Motivating the Unmotivated Patient with Diabetes

Susan Jung Guzman, Ph.D.
Behavioral Diabetes Institute
July 30, 2012

Overview

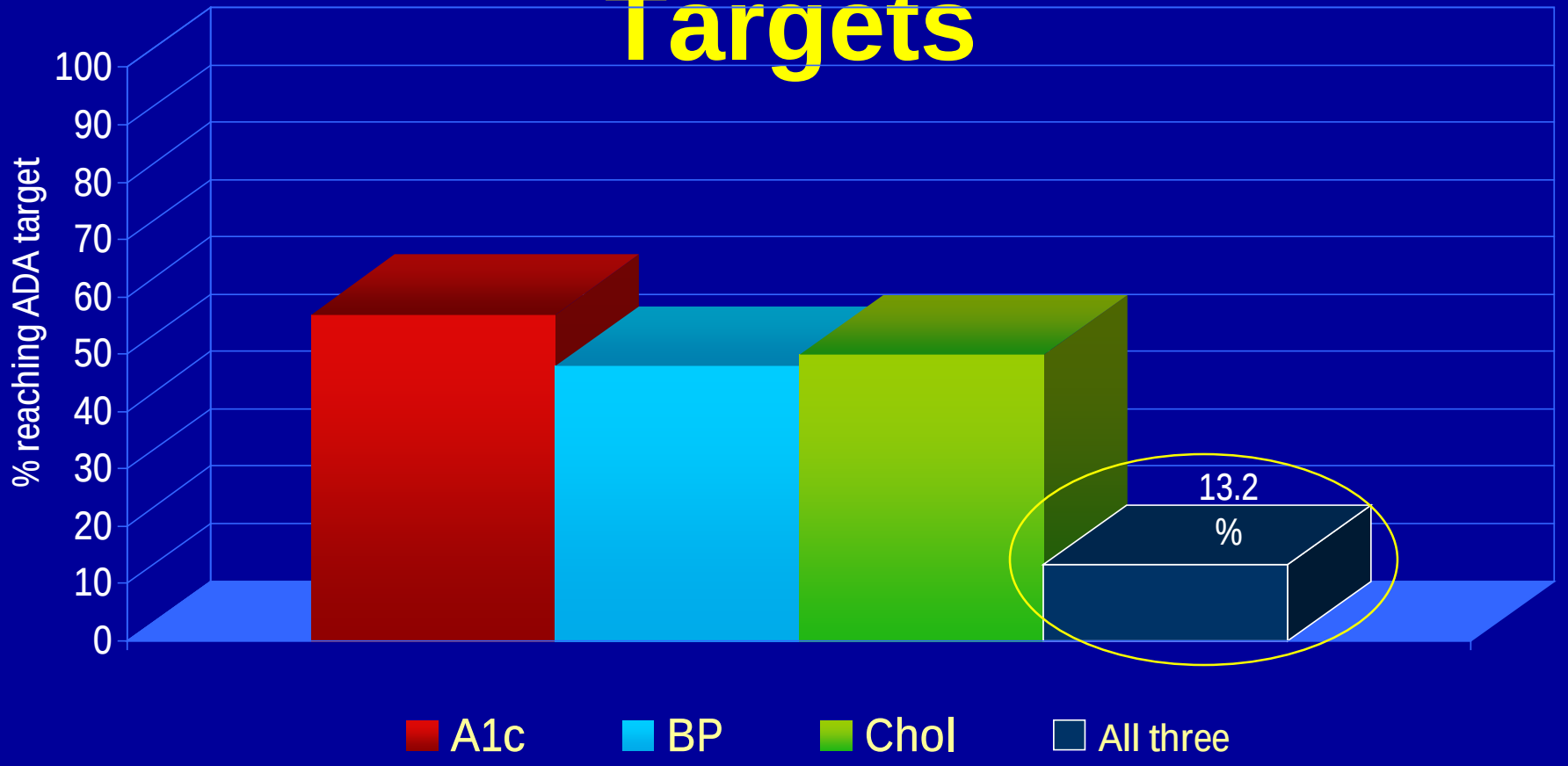
- The problem
- A new way to look at adherence
- Strategies for helping improve adherence

The Diabetes Epidemic

- Number people with diabetes has tripled in 20 years
- In US, 25.8 million people have diabetes; 8.3% of population, 25% undiagnosed
- 79 million more have “pre-diabetes”
- Among children born in US in 2000, 1/3 will develop diabetes

ADA, 2011

Percentage of Patients Achieving ADA Treatment Targets



Ong et al. Ann Epidemiol. 2008;18; 222-229

Scope of Self-Care Problems in Diabetes

- Regimen is complex: including medications, SMBG, exercise, meal planning, foot care, frequent medical visits and more.

Scope of Self-Care Problems in Diabetes

- 39% of insulin users and 5-6% of patients treated with OHA or diet alone checked their BG at least 1X/day. (Harris, 2001)
- Adherence even more problematic for diet, exercise and daily foot checks.
- Adherence in one area (e.g., diet) does not relate to adherence in another area (e.g., exercise)

Scope of Self-Care Problems in Diabetes

- HMO and PBO databases, 11 retrospective studies: OHA compliance was 36 – 93%
- MEMS data, 5 prospective studies (3 – 6 months): OHA compliance was 61 – 85%
- THUS, similar to studies of other illnesses, the average patient may be missing approximately 25% of prescribed OHA(s)

Cramer et al, 2004

Scope of Self-Care Problems in Diabetes

- *Medicaid data. Patients had enough medication for 130 days/year*
- *16% – 85% of patients stop taking OHA's within the first year.*
  - *Glipizide, 65%*
  - *Acarbose, 85%*

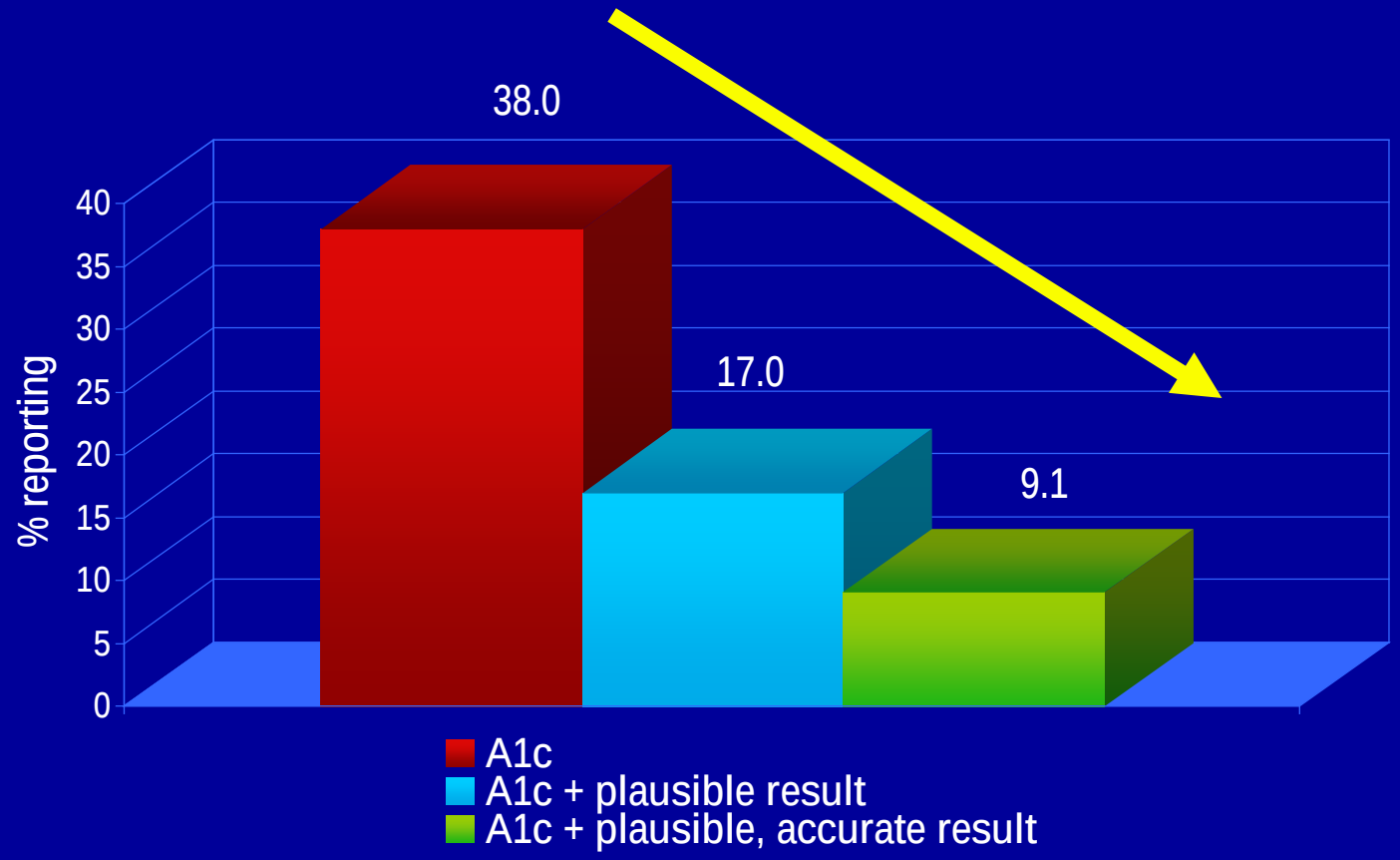
Dailey et al, 2001; Dezii et al, 2002; Catalan et al, 2001

The Scope of Self-Care Problems in Diabetes

- Similar problems seen with blood pressure and lipid control medications
- 6 months post-MI, 20% quit ACE inhibitors, 13% quit statins and 12% quit beta blockers.
- In an elderly sample, statin compliance (> 80% PDC) was seen in only 39% of patients at 1 year.

Benner et al, 2002; Eagle et al, 2004

How Many are “A1c Aware”?



Polonsky et al, 2003

Inaccurate Beliefs About Poor Adherence

("strong" endorsements by physicians)

poor self-discipline	**53.2%**
poor will-power	**50.0%**
not scared enough	**36.9%**
not intelligent enough	**16.3%**

Polonsky WH, Boswell SL, Edelman SV (1996)

Hagar The Non-Adherent

Strategies That Don’t Work

- Urging more willpower

  “you need to try harder…”
- Threatening bad outcomes

  “you’ll go blind if you don’t do what I tell you to do…”
- Unwanted advice

  “you should join a gym…”

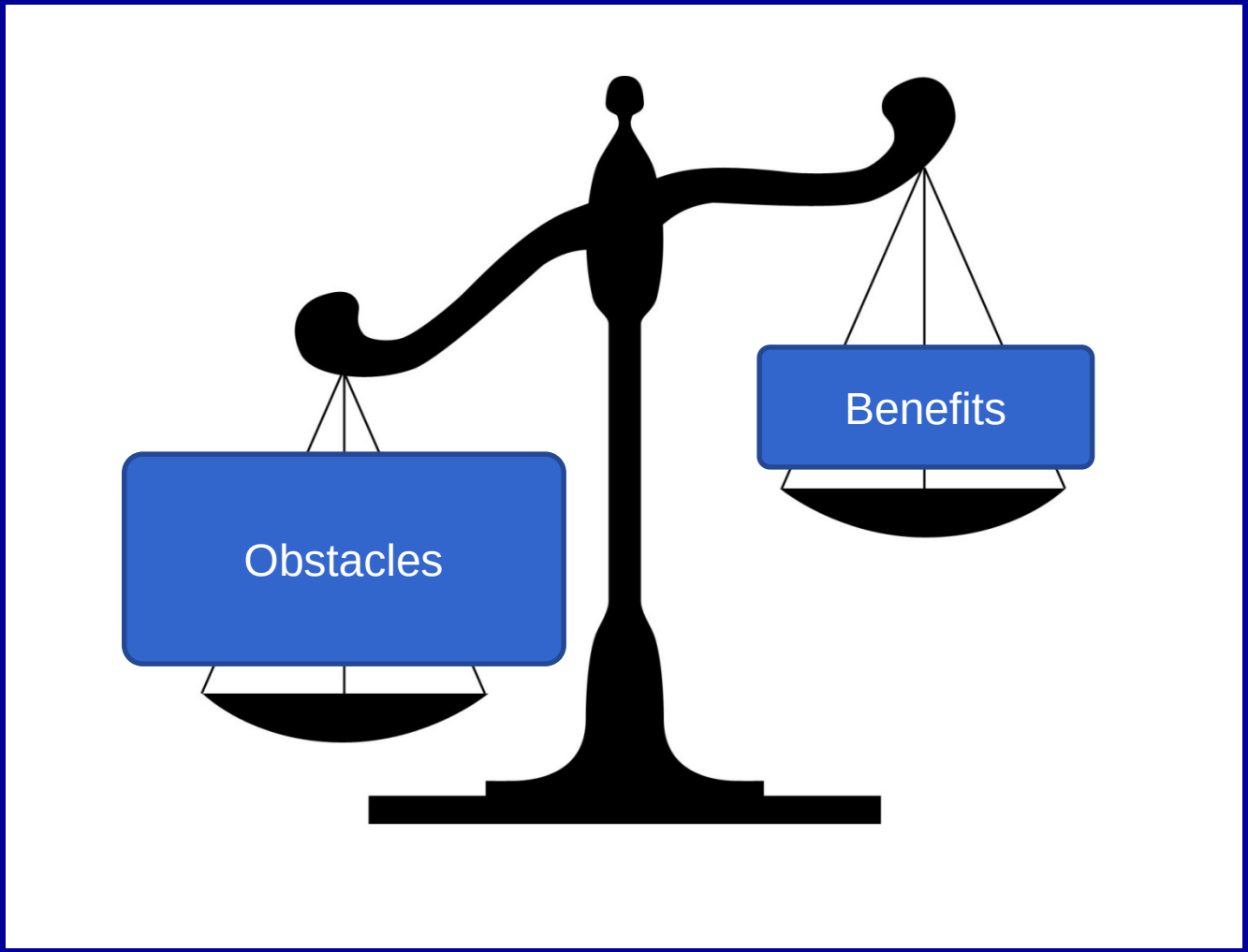
Why Don’t These Work?

Based on the false premise that most non-adherent patients are unmotivated, lack willpower and/or not scared enough

RESULT:

- More frustrated and disengaged
- Immobilized with fear
- Hopeless about ever achieving goals

Motivation in Diabetes



Major Obstacles to Effective Self-Care

- Lack of knowledge/skill
- Health care provider/patient communication problems
- Depression
- Harmful health beliefs
- Unachievable goals
- Environmental obstacles

Major Obstacles (cont'd)

- Poor social support
- Ineffective coping styles
- Cultural issues that interfere
- Elements of diabetes (our tools are imperfect, and it gets harder to manage over time)

Two Questions

In making a decision about healthcare recommendations the patient considers:

- Is it worth it?
- Can I do it? Is it achievable?

Barriers to perceptions of “It’s worthwhile”

Three major factors:

- Depression
- Belief there are no real benefits
  - Dangerous beliefs about diabetes
- Belief that the “costs” are too high
  - Financial
  - Side effects
  - Social (i.e. shame, embarrassment)

Barriers to perceptions of "It's achievable"

Three major factors:

- Lack of knowledge/skill
- No clear plan for action
- Environmental barriers:
  - Time
  - Access to healthcare
  - Financial pressures

Strategies to increase adherence

involve increasing perception of

“It’s worth it”
and
“I can do it”

Meet Mr. Smith

- 64 year old Caucasian male, married “handyman”
- 30+ year history of Type 2 diabetes, has CAD, PAD, neuropathy, severe retinopathy
- On insulin, many oral meds
- Presents with small DFU on left foot
- Acknowledges difficulty taking insulin and offloading

Meet Mr. Smith

When asked about his diabetes, treatment, and his DFU, he acknowledges:

- Long history of depression, no treatment
- Serious and scary episodes of hypoglycemia, “guessing” insulin dosages
- Reports that his mother “lost her legs to diabetes”, thinks same fate is inevitable and very afraid
- Conflict with wife about “lying around”

Strategies to increase adherence to self-care recommendations

1) Address underlying depression

- Know the two cardinal symptoms of depression
  (feeling down, sad or hopeless OR having little interest or pleasure in doing things)
- Consider using a depression screener (PHQ-9)
- Reassure patients that depression is treatable
- Provide referrals for treatment

Remember treating depression is necessary but not sufficient for improving health behaviors.

Mr. Smith

- PHQ-9 = severe level of Major Depressive Disorder
- Referred to psychiatry, as well as weekly individual counseling
- Improvement in mood led to increased interest in self-care, as well as energy and concentration

Strategies to increase adherence

2) Strengthen interest in own self-care by *increasing* the understood benefits and *decreasing* the perceived costs

- Explain how recommendation **will help**
- Offer hope
- Ask about “costs” of following thru
- Address “costs” where possible

Mr. Smith

- Was explained that contrary to what he believed there was a lot he could do to help his foot heal properly (offloading, and better glucose control)
- Discussed “costs”:
  - taking insulin = fear of hypoglycemia due to guessing with dosage
  - offloading = financial concerns, conflict with spouse

Mr. Smith

The following plan was discussed:

- Ask patient's endocrinologist if Mr. Smith could be prescribed insulin pens instead of syringes
- Short-term disability leave from work
- Ask Mr. Smith to bring his wife to the next appointment

Strategies to increase adherence

3) Assess common problematic beliefs about diabetes and address them.

- Ask “What do you think about having diabetes?”
- Help patients see that:
  - having diabetes *is* an important immediate concern
  - is *not* a death sentence
  - treatments actually accomplish something

Focus on the benefits of self-care vs. scary outcomes!

Mr. Smith

- Empathize with his belief (“Many people who witness scary things happen to their loved ones believe that having diabetes is a death sentence”)
- Challenge with facts and hope (“We now have knowledge and tools to manage well and prevent those same outcomes”)
- Reassured that with proper care and his efforts, he *could* heal well

Strategies to increase adherence

4) Help prioritize goals and make a clear, reasonable, specific plan for action.

- Collaborate on selecting goal (choose 1 or 2)
- Help them identify potential obstacles (“What might get in your way?”) Help *them* problem solve.
- Make specific step-by step plan for action
- Ask them to state out loud *exactly* what they are going to do.

Mr. Smith

Together decided on goals:

1) increase the number of nights he took his long-acting insulin and
2) wear an off-loading boot and elevate his foot as much as possible.

Mr. Smith

Specific plan with action steps:

Goal #1 Nighttime insulin: pick up new pens have pharmacist demonstrate how to use them. Set an alarm for 9 p.m. as a reminder to take long-acting insulin. His glucometer and glucose tablets would be kept with him to treat hypoglycemia

Mr. Smith

Goal #2 Offloading: Put on off-loading boot as soon as he got home that day.

Discuss plan for a short disability leave from work with wife and explain to her the importance of off-loading and ask for her support and encouragement in getting off foot at home.

Strategies to increase adherence

5) Be sure to follow-up, provide feedback for the steps taken, recognize previously unidentified barriers, and adjust plan as needed

Mr. Smith

At the following week's appointment:

- Took insulin 6/7 nights, no hypos, loved pens
- Wife came with him and was supportive
- Has been wearing boot, and DFU much less painful, BUT this made offloading at home harder to prioritize

Mr. Smith

- Reminded him that his efforts continue to be very important in upcoming weeks for his foot to heal properly, even if he started to feel better
- Mrs. Smith offered to help remind him
- He agreed and stated that he would continue to wear his boot, stay off his foot as much as possible, and continue with the efforts to remember his insulin

Take Away Messages

1) There are a lot of obstacles to managing diabetes well
2) Addressing depression is worth the effort
3) Help patients prioritize actions to take
4) Work together to create plan for action

Is it worth it?
Can you achieve it?

Resources

- Anderson BJ, Rubin RR. *Practical Psychology for Diabetes Clinicians, 2nd Ed.* Alexandria, VA: ADA; 2002.
- Guzman, S. *How To Facilitate Adherence In High-Risk Patients,* Podiatry Today, *(23) 3 Mar 2010*
- Polonsky WH. *Diabetes Burnout: What To Do When You Can't Take It Anymore*, Washington: ADA; 1999.
- Rollnick S, et al. *Motivational Interviewing in Health Care.* New York: Guilford Press; 2008.

Training Videos

- VIDEO. Polonsky WH. *Techniques for Effective Patient Self-Management. http://www.chcf.org.*
- VIDEO. Polonsky WH. *Understanding Behavior Change to Help Improve Diabetes Outcomes. http://www.diabetesbehaviorchange.com*

www.behavioraldiabetes.org