Engaging the challenging patient in self-management can be very difficult, but understanding how our brains change with learning and how we are motivated can help. Several strategies and communication techniques have been shown to improve patient engagement and motivation to change behavior. This workshop will discuss ‘brain friendly’ approaches to interacting with patients, factors that can influence patient engagement and strategies that health care professionals can utilize to facilitate self-management. Participants should be prepared to discuss their own cases, and other cases will be presented and discussed.

1. What is DSM, DSME?
2. How we learn
   a. Brain friendly teaching and learning
   b. Implications
3. Patient centered care/strategies
   a. Communication approaches
   b. Barriers/Considerations
   c. Assumptions
4. Strategies to engage patients in self-care
   a. Interventions targeted to stages of readiness to change
   b. Assessing conviction and confidence
   c. Countering negative automatic thoughts
   d. Goal setting
5. Case discussions

References:

How to Engage the “Challenging Patient” in Diabetes Self-management

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Challenging????

- Testing one’s ability, endurance
- Stimulating, interesting and thought-provoking
- Something that by its nature or character serves as a call to battle
- A call to fight
- A demand to explain, justify
- Difficulty in a job or undertaking that is stimulating to one engaged in it

Today’s approach

- What is DSME
- Brain, learning & motivation
- Strategies to enhance “learning/motivation”
- Techniques to help provide patient-centered care and facilitate patient engagement
- Cases, exercises
- Goal: Tools to engage the challenging patient

Fundamental Goal of DSME

- Prepare Individuals to
  - Make informed decisions
  - Engage in effective diabetes self-management
  - Implement self-care behaviors that allow individuals to maximize their physical and psychological well-being.

- Prepare people to:
  - Make informed decisions
  - Cope with the demands of living daily with a complex chronic disease
  - Make changes in their behaviour that support their self-management efforts and improve outcomes.

AADE, The Diabetes Educator, Sept/Oct 2003
IDF Position statement DSM and DSMS, 2011

DSME tenets

- Knowledge is a means to an end rather than an end in itself
- Useful knowledge is knowledge that helps individuals better manage and/or live with their diabetes
- Knowledge which does not contribute to a higher goal is not worth teaching, nor does it help change behavior

AADE, The Diabetes Educator, Sept/Oct 2003

How and why we learn things

- Learning is the business of the brain
- Learning is physiological (brain changes)
- Rote learning is not brain compatible

Brain friendly teaching/learning

- Brain generates networks (patterns, pathways) when things are meaningful
- Emotions are critical to patterns
- Brain resists meaningless or isolated bits of information
- We remember what WE believe is significant

Zull, The art of changing the brain, 2002

Implications

- Address what is meaningful

Engage the Whole Brain

Getting information → Making meaning of the information → Creating new ideas from meaning → Acting on those ideas (active testing) → Information and feedback

Zull, The art of changing the brain, 2002, 2004

Implications

- Step by step information
- Build upon prior knowledge
- Familiar to new information
- Incorporate into REAL experience


Implications- Don’t explain

- Use metaphors
- Keep sessions brief, simple

Brain friendly learning

- Everything that affects physiological functioning, affects our ability to learn
Content vs Patient Centered

Lecturing patients about information irrelevant to their situation
Content completion
Measures knowledge change
“Did we deliver the right content?”

- Current Knowledge & Skills
- Current Behavior
- Barriers or Facilitators
- Barrier Resolving
- Measures behavioral change
- “Did the patients achieve their desired outcomes?”

DSME Approaches
“Patient-Centered” vs. “Content Driven”

- Who’s agenda is it?
- Who is “Shoulding” who?
  - “You should be eating better, you should start an exercise program…”

General Teaching Implications

- Don’t explain….Explaining negates the emotions needed for changing the brain!
- Show, demonstrate
- Use stories, metaphors
- Build on errors
- Engage the whole brain
- Get at what has meaning for the patient


Communication

- Be curious!! ASK
- Open ended questions (Tell me about…)
- Get a good history of patient’s lifestyle (i.e. “take me through a typical day…”)
  - Reflect, restate
  - Validate
  - Empathy (The ability to understand and share the feelings of another)

Questions to ask

- How is diabetes affecting your daily life and that of your family?
- What questions do you have?
- What is the hardest part right now about your diabetes, causing you the most concern or most worrisome to you about your diabetes?
- How can we best help you?
- What is one thing you are doing or can do to better manage your diabetes?


Implications- Communication

- Personal meaning
  - Tie everything back to what the patient told you
  - Give choices
Implications - Communication

- Give patient the control
- Avoid judgement
- Don't argue - Ask permission
- "Roll with resistance" (Miller, W. Motivational Interviewing)
  - Reflect...So you... You feel... restate

Case #1

- 75 yr old Hispanic gentleman with type 2 dm x 12 yrs referred by PCP for his poorly controlled diabetes (A1C 9.5%). Arrives very agitated - "I don’t know why my doctor referred me here, I’m fine". "I feel fine". "Don't bother talking to me about diet and exercise because I've worked hard my whole life and I feel like now is the time I can sit back and relax...and not have to do anything I don't want to do... oh and I am NOT going to check my blood sugars, it's a waste of time. and I am not going to take insulin, no way.

Do NOT assume....

(adapted from DO’s and DON'Ts for the initial conversation about prediabetes - NDEP)

- you know how the patient is reacting. Ask questions, try to find out patients concerns and feelings
- that all patients understand things the same way
- That older people will not make lifestyle changes
- Do not TELL people what you think they should do. Explain the benefits of lifestyle change, medications, DSME. Talk about evidence. People need to make up their own minds
- Do not TELL people to lose weight and increase their physical activity. Need to offer specifics on how they can do this
- Learn something about your patient

Factors That Influence Engagement

Increase motivation

1. Provide choices
2. Make it relevant (relate to family, job, neighborhood, love, health, etc)
3. Engaging (make it emotional, energetic, let patient set guidelines)

Increase apathy & resentment

1. Fear, coercion, paternalism, confrontation
2. Irrelevant, impersonal, useless, out of context
3. Passive (Disconnected from the real world, low interaction, lecture, video)


Other considerations

- Limited health literacy and numeracy
- Food insecurity
- Finances
- Other illnesses
- Family issues
- Other priorities
- "I’m a bad diabetic" "I’ve already been to diabetes school" "I know what to do. I just don’t do it"

Case #2

- 19 year old women with type 1 for 8 years comes in because "I want to get my diabetes under control". A1C is 10.2%. Saw a diabetes educator upon diagnosis, lives in a rural area in NM, never followed by an endo or CDE. Hasn't taken her insulin regularly, doesn't follow any specific diet, unemployed, lives with mother. Is sexually active, not using contraception. She is referred to Women's Health for birth control. Also referred to RD CDE
Case #2 (cont)

> 2 weeks later, I receive a call from our RD, COE that this patient is pregnant! Too late. Our RD sees her weekly for several visits to get her checking her glucose and counting CHO, etc. She misses her monthly meeting with me and her A1C is still > 10%. States she misses a lot of injections. Insists she is excited about this pregnancy and wants a healthy baby.

> Sees midwife with BG of >400, she states she forgot to take her premeal insulin, and ate some “sugar”. My discussion with midwife is that she will be admitted if her A1C continues to be elevated.

Readiness

- Stages of Change
  - Precontemplative
  - Contemplative
  - Preparation
  - Action
  - Maintenance


Readiness to change

40% precontemplators, 40% contemplators, 20% preparation
(Dijkstra et al, 1996; Fava, Velicer & Prochaska, 1995)

Interventions for stages

- Precontemplators-validate, give info
- Contemplators-ID benefits, solicit beliefs, patient choice
- Preparation-self efficacy, praise, help prioritize, assist with problem solving, small steps, social support, encourage positive thinking
- Action-Encourage positive thinking, benefits, plan, internal rewards, guidance
- Maintenance-problem solving; relapse prevention, encouragement

There is no such thing as:
- “The patient is not motivated”
- “The patient is noncompliant”

People are motivated to do EXACTLY WHAT THEY ARE DOING!!!...and compliant with what they want to do!!

Ambivalence

- “The coexistence in one person of contradictory emotions or attitudes (such as love or hatred) towards a person or thing” - Oxford English Dictionary.
Ambivalence is powerful

- Patients who seem resistant, in denial or irresponsible in terms of their health are stuck in an ambivalent state.
- We can increase ambivalence (plead, threaten).
- Known "evil" is easier to tolerate than the unknown "evil".
- Don’t waste your time giving advice to someone who isn’t ready for it.
- Need replacements for pleasures they will lose with change in behavior.

Platt & Gordon (1999) Field guide to the difficult patient interview

Assessing importance and confidence (conviction and confidence)

- On a scale of 1-10 with 1 being not at all important and 10 being extremely important, how important do you think (blood glucose monitoring, medication taking, physical activity, controlling diabetes, eye examinations etc.) is?
- On a scale of 1-10 with 1 being no confidence and 10 being very confident, how confident are you that you can ____________________________.

Pros and Cons: Decision balance

Benefits | Risks
--- | ---
What do you enjoy about...? | What are the negative things that would happen if you...?
What are the good things about? | 

Practice Activity- groups of 3

- Patient role-choose a behavior you want to change
- HCP-help patient to think about the change
- Retate, reflect, empathy
- Elicit beliefs
- ID barriers/facilitators
- Assess importance and confidence
- Decision balance

- Observer/Note taker- jot down what kind of strategies were used
Helping patients to change

- Dealing with negative automatic thoughts
- Assist in setting goals

**Automatic thoughts!**

- Mind Reading: “you’re going to kill me”
- All or nothing: “I screwed up, so what is the point” “I should give up”
- Feeling overwhelmed: “Its just too much”
- Shoulding yourself: “I should...”
- Labelling: “I’m bad” “I must be stupid or something”
- Always and never: “I never succeed”

Countering negative automatic thoughts

- What’s the evidence for what I’m thinking?
- Is there another way of looking at it?
- Is what I’m telling myself sensible?
- Is this a thought or a fact?
- What’s the worse thing that could happen?
- Am I overlooking my strong points?
- What good does it do to focus on these thoughts?

**Countering negative automatic thoughts**

- Personal scientist approach (it’s an experiment)
  - Collect data
  - Don’t judge
  - Keep a record
  - Together...review the data
  - Use “I wonder” statements

**Why develop goals?**

- How will anyone else know what goals have been set?
- How will the health care professional evaluate and document success or failure?
- How will patients keep track of their progress?

**SMART GOALS**

- S - SPECIFIC
- M - MEASURABLE
- A - ACHIEVABLE
- R - REALISTIC
- T - TIME SPECIFIC
Goal setting activity

Barriers to Motivation and Goal Setting
- Can only have 'motivation'... IF
  - Belief in importance
  - Consistent with values
  - Belief it can be accomplished
  - Ready to try

Summary” Health Professional’s Role
- It’s not about YOU
- Incorporate brain friendly principles
- Encourage patients to express concerns
- Encourage active participation in process
  - Allow patient to talk about what is important to them
  - Allow & encourage patient to make decisions
  - Assist with goal setting

Bottom line
- Listen more than you talk
- Be aware of your non verbal expressions
- Recognize that you may NOT be able to change patient behavior but you can move them closer to action
- Sometimes, it isn’t about Fixing things!!

Thank you

Case #3

- 77 year old with ~ 9 year history of DM, also has HTN, dyslipidemia, CRF, hypothyroidism. Meds: insulin treated 70/30 twice a day and “6 other medicines”
- Reports testing 3x day (“pretty good 150-180”)
- Denies missing any injections or medications
- A1C 11%
- “my doctor says my kidneys are good”
- “it don’t do any good to worry, it won’t change anything”

Case #3 (con’t)

- Assessment
  - Memory meter showed testing 1-3 times a week with wide fluctuations most > 200
  - How many times in a week do you miss an insulin injection…(“oh, about 3 or 4”)
  - Microalb: 586 mcg; s-creatinine 2.1

Thoughts about case 3

- Is he noncompliant, in denial?
- What is it about taking insulin that is difficult?
- How to remember? Where do you keep the insulin, the meter, who do you live with?
- What other concerns?