Executive Summary

Lexicon for Behavioral Health and Primary Care Integration

Concepts and Definitions Developed by Expert Consensus

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Executive Summary

Lexicon for Behavioral Health and Primary Care Integration

Concepts and Definitions Developed by Expert Consensus

Prepared for:
Agency for Healthcare Research and Quality
540 Gaither Rd.
Rockville, MD 20850

AHRQ Grant No. 1R13HS021053-01.

Prepared by:
C.J. Peek, Ph.D., University of Minnesota
and
The National Integration Academy Council

This **Executive Summary** is excerpted from **Lexicon for Behavioral Health and Primary Care Integration** (http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf), which updates *A Collaborative Care Lexicon for Asking Practice and Research Development Questions,* in *A National Agenda for Research in Collaborative Care*, Agency for Healthcare Research and Quality, July 2011. http://www.ahrq.gov/research/findings/final-reports/collaborativecare/

AHRQ Publication No. AHRQ 13-IP001-1-EF
April 2013

Suggested Citation

Peek CJ and the National Integration Academy Council. *Executive Summary*--Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-1-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon_ExecSummary.pdf

Creators of the Lexicon for Behavioral Health and Primary Care Integration*

Macaran Baird MD, MS	University of Minnesota
Alexander Blount, EdD	University of Massachusetts
Ned Calonge, MD, MPH	The Colorado Trust
Teresa Chapa, PhD, MPA	U.S. Dept. of Health & Human Services; Office of Minority Health
Deborah Cohen, PhD***	Oregon Health & Science University
Dave deBronkart	Patient representative; speaker and advocate
Frank deGruy, III, MD, MSFM	University of Colorado
Barbara Degnan**	Patient representative; Minnesota health care groups
Rita Havercamp, MSN, CNS**	Kaiser Permanente
Roger Kathol, MD, CPE	Cartesian Solutions Inc.
Parinda Khatri, PhD	Cherokee Health System
Neil Korsen, MD, MSc	MaineHealth
Stephen Melek, FSA, MAAA	Milliman
Benjamin Miller, PsyD***	University of Colorado
Garrett Moran, PhD***	Westat
Charlotte Mullican, MPH****	Agency for Healthcare Research and Quality (AHRQ)
Gary Oftedahl, MD**	Institute for Clinical Systems Improvement (ICSI)
Steven Waldren, MD, MS	American Academy of Family Physicians (AAFP)
Jürgen Unützer, MD, MA, MPH	University of Washington
C.J. Peek, PhD*(process leader and first author)*	University of Minnesota

*All creators are members of the AHRQ National Integration Academy Council (NIAC) with the following exceptions: ** indicates a consulting expert; *** indicates Academy staff, and **** indicates the Federal task order officer.

*Members of the 2009 AHRQ Collaborative Care Research Development Conference Committee Who Authored the Original Article on the Lexicon: A Collaborative Care Lexicon for Asking Practice and Research Development Questions (*In: *A National Agenda for Research in Collaborative Care, Peek, 2011.)*

C.J. Peek, PhD	University of Minnesota *(process leader and first author)*
Benjamin Miller, PsyD	University of Colorado
Gene Kallenberg, MD	University of California San Diego
Rodger Kessler, PhD	University of Vermont

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.

Charlotte A. Mullican, MPH, Senior Advisor for Mental Health Research
Center for Primary Care, Prevention, and Clinical Partnerships
Agency for Healthcare Research and Quality

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.

Contents

This page intentionally left blank.

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 *What integrated behavioral health needs to look like in action*	**Corresponding Parameters** *Calibrated acceptable differences between practices*
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** • 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** • 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** • 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** • 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** • 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** • 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** *(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

5A. Protocols in place or not for engaging patients in integrated care	**Protocols not in place** (*Not acceptable—described here only for context)* 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%** (*Not acceptable*)	**Protocols followed more than 50% but less than 100%** *(an interim state)* 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%** *(Not acceptable*) 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"

6B. Degree that care plans are implemented and followed	**Less than 50%.** (*Not acceptable)* Care plans implemented and followed for less than 50% of patients.	**More than 50%, less than 100%** *(An interim state, not final state)* 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".

7. Level of systematic follow up* (Percent of patients in the practice population or target sub-population)	**Less than 40 %** *(Not acceptable—shown here only for context)*	**40% to 75%** Significant but incomplete follow-up being done	**76% to 100%** Goal is 100%--"standard work"
*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** *(Not acceptable—shown here for context)* 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** *(Not acceptable—shown here only for context)* 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 *Inspired by Schein (2004), Collins (1996)*	**Misaligned** *(Not acceptable—shown here only for context)* 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)** *(A startup state only—not a desired final state)* 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)** **(***An interim state, not a desired final state)* 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

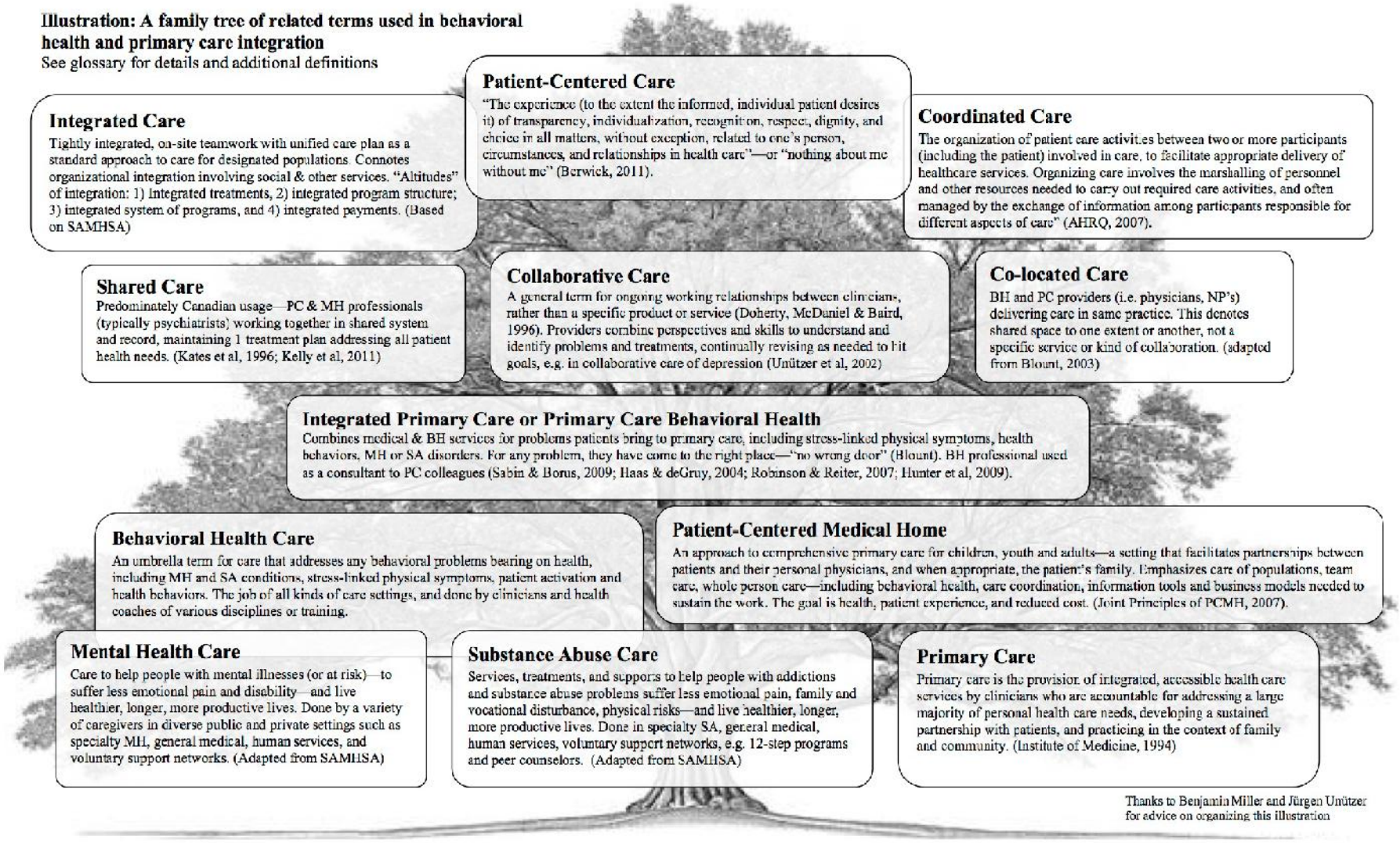
These may be useful for specific purposes, though not considered central to the full lexicon.

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** 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.	**Non-targeted** 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** 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

Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions



From: Peek CJ and the National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration:* AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf