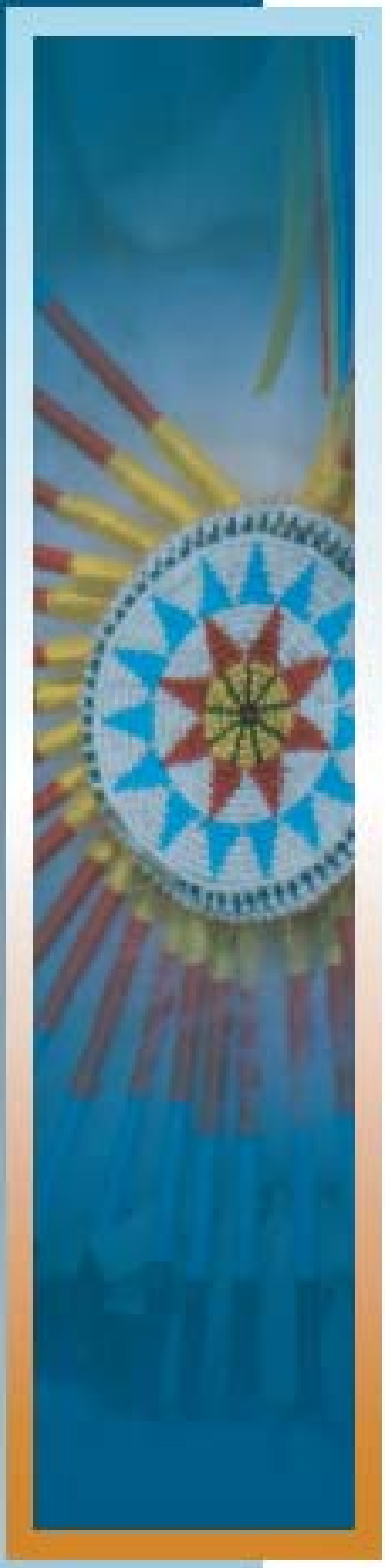

INDIAN HEALTH DIABETES BEST PRACTICE

Depression Care

Revised April 2011

Indian Health Service
Division of Diabetes Treatment and Prevention
5300 Homestead Road NE
Albuquerque, New Mexico 87110
http://www.ihs.gov/MedicalPrograms/Diabetes

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Table of Contents

Instructions for Using This Best Practice 3
Summary of Key Recommendations and Key Measures..... 4

PART 1 ESSENTIAL ELEMENTS OF IMPLEMENTING THIS BEST PRACTICE..... 5
Purpose and Target Population 6
Intended Users of this Best Practice..... 6
Definition of Depression Care 6
Goals of This Best Practice 6
Key Recommendations..... 7
Planning for Your Program and Evaluation..... 8
Key Action Steps..... 8
Key Measures 8

PART 2 KEY RECOMMENDATIONS..... 10
Note! Part 2 provides important detail on the “why?” and “how?” of implementation of each Key Recommendation..... 10

PART 3 APPENDICES, TOOLS, AND RESOURCES..... 23

PART 4 REFERENCES 37

Instructions for Using This Best Practice

The Best Practices are organized into topics on how to plan for and successfully implement a Best Practice in your community.

- **Part 1** provides background information on planning for your program and evaluation, Key Recommendations, and Key Measures.
- **Part 2** provides details on implementation of the Key Recommendations.
- **Part 3** includes appendices, tools, and resources.
- **Part 4** provides a list of references.

As you prepare to select, implement, and evaluate a Best Practice, consider these planning guidelines:

- Meet with your diabetes team to discuss which Best Practice(s) is best suited for your situation and resources.
- Use data from your *Diabetes Care Outcomes and Audit* and/or from a community needs assessment to guide your selection of the Best Practice(s).
- Determine your program goal(s) as a team. For example, your team may decide to work toward increasing the number of people who receive eye exams.
- Print out at least Part 1 of the Best Practice(s) your team feels is most appropriate to implement.
- Work with your diabetes team to review and discuss the Best Practice(s). You may choose to read it together as a team.
- Choose at least one Best Practice after carefully considering your goals and resources (funding, staff, and time).
- **Review the entire Best Practice(s) you have selected with your diabetes team:**
  - Confirm that you have selected a Best Practice(s) appropriate for your community needs and resources and that you are confident that your team can successfully implement, evaluate (measure), and document progress and outcomes.
  - Target the population your team wants to improve outcomes for with the Best Practice(s). Remember, you probably do not have resources to do everything for everyone.
  - Carefully consider the Key Recommendations. The recommendations are based on evidence and have been proven to be effective. You may already be doing some of the recommendations and can easily fit these into your plan, or you may want to consider some new recommendations to enhance and strengthen your program. Identify those your team can implement.
  - Carefully review the Key Measures. Choose those that best fit with your goals and the Key Recommendations you have chosen to implement.
  - If one Best Practice does not fit, then review another Best Practice until you find one that fits.

Throughout the document you will find links that draw your attention to important items within the Best Practice pdf. Here is a list of the items:

- **Action!** Indicates a **link**. Please use the link to access more detailed descriptions.
- **Note!** Indicates an **important** item. Pay special attention to this **important** item.

Summary of Key Recommendations and Key Measures

These are evidence-based actions that will lead to improved outcomes in the community. Action! See Part 2 for details on the implementation of each key recommendation.

For Your Patients with Diabetes:

1. Educate providers on how to screen for and treat depression.
2. Screen for depression in all patients with diabetes.
3. Provide depression care and treatment.
4. Recognize when to refer patients for specialist mental health care.

For Your Health Care System:

5. Commit to improving depression care in people with diabetes.
6. Dedicate funds to improve depression care in people with diabetes.
7. Coordinate depression care between behavioral and primary care settings.
8. Design and implement an education program for the community and help patients connect to community resources.

These are specific measures that can be used to document changes in outcomes related to implementing the Best Practice.

Note! All SDPI grant programs that choose this Best Practice must report as required in the terms and conditions attached to the notice of award on the indicated Measures. Programs may report on other measures as well.

*The following measures are of primary importance:

1. ***Percentage of diabetes patients who were ***screened*** for depression in the past twelve months.
2. ***Percentage of diabetes patients with documented depression that received ***treatment*** for depression in the past twelve months.

PART 1 Essential Elements of Implementing This Best Practice

Purpose and Target Population

This Best Practice provides guidance for programs that seek to improve individuals' diabetes and mental health status, and to enhance delivery of effective diabetes care. It describes depression screening and treatment options. The target population to be covered by the Best Practice is any individual with type 1 or 2 diabetes.

Action! See Part 3 – Appendix A. for the importance of depression care.

Intended Users of this Best Practice

- Primary health care providers and teams,
- behavioral and mental health care providers and teams,
- diabetes teams, and
- leaders of health care organizations.

Action! See Part 3 – Appendix A. Supplemental Information for discussion of the benefits and risks of implementing this Best Practice.

Definition of Depression Care

Depression care involves providing effective support, screening, and interventions to improve a person's emotional well-being, whether he/she is experiencing, has experienced, or is at increased risk for depression and other emotional health issues.

Goals of This Best Practice

- To increase knowledge of how to screen for depression in patients with diabetes.
- To increase percentage of patients with diabetes who receive appropriate depression care and treatment.
- To increase referrals of patients with diabetes and depression for specialist mental health care.

Key Recommendations

These are evidence-based actions that can lead to improved outcomes for persons with type 1 or type 2 diabetes.

These are evidence-based actions that will lead to improved outcomes in the community. Action! See Part 2 for details on the implementation of each key recommendation.

For Your Patients with Diabetes:

1. Educate providers on how to screen for and treat depression.
2. Screen for depression in all patients with diabetes.
3. Provide depression care and treatment.
4. Recognize when to refer patients for specialist mental health care.

For Your Health Care System:

5. Commit to improving depression care in people with diabetes.
6. Dedicate funds to improve depression care in people with diabetes.
7. Coordinate depression care between behavioral and primary care settings.
8. Design and implement an education program for the community and help patients connect to community resources.

Action! See Part 2 for details on the implementation of each key recommendation.

Planning for Your Program and Evaluation

Key Action Steps:

1. **Identify your program's goal(s).** There are many program goals consistent with the Key Recommendations of this practice. Examples of program goals include:
   - Increase the number of people with diabetes who are screened for depression.
   - Increase the number of people with diabetes and depression who receive appropriate treatment for depression.

2. **Define program objectives** that will be met to reach the program goal(s) in the **SMART format** (specific, measurable, action-oriented, realistic, and time-bound).

   Examples of SMART objectives for this Best Practice:
   - Increase the percentage of people with diabetes who received diabetes screening from 75% to 95% by the end of the fiscal year.
   - 100% of people with diabetes who have a positive depression screen will be referred to a health care provider for depression evaluation and treatment.

3. **Use Key Measures**. The following Key Measures can be used to monitor progress and the effectiveness of implementing this Best Practice. Results of measures will indicate the degree of success in implementing the **Key Recommendations** and meeting program goals.

   Measures of progress need to occur before the intervention (baseline) and at designated times thereafter. Measurement needs to be frequent enough to provide meaningful information for planning and evaluation.

Key Measures

These are the specific measures that can be used to document changes in outcomes related to implementing the Best Practice.

Note! All SDPI grant programs that choose this Best Practice must report as required in the terms and conditions attached to the notice of award on the indicated Measures. Programs may report on other measures as well.

***The following measures are of primary importance:**

1. ***Percentage of diabetes patients who were ***screened*** for depression in the past twelve months.

2. ***Percentage of diabetes patients with documented depression that received ***treatment*** for depression in the past twelve months.

4. **Collect, record, and analyze data** on an ongoing basis; share with the team and the organization leadership.

5. **Use creative ways to display data and measure outcomes, such as graphs or charts.** This helps the team understand the data and know whether there are improvements.

6. **Think about what the data are telling you.** What changes are you seeing? Are there improvements? Use data for planning next steps.

Action! See the following resources to help your program improve.

See Part 3 – Appendix B. Key Measures Example to assist you with identifying ways to choose Key Measures that incorporate your community data.

See Part 3 – Appendix C. Improving Depression Care Programs Example to assist you with applying Key Recommendations and Key Measures to a program plan.

Action! See an **online training** and a **workbook** to get more ideas about setting goals and objectives and developing a program plan. Available from: http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Training/WebBased/Basics/Creating/Workbook.pdf (see pages 23–28).

Team Notes:

PART 2 Key Recommendations

Note! Part 2 provides important detail on the "why?" and "how?" of implementation of each Key Recommendation.

Key Recommendation 1. Educate providers on how to screen for and treat depression.

Why?

Health care providers who receive appropriate training in mental health care can 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 to Implement the Key Recommendation

Health care systems and organizations need to ensure that providers obtain education on screening for, and basic treatment of, depression.

The goals and content of the provider education should include:

- depression prevalence
- screening for depression
- depression diagnosis
- skills development in active listening
- assessment for suicidal ideation, co-existing substance abuse, and other mental health issues
- treatment options, both pharmacologic and non-pharmacologic, and
- criteria for and resources available for referring patients for behavioral health care including counseling, substance abuse treatment, psychiatric care, and hospitalization.

Team Notes:

Key Recommendation 2. Screen for depression in all patients with diabetes.

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 (Anderson, 2001; Ciechanowski, 2000; Ell, 2010; Katon, 2006, 2010; Lustman, 1998, 2000; Singh, 2004; Snoek, 2011;).

The American Diabetes Association's *Standards of Medical Care in Diabetes—2011* states that "Assessment of psychological and social situation should be included as an ongoing part of the medical management of diabetes" (ADA, 2011. p. S25).

How to Implement the Key Recommendation

A. **Many types of health professionals can screen for depression**.

B. **Screen the patient verbally, or provide the patient with a pre-printed screening form** for him or her to complete.

C. **Use a screening tool that is simple to administer and assess, such as the PHQ-9** (Patient Health Questionnaire Mood Scale) screening tool, which assesses Diagnostic and Statistical Manual of Mental Disorders (DSM) depression criteria and is designed for use in primary care settings (Kroenke, 2001).

Patient Health Questionnaire Mood Scale (PHQ)-9 Screening Tool for Use in Primary Care

Screening Questions
Step one: Two-question basic screening—Over the last two weeks, how often have you been bothered by any of the following problems: • Having little interest or pleasure in doing things? • Feeling down, depressed, or hopeless? **Step two:** If the response to either question is "yes," administer the seven remaining items: • Trouble falling or staying asleep, or sleeping too much, • Feeling tired or having little energy, • Poor appetite or overeating, • Feeling bad about yourself, that you are a failure, or that you have let yourself or your family down, • Trouble concentrating on things, such as reading the newspaper or watching television, • 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, and, • Thoughts that you would be better off dead or of hurting yourself in some way.

Alternatively, it is also fine to administer all nine questions at once instead of as a two-step process as above.

<u>A screen should be considered positive</u> if the patient answers "yes" to *either* of the first two questions (Step one in the table above). Screening results should be given to the patient's provider and, if the screen was positive, the provider should address this in the visit and document the result in a note. A positive screen does *not* necessarily mean that the patient has depression, because there are other medical/ psychological conditions that can cause the patient to answer "yes" to these questions (e.g., CHF exacerbation, hypothyroidism, advanced chronic kidney disease, chronic stress, etc.). What is important is that the patient is screened so the provider can investigate and intervene in whatever is causing these symptoms.

Score each PHQ-9 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. The likelihood that the patient has true depression increases as the PHQ-9 score increases, but it is still important that the provider evaluate the diagnosis as well as develop a treatment plan in collaboration with the patient.

D. **Share results** with the patient and give to his/her provider so they can be addressed during clinic visit.

E. **Program the 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.

Action! Learn more about the PHQ-9 at: http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/.

Team Notes:

Key Recommendation 3. Provide depression care and 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, 2005; Surwit, 2002).

How to Implement the Key Recommendation

A. **A skilled health care provider, social worker, mental health counselor, psychologist, or psychiatrist can provide depression care or treatment**.

B. **Listen to patients** and inquire about their emotional health:

- ADA recommends that, "Psychosocial screening and follow-up should include, but is not limited to, attitudes about the illness, expectations for medical management and outcomes, affect/mood, general and diabetes-related quality of life, resources (financial, social, and emotional), and psychiatric history" (ADA, 2011, p. S25).
- Ask about substance use/abuse.
- For patients whose depression screen is positive, providers should then determine whether their symptoms are due to depression and/or to another condition, then institute an appropriate treatment plan. Ask about coexisting substance abuse and other mental health issues.

C. **Prescribe different therapies as appropriate** to the patient:

- antidepressant medications
  - patients with severe depression are more likely to benefit than those with milder symptoms (Fournier, 2010)
- physical activity
- support groups, including twelve-step programs as applicable
- group and individual therapies, including:
  - 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
- psychoeducation, 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 psychoeducation includes teaching coping strategies and problem-solving skills to families, friends, and caregivers to help them more effectively deal with the patient.
- coping skills and problem-solving training (King, 2010)

- various activity-type therapies (e.g., movement therapy, art therapy, equine-assisted psychotherapy)
- relaxation, meditation and mindfulness, guided imagery, and breathing techniques
- light therapy, which is especially helpful for seasonal affective disorder
- encourage patients to talk to spiritual counselors and/or to participate in ceremonies as is appropriate to their belief system.

D. **Because physical activity has been shown to be an effective approach to reducing depression, sponsor community programs** such as traditional dance, yoga, tai chi, walking, running, and exercise programs.

E. **Sponsor or promote programs addressing *historical trauma issues***—designed by the local Tribe or organizations such as White Bison/Wellbriety.

F. **Offer programs or refer patients for appropriate complementary therapies**, such as acupuncture and massage. Although these therapies have not been proven to affect depression directly, they have been proven to be effective for chronic pain, which can contribute to depression.

G. **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) programs 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 elders and people with disabilities,
  - domestic violence shelters,
  - social services, and
  - literacy programs.

H. **Provide access to consultation** by behavioral health specialists or providers with depression-related expertise—in person or by telemedicine, telephone, or radio as available.

I. **Offer options for diabetes and depression care**

- group medical visits (Davis, 2008)
- collaborative care management: nurses who provide guideline-based patient-centered case management of diabetes and depression significantly improve both conditions (Katon, 2010)
- web-based or online treatment, including
  - telepsychiatry/telepsychology (van Bastelaar, 2011)
  - case management
  - psychoeducation
  - support groups

Action! See Part 3 – Appendix D. for specific examples of Depression Care Best Practice Program Components.

Team Notes:

Key Recommendation 4. Recognize when to refer for specialist mental health care.

Why?

Early recognition, accurate assessment, and referral of patients with depressive symptoms to appropriate health care providers and systems can reduce negative outcomes (Delamater, 2001; Lustman, 1998).

How to Implement the Key Recommendation

Although many patients with depression can be managed by the primary care team, it is important to identify those for whom specialty mental health care is indicated:

A. **Assess the patient for suicidal ideation, plan, and intent.**

B. **Determine if other mental health issues exist** that would complicate the accurate diagnosis and appropriate treatment of the patient, e.g., symptoms suggesting bipolar disorder, thought disorders, personality disorders, or co-occurring substance abuse disorders.

C. **As indicated, refer patient to the appropriate mental health provider** and/or hospital in the timeframe necessitated by his/her condition.

Team Notes:

Note! Recommendations for Your Health Care System

Working Together with Your Community and Organization

Programs need to work on broader community and organizational support of the goals they are trying to achieve.

Key Recommendation 5. Commit to improving depression care in people with diabetes.

Why?

Improvements in health care systems can help improve the delivery of appropriate care to people with diabetes and depression (Katon, 2006).

How to Implement the Key Recommendation

Health care systems and organizations can help improve depression care for people with diabetes by:

A. i**mplementing and sustaining systems** that provide depression screening for all individuals with diabetes,

B. **providing annual training** in identifying and treating depression including diagnosis, differential diagnoses, and interventions,

C. **implementing culturally- appropriate approaches** for supporting patients in the many social and environmental stresses they face that can contribute to risk for developing depression,

D. **conducting routine meetings** between administration, medical providers, and behavioral health care providers to facilitate referrals, follow-up, consultation, and treatment,

E. **providing resources** and adequate staff time to facilitate community linkages,

F. **facilitating and initiating community partnerships**, and

G. **actively promoting depression treatment in individuals with diabetes at all levels** by including depression topics in conferences, strategic plans, standards of care, audits, and training materials.

Team Notes:

Key Recommendation 6. 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 to and training in 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 mental health issues like depression, is vital to providing the best diabetes care and to obtaining positive outcomes (ADA, 2011).

How to Implement the Key Recommendation

Health care systems and organizations can use funds to:

A. **hire or contract with behavioral health specialists** to integrate into or coordinate with diabetes programs,

B. **redesign or expand space** to support behavioral health integration,

C. **support a range of antidepressant medications** in the pharmacy, and

D. **provide contract care funding** for specialty and inpatient behavioral health care when needed.

Team Notes:

Key Recommendation 7. Coordinate depression care between behavioral and primary care settings.

Why?

Coordination of care between behavioral and primary care can contribute to a comprehensive diabetes treatment plan. Research shows that:

Elderly patients with diabetes and depression are more likely to require *preventable* medical hospitalization than patients with diabetes who are not also depressed (Niefeld, 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 Implement the Key Recommendation

To coordinate behavioral and medical care, the diabetes team should:

A. **Be an integral part of the patients' behavioral health care**, even if the patient is referred for mental health services.

B. **Invite other programs, community organizations, and community members** to discuss how to address depression and other mental health issues.

C. **Design systems that incorporate depression care into diabetes care**.

Team Notes:

Key Recommendation 8. Design and implement an education program for the community and help patients connect to community resources.

Why?

Depression is often stigmatized and under-diagnosed. By developing a community education campaign, individuals are more likely to be aware of depression, seek help for it, and appreciate that depression is a treatable medical condition. Community education also helps to de-stigmatize depression.

How to Implement the Key Recommendation

Messages should be developed in a culturally appropriate and educationally accessible manner. Varied media can be used.

Community Education Messages
Diabetes and depression are often connected. There are recognizable symptoms of depression. There is an increased likelihood of depression when individuals and communities have experienced significant trauma and/or loss. Reduce the stigma of depression and encourage people to talk to their health care providers if they have symptoms. Effective treatment options are available in the community. Support family and friends who have depression symptoms and encourage them to talk to their providers.

Team Notes:

PART 3 Appendices, Tools, and Resources

Appendix A. Supplemental Information

1. Importance of a Depression Care Program

Depression is intertwined with type 2 diabetes and the association between the two is "bidirectional", meaning that the presence of one increases the risk that the other will develop. As many as a third of patients with diabetes will develop depression at some point. In addition, 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:

Rates of childhood and adult stress and trauma exposures are higher in Native American people as compared with the general population. These experiences are significantly associated with increased risk of having diabetes (Jiang, 2008; Manson, 2005).

Depression rates in Native Americans are several times higher than for the general U.S. population (Singh, 2004).

The prevalence of depression in people with diabetes is higher than in those without diabetes (Lin, 2010; Pan, 2010).

A1C levels are higher in Native American patients with diabetes and depression—1.2% higher in one study (Sahota, 2008; Singh, 2004).

The overall rate of depression in people with diabetes was 8.3% in the *2006 Behavioral Risk Factor Surveillance System (BRFSS)*, but *in American Indians/Alaska Natives it was **27.8%*** (Li, 2008).

Major depression is associated with a 25% increased risk of macrovascular complications and a 36% increased risk of microvascular complications in patients with type 2 diabetes (Lin, 2010).

Depression puts patients at significantly increased risk of death beyond the risk from their diabetes alone (Lin, 2009). In addition, diabetes is associated with a substantial excess of deaths from intentional self-harm (The Emerging Risk Factors Collaboration, 2011).

2. Benefits and Risks of Implementing This Best Practice

Depression is often under-identified and under-treated, especially in minority patients with diabetes (Sorkin, 2011), which can contribute to increased mortality (Pan, 2011), morbidity, and worse diabetes control. Even depressive symptoms that do not meet the diagnostic criteria for depression are associated with non-adherence to important aspects of diabetes self-care (Gonzalez, 2007) and may require different interventions than treatment of clinical depression (Fisher, 2007).

Effective treatment of depression and diabetes has been shown to significantly improve both, as well as quality of life and a number of functional outcomes (Ell, 2010; Katon, 2010).

Clearly, depression screening, monitoring, and treatment need to be incorporated into the care of Indian Health Services patients with diabetes.

Potential Risk: Despite the best efforts of the diabetes team to communicate the facts about depression, a few patients will still feel that being diagnosed with depression carries a negative stigma.

3. Health Questions Addressed by Best Practice

The health questions addressed in this Best Practice are:

- Why is depression an important issue in diabetes care?
- How can clinics screen for depression?
- What types of treatment options can be offered to patients who are diagnosed with depression?

4. Sustaining a 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.
- Build depression screening into clinic processes (e.g., visit planning, standards of care review, patient screening at time of visit).
- Share successes with the community by making presentations to the Tribal health board and council, and by 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 of behavioral and medical care.
- Refine the clinic appointment scheduling system as needed.

Appendix B. Key Measures Example

Remember—this is an example! Apply this process to your community using your data.

Depression is increasing among people with diabetes. Our health care center and community are concerned about the increasing number of people with depression.

Diabetes team takes action. Our diabetes team talked about addressing this problem and how the diabetes team could be more involved. We read the Depression Care Best Practice and talked about the Key Recommendations.

Identified sources of data. Local data included:

- Audit data
- RPMS data
- Medical Record review
- Contract health data
  - 49% of patients with diabetes had been screened for depression in the past twelve months
  - about 50% of patients with diabetes who had a diagnosis of depression were receiving follow-up treatment

Selected suitable Best Practice. After thinking carefully about our goals and resources, and reviewing data, we decided the Depression Care Best Practice was a good fit for us. We chose to work on two of the Key Recommendations: screening for depression and treatment rates of people with diabetes and documented depression.

Identified target population. We decided to start implementing this Best Practice with the current patients listed in our diabetes registry.

Identified program goals:

- To increase the number of people with diabetes who received depression screening.
- To increase the number of people with diabetes and depression who received depression treatment.

Identified SMART objectives based on our resources and data:

- The percentage of patients with diabetes who receive depression screening will increase from 49% to 60% in the next twelve months.
- The percentage of diabetes patients with documented depression who receive treatment for depression will increase from 50% to 60% in the next twelve months.

Selected Key Measures. We chose the corresponding Key Measures for these Objectives and these Key Recommendations. Data will be collected and reviewed at baseline and mid-year.

Table 1. Selected Key Measures

A. Measure	B. Baseline or beginning value and date (collected prior to starting activities)	C. Most recent value and date (if applicable)	D. Data source (where did these numbers come from)
1. * Percentage of diabetes patients who were screened for depression in the past twelve months	49% as of 12/2/2010	50% as of 5/10/2011	Chart review and audit data
2. * Percentage of diabetes patients with documented depression who received treatment for depression in the past twelve months	50% as of 12/2/2010	55% as of 5/10/2011	Contract Health Data

* Required Key Measure

Appendix C. Improving Depression Care Programs Example

Remember—this is an example! Ask these questions in your community, thinking about your local needs, resources, and tracking systems.

There are four fundamental questions to ask as you plan and implement your best practice. These questions (and sample answers) are:

1. **What is the target population?**
   - Adults with diabetes and depression
2. **What are you trying to accomplish by implementing this Best Practice?**
   - Improve depression care and services for people with diabetes in order to improve individual and community health, and
   - Help patients set their own goals through prompting and support from the diabetes care team.
3. **How will you know if what you do makes things better?**

Collect and display data on an ongoing basis. Analyze the data and use it to plan next steps. Improved data results suggest that things are getting better. Examples:

- Over one year, a 15% increase in the number of individuals with diabetes screened for depression.
- Within six months, a 10% increase in the number of patients who are diagnosed with depression who receive documented appropriate treatment and/or referral.
- Within one year, a 20% increase in the number of patients with diabetes and depression who are enrolled in a nurse case management program.

4. **What can you do to make things better?**
   - Receive leadership support to improve diabetes-related depression care.
   - Ensure that the diabetes team works together to increase the number of people screened and treated for depression.
   - Integrate behavioral health into diabetes care.
   - Have the diabetes team present available services, provide general information about depression and diabetes, and seek input at community events.

Appendix D. Examples of Depression Care Best Practice Program Components

1. Basic Depression Care Programs

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.

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, and related to, physical health.
- Enable staff to obtain appropriate training in behavioral health management techniques.
- Encourage novel approaches to depression screening, support, and treatment.
- Facilitate maximal coordination between behavioral and medical providers.

Patient Self-Management Support

- Present patient education on depression verbally and 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 antidepressant medications.
- Encourage patients to become aware of mood fluctuations and report any suicidal ideation.
- Discuss the connection of mood, depression, and anxiety with blood sugar levels.
- Provide instruction in 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.

Delivery System Design: Services, Programs, Systems, and Procedures

- Establish a diabetes team that includes administration, information technology, clinical professionals, and as appropriate, patients. Organize the team to integrate effective depression screening and treatment into clinic processes.
- Coordinate and integrate the diabetes clinic and behavioral health providers.
- Train health aides, CHRs, and other available personnel how to screen for depression and establish a protocol for following up positive screens.

- Make consultation by behavioral health specialists or other health care providers with depression-related expertise available by teleconference, telephone, or radio.
- Enable patients to see the same provider at each visit.

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, 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.

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 electronic health record fields in which to document depression screening results and treatment plans.
- Document depression screening in the medical record.
- Include depression questions on the annual diabetes audit.
- Implement diabetes summary, flow sheets, 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 electronic or paper chart to facilitate communication between diabetes and behavioral health providers.
- Create and/or modify electronic or PCC+ note templates to ensure they are maximally useful for local providers.

2. Intermediate Depression Care Programs: Basic program *plus the following:*

Community Resources and Policies

- Develop an inventory of behavioral health resources.
- Ensure the community has access to a mental health professional through established referral channels.

Organization Leadership

- Incorporate depression prevention, identification, and treatment into the clinic's annual goals.
- Ask the diabetes team to design a clinic plan that incorporates depression care.

Patient Self-Management Support

- Provide education within the framework of an IHS, AADE or other recognized diabetes curriculum.
- Ensure access to a program that appropriately treats chronic pain.
- Make group interventions available, such as group medical visits, support groups, and classes.

Delivery System Design: Services, Programs, Systems, and Procedures

- Screen for depression in all patients with diabetes 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 medications available.
- Ensure that providers have the ability to schedule adequate and flexible appointment times.
- Screen for substance abuse and domestic violence.

Decision Support: Information and Training for Providers –

- Offer at least annual training for providers on diagnosis, differential diagnoses, and treatment of depression.
- 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 twelve-step groups).
- Include all diabetes team members in trainings (because it may be the nutritionist, nurse educator, or CNA who hears what is going on in a patient's life and identifies the problem).

Clinical Information Systems: Collecting and Tracking Information –

- 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.

3. Comprehensive Depression Care Programs: Basic and Intermediate programs *plus the following:*

Community Resources and Policies

- 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 addressing issues related to intergenerational grief. Activities could include conferences, healing ceremonies, and genograms in therapeutic work.
- Create lists of and connect patients to community resources that address life stresses such as helping with food security, literacy, employment, housing, transportation, elder support, etc.
- Use case managers to provide guideline-based clinical care and to link patients to mental health and other services.
- Have case managers from different agencies and programs meet regularly to collaborate on service delivery.
    - Example: the heads of the diabetes clinic and the commodity food program meet to discuss ways to increase collaboration.

Organization Leadership

- 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 clinic space to support improved coordination and/or integration of behavioral health and diabetes programs.
- Include depression and other psychosocial issues in local/regional/area conferences, strategic planning, audits, and training materials.
- Build and maintain clinic systems that ensure that all patients with diabetes are screened for depression and then offered a wide range of appropriate treatment, support, and interventions.
- Provide funds and support to ensure that providers receive training at least annually in mental health issues.
- Enable the diabetes team to invite other programs, community organizations, and community members to brainstorm ideas on how to address depression and diabetes.
- Hold regular meetings between medical and behavioral health providers.

Patient Self-Management Support

- Develop and implement a variety of group programs, such as group medical visits, psychosocial education groups, support groups, classes for patients or family members, and peer-led groups such as Alcoholics Anonymous and Al-Anon.
- Provide concise, easy-to-understand information about depression and its treatment in written and verbal formats.
    - Include depression in diabetes education through curricula such as *Living with Diabetes*, which includes a module on depression. The IHS *Balancing Your Life and Diabetes* curriculum also includes information on depression.
- Provide community education on depression, coping with stress, and related topics.
- Ask patients on antidepressant medications at each appointment whether they are taking their medications and verify pharmacy refills.
    - Use checklists to prompt the educator to discuss side effects and response to medications.

- Consider asking patients to 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 patients in determining self-management goals for diabetes and depression.
    - Actively listen to patients' priorities, help problem-solve, and encourage patients to meet goals—instead of lecturing patients about behavior change.
- Teach relaxation techniques to patients dealing with significant stress.
- Base patients' appointment frequency on clinical factors, such as depression symptom severity as well as their A1C and diabetes complications.
- 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, including depression screening, are current.
    - Have public health nurses contact patients who have been lost to follow-up.
- Engage family members in the patient's treatment plan as appropriate and offer support and interventions as needed.

Delivery System Design: Services, Programs, Systems, and Procedures

- Integrate behavioral health personnel into diabetes care.
    - Provide office space for the behavioral health specialist and ensure that clinic flow supports visits with them.
    - Hire or contract with a behavioral health specialist who offers training, consultation, and attends diabetes team meetings.
    - Hold regular meetings with all diabetes team members, including the behavioral health provider(s).
    - Use case conferences to allow diabetes team members to give input on whether patients are responding to current therapy.
- Allocate funds in the pharmacy budget to support a wide range of antidepressant classes/medications.
- Develop a written depression treatment protocol.
- Assign specific staff members to administer and score the clinic's depression screening tool.
- Ensure that at least one member of the diabetes team is available to address same-day care needs, including behavioral health issues.
- 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.

Decision Support: Information and Training for Providers –

- Review the American Psychological Association's (APA) depression guidelines with the diabetes care team.

- Have the diabetes care team review significant elements of good diabetes care with behavioral health specialists.
- Offer continuing education credits for trainings related to depression and diabetes.
- If diabetes care is provided in an outside clinic, have patients take cards listing the diabetes standards of care to their appointments and ask those providers to document the diabetes care provided, including depression screening.

Clinical Information Systems: Collecting and Tracking Information

- Monitor depression treatment outcomes.
- Adjust depression protocol based on outcome data, including patient satisfaction and use of services.
- If not available in-house, contract with an information technology firm to develop a tracking database for depression screening and other care elements in diabetes treatment.
- For small clinics without an electronic medical record, develop a paper-based system to track patients with diabetes.
- Routinely audit a sample of medical records to evaluate the quality of depression care provided, including whether individualized treatment plans are documented.
- Distribute quarterly reports to the diabetes care team on the percentage of patients screened for depression.
- Have the diabetes team review results from the yearly audit and use this information to improve care, including for depression.
- Store notes from all providers by date of service in one chart or ensure that medical and behavioral health providers have appropriate access to each other's notes in the electronic record.

Tools and Resources

Web-based Resources

Division of Diabetes Treatment and Prevention [Internet]. An online training course on effective program planning and evaluation [Developed July 2009]. Creating Strong Diabetes Programs: Plan a Trip to Success.
http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=trainingBasicsCreating

Division of Diabetes Treatment and Prevention [Internet]. A workbook (with online training course) on effective program planning and evaluation [Developed July 2009]. Creating Strong Diabetes Programs: Plan a Trip to Success.
http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Training/WebBased/Basics/Creating/Workbook.pdf

American Association of Diabetes Educators http://www.diabeteseducator.org/

American Psychological Association http://www.apa.org/

Chronic Care Model: Self-management support
http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Institute for Healthcare Improvement http://www.ihi.org/ihi

MacArthur Initiative on Depression in Primary Care at Dartmouth and Duke
http://www.depression-primarycare.org/about/mission/
http://www.depression-primarycare.org/clinicians/toolkits/

National Institute of Mental Health
http://www.nimh.nih.gov/health/topics/depression/index.shtml

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/

White Bison and Wellbriety Training Institute http://whitebison.org/

Examples of Current Best Practice Programs

Cherokee Diabetes Program (CDP)
Eastern Band of Cherokee Indians
Sally Sneed, RN
(828) 497-1991 sallsnee@nc-cherokee.com

This Tribally run SDPI program in Cherokee, North Carolina, screens all patients for depression at least annually and at every scheduled appointment. They also have on-site contract providers of acupuncture and massage, which have been very popular with patients; these complementary therapies have helped patients to reduce chronic pain and improve other aspects of their health. CDP provides group diabetes classes, which include segments on depression and coping skills. They are also offering group drumming sessions, a walking club, and other activities, which help patients reduce stress, increase physical activity levels, and support each other. CDP actively promotes community programs that address intergenerational trauma issues. The Tribe pays to augment the Tribal hospital formulary (including antidepressants) as well as for a comprehensive behavioral health/substance abuse program, which includes a telepsychiatrist, PhD psychologists, and master's-level counselors.

Southcentral Foundation

Steve Tierney, MD, Quality Improvement Director
(907) 729-3340

Denise Dillard, PhD
Psychologist
(907) 729-8518

Southcentral Foundation
Alaska Native Medical Center
4320 Diplomacy Drive
Anchorage, AK 99508

This program, located in Anchorage, Alaska, has completely integrated behavioral health staff into primary care clinics. They have developed many innovative programs to screen for and treat depression and provide culturally appropriate support for patients in many areas of their lives with an emphasis on focusing on a person's social milieu first and then the illness that they may have. Many different complementary and Alaska Native traditional therapies are offered.

Additional Contacts

Persons or programs that sites might contact for further ideas and assistance.

Area Diabetes Coordinators. Contact information for Area Diabetes Consultants can be viewed at:
http://www.ihs.gov/MedicalPrograms/diabetes/index.cfm?module=peopleADCDirectory

PART 4 References

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