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Discussion

It Is Time to Act: Making Diabetes Distress Screening Standard in Clinical Practice

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Thirty Years of Evidence—What's Next?

Diabetes distress (DD)—the emotional burden of living with and managing diabetes—has been recognized clinically and in the literature as early as 1995.[1] Over the past 3 decades, robust research has linked DD to poor glycemic outcomes, treatment disengagement, and reduced quality of life for persons with type 1 diabetes (PwT1D).[2-4] Encouragingly, DD is highly responsive to intervention, with numerous studies demonstrating that targeted support significantly reduces distress and improves outcomes.[5-8]

Since 2014, the American Diabetes Association has recommended routine psychosocial screening, including DD, in its annual Standards of Care.[9] Validated DD screening tools, such as the Problem Areas in Diabetes (PAID) and the Type 1 Diabetes Distress Assessment System for adults, as well as the PAID-T (ages 12-18) and PAID-C (ages 8-11) for youth, make screening feasible and efficient, especially when integrated into the electronic health record (EHR).[10-13]

Here, we present findings from the 2024 annual survey conducted by the T1D Exchange Quality Improvement Collaborative (T1DX-QI). To our knowledge, this is the first multicenter survey to assess DD screening practices as part of routine clinical care in the United States. In addition, we propose strategies to strengthen screening and psychosocial support using a quality improvement (QI) framework.

A Snapshot of Missed Opportunity

The T1DX-QI is a network of pediatric and adult diabetes centers from across the United States working together to improve care and outcomes for people with diabetes through data-driven QI.[14] The T1DX-QI launched a dedicated Diabetes

Abbreviations: DD, diabetes distress; EHR, electronic health record; PAID, Problem Areas in Diabetes; PwT1D, persons with type 1 diabetes; PwT2D, persons with type 2 diabetes; QI, quality improvement; T1DX-QI, T1D Exchange Quality Improvement Collaborative.

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Pre-Visit

- Outline how and by whom PwT1D in need of screening will be identified.
- Define whether screening will occur at a fixed interval (e.g., annually) or a dynamic interval (e.g., sooner if uncontrolled, recent high DD score, or during life transitions).
- Clarify whether screening assignment is handled manually by staff or automated through the EHR.
- Determine whether the questionnaire can be assigned prior to the visit to reduce rooming time.

Best Practice Tip: Automatic EHR assignment of the questionnaire based on diagnosis and interval increases screening rates, saves provider/staff time, and supports scalability across sites. However, it may require a back-up process in place for patients unable or unwilling to complete the questionnaire electronically.

Day-of Visit (Arrival)

- Specify the team member(s) and workflow responsible for ensuring eligible PwT1D are identified for screening (if not already performed pre-visit).
- Decide whether the questionnaire will be administered electronically (tablet, kiosk, patient portal) or on paper.
- If paper administration is used, establish process for how paper results will be captured and entered into the EHR (e.g., scanning, manual entry).

Best Practice Tip: Clearly designate ownership (front desk staff, medical assistants, or nurses) for distributing and collecting questionnaires. Electronic entry is preferred for accuracy and efficiency, although paper-based methods may be more practical in certain clinic environments.

Day-of Visit (During Appointment)

- Identify who is responsible for reviewing questionnaire results and how results are accessed.
- Ensure elevated scores are flagged in the system to be visible and addressed.
- Provide training for providers or other designated staff such as psychologists, social workers, or Certified Diabetes Care and Education Specialist (CDCES) on interpreting elevated scores and responding appropriately.
- Document that elevated scores were reviewed and discussed.
- Evaluate whether the treatment plan needs adjustment based on the source of distress (e.g., situations of regimen or technology-related distress).
- Consider screening for and address overlapping psychosocial issues (e.g., depression, anxiety, disordered eating).

Best Practice Tip: Given the high prevalence of DD in PwT1D, providers should be equipped with strategies described in the literature to address DD during the clinical encounter, such as acknowledging and normalizing feelings and helping patients reframe challenges.[15] For high or persistent DD, ensure referral pathways and mental health resources are known and accessible.

Post-Visit Follow-Up

- Implement a system to follow up with patients who had high DD scores.
- Close the loop on referrals (psychologist, social worker, CDCES) to ensure contact is made.
- Monitor whether treatment plan changes are effective (e.g., through phone calls, portal messages, or earlier visits).
- Determine whether patients require more frequent visits to address distress.
- Establish a plan for re-screening at shorter intervals if distress is ongoing.

Best Practice Tip: A structured follow-up system (designated staff for outreach, earlier re-screening, referral tracking) ensures patients' needs are met and builds trust in the screening process.

Fig. Diabetes distress screening process considerations and best practice tips.[15]

Distress Working Group in 2023. To better understand the current state of DD screening among its member institutions, T1DX-QI surveyed 62 participating centers as part of its annual survey in 2024.

The survey was completed by 19 of 22 (86%) adult centers and 38 of 40 (95%) pediatric centers for an overall response rate of 92%. Only 35% of centers reported screening for DD in PwT1D or their caregivers, with pediatric centers (16/38; 42%) more likely to

screen than adult centers (4/19; 21%). Only 9 centers (16%) reported screening at least 50% of PwT1D seen at their site each year. Among centers that screen, most (70%) incorporated the screening into the EHR, with pediatric centers most commonly using a version of the PAID (13/16) and adult centers using the Type 1 Diabetes Distress Assessment System (3/4). Our findings highlight an important implementation gap, with limited adoption despite long-standing clinical guidance to support DD screening, availability of validated tools, and feasibility of EHR integration.

A Collaborative Response

The case for integrating psychosocial support into diabetes care is compelling, and yet, these data suggest that routine screening for DD in PwT1D remains far from standard practice. Why?

Bridging the gap between evidence and implementation requires more than awareness—it requires coordinated action.

The T1DX-QI Diabetes Distress Working Group is focused on helping clinical teams close the implementation gap in T1D psychosocial care through QI methodologies. Ongoing efforts include.

- Sharing best practices and disseminating strategies from high-performing centers for screening implementation.
- Promoting standardization of validated screening instruments.
- Benchmarking progress leveraging the T1DX-QI data infrastructure and large number of participating practices.
- Tracking outcomes to ultimately assess how DD screening influences clinical outcomes over time.

Figure provides a practical starting point by outlining key process considerations for integrating DD screening into routine care. The framework maps the previsit, day-of-visit, and postvisit phases, highlighting important decision points, common challenges, and best practice strategies drawn from high-performing centers. Our goal is to provide a useful, adaptable model for centers wishing to initiate or refine DD screening workflows in ways that are responsive to local needs. By grounding this work in QI methodologies rather than applying a one-size-fits-all approach, centers can tailor this framework to local populations, staffing, EHR capabilities, and resource constraints. Plan-do-study-act cycles allow for iterative improvements in the process, thereby supporting long-term sustainability.

Although the T1DX-QI survey results and Figure screening framework focus on PwT1D, DD is also highly prevalent and clinically meaningful in persons with type 2 diabetes (PwT2D). Screening for DD in PwT2D presents distinct implementation challenges given the larger patient population, greater treatment heterogeneity, and shared management across primary and specialty care settings. Despite these complexities, PwT2D would similarly benefit from the core elements of this framework, including routine standardized screening, structured workflows, and timely, tailored psychosocial support.

Of note, our efforts are significantly informed by the many leaders in this space who have championed the integration of psychosocial care into diabetes management. We therefore also want to recognize the important work being done by the American Diabetes Association, breakthrough T1D, and numerous academic and clinical teams that have laid the groundwork through both research and translational initiatives.

From Detection to Person-Centered Support

Screening for DD is a critical first step, but it must lead to meaningful action. To honor the time and trust patients place in us, screening should be more than a checkbox. Supporting PwT1D requires systems that can respond when DD is identified and workflows that turn results into timely, person-centered care.

Fortunately, a range of evidence-based interventions already exist, including diabetes educator-led programs, psychology-based models, and peer support.[5-8] Yet many clinics face barriers to implementing these resources, from limited access to mental health providers with diabetes expertise to constraints on staffing and time. For physicians, there may also be the challenge of feeling unprepared to address emotional concerns. These challenges can feel daunting, but they are not insurmountable. By learning from centers that have successfully integrated psychosocial care, we can identify practical strategies that work in real-world settings. Sharing tools, workflows, and lessons across institutions can help more practices adopt sustainable approaches without duplicating effort.

A Call to Make Diabetes Distress Screening Standard in Clinical Practice

We now stand at a critical inflection point in diabetes care. Years of evidence have confirmed what people with diabetes have long known: emotional health is inseparable from physical health. Advances in diabetes technology have improved glycemic control and reduced complication risk, but they have not always lessened the self-care burden or alleviated DD. Psychosocial screening must become a consistent, expected part of care—not an exception. We have the tools. We have the evidence. What we need now is the shared will to make it happen.

Improving psychosocial care is a central tenet to achieving better outcomes for PwT1D. Let us honor what we have learned by embedding screening into clinical care, responding compassionately to those who are struggling, and working together to ensure that every person with type 1 diabetes has access to the support they need.

Disclosure

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