Indian Health Diabetes Best Practices:

Depression Care and Diabetes

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Contents

What is depression care?

Depression care involves providing effective interventions to improve a person's emotional well-being when they are experiencing or have experienced depression.

Why is depression care important?

Depression is intertwined with diabetes. The presence of diabetes doubles the odds of co-morbid depression: as many as a third of patients with diabetes will develop depression. And individuals with depression are *at increased risk of developing diabetes*. Furthermore, depression affects patient self-management efforts, such as medication adherence and physical activity. Consider these facts (Singh *et al.*, 2004):

- Depression was higher among some American Indian tribes as compared with the general population.
- The prevalence of depression was higher in people with diabetes.
- A1c levels were 1.2% higher in depressed patients with diabetes.

The good news is that effective treatment of depression may improve diabetes outcomes and definitely improves quality of life and the ability to self-manage diabetes. Conversely, under-treatment of depression can contribute to increased morbidity and poorer diabetes control.

Best practices for depression care and diabetes

The best practices for depression care and diabetes describe the best methods for:

- Obtaining education on screening for and conducting basic treatment of depression.
- Screening for depression among patients with diabetes.
- Providing depression care and treatment.
- Recognizing when to refer patients for expert care.

Table 1 summarizes the best practices for depression care and diabetes.

Table 1. Best practices for depression care for people with diabetes.

Provider Recommendations	Best Practices
1. Obtain **education on screening for and conducting basic treatment of depression**	***Why?*** Health care providers who are trained in mental health care can often identify depression early and treat it successfully. Provider education on screening and treatment for depression can also support efforts to integrate behavioral health into diabetes care. ***How?*** Health care systems and organizations need to ensure that providers can obtain education on depression screening for and conducting basic treatment of depression. The goal and content of the provider education should include: – Screening for depression. – Depression diagnosis. – Depression prevalence. – Skill development in active listening. – Assessment for suicidal ideation, plan, and intent. – Treatment therapies.
2. **Screen for depression** among patients with diabetes	***Who?*** Skilled health professionals or health aides can screen for depression. ***Why?*** As many as a third of patients with diabetes will develop depression in their lifetimes. Depressed patients with diabetes have higher A1c levels than non-depressed diabetes patients, and depression affects patients' self-management efforts, such as medication adherence and physical activity. Early recognition and effective treatment of depression can improve physical and behavioral outcomes, quality of life, and the ability to self-manage diabetes (Katon *et al*., 2006; Singh *et al*., 2004; Anderson *et al*., 2001; Ciechanowski *et al*., 2000; Lustman *et al*., 2000; Lustman *et al*., 1998). ***How?*** – Screen the patient verbally, or provide the patient with a pre-printed screening form for him or her to complete. – Use a screening tool that is simple to administer and assess, such as the PHQ (Patient Health Questionnaire Mood Scale) screening tool, which assesses DSM-IV criteria and is designed for use in primary care settings (Kroenke *et al*., 2001):

(Table 1 continued on next page)

Table 1. Best practices for depression care for people with diabetes. (continued)

Provider Recommendations	Best Practices
2. **Screen for depression** among patients with diabetes (continued)	• Step one: Two-question basic screening— Over the last two weeks, how often have you been bothered by any of the following problems: 1. Little interest or pleasure in doing things? 2. Feeling down, depressed, or hopeless? • Step two: If the response to *either* question is "yes", administer the seven remaining items— 1. Trouble falling or staying asleep, or sleeping too much. 2. Feeling tired or having little energy. 3. Poor appetite or overeating. 4. Feeling bad about yourself, that you are a failure, or that you have let yourself or your family down. 5. Trouble concentrating on things, such as reading the newspaper or watching television. 6. Moving or speaking so slowly that other people could have noticed. Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual. 7. Thoughts that you would be better off dead or of hurting yourself in some way. • Score each item on a Likert scale from 0 to 3 (0=Not at all, 1=several days, 2=more than half the days, 3=nearly every day). Add items for a score ranging from 0 to 27. Scores of 0–4 suggest negligible depressive symptoms, 5–9 mild, 10–14 moderate, 15–19 moderately severe, and 20–27 severe. – Share results immediately with the patient and other providers. – Program documentation sections to print automatically on Patient Care Component (PCC+) forms and to appear as either an optional or required field in the electronic health record.

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Table 1. Best practices for depression care for people with diabetes. (continued)

Provider Recommendations	Best Practices
3. Provide **depression care and treatment**	***Who?*** A skilled health care provider, social worker, mental health counselor, psychologist, or psychiatrist can provide depression care or treatment. ***Why?*** Patient education and depression care and treatment can improve depression symptoms and improve diabetes-related outcomes. Even simple interventions for depression performed by non-behavioral health professionals can be effective (McGinnis *et al*., 2005; Surwit *et al*., 2002). ***How?*** – Listen to patients and inquire about their emotional health. – Prescribe different therapies, including antidepressant medications, physical activity, support groups, and group and individual therapy: • Cognitive behavior therapy. • Interpersonal therapy. • Solution-focused techniques. • EMDR (eye movement desensitization and reprocessing), which is an integrated approach to psychotherapy that includes elements of psychodynamic, cognitive, behavioral, interpersonal, experiential, and body-centered therapies. • Psycho-education, which involves teaching people about their problem, how to treat it, and how to recognize signs of relapse so that they can get treatment before their problem worsens or occurs again. Family psycho-education includes teaching coping strategies and problem solving skills to families, friends, and caregivers to help them more effectively deal with the patient. • Coping skills training. • Relaxation, meditation and mindfulness, guided imagery, and breathing techniques. • Light therapy. • Various activity-type therapies (e.g., movement therapy, art therapy, equine-assisted psychotherapy, and gestalt therapy). – Sponsor physical activity programs that have been found to be *very effective* treatments for depression, such as traditional dance, yoga, tai chi, walking, running, and exercise programs.

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Table 1. Best practices for depression care for people with diabetes. (continued)

Provider Recommendations	Best Practices
3. Provide **depression care and treatment** (continued)	– Offer programs or refer patients for appropriate complementary therapies, such as acupuncture and massage. Although these therapies have not yet been proven to affect depression directly, they have been proven to be effective for chronic pain. – Provide treatment that is holistic, particularly because psychosocial and socioeconomic factors play large roles in depression. – Link patients to resources that can assist with socioeconomic life circumstances, which are often related to depression. Resources may include: • Vocational rehabilitation. • General equivalency diploma (GED) and other education services. • Food stamps. • Commodity food programs and other food resources. • Referral to public health nursing, home health, and other home assistance services. • Housing programs. • Child care services. • Transportation assistance. • Tribal services, such as those for the disabled and elderly. • Domestic violence shelters. • Social services. • Literacy programs. – Provide access to consultation by behavioral health specialists or providers with depression-related expertise by telephone or radio.
4. Recognize when to **refer patient for expert care**	***Why?*** Early recognition, accurate assessment, and referral to appropriate health care providers and systems can reduce negative outcomes (Delamater *et al*., 2001; Lustman *et al*., 1998). ***How?*** – Assess the patient for suicidal ideation, plan, and intent. – Refer patient immediately to appropriate health care providers and centers.

Best practices for health care organizations

A health care organization that wants to improve depression care must be motivated and prepared for change throughout the entire organization. The organization's leadership must identify depression care as important work. They must also develop clear improvement goals, policies, and effective improvement strategies. This will help encourage the entire organization to make changes that will help improve depression and diabetes care.

Table 2 describes the best practices for health care organizations.

Table 2. Best practices for health care organizations.

Organization Recommendations	Best Practices
1. Commit to **improving depression care** in people with diabetes	***Why?*** Improvements in health care systems may improve the delivery of appropriate care to people with diabetes and depression (Katon *et al*., 2006). ***How?*** Health care systems and organizations can help improve depression care for people with diabetes by: – Addressing behavioral health issues in treating depression and diabetes. – Screening all individuals with diabetes for depression. – Providing annual training in treating depression and behavioral health management techniques, including diagnosis, differential diagnosis, and interventions. – Conducting novel approaches to screening and treatment for depression and diabetes. – Conducting routine meetings between administration, medical providers, and behavioral health providers. – Providing adequate staff time to facilitate community linkages. – Facilitating and initiating community partnerships. – Actively promoting depression treatment in diabetes at all levels, including the national level by including depression topics in conferences, standards of care, audits, and training materials.

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Table 2. Best practices for health care organizations. (continued)

Organization Recommendations	Best Practices
2. **Dedicate funds** to improve depression care in people with diabetes	***Why?*** People with diabetes have a multi-system chronic disease. They are best cared for by a diabetes team who has access and training to the latest diabetes technology, information, treatments, and medications. Therefore, a health system that provides financial support for the care and treatment of the whole patient, including depression, is vital to providing the best diabetes prevention and care and to obtaining positive outcomes (ADA, 2006). ***How?*** Health care systems and organizations can use funds to: – Hire or contract with behavioral health specialists to integrate into or coordinate with diabetes programs. – Redesign or expand space to support behavioral health integration. – Support a range of antidepressant medications in the pharmacy. – Provide contract care for behavioral health care when needed.
3. **Coordinate care** between behavioral and primary care	***Why?*** Coordination of care between behavioral and primary care can contribute to a comprehensive diabetes treatment plan. Research shows that: – Elderly consumers with diabetes are more likely to require preventable medical hospitalization when there is comorbid depression (Niefeld *et al*., 2003). – Generalized anxiety disorder results in decreased work productivity and increased use of health services, particularly primary health care (Wittchen, 2002). – Delayed treatment of comorbid depression increases morbidity, represented by increases in medical and psychiatric treatment costs by 23% (Sheehan, 2002). ***How?*** To coordinate behavioral and medical care, the diabetes team should: – Be an integral part of behavioral health care, even if the patient is also referred for specialty care. – Invite other programs, community organizations, and community members to brainstorm about how to address depression with diabetes. – Design an approach to incorporate depression into diabetes care.

Essential elements of best practice depression care programs

High quality depression and diabetes care involves implementing six essential elements* in your health care organization. These elements are:

- Community resources and policies.
- Health care organization leadership.
- Patient self-management support.
- Delivery system design: Services, programs, systems, and procedures.
- Decision support: Information and training for providers.
- Clinical information systems: Collecting and tracking information.

Table 3 summarizes how these elements apply to basic, intermediate, and comprehensive depression care programs for patients with diabetes.

*Adapted from the Chronic Care Model, which was developed by the MacColl Institute for Healthcare Innovation at the Group Health Cooperative. For more information on the Chronic Care Model, visit their website at www.improvingchroniccare.org.

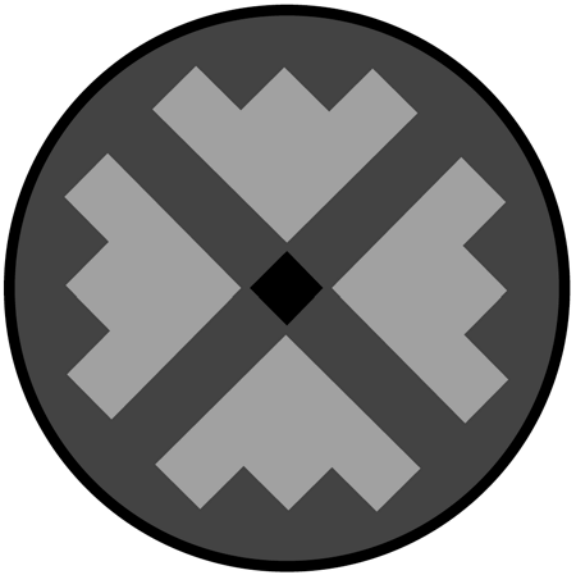

Table 3. Essential elements of basic, intermediate, and comprehensive best practice depression care programs for patients with diabetes.

Basic Depression Care Programs	Intermediate Depression Care Programs Basic program *plus*:	Comprehensive Depression Care Programs Basic and intermediate programs *plus*:	Examples
Community resources and policies			
– Develop clear mechanisms for referring patients to specialists. – Have the diabetes team present available services, provide general information about depression and diabetes, and seek input at community events.	– Train field health personnel in depression screening. – Develop an inventory of behavioral health resources. – Ensure the community has access to a mental health professional through established referral channels.	– Coordinate and integrate behavioral health services and the diabetes program. – Develop and implement a community education program on depression. – Actively promote cultural connection, spiritual wellness, and social support. – Sponsor activities designed to intervene at the community level and address issues related to intergenerational grief. Activities could include conferences, healing ceremonies, and genograms in therapeutic work.	– Create lists of community resources. – Use case managers to facilitate linkages between the diabetes program, mental health program, and other resources. – Have the head of the diabetes clinic contact the head of the commodity food program to discuss ways to increase collaboration. – Have case managers from different agencies and programs meet once per quarter to collaborate on service delivery.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice depression care programs for patients with diabetes. (continued)

Basic Depression Care Programs	Intermediate Depression Care Programs Basic program *plus*:	Comprehensive Depression Care Programs Basic and intermediate programs *plus*:	Examples
Organization leadership			
– Support quality improvement in depression care. – Actively promote the importance of addressing behavioral health and depression in treating diabetes. – Recognize that emotional and mental health is as important as physical health. – Enable staff to obtain appropriate training in behavioral health management techniques. – Encourage novel approaches to depression screening and treatment. – Facilitate maximized coordination between behavioral and medical care. (Table 3 continued on next page)	– Incorporate depression prevention, identification, and treatment in the clinic's annual goals. – Assign a team to design an approach to incorporating depression into diabetes care. Team members should include administration, information technology, all levels of providers, and patients (as appropriate).	– Include specific depression outcome measures in annual performance-based objectives.	– Allocate funds to hire or contract with behavioral health specialists. – Allocate funds to redesign or expand space to support coordination between behavioral health and diabetes programs. – Support a range of antidepressant classes in the pharmacy budget. – Advocate for the Indian Health Service (IHS) Division of Diabetes Treatment and Prevention to include depression in conferences, standards of care, audits, and training materials. – Screen all individuals with diabetes for depression, and offer interventions that target depressive symptoms. – Train providers annually on diagnosis, differential diagnosis, and interventions. – Enable the diabetes team to invite other programs, community organizations, and community members to brainstorm ideas on how to address depression that occurs with diabetes. – Hold routine meetings between medical and behavioral health providers.

Table 3. Essential elements of basic, intermediate, and comprehensive best practice depression care programs for patients with diabetes. (continued)

Basic Depression Care Programs	Intermediate Depression Care Programs Basic program *plus*:	Comprehensive Depression Care Programs Basic and intermediate programs *plus*:	Examples
Patient self-management support			
– Present patient education on depression verbally with easy-to-read handouts. Handouts could include information on common symptoms of depression, prevalence of people with chronic illness who have depression, and information on antidepressants. – Encourage patients to become aware of mood fluctuations and report any suicidal ideation. – Provide instruction in and practice of coping skills. – Create checklists of self-management support topics to prompt discussion and address areas for intervention. – Implement procedures for recall, reminders, missed appointments, and follow-up. – Help patients set their own goals through prompting and support from the diabetes care team. – Train the diabetes care team in active listening, relaxation techniques, and effective behavior change interventions.	– Provide education within the framework of an IHS-certified (or equivalent) curriculum. – Ensure access to a program that appropriately treats chronic pain. – Make group treatments available, such as group medical visits, support groups, and group classes.	– Develop and implement a variety of group programs, such as group psychotherapy, group medical visits, psychosocial education groups, support groups, group classes for patients or family members, and peer-led groups similar to Alcoholics Anonymous and Al-Anon.	– Ask patients at each appointment whether they are taking their medications, and verify pharmacy refills. – Have patients log their mood several times a day and write down what occurred (e.g., the patient heard good or bad news, blood sugar fluctuations, and exercise). – Encourage providers to form effective partnerships with the patients in determining self-management goals for diabetes and depression. – Use checklists to prompt the educator to discuss side effects and response to medications. – Encourage members of the diabetes team to model and practice deep breathing techniques with stressed patients. – Provide concise, easy-to-understand information about depression and its treatment in written and verbal formats.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice depression care programs for patients with diabetes. (continued)

Basic Depression Care Programs	Intermediate Depression Care Programs Basic program *plus*:	Comprehensive Depression Care Programs Basic and intermediate programs *plus*:	Examples
Patient self-management support (continued)			
			– Base appointment frequency on clinical factors, such as A1c and complications. Have public health nurses contact patients who have been lost to follow-up. – Search the Resource and Patient Management System (RPMS) diabetes registry for long intervals since the last appointment. Review the diabetes summary to ensure standards of care are current. – Have the diabetes team encourage the patient to identify their own priorities, listen to what has worked and not worked, and offer suggestions—instead of identifying goals for the patient. – Actively listen to patients' priorities, help problem-solve, and encourage patients to meet goals—instead of lecturing patients about behavior change. – Interact with family members and offer support and other interventions. – Present annual reports and education to the tribal council.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice depression care programs for patients with diabetes. (continued)

Basic Depression Care Programs	Intermediate Depression Care Programs Basic program *plus*:	Comprehensive Depression Care Programs Basic and intermediate programs *plus*:	Examples
Delivery system design: Services, programs, systems, and procedures			
– Establish a diabetes team that includes administration, information technology, all levels of providers, and as appropriate, patients. Organize the team to accomplish effective depression screening and treatment, and to design approaches to incorporate depression into diabetes care. – Coordinate and integrate the diabetes clinic and behavioral health specialists. – Screen—either through writing or verbally—for depression by a health aide or other available personnel. – Make consultation by behavioral health specialists or other health care providers with depression-related expertise available by telephone or radio. – Allow patients to see the same provider at each visit.	– Screen for depression at least annually. – Include depression in follow-up and treatment protocols and duties if case management exists. – Inquire about patient use of medicines from their tribal healing traditions, as well as use of herbal, naturopathic, homeopathic remedies, and nutritional supplements. – Make a wider range of antidepressant medication classes available. – Ensure that providers have the ability to schedule adequate and flexible appointment times. – Consider screening for substance abuse and domestic violence.	– Integrate behavioral health personnel into diabetes care. – Make a wide range of antidepressant medications available. – Develop a written depression treatment protocol.	– Hire or contract with a behavioral health specialist who offers training, consultation, and attends diabetes team meetings. – Assign specific staff to administer and score simple screening tools. – Hold regular meetings with all diabetes team members, including the behavioral health specialist. – Provide office space for the behavioral health specialist and ensure that clinic flow supports visits with the specialist. – Ensure that at least one member of the diabetes team is available to address same-day care needs. – Search the diabetes registry to identify patients who have not been screened for depression. – Ensure that patients can see the provider of their choice, at least for scheduled appointments. – Develop and routinely use appropriate channels for information sharing. – Use case conferences to allow diabetes team members to give input on whether patients are responding to current therapy.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice depression care programs for patients with diabetes. (continued)

Basic Depression Care Programs	Intermediate Depression Care Programs Basic program *plus*:	Comprehensive Depression Care Programs Basic and intermediate programs *plus*:	Examples
Decision support: Information and training for providers			
– Identify evidence-based guidelines for depression and diabetes. Provide the guidelines in an easy-to-read format and monitor their use. – Conduct needs assessments to identify staff training needs. – Train providers in depression diagnosis, prevalence, basic treatment, antidepressant medications, and referrals. – Include training on how to assess for suicidal ideation, plan, and intent. – Train providers in active listening, behavior change, and patient empowerment. – Identify a local "champion" who can offer or coordinate training for providers. A local champion may be a medical provider with an interest in behavioral health or a behavioral health provider with strong medical knowledge. – Include depression in diabetes education. (Table 3 continued on next page)	– Offer at least annual training for providers on diagnosis, differential diagnosis, and treatment. – Train providers on simple and easy-to-teach interventions, including exercise, relaxation techniques, identification of disordered thinking, sleep hygiene, and basic coping skills. – Train providers in local resources that would help patients who are dealing with depression and other psychosocial issues (e.g., support groups and 12-step groups). – Include all diabetes team members in trainings (because it is often the nutritionist or nurse educator who hears what is going on in a patient's life and identifies the problem).	– Provide community education in depression.	– Review the American Psychological Association's depression guidelines with the diabetes care team. – Have the diabetes care team review significant elements of good diabetes care with behavioral health specialists. – Invite a local speaker with expertise in depression to present to the diabetes team. – Offer continuing education credits for trainings related to depression and diabetes. – Have patients take self-care cards to their contract medical appointments to document depression screening. – Include depression in diabetes education through curricula such as the *Living with Diabetes* curriculum, which includes a module on depression. The IHS *Balancing Your Life and Diabetes* curriculum has also been modified to include depression.

Table 3. Essential elements of basic, intermediate, and comprehensive best practice depression care programs for patients with diabetes. (continued)

Basic Depression Care Programs	Intermediate Depression Care Programs Basic program *plus*:	Comprehensive Depression Care Programs Basic and intermediate programs *plus*:	Examples
Clinical information systems: Collecting and tracking information			
– Develop a diabetes registry. – Provide the information technology support and training necessary to maintain the registry. – Identify a designated staff person responsible for the registry. Ensure that data are entered accurately and promptly. – Train providers on the appropriate fields to examine. – Document depression screening in the medical record. – Include depression questions on the annual diabetes audit. – Implement diabetes summary, flowsheets, electronic reminders, and other tracking systems. – Produce individual provider and clinic reports. – Train providers on how to share, examine, and use data. – Use a common chart to facilitate communication between diabetes and behavioral health providers. – Modify treatment plan templates for individual patient needs. Document treatment plans.	– Record and monitor depression screening. If data entry into RPMS occurs, depression screening should be reflected in the diabetes health summary. Depression screening should be added to manual flow sheets.	– Monitor depression treatment outcomes. – Adjust depression protocol based on outcome data, including patient satisfaction with and use of services.	– Contract with an information technology firm to develop a tracking database for depression screening and other care elements in diabetes treatment. – For small clinics, develop a paper-based system to track patients with diabetes (e.g., a binder with diabetes summaries or flowsheets). – Place the health summary sheet in a prominent location in the chart. – Ensure that empty fields are easily recognizable. – Routinely audit a sample of the medical records for degree of agreement measured, improvements implemented, and whether individualized treatment plans exist. – Distribute quarterly reports to the diabetes care team on the percent of patients screened for depression. – Have the diabetes team share information from the yearly audit and what it means with the rest of the clinic staff. – Store notes from all providers by date of service in one chart.

Evaluating your depression care program

Evaluation is important because it helps you see what is working and what is not working in your depression care program for people with diabetes. It will show you if adjustments or changes need to be made to improve your program. Evaluation also provides you with information that you can use to share your successes with patients, providers, tribal leaders, administrators, the community, funders, and other stakeholders.

Consider including the following when developing your program and evaluation:

- Depression screening documentation.
- Behavioral health involvement documentation.
- Suicide attempt rates.
- User rates for activities offered by the program.
- Improvement of outcome measures such as A1c, lipids, and self-management subsequent to interventions.

Sustaining your depression care program

Often, for care goals to be reached, programs must be in place for more than a few years. Here are some helpful tips for sustaining your program:

- Maximize billing opportunities.
- Ensure ongoing information technology support.
- Provide adequate space that is designed to allow for confidentiality.
- Share success with the community by making presentations to the tribal health board and tribal council and sharing news with tribal newspapers.
- Provide ongoing training for diabetes team members.
- Ensure that the clinic and health system are committed to integration and collaboration.
- Refine the scheduling system as needed.

Contacting others for help

Contacting other people involved in depression care is important because they can help you get started with your program. Your peers at other health care organizations can share their expertise, materials, and ideas, and can also tell you what has worked for them and what has not worked. This can help you avoid reinventing the wheel. Here are some tips on how to connect with others:

- Ask your Area Diabetes Consultant for the names of people who may be able to help you.
- Contact the IHS Division of Diabetes Treatment and Prevention for ideas. They may be able to point you in the right direction.
- Ask the IHS Integrated Diabetes Education Recognition Program for suggested contacts. They have names and contact information for people who work with IHS-accredited diabetes education programs.

- Flip through issues of *Health for Native Life Magazine*. The magazine profiles many diabetes programs throughout Indian Country. The articles may give you ideas for activities to try and people to contact.
- Review resources from the National Diabetes Education Program (NDEP). NDEP offers materials that will help your program get started, including information specifically for American Indians and Alaska Natives. You can access these resources at the website: www.ndep.nih.gov

Real-world best practice programs

Cherokee Diabetes Program

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✉ Cherokee Diabetes Program
Health and Medical Division
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This program uses group medical visits, complementary therapies (e.g., acupuncture, massage, and yoga), traditional counseling to improve patients' coping skills, and community stress reduction workshops. This program also actively participates in programs sponsored by the Wellbriety Group that address intergenerational trauma. The Tribal health program pays for SSRI antidepressant to augment the hospital formulary.

Colorado River Service Unit

Jo Ann Holland, RD

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✉ Parker PHS Indian Hospital
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This program screens all patients in the diabetes clinic for depression. The comprehensive diabetes team is comprised of pharmacy, lab, dental, medical, health education, public health nursing, social work, and psychiatry staff and providers. The team meets monthly to discuss issues and problems.

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Alaska Native Medical Center
4320 Diplomacy Drive
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Helpful websites

American Association of Diabetes Educators

www.aade.org

American Psychological Association

www.apa.org

Chronic Care Model: Self-management support

www.improvingchroniccare.org/change/model/smsupport.html

Institute for Healthcare Improvement

www.ihi.org

MacArthur Initiative on Depression in Primary Care at Dartmouth and Duke

www.depression-primarycare.org/about/mission/

www.depression-primarycare.org/clinicians/toolkits/

National Institute of Mental Health

www.nimh.nih.gov

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