Psychological Care for People with Diabetes

W. Douglas Tynan, PhD, ABPP
Professor of Pediatrics, Thomas Jefferson University
Coordinator Mental Health Education – American Diabetes Association

Disclosures

No conflicts of interest to disclose.

Learning Objectives

- Describe the two major types of diabetes and treatment required
- Describe psychosocial issues associated with diabetes, which range from normative diabetes-related distress to diagnosable mental health disorders.
- List screening tools for assessing symptoms of psychosocial issues within routine care.
- Indicate appropriate referral and treatment options for people impacted by both sub-clinical and clinical psychological distress.

What is diabetes?

- Lifelong disease affecting body's ability to make or use insulin.
- Diabetes causes blood glucose (blood sugar) levels to go up higher than normal.
  - People without diabetes have blood sugars between approx. 70-125 mg/dL when fasting
- We refer to people living with diabetes as PWD

- Insert video #EverydayReality Anthem here:

https://vimeo.com/297604817

Types of Diabetes

Type 1	Type 2	Gestational	Pre-diabetes
• Body attacks beta cells in pancreas • No insulin made • Sudden onset, acute, myriad symptoms • Requires externally administered insulin to sustain life • Onset often (but not only) in childhood	• Body produces insulin • Progressive loss of adequate insulin secretion from beta cells • Often body also has difficulty absorbing insulin ("insulin resistance") • Delayed diagnosis due to vague or no symptoms until complications • Necessitates oral medications and/or insulin	• During pregnancy • Insulin resistance causes elevated blood sugars • Increases risk of developing type 2 diabetes	• Risk factor for/precursor to type 2 diabetes • Higher than normal blood glucose levels, do not meet type 2 diabetes diagnostic criteria • Often unknown to the person

Primary focus of this talk

KEY CONCEPTS IN DIABETES

Insulin

- Insulin is a hormone made by beta cells in pancreas needed to convert food into energy.
- Administered via injections or infusion (pump)
- Insulin is the key that allows glucose to be used by the cells

Insulin

Everyone without diabetes has insulin created by the body

Type 1

The body doesn't produce insulin and must be administered – total dependence on exogenous insulin

- Without insulin develop acute hyperglycemia and die within a week
- Physiologic symptoms are rapid and acute

Type 2

- Due to disease progression, many people will eventually need to take insulin in addition to medications.
  - Some people may be started on insulin therapy at diagnosis to lower BG (may be taken off later)
  - Insulin is often needed and may be perceived as worsening of the disease.
  - Can cause hypoglycemia

Blood Glucose (BG)

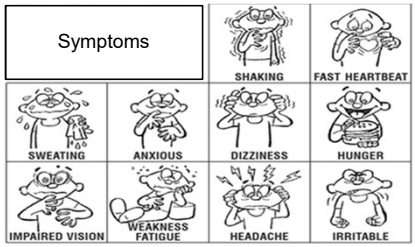
- Concentration of glucose (sugar) in blood
  - People use glucose, sugar, BG interchangeably
- Impacted by:
  - Diabetes type
  - Insulin in body
  - Body's ability to process insulin
  - Food, physical activity
  - Stress, sleep, illness
- BG Targets:
  - American Diabetes Association: 90-150
  - International Society of Pediatric & Adolescent Diabetes 70-140
  - Tailored to individual circumstances, needs
- No one with diabetes has BG in target range at all times!

Hypoglycemia (Low Blood Glucose)

- Blood glucose < 70mg/dL
- Can impact cognition and functioning
- Rapid drops very dangerous
  - Seizures, loss of consciousness
- Requires immediate treatment:
  - Fast acting carbs/sugar
  - Monitor glucose levels
  - May require injected glucagon and assistance of emergency medical support
- Very common
  - 90% experience some hypoglycemia
  - 10-30% experience a severe episode at least annually
  - >200,000 ER visits/year for hypoglycemia in adults
- More likely:
  - with longer diabetes duration
  - at night

Cryer PE. Hypoglycemia in Diabetes: Pathophysiology, Prevalence, and Prevention. American Diabetes Association, 2009.

Hypoglycemia Symptoms



http://glutenanddiabetes.com/2013/12/30/symptoms-hypoglycemia-hyperglycemia/

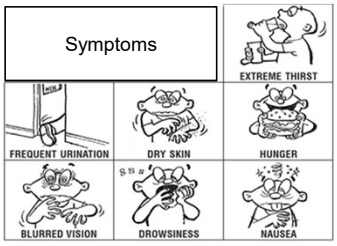
Hyperglycemia (High Blood Glucose)

- Blood glucose >180mg/dL
  - >300mg/dL is severe hyperglycemia

Treat elevated BGs with:
- Insulin
- Drink water
- Light physical activity
- Monitor glucose levels

- Immediate risks, if severe:
  - Cognitive symptoms, disorientation
  - Diabetic ketoacidosis (DKA) requiring hospital treatment
  - Coma, death
- Risks of chronic hyperglycemia:
  - Macro and microvascular complications
  - Cognitive impacts
  - Shortened lifespan

Symptoms of Hyperglycemia



NOTE: May say "I am high" when their BG is above their target range

http://glutenanddiabetes.com/2013/12/30/symptoms-hypoglycemia-hyperglycemia/

Glycemic Outcomes – A1c

What is Hemoglobin A1c?

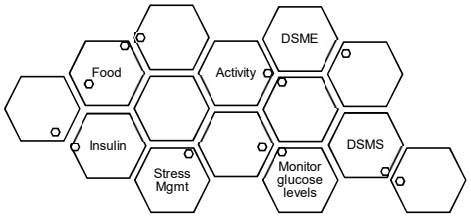
- Blood assay estimating average blood glucose over the last 2-3 months.
- Routinely measured every 3-6 mos. in clinics as index of overall diabetes status
- Goal: <7.0-8.0% depending on age, individual circumstances

Contributors to A1c

Genetics	Adequate insulin	Physical activity
Food intake	Illness	Stress
Unpredictability of diabetes		

MANAGING DIABETES

Diabetes Self-Management



Treatment for Type 1

- BG monitoring multiple times per day
  - via meter and/or continuous glucose monitor (CGM)
- Calculate & administer insulin throughout day & night
  - via syringe, pen or insulin pump
  - Calculate based on current BG level, planned food intake, circumstances
  - constant attention to timing, dose, impact of insulin
- Careful attention to food, exercise and stress
  - Monitor impact on BG and adjust insulin/activity accordingly

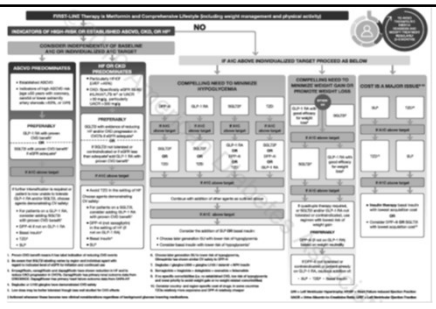
Treatment of Type I Diabetes

- Insert Video: Hunters's #EverydayReality
- https://vimeo.com/297390691

19

Treatment for Type 2

- Complex algorithm-driven medication treatment
- Diabetes self-management and lifestyle change goals
  - Weight management
  - Nutritional choices
  - Physical activity
  - Comorbidity and complications management
- Treatment may also include
  - BG monitoring (varying frequency)
  - Insulin via syringe, pen or insulin pump



https://care.diabetesjournals.org/content/diacare/suppl/2019/12/20/43.Supplement_1.DC1/Standards_of_Care_2020.pdf

Treatment of Type II Diabetes

- Insert Video: Tracey's #EverydayReality
- https://vimeo.com/297395614

22

Healthy Eating

- Food is a cornerstone of diabetes treatment
- Certain foods increase BG levels
  - Higher carbohydrate foods increase BG, require more insulin to manage
- Certain eating patterns increase risk for obesity
- Important for psychologists to support healthy food choices without judgement, stigma

Physical Activity

- Can contribute to better overall health:
  - Reduced cardiovascular risks
  - Support weight loss and maintenance
  - Improve mood
- Can contribute to better diabetes outcomes:
  - Lower BG
  - Improve insulin sensitivity
  - Prevent or delay onset of type 2

Colberg et al. *Diabetes Care*, 2016;39(11):2065–2079

Why Self-Management is Difficult

- Treatments are very complex and demanding
  - No vacations → feeling burned out
  - Requires upfront effort, often with little *immediate* positive feedback
  - Calculations of carbohydrates, insulin, etc require advanced cognitive skills
- Adherence does not guarantee desired results
  - Can follow all requirements and still have out of range BGs
  - Treatments have improved over time but are still far from perfect
  - Effective treatments are often not prescribed
- Circumstances make self-management difficult
  - Environments and social contexts often discourage health behaviors
  - May conflict with cultural and health beliefs
  - May conflict with developmental stages of childhood
  - Intergenerational context of type 2

Psychosocial Care: Position Statement

Psychosocial Care for People With Diabetes: A Position Statement of the American Diabetes Association
Diabetes Care 2016 Dec; 39(12): 2126-2140

Authors

- Deborah Young-Hyman, PhD, *NIH Office of Behavioral and Social Science Research*
- Mary de Groot, PhD, *Indiana University School of Medicine*
- Felicia Hill-Briggs, PhD, ABPP, *Johns Hopkins University School of Medicine*
- Jeffrey S. Gonzalez, PhD, *Yeshiva University and the Albert Einstein College of Medicine*
- Korey Hood, PhD, *Stanford University School of Medicine*
- Mark Peyrot, PhD, *Loyola University Maryland*

Psychosocial Care: Life Course and Continuum of Care

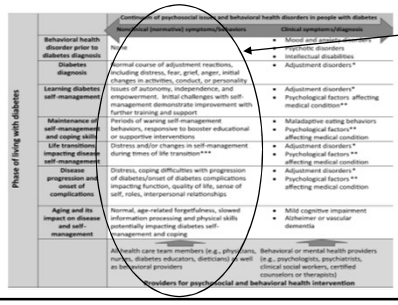
Phase of living with diabetes	Continuum of psychosocial issues and behavioral health disorders in people with diabetes	
	Nonclinical (normative) symptoms/behaviors	**Clinical symptoms/diagnosis**
Behavioral health disorder prior to diabetes diagnosis	None	• Mood and anxiety disorders • Psychotic disorders • Intellectual disabilities
Diabetes diagnosis	Normal course of adjustment reactions, including distress, fear, grief, anger, initial changes in activities, conduct or personality	• Adjustment disorders*
Learning diabetes self-management	Issues of autonomy, independence, and empowerment. Initial challenges with self-management demonstrate improvement with further training and support	• Adjustment disorders* • Psychological factors** affecting medical condition
Maintenance of self-management and coping skills	Periods of waning self-management behaviors, responsive to booster educational or supportive interventions	• Maladaptive eating behaviors • Psychological factors** affecting medical condition
Life transitions impacting disease self-management	Distress and/or changes in self-management during times of life transition***	• Adjustment disorders* • Psychological factors** affecting medical condition

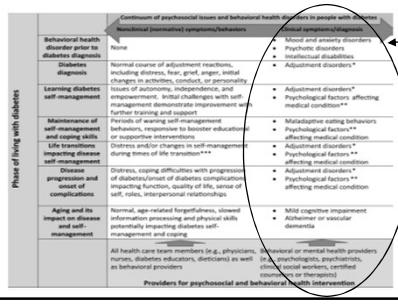
*With depressed mood, anxiety, or emotion and conduct disturbance. **Personality traits, coping style, maladaptive health behaviors, or stress-related physiological response. ***Examples include changing schools, moving, job/occupational changes, marriage or divorce, or experiencing loss.

(continued)

Phase of living with diabetes	Continuum of psychosocial issues and behavioral health disorders in people with diabetes	
	Nonclinical (normative) symptoms/behaviors	**Clinical symptoms/diagnosis**
Disease Progression and onset of complications	Distress, coping difficulties with progression of diabetes/onset of diabetes complications impacting function, quality of life, sense of self, roles, interpersonal relationships	• Adjustment disorders* • Psychological factors** affecting medical condition
Aging and its impact on disease and self-management	Normal age-related forgetfulness, slowed information processing and physical skills potentially impacting diabetes self-management and coping	• Mild cognitive impairment • Alzheimer's or vascular dementia
	All healthcare team members (e.g., physicians, nurses, diabetes educators, dieticians) as well as behavioral providers	Behavioral or mental health providers (e.g., psychologists, psychiatrists, clinical social workers, certified counselors or therapists)
	Providers for psychosocial and behavioral health intervention	

Life Course and Continuum of Care





Screening Recommendations

1. Include routine psychosocial assessment as part of ongoing diabetes care using a collaborative, person-centered approach.
2. Psychosocial issues should be understood through a life-course lens, understanding that life circumstances and therefore the needs of the person with diabetes, will change over time.
3. Screening and follow-up should include attitudes, expectations, mood, general and diabetes-related quality of life, resources, and psychiatric history.

Continued...

Standards of Medical Care in Diabetes. *Diabetes Care* 2015; 38 (Suppl. 1): S1-S93

Screening Recommendations (Cont'd)

4. Upon screening, symptoms that reach the level of clinical significance require referral to appropriate care providers.
5. Routinely screen for diabetes-related distress, depression, anxiety, and disordered eating behaviors.
6. Older adults should be considered a high priority population for screening & treatment.

Standards of Medical Care in Diabetes. *Diabetes Care* 2015; 38 (Suppl. 1): S1-S93

When to Screen

- At diagnosis
- Regularly scheduled visits
- Changes in medical status
- During hospitalization(s)
- When new-onset complications occur
- Whenever problems are identified with:
  - Glucose control
  - Self-management
  - Quality of life

Standards of Medical Care in Diabetes. *Diabetes Care* 2017; 40 (Suppl. 1): S39-40

When Mental Health Provider Services are Indicated

- Self-care impaired after tailored diabetes education to ensure knowledge, skill, and resources to perform self-care
- Evidence of persistent diabetes distress on observation or through discussion during clinical encounter
- Positive screen on a validated screening tool (for depression, anxiety)
- Symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating specific to the care regimen
- Intentional omission of insulin or oral medication to cause weight loss

Continued…

Mental Health Provider Indications (cont'd)

- Serious mental illness is previously documented or suspected
- Youth and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, or significant distress
- Screen positive for cognitive impairment
- Declining or impaired ability to perform diabetes self-care behaviors
- Before undergoing bariatric or metabolic surgery and after surgery for 1yr

Common Psychosocial Issues

- Diabetes distress
- Mental health disorders
  - Depression
  - Anxiety
  - Disordered eating

Diabetes Distress

Diabetes Distress

- Significant negative emotional reaction
  - Diagnosis of diabetes
  - Worry and fear regarding health, longevity, complications
  - Financial and behavioral burden of living with diabetes
  - Onset of complications
  - Impact on lifestyle of self-management demands
  - Lack of social support or resources for managing diabetes

Gonzales et al. *Diabetes Care* 2011; 34:2222–2227

Diabetes Distress: Prevalence and Impact

- 18-45% with an incidence of 38-48% over 18 months
- High levels of diabetes distress significantly impact medication-taking behaviors
- Linked to higher A1C, lower self-efficacy, poorer dietary and exercise behaviors
- One-third of adolescents with diabetes develop diabetes distress (associated with declines in self-management behaviors and suboptimal blood glucose levels)
- Parents of children with type 1 diabetes prone to diabetes distress, which impacts their ability to provide support for their child

Diabetes Distress: Survey Instruments

- Problem Areas In Diabetes (PAID)
- Diabetes Distress Scale (DSS)
- PAID-Peds
- PAID-Teen Version
- PAID-Parent Revised Version

Diabetes Distress: Treatment

- Develop a step-by-step action plan to address key concerns
- Provide continuing emotional and instrumental support: reduce burden of care whenever possible through shared responsibility taking
- Follow up with feedback about health status and constructive feasible strategies to improve outcomes
- If setting goals, make sure they are “SMART:”
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Time-limited in duration

Depression

Depression Impact

- Affects one in four people with type 1 or type 2 diabetes
- Associated with poorer self-care and medication adherence
- Associated with diabetes complications
- Increases risk for obesity, sedentary lifestyle, smoking
- Increases health care service utilization and costs
- Increases risk for type 2 diabetes

Ciechanowski PS, et al. *Arch Intern Med* 2000; 160:3278–3285
Lin EHB, et al. *Diabetes Care* 2004; 27:2154–2160

Association with Diabetes Complications

Depression is associated with:

- Retinopathy (.17)*
- Nephropathy (.25)*
- Neuropathy (.28)*
- Sexual dysfunction (.32)*
- Macrovascular complications (.20)*

(* Weighted R values)

de Groot et al., *Psychosom Med* 2001; 63: 619-630

Major Depressive Disorder (MDD)

- Either depressed mood or loss of interest/pleasure for 2 week period, AND at least five (5) additional symptoms:
  - Depressed mood --Insomnia or hypersomnia
  - Diminished interest/pleasure --Feelings of worthlessness/excessive guilt
  - Lack of energy --Thoughts of death/suicide
  - Concentration difficulties --Significant weight loss/gain, appetite change
  - Psychomotor retardation/agitation
- Clinically significant impairment in social, occupational, or other important areas of functioning; Represents a marked change in functioning
- Not attributable to the physiological effects of a substance or to another medical condition

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5

Depressive Symptomatology

- Symptoms, but not meeting criteria for Major Depressive Disorder (MDD)
  - Depressed mood --Changes in sleep
  - Diminished interest --Feelings of worthlessness/excessive guilt
  - Lack of energy --Thoughts of death
  - Concentration difficulties --Changes in appetite/weight
  - Psychomotor retardation/agitation
- Common among people with diabetes
- Associated with poor self-care, complications, and mortality

Gonzales et al. *Diabetes Care* 2011; 34: 236-239

Depression: Who Should be Screened

Routine screening recommended for persons with:

- Prediabetes (particularly overweight patients)
- Type 1 and type 2 diabetes
- Gestational diabetes
- Postpartum diabetes

Depression: Survey Instruments

- Patient Health Questionnaire (PHQ-2, PHQ-9)
- Beck Depression Inventory II (BDI-II)
- Child Depression Inventory (CDI-2) in ages 7-17 years
- Geriatric Depression Scale (GDS) ages 55-85 years

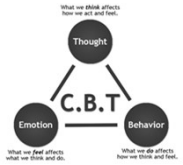

PATIENT HEALTH QUESTIONNAIRE-9

Depression: Referral

Referrals for treatment of depression should be made to mental health providers with experience in:

- Cognitive behavioral therapy (CBT)
- Problem-solving therapy

Pharmacotherapy should also be considered if symptoms interfere with effective self-care behaviors. Referral to a psychiatrist familiar with diabetes is preferred.



Anxiety

Anxiety: Common Disorders

- Generalized anxiety disorder (GAD)
- Body dysmorphic disorder
- Obsessive compulsive disorder (OCD)
- Specific phobias, particularly needle phobia and fear of hypoglycemia
- Posttraumatic stress disorder (PTSD)

Anxiety: Prevalence and Impact

- Lifetime prevalence of GAD to be 19.5% in people with either type 1 or type 2 diabetes
- Common diabetes-specific anxiety:
  - Fears related to hyperglycemia
  - Not meeting blood glucose targets
  - Insulin injections
  - Fear of hypoglycemia (FoH)
- General anxiety is a predictor of injection-related anxiety and FoH

Anxiety: Who Should be Screened

- Exhibiting anxiety or worries that interferes with self-management behaviors regarding:
  - Diabetes complications
  - Insulin injections or infusion
  - Taking medications
  - Hypoglycemia
- Express fear, dread, or irrational thoughts and/or show anxiety symptoms:
  - Avoidance behaviors (including medical care)
  - Excessive repetitive behaviors
  - Social withdrawal

Continued...

Anxiety: Who Should be Screened (Cont'd)

- Preoccupation with an imagined defect in appearance that interferes with social, occupational, or other areas of function - body dysmorphic disorder
- Exhibits excessive diabetes self-management behaviors to achieve glycemic targets, reports repetitive negative thoughts about inability to prevent poor health outcomes, and/or has related thoughts and behaviors that interfere with daily living – OCD
- Severe hypoglycemia - PTSD and PTSD-like and panic disorder symptoms

Anxiety: Survey Instruments

- State-Trait Anxiety Inventory (STAI) and for Children (STAIC)
- Beck Anxiety Inventory (BAI)
- Hypoglycemia Fear Survey – II (HFS-II)
- Children's Hypoglycemia Index (CHI)

Anxiety: Referral and Treatment

- In hypoglycemia unawareness (can co-occur with fear of hypoglycemia)
  - Treat using Blood Glucose Awareness Training (BGAT) to help re-establish awareness and reduce fear
- In OCD
  - Referral to a mental health professional familiar with OCD treatment should be considered if diabetes re-education is not effective in reducing obsessive thoughts, behaviors, or feelings of general anxiety

Anxiety: Referral and Treatment (cont'd)

- FoH without symptoms of hypoglycemia
  - A structured program (Blood Glucose Awareness Training) should be delivered in routine clinical practice to improve A1C, reduce the rate of severe hypoglycemia and restore hypoglycemia awareness

Disordered Eating Behavior

Disordered Eating: Behaviors and Impact

- In type 1 diabetes, insulin omission causing glycosuria in order to lose weight is the most commonly reported disordered eating behavior. People with type 2 diabetes treated with insulin, also frequently report intentional omission.
- In type 2 diabetes, bingeing (excessive food intake with an accompanying sense of loss of control) is most commonly reported.
- Persons with disordered eating, disrupted eating patterns, and eating disorders have higher rates of diabetes distress and FoH than those without these symptoms

Disordered Eating: Who to Screen

- Unexplained hyperglycemia and weight loss, despite self-report of adherence to medical regimen including medication dosing and meal plan
- Self-report of excessive caloric restriction and/or excessive physical activity.
- Expression of significant dissatisfaction with body size, shape or weight.
- Report of loss of control over eating.
- Repeated unsuccessful dieting attempts.

Disordered Eating: Survey Instruments

- Eating Disorders Inventory-3 (EDI-3)
- Diabetes Eating Problems Survey (DEPS-R)
- Diabetes Treatment and Satiety Scale (DTSS-20)

Disordered Eating: Screening Considerations

- Potential confounders to the identification of symptoms are:
  - Behaviors prescribed as part of treatment (carbohydrate counting, calorie restriction)
  - Behaviors or effects e.g., loss of control over satiety regulation
  - Adverse effects of treatment, such as excessive hunger secondary to hypoglycemia

Disordered Eating: Screening Considerations (Cont'd)

- When evaluating symptoms, etiology and motivation for the behavior should be considered
  - Missed insulin injections due to suboptimal self-management differ significantly from intentional medication omission to produce weight loss
- Assessment and screening requires methods that account for:
  - Treatment prescription, regimen behaviors and diabetes-specific eating problems

Disordered Eating: Referral and Treatment

- Review of the medical regimen is recommended to identify potential treatment-related effects on hunger/caloric intake
- If night eating syndrome (recurrent eating at night) is diagnosed, changes to the medication regimen are required until maladaptive eating patterns are modified
- Adjunctive medication such as glucagon-like peptide 1 receptor agonists may help
  - Meet glycemic targets
  - Regulate hunger and food intake
  - Potential to reduce uncontrollable hunger

Disordered Eating: Referral and Treatment

- Bulimia, the most commonly reported symptom in persons with diabetes, should be evaluated in the context of treatment, especially insulin dose.
- If a diagnosis of Bulumia Nervosa is established via clinical interview by a qualified professional, use of anti-depressant and anti-anxiety medications is often effective when accompanied by psychotherapy.
- In severe cases of Bulimia or Anorexia, hospitalization may be necessary to stabilize diabetes and mental health.

Older Adults

- Older adults with diabetes:
  - 73% increased risk of all types of dementia
  - 56% increased risk of Alzheimer's dementia
  - 127% increased risk of vascular dementia
- People ≥65 years of age should receive screening annually for mild cognitive impairment or dementia

Bariatric Surgery

- Increased risk of:
  - Depression and other major psychiatric disorders
  - Body image disorders, sexual dysfunction and suicidal behavior
- People presenting for bariatric surgery should be assessed by a professional familiar with weight-loss interventions and post-bariatric surgery behavioral requirements
- If psychopathology is evident (particularly suicidal ideation and/or significant depression), postponement of surgery should be considered until psychosocial issues are resolved or stabilized
- Consider ongoing mental health services to help patients adjust post-surgery

COVID19 & Diabetes

- For patients with COVID19 admitted to ICU: High rate of elevated BG
  - Possible development of Type I post COVID infection
- Up to 35% of all fatalities are People with Diabetes.
- PWD often have co-morbidity with HD, Renal complications
  - COVID patients sometimes experience renal failure / dialysis.
- PWD are high risk patients for COVID19 infection.

COVID19 & Diabetes

- Increased stress direct impact on BG.
- Strict adherence to infection control – more isolated socially
  - Fewer social supports that can help with adherence to regimen
- Increased rates anxiety & depression / helplessness
- Access to healthy food, medication may be limited.
- Preliminary research indicates extended quarantine related to increased carbohydrate and fruit consumption, decreased exercise.

COVID19 & Diabetes

- Consider all PWD as under more stress.
- Recommend more frequent check in
  - Screen for depression/anxiety/self harm/ substance abuse
- Shorter more frequent sessions
- Maintenance of daily routine becomes essential.
- Assist with problem solving around exercise, access to food and medication.

Implementing Team-Based Psychosocial Care

Embedded Behavioral Specialist	Referral to Behavioral Provider	Collaborative Care Model (CCM)
• In primary care and diabetes specialty clinics • Behavioral care carried out by a psychologist or clinical social worker embedded within the clinical practice site • Behavioral specialist participates as consultant and/or engages with practice as member of interdisciplinary team	• Referral outside of the medical practice • Concurrent, non-integrated behavioral care provided by behavioral specialist or mental health practice • Arrangement of formal methods of communication (e.g. medical records sharing, formal methods for behavioral provider ongoing progress feedback to referring physician)	• In primary care or specialty medical care • Integrated behavioral care carried out by behavioral health Care Manager, with Psychiatrist consultant • Weekly team meetings include PCP/specialist, CM, psychiatrist consultant • Use of a dashboard and metrics for individual patient progress monitoring

CMS Reimbursement for Embedded Primary Care Behaviorist Model (Integrated Care)

Treating (billing) Practitioner: A physician or non-physician primary care or other specialty medical or nursing clinician, can bill CPT code 99484

Patient – Member of the Care Team

Mental Health Staff – The billing practitioner may use qualified clinical staff to provide services using a team-based approach. Can bill for appropriate mental health or health behavior assessment codes.

Medicare Learning Network. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

72

CMS Reimbursement for Care Management: Collaborative Care Approach (CoCM)

CARE TEAM MEMBERS

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology)
- **Behavioral Health Care Manager** – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner
- **Psychiatric Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications
- **Beneficiary** – The beneficiary is a member of the care team

Medicare Learning Network. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

73

New Payment Models

- CMS/CMMI have piloted over 25 new payment models in the past 5 years.
- Know what is emphasized to the clinics you are consulting.
- Common themes:
  - Decreased reimbursement for fee for each service.
  - Additional payment for quality of care.
  - Current emphasis on payment for outcome (e.g. BP, A1C)

Summary

- Described psychosocial issues that are common in people with diabetes, ranging from normative diabetes specific distress to diagnosable mental health disorders.
- Presented implementation models for integrating psychosocial services into team-based care.
- Reviewed screening recommendations and tools for use within routine care.
- Described appropriate referral and treatment recommendations for people impacted by both sub-clinical and clinical psychosocial distress.

Helpful Resources

Diabetes Mental Health Provider Education Program

Mental Health Provider Diabetes Education Program

ADA and American Psychological Association (APA) partnered to create the first ever, diabetes-focused, continuing education (CE) program for licensed mental health providers.

Upon successful completion of the Continuing Education program, the provider can:

- Become an ADA member at the Associate level
- Receive 12 CE credits from the APA
- Become eligible for inclusion on the Mental Health Provider Referral Directory
- Access the ADA's new listserv for behavioral health and psychosocial topics
- Access monthly "mentoring" calls with experts in the field

ADA's Online Mental Health Provider Referral Directory

Mental Health Provider Diabetes Education Program

Living with diabetes is exhausting. People need support and empowerment to live their best life.

ADA is pleased to announce the launch of the new Mental Health Provider Referral Directory, which can help you locate mental health professionals in your area with demonstrated expertise in diabetes care.

https://professional.diabetes.org/ada-mental-health-provider-directory

American Association of Diabetes Educators (AADE)

Mental Health and Diabetes Website

- Mental Health and Diabetes Practice Paper
- How-To Resources
- Patient education materials
- Videos

https://www.diabeteseducator.org/practice/educator-tools/mental-health-and-diabetes

Diabetes Self-Management Education

- Find a recognized Diabetes Self-Management and Support program
- Become a recognized provider of DSME/S
- Tools and resources for DSME/S
- Online education documentation tools

Professional.Diabetes.org/ERP

Training Resources for Primary Care Providers

- American Academy on Communication in Healthcare (DocCom Online CME modules http://www.doccom.org/Content

  Ex: The therapeutic relationship in medical encounters, Exploring difficult topics (emotions, sexual activity), Encountering behavioral health issues (anxiety, panic), Shared decision-making

- Motivational Interviewing Training Programs http://www.motivationalinterviewing.org/
- Conducting the Cognitive Screening Assessment During the Medicare Annual Wellness Visit (PCP Instructional videos and assessment tools) http://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp

Thank You!