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RESEARCH ARTICLE

INCORPORATING BEHAVIORAL HEALTH SERVICES INTO PRIMARY CARE PROGRAMS: A REVIEW STUDY

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ABSTRACT

Behavioral health problems are common and have a great impact on the patients. Therefore, delivering the services behavioral health within the main care setting improves access for caring produces improved patient outcomes. This study aimed at studying the followed methods to incorporate behavioral health services into primary care programs in order to build a base for any contributions for innovative models and methods to incorporate behavioral health services into primary care programs. In this study the Primary Care Behavioral Health (PCBH), IMPACT model, Three-component model, Reverse integration and Telemedicine models were reviewed.

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INTRODUCTION

The problems of Behavioral health are significantly, common and affect patients' quality of life and health. Even though most dealing with general mental disorders is given in main concern, there are important opportunities for development in both outcomes and processes (Lewis *et al*., 2014; Unützer & Park, 2012). For instance, as few as twenty percent of patients treated in "general" primary care demonstrate substantial clinical development (Unützer *et al*., 2002).Unluckily, basically referring patients for the mental health expert as well is not effectual for achieving improved outcomes or better access (Grembowski *et al*., 2002). Delivering the services behavioral health within the main care setting improves access for caring, produces improved patient outcomes (Archer *et al*., 2012), decreases health care expenses (Unützer *et al*., 2008), and possibly improve the patient's care experience (Grembowski *et al*., 2002).High-risk populations, particularly, for example those served through safety net clinics, can benefit from programs up to address both behavioral health and physical health needs. The literature is wealthy with information of primary care as well as behavioral health integration, particularly as it is relating to despair.

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There are wide-ranging reviews of the randomized controlled trials (RCTs), emerging practices and model programs, as well as financial implications, detailed program descriptions and lessons learned. As well, a lot has been written about the need for adequate payment, the integrated models cost, and the significance of eliminating the silo advance to services when behavioral health is imprinted out of the health care services within most health tactics. "How-To" guides have been expanded to illustrate how to apply an integrated program within a primary care practice, moreover websites and books are dedicated for the topic. A number of foundations have financed projects associated with integrated behavioral health (Dall, 2011). In this study, the followed methods to incorporate behavioral health services into primary care programs will be reviewed by selecting the main studies that were an addition to this subject. This study aims also at finding a base for any further studies to come up with innovative models and methods to incorporate behavioral health services into primary care programs.

Levels of Integration

The description of "integrated care" differs significantly, conditional on who is describing it. On one continuum end, some believe integration for referring simply to ornamental the connection between behavioral and physical health providers in order that the patient receives extra comprehensive services.

Others suppose that integrated care only has been accomplished as behavioral and physical health suppliers work together like a team for developing a combined patient care strategy. The Evidence Report/Technology Assessment (AHRQ) (Butler *et al*., 2008) illustrates the variety of integrated care definitions:

- Integrated care "illustrates care in that there is single treatment plan with medical and behavioral elements quite than a couple treatment plans. This is delivered through a team which works together extremely closely or through pre-arranged protocol".
- "Integration occurs as the provider of mental health is considered an ordinary division of the health care team".
- Integrated services "have behavioral and medical health components in one treatment plan to a population of patients or specific patient.
- "Integration is described by a great degree of teamwork among the a diversity of health qualifies serving patients in order to assessment, outcome evaluation, treatment Planning and treatment implementation ".

One of the mainly detailed the continuum of integration descriptions describes 3care levels: integrated, coordinated, and co-located (Collins *et al*., 2010) (see Figure 1). Among coordinated care, the PCP screens to the behavioral health problems as well as develops a recommendation relationship between behavioral health and primary care, that may be situated off or on- site. Among co-located care, behavioral and medical health services are situated in the identical facility moreover enhance communication is taking place among the providers. Within integrated care there is 1 treatment plan to the individual which includes both behavioral and medical components. Teams of care are organized about meeting the behavioral and physical person health needs (Collins *et al*., 2010).

Behavioral Health services integration models into Primary Care

Primary Care Behavioral Health (PCBH)

Reiter, Dobmeyer and Hunter (2017) present the PCBH model detailed overview. Incorporated is a brief operational zed description of the model, extended from assessment of the multiple published resources in addition to consultation among nationally recognized PCBH model specialists. The present study also give a detailed explanation of a key PCBH model mechanisms under the structure of the contraction GATHER, wherever “G” is to “Generalist approach,” “A” is to “Accessibility,” “T” is to “Team-based,” “H” is to “High productivity,” “E” is to “Educator,” in addition to “R” is to “Routine.” Every component is extra fleshed out among clinical examples and clinical strategies in line through core component in addition to the rationale to those strategies. We make a exacting point of illumination the model population health basis. Finally, we as well provide a short comparison for the PCBH model for additional integration approaches as well as a focused abstract of PCBH model study. Hunter *et al*. (2017) tackle the science following the model within the 2nd article. They offer a qualitative evaluation of the published PCBH model research going on patient (functioning, symptoms, satisfaction) and implementation (appropriateness, acceptability, cost, adoption, penetration, feasibility, sustainability, fidelity) outcomes. A review of twenty nine studies with exclusive samples is incorporated within the analysis. Research gaps are recognized and ways for addressing those gaps during multiple levels for research participation as well as patients, academic researchers, practitioners, and healthcare systems are discussed. Runyan, Carter-Henry, and Ogbeide (2017) employ the complex ethics topic. They highlight contradictory ethical principles in addition to guidelines occurring among PCBH model inter expert collaboration. They analysis the existing literature across identify gaps, disciplines, as well as propose novel ethical guidelines to overpass those gaps. The present study discusses general ethical dilemmas sole for the PCBH model of the service delivery among case examples in addition to illustrate the request of the recently proposed guidelines for efficiently navigate those predicaments.

Sandoval *et al*., (2017) give a deep dive going on patient-centered care delivery strategies within the PCBH model, which can advance clinical patient, outcomes and cost, and main care provider approval with services. They talk about the importance of the behavioral health consultants (BHCs) like integral clinical path team members for maximizing pathway impact. The significance of BHC appointment for alcohol misuse, depression, obesity, persistent pain, insomnia, hypertension, in addition to social determinants of the health clinical ways are analysis. They end by a clinical pathway expansion primer.

IMPACT model

The collaborative care IMPACT model was initially conceptualized like a chronic disease management program to older adults by depression (Unutzer *et al*., 2001, 2002). This model is involving a team-based advance to managing despair from inside primary care. The care team is including a consulting psychiatrist, a trained depression care manager, and a primary care provider. The team applies a stepped-care approach for managing depression, through a 3-step evidence-based treatment algorithm utilized to direct care advancement. At every step, psychiatric consultation is measured if clinically designated; moreover, care plans are talked about through the PCP in addition to the consulting psychiatrist. Patients get routine screening for depression. The maintenance and acute depression phases are tracked through a nurse , the care manager, or psychologist who presents care management, education, in addition to psychotherapy or medication support, with ordinary telephone follow-up along a year (every week at first, and after that less frequent like depression lessens). Treatment choices include brief psychotherapy or antidepressant medication (Problem-Solving Treatment in Primary Care).

The IMPACT model has great empirical support, crosswise some of health care populations and settings. In the first grant-supported, multisite randomized test, those within the intervention collection had higher charge of the depression treatment (odds ratio [OR] = 2.98 [2.34, 3.79], $p < 0.001$) as well as experienced significantly larger odds of fifty percent reduction within depression symptoms than those within the standard care group (OR = 3.45 [2.71, 4.38], $p < 0.001$; (Unutzer *et al*., 2002). Common care patients were as well screenedto depression moreover could receive treatment for depression duringevery existing channel.

Figure 1. Collaborative Care Categorizations (Collins *et al*., 2010)

Coordinated	Co-Located	Integrated
Routine screening to the behavioral health problems carried out within primary care setting	Behavioral health services and medical services located in the identical facility	Behavioral health services and medical services located either within separate locations or within the same facility
Referral relationship among behavioral health and primary care settings	Referral process to the medical cases for being seen through behavioral specialists	One treatment plan with medical and behavioral elements
Routine switch of information among both treatment settings for bridging cultural differences	Enhanced informal communication amongthe behavioral health provider and the primary care provider because of proximity	In general a group working together for delivering care, by a prearranged protocol
Primary care provider for delivering behavioral health interventions by brief algorithms	Consultation among the medical providers and behavioral health toenlarge the skills of the two groups	Teams collected of a physician in addition to one or more of the next: nurse, physician's assistant, , case manager, nurse practitioner, behavioral health therapist, family advocate.
Connections made among the resources and patient within the community	Increase within the quality and level of behavioral health services obtainableimportant reduction of no- shows to the behavioral health treatment	applythe database for tracking the care of patients who are screened addicted to behavioral health services.

Evidence also proposed that the interference led for lesser health care is costing over a 4-year period (Unutzer *et al*., 2008).

Three-component model

A different model is the 3-component model (TCM), described by a prepared practice, care management and enhanced mental health support (Oxman *et al*., 2002). Care management within this model can be whichever localized within a practice or centralized in an organization, with a services spectrum such as limited psychotherapy and telephone calls. The care management important goals include assessment of treatment response, patient education, and communication with additional clinicians involved within a patient's care, and counseling for adherence and self-management. A psychiatrist is one more significant component— she or he provides and supervises guidelines to the care manager, provides consultation services for the PCP, plus facilitates appropriate employ of extra mental health sources. The psychiatrist as well plays a significant role in arranging a practice for implementing the model (care plans, risk assessment, and mainly providing psychiatric education concerning diagnosis) as well as providing this education ongoing reinforcement.
The (RESPECT-D) (Re-Engineering Systems for Primary Care Treatment of Depression)project was an intervention cluster randomized trial rooted in the 3-component model (Dietrich *et al*., 2004). The intervention patients had about twice the odds of achieving a fifty percent reduction within depression symptoms and remission at 3 and 6 months. The plan was supported via quality improvement and training manuals resources, relatively than research protocols as well as grant funding—potentially to make this an extra sustainable approach (Lee *et al*., 2007). The evaluation and implementation of RESPECT-D within the military setting (RESPECT-Mil) to the treatment of the service members among post- traumatic stress depression and disorder illustrated that the 3-component model was acceptable, feasible, moreover led to clinically important improvement within that context (Engel *et al*., 2008).

Reverse integration

Reverse integration models hold up getting primary health care to the patients with harsh mental illness within specialty settings of the mental health, whichever through collocated primary care coordination or care providers.

The VA system has as well been the context to a number of reverse integration models (Druss *et al*., 2001;Druss*et al*., 2010; Saxon *et al*., 2006). For example, Referral, the Primary Care Access, in addition to the Evaluation (PCARE) study is a primary care management randomized trial for patients through severe mental illness being cared for within a community center of the mental health (Druss *et al*., 2010). In the present study, nurse care managers achieved 2 major roles, the first one to encourage patients for seeking medical care to their medical conditions during motivational interviewing and patient education, the second is assisting patients through navigating and accessing the primary care system throughout addressing and advocacy system-level barriers for example lack of insurance.

At the PCARE twelve-month follow-up, the intervention patients were extensively more expected than normal care patients and to have lesser cardiovascular risk, derived from Framingham Cardiovascular Risk scores, to have established suggested preventive services (58.7 % vs. 21.8 %), to have practiced greater improvements within mental health status, derived from the SF-36 (8 % improvement vs. 1 % decline), (Druss *et al*., 2010).

Telemedicine

Circumstances can exist that stop onsite mental health services—however, innovation within the health information technology (HIT) field, particularly mobile HIT, can present new integration opportunities, particularly within rural settings wherever onsite mental health is not possible. Many telemedicine models have been put through evaluation and research (Rollman *et al*., 2009; Simon, Ludman & Rutter, 2009).

The previous models consist of antidepressant consultation among an off-site psychiatrist by video conference (Fortney *et al*., 2006), telephone care management in addition cognitive behavioral psychotherapy to patients taking antidepressant medication (Ludman, *et al*., 2007; Simon *et al*., 2009; Simon *et al*., 2004), telephone-based care management to depression during patients recovering as of coronary artery sidestep graft (Rollman *et al*., 2009). The employ of telemedicine to deliver mental health services has been well-liked during rural Australia within latest decades (Lessing & Blignault, 2001), predominantly for consultation and assessment rather than psychotherapy, through movements over time performance an increased admission to care.

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