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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%)
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
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