



Behavioral Health
Integration Initiative

Integrated Care: Behavioral Health Services and Primary Care / Diabetes

Thursday, December 17, 2020, 9:00 a.m. PT

Jennifer E. Edwards, M.D. and Lori Raney, M.D.

Introducing the Presenters

Jennifer E. Edwards M.D. (Tlingit/Tsimshian)



Dr. Jennifer Edwards (Tlingit/Tsimshian) has worked as a primary care physician for 20 years in various settings including Tribal, private practice and rural community health centers. She served in a core faculty role for family practice resident training programs. Dr. Edwards' experience includes working for Southcentral Foundation, Alaska Native Medical Center in full-spectrum family practice, with low-risk obstetrics and village travel. She currently works and serves as the Medical Director for Northern Nevada HOPES Clinic.

During Dr. Edwards experience as a primary care physician, she has developed a deep appreciation for the importance of integrating behavioral health services in primary care settings; she has found that behavioral health integration in primary care helps patients navigate the health care system more effectively and remain more engaged in improving overall health status. Dr. Edwards earned her undergraduate degree in Human Biology from Stanford University and her doctorate of medicine from the University of Washington in Seattle.

Introducing the Presenters

Lori Raney, M.D.



Dr. Lori Raney is a board-certified psychiatrist and Principal with Health Management Associates in Denver, Colorado. She is considered a leading authority on the collaborative care model and the bidirectional integration of primary care and behavioral health.

Dr. Raney served for 15 years as the medical director of a community mental health center, where she fostered the development of a full range of evidence-based services few of which include development of a telepsychiatry program, working in and deploying psychiatric providers in correctional health settings, developing an inpatient psychiatric treatment unit, etc. She has worked for over 15 years with the Indian Health Service in clinics in the Southwest. Dr. Raney continues her clinical work with the Albuquerque Area Indian Health Service with the Ute Mountain Utes in Towaco, Colorado.

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BH21 Grantees



Learner Objectives

- Describe the behavioral health conditions that co-occur with diabetes.
- Implement interventions to support health behavior change in a person with diabetes.
- Utilize integrated care interventions to address the behavioral health conditions in a person with diabetes.



Diabetes and Anxiety

- 20% higher prevalence of lifetime diagnosis of anxiety than those without DM.
- Increased in Hispanics and young adults (18–29-year-olds)
- Complicates DM Management:
 - Symptoms overlap with hypoglycemia
 - Anxiety about injections/blood draws may trigger panic symptoms.
 - Fear of hypoglycemia may lead patients to purposely keep glucose levels above target levels
 - Stress hormones contribute to glucose fluctuations.

Diabetes and Depression

- People living with diabetes (type 1 and 2) are at increased risk for depression, anxiety, and eating disorders.
- Rates of depression across the lifespan are 2–3 times greater for people with diabetes than in the general population.
- Almost 1 in 4 adults with Type 2 DM experience Depression (23% male; 34% female)
- Only 25%–50% of people are diagnosed and treated.

Diabetes Distress vs. Depression

Diabetes Distress

Symptoms are linked to diabetes and management of this disease.

- feeling overwhelmed by the demands of living with DM
- failure in following a prescribed DM routine
- feeling unsupported by friends and family
- feeling angry, scared, and/or depressed about living with DM
- feeling that long-term complications of DM are inevitable.

Depression

At least 5 of the DSM-5 criterion for MDD nearly every day during the same 2-week period.

- Depressed mood most of the day
- Reduced interest/pleasure in all/almost all activities
- Marked weight loss/gain
- Sleep disorders
- Psychomotor agitation/ retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt (excessive/inappropriate)
- Problems concentrating or indecisiveness
- Recurrent thoughts of death, SI or suicide attempt

Diabetes Distress Screening

- Diabetes Distress Scale: 17 potential problem areas that people with DM may experience.
- Degree of distress/bothered by situations “During the past month.” (rated 1–6)
- Moderate or high distress scoring associated with higher A1c— responds to addressing distress not antidepressants.

BH Conditions Make Diabetes Management Challenging

- Difficulty adhering to treatment plans
 - Medication use
 - Physical activity
 - Dietary
 - Blood sugar monitoring
 - Inconsistent f/u with providers
- Metabolic effects of antipsychotic medications
 - weight gain, increase in blood sugar and lipids
- Conflict and stress

ADA Standards of Medical Care in Diabetes- 2016/2018

PSYCHOSOCIAL ISSUES- Recommendations

- Psychosocial care should be integrated with a collaborative, patient-centered approach and provided to all people with diabetes, with the goals of optimizing health outcomes and health-related quality of life. **A**
- Psychosocial screening and follow-up may include, but are not limited to, attitudes about diabetes, expectations for medical management and outcomes, affect or mood, general and diabetes-related quality of life, available resources (financial, social, and emotional), and psychiatric history. **E**
- Providers should consider assessment for symptoms of diabetes distress, depression, anxiety, disordered eating, and cognitive capacities using patient-appropriate standardized and validated tools at the initial visit, at periodic intervals, and when there is a change in disease, treatment, or life circumstance. Including caregivers and family members in this assessment is recommended. **B**
- Consider screening older adults (aged ≥ 65 years) with diabetes for cognitive impairment and depression. **B**

BH Integration Is Not Yet the Standard of Care in Clinical Practice

According to a 2018 study that systematically evaluated the prevalence of BHI in U.S. DM Practices, less than ½ of the practices employed at least one BHP at an avg of 0.6 FTE and many did not have BH professionals accessible to their patient population internally or externally.

Barry, S. A., Harlan, D. M., Johnson, N. L., & MacGregor, K. L. (2018).

Possible Barriers to Integrated BH

- A shortage of BH providers trained to deliver lifestyle interventions tailored specifically for individuals with diabetes
- Reimbursement issues
- Patient engagement
- Provider engagement/acceptance of the integrated model of care

Integrated Care

Collaborative Care



**Informed,
Activated Patient**



***PRACTICE
SUPPORT***



**PCP supported by Behavioral Health
Care Manager**



**Measurement-based
Treat to Target**



**Psychiatric
Consultation**



**Caseload-focused
Registry review**



Training

What Can a BHP Do in a PC Setting?

Condition

- Anxiety
- Depression
- Trauma and PTSD
- Substance abuse/use disorders
- ADHD/ADD/Autism Spectrum
- Grief reactions/Bereavement
- Relationship problems
- Parenting concerns
- Stress reduction

Intervention

- Introduction and warm hand-off
- Behavioral Activation
- Problem Solving Therapy
- Solution-focused Brief Therapy
- Motivational Interviewing
- Cognitive Behavioral Therapy
- Dialectical Behavior Therapy
- Skills (distraction, deep breathing)

What Else?

- Coordinate care with specialty behavioral health/psychiatry for patients with more severe mental illness.
 - Schizophrenia, OCD, Bipolar DO, Eating Disorders, etc.
- Motivational Interviewing for change behaviors for chronic medical conditions
 - Medication compliance, dietary changes, sleep hygiene, exercise, tobacco/substance use cessation

Diabetes Treatment Strategies



How Can Behavioral Health Providers Help?

- Identify Clinical/Subclinical BH Problems/Substance Use
- Helping patient with Realistic Goal Setting
- Identifying Barriers and Solutions
- Providing Individual and Group Support
- Helping improve communication with Medical Provider

BHPs Are Experts in Behavior Change: Can Include *Health* Behavior Change



Motivational Interviewing & Patient Engagement

- Depression/Anxiety/Substance use Screening
- Realistic Goal Setting/Readiness for Change
 - “How is your current weight affecting your life right now?”
 - “What concerns do you have about ----- (losing weight, eating healthier, exercising)?”
- Barriers and Solutions
 - “What things stand in your way of taking a first step/succeeding?”
 - “Are there things that you have found helpful in previous attempts to change?”
- Individual and Group Support
- Improve Communication with Medical Provider
 - “How do you feel about sharing your goals with Dr. Edwards?”

Supporting Healthy Patient & Family Dynamics

Practical Arguments for Taking a Family Approach

- Much of DM management relies upon lifestyle changes that involve family members, particularly diet and exercise
- Emotional reactions to having a serious chronic disease affect patients and families alike
- DM and its care may alter family roles and power relations
- Symptoms may interfere with harmonious family functioning
- Conflicts and communication difficulties may result from the illness demands

Features with *Positive* Effects on Diabetes Management & Outcomes

- Family and partner support/expression of support
 - Understanding/learning about the disease and impact on lifestyle
 - “Nice” reminders about taking medications and glucose monitoring
 - Monitoring and responding to potential crises (i.e., hypoglycemic crises)
 - Expressions of Empathy and what family member is going through
- Marital adjustment/Intimacy/Stress Management
 - Acknowledging need for independence/privacy
- Sharing Responsibilities
 - Food preparations
 - Coordinating routines/accommodating need to exercise

Features with *Negative* Effects on Diabetes Management & Outcomes

- Conflict or criticism
 - Oppositional behaviors
 - Buying/consuming unhealthy food
 - Cooking high fat meals/desserts
 - Lack of accommodation of Diabetes management regimen (i.e., not leaving time for exercise/mealtimes)
- Lack of emotional and practical engagement
- Focusing on the negative aspects of DM and DM outcomes
- Not sharing in the burden of DM responsibilities
- Persistent chiding/nagging about Diabetes restrictions/activities

The Good News Is. ..

- Family interventions can improve these patterns! Evidence is stronger for increasing support and engagement than for limiting conflict.
 - Improves patient and family knowledge
 - Improves family support and involvement
 - May make improvements in glucose control more durable/longstanding



In Summary...

- People with DM have high rates of anxiety, depression, and Diabetes Distress and should be screened regularly.
- If not addressed, BH conditions can negatively impact DM management.
- Integrated BH Services are considered Standard of Care by the ADA, but not consistently available.
- BH Providers can be indispensable members of the Diabetes Care Team.
- Supporting healthy family dynamics can result in improved glycemic control and quality of life.





Questions?

Resources

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