?”

For policymakers and business modelers. “If I am being asked to change the rules or business models to support integrated behavioral health, exactly what functions need to be supported?”

For researchers. “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?”

How to Read This Lexicon

This lexicon is a source document that contains all the detail that the creators found necessary to answer: “What do you mean by that?” It contains the defining information that can be used to create customized summaries, tools, and derivative documents for specific applications.

This lexicon does not include task-specific or audience-specific summaries or derivative tools, although these will be important to generate while applying this lexicon to specific practical problems.

Organization of the Lexicon

The **Lexicon for Integration of Behavioral Health and Primary Care at a Glance** starts with a general definition (“what”), followed by defining clauses (“how” and “supported by”) and named parameters.

- *The defining clauses* state what genuine behavioral health integrated in primary care looks like in action—an extended definition for what is in common across genuine instances of integrated behavioral health.

The parameters are a vocabulary for how one instance of integrated care practice might legitimately differ from another one across town.

Lexicon Part I. “How” and “Supported by” Defining Clauses

- Sub-clauses are specified, often with bullet points.
- Annotations define terms, refer to literature, or clarify concepts and where balances may need to be found between desirable but conflicting values or goals.
- Some defining clauses include “alternatives”—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.” See Appendix 3 for a description of the method.
- Where no alternatives appear, the defining clause is required as stated.

A defining clause is a set of required functions, not a specific way of carrying out the functions. A defining clause represents fidelity to the definition of behavioral health integrated in primary care, but leaves room for (and requires) local adaptation such as specific workflows. Consider these defining clauses as patterns, not “cookie cutters.”

Lexicon Part II. “How” and “Supported by” Parameters—a Vocabulary for Legitimate Differences

- Each parameter has a set of *categories* (in boxes) that represents possible types, levels, or methods that might legitimately differ among integrated behavioral health practices.
- Some parameters articulate *types*—different legitimate approaches. Other parameters outline *levels* that might be regarded as developmental stages toward fully developed or mature functions of integrated behavioral health.
- There is no presumption that one of these variations is empirically proven best.
- Some parameters show categories that are shaded gray. These are not acceptable variations. They are shown only as context for the others.

Annotation:

Isn't this just good care in general? The defining clauses and parameters may come across as describing good care in general, not just good integrated behavioral health care. If so, why feature them separately from all good care? The answer is largely historical: The principles for good health care in general are well established and not all that controversial at their core—and need to be applied to the historically challenging area of behavioral health integration. Integrated behavioral health care follows the same principles as other good health care, so this lexicon reflects that. This will contribute to common understanding and a culture of “good care” across both physical health and behavioral health clinicians and administrators—knowing that all of them need a common language.

Lexicon 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 <i>What integrated behavioral health needs to look like in action</i>	Corresponding Parameters <i>Calibrated acceptable differences between practices</i>
(Parameter numbering at right does not correspond to clause numbering below.)	
How 1. A practice team tailored to the needs of each patient and situation <ul style="list-style-type: none"> A. With a suitable range of behavioral health and primary care expertise and role functions available to draw from B. With shared operations, workflows and practice culture C. Having had formal or on-the-job training 2. With a shared population and mission <ul style="list-style-type: none"> A panel of patients in common for total health outcomes 3. Using a systematic clinical approach (and a system that enables the clinical approach to function) <ul style="list-style-type: none"> A. Employing methods to identify those members of the population who need or may benefit B. Engaging patients and families in identifying their needs for care and the particular clinicians to provide it C. Involving both patients and clinicians in decision-making D. Using an explicit, unified, and shared care plan E. With the unified care plan and manner of support to patient and family in a shared electronic health record F. With systematic follow-up and adjustment of treatment plans if patients are not improving as expected 	1. Range of care team function and expertise that can be mobilized 2. Type of spatial arrangement employed for behavioral health and primary care clinicians 3. Type of collaboration employed 4. Method for identifying individuals who need integrated behavioral health and primary care 5. Protocols <ul style="list-style-type: none"> A. Whether protocols are in place or not for engaging patients in integrated care B. Level that protocols are followed for initiating integrated care 6. Care plans <ul style="list-style-type: none"> A. Proportion of patients in target groups with shared care plans B. Degree to which care plans are implemented and followed 7. Level of systematic follow-up
Supported by 4. A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care. 5. Supported by office practice, leadership alignment, and business model <ul style="list-style-type: none"> A. Clinic operational systems and processes B. Alignment of purposes, incentives, leadership C. A sustainable business model 6. And continuous quality improvement and measurement of effectiveness <ul style="list-style-type: none"> A. Routinely collecting and using practice-based data B. Periodically examining and reporting outcomes 	8. Level of community expectation for integrated behavioral health as a standard of care 9. Level of office practice reliability and consistency 10. Level of leadership/administrative alignment and priorities 11. Level of business model support for integrated behavioral health 12. Extent that practice data is collected and used to improve the practice

Part I. Defining Clauses and Acceptable Alternatives That Comprise the Definition

What—A General Definition

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.

“How” Defining Clauses (1-3)

(Clauses that describe functions required to accomplish the “what”)

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

Goal: To create a patient-centered care experience and achieve a broad range of outcomes (clinical, functional, quality of life, and fiscal), patient-by-patient, that no one provider and patient are likely to achieve on their own.

Annotations—team:

A team has specific tasks that require interdependent and collaborative efforts of its members. (Wise et al, 1974 as cited by Bodenheimer, 2007). Outcomes commonly desired from teams include: clinical outcomes superior to “usual care”, conservation of expensive physician or other clinician labor, and reduced clinician workload on activities that could be done by others (Bodenheimer, 2007; Willard & Bodenheimer 2012). Put another way, team outcomes superior to “usual care” involve appropriate use of professionals and staff for patient assistance, diagnostic assessments, and intervention based on background, training, and skills that leads to maximum clinical and functional benefit while conserving health related resources.

- A small interdependent team defined at the level of each patient has been referred to as a “clinical microsystem” that forms to meet particular patient and family needs—typically led by a physician or advanced practice provider with some combination of team members in roles such as nursing, care coordination, social work, behavioral health, pharmacy, physical therapy or others. This microsystem changes as the needs of the patient and family shift even as its members often remain embedded in a larger organization or system (Microsystem Academy, Bodenheimer & Laing, 2007).
- Some team roles or members will likely be the same in a practice and across patients with common needs, while other team roles or individuals will vary with regard to access and dedicated time based on practice population characteristics and desired targeted outcomes.
- “Team” as used here does not require that all team members are from the same organization or “network”. However, for some people, “team” may connote professionals that work in the same organization or unit (e.g., a clinic) rather than those brought in from disparate organizations for a particular patient. The term “collaboration” could be used by those who wish to restrict “team” to members of one clinic or organization.

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. See Table 1 on page 23 for examples. These functions include exercise of appropriate cultural and linguistic competence.

- Integrated behavioral health and primary care role functions include chronic illness care, acute care, common physical symptoms associated with stress without serious disease present, acute life stresses, wellness and prevention, health behavior change, and mental health/substance abuse dimensions of the total care of patients.

Annotations:

- “Suitable” range of expertise means the range of expertise actually *required* for the particular patients or target subpopulations that the practice is responsible for or has chosen to focus on. “Suitable” is used here to denote tailoring, not to connote loose approximation.

- These functions include medical treatments, psychopharmacology, and psychological therapies, employing clinicians or others appropriate for those functions, including care coordination whether done by a coordinator or others on team.
- See Table 1 on page 23 for examples of collaborative care role functions and personnel capable of performing them. The skills and capabilities of mental health professionals often differ even among members of the same discipline, let alone between different kinds of mental health professionals such as psychiatrists, psychiatric nurse practitioners, psychiatric physician assistants, psychiatric clinical nurse specialists, psychologists, clinical social workers, licensed marriage and family therapists, substance abuse counselors or other licensed counselors or therapists. Mental health professional capabilities assembled must match the clinical needs of patients being seen for collaborative care in the practice. Likewise, primary care providers—such as family physicians, general internists, medical advanced practice nurses or clinical nurse specialists and medical physician assistants—do not all have all the capabilities that may be required for a practice’s patients functions and typical personnel capable of performing those functions.
- With patients and families considered part of the team.

Annotations—part of the team:

- Patient, family and caregiver roles on the team include at least: 1) being a participant in a healing relationship; 2) providing information on needs, preferences, values, and priorities used in shared decision-making and customizing care (family members may need permissions as well as willingness); 3) being the source of control (IHI patient-centered care charter, 2005) and 4) taking an active role or “ownership” of health.
- Patient engagement has been defined as “actions individuals must take to obtain the greatest benefit from the health care services available to them”. (Gruman et al 2009; Center for Advancing Health, 2010). This focuses on the behaviors of individuals that are critical to health outcomes rather than the actions of professionals or institutions. Domains include finding safe decent care from among the alternatives; communication with professionals; organizing and paying for health care; participation in treatment decisions and treatment; promoting health knowledge, health behaviors, and preventive care; planning for end of life. In this view, “engagement” is an active inquiry and set of behaviors by individuals not merely “compliance”. (Gruman, 2010)
- With specific team members—and clear roles—identified and organized as a team (who specifically does what) to help patients achieve functional and/or disease goals (and personal preferences) articulated in a shared treatment plan. These goals and needs may change according to the active problems and resources needed for those problems.

Annotations:

- “Organized as a team” implies clearly stated interdependence of team members all having the same clinical and functional goals formulated with the patient.
- The patient is to experience the addition of team members (such as a behavioral health clinician) as a valuable part of their care through 1) understanding why the situation and plan needs other professionals to be involved and 2) seeing current providers endorse the credibility and work of the new clinician(s).

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 1

Change “Shared physical space—co-location” to “A set of working relationships and workflows between collaborating clinicians in separate spaces that achieves communication, collaboration, patient-centered operations, and shared workflows and practice culture requirements.”

- Shared workflows, protocols, and office processes that enable and ensure collaboration—including one accessible shared treatment plan for each patient.

Annotations:

Shared workflows: Working from shared workflows, protocols, and office processes goes beyond spatial proximity or “co-location”—which does not by itself establish shared workflows. Shared workflows could be regarded as “shared process space” in contrast to “shared physical space”.

Co-location does not ensure collaboration. Collaboration has to do with the interactions of clinicians, not where they are. For example, there can be co-located practices that are not as effective as collaborative practice arrangements with shared protocols and workflows where not all providers are physically located in the clinic. Shared workflows and protocols could take place among closely collaborating clinics and clinical partners, not only those co-located in same physical space. Although not a requirement, co-location (shared physical space) is good to have because:

- It helps clinicians and staff establish relationships with one another.
- It promotes communication, spontaneous interdependent function and consultation.
- It allows patients to observe the interaction and behavior of the team in action.
- It reduces barriers to patient access and follow-through that result from traveling from one place to another. From the patient perspective, value in shared space comes from not having to go to a different place for part of their care, even if the clinicians are well linked by workflows and communication. Teleconferencing may also reduce the barriers to “going to a different place”, especially after clinicians and patients have developed initial face-to-face relationships. But in general, moving from one space to another is a barrier for patients.

Collaboration in “virtual space” (e.g., telemedicine, conference call) is possible but thought to work best when the people in separate locations already know each other well and have established relationships vis-à-vis patient care.

- A shared practice culture rather than separate and conflicting behavioral health and medical practice cultures.

Annotations--shared practice culture:

- *Shared practice culture* refers to identity, purpose, and roles as a clinician in the context of interdependency; customs (as expressed in workflows) for communication, interruptions, and confidentiality; a shared picture of what it means to be patient-centered, how you relate to each other’s power and influence; and how you engage in clinical systems. Behavioral health in primary care takes on much of the overt style and practice culture of primary care. (McDaniel & Campbell, 1995)
- *Demonstrable commitment to building a shared practice culture* (when accompanied by specific plans and timeframes) is an acceptable interim state on the way to actually having a shared practice culture.

- C. *Having had formal or on-the-job training* in preparation for the clinical roles and relationships of collaborative care, including culture and team-building (for both medical and behavioral clinicians).

Annotation:

This “training” subclause is an enabling condition for successful integrated behavioral health in action. It is based on the common practical observation that clinicians are often not trained for collaborative care roles, and that collaborative care in action requires specific training at this point in history (though perhaps not in the future).

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.

Annotations—accountabilities:

- Behavioral health and medical team members take responsibility for total health outcomes by providing coordinated assessments, treatment, follow-up, treatment adjustment as needed, and a population health approach.
- Medical, behavioral health, and chemical dependency are core components of practice—functions needed to enhance total health and improved outcomes can be expected while conserving health care resources. Accountability is for both medical and mental health outcomes by team members from both behavioral health and medical backgrounds, including cross-disciplinary service delivery where needed.

Annotation—team members:

- May include behavioral health, medical /physical health, and substance abuse among others such as care coordinators. See “family tree of terms” in Appendix 3 for definitions of mental health, behavioral health, substance abuse, and primary care.
- All clinicians, including behavioral health clinicians, recognize when specialists are needed, whether medical or behavioral health specialists outside the immediate team.

Alternative 2

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, e.g., age group, disease cluster, gender, culture, ethnicity, or other population.”

Annotation:

This simply means that a team may focus its integrated behavioral health work on a particular subset of the entire practice panel or population rather than all patients who come to the clinic.

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

A. *Employing methods to identify those members of a population who need or may benefit from integrated behavioral/medical care, at what level of severity or priority. (See Table 2 on page 24 for scope.)*

Annotations:

- This clause is primarily aimed at identifying those who specifically need integrated behavioral / medical care at a particular level of intensity or priority. However, it is understood that population-level identification takes place in the larger context of all care, not only individuals requiring integrated behavioral health.
- Prioritization may be based on what the practice actually can do that makes a difference *and* that the patient wants to have done and to participate in.
- Identification is for “case-finding” for behavioral health integration and is not the same as universal screening for conditions. Identification could take place within populations considered high risk or as universal screening.
- Identification of need for integrated behavioral/medical care is a broad concept that includes the identification and need for treatment of mental health/substance abuse conditions, behavioral factors (or mental health conditions) embedded in chronic illness care, common physical symptoms or complaints not attributed to disease processes, health behavior change, social determinants of health, and how the organization of care or the care system may complicate or interfere with care for conditions (Table 2, page 24). Use of a registry can be helpful but is not required.

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. (See Table 3, page 25 for the kinds of clinic systems required for different needs.)*

Annotations:

- Engaging patients also includes helping patients identify what goals they would like health care professionals to help them meet, exploring what patients can do to participate in their own care, being a prepared communicator, tracking their own progress as well as other patient engagement behaviors (Center for Advancing Health, 2010).
- Engaging patients means clarifying the reasons for integrating behavioral health and inclusion of the behavioral health clinician on the team and in a shared record—exploring its benefits and risks as seen by both patient and provider.
- “Group of health professionals” may be a local clinical team or include specialists and others outside the patient’s primary care clinic. This may also include professional interpreters, a patient navigator, or a community health worker. (U.S. DHHS, 2011)

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

Annotation:

Clinicians have talked about the value of patient involvement in decisionmaking for a long time. A more specifically articulated field of “shared decisionmaking” (jointly assessing risks and benefits of alternative therapies in light of patient values and preferences, often using decision aids) has emerged as a systematic discipline with its own literature, roles, goals, tools, and protocols. (FMDM, 2011; Epstein et al, 2004; Gafni & Whelan, 1997) Definitions and requirements are becoming more clearly articulated. (Moumjid et al, 2007; MSDMC, ICSI & UM, in press)

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 Table 3, page 25 for processes across prevention, acute, chronic/complex care.)*

Elements of care plans:

1. Team roles and goals—specific goals and team members responsible for specific goals or tasks
2. Documentation of dialogue with the patient on why a shared record is an important component—the benefits (and any risks) to the patient—with serious exploration of any patient concerns about shared records and any precautions taken to protect the confidentiality of behavioral health records. *See box below.*
3. Patient education about their conditions, treatments, and self-management.
4. Medical treatments, including pharmacologic treatment; for example. A single shared medication list and problem list
5. Psychotherapy, community groups, or other non-pharmacologic behavioral health or substance abuse therapy or support
6. Counseling or coaching, e.g., motivational interviewing, behavioral activation
7. Plans tailored to the patient /family context, e.g., family, cultural groups, language, schools, vocational, community.

Implementing a care plan means:

1. All involved providers read and work from the care plan—these are *shared* care plans.
2. Likely indicators that improvement has begun are listed, along with who is most likely to notice the change first.
3. Likely indicators that the care plan isn't working and may need to be revised are listed, along with who should be informed that the care plan needs changing.

Annotations:

- *Educational and community resources:* Educational materials need to be accurate and readily understandable, matching the patient's health literacy level. Not all these educational or support resources may be in the clinic itself, but should be included in the care plan.
- *Evidence-based:* Medical, psychological, and counseling treatments or techniques are to be supported by research evidence as much as possible.

Dialogue With Patient on Information Sharing and Confidentiality

Be prepared for the possibility that a patient may not want a shared record. Primary care involves sharing of information but the clinician has a responsibility to initiate dialogue with the patient that explains why it is important to have a shared record and then to listen to patient concerns and negotiate a resolution. This could be applicable to privacy issues for HIV, STDs, and other conditions as well as behavioral health aspects of care.

The general principle is that the patient came to the primary care clinic to get health care—which in this practice is integrated and therefore charted for the team to view (and potentially others if the patient releases information). The patient doesn't have to enter a fully integrated primary care clinic—this may not be the choice for everyone. And of course, legally, every patient has a right to refuse providers outside the practice access to their medical information.

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

Annotations:

- A separate behavioral health record that is not shared or shareable in any way is not acceptable (but see boxed annotation above).
- A “shared electronic medical record” increasingly means patient access to records, an aspect of “meaningful use” and will at some point be required.

Alternative 3

Change “unified care plan in shared medical record” to “the problem list and shared plans are contained in provider notes or other records in the same organizational medical record which everyone reads and acts upon.”

Alternative 4

Delete “electronic” in “shared electronic medical record.”

Annotation:

At this time, not every practice is required to have an electronic medical record containing all aspects of collaborative care, but this is an interim state, not a desired final state.

F. *With systematic followup and adjustment of treatment plans* if patients are not improving as expected. This is the “back-end” management of patients from “front-end” identification.

- Use of population-based registry for systematic followup of individual patients and to monitor the status of populations tracked in the registry.
- Outreach to patients who do not follow up
- Regular monitoring of treatment response, side effects, and how treatments are fitting the patient’s actual life, goals, and priorities
- Adjust care plan quickly for patients who are not improving, whose care doesn’t fit their goals or life—who are not engaged, who are not responding to initial treatments, or are experiencing troublesome treatment side effects / complications or other adverse events. Revise the plan or move it to a more intensive level.
- Establish and support relapse prevention plans when patients are substantially improved.

Annotations:

- Systematic follow-up may involve a wide range of tools or methods selected by particular clinics, such as appointment reminders, panel reviews using a registry and many others. The functions above are required but particular methods are not prescribed.
- Clause 3F establishes a pattern of function for integrated behavioral health practices, but does not require that every single patient seen in the practice is on a registry or receives all aspects listed here. An initial target population for systematic follow up is likely a subset of the clinic’s entire panel, such as patients with complex, high-cost, treatment-resistant conditions.

“Supported by” Defining Clauses (4-6)

(Necessary for the “how” clauses to become sustainable action 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.

Annotations:

- *Why include this clause:* The term “expecting. . . as a standard of care” addresses the observation that patient demand and expectation will be needed to drive the widespread adoption of integrated/collaborative care. Hence a definition of integrated behavioral health care in action needs to include the reminder that patient expectation and widespread awareness of the need will be required for it to take hold on a meaningful scale.
- *Definitions:* Refer to the “family tree of terms” in Appendix 3 for definitions of “behavioral health” and “primary care”. “Integrated care” in this context means that health care clinicians work together (collaborate) so that their actions show an awareness of, value for, and attention to, the actions of other health care providers—that their actions are structured and coordinated to create a clinically appropriate and patient-centered experience for each patient.

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 5

Delete “consistently and reliably.”

Annotation:

Highly consistent and efficient office processes are an aspiration but are not yet required for a practice to be considered an integrated behavioral health practice. But this is an interim state, not a final state.

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

Annotations:

- Integrated behavioral health, as a “new” functional model in most practices will require realignment of purposes, incentives, philosophy, and systems if it is not to work at cross purposes with existing habits. One aspect of leadership alignment is being committed to tracking a set of population-level program outcomes and to making program changes if the program is not as effective as expected.
- A particular practice within a large organization may be ready to integrate behavioral health care, but the various clinics within a large organization may be at different points of readiness. These practices are not likely completely independent of the larger organization, so incentives and leadership at the level of the larger organization may affect how far a particular practice can go in making the changes required.

Alternative 6

Substitute “Intention and process underway to align...” for “alignment of.”

Annotation:

“Intention and process underway” is an interim state, not a desired final state. Aligned incentives and leadership will ultimately be required if collaborative care is to be successful on a meaningful scale.

- 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.

Annotation:

- At present, collaborative care business models are often regarded as not sustainable. See parameter 10 (level of business model support for integrated behavioral health) for how sustainability might be defined along with examples of payment or non-payment revenue that might be in the mix.

Alternative 7

Substitute “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.

Annotations

- Practice-based data is collected as a standard part of clinic operations at the practice site or is reported back to the practice site from a central administration or other source. Other data on total cost of care, such as hospital, pharmacy, readmissions, emergency services, referral, or other utilization may or may not be reported back to the clinic and is not necessarily counted as “practice-based data” or collected or sent by others to practices.
- Much practice-based data is collected as quality improvement or program evaluation data. Other data may be collected as research data, such as measuring clinical and cost outcomes--using pre-post or quasi-experimental designs --in subsets of patients who are exposed to collaborative care services for complex or not so complex patients.

- Collection of uniform demographic data such as race/ethnicity and language is outlined in the Affordable Care Act Section 4302. The law requires that data collection standards for these measures be used, to the extent practicable, in all national population health surveys. They will apply to self-reported information only. The law also requires that any data standards published by HHS comply with standards created by the Office of Management and Budget (OMB).

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.

Annotations:

- *Outcomes at 3 levels:* Teams using the well-supported clinical approach achieve outcomes at 3 levels: patient level outcomes such as clinical improvement, satisfaction, and improved function; the same outcomes at practice/panel level, but including provider satisfaction; population-level outcomes such as the Triple Aim.
- *Triple Aim* (IHI, 2010): The Institute for Healthcare Improvement believes that new designs can and must be developed to simultaneously accomplish three critical objectives: 1) improve the health of the population; 2) enhance the patient experience of care (including quality, access, and reliability); and 3) reduce, or at least control, the per capita cost of care.
- *Alignment of outcomes reported and patient goals.* To have the best value for patients, outcomes reported should be aligned with the goals that patients set for themselves and the services they want to receive.
For underserved populations it may also be necessary to look at figures such as improved engagement, rates of follow-through, or penetration of services in the population (US DHHS, 2011).

Tables Clarifying or Expanding the Defining Clauses

Table 1: Examples of collaborative care role functions and personnel capable of performing them
(Thanks to Roger Kathol)

Functional area*	Role functions	Personnel capable of performing functions as part of total health care team
Triage/screening with or without registry	Connect those in higher-highest need to treatment capabilities; maximize resource use <ul style="list-style-type: none"> • PH and preventive measures needed • PH and illness screens • Complexity identification, esp. for high-risk patients (social or care system interferences with care) 	Non-medical staff; medical aide; triage nurse, other
Behavioral activation	Improvement in patient-centered outcomes—health behavior change (wellness), prevention, participation and engagement in own care	Clinic nurse, psychologist, social worker, care coordinator, trained medical aide, other; all supported by treating practitioners
Psychological support/crisis intervention	Increase patient's ability to adhere to treatment; increase healthy behaviors; decrease impairment: Coping skills training, handling stress, problem solving	Behavioral health and substance use disorder counselors, psychologists [all levels], social workers, psychiatric nurses, trained medical nurses, treating practitioners, psychiatrists
Social support	Family interventions; Assisting with access to community resources; assisting with medically-related financial issues—buying meds, getting to appointments, housing; Find needed services.	Nurses, social workers, psychologists, counselors, “lay navigators,” care coordinators trained in this function; community health workers, <i>promotoras</i> , or health educators
Straightforward BH psychological and somatic interventions	Sustained reduction in symptoms and impairment; reduced disability, augmented performance or function; lower total health care cost <ul style="list-style-type: none"> • Straightforward non-chronic medical patients—depression, anxiety, substance use, somatization, other • Straightforward chronic medical patients 	PsyD/PhD psychologists, selected masters level psychologists, psychiatric nurses, or social workers, or counselors, primary and specialty care practitioners, psychiatrists trained for this role.
Straightforward MH condition pharmaceutical interventions	To reduce symptoms, reduce disability, augment performance or function	Primary care and specialty medical physicians, nurse practitioners, clinical nurse specialists, physician assistants with supervision, psychiatrists, PharmD consultation
Complex MH condition medical/somatic interventions	Sustained reduction of symptoms and impairment; reduce disability, augment performance or function; lower total health care costs <ul style="list-style-type: none"> • Treatment resistant—nonresponders to straightforward care • Severe or psychotic—SPMI, psychotic/suicidal depression, severe eating disorders, chronic CD, other 	Psychiatrists, psychiatric nurse practitioners, psychiatric clinical nurse specialists, psychiatric physician assistants (the latter three with psychiatrist supervision); clinical psychologists or clinical social workers
Chronic / complex illness care	Improve/stabilize health, reduce impairment; lessen total health care cost: Assistance to high cost/high need patients through integrated care management	Trained nurse and social work integrated case managers, other professionals with medical and/or mental condition backgrounds willing to undergo training in cross-disciplinary work
Outcome measurement to enable timely adjustment in care	Clinical, functional, fiscal satisfaction, quality of life: <ul style="list-style-type: none"> • Document improvement in each outcome domain • Change/escalate assistance/intervention when outcomes not achieved, especially in high cost-high need patients 	All practitioners and non-medical personnel involved in assisting with patient improvement; escalation of intensity or changing kind of care generally initiated or supervised by medical or behavioral health professionals
Followup	Documented clinical improvement: <ul style="list-style-type: none"> • Health stabilization; impairment reduction/control • Total health cost reduction (long term—short term cost may and likely will be more) 	All treating practitioners for chronic conditions or complex care with assistance by support staff—preventive, acute, chronic care); Add integrated care managers for the most significantly ill or complicated patients.

PH = physical health; BH = behavioral health; MH = mental health; SPMI = serious and persistent mental illness; CD = clinical depression.

*Professional interpreters may be needed for specific patients in any of these functional areas.

Table 2: Scope of integrated behavioral health—what kinds of cases to identify

(Thanks to C.J. Peek and N. Calonge)

Identification of individuals (cases) whose care plans require blended behavioral health and medical expertise				
Identification of mental health and substance abuse conditions (Identifying individuals for whom further diagnostic assessment is warranted)		Identification of clinical situations (that are not diseases or conditions) in which behavioral health expertise is needed in care plan		Identification of need for health behavior change as part of plan for any condition
<i>Screening or other identification for MH/SA conditions that can be understood and treated more or less independently of other health concerns</i> (Examples: ADHD or depression in an otherwise healthy adolescent; bipolar disorder in an adult with ordinary medical picture Evidence basis, e.g., from USPSTF.	<i>Screening or other identification for MH/SA conditions that are deeply intertwined with medical conditions or chronic illnesses</i> (Example: Major depression in a person with poorly regulated diabetes who considers diabetes their main health issue) Evidence basis, e.g., from USPSTF.	<i>Identification of physical symptoms or common complaints not fully explained via disease processes; BH expertise needed</i> (Examples: Pain, headache, delayed recovery from injury, fatigue, insomnia, stress, family distress or fear of violence) Evidence basis: Stress and somatization literature	<i>Detection of care delivery patterns associated with:</i> <ul style="list-style-type: none"> • Overutilization • Unfocused utilization • Unplanned visits, ER, hospital, urgent care • Many failed services • Distrustful patient-clinician relationship • Patient unhappiness with care—feeling stuck • Provider feeling stuck Evidence basis: Health services research literature	<i>Identification of</i> <ul style="list-style-type: none"> • Health behavior change in chronic illness or prevention • Health behavior change in areas of addiction and SA, eating disorders required for care or prevention of medical conditions Evidence-basis: Self-management, chronic care, SA care literature
Methods: <ul style="list-style-type: none"> • MH /SA screening tools • Health risk assessment • Med record history/hx 	Methods: <ul style="list-style-type: none"> • MH/SA screening tools • HRA • Medical facts, history 	Methods: <ul style="list-style-type: none"> • General sx checklists, HRA • MH screen/careful interviewing • History and medical facts • Claims data 	Methods: <ul style="list-style-type: none"> • General sx checklists • Claims data • Visit data • Patient and provider report 	Methods: <ul style="list-style-type: none"> • Behavior and wellness behavior checklists, HRA • SA screens • Behavioral factor information in medical records

MH = mental health; SA = substance abuse; ADHD = Attention Deficit Hyperactivity Disorder; USPSTF = U.S. Preventive Services Task Force; BH = behavioral health; HRA = health risk assessment;

Table 3: Examples of clinic care planning and care delivery processes to facilitate prevention and acute and chronic/complex care

(Thanks to R. Kathol)

<p>Prevention</p> <ul style="list-style-type: none"> • Guidelines-based medical and behavioral screening, vaccinations and inoculations, and chronic illness follow-up examinations • Educational programs for problematic health behaviors, e.g., smoking, weight, diet, poor coping mechanisms, other • Proactive claims, discharge, or clinical identification-based complex case finding 	<p>Acute care</p> <ul style="list-style-type: none"> • Non-referral-based behavioral health assessments in patients at high risk for Behavioral health contributions to medical outcomes. (Contact only with the number of patients for whom successful assistance can be provided by the number of personnel available—with preference to those with higher complexity) • Onsite acute support/crisis intervention • Collaboration with primary care practitioners in providing psychological support/intervention during practitioner-based medical management 	<p>Chronic/complex care to reduce high cost, improve function, improve health status</p> <ul style="list-style-type: none"> • Assignment of high end complex patients to integrated physical health and behavioral health (cross-disciplinary) case managers (based on number of managers available) • Multi-domain integrated case management with measurement of clinical, functional, fiscal, satisfaction, and quality of life outcomes
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Part II: Parameters of Integrated Behavioral Health and Primary Care Practice

How one integrated practice might differ from another

Parameters 1-7 Related to the “How” Defining Clauses

Parameter 1. Range of care team function and expertise that can be mobilized to address needs of particular patients and target populations	Foundational functions for target population (See definitions in Table 1 on page 23.)	Foundational plus other functions for population (Foundational ++)	Extended functions (foundational++), add
	<ul style="list-style-type: none"> • Triage/identification with or without registry • Behavioral activation/self management • Psychological support/crisis intervention • Straightforward community resource connection • Straightforward, general MH/SA psychological interventions • Straightforward MH pharmaceutical interventions • Common chronic/complex illness care • Follow-up, outcome monitoring for timely adjustment of care and coordination • Cultural and linguistic competence 	<ul style="list-style-type: none"> • Triage/identification with registry and tracking /coordinating functions • Complex or more specialized MH therapies needed for population • Complex or more specialized pharmacologic interventions 	<ul style="list-style-type: none"> • Specialized disease experts, i.e., specialists and educators • Specialized population experts, e.g., culture, age, geographic, other groups • Experts brought in from cultural, school, vocational, spiritual, corrections, and other areas of intersection with health care or specialized care managers

MH = mental health; SA = substance abuse

Annotations:

- “Foundational” is the minimum set of functions that can be mobilized for a given target population. “Foundational +” and “Foundational ++” represent enhancements to broaden the range of available expertise as needed. The lexicon creators visualized this metaphorically as a “food pyramid.”
- This table depicts functions but not disciplines because individuals with particular functional expertise are likely to vary from place to place and discipline to discipline. This parameter depicts an increasing range of functional expertise (built on a foundation) that the practice can mobilize for any given patient or population. However, different kinds of behavioral health and medical professionals are more likely or more typically associated with particular functions (Table 1, page 23).
- “Team” does not imply that all the patient’s clinicians are in the same practice. Some may be brought in for specific patients or populations from other specialty clinics or organizations; some are part of the “team” only briefly or for circumscribed purposes, e.g., a surgeon. What makes it a “team” is not their location, organizational affiliation, or particular role but the fact that they are brought together and “networked” for a particular patient at a particular time and agree to communicate and collaborate as clinically needed.
- Straightforward community resource connection may well include figures such as community health workers or *promotoras*.
- Cultural and linguistic competence (U.S. DHHS, 2011; 2001): “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.” Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.”
- Competence with geographical differences such as rural, frontier, or border communities may also be needed.

Parameter 2. Type of spatial arrangement employed	Mostly separate space <ul style="list-style-type: none"> Behavioral health and medical clinicians spend little time with each other practicing in same medical clinic space. Patient has to see providers in at least two buildings. 	Co-located space <ul style="list-style-type: none"> Behavioral health and medical clinicians are in different parts of the same building, spending some but not all their time in same medical clinic space. Patient typically has to move from primary care to behavioral health space. 	Fully shared space <ul style="list-style-type: none"> Behavioral health and medical clinicians share the same provider rooms, spending all or most of their time seeing patients in that shared space. Typically, the patient is in one exam room and the clinicians (primary care and behavioral health) see the patient in that room.
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Parameter 3. Type of collaboration employed	Referral-triggered periodic exchange Information exchanged periodically with minimally shared care plans or workflows	Regular communication/coordination Regular communication and coordination, usually via separate systems and workflows, but with care plans coordinated to a significant extent	Full collaboration/integration Fully shared treatment plans and documentation, regular communication facilitated by a care coordinator and/or clinical workflows that ensure effective communication and coordination of care.
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Annotations:

- Types:* These describe existing types of location or collaboration between behavioral health and medical clinicians. There is no assumption or “value judgment” made that any one of these is better or more appropriate than any other. This is both an empirical question (which arrangements produce what benefits for whom) and a matter of a clinic’s vision for patient-centered care (even if outcomes are the same). Moreover, different patient situations call for different levels or kinds of collaboration. Not every clinical need requires maximal collaboration (or co-location) between behavioral health and medical clinicians and staff. *There is no assumption that one type of spatial arrangement always implies one type of collaboration.* For example, it is possible to share physical space but have relatively few shared workflows or treatment plans. It may be possible to employ mostly separate space but build up considerable shared workflows and treatment plans.
- These parameters recognize staff as well as clinician interactions:* The “types” may also recognize location or collaboration among different staff roles within practices. For example, a medical or behavioral health clinician also interacts with the people who schedule appointments; handle billing; do nursing, rooming, care coordination, or patient education; or perhaps serve as community health workers. Clinicians know the scope of their skills, when to refer something to them, and when they should refer something to the clinician. This mutual awareness lets the overall job get done effectively and efficiently.
- Virtual space:* Manner of space-sharing or collaboration is increasingly affected by videoconferencing, telemedicine, telepsychiatry and Skype, which augment “shared space” in the customary physical sense. In rural areas and smaller clinics, such methods to create “virtual space” in which to collaborate may increasingly be figured into the “types” above.

Parameter 4.Method for identifying individuals (who need integrated behavioral health and medical care)	Patient or clinician Patient or clinician identification done in a non-systematic fashion	Health system indicators (Other than patient screening) Demographic, registry, claims, or other system data, at risk for complex needs or special needs	Universal screening or identification processes All or most patients or members of clinic panel are screened or otherwise identified for being part of a target population
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Annotations:

- Identifying individuals in what populations:* The target population for integration of behavioral health in a primary care setting is all the patients in the clinic panel whose clinical situations call for a blend of behavioral health and medical care. However, a particular clinic might choose to focus on one or more particular subpopulations that they define for practical or strategic reasons or because of particular panel characteristics, e.g., many elderly or complex situations. There is almost no limit to how a clinic could subdivide its population or prioritize efforts to integrate behavioral health care. See Table 2 on page 24 for typical target conditions or situations for integrated behavioral health. But whatever the clinic’s target population (its entire panel or a specified subset), it will need a method for identifying individuals in the target group. An auxiliary

parameter called “target population” appears in the Appendix 1 to illustrate how target subpopulations might be distinguished if a practice chose to do so.

- *Identification done in other settings:* In some settings (e.g., schools, spiritual organizations, employee health programs), teachers, counselors, or others may identify individuals in need of integrated care (not only “patients and clinicians” in context only of the medical clinic).
- *Screening and identification:* “Screening” means disease screening according to evidence-based protocols. “Identification” is a broader concept that includes non-disease states of affairs that indicate need for integrated behavioral health (see defining clause 3 on page 18). Identification can take place as a clinician finding at a visit, as the result of a screen or identification process done by the team at a visit, as a system finding, or as a universal screen/identification process for individuals not previously in front of the doctor or team.
- *Health system indicators and universal screening may both be employed.* There is no presumption here that universal screening is superior to health system indicators for identifying patients who may benefit from integrated behavioral health.

Parameter 5A. Protocols in place or not for engaging patients in integrated care	Protocols not in place <i>(Not acceptable—described here only for context)</i> Undefined or informal: Up to individual clinician and patient whether and how to initiate/engage with integrated behavioral health care, e.g., whose care should be integrated, goals, appropriate team and roles, main contact person.	Protocols in place Protocols and workflows for initiation and engagement in collaborative care are built into clinical system as standard part of care process
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Parameter 5B. Level that protocols are followed for initiating integrated care	Protocols followed less than 50% <i>(Not acceptable—described here only for context)</i>	Protocols followed more than 50% but less than 100% <i>(An interim state, not a desired final state)</i> Protocols for initiating integrated behavioral health care are followed for 75% to 100% of patients identified in priority group.	Protocols followed nearly 100% Protocols for initiating integrated behavioral health care are followed for nearly 100% of patients identified in priority group. Goal is 100%—as in “standard work”.
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Annotations:

- Having protocols and defined processes for engagement in integrated behavioral health care can be regarded as a baseline level of standardization that still encourages clinicians to personalize the protocol to individual needs and situations using the expertise of the care team. Especially in unusual situations, care team members will have to choose, sequence, and differentially emphasize different things.
- “Standard work” is defined in Lean (the product improvement philosophy and methodology inspired by Toyota) as “work specified for content, sequence, timing, location and outcome” or, more simply, “the current best way to do something. This can apply to clinical processes that need to be done consistently and reliably – including standard and reliable approaches to patient-centered tailoring of care. This allows for keeping a balance of standardization and flexibility to learn from experience.

Parameter 6A. Proportion of patients in target groups with shared care plans With care plan elements in clause 3C relevant to patient situation	Less than 40% <i>(Not acceptable—described here only for context)</i> Most patients in targeted groups for integrated behavioral health do not have written care plans.	40% to nearly 100% <i>Interim state—not a desired final state</i> A meaningful proportion but less than full-scale integrated behavioral health care planning for targeted groups	Nearly 100% Nearly 100% of patients in targeted groups with care plans—as in “standard work”
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Annotation:

“Standard work” is defined in Lean (the product improvement philosophy and methodology inspired by Toyota) as “work specified for content, sequence, timing, location and outcome” or, more simply, “the current best way to do something. This can apply to clinical processes that need to be done consistently and reliably – including standard and reliable approaches to patient-centered tailoring of care. This allows for keeping a balance of standardization and flexibility to learn from experience.

Parameter 6B. Degree that care plans are implemented and followed	Less than 50%. <i>(Not acceptable—described here only for context)</i> Sufficient care plans implemented and followed for less than 50% of patients.	More than 50%, less than 100% <i>(Interim state, not a desired final state)</i> Significant but incomplete accomplishment of care planning process	Care plans implemented/followed nearly 100% Sufficient care plans implemented and followed for nearly 100% of patients identified in priority group. Goal is 100%—as in “standard work”.
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Annotations:

- *The goal is for all patients in target groups for integrated behavioral health have shared care plans in place.* (These plans are to be sufficient—having the essential elements in the care plan relevant to the situation (See defining clause 3C, page 18).
- *This suggests that clinics will track and report the information* on who is in the target population for integrated behavioral health, the proportion that have documented care plans, and the proportion that are implemented and followed. If this requires manual recordkeeping and reporting (rather than electronic), it may not be seen by practices as feasible for them.
- “Standard work” is defined in Lean (the product improvement philosophy and methodology inspired by Toyota) as “work specified for content, sequence, timing, location and outcome” or, more simply, “the current best way to do something. This can apply to clinical processes that need to be done consistently and reliably – including standard and reliable approaches to patient-centered tailoring of care. This allows for keeping a balance of standardization and flexibility to learn from experience.

Parameter 7. Level of systematic follow up <i>Mark which % row applies in each column.</i>	% of patients with at least one follow-up (those engaged in care, not merely identified for care)	% of patients with at least one follow-up in initial 4 weeks of care	% of patients who have their cases reviewed for progress on regular basis (e.g., every 6-12 weeks)	% of patients with treatment adjustments if not improving
76% to 100% of patients in target group or practice panel. Goal is 100%—“standard work”.				
40% to 75% Significant but incomplete follow-up being done				
Less than 40% <i>(Not acceptable—shown here only for context)</i>				

Annotations:

- *The denominator* for the percent in this parameter is the practice panel or designated priority group identified by the practice.
- *The level of follow-up is tailored to the level of need* (which is determined by patient and health care professionals). The simplest clinical situations may not require all these elements of follow-up. This parameter is geared toward clinical situations that do require collaborative care and systematic follow-up. In general, however, any patient who is not improving needs treatment adjustment (rightmost column), no matter how “simple” the care is.
- These are general purpose “default” time intervals. Clinically appropriate follow up intervals for particular situations may vary.

Parameters 8-12 Related to the “Supported by” Defining Clauses

*(Conditions Needed for Success of the Clinical Action in the Real World
on a Meaningful Scale)*

Parameter 8. Level of community expectation for integrated behavioral health as a standard of care	Little or no understanding and expectation <i>(Not acceptable—shown here only for context)</i> Insufficient reach of understanding and expectation to enable integrated behavioral health programming to start and function in this community or practice	Expected as standard of care only in pockets Partial but substantially incomplete community understanding and expectation for integrated behavioral health as a standard of care; need for continuing education, consciousness-raising, clarification	Widely expected as standard of care Almost universal community understanding and expectation for integrated behavioral health as a standard of care
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Annotations:

- “Community expectation” includes both the public and those clinicians and others in the health care system.
- Patient demand will be needed to drive widespread adoption of integrated /collaborative care as a standard of care.
- Individual practices can make changes that likely affect the expectations (and demand for integrated behavioral health) of the public and the clinicians within the practice, but cannot be held accountable by themselves for generating this expectation and demand. This may be similar to creation of expectation for health IT as a standard of care or the creation of new business models that can sustain new models of care.

Parameter 9. Level of office practice reliability and consistency	Nonsystematic: <i>(Not acceptable—shown here only for context)</i> Referral, communication, and other processes are nonstandard and vary with clinician and clinical situation.	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.
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Annotations:

- “Standard work” is defined in Lean (the product improvement philosophy and methodology inspired by Toyota) as “work specified for content, sequence, timing, location and outcome” or, more simply, “the current best way to do something.
- This can apply to clinical processes that need to be done consistently and reliably – including standard and reliable approaches to patient- centered tailoring of care. This allows for keeping a balance of standardization and flexibility to learn from experience.

Parameter 10. Level of leadership/ad ministrative alignment and priorities <i>Inspired by Schein (2004), Collins (1996)</i>	Misaligned <i>(Not acceptable—shown here only for context)</i> Integrated behavioral health care is one among several strategic initiatives, but practical conflicts with other organizational priorities, resource allocation, incentives, and habits are apparent. Such tensions may or may not be articulated openly.	Partially aligned Some alignment achieved but with constructive ongoing work to bring to the surface and resolve unresolved tensions between purposes, incentives, habits, and standards.	Fully aligned Constructive balance achieved between priorities, incentives, and standards. Integrated behavioral health functions are fully designed into priorities and incentives. Emerging conflicts are routinely addressed and respected as part of what the organization does to improve.
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Annotation:

Leadership/administrative alignment refers to the degree that espoused organizational directions and initiatives in integrated behavioral health are supported by corresponding adjustments to other priorities, resource allocations, incentives, and habits. It is an empirical question whether practices with high degrees of leadership/administrative alignment get better outcomes than those who are misaligned to some degree.

Parameter 11. Level of business model support for integrated behavioral health	Behavioral 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. If these functions are maintained, it is by diverting resources not designated for these purposes or through unsustainable funding such as grants or gifts.	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. No diversion of funds marked for other purposes nor unsustainable sources of funding are required.
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Annotations:

- “Business model” refers to an ongoing financial arrangement (with those who pay the practice) and allocation of resources within the practice that support the services rendered and other costs of the practice, including financial reserve. A business model is not strictly limited to each service paying for itself independently (price per widget). A business model can choose to “balance the books” not only at the level of specific services but at higher, more global levels that provide financial support for services that are not paid as individual transactions.
- Examples of payment or non-payment revenue that might be included in some mix in a business model:
 - Traditional fee-for-service (and new codes and provider types)
 - Bundled care management fees, capitation-type arrangement, or other bundled payment
 - Self-pay—consumer payment without insurance
 - Pay-for-performance, outcomes, or quality bonuses
 - “Gain-sharing” contracts that reward for saving needless hospital, referral, and other costs beyond the clinic such as in an “accountable care organization” model
 - Global payments such as “baskets of care”, perhaps as part of a larger “accountable care” arrangement
 - Philanthropic grants or charitable support; investment, royalty, research, or consulting income

Parameter 12. Scale of practice data collected and used (On at least the integrated medical/ behavioral health aspect of the practice)	Minimum: (less than 40% of patients) <i>(A startup state only—not a desired final state)</i> A system for collecting and using practice data from a limited number of patients or situations—to improve quality and effectiveness (of integrated behavioral health), especially at the individual patient level	Partial: (40%-75% of patients) <i>(An interim state, not a desired final state)</i> Significant but less than full collection and use of practice-based data for decision-making—to improve quality, effectiveness, and reporting at the system or unit level	Full /standard work: (76% -100% of patients) Routine data collection on most patients with integrated behavioral health—with internal reporting of “triple aim” outcomes and their use in decision-making to improve effectiveness at the system, unit, or community /population level
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Annotations:

- *This parameter is for practice-based data used to improve the quality and effectiveness of integrated behavioral health even though the ability to collect and use practice-based data is important everywhere in the practice. This parameter does not distinguish pilot experiments, larger projects, and full-scale, mainstream implementations. An auxiliary parameter, “breadth of outcomes expected depending on program scale or maturity,” appears in Appendix 1. Naturally, pilots, larger projects, and mainstream implementations collect data on far different scales that are appropriate to their stage of development or diffusion into the larger health system. Many collaborative care initiatives start small and grow into larger projects and then into full-scale innovations that re expected to have an impact on a meaningful scale. But it is not realistic to expect broad-based, full-scale outcomes from pilot projects or even projects somewhat larger than pilots.*
- *Representative patient samples* such as in the “minimum” column may be appropriate for research and outcomes reporting, but for monitoring each case and adjusting treatment accordingly, the practice needs to collect and use some treatment data on each patient.
- *“Standard work” is scaled at 76%-100% because 100% may not be attainable* given patients moving their care from place to place or going in and out of the clinic panel or insurance pool. Setting this range to include less than 100% does not imply that doing only three-quarters of the job is OK.
- *The use of financial and claims data not generated by the practice is important*, although not all practices can or are likely to gather claims data—having to seek it from health plans or others.
- *A clinic must be flexible and willing to change in response to data.* There will likely be differing perspectives on what if anything to do differently, and such conflict can be used to energize dialogue on quality improvement in the clinic.

Auxiliary Parameters

Auxiliary parameters are not a standard part of this lexicon but may have specialized applications and hence are presented in this appendix. For example “target population,” “program scale,” and “degree that program is targeted” may be useful in research or descriptive studies of the kinds of integrated behavioral health taking place across the country. Auxiliary parameters were created in earlier versions of this lexicon but are not felt to be central to the current version.

Target subpopulations for integrated behavioral health	A. Locus of care	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 High risk and often high stress for clinics	Mental health or substance abuse conditions Patients with one or more typical mental health or substance abuse conditions; family, partner, and relationship problems affecting health	Stress-linked physical symptoms Patients with stress-linked or “psycho-physiological” symptoms, e.g., headache, fatigue, insomnia, other	Medical conditions Patients with one or more medical diseases or conditions, e.g., diabetes, asthma, cardiovascular disease, lung disease	Complex cases Complex blend of symptoms, problems, conditions, diseases, personal situations, social determinants of health	
D. Type of situations targeted	No contact Patients with no presenting problems or no contact with health system, even for prevention	Diseases, conditions	Prevention, wellness	Acute life stress Unsafe environment, social risks, isolation, financial, other	Culture, race, ethnicity, language, or other special populations linked to disparities	High risk and/or high cost cases	

Annotations:

- A, B, C, and D are separate sub-parameters listed as independent rows to be read horizontally only.
- The target population for integration of behavioral health in a primary care setting is all the patients in the clinic panel whose clinical situations call for a blend of behavioral health and medical care. But a particular clinic might choose to focus on one or more particular subpopulations that they define for practical or strategic reasons or because of a particular panel's characteristics.
- Examples shown in this auxiliary parameter do not address all target subpopulations that a health system might identify for any reason. There is almost no limit to how a clinic could subdivide its population or prioritize efforts to integrate behavioral health care.
- Common physical symptoms not caused by medical disease, when pronounced and persistent, are often called "somatization" (stress reactions translating into bodily complaints).
- Target subpopulations could also include rural, urban, border, frontier, those with limited English proficiency, BGLT or any other segment chosen for specific reasons.

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

Sufficiency of care plans in place Contain essential elements in clause 3D when relevant to the patient's situation	Insufficient: missing essential elements <i>(Not acceptable—described here only for context)</i> Typical care plans are missing many essential elements required for the particular patient and situation.	Sufficient: Care plans typically contain all or most essential elements relevant to the particular patient and situation
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Level of systematic follow up A and B are alternate ways to scale this.	A. Proportion of follow-up elements typically present	Minimal <i>(not acceptable)</i> Follow-up typically involves at least half of the elements listed in clause 3F <i>when required</i> for the clinical situation	Partial Follow-up typically involves more than half, but less than all the elements listed in clause 3F required for the situation	Full Follow-up typically involves all elements listed in clause 3F required for the clinical situation
	B. Proportion of patients in target groups for integrated behavioral health experiencing these follow-up elements if needed	Minimal: Fewer than 50% <i>(not acceptable)</i> Patients actually experiencing the follow-up elements in clause 3F: <ul style="list-style-type: none"> • Use of population-based registry for systematic follow up. • Outreach to patients who do not follow up. Regular monitoring of treatment response, side effects and how the treatments are fitting the patient's life, goals, and priorities. • Adjust care plan quickly for patients who are not improving, whose care doesn't fit their goals or life, who are not responding to initial treatments, or who are experiencing troublesome treatment side effects/complications or other adverse events. Revise the plan or move it to a more intensive level. • Establish and support relapse prevention plans when patients are substantially improved. 	Partial: 50-75% <i>(significant but incomplete)</i>	Full: 51-100% <i>(Follow-up elements for nearly 100%--"standard work")</i>

Annotation:

The level of follow-up is tailored to the level of need, which is determined by patient and health care professionals. The simplest clinical situations may not require all these elements of follow-up. This parameter is geared toward clinical situations that require collaborative care and systematic follow-up.

Breadth of outcomes expected depending on program scale or maturity <i>From Davis, 2001</i>	Pilot scale Limited expectations for a limited set of outcomes for a limited group of patients: A "pilot" is a demonstration of feasibility or starter "test of change" with limited number of patients or clinical scope	Project scale Significant, but not full-scale, outcomes expected: Multiple promising pilots gathered together with a larger, but still not full scale, population but led visibly as a project aiming toward the mainstream.	Full-scale Full-scale and broad-based outcomes expected: Full scale way of life in the organization for the entire population of patients—the way things are done, no longer a project attached to the mainstream that hasn't changed
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Annotation:

This parameter recognizes that many collaborative care initiatives start small and grow into larger projects and then into full-scale innovations that are expected to have an impact on a meaningful scale. But it is not realistic to expect broad-based, full-scale outcomes from pilot projects or even those somewhat larger. Expectation for broad and full-scale outcomes is associated with full-scale programs, not pilots. This parameter also recognizes that, especially in primary care, collaborative care pilot projects are not always for narrowly defined populations such as one medical or mental health condition.

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Appendix 1. The Need for Consistent Concepts, Definitions, and Lexicons in New Fields *Adapted from Peek (2011)*

Why include lexicon/conceptual/definitional work as part of forming practice development or research agendas in areas such as integration of behavioral health and primary care? Questions about terms often come early in conversations intended to create research or practice-development agendas for emerging health care fields. For example:

“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 implementing them or investigating their effects? Do we have a shared view of the edges of the concept 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 will confuse practices and funding organizations.. .” (Peek, 2011)

Clearer and more consistent concepts and definition for a field are needed when:

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 a genuine example of it” for describing to the public, setting expectations, assigning insurance benefits, certifications, or saying how something is different than “usual.”
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 within these components?”
4. Researchers want to ask quality or research questions more consistently and clearly—especially in geographically distributed research or quality improvement networks.
5. There is a felt need to improve the consistency or reputation of an area with “outsiders,” e.g., policymakers, legislators, funders, and others not internal to the field.
6. When your field is being distorted or misunderstood by the public or subset—when practitioners themselves are inconsistent in the way they present the field to the outside world.

“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. These lexicons are developed for practical reasons of communication among professionals doing the real work of science and practice.

Systematically related concepts have an esteemed place in the history of mature fields that we now take for granted, e.g., electrical engineering, physics, and software development. Conceptual development in these fields has enabled them to become mature sciences or technologies with associated empirical triumphs. In many cases the 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 empirical achievements.

But it takes a generally understood system of concepts and distinctions to do good science. . .”

From Peek (2011); inspired by Bergner, R. (2006). An Open Letter From Isaac Newton to the Field of Psychology. *Advances in Descriptive Psychology*, Vol. 8. Descriptive Psychology Press, Ann Arbor MI.

Lexicon/conceptual development aimed at creating consistently understood practice development or research questions has been used in emerging health care fields such as integration of behavioral health and primary care (Peek, 2011), palliative care (Peek & ICSI, 2012), shared decision-making (MSDMC, ICSI & UM, 2012), and patient-centered medical home (Peek & Oftedahl, 2010). The methodology employed is paradigm case formulation and parametric analysis (Ossorio, 2006).

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Appendix 2. The Method for Creating a Consensus Operational Definition: Paradigm Case Formulation and Parametric Analysis

Adapted from Peek (2011)

Consensus. An operational 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.

Definition. Fortunately, methods for defining complex subject matters that meet the requirements exist in the published literature (Ossorio, 2006). 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.

Requirements: A method for creating an operational definition with standing in the field would:

- Be consensual but analytic (a disciplined transparent process—not a political campaign).
- Involve actual implementers and users (“native speakers” of the integrated behavioral health language).
- Focus on what functionalities look like in practice (not just on principles, values, or visible ‘anatomical features’).
- Specify acceptable variations around the required pattern—so it is not a rigid prescription.
- Be amenable to gathering around it an expanding circle of “owners” and contributors (not just an elite group coming up with a declaration).

Peek (2011)

Other applications of this methodology include palliative care in practice (Peek & ICSI, 2012), health care home in action (Peek & Ofstedahl, 2010) and shared patient-clinician decision-making (MSDMC, ICSI & UM, 2012).

The consensus process is facilitated in two stages. 1) A core group draft done in this case by four people, followed by 2) a “second ring” review/contributor group in this case of nineteen people. In each stage, the product contains parts A-C—progressively refined until good enough to use:

- 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.*
- Introduce **alternatives** of this paradigm case.* The purpose of *alternatives* 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 alternatives, when taken together is our “definition” of behavioral health integrated in primary care.
- Define **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.

Process and facilitation specifics for this group consensus process were devised by C.J. Peek and are beyond the scope of this report. For more information, contact cjpeek@umn.edu.

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Appendix 3. Terms Commonly Used in the Field of Behavioral Health and Primary Care Integration

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About Mental Health, Substance Abuse and Behavioral Health

Mental Health Care. Broad array of services and treatments to help people with mental illnesses and those at particular risk of developing them—to suffer less emotional pain and disability and live healthier, longer, more productive lives. Although often defined separately, substance abuse services sometimes are regarded as part of “mental health care. May be done by a variety of caregivers in diverse public and private settings such as:

- *Specialty mental health sector:* mental health professionals trained specifically to treat people with mental disorders and substance use conditions in public or private practices, psychiatric units, general hospitals, school-based mental health clinics, or other treatment centers
- *General medical sector:* Healthcare professionals such as physicians and other providers in clinics, hospitals, nursing homes.
- *Human services sector:* Social services, school-based counseling and referral, residential rehab, vocational rehab, criminal justice/prison-based services, religious professional counselors.
- *Voluntary support network sector:* Self-help groups such as 12-step programs, peer counselors, and networks, including online self-help communities.

Health workers such as *promotoras*, community health workers, and health aides may be part of the workforce in any of these sectors. (Adapted from SAMHSA)

Chemical Dependency/Substance Abuse Care. Services, treatments, and supports to help people with addictions and substance abuse problems of all kinds suffer less emotional pain, family and vocational disturbance, and physical risks and live healthier, longer, more productive lives. Sometimes included under “mental health care”. Settings include:

- Specialty addictions or substance abuse treatment clinics or settings
- General medical or hospital settings. These services may be integrated with general medical care and/or rely on referrals.
- Human services or community-based contexts such as schools, rehabilitation centers, criminal justice systems or religious-based counseling.
- Voluntary support networks such as 12-step programs and peer counselors.

Clinicians or counselors of different disciplines who assess and treat substance abuse and addictions may work one or more any of these care settings, e.g., a specialty substance abuse or mental health clinic, primary care clinic or other care setting. (Adapted from SAMHSA)

Behavioral Health Care. A very broad category often used as an umbrella term for care that addresses behavioral problems bearing on health, including patient activation and health behaviors, mental health conditions, substance use, and other behaviors that bear on health. In this sense, behavioral healthcare is the job of all kinds of care settings, and is done by clinicians and health coaches of various disciplines or training, including but not limited to mental health professionals. It is a competency of clinics, not only of individuals.

About Integration and Collaboration

Integrated Care. Tightly integrated, on-site teamwork with a unified care plan as a standard approach to care for designated populations. Connotes organizational integration as well, often involving social and other community services. “Altitudes” of integration (Based on SAMHSA):

- *Integrated treatment:* Interactions between clinicians to address patient needs combining interventions for mental health disorders in a primary treatment relationship or service setting.
- *Integrated program:* An organizational structure that ensures staff and linkages with other programs to address all patient needs.

- *Integrated system:* An organizational structure that supports an array of programs for individuals with different needs through funding, credentialing, licensing, data collection/reporting, needs assessment, planning, and other operational functions.
- *Integrated payment:* A payment structure that facilitates and incentivizes close collaboration between team members, care management, and care coordination, and achievement of patient-centered, effective care/outcomes.

Integrated Primary Care. Combines medical and behavioral health services for the spectrum of problems that patients bring to primary medical care. Because many patients in primary care have a physical ailment affected by stress, problems maintaining healthy lifestyles or a mental health or substance use disorder, it is clinically effective to make behavioral health providers part of primary care (and likely cost-effective, too). Patients can feel that for any problem they bring, they have come to the right place—that there is “no wrong door” for entry, including with their familiar medical providers. Teamwork of mental health and medical providers is an embodiment of a more integrated, less fragmented care model and reunifies in practice the separate worlds of medical and mental health treatment. (Adapted from Blount—Certificate program)

The same or similar concept is “Primary Care Behavioral Health” (PCBH), in which the behavioral health provider is a consultant (“Behavioral Health Consultant”) to primary care colleagues (Robinson & Reiter, 2007; Sabin JE & Borus JF; 2009; Haas deGruy, 2004; Hunter et al, 2009). The reasons and approach are similar to that described above in “Integrated Primary Care”.

Collaborative Care. A general term describing ongoing relationships between clinicians over time (Doherty, McDaniel, & Baird, 1996) rather than a specific product or service to patients. This is not a fixed model, but a larger construct of various components which can be combined. (Craven and Bland, 2006). Collaboration denotes going beyond synchronizing independent care from independent providers. For example, multiple providers, with their patients, combine perspectives to understand and identify the problems, opportunities, and treatments, often within an ongoing relationship with each other and with patients to continually revise the treatment as needed to hit treatment goals, e.g., the collaborative care of depression among primary care providers, care coordinators, and consulting psychiatrists (Unützer et al, 2002).

Behavioral Medicine. “Behavioral Medicine is the interdisciplinary field concerned with the development and integration of behavioral, psychosocial, and biomedical science knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation” (Society for Behavioral Medicine). This term identifies a field of practice and research, but not a kind of setting such as primary care, a particular role such as “primary care behavioral health” or a kind of relationship such as “collaborative care”. As with other terms, local connotations vary.

About Forms of Collaborative Activity

Co-located Care. Behavioral health - and primary care providers (i.e., physicians, nurse practitioners) delivering care in same practice. This denotes working in shared space to one extent or another, not a specific service or kind of collaboration. This may be regarded as a step forward for clinicians who have been separated from each other by distance, or in other situations something to go beyond to achieve increasingly shared workflows, culture, and levels of collaboration. (Updated from Blount, 2003)

Shared Care. Predominately Canadian usage—primary care and mental health (typically psychiatrists) professionals working together in a shared system, maintaining one treatment plan addressing all patients' health needs in a shared medical record. (Kates et al, 1996; Kelly et al, 2011)

Consultation/Liaison. Activities of psychiatry, psychology, or nursing that specialize in the interface between medicine and mental health, usually in a hospital or medical setting. This role has two parts:

- *Consultation:* To see patients in medical settings by request of medical clinicians as a consult", or regular consultation to medical clinicians or care coordinators in clinics to help medical clinics manage their patient panels better, especially those with mental health conditions.
- *Liaison:* An ongoing relationship in which the consultant gets to know the culture, types of patients, and clinical challenges faced by providers and provide effective programmatic or 'curbside' consultation and advice that goes beyond or does not require a formal consultation on a specific patient.

Example: consultation-liaison to transplant programs. The consultation part includes seeing specific patients for consultation. The liaison part covers things like sitting on the transplant review committee and advising the team on policies such as what to do with clinical challenges related to mental health/substance use or how to build clinical workflows that help address these needs effectively.

About Patient-centered Medical Home and Patient-centered Care

Patient-centered Medical Home (PCMH). "An approach to comprehensive primary care for children, youth and adults—a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family". PCMH is shorthand for primary care delivery that emphasizes care of populations as well as individuals, team care—including patient and family engagement in care, whole person care (patient-centered)—including behavioral health—the information tools needed, and a business model to support this work. The goal is health and quality care, improved patient experience, and better use of healthcare resources. (Joint Principles of PCMH, 2007).

Variations on this have been suggested for specific populations or purposes such as "family centered medical home" that emphasize parent and family involvement in child health; "person centered health care home" (Mauer 2009) emphasizing behavioral health in primary care and primary care in specialty mental health settings; or "health care home" and "advanced primary care" as alternate terms.

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 though mottos such as "care as seen through the patient's eyes", or "nothing about me without me". (Berwick, 2011). Realizing the full potential of patient-centeredness requires both patient and provider behavior. (Peek, 2010):

- *Patient-centered provider behaviors:* Patient-centered operations (access, hours, schedules, office processes, records available 24x7, asynchronous communication) institutional rules and policies that are comforting rather than "what if" based; whole person centered concepts of health, illness and care; attention to values and preferences in cultural & family context. (Berwick 2011)
- *Engaged patient behaviors:* "Actions individuals must take to obtain the greatest benefit from the health care services available to them". Domains include 1) find safe, decent care; 2) communicate with healthcare professionals; 3) organize your healthcare; 4) pay for healthcare; 5) make good treatment decisions; 6) participate in treatment; 7) promote your health; 8) get

preventive healthcare; 9) plan for the end of life; and 10) seek personalized health knowledge. (Gruman et al 2009; Center for Advancing Health, 2010).

About Care Coordination and Care Management

Care Coordination. “The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate appropriate delivery of healthcare services. Organizing care involves marshalling personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.”

Care coordination is especially needed when: 1) numerous participants are typically involved in care coordination; 2) participants are dependent on each other to carry out disparate activities in a patient's care; 3) each participant needs adequate knowledge about their own and others' roles and available resources; 4) participants rely on exchange of information.

Components of care coordination: 1) Assess patient for likely coordination challenges, 2) develop plan for coordination challenges and organize care plans, 3) identify participants in care and specify roles, 4) communicate to patients and all other participants and across all care interfaces, 4) implement the coordination interventions, 5) monitor and adjust for coordination failures, monitor outcomes and identify coordination problems that affect outcomes. (AHRQ 2007)

Care Management. “Care management is a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aims of improving patients' functional health status, enhancing the coordination of care, eliminating the duplication of services, and reducing the need for expensive medical services.” (Bodenheimer and Berry-Millett (2009). Other definitions (Mechanic, 2004) emphasize application of systems, science, incentives, and information to improve medical practice and assist consumer engagement in managing medical/social/mental health conditions. Care coordination is one part of care management.

Case Management. This concept is similar to “care management” though it may imply a personified “case manager”, whereas “care management” is a function or capability of the practice whether done by a particular person or not. “Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes”. “The underlying premise...is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources.”

Case management is a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source. . .” (Case Management Society of America)

Illustration: A family tree of related terms used in behavioral health and primary care integration

See glossary for details and additional definitions

Integrated Care

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

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, to 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).

Shared Care

Predominately 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)

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 skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

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)

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 PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

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.

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).

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, human services, and voluntary support networks. (Adapted from SAMHSA)

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)

Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

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