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Integrated Treatment of Diabetes and Depression

Lessons from the Diabetes Initiative of the Robert Wood Johnson Foundation

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Outline

- Review diabetes-depression-self management
- RWJ Self Management Initiative
- Screening
- Practice models
- Summarize RWJ SM conclusions

The Challenge

- How to teach a patient to:
  - Loose weight, count carbs and calories, increase fiber, avoid saturated fats, read food labels, do ½ ~ ¾ hour aerobic and/or resistance exercise daily, quit smoking, prick their finger 1~3 times per day, take at least 3~5 medications at different times, and perhaps inject insulin
- When they have major depression *and* are:
  - poor, medically underserved, non~English speaking, and of a different cultural background

Question 1: Can self management improve diabetes outcomes?

- Programs must help patients carry out key behaviors in their daily lives
- Self efficacy is critical
- Goals must be realistic, patient-derived, and grounded in specifics
- Meta-analysis: DM SM programs improve DM outcomes

Question 2: What is the impact of depression on self management?

- Facts
  - ❑ 18-31% of diabetic patients have co-morbid depression (2x the prevalence of non diabetic population)
  - ❑ Increased symptoms of diabetes
  - ❑ Decreased physical functioning
  - ❑ Increased healthcare utilization
  - ❑ Worse glycemic control
  - ❑ Worse self management

Question 3: Can treatment for depression improve diabetes outcomes, including SM?

- Pathways study: 329 patients DM/depression randomized to usual care, or intensive case management, problem solving therapy.
- Results: Depression improved, DM did not
- Other studies have shown similar results

RWJ Self Management Initiative

- Focus on providing resources and supports for underserved patients in real world settings to engage in self management
  - Immigrants
  - Native Americans
  - Urban minority populations
- From the outset, depression posed a major barrier

Screening for Depression

- Not recommended by ADA, others
- PHQ-9 for screening
- Benefits include:
  - ~ Simplicity
  - ~ Brevity
  - ~ Validity
  - ~ English/Spanish
  - ~ Used as both a screening tool and a severity assessment

Screening Results

- Different methods of screening
  - Self administered
  - Staff-administered
    - PCP
    - RN
    - Promotora
    - MA
    - Telephone
- Prevalence of 31% (range 30-70%)

RWJ Grantees

- Empirically derived models of care
- Key elements of the models:
  - Using available resources
  - Self management and depression care need to be complementary
  - Primary care delivery
  - Emphasis on non-pharmacologic treatments
  - Cultural factors
  - Group sessions
  - Lay-health workers

Models of Care

- PCP-driven model
- Promotora-led interventions
- Culturally specific models
- Mind-body focus
- Integrated MH/DM care

Provider driven models

- Emphasize primary care-based treatment of depression
- Medical Assistants screen patients
- Medication
- Self management education provided by primary care staff
- Onsite mental health for consultation/ support for resistant cases

Promotoras

- US/Mexico border
- Peer coaches, focused on behavior change
- Common in Mexico
- More informal relationship with patient
- weekly phone contact, trouble-shooting of antidepressant medications, suicide prevention, home visits

Culturally specific treatments

- Native American health clinic
- Medication treatment from a primary care provider and/or counseling with an on-site Native American behavioral health specialist.
- The specialist incorporates Native American beliefs and traditions into his/her counseling
- Referred to "Talking Circles" group sessions facilitated by a council member based on Native American traditions to provide support to patients with health issues including depression.

Mind-body focus

- Relaxation exercises taught and practiced, and the inter-relationship of physical and psychological symptoms is emphasized.
- Physical, mental, emotional and spiritual factors honored in the counseling sessions and talking circles for Native American patients.
- Yoga sessions

Integrated mental health

- Coordinated treatment between primary care, behavioral health, and self management educator
- Solution Focused Brief Therapy alternating with diabetes self management sessions

Solution focused brief therapy

- **Structural Aspects**
  - Duration: 6 ~ 10 sessions, 30 min each
  - Charting in the medical chart
  - Collaboration between medical and psych
- **Intervention Foci**
  - Establish and nurture the patient/provider alliance
  - Guide Goals and Behavioral Activation
  - Stimulate Self-Efficacy

SFBT and Chronic Disease

- Emphasis on solutions, self efficacy and brief treatment
- Ideally suited to chronic disease~self management integrated model
- Patients work concurrently with self management specialist, behavioral health specialist, and PCP

Summary

- High rates of depression in diabetic patients in real-world, under-resourced settings
- Major barrier to effective self management
- Grantees developed integrated treatment models based on local resources, cultures, and values
- Emphasis on non-pharmacologic tx

Summary

- Treatment models emphasized:
  - Integration
  - Primary care
  - Lay health workers
  - Group sessions
  - Mind-body focus
  - Cultural factors

Conclusion

- RSSM:
  - Individualized assessment
  - Choice of treatment approaches
  - Skill enhancement
  - Collaborative goal setting
  - Follow up and support
  - Community support
  - Continuity of quality care