Practical Approaches to Integrated Behavioral Health: Focus on Diabetes

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Disclosure

- The presenter has no financial arrangement related to the content of this continuing education activity.
Objectives

At the completion of this activity, participants will be able to:

• Describe models and approaches used to integrate behavioral health and primary care.

• Identify practical, time-effective methods for addressing emotional and behavioral issues related to diabetes.

• Identify specific considerations in planning, implementing or evaluating integrated behavioral health and primary care in community settings.
Definition of Integrated Care

The care that results from a practice team of primary care and behavioral health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

(SAMHSA-HRSA Center for Integrated Health Solutions, 2016)

www.integration.samhsa.gov
COORDINATION
Discuss patients, exchange info if needed; collaboration from a distance

CO-LOCATION
In the same facility, may share some functions/staffing, discuss patients

INTEGRATION
System-wide transformation, merged practice, frequent communication as a team

Doherty et al, 2013
Meeting Patients Where They Are: Deploy integrated behavioral health expertise to reduce stigma and increase access.

Integrated Care for Mental Health Conditions
- Depression/Anxiety
- Substance Use d/o
- ADHD
- PTSD
- Other

Integrated Care for Medical Conditions
- Diabetes/Obesity
- HTN/Heart Disease
- Childhood Chronic Illness
- Stress-linked Physical Symptoms

Integrated Care for Persons: Social and Care Complexity
- Functional impairments or diagnostic uncertainty
- Distress, distraction & readiness to engage in care
- Social safety, support & participation
- Organization of care / relationships in health system
- Shared language with providers / sufficient insurance

Patient Centered Primary Care Collaborative, 2014; Original source: Peek, C.J. & Baird, M., 2010
Behavioral health needs of the primary care population: What is your range of services?

- High severity or specialty mental health
- Multi-morbid mental and physical health problems
- Mental health and substance use – moderate severity
- Medical health problems requiring behavioral or psychological intervention
- Psychosocial barriers to care
# Scope of Integrated Behavioral Health: A Range of Goals

| Patients with mental health/substance abuse conditions / risks | Depression/Anxiety/PTSD/ADHD, other  
|• Substance Abuse/Dependence |
|---|---|
| Patients with stress-linked or unexplained physical symptoms. | Headache, insomnia, pain, fatigue, dizziness, numbness, “don’t feel well”, frequent visits for no apparent medical cause |
| Patients with unmanaged behavioral risk factors in chronic illnesses | Diabetes / High BP / Obesity / Heart Disease  
|• Asthma / Childhood Chronic Illness  
|• Other |
| Persons with any complex social/medical situation that interferes with standard care | Functional impairment, diagnostic uncertainty  
|• Multiple interacting conditions  
|• Distress, distraction, difficulty engaging care  
|• Lack of social safety & support  
|• Disorganized care or patient-clinician relationships  
|• Language / Culture / Insurance barriers |
| Clients with mental health/substance abuse conditions receiving care in intensive mental health / substance abuse settings | Basic primary care / chronic illness management  
|• Timely preventive care  
|• Health behaviors  
|• Coordination with functional supports |

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Patient Centered Primary Care Collaborative, 2014; Original source: Peek, C.J. & Baird, M., 2010
Why provide integrated behavioral health in primary care?

- At least 50% better access to mental health care if offered in primary care (Bartels, et al., 2004).
- Without integrated care, people of color, children/adolescents, older adults, uninsured, and low-income patients more often receive inadequate care for behavioral health problems (SAMHSA, 2016)
- Care in medical setting is a better cultural fit for many patients, and stigma is reduced.
- Builds personal relationships, which helps support more culturally responsive care.
- Behavioral Health clinicians free up time for PCPs to spend with other patients, while enhancing patient satisfaction and self-efficacy (Blount & Olmedo, 2011).
- Greater improvement in anxiety, depression, and quality of care (Bradford, et al., 2011; Roy-Byrne, et al., 2010; Lang, 2003)
Integrated behavioral health in primary care can be especially helpful for patients with diabetes because:

A. Management of diabetes includes numerous behavioral issues which PCPs may lack the time to address.
B. Patients with diabetes may have multiple interacting health and mental health conditions.
C. Less stigma and easier access.
D. All of the above.
Diabetes Overview

• Type 1 diabetes is most common: 95% of AI/AN with diabetes have type 1.
• Type 1 is characterized by insulin resistance rather than insulin deficiency found in type 2 diabetes.
• Insufficient number of insulin receptors on the cells causes glucose to remain in the blood instead of being transported into the cell, where it is needed to produce energy.
• Fasting blood glucose level > 126 mg/dl indicates diabetes.
• A1c measures how much sugar has been present in the blood over a 3-month period.
• A1c < 7 indicates consistent healthy blood sugar levels and well-controlled diabetes.
Diabetes among American Indians and Alaska Natives

2.2 times higher – Likelihood of American Indians and Alaska Natives to have diabetes compared with non-Hispanic whites

68% – Percent increase in diabetes from 1994 to 2004 in American Indian and Alaska Native youth aged 15-19 years

30% – Estimated percent of American Indians and Alaska Natives who have pre-diabetes

1.6 times higher – Death rate due to diabetes for AI/AN compared to the general US population

1.9 times higher – Incidence of kidney failure due to diabetes in AI/AN compared with the general US population.

3-8 times higher – Risk for cardiovascular disease among AI/AN adults compared to those without diabetes.

16.1 percent of the total adult population served by IHS in 2004 had diagnosed diabetes;

Rates vary by region from 5.5 percent among Alaska Native adults to 33.5 percent among American Indian adults in southern Arizona.

Sources: American Diabetes Association; US Dept. of Health and Human Services; Centers for Disease Control
Consequences of Poorly Controlled Diabetes

• Hypoglycemia, low blood glucose levels
  • Causes elevated heart rate, headache, hunger, shakiness, sweating, decreased concentration, mood changes and confusion
  • If untreated may lead to coma and death
  • Is easily detected and corrected by the individual

• Hyperglycemia, high blood glucose levels
  • Causes increased thirst, increased urination, and glucose in the urine
  • Is not easily noticeable and is reliably identified only by monitoring blood sugar levels

• Long term impact of hyperglycemia leads to extensive vascular diseases which in turn cause:
  • High blood pressure, heart disease and stroke;
  • Blindness;
  • Kidney failure;
  • Neuropathy (pain and loss of sensation);
  • Circulatory problems and infections in the limbs, resulting in need for amputation.
Essential Treatment of Diabetes

• Key aspects of improving blood sugar levels and controlling diabetes include:
  • Healthy eating
  • Weight loss
  • Consistent physical activity
  • Oral medications that improve the body’s use and production of insulin
  • Injectable insulin

• To effectively coordinate the different parts of a diabetes treatment plan, frequent self-monitoring of blood glucose levels is essential.
Integrated Behavioral Health Improves Diabetes Care by:

- Treating common comorbid mental health conditions;
- Improving patient adjustment and stress coping;
- Facilitating effective behavior change and diabetes self-management;
- Providing consultation to primary and specialty medical providers;
- Integrating behavioral interventions and strategies into diabetes education and prevention programs.
Diabetes and Depression

Depression and diabetes interact in multiple ways:

• Persons with diabetes are at greater risk of depression.
• Depression is a risk factor for developing diabetes.
• Depression is associated with decreased diabetes self-management behaviors, and thus increased risk of complications.
• Depression and diabetes are associated with increased risk of dementia.
• Brain regions associated with cognition and emotion regulation may be damaged by hyperglycemia and insulin resistance.
Diabetes and Depression Among American Indians and Alaska Natives

- AI/AN individuals with diabetes have higher rates of depression than those without diabetes.
- There is a positive relationship between severity of depression and A1c levels.
- AI/AN with severe depression have higher A1c levels than those with moderate-to-no depression.

Diabetes, Anxiety, Stress and Coping

• Some evidence exists for increased risk of anxiety disorder.
• 40 % of persons with diabetes experience some symptoms of anxiety.
• Diabetes self-management, and loss of function associated with diabetes complications, can create significant life-changes, transitions and grief/loss responses.
• Stress and psychosocial determinants of health mediate interactions between endocrine and central nervous systems.
• Stress is associated with elevated blood glucose levels and decreased diabetes self-management behaviors.
• Use of stress management techniques is associated with improved glycemic control.
• For purposes of diagnostic conceptualization, Adjustment Disorder with depressed or mixed anxious and depressed mood may be a useful perspective.
Time-effective treatment of depression and anxiety in the primary care setting

• Review medical record and referral question to establish focus (or hallway consult with PCP)

• Be prepared to blend assessment and intervention at first visit (and possibly at subsequent visits)

• To respond to different patients’ needs, develop a portable file of educational material and interventions including: one-page handouts, lengthier packets, easy-reading, large font, and bilingual.

• Be prepared to discuss medication history and provide education as needed to support patient’s informed decision-making with their PCP.

• Create an efficient method to communicate back to the PCP.
Psychoeducation about Medication

- **SSRI Medications**
  - Can improve both depression and anxiety
  - Gradual response over 2-6 weeks
  - In 1 week, sleep & appetite may improve; longer for mood, energy and negative thinking.
  - Take medication as prescribed.
  - Early side effects may improve; contact provider if they persist.
  - If one SSRI does not produce improvement, another might; inform your provider if no change.
  - Continue medication at least 6 months, even if you feel better; contact provider before discontinuing.

- **Benzodiazepines**
  - Best used as short-term relief for stress reactions.
  - Long-term use leads to tolerance i.e. need for higher dosage
  - Higher dosage increases risk of dependence, withdrawal, overdose, drug/drug interactions.
  - Benzodiazepine monotherapy has not been demonstrated to be an effective treatment for anxiety.

James, L. & O’Donohue, W., 2009
Time-effective treatment of depression and anxiety

• When assessing, be attentive to:
  • Context of individual’s cultural and values perspectives;
  • Their current priorities: what matters most to them now?
  • Readiness, ambivalence, and change talk (MI);
  • Clinical presentation and general history.

• Psychoeducation about Depression or Anxiety
  • Practical information about signs, symptoms and common occurrence;
  • Be selective about the information you offer:
    • Use examples from the person’s presentation and history;
    • Focus on destigmatizing the condition and offering hope;
    • Goal is to empower through awareness – every person wants health and wellness, and will make choices to pursue this in their own way.
Balance challenging (CBT) and accepting (ACT) distressed thoughts and feelings based on client needs

• Cognitive Behavioral tools are a staple (e.g. Burns’ *Feeling Good*); have a selection of handouts to fit patient needs (see handouts).

• Acceptance and Commitment Therapy emphasizes:
  • Observing internal and external events with openness and curiosity, without trying to change them;
  • Increasing awareness of personal values, which provide meaning and motivation to make the changes that are needed to feel satisfied with life;
  • Pursuing behavior that is consistent with valued goals and life directions.

• Overlap between ACT and CBT produces a shift away from resisting “irrational” or “distorted” thinking to noticing and changing perspective of reactive “automatic thoughts.”

• Cultivating mindful awareness, functional perspective and “workability” (see handouts):
  • Practice being mindfully aware.
  • Is my belief/behavior/feeling workable or helpful?
  • If not, how might I be less focused on it? (grounding, self-soothing, changing perspective)
  • What do my values lead me to do next?
The purpose of psychoeducation about a specific mental health condition is to:

A. Compel the patient to acknowledge the urgent need for treatment of serious symptoms.
B. Empower individual decision making through increased awareness.
C. Reduce stigma associated with mental health conditions.
D. Both B and C.
Behavioral Activation (1)

• Explain rationale for patient behavior change: “When we feel down or ill, we sometimes stop doing many activities that we used to like to do. This can make depression worse. Research has shown that depression can be improved when we increase activities that provide enjoyment or sense of accomplishment.”

• Acknowledge difficulty of depression and that sometimes no activities feel enjoyable. Strategically take small steady steps even if activities initially feel difficult or awkward instead of pleasurable. Words to describe this:
  • Act first, Feel later; “Outside-In”; Act according to plan/goal, not feeling; “Fake it ‘til you make it.”

• With chronic illness, functional limitations can be seen as insurmountable barriers. The manner or extent of participation in previous activities may need to change due to functional limitations. Use problem-solving approaches and CBT to work with this.
Behavioral Activation (2)

• Select activities that:
  • Are likely to increase pleasure or sense of accomplishment;
  • They used to enjoy; or they already do but would like to do more often;
  • Include elements of physical exercise and social interaction, setting goals that are realistic for the individual.
  • Are realistic considering the person’s resources.

• Follow up may include:
  • Track and monitor to help them notice progress.
  • Use solution-focused strategies / problem-solving as needed to resolve barriers.
  • Reinforce positive behavior change.
  • Reset goals as needed when a goal is accomplished, or if barriers are encountered.
  • Strengthen or refine active behavior using stimulus control (cues/reminders) and positive reinforcement (consequences/rewards).
  • If needed, address communication skills for engaging or being assertive with significant others.
Reducing Anxiety And Coping With Stress

• Psychoeducation about stress and anxiety
  • Adaptive nature and physiological aspects of threat response
  • Fight or Flight and the Sympathetic Nervous System
  • Interaction of biological sensitivity with environmental cues and stressors over time can lead to anxiety: fear that is disproportionate to the actual threat.
  • Information about specific anxiety disorder(s) if appropriate
  • Knowledge = power = control = comfort for the anxious person.

• Managing Panic and Worry
  • Self-talk, self-soothing, and relaxation techniques
  • Questioning automatic thoughts
  • Using new knowledge
  • Role of medication

• Introduction to Mindfulness-Based Stress Management
  • Brief handout
  • Evidence-based
  • Informal mindfulness practice and link to mindful meditation/relaxation
Time-effective treatment of anxiety: Relaxation and Meditation

• Train the patient in specific techniques depending on individual needs and aptitudes:
• Briefly explain empirical basis with reference to anxiety physiology.
• Importance of practice and proficiency before using in a crisis
• Establish consistent routine of daily practice prophylactically – “like brushing your teeth”
• Can be combined with personal spiritual practice: prayer, reflection, meditation
• Share with trusted others (family)
Behavioral and Lifestyle Changes in Diabetes Care

Use BH Diabetes Screener (in downloadable handouts) for initial assessment of patient’s specific needs or concerns. Major behavioral changes can include:

• Self-monitoring of blood glucose levels
• Dietary changes
• Regular moderate physical exercise
• Limiting alcohol consumption
• Foot care
• Adherence to multiple and complex medication regimens
• Multiple physician appointments; communication with medical providers
• Family and social support and expectations
• Economic constraints
Supporting Behavior Change and Self-Management of Diabetes

• Diabetes Self-Monitoring Form (in downloadable handouts)
  • Eating, exercise, medication, and stress management to keep blood sugar within healthy range;
  • Can be easily modified to fit individual patient needs, e.g. eliminate medication section, or change the mood type that is monitored).

• Discussing use of the form can lead to identification of practical and psychological barriers to monitoring blood glucose levels.
  • Address with problem-solving and CBT as appropriate

• Help coordinate communication between patient and PCP about how to respond to daily high or low blood sugar levels.

• Don’t try to do everything at once: identify where the patient sees the greatest need for change, chance of initial success, interest or motivation.
Supporting Diabetes Behavior Change; Diet and Exercise (1)

- What is the PCP recommendation or request?
- Are there any specific limits on exercise?
- Are there any specific diet or exercise recommendations, e.g. from cardiology, endocrinology, special diabetes, gastroenterology, physical therapy?
- Consider a nutritionist referral if
  - Complex dietary needs exist;
  - Patient needs additional technical support regarding diet/menu.
  - The patient is struggling with identifying their basic nutrition needs.
- Utilize available groups/classes (e.g. diabetes education)
- Link with Community Health Representatives (CHR) or other home & community based services as needed.
Supporting Diabetes Behavior Change; Diet and Exercise (2)

• Identify individual interests and desired changes or goals for both diet and exercise. (May be different from medical provider recommendations!)

• Value-based action: how would your life be different when you lose weight?

• Set realistic, attainable goals, e.g. 1-2 pounds/week, exercise 4 days/week.

• Identify barriers and potential solutions for those barriers, e.g. strategies to regulate food intake when attending family gatherings, etc.

• Assist patient in creating action steps at each visit, and follow up to set new goals as they are achieved or if barriers arise.

• Set realistic goals and gradually increase. Avoid cycle of over activity and inactivity. Build in to daily routine. Track your progress and reward self!

• Build up to CDC-recommended levels:
  • 150 minutes/week of moderate-intensity aerobic activity (brisk walking);
  • Or 75 minutes/week of vigorous-intensity aerobic activity (running/jogging);
  • And muscle strengthening activities on 2 or more days/week.
  • **Aerobic activity can be done in periods as short as 10 minutes**
Other Useful Behavioral Interventions for Patients Coping with Chronic Medical Conditions

• Problem-Solving skills
• Communication Skills
  • With family and support system
  • With medical providers
• Understanding and organizing medical information
• Identifying and accessing community and social supports
• Understanding health plans and patient financial services
Question:

An essential ingredient in patient self-care of diabetes is:

A. Learning to communicate with others about their medical condition.
B. Being aware of blood glucose level and how to manage it.
C. Improving diet and exercise.
D. All of the above.
Clinic and Community Considerations

**Special Diabetes Program**

- Since 1997, has funded nearly 400 community-directed programs;
- Provides local tribes and health programs the opportunity to set priorities around prevention and treatment that meet the needs of the community.
- Helps translate the science of diabetes into real-world settings.
- Special Diabetes Programs have led to demonstrated and continued improvements in diabetes prevention and care in American Indian and Alaska Native communities.
- Check with your local program, or see more at:

  [http://www.diabetes.org/advocacy/advocacy-priorities/funding/special-diabetes-programs.html#sthash.ioT7374g.dpuf](http://www.diabetes.org/advocacy/advocacy-priorities/funding/special-diabetes-programs.html#sthash.ioT7374g.dpuf)
The goal of behavioral health consultation and intervention is to empower individuals and provide tools to take action.

“I took classes on heart health and managing diabetes, and learned about reading labels to pick which foods to eat. The most challenging part for me has been trying to maintain a steady weight and keeping up with a vigorous schedule for exercise. I ride bikes, walk, jog, and use the Hualapai Fitness Center and always invite others in the community to join me.

I try to let everyone know that our tribe has programs like Healthy Heart that will show them how to commit to make small changes and start eating healthy and exercising, not just to help them control their diabetes but to hopefully one day prevent it. Diabetes is something that we should attack and pay attention to as a Native nation. We need to fight diabetes, using our cultural and traditional methods because we now know that we can control our blood sugar.”

Rudy Clark, Hualapai
Hualapai Healthy Heart Project
References/Resources


References/Resources


Questions?

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