

Comparing national policy and programme strategies for managing the psychosocial aspects of diabetes

- Katharina Kovacs Burns**
Alberta Health Services and University of Alberta, Quality Healthcare and Improvement and Health Sciences, Edmonton, Canada
- Søren Skovlund**
Novo Nordisk, Health Economics and Outcomes Research, Søborg, Denmark
- Marco Comaschi**
ICLAS GVM Care and Research, Internal Medicine, Rapallo, Italy
- Norbert Hermanns**
Research Institute Diabetes, Diabetes Zentrum Mergentheim, Bad Mergentheim, Germany
- Bernhard Kulzer**
Research Institute of the Diabetes Academy Mergentheim FIDAM-Diabetes Center Mergentheim, Bad Mergentheim, Germany

- Wija Oortwijn**
Ecorys Nederland, Health, Rotterdam, Netherlands
- Mark Peyrot**
Loyola University Maryland, Sociology, Baltimore, Maryland, USA

on behalf of the DAWN2 Study Group

Introduction

- The DAWN2 study explored the perceptions of PWD, HCPs and FMs in 17 countries, focusing primarily on the psychosocial aspects of diabetes, its management, and improvements needed in areas of care and support.¹
- The findings are considered benchmarks for psychosocial indicators related to the impact, burden, distress and depression experienced by PWD and FMs, and for diabetes management and education particularly identified by HCPs.²⁻⁴
- Improvements in the care and supports to help PWD manage their diabetes, including the psychosocial aspects, were identified.² Improved access and availability to psychological and support resources, experts and education, were identified by HCPs.⁴
- A secondary study of DAWN2 was a situational analysis conducted in 2012 on existing policies in each of the 17 countries, for patient-centred psychological care and supports, and diabetes treatment and reimbursement.¹

Aim

- The aim of this poster is to present the situational analysis of existing diabetes-related policies and strategies in the 17 countries specifically relevant to the management and care of the psychological/psychosocial aspects of diabetes.

Methods

Study design

- The full study design for the DAWN2 study has been previously described.¹
- Briefly, DAWN2 is an international, interdisciplinary, multi-stakeholder study conducted in 17 countries across four continents.
- DAWN2 was conducted in accordance with relevant ethical requirements in each country.
- The DAWN2 survey methodology regarding PWD, FMs and HCPs participation and needs concerning diabetes education and training are published elsewhere.¹⁻⁴ This methodology includes the recruitment of PWD, HCPs and FMs across the 17 countries, and the use of validated, adapted and new questions specific to diabetes education participation. Global (overall) scores were reported as mean % with country variations expressed as minimum to maximum mean % range.
- The country policy/situational assessments were undertaken in five steps:¹
 - scoping review process:** document searches on electronic databases
 - desk research through literature review and synthesis:** guided by four topic areas (patient involvement, equal access to care, self-management education and psychosocial support)
 - in-depth questionnaire-based interviews in each participating country:** interviewees with experience/knowledge of country policies/strategies were selected with the support of the national DAWN2 expert network and represented key national stakeholder groups (patient organisation, diabetes expert/advisor to government, policymaker)
 - ranking of performance on each indicator in each country:** experts ranked 28 identified indicators across countries using a ranking scale between 2 to 10, and categorised as: 1 (no information); 2-4 (no policies/strategies in place); 5-7 (policies/strategies in place and only partially endorsed or implemented); and 8-10 (policies/strategies in place and fully endorsed and in practice)
 - validating research by matching findings with interview data and expert committee.**

Results

- Survey results of experiences and perceptions of 8,596 PWD were previously published² as were perceptions of 4,785 HCPs regarding treatment, care, education and supports for PWD.³
- Twelve policy and strategy indicators from the situational analysis were definitive across all 17 countries, three of which related specifically to psychosocial aspects of diabetes and care (see Table 1).

Table 1. Twelve policy and strategy indicators selected across 17 countries

Indicators for country diabetes-related policies and strategies
Structured national diabetes policy supporting delivery of person-centred care
Patients/patient organisations involved in structured national diabetes policy drafting process
Patient feedback is part of ongoing diabetes quality care and evaluation
Legislative support for the right of PWD to receive quality self-management education
Reimbursement of diabetes self-management education
Government policy addresses special educational needs in diabetes subpopulations
Government policy includes or endorses quality standards for diabetes self-management education
Certified education for diabetes HCPs in patient-centred care
Tele-health and IT solutions to empower self-management by PWD is part of government policy
Government policy includes or endorses evidence-based guidelines on management of psychosocial aspects of diabetes
Regular QoL/mental health assessment in diabetes care standards
Reimbursement of psychological care for PWD

- Results in this poster are presented under the three selected indicators.

(1) Government policy includes or endorses evidence-based guidelines on management of psychosocial aspects of diabetes

- Results of the 2012 situational analysis of country policies pertaining to this indicator, suggest that:
 - 29% of HCPs indicated that their countries (Mexico, Spain, Denmark, the UK and France) have a government policy that includes or endorses national guidelines on psychosocial management. An equal number have no policies in place for this (India, Japan, Turkey, Algeria and China). Another 42% of countries are either developing or have existing policies but have not endorsed them (Figure 1)

- more countries have clinical guidelines and medications for treatment of diabetes than they have clinical guidelines for psychological issues management
- there are discrepancies in the situational/policy data compared with the HCP survey responses regarding psychological issues management in the following two examples:
 - in the situational responses, China and India scored 2-4 meaning that they do not have any policies/strategies or guidelines in place regarding psychological issues management. However, a significant percentage of HCPs clearly indicated that clinical guidelines for psychological issues management are in place and used in both China (78%) and India (64%)
 - Spain was one country which scored 8-10 for having guidelines in place and having them endorsed and used, but only 20% of HCPs in Spain indicated that they had guidelines in place for psychological issues management.

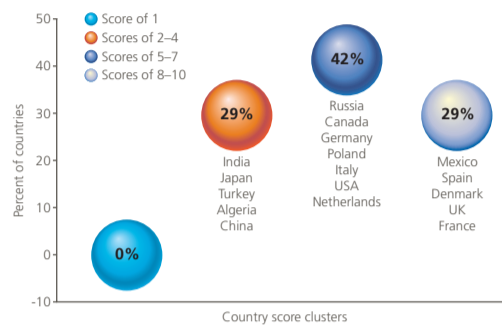


Figure 1. Percent of countries in each of the four score clusters described as: 1 = no information available; 2-4 = no government policy includes or endorses guidelines of diabetes, and no official guidelines exist; 5-7 = government policy on psychosocial management of diabetes is in development/exist but is not endorsed; 8-10 = government policy includes or endorses national guidelines on psychosocial management.

- Relevant to the situational policy analysis are considerations of DAWN2 survey results for PWD² and HCPs³ which indicate that:
 - 58.8% of PWDs (range 18.5-67.6) said they were satisfied that their care was well organised 'most of the time'/'always'
 - 29.6% of HCPs (range 7.4-67.1) agreed that healthcare in their countries was well organised for the management of chronic conditions, and 49.6% agreed that diabetes should be given a higher priority than it currently receives
 - 28.3% (15.5-78.4) said that practical clinical guidelines for management of psychosocial issues related to diabetes were in place for their practice. Country responses are shown in Figure 2
 - 53.7% (32.1-70.9) claimed that clinical guidelines and medications for pharmacological treatment of depression or anxiety were in place for their practice. Country responses are shown in Figure 2.

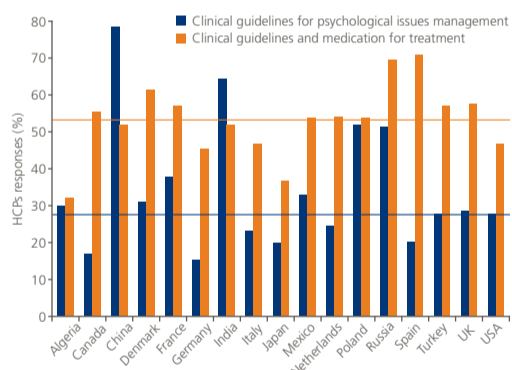


Figure 2. Percent of HCPs responses in each of the 17 countries regarding practical clinical guidelines for management of psychosocial issues related to diabetes, and clinical guidelines and medications for pharmacological treatment of depression or anxiety.

(2) Regular QoL/mental health assessment in diabetes care standards

- Results of the 2012 situational analysis of country policies pertaining to this indicator, shown in Figure 3, suggest that:
 - with this indicator, 47% of countries had formal standards recommending regular QoL/mental health assessment but implementation is not widely done
 - another 41% had formal care standards but they did not mention monitoring of regular QoL/mental health
 - only the UK had formal care standards in place which required regular QoL/mental health monitoring to be done as part of standard diabetes care. This finding does not correspond with the discrepancies found in the survey findings for 16% of PWD who said they had been asked by HCPs if they had been anxious or depressed, and for 46% of HCPs who said they asked their patients how diabetes affected their lives.

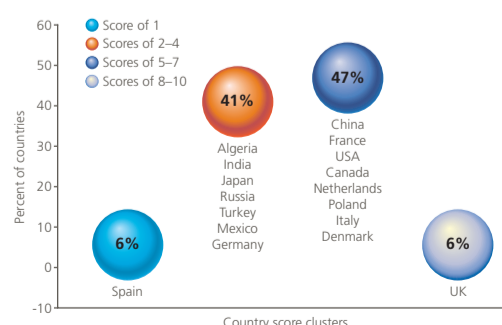


Figure 3. Percent of countries in each of the four score clusters described as: 1 = no information available; 2-4 = formal care standards do not mention monitoring of regular QoL/mental health; 5-7 = formal care standards recommend QoL/mental health monitoring but implementation is not widely done; 8-10 = formal care standards require regular QoL/mental health monitoring to be done as part of standard diabetes care.

- Relevant to the situational policy analysis are considerations of DAWN2 survey results for PWD² and HCPs³ which indicate that:

- about 13% of PWD indicated having a 'poor'/'very poor' QoL (country range: 7.6-26.1) and experienced 'likely' depression (range: 6.5-24.1)
- 42.6% of PWD across the 17 countries experienced high distress living with and managing diabetes. Countries in which PWD reported distress higher than the global mean value included Mexico, Italy, Spain, Poland, Russia, Algeria, Turkey, India and China. The USA, Canada, France, Germany, Netherlands, Denmark, the UK and Japan reported distress values below the global mean value
- less than one-third of PWD said that in the past 12 months they had been asked by their HCPs whether they were anxious or depressed (31.9% [range 14.6-57.3])
- less than one-quarter of PWD were asked by their HCPs how diabetes affected their lives 'most of the time'/'always' (23.7% PWD [range 6.6-45.1]). Countries in which PWD responses were at or above the global mean of 23.7% were Mexico, Spain, Poland, Turkey, India and China
- 50.7% of HCPs (country range 34.0-74.6) said they asked their patients how diabetes affected their lives 'most of the time'/'always'. Countries in which HCP responses were at or above the global mean % were Mexico, Netherlands, Italy, Russia, Algeria, Turkey, India, and China.

(3) Reimbursement of psychological care for PWD

- Results of the 2012 situational analysis of country policies pertaining to this indicator, shown in Figure 4, suggest that:
 - 29% of countries have reimbursement for psychological care for PWD
 - 59% have partial coverage in place
 - two of the 17 countries have no reimbursement in place (France and Russia). However, survey responses of 37% of HCPs in France concerning the need for resources for the provision of psychological support and care for diabetes, was lower than all but two other countries
 - of the five countries which scored 8-10 on having psychological care reimbursed for PWD, Poland and Algeria had some of the highest need of all countries for resources for the provision of psychological support and care.

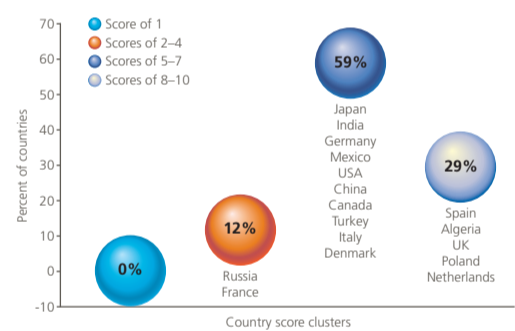


Figure 4. Percent of countries at each of the four score clusters described as: 1 = no information available; 2-4 = psychological care for PWD is not reimbursed; 5-7 = psychological care for PWD is only partially reimbursed or requires special/additional/membership/insurance; 8-10 = psychological care for PWD is reimbursed for all patients' diabetes care.

- Relevant to the situational policy analysis are considerations of DAWN2 survey results for HCPs³ (Figure 5) which indicate that:

- 12.1% of HCPs (range 5.5-27.9) said they had no resources to offer patients who are emotionally distressed or at risk of depression (country responses shown in Figure 5)
- 65.7% of HCPs (range 40.6-79.6) felt that one area needing improvement was the availability of resources for the provision of psychological support and care for their patients
- 58.2% of HCPs (range 27.6-83.9) indicated that there should be better access to psychologists or psychiatrists for referral
- 49.2% of HCPs (range 13.3-80.0) said that the healthcare remuneration system is a barrier to effective diabetes management (Figure 5)
- 5.8% (range 0.8-36.7) were reimbursed for their time spent to evaluate and counsel regarding psychological issues (Figure 5).

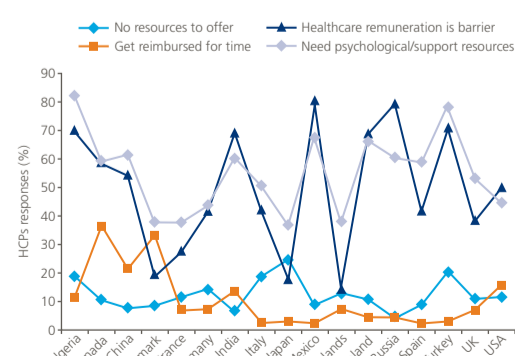


Figure 5. Percent responses of HCPs by country, regarding lack of and need for psychological resources to offer PWD as well as reimbursement for their time evaluating and counselling PWD, and whether healthcare remuneration was a barrier to effective diabetes management.

Summary of three indicators by country

- Countries which were consistently above average on each indicator as well as combined included the UK, Poland, Netherlands, Italy, Denmark, France, the USA and Canada. For these countries, policies or strategies were either being developed or existing and were being implemented in some way (Figure 6).
- Of these countries, less than 33% of HCPs in the USA, UK, Italy, Canada and the Netherlands indicated that clinical guidelines for psychological issues management were in place, and 50% or more in the UK, Poland and Canada indicated that they needed more psychological support/care resources (Figures 2, 5 and 6).

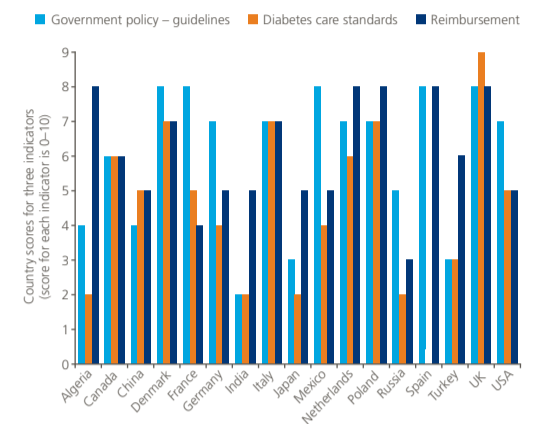


Figure 6. Country scores for the three indicators for psychosocial care related to diabetes.

- Globally, most countries have policies/strategies endorsing practice guidelines, diabetes care standards for regular QoL/mental health assessments and reimbursement of psychological care for PWDs, but they are not fully implemented or applied (Figure 7).
- 29% of countries have implemented policies which endorsed guidelines on management of psychosocial aspects of diabetes and reimbursed psychological care for PWD.
- Over 40% of countries have no diabetes standards regarding regular QoL/mental health assessment. Only one country has implemented this.

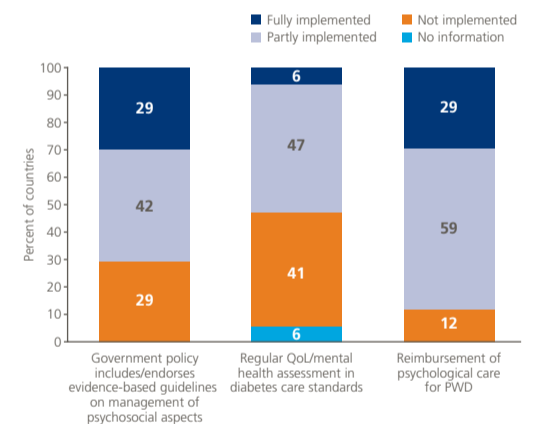


Figure 7. Global situational analysis of policies for guidelines, diabetes care standards and reimbursement of psychological care.

Conclusions

- The DAWN2 findings emphasise the importance of having national person-centred diabetes care policies supporting clinical guidelines or standards of care that include regular psychosocial assessments, and reimbursement of psychological care as part of routine diabetes care.
- The responses of HCPs and PWD across the 17 countries confirm the need for policies, diabetes care standards and reimbursement for psychological aspects of diabetes.

References

- Peyrot M, et al. *Diabetes Res Clin Pract* 2013;99:174-84.
- Nicolucci A, et al. *Diabet Med* 2013;30:767-77.
- Kovacs Burns K, et al. *Diabet Med* 2013;30:778-88.
- Holt RIG, et al. *Diabet Med* 2013;30:789-98.

Abbreviations

DAWN, Diabetes Attitudes, Wishes and Needs (study); DAWN2, second Diabetes Attitudes, Wishes and Needs (study); FMs, family members; HCPs, healthcare professionals; IAPO, International Alliance of Patients' Organizations; IDF, International Diabetes Federation; IPPC, International Publication Planning Committee; PWD, people with diabetes; QoL, quality of life.

Acknowledgements

The DAWN2 study is a global partnership of established organisations, including the IDF, the IAPO and the Steno Diabetes Center, and Novo Nordisk. DAWN2 study group: R. Malek; J. Wens; J.E. Salles; K. Kovacs Burns; M. Vallis; X. Guo; I. Willaig; G. Reach; N. Hermanns; B. Kulzer; S. Kalra; A. Nicolucci; M. Comaschi; H. Ishii; M. Escalante; F. Pouwer; A. Kokoszka; A. Mayorov; E. Menéndez Torre; I. Tarkun; M. Davies; R. Holt; A. Forbes; N. Munro; M. Peyrot; with S.E. Skovlund and C. Mullan-Jensen (Novo Nordisk). For more information contact dawninfo@novonordisk.com.

Funding: Novo Nordisk AVS funded the DAWN2 study, including planning and designing in collaboration with national, regional and global partners. Novo Nordisk funded medical editing support by Bioscript Medical Ltd and independent data collection by Harris Interactive. Data analysis and publication preparation were performed by members of the DAWN2 IPPC and authors. DAWN and DAWN2 are registered trademarks of Novo Nordisk.