State of Behavioral Health Integration in U.S. Diabetes Care: How Close Are We to ADA Recommendations?

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In December 2016, the American Diabetes Association (ADA) published a position statement on psychosocial care in diabetes, with evidence-based guidelines for psychosocial assessment and care of individuals with diabetes (1). As a part of this position statement, it is recommended that diabetes practitioners identify and coordinate with qualified behavioral/mental health providers who are ideally embedded in the diabetes care setting and knowledgeable about diabetes treatment and psychosocial aspects of diabetes. These comprehensive recommendations were reiterated in the 2018 *Standards of Medical Care in Diabetes* (2).

Despite the documented benefit of psychosocial intervention and the ADA recommendation, we believe that behavioral health integration is not yet standard care. Moreover, little is known about the prevalence of behavioral health integration. Here, we targeted U.S. academic adult diabetes practices in order to understand the current state of behavioral health integration in diabetes care across the U.S. We identified diabetes practices by their membership to one of two well-known diabetes groups and administered surveys to clinic leadership. Respondents identified as clinic directors (35.1%), physician leaders (29.7%), providers (24.3%), nurse managers (5.4%), and administrative staff (5.4%).

Of the 37 institutions represented in the study sample (86.5% teaching hospitals; 70.2% following more than 2,000 individuals with diabetes per year), 100% reported that their practices included endocrinologists and most reported having nurse practitioners (NPs) (91.9%), registered dietitians (RDs) (91.9%), and/or certified diabetes educators (CDEs) (97.3%). And yet, only 40.5% of practices reported having integrated a behavioral health professional, with either psychology (18.4%) and/or social work (34.2%). Practices reported supporting endocrinology at an average of 5.5 full-time equivalents (FTE) (SD = 4.0), CDEs at 2.9 FTE (SD = 2.4), NPs at 2.8 FTE (SD = 2.1), and RDs at 2.1 FTE (SD = 1.9). Practices with a behavioral health presence reported supporting behavioral health at an average of 0.6 FTE (SD = 0.5). Of the 22 practices reporting no behavioral health presence (i.e., absence of psychiatry, psychology, and social work in the practice), only 5 (22.7%) reported having identified an external behavioral health referral source with a diabetes or chronic illness specialty.

Although the literature includes anecdotes that behavioral health integration is not yet standard care, this is the first study to systematically evaluate the prevalence of behavioral health integration in U.S. diabetes practices. The vast majority of diabetes practices employ endocrinologists, NPs, RDs, and CDEs, with a minimum average of three hired professionals at 2.0 FTE across disciplines. This is to be expected, given the long-standing recommendations for inclusion of these disciplines. However, less than half of the diabetes practices sampled employ at least one behavioral health provider at an average of 0.6 FTE. Given the discrepancies between ADA recommendations and the integration that appears to exist in U.S. clinical practices, opportunities for referrals were also evaluated. Seventeen practices, almost half of those sampled, do not have behavioral health integrated into the clinic and have not identified an internal or external behavioral health professional with a relevant expertise accessible to their patient population.

The discrepancy between ADA recommendations (1,2) and the current state of practice is especially notable given that this sample included practices that are recognized by the ADA or American Association of Diabetes Educators (92%) and that are on the *U.S. News and World Report* list of top 50 practices in diabetes and endocrinology (43%), suggesting that this group of practices are among the most advanced and distinguished in the field.

Barriers to integrating behavioral health into diabetes care are not well understood. The literature suggests that

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there is a possible shortage of behavioral health providers trained to deliver lifestyle interventions tailored specifically for individuals with diabetes (1) and that there are several system-level barriers (principally poor reimbursement) that complicate the successful integration of psychology (3). These barriers suggest that it may prove difficult for diabetes practices to adhere to *Standards* recommendations. Future research should aim to better understand the specific barriers inherent to behavioral health integration, the models that exist in the field and the clinical outcomes they achieve, and changes that can be made at the clinic-, community-, legislative-, and health care–system levels to facilitate change and make the "ideal" level of behavioral health access the norm.

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