Journey Toward a Lexicon

The 2013 *Lexicon for Behavioral Health and Primary Care Integration* evolved from 4 years of work across two groups supported by AHRQ small conference grants and many individuals along the way. The lexicon, like language in any community, will no doubt continue to evolve as the field of integrated behavioral health develops and spreads.

Why Have a Lexicon?

A shared lexicon is not so important at a stage when people are concerned primarily with getting their *own* projects up and running by themselves—because local vocabulary assures people, "We all know what we mean *here* by [fill in the blank]." On the other hand, a *shared* lexicon becomes important when people try to collaborate across different geographical, practice, intellectual, disciplinary, or agency traditions.

For example, the subject matter called "integrated behavioral health" also goes by "collaborative care," "mental health integration," "integrated care," "shared care," "co-located care," "primary care behavioral health," "integrated primary care," and other terms. Each encompasses a similar core of subject matter, but in local "dialect" that is not always clear across participants.

When conversation turns to integrated behavioral health, it is not uncommon to hear someone say, "Integrated behavioral health—*we already do that,*" followed by an example such as having a referral relationship in place. Then someone else in the group says, "*I wouldn't count that as integrated behavioral health,*" and the discussion becomes side-tracked and personalized for lack of shared concepts for "What is integrated behavioral health?"

The purpose of a shared lexicon is to have more productive and less distracting conversations as the field grows—by aggregating experience across settings, asking evaluation questions across practices, and engaging policymakers and business modelers. To go mainstream, integrated behavioral health must not only show its effectiveness empirically, but must become consistently and widely understood in language and practice by the public, policymakers, researchers, and practitioners. That's the reason to build a shared lexicon—to facilitate collaboration across the many persons, groups and distinctive "dialects" in use across the field.

A Preliminary Lexicon in 2009

The original version of this lexicon emerged through a 2009 AHRQ small conference grant to the University of Colorado to develop a national research agenda for integrated behavioral health—tapping the wisdom of twenty research and practice experts across the country.

What did you mean by that? Throughout the planning process for that meeting, it became clear that people were struggling to find common language related to integration. For example, conference calls were slowed down by observations such as, "I'm not sure we mean the same thing by that," or "I thought I understood where you were going 5 minutes ago, but now I don't think so," and "I wonder if what I call X, you call Y and if there is any real difference." When participants brainstormed a list of potential research questions, the terms "continuum of integration," "extent of collaborative care components," and "degree of collaborative care" appeared—along with a conversation about whether these are the same, and whether anyone would know how to measure them. The following questions arose:

- "Do we have a *good enough* shared vocabulary for asking **consistently understood research questions** across many practices?
- Do we mean similar enough things by the words we use or how we distinguish one form of practice from another to investigate their effects?
- Do we have a shared view of the edges of the concepts we are investigating—the boundaries of integrated behavioral health or the scope of this 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. These communication gaps will confuse our network practices and our funding organizations.

A lexicon for that *conference.* The initial lexicon was developed by a subgroup of the 2009 conference participants to answer those specific questions—but only for purposes of that meeting. That lexicon was considered very helpful for carrying out that task and a promising idea to develop further.

Collecting Lexicon Suggestions, Questions, and Applications from 2010 to 2011

Conference participants in 2009 agreed that a lexicon would be an important advancement for the field, but that it would need to be broadened and deepened beyond this "first ring" of contributors—with more views from more stakeholders—patients and policymakers as well as clinician leaders and researchers. Other contributions emerged from a lexicon presentation at a Collaborative Family Healthcare Association meeting 3 weeks later, followed in 2010 and 2011 by many other informal suggestions. All these were saved for later consideration. The AHRQ report, *National Agenda for Collaborative Care*, that Miller, Kessler, Peek, and Kallenberg released in 2011 described in detail how the preliminary lexicon was used to complete the task of creating a research agenda, how lexicons are used in other emerging scientific fields, and the consensus methods employed.

Broadening and Deepening the Lexicon in 2012

A working lexicon that would have standing in the field would have to be created by an expanded circle of "native speakers" in the field using consensus methods. In 2012, AHRQ awarded a second small conference grant to support a "second ring" of contributors to systematically broaden and deepen the lexicon, making it more responsive to a wider range of stakeholders.

The initial lexicon, plus questions and suggestions saved and gathered since 2009, formed a starting point for this second ring—20 members of the AHRQ National Integration Academy Council and an additional patient representative and care manager clinician. Systematic methods for creating consensus definitions in complex subject matters were employed in the lexicon meeting itself and in several months of email and phone exchanges as the contents were agreed on as good enough to use now, knowing that the lexicon will evolve over time. (Peek and the National Integration Academy Council, 2013.)

Applying and Evolving the Lexicon in 2013 and Beyond

As stated at the outset, the lexicon is intended to meet the practical needs of members of this field trying to work together across geographic, disciplinary, agency, or other boundaries. The 2013 lexicon is not intended to restrict innovation or freeze the field and its language in its present state. As with lexicons for other emerging fields in the history of science, this lexicon is a living document designed to evolve with the field. The 2013 lexicon is something tangible to use *now* and evolve *from*. The creators and other contributors regard themselves as fortunate to have had AHRQ support for this effort over these years.

Goals for 2013 and beyond: The first goal for 2013 and beyond is to apply the lexicon to improve the clarity of stakeholder conversations—especially those concerning research, measurement, practice

development, and aggregating lessons learned across settings. This will help gradually collect the wisdom of those "native speakers" regarding fundamental concepts of the field—so that another lexicon iteration (in effect, a "third ring" at some time in the future) can help move the field along on its journey toward good enough shared language.

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