Addressing Depression and Distress in Patients with Diabetes: The EPiC-4DM Project

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October 14, 2016
Burden of Diabetes

- An estimated 12-14% of the US population has diabetes\(^7\)
- As many as 49% of adults with diabetes do not meet targets for glycemic control\(^1\)
- Daily self-care activities include blood glucose monitoring, adapting a healthy diet, engaging in regular physical activity, and medication adherence
- Comorbidities
Diabetes Distress

- The sense of being overwhelmed by the requirements of managing a chronic disease
  - Includes psychological distress related to:
    - Regimen burden
    - Interpersonal burden
    - Emotional burden
    - Healthcare navigation burden
  - Interferes with adherence and self-management
  - Adversely affects quality of life and disease control
- Screening using the 2-item and/or 17-item Diabetes Distress Scale
Diabetes Self-Management Support

• Patients with diabetes benefit from comprehensive diabetes self-management education (DSME) and self-management support (SMS) in primary care.  

Figure 1  Five As self-management model: a guide for making decisions about self-management plans.
EPiC-4DM Project Goals

“Enhancing Patient, Practice, and Community Capacity for Collaborative Diabetes, Depression, and Diabetes Distress Management”

1. To improve self-management, mental and physical health, and the experience of health care for patients with diabetes and depression and/or diabetes distress

2. Link patients with diabetes and additional mental and behavioral health concerns to practice and community-based resources
EPiC-4DM Intervention

**Basic SMS** (5As using Connection to Health [CTH] web tools) by an integrated care team for patients with diabetes

Targeted services for behavioral health concerns (depression and disease distress)

**Handoff to internal SMS resources:**
E.g., Health Education, BHPs

**Linking to external SMS resources:**
resource directory in CTH
Priorities to discuss with healthcare team:

1. Mood: discuss my symptoms of feeling down or depressed
2. My health concerns: discuss how to get more support from friends or family for my health issues

Potential High Risk Issues:

1. The patient scored 32 on the PHQ-8, which suggests a high level of depressive symptoms. The PHQ-8 does not assess suicidal thoughts. The patient should be evaluated for depressive symptoms and suicide risk factors.

Recommendations for Health Priorities:

**Mood**

Your patient had a score on the PHQ-8 depression symptom screener of 32. They have significant symptoms of depression and need further evaluation and treatment. We would recommend screening for suicidal ideation as the PHQ-8 does not ask about suicidal thoughts.

**Health concerns**

Your patient indicates a significant level of distress around their chronic illness(es). Encourage brief discussion about what is causing them to feel this way, as just listening supportively can be therapeutic. Specifically:

- Patient indicates distress about feeling overwhelmed by health problems. Use what patient tells you regarding what specifically is overwhelming them to determine a more specific response (such as sending for disease specific education or to a chronic disease class or support group).

- Patient indicates distress about not getting enough help from the health care team. Try to determine where the problem is. If not specific, more regular contacts (by phone, email, or in person - can be done by other staff members) can often reduce the stress and save clinician time.

- Patient indicates feeling that they are failing at managing their treatment regimen. Identify which aspect of their regimen is problematic and consider simplifying their regimen, more intensive patient education, or referral to a community resource.

- Patient indicates feeling a lack of social support. Identify current support system and where a specific problem might be; 3) take specific actions depending on situation (e.g., bringing in spouse or others for discussion and education, referral to community resources for support and education).

- Patient indicates feeling limited by their chronic disease. Discuss rehabilitation efforts that might assist patient in overcoming or dealing with limitations.
CTH Action Plan with Resources

Add New Action Plan

Goal: What health issue will you work on?
- Will improve my symptoms for depression.

Specific: Be specific about what the 1 or 2 things you will do and how often you will do them.
- Strategy 1
  - What will you do?
    - I will seek counseling to help me with managing my depression.
  - How often will you do it?

Practice & Community Resources to Help Achieve this Goal

- Aurora Recreation Centers
- Diabetes-Related MeetUps
- Wheat Ridge Recreation Center
- Jefferson Center for Mental Health Wellness Now!
- MCN Behavioral Health Providers

Description: Behavioral Health Providers (BHPs) are located at most sites on a variable basis and can help patients with mental and behavioral health needs.

Location:

Services Offered: Behavioral Health services are limited to usually 1-6 sessions with a patient and use a short-term, brief therapeutic model.

Phone: 303-356-7700

Website: http://mcnp.org/about-us/behavioral-health-services/

Cost: Free

Eligibility Criteria: MCN patient

Key Contacts:

When will you start? 
Follow up date: 

We hope these resources will be helpful in achieving your goal.
Practice-Level Intervention

• Implementation of SMS using CTH tools
  • 4 practices from the Metro Community Provider Network (MCPN)
    • 2 SMS Education + CTH tools
    • 2 SMS Education + CTH tools + coaching
  • Training on SMS, use of CTH, identifying and addressing depression and distress, connection to internal and external resources
  • Practice coaching to inform local implementation (roles, workflows, overcoming barriers)

• Organizational leadership engaged in implementation planning and decision making
RESULTS
Implementation

- CTH Assessments and Action Plans
  - Patient Navigators
  - Identifying depression and distress using the CTH Clinician Report
- Internal referral mechanisms
  - Review of Clinician Reports
  - Flagging care team members (health educators, behavioral health providers, primary care providers, care coordinators)
- Diagnosis and interventions for depression and distress
## Assessments and Action Plans

### Assessments Completed

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<th>Assessments Completed</th>
<th>Pre-Diabetes Patients</th>
<th>Diabetes Patients</th>
<th>Total</th>
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<tr>
<td>Practice 1 (w/ coaching)</td>
<td>101</td>
<td>52</td>
<td>153</td>
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<tr>
<td>Practice 2 (w/ coaching)</td>
<td>36</td>
<td>16</td>
<td>52</td>
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<tr>
<td>Practice 3 (no coaching)</td>
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<td><strong>Total</strong></td>
<td><strong>168</strong></td>
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</table>

### Action Plans Completed

<table>
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<th>Action Plans Completed</th>
<th>Pre-Diabetes Patients</th>
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<th>Total</th>
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<td>Practice 1 (w/ coaching)</td>
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<td>Practice 2 (w/ coaching)</td>
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<td>Practice 4 (no coaching)</td>
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<td>8</td>
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<td><strong>Total</strong></td>
<td><strong>114</strong></td>
<td><strong>54</strong></td>
<td><strong>168</strong></td>
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</tbody>
</table>
Action Plan Details: Self-Management Goals

- Dietary Changes (47%)
- Weight Loss (16%)
- Exercise (23%)
- Improve Mood (7%)
- Tobacco Cessation (4%)
- Medication Adherence (2%)
- Improve Stress (1%)
- Medication Adherence (2%)
- Improve Stress (1%)
- Tobacco Cessation (4%)
- Weight Loss (16%)
- Exercise (23%)
- Improve Mood (7%)
- Dietary Changes (47%)

SELF-MANAGEMENT GOALS
Action Plan Details: Resources

Total Action Plans = 105

Internal Resources = 17 (16%)

- Diabetes/Health Ed = 14 (13%)
- Behavioral Health = 2 (2%)
- Patient Navigator = 1 (1%)

External Resources = 56 (53%)

- Rec Centers/Gyms = 39 (37%)
- Other Community Resources = 9 (9%)
- Meetups = 8 (8%)

Other = 10 (10%)

No Resources = 22 (21%)
Addressing Diabetes Distress

• Nearly two-thirds of patients screened positive for disease distress, compared to ~25% screening positive for depression
• Few patients self-selected depression or distress as self-management goal
• Additional efforts needed to address depression and distress
Lessons Learned

• Team-Based Care for Diabetes SMS
  • Workflow, roles, time available
  • Importance of patient navigator
  • Value of the clinician report
  • Diabetes clinic model: all disciplines (PCP, HE, BHP, PT Nav) collaborate to determine the care plan, identify & address barriers, identify resources
Questions?
Thank you!

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Metro Community Provider Network

Connection to Health project team (Perry Dickinson & Bonnie Jortberg)

This project was supported by grants from the Bristol Myers Squibb Foundation’s Together on Diabetes Initiative (PIs: Bethany Kwan & Russ Glasgow) and Comparing Strategies for Translating Self-management Support into Primary Care (NIH-NIDDK 1R18DK096387-01; PI Perry Dickinson)
References


