# Engaging the Disengaged:

## Innovative Strategies for Promoting Behavior Change in Diabetes

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# Engaging the Disengaged: Innovative Strategies for Behavior Change in Diabetes

April 18, 2026

This activity is supported by an independent educational grant from Abbott Diabetes Care Inc.

Learning Objectives

- Describe the complex role of motivation in diabetes self-management.
- Perform a comprehensive assessment of the common psychosocial obstacles to effective self-management, including cardiometabolic medication-taking behaviors.
- Describe the key strategies for addressing patient reluctance to initiate new cardiometabolic medications and/or maintain medication adherence over time.
- Describe the major strategies for addressing depression and diabetes distress.
- Demonstrate collaborative communication skills aimed towards enhancing patients' belief that adequate self-management is necessary and worthwhile.
- Demonstrate the use of diabetes-focused action planning strategies.
- Describe the key strategies for providing the ongoing support and resources needed to make self-management doable over the long-term.

**Joint Accreditation Statement**

In support of improving patient care, this activity has been planned and implemented by Partners for Advancing Clinical Education (Partners) and Behavioral Diabetes Institute. Partners is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

**Physician Continuing Education**

Partners designates this live activity for a maximum of 6.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Nursing Continuing Professional Development**

The maximum number of hours awarded for this Nursing Continuing Professional Development activity is 6.0 contact hours.

**Pharmacy Continuing Education**

Partners designates this continuing education activity for 6.0 contact hour(s) (0.6 CEUs) of the Accreditation Council for Pharmacy Education.
(Universal Activity Number - JA4008073-9999-26-105-L01-P)
Type of Activity: Application

**Dietitian Continuing Education**

This program offers 6.0 CPEUs for dietitians.

**PA Continuing Medical Education**

Partners has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 6.0 AAPA Category 1 CME credits. PAs should only claim credit commensurate with the extent of their participation.

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| Faculty | Financial Relationships |
|---|---|
| Susan Guzman, PhD | Consultant, Advisor, Speaker: Abbott Diabetes, Embecta |
| William H. Polonsky, PhD, CDCES | Consultant, Advisor, Speaker: Abbott Diabetes, Eli Lilly, Dexcom, Vertex, Insulet, Mannkind, Sanofi |

## Instructions for Claiming Credit

To receive CE credit, learners must follow these steps:

1. Visit http://cme.partnersed.com/BDI426 or scan the QR Code:
2. Sign Up or Log in.
3. Complete the activity evaluation.
4. Upon completion of all evaluation questions your credit will be made available for download immediately.

For Pharmacists: Upon successfully completing the activity evaluation, your credit will be submitted to CPE Monitor. Please check your NABP account within thirty (30) days to make sure the credit has posted.

# Agenda

| TIME | CONTENT |
| --- | --- |
| 9:00 – 10:00 AM | A new perspective on motivation |
| BREAK | |
| 10:15 – 11:45 AM | Setting the mood |
| LUNCH | |
| 12:45 – 1:45 PM | Providing new perspectives |
| BREAK | |
| 2:00 – 3:00 PM | Encouraging behavior change |
| BREAK | |
| 3:15 – 4:00 PM | Putting it all together |

# The Goal

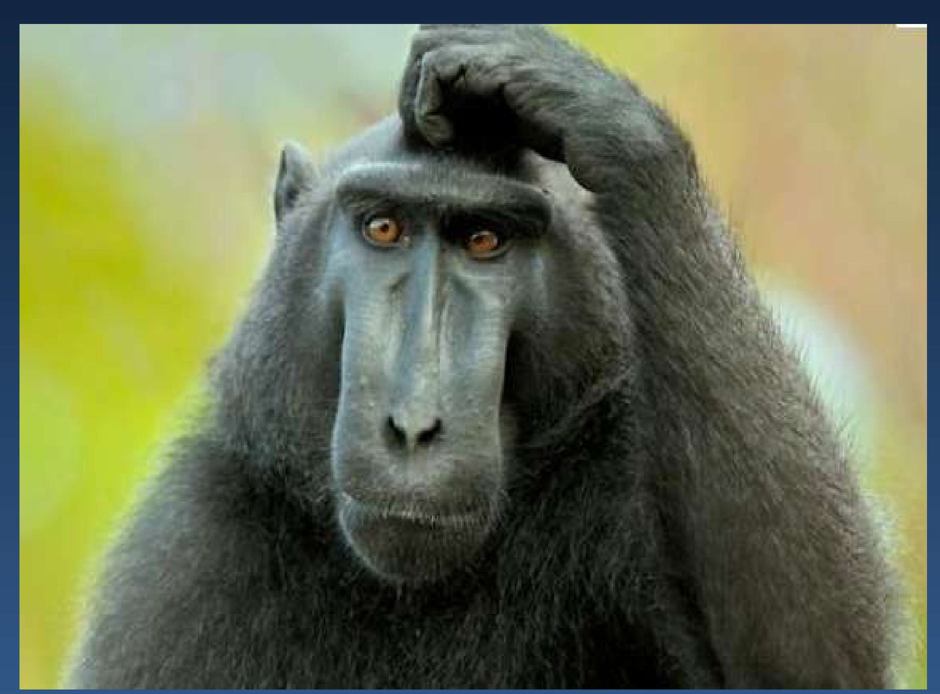
- Leave this program with at least one new strategy you can use when faced with a reluctant or struggling patient

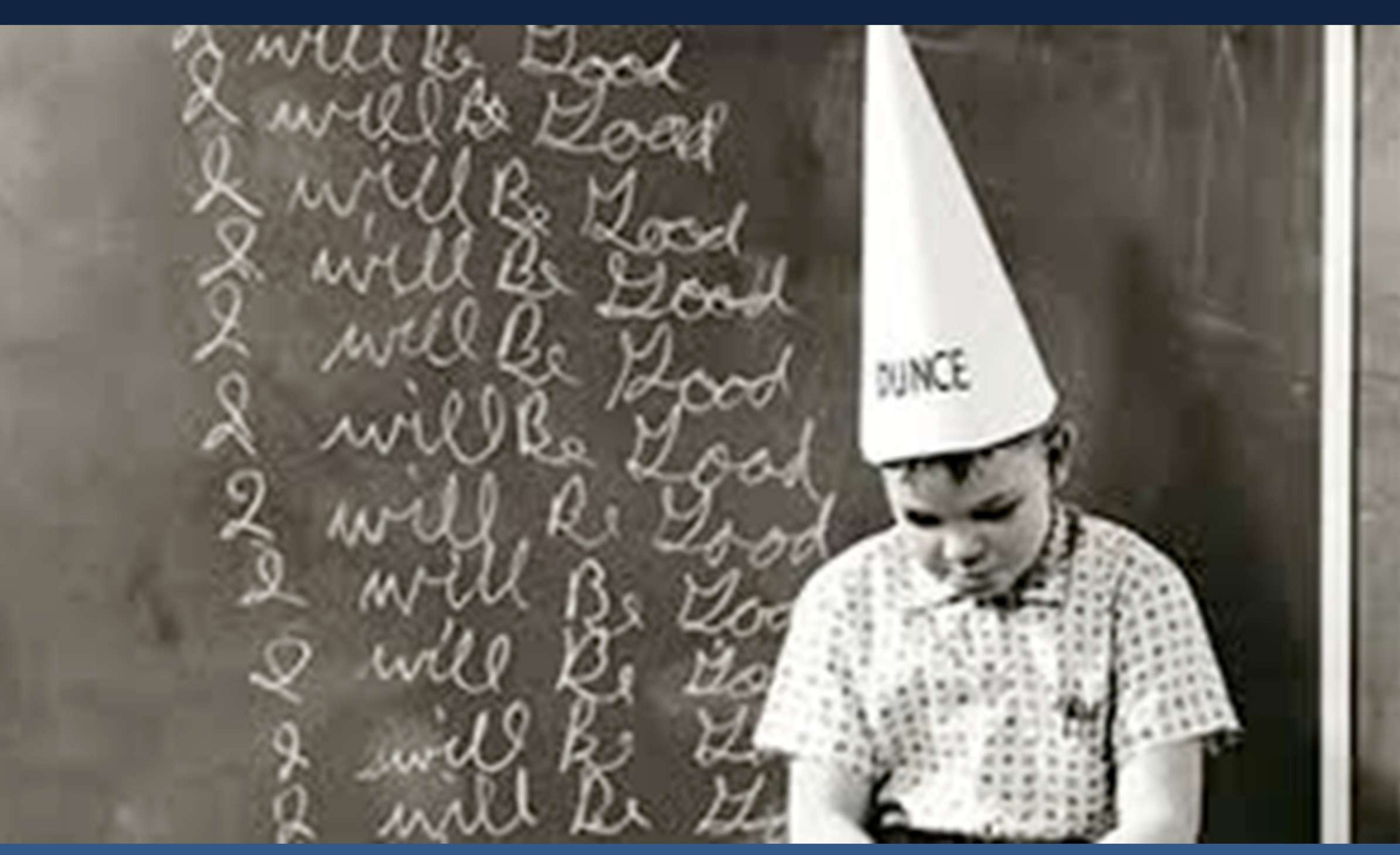
# BDI's Three Operating Principles

1. Living with diabetes can be tough
   - It is a time-consuming job
   - It is a balancing act that requires vigilance and an ability to deal with frustration

# BDI's Three Operating Principles

1. Living with diabetes can be tough
2. The typical reasons why we think its tough are wrong

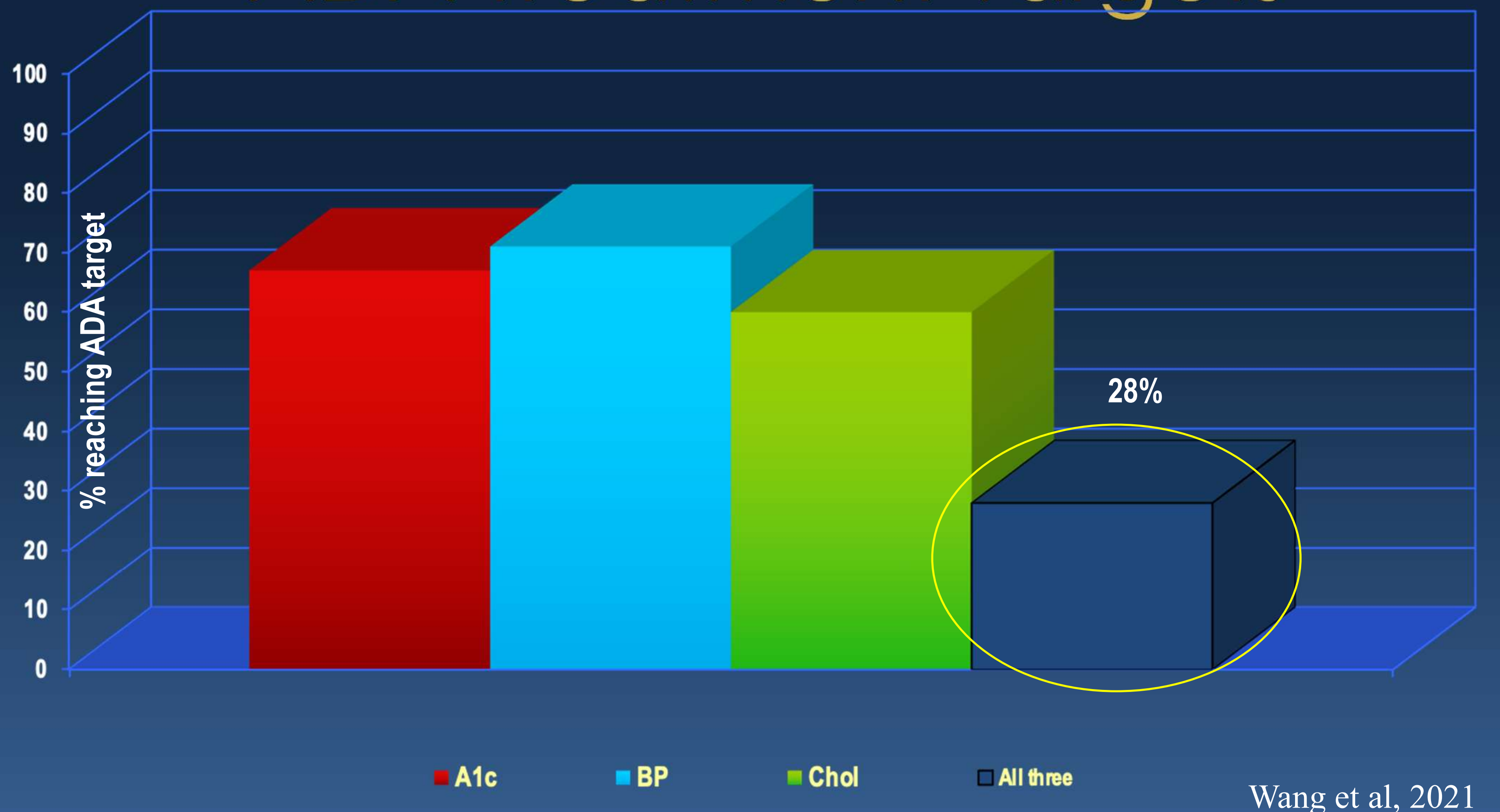



I will Be Good
I will Be Good
I will Be Good
I will Be Good
I will Be Good
I will Be Good
I will Be Good
DUNCE

# BDI’s Three Operating Principles

1. Living with diabetes can be tough
2. The typical reasons why we think its tough are wrong
3. No one is unmotivated to live a long and healthy life

# Percentage of Patients Achieving ADA Treatment Targets




Wang et al, 2021

# Contributors to Poor Metabolic Outcomes

- Macroeconomic factors (e.g., insurance)
- Limitations of currently available tools
- HCP behavior (e.g., clinical inertia)
- Patient behavior (e.g., self-management)

# Motivation in Diabetes

- If no one is unmotivated, then what's the problem?
- Obstacles to self-care outweigh possible benefits
  - And there are a TON of obstacles!
  - The underlying theme to most obstacles is a lack of "worthwhileness"

# Lack of Worthwhileness

- An invisible and non-urgent disease

*"Look, I'll start worrying about my diabetes as soon as something something falls off."*

# Lack of Worthwhileness

- An invisible and non-urgent disease
- Hopelessness

*"What's the difference? This disease is going to get me no matter what I do.*

Diabetes factoid #1:

DIABETES IS THE LEADING CAUSE OF KIDNEY FAILURE.

source: www.diabetes.org

# BLINDNESS

Diabetes is the

**LEADING CAUSE**

of new cases of **blindness** among adults **aged 20-74.**

#WAFD13

MPH@GW

QUIZ
TiME

# Quiz #1

What percent of adults with diabetes despair that they will end up with serious long-term complications, no matter what actions they may be able to take?

1. All of them
2. About two-thirds
3. About one-third
4. Less than 10%

# Feeling Hopeless about Diabetes

| STATEMENT | POPULATION | A MODERATE PROBLEM, OR WORSE |
|---|---|---|
| "I will end up with serious long-term complications, no matter what I do." | 254 T1Ds | 70.5% |
| | 414 T1Ds | 66.4% |
| | 268 T2Ds | 74.3% |
| | 424 T2Ds | 71.0% |

# Quiz #1

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# Diabetes Fatalism

| | $\beta^*_1$ (95% CI) | $P$ value |
|---|---|---|
| Medication adherence | 0.027 (0.013; 0.039) | <.001 |
| Diabetes knowledge test | −0.040 (−0.083; 0.002) | .061 |
| General diet | −0.060 (−0.036; −0.085) | <.001 |
| Exercise | −0.049 (−0.022; −0.077) | <.001 |
| Blood sugar testing | −0.056 (−0.023; −0.088) | .001 |
| Foot care | −0.014 (−0.044; 0.015) | .343 |

$\beta^*$=linear regression model a ent.

$\beta^*_1$=linear regression model and depression.

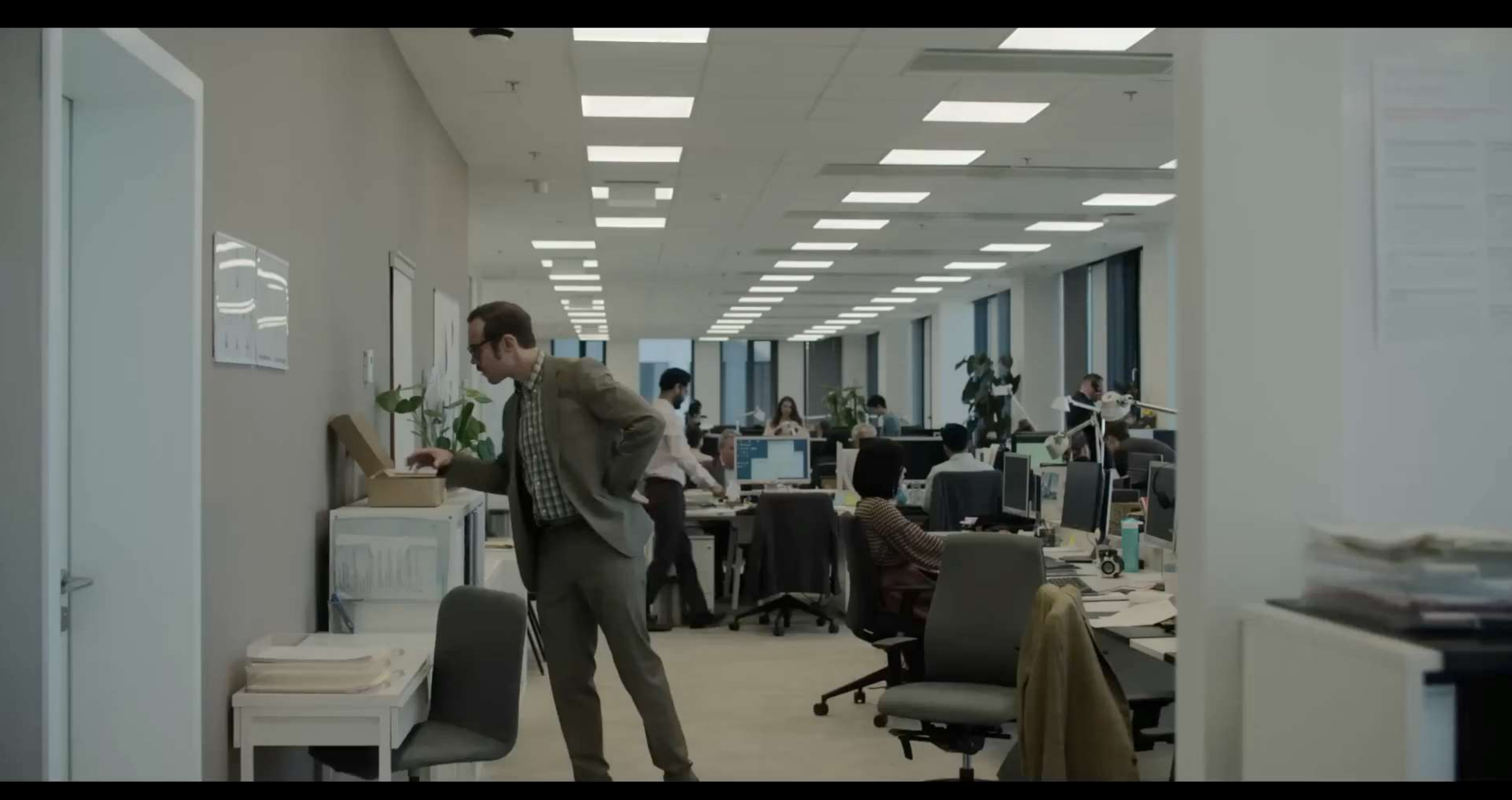
Walker et al, 2012

# Lack of Worthwhileness

- An invisible and non-urgent disease
- Hopelessness
- Discouragement

*"I did everything I was supposed to, and now you're telling me I have to take even more medications?!"*

I have no idea what I'm doing
gifbin.com



# Job #1: Identifying the Critical Obstacles

# Case 1: Ineffective Medication Use

- Age 59, recently divorced, lives alone, self-employed
- T2D 12 yrs, BMI 34, last A1C 8.8%
- Admits that he often "forgets" his OHAs and basal insulin
- Rarely checks BGs ("no point to it")
- Never misses medical appointments
- Knows diabetes can harm him, but has many other things to worry about that seem more pressing

# Quiz #2: The Key Obstacle?

A. Forgetfulness
B. Clinical depression
C. Treatment complexity
D. Medication costs
E. Patient-provider trust
F. Beliefs about diabetes and medications

Gadkari and McHorney *BMC Health Services Research* 2012, **12**:98
http://www.biomedcentral.com/1472-6963/12/98

**RESEARCH ARTICLE** **Open Access**

# Unintentional non-adherence to chronic prescription medications: How unintentional is it really?

Abhijit S Gadkari* and Colleen A McHorney

"Patient' s medication beliefs, especially perceived need for medication and perceived medication affordability, were strong predictors of unintentional non-adherence."

Gadkari and McHorney, 2012

# Quiz #2: The Key Obstacle?

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# Patients’ Medication Beliefs

- Medication-taking improves when medication is perceived as worth the effort
  - Dosage must be sufficient
  - Patients must know why they are taking their medications, and how to take them
- Perceived gain must outweigh perceived cost

# T2D Patient Perspectives on OHAs

Six focus groups, n=50 T2D adults

- OHA intensification was perceived as:
  - Evidence of personal failure
  - Increasing risk of long-term complications (NOT a means towards reducing risk)
- De-intensification was viewed a primary goal
- No concerns about delaying intensification

Grant et al, 2010

# Suspicions about Medications

Saiontz & Kirk, P.A.

www.YouHaveALawyer.com

## Failure to Warn Claims

Invokana\Invokamet

Farxiga

Jardiance

Glyxambi

Xigduo XR

**Call Now**
**If You Suffered**

Ketoacidosis

Kidney Failure

Heart Attack

Wrongful Death

# 1-888-LAW-2390

# Case 1: Ineffective Medication Use

- Age 59, recently divorced, lives alone, self-employed
- T2D 12 yrs, BMI 34, last A1C 8.8%
- Admits that he often "forgets" his OHAs and basal insulin; not so sure they are even working
- Rarely checks BGs ("no point to it")
- Never misses medical appointments
- Knows diabetes can harm him, but doesn't see it as a big priority

# Quiz #2: The Key Obstacle?

A. Forgetfulness
B. Clinical depression
C. Treatment complexity
D. Medication costs
E. Patient-provider trust
F. Beliefs about diabetes and medications

# Case 2: Living with T1D

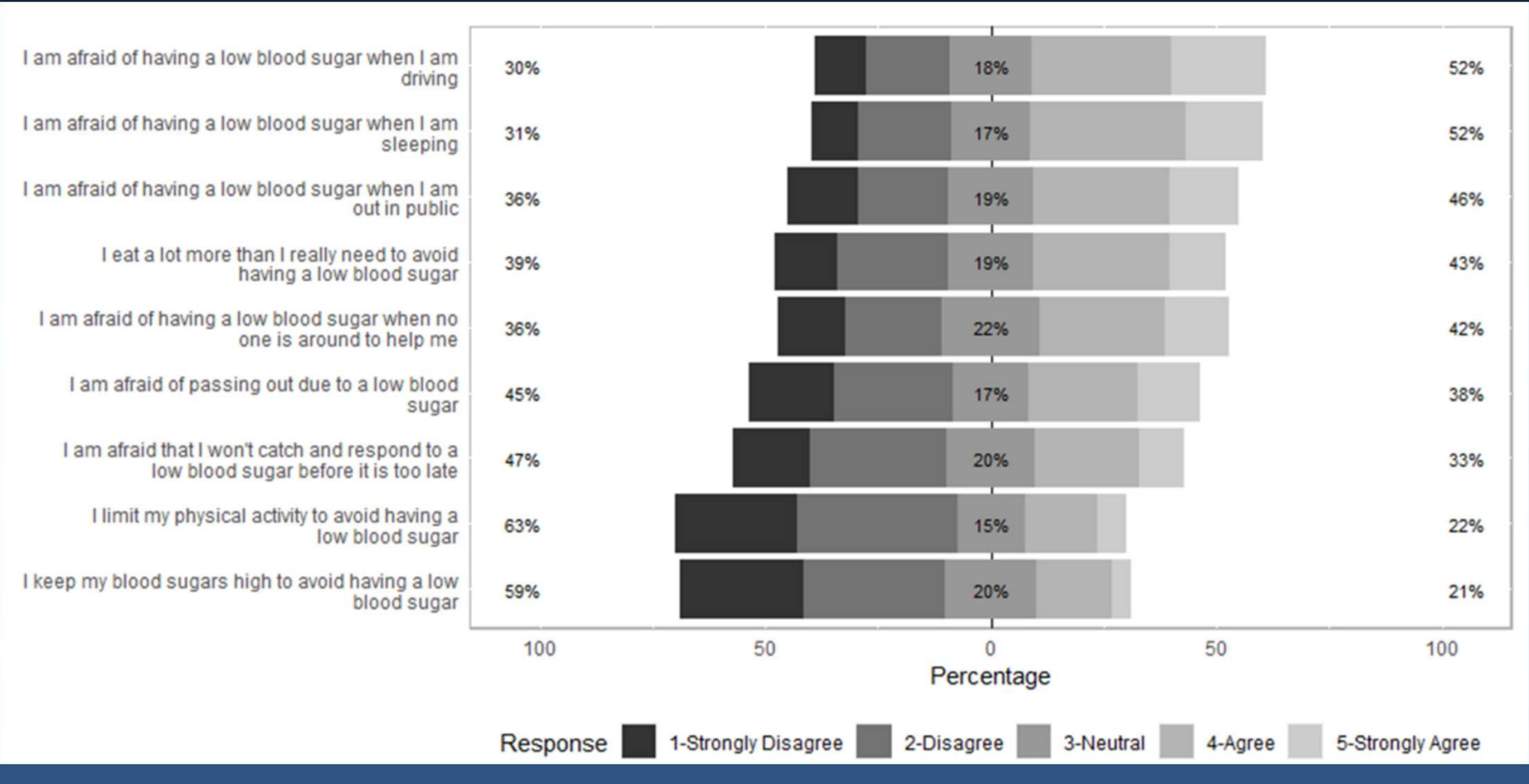
- 34 years old, T1D since age 9, lives alone, pediatric nurse
- A1C= 7.9%, MDI and CGM
- History of severe hypo episodes; worries that more will occur
- Admits to often delaying or skipping mealtime boluses
- Describes how tired she is of being chewed out by her HCP

*"There's just so much to do and to worry about with T1D. And no matter what I do, I can't get the results I want. So why do I even bother?"*

# Quiz#3: What Obstacle to Target First?

A. Lack of motivation
B. Fear of hypoglycemia
C. No perceived urgency
D. Major depressive disorder

# Prevalence of High Hypo Fear




Peter et al, 2023

# Case 3: Disengaged from Diabetes

- Age 45, dental hygienist, T2D 10 yrs
- Single mother, four children; lives with sister and her two kids
- Angry and frustrated about having diabetes; often just ignores it
- On maximum doses of 3 oral meds; not sure they are working
- A1C is 9.3%, which worries her
- Believes serious complications are inevitable; mom died of complications 18 months ago.
- Quiet and passive at medical visits

# Quiz #4: Key Obstacle?

A. Depression
B. Diabetes fatalism
C. "Life is in the way"
D. Treatment skepticism
E. Beliefs about diabetes medications

# Quiz #5: How Common is Clinical Depression in DM?

- More than 50% of patients
- About 35% - 40% of patients
- About 25% of patients
- Less than 20% of patients

# Depression Prevalence in DM

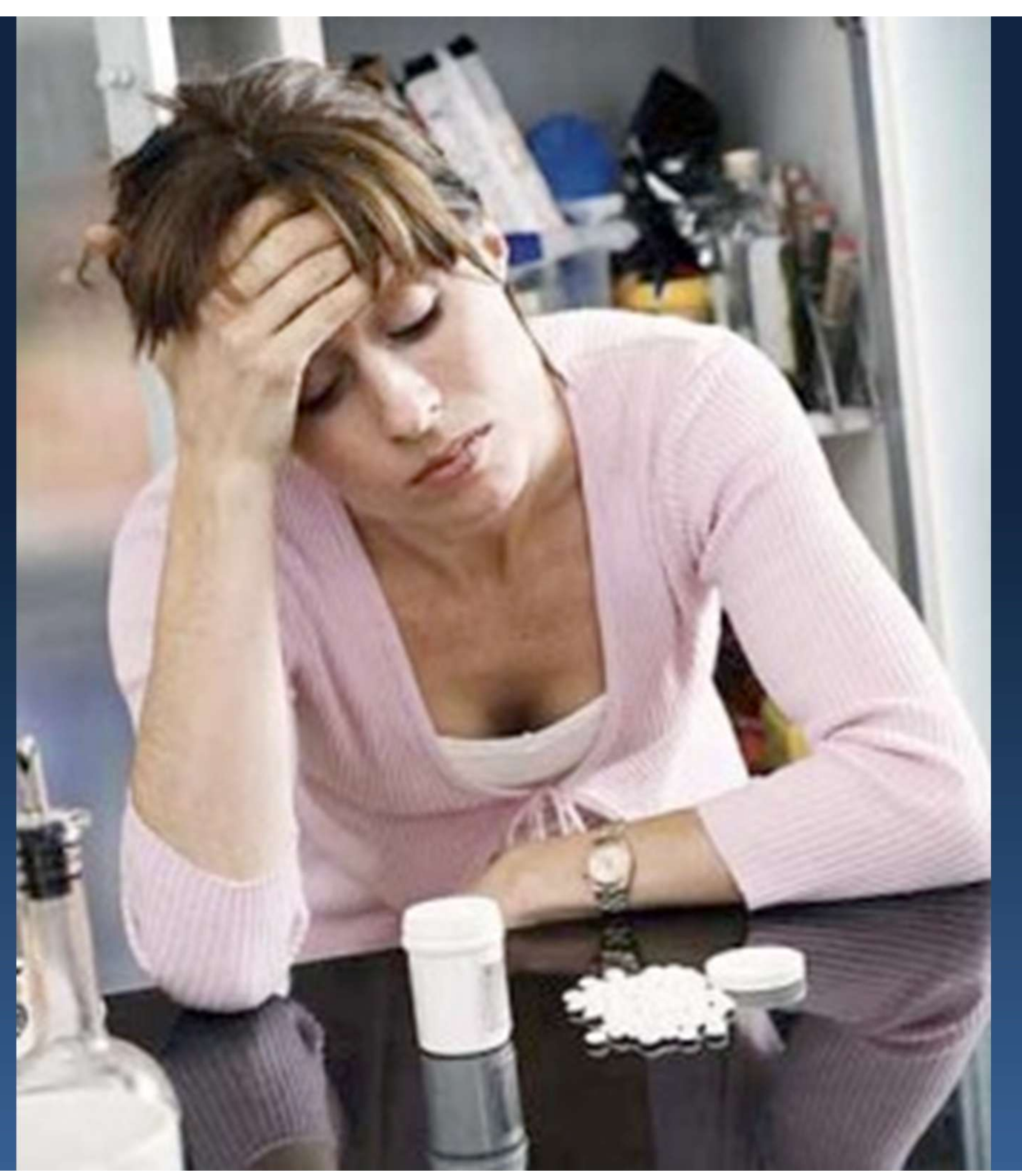
- Worldwide data:
  - Type 1 diabetes: 16% (no diabetes: 12%)
  - Type 2 diabetes: 18% (no diabetes: 11%)
  - Diagnostic interviews: 11%

Farooqi et al, 2021

# A Measurement Issue

- False positives when compared to a SCID diagnosis:
  - PHQ8 >10 = 71.4%,
  - PHQ8 >12 = 65.4%,
  - PHQ8 >15 = 57.1%,
  - DSM algorithm = 52.9 %.

Fisher et al, 2015



# Depression: Still a Big Deal?

- The data is <u>mixed</u> regarding whether:
  - Depression is linked to glycemic outcomes
  - Depression remission is linked to glycemic improvement
  - Treating depression improves glycemic outcomes
  - Depression contributes to mortality

# Bottom Line

- Clinical depression may be less common in diabetes than we think (but it still sucks!)
- The negative impact of clinical depression on diabetes outcomes is uncertain
- BUT people with diabetes are a lot more emotionally distressed

# What Is Diabetes Distress?

- The felt burden of living with a tough, demanding disease
  - Despair: “I will end up with serious long-term complications, no matter what I do”
  - Discouraged: “I am often failing with my diabetes”
  - Overwhelmed: “This is taking up too much of my mental and physical energy every day”

Polonsky et al, 1995; Polonsky et al, 2005

# Case 2: Living with T1D

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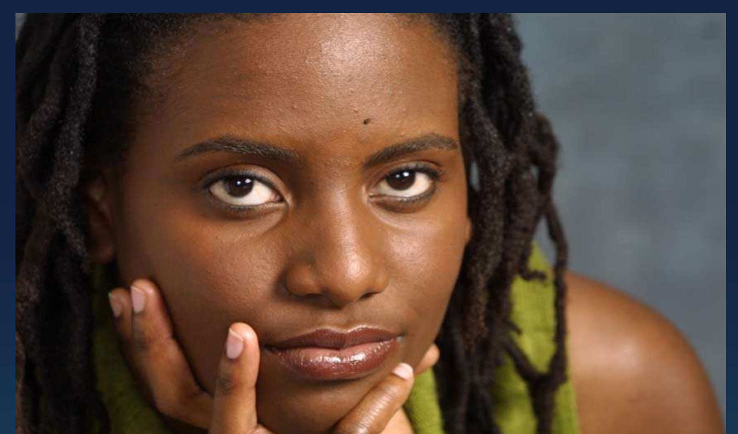


# Prevalence of Diabetes Distress

| Prevalence | T2-DDAS | T1-DDS | T1-DDAS | PAID: T1D | PAID: T2D | MEAN |
|---|---|---|---|---|---|---|
| | N = 599 | N = 414 | N = 650 | N = 883 | N = 1036 | N = 3582 |
| % above TOTAL, CORE, or PAID cut-point | 61.8% | 42.5% | 77.4% | 24% | 15% | 44.1% |
| % with at least one source (≥2) or 2 items above cut-point | 87.5% | 83.8% | 97.1% | 71% | 58% | 79.5% |

Browne, et al., 2017; Fisher, et al, 2016; Polonsky, et al., 2022

# Diabetes Distress is NOT Pathology!

- DD is:
  - An *expected* response to living with diabetes.
  - Simply reflects the emotional side of diabetes.

- However:
  - Greater DD is linked to higher A1C, lower QOL
  - DD is often hidden, unacknowledged and rarely addressed

# How Diabetes Distress Affects Clinical Outcomes

- How you feel and what you believe drives what you do (and what you don't do)
- High levels of diabetes distress constrains energy, restricts problem solving ability, lowers interest in engaging with care, and reduces responsiveness to other interventions.

Fisher et al, 2018

- No one is unmotivated to live a long, healthy life
- Think of yourself as ***obstacle removers***, not ***agents of motivation***
- *Job #1:* stay alert of those key obstacles

# Be Wary of "Not Key" Obstacles

- Lack of will-power
- Non-compliance
- Lack of motivation
- Not frightened enough ("serious" disease)
- Depression
- Forgetfulness

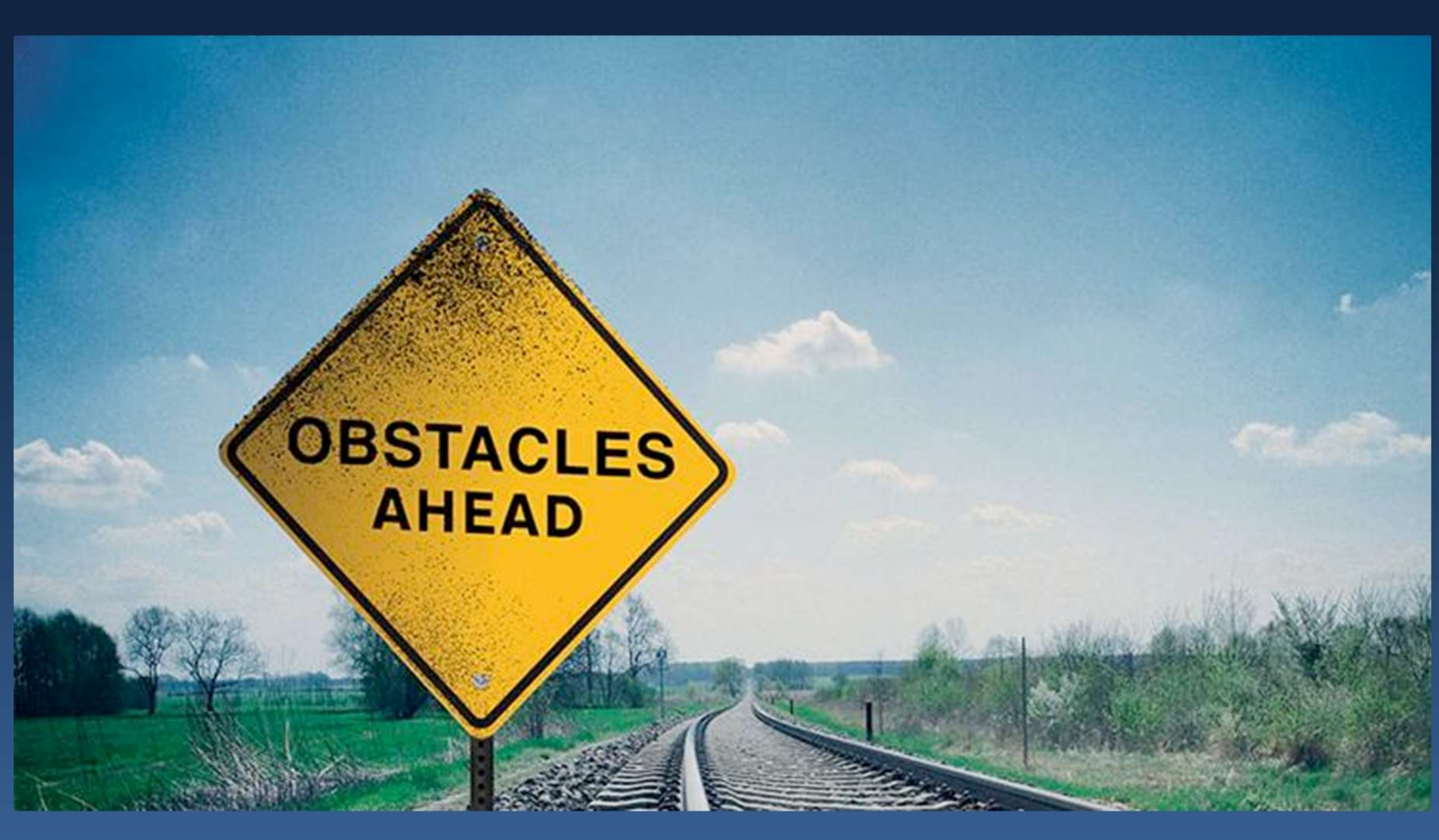
# Be Alert for FIVE Key Obstacles

1. Emotional distress
   - For example: diabetes-related distress; life stress
2. Perceived benefits are nil
- For example: hopelessness, treatment skepticism
3. Perceived costs are too high
- For example: hypoglycemia, weight gain, financial burden
4. Discouraging HCP-patient communication problems
- For example: mistrust, "hurried communication"
5. Environmental pressures (or lack of resources)
- For example: "no time"

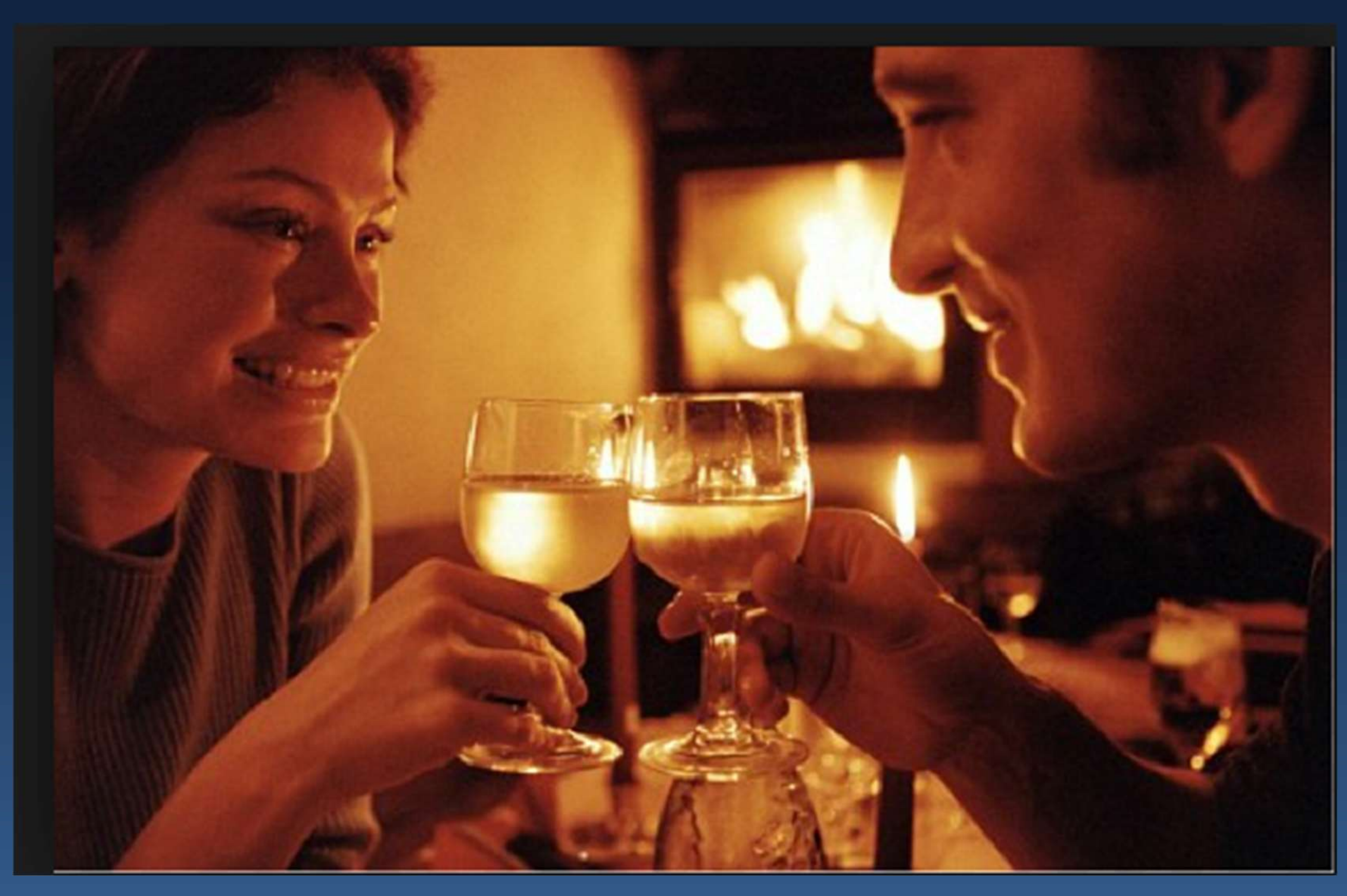
# Questions/Comments

# Time for a Break!

# Job #1: Identifying the Critical Obstacles



# Job #2: Setting the Mood



# Job #2: Setting the Mood

- Goal: creating an alliance
- How to do so: recognizing/appreciating the patient's perspective
- Practice: the "journalist" intervention*

# Time to Practice #1

**Can you think of a healthy change you'd like to make in your life, but you just haven' t made it yet?**

# Practice #1: Be Persuasive

- Explain why he/she should make this change
- Give at least three specific benefits that would result from making the change
- Tell him/her how to change
- Emphasize how important it is for him/her to change
- Tell him/her to just do it
- You have many things to say, interrupt often

# What Did You Think?

# Strategies That Don't Work

<u>Taking sides</u> in the patient's ambivalence

# Strategies That Don't Work

Taking sides in the patient's ambivalence

- Urging more willpower
  - "if you would just try harder…"
- Threatening bad outcomes
  - "you'll go blind if you don't do what I tell you to do…"
- The gift of advice
  - "maybe if you joined a nice fitness center…"

# Time to Practice #2

**Can you think of a healthy change you'd like to make in your life, but you just haven't made it yet?**

# Practice #2: Journalist Intervention

1. Get the details, stay neutral, listen carefully
    - Ask questions for clarification only,
    - Goal is to identify why he/she wants to do this and why he/she doesn't.
2. Summarize and feed back the story you've heard

DO NOT OFFER ANY HELP OR ADVICE

# What Did You Think?

# Melanie's Tale

"Telling me I was uncontrolled and non-compliant and that I just needed to do it, never addressed the real problem.

All this told me was, 'This is *your* problem. It is not *my* problem or an *our* problem. So, come back when you've got yourself together.' And, I didn't know how to address it on my own.

And I heard this from multiple HCPs, in different specialties, in different healthcare systems and even in different States. "

# Melanie’s Tale

“The turning point for me was when I had an endocrinologist *actually listen to me*. I felt heard and validated. When I said that insulin caused weight gain and I was afraid of that, she said that we would work together to find away to manage both my weight and my diabetes.”

Melanie’s takeaway:

“Please assume that I want to be well and I am trying my best.”

# But Does This Really Matter?

Association Between Primary Care Practitioner Empathy and Risk of Cardiovascular Events and All-Cause Mortality Among Patients With Type 2 Diabetes: A Population-Based Prospective Cohort Study

*Hajira Dambha-Miller,* MRCGP, PhD[1,3]

*Adina L. Feldman,* PhD[2]

*Ann Louise Kinmonth,* FRCGP,

**ABSTRACT**

**PURPOSE** To examine the association between primary care practitioner (physician and nurse) empathy and incidence of cardiovascular disease (CVD) events and all-cause mortality among patients with type 2 diabetes.

Dambha-Miller et al, 2019

# The Actual Questions

How good was your HCP at:

1. making you feel at ease
2. letting you tell your story
3. really listening
4. being interested in you as a whole person
5. fully understanding your concerns
6. showing care and compassion
7. being positive
8. explaining things clearly
9. helping you to take control
10. making a plan of action with you

Dambha-Miller et al, 2019

# Quiz #6: Impact on Clinical Outcomes?

1. More than 40% drop in mortality
2. About 20% drop in mortality
3. About 10% drop in mortality
4. No drop in mortality

# HCP Empathy and Mortality Outcomes

"In this 10-year follow up of patients with newly diagnosed type 2 diabetes, those reporting better experiences of empathy in the first 12 months after diagnosis had a significantly lower risk (40% to 50%) of all-cause mortality over the subsequent 10 years compared with those who experienced low practitioner empathy."

Dambha-Miller et al, 2019

# Quiz #6: Impact on Clinical Outcomes?

1. More than 40% drop in mortality
2. About 20% drop in mortality
3. About 10% drop in mortality
4. No drop in mortality

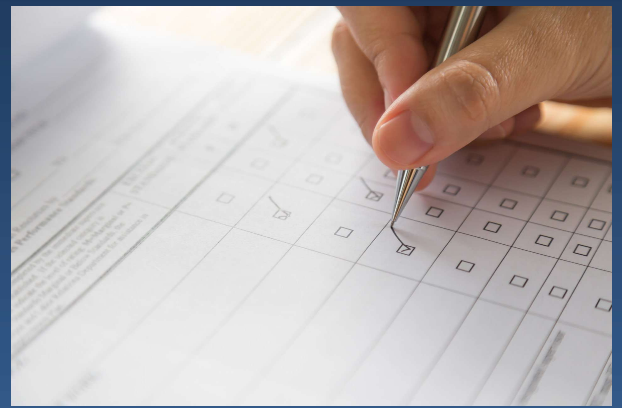
# Take-Home Messages

- DON'T:
- "You are in terrible control; don't you care about your health?

- DO:
- Get the story
- This helps to set the mood *and* to identify key obstacles.

# Adapting the Journalist Intervention for Diabetes

- The informal approach:
  - "What's one thing about diabetes that's driving you crazy?"
- The formal approach: use self-report instruments

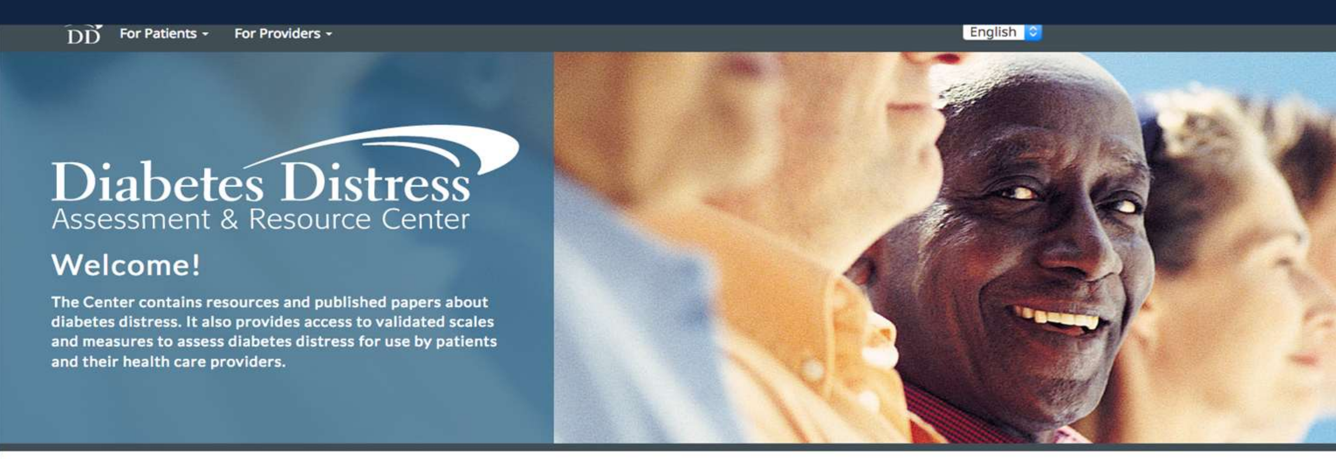


# Measuring Diabetes Distress

- **PAID (Problem Areas in Diabetes Scale)**
- **DDS (Diabetes Distress Scale)**
- **T2-DDAS (T2-Diabetes Distress Assessment System)**
  - 8-item Core scale, seven 3-item Sources scales
- **T1-DDAS (T1-Diabetes Distress Assessment System)**
  - 8-item Core scale, ten 2-item and 3-item Sources scales

Polonsky et al, 1995; Polonsky et al, 2005; Polonsky et al, 2022; Fisher et al, 2024

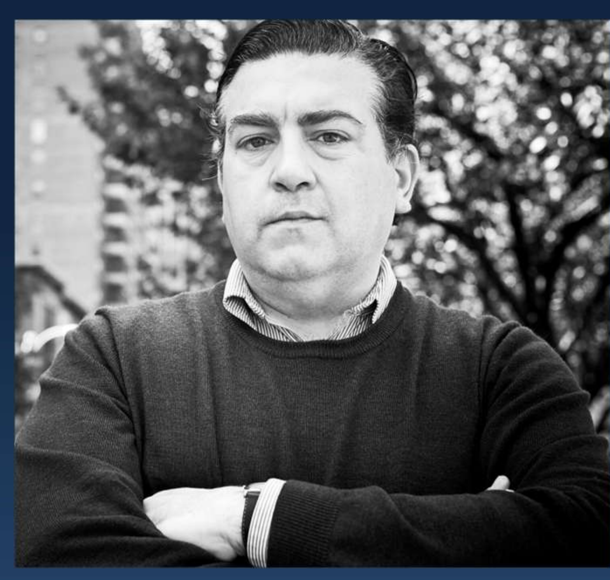
# Diabetesdistress.org



- All scales in English & Spanish
- Automatically scored, with printable reports

# Sam's Story

- Age 42, married, school teacher
- T2D 6 yrs, BMI 33, last A1C 8.4%
- Steady weight gain since dx
- No longer checks BGs due to "consistently high readings".
- On MDI, admits to frequently missing basal and prandial shots.
- Tells HCP he is "so sick and tired of all this", but he will "try harder".
- Since then, has begun to skip scheduled appointments.

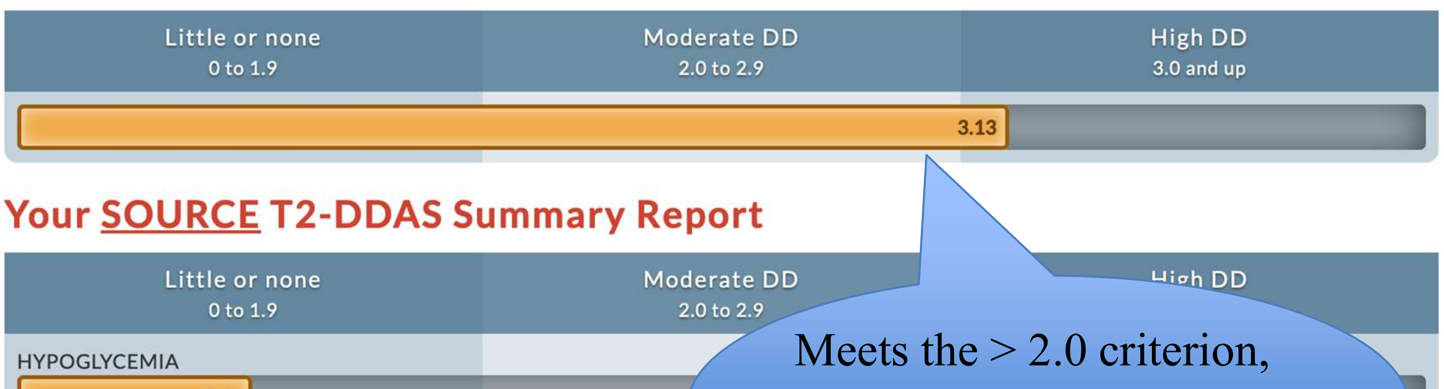


## Your CORE T2-DDAS Summary Report

## Your SOURCE T2-DDAS Summary Report

A score of 2.0 or higher on any scale suggests significant diabetes distress.

## Your CORE T2-DDAS Summary Report




## Your SOURCE T2-DDAS Summary Report

Little or none (0 to 1.9) | Moderate DD (2.0 to 2.9) | High DD

HYPOGLYCEMIA 1.00

LONG-TERM HEALTH

HEALTHCARE PROVIDER 1.67

INTERPERSONAL ISSUES 2.00

SHAME/STIGMA 2.33

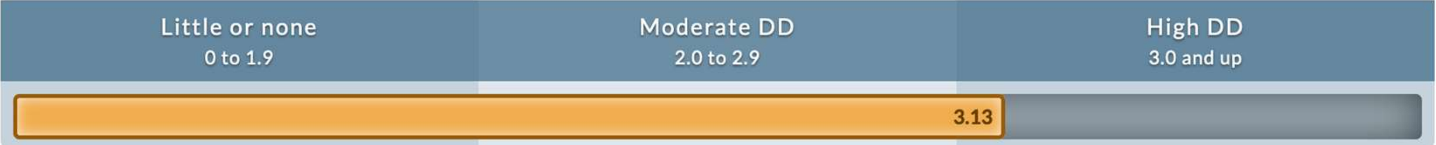
HEALTHCARE ACCESSS 1.00

MANAGEMENT DEMANDS 2.67

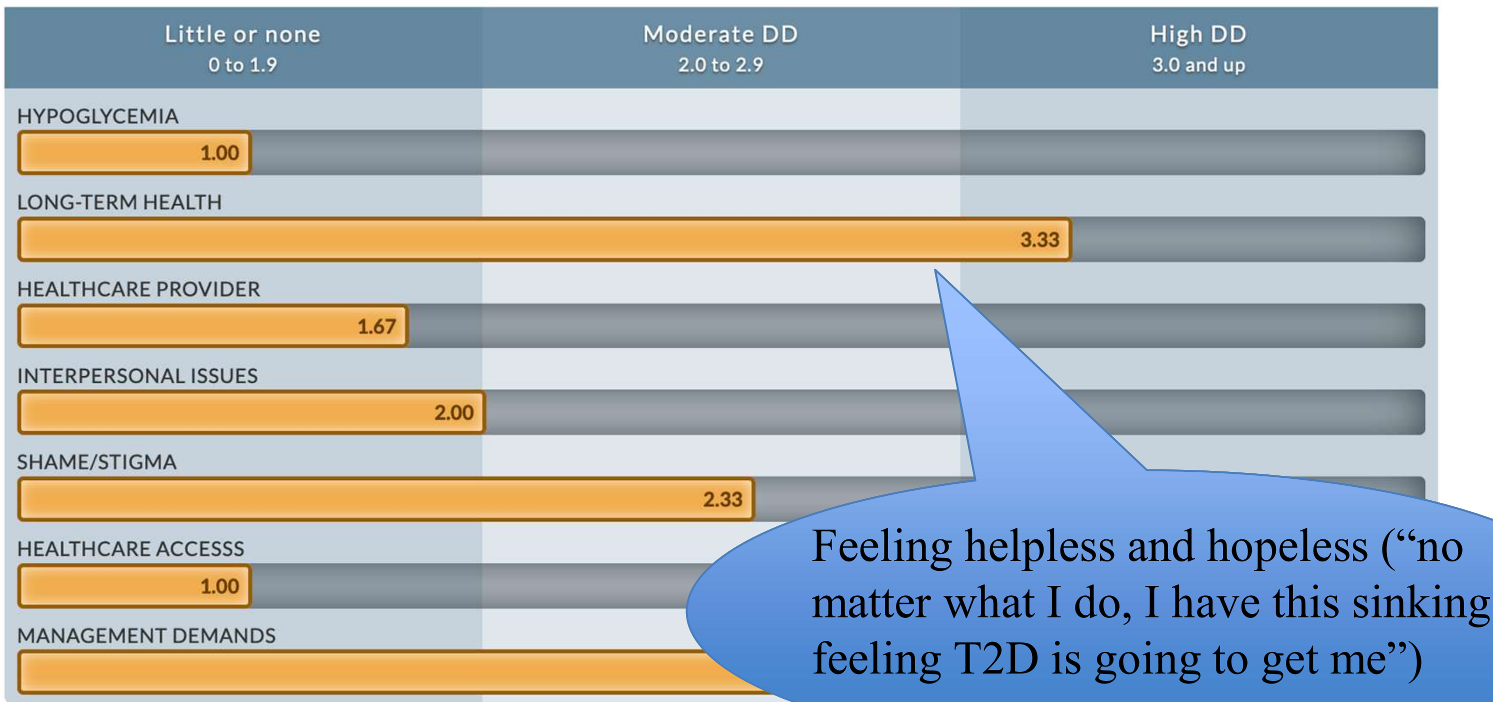
Meets the > 2.0 criterion, suggesting clinically relevant diabetes distress

A score of 2.0 or higher on any scale suggests significant diabetes distress.

## Your CORE T2-DDAS Summary Report



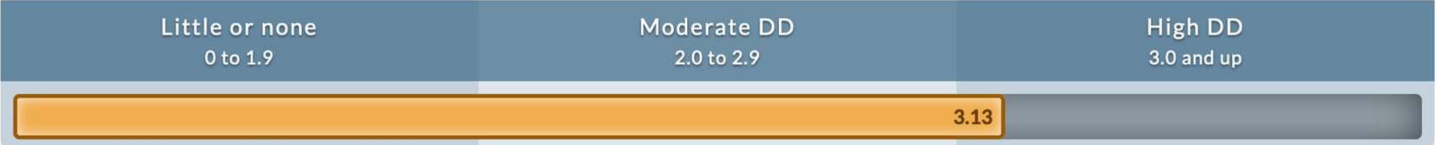

## Your SOURCE T2-DDAS Summary Report




Feeling helpless and hopeless ("no matter what I do, I have this sinking feeling T2D is going to get me")

A score of 2.0 or higher on any scale suggests significant diabetes distress.

## Your CORE T2-DDAS Summary Report

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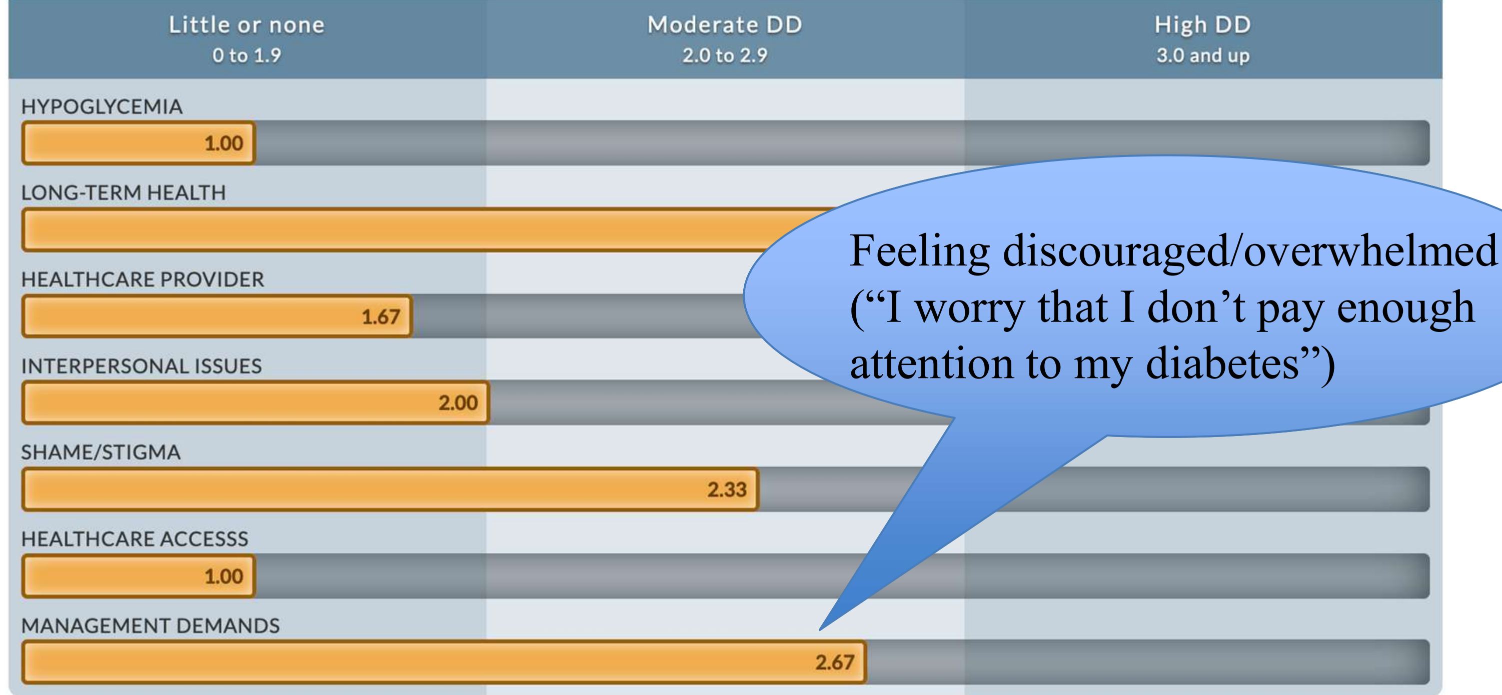
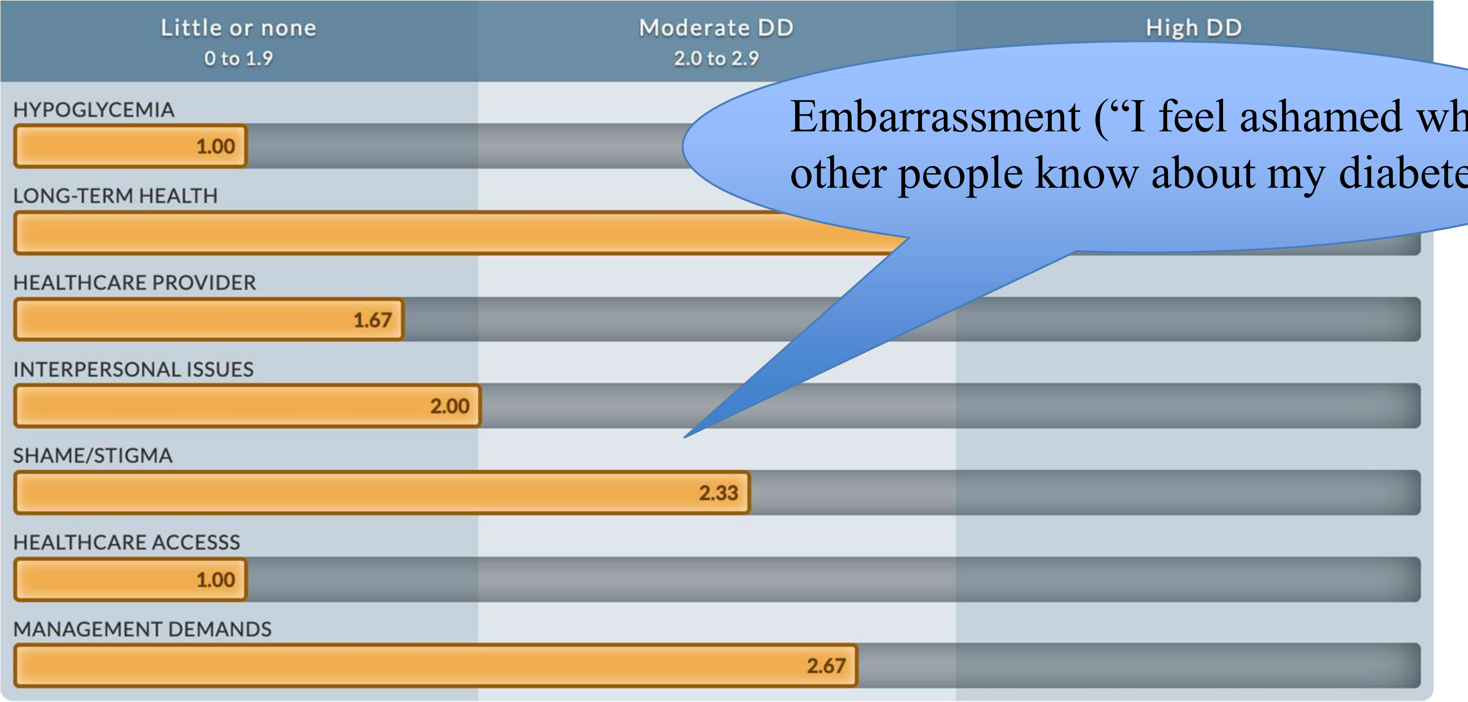



Feeling discouraged/overwhelmed (“I worry that I don’t pay enough attention to my diabetes”)

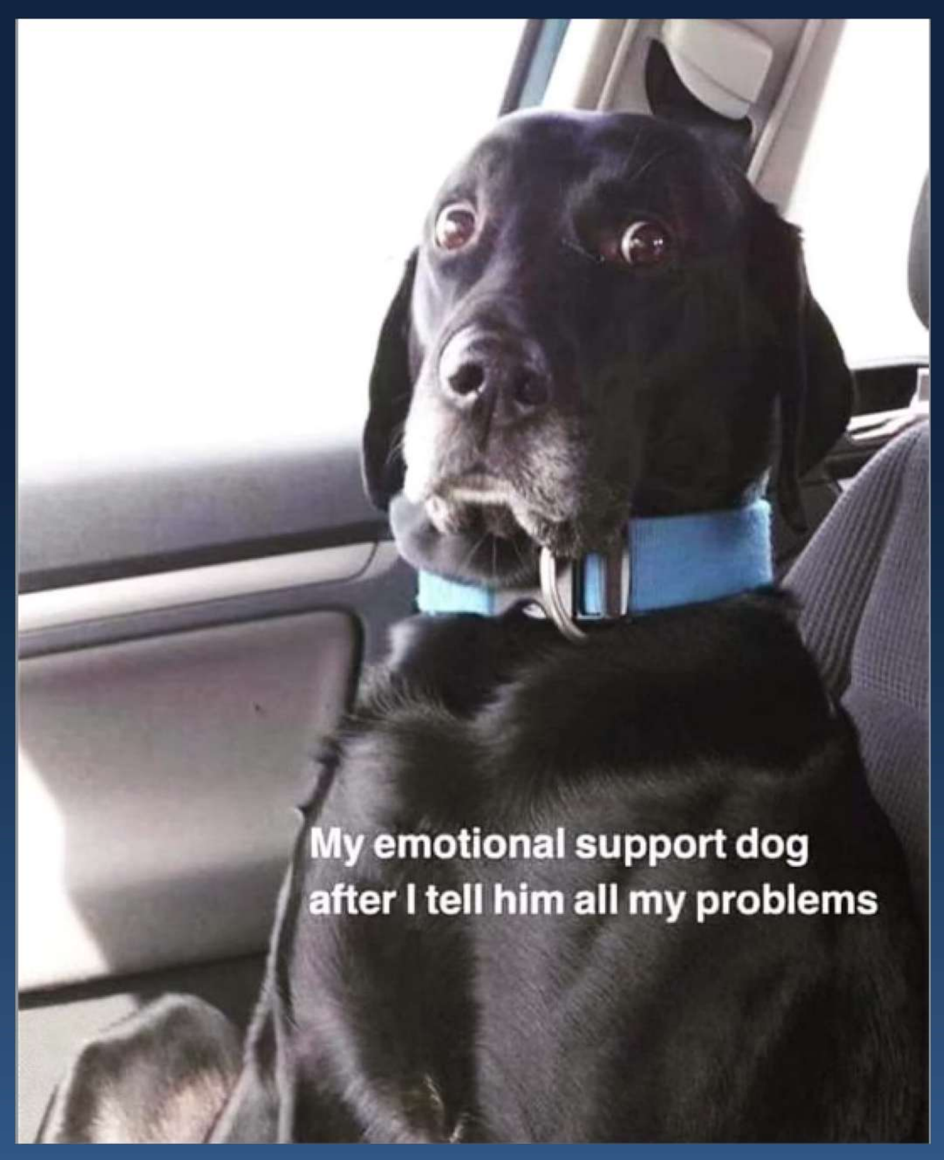
A score of 2.0 or higher on any scale suggests significant diabetes distress.

## Your CORE T2-DDAS Summary Report

## Your SOURCE T2-DDAS Summary Report




A score of 2.0 or higher on any scale suggests significant diabetes distress.


My emotional support dog
after I tell him all my problems

# Adapting the Journalist Intervention for Diabetes

- The informal approach:
  - "What's one thing about diabetes that's driving you crazy?"
- The formal approach: use self-report instruments
- Then as before, summarize and feed back the story you've heard

# Addressing Diabetes Distress

Three steps:

1. Use DDAS to examine current experience of diabetes
2. Have an empathic, judgement-free conversation
3. Express a willingness to be helpful

Note that DD is remarkably malleable and can change very quickly with an emotion-focused conversation

# Addressing Diabetes Distress

1. Use DDAS to examine current experience of diabetes
   - Ask the individual to complete the appropriate scale at diabetesdistress.org
   - Print scored results
   - Note the results of the Core Scale and Sources Scales
   - Review together "Does this fit your experience?"

*"Diabetes can take an emotional toll; we call this diabetes distress. It is common and can make diabetes even harder to live with and manage. This questionnaire tells us how distressed you are about diabetes and what you might be distressed about."*

*"Seems like feeling hopeless about your future and feeling frustrated with how you are handling your diabetes are really getting you down. Do I have that right?"*

# Addressing Diabetes Distress

2. Have an empathic, judgement-free conversation
   - With curiosity, ask open-ended questions
   - Name the feelings, normalize and empathize

*“What has this been like for you lately?”*
*“Does this affect your management decisions?”*
*“How do you respond when this happens?*

*“That sounds really scary/frustrating/overwhelming.”*
*“I might feel the same way if I were in your shoes.”*
*“A lot of people I see with diabetes feel the same way.”*
*“I see how this might be making things tough for you.”*

# Addressing Diabetes Distress

3. Express willingness to be helpful
   - Make good use of the person's own expertise
   - If appropriate, collaborate on a specific plan of action

*"What do you think would be helpful? Are you willing to try something different?"*

*"Would you like to work together to make a plan that you feel good about? How might you go about making that change?"*

# Time to Practice #3

Reviewing DDAS in dyads

Important note: Main job is to have a DD-focused conversation. No need to fix anything!

# Meet Amy

- Age 47, single, T2D for 2 years, works as sales manager. Lives with mother.
- Though A1C has been climbing, reluctant to change or adjust medication (GLP-1 has been recommended) and she has now cut back on current OHA's.
- Does not check BG
- Enjoys walking
- Last A1C = 8.4% (7.6% at last appt).

# Amy's T2- DDAS Results

**Your CORE T2-DDAS Summary Report**

| Little or none 0 to 1.9 | Moderate DD 2.0 to 2.9 | High DD 3.0 and up |
|---|---|---|
| | 3.00 | |

**Your SOURCE T2-DDAS Summary Report**

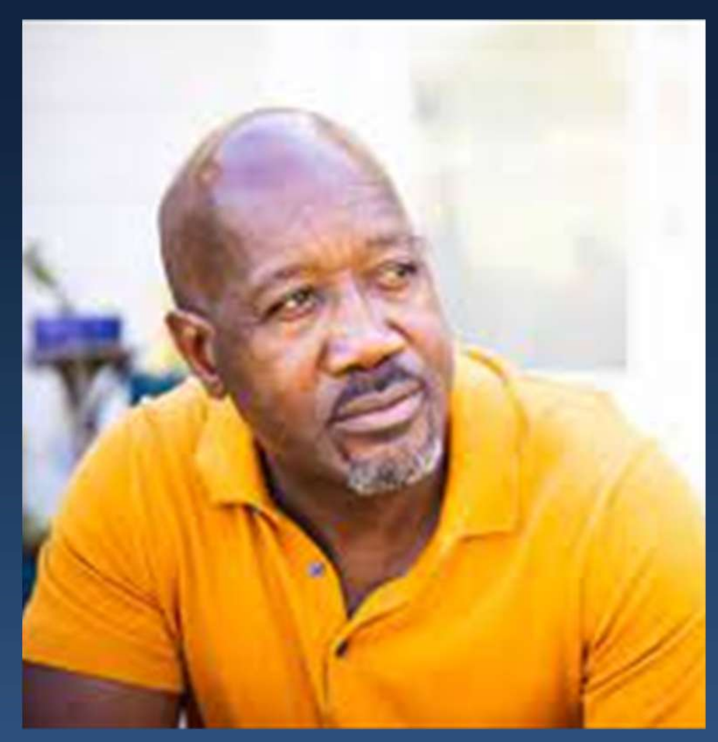
| | Little or none 0 to 1.9 | Moderate DD 2.0 to 2.9 | High DD 3.0 and up |
|---|---|---|---|
| MANAGEMENT DEMANDS | | | 3.00 |
| HYPOGLYCEMIA | 1.00 | | |
| INTERPERSONAL ISSUES | | | 3.33 |
| HEALTHCARE PROVIDER | 1.00 | | |
| SHAME/STIGMA | | | 4.33 |
| LONG-TERM HEALTH | | 2.33 | |
| HEALTHCARE ACCESS | 1.00 | | |

# Amy's T2- DDAS Results

| Question | Not a Problem (1) | A Little Problem (2) | A Moderate Problem (3) | A Serious Problem (4) | A Very Serious Problem (5) |
|---|---|---|---|---|---|
| **Core Level Of Distress** | | | | | |
| I feel burned out by all of the attention and effort that diabetes demands of me. | | ✓ | | | |
| It bothers me that diabetes seems to control my life. | | | ✓ | | |
| I am frustrated that even when I do what I am supposed to for my diabetes, it doesn't seem to make a difference. | | | ✓ | | |
| No matter how hard I try with my diabetes, it feels like it will never be good enough. | | | ✓ | | |
| I am so tired of having to worry about diabetes all the time. | | ✓ | | | |
| When it comes to my diabetes, I often feel like a failure. | | | | ✓ | |
| It depresses me when I realize that my diabetes will likely never go away. | | | | ✓ | |
| Living with diabetes is overwhelming for me. | | | ✓ | | |
| **Management Demands** | | | | | |
| It frustrates me that my eating often feels out of control. | | | ✓ | | |
| I worry that I don't pay enough attention to my diabetes. | | | | ✓ | |
| It bothers me that I don't get as much exercise as I should. | | ✓ | | | |
| **Interpersonal Issues** | | | | | |
| When it comes to family and friends, it disappoints me that I am pretty much on my own with diabetes. | | | | ✓ | |
| It frustrates me that people in my life tempt me to eat foods or do things that are not good for my diabetes. | | ✓ | | | |
| It hurts me that many people in my life don't understand what living with diabetes is really like. | | | | ✓ | |
| **Shame/Stigma** | | | | | |
| It makes me feel bad that I must hide my diabetes from others. | | | | | ✓ |
| It upsets me that people in my life think less of me because I have diabetes. | | | | ✓ | |
| I often feel ashamed or embarrassed when other people know about my diabetes. | | | | ✓ | |

# Meet Dennis

- Age 58, married, T1D 40 years, stressful job in biotech.
- Last A1C is 8.1%
- Insulin pump, CGM (not closed loop).
- Often misses bolus insulin during day.
- Struggles with eating choices, especially when at work.
- Has several mild complications (retinopathy and neuropathy)
- Enjoys weightlifting



# Dennis T1-DDAS Results

**Your CORE T1-DDAS Summary Report**

| Little or none 0 to 1.9 | Moderate DD 2.0 to 2.9 | High DD 3.0 and up |
|---|---|---|

Core score: 3.25

**Your SOURCE T1-DDAS Summary Report**

| Little or none 0 to 1.9 | Moderate DD 2.0 to 2.9 | High DD 3.0 and up |
|---|---|---|

| Source | Score |
|---|---|
| MANAGEMENT DIFFICULTIES | 3.00 |
| HYPOGLYCEMIA CONCERNS | 2.00 |
| INTERPERSONAL CHALLENGES | 1.50 |
| HEALTHCARE QUALITY | 1.00 |
| SHAME | 4.00 |
| WORRIES ABOUT COMPLICATIONS | 3.00 |
| FINANCIAL WORRIES | 1.50 |
| LACK OF DIABETES RESOURCES | 1.00 |

# Highest Source Scales and Items

| Core Level Of Distress | | | | | |
|---|---|---|---|---|---|
| I feel burned out by all of the attention and effort that diabetes demands of me. | | | | ✔ | |
| It bothers me that diabetes seems to control my life. | | | | ✔ | |
| I am frustrated that even when I do what I am supposed to for my diabetes, it doesn't seem to make a difference. | | | ✔ | | |
| No matter how hard I try with my diabetes, it feels like it will never be good enough. | | | ✔ | | |
| I am so tired of having to worry about diabetes all the time. | | | | ✔ | |
| When it comes to my diabetes, I often feel like a failure. | | | | ✔ | |
| It depresses me when I realize that my diabetes will likely never go away. | ✔ | | | | |
| Living with diabetes is overwhelming for me. | | | ✔ | | |

| Management Difficulties | | | | | |
|---|---|---|---|---|---|
| I feel discouraged when I see high blood glucose numbers I can’t explain. | | | ✔ | | |
| I feel that thoughts about food and eating control my life. | | ✔ | | | |
| I get angry at myself for not managing diabetes better. | | | | ✔ | |

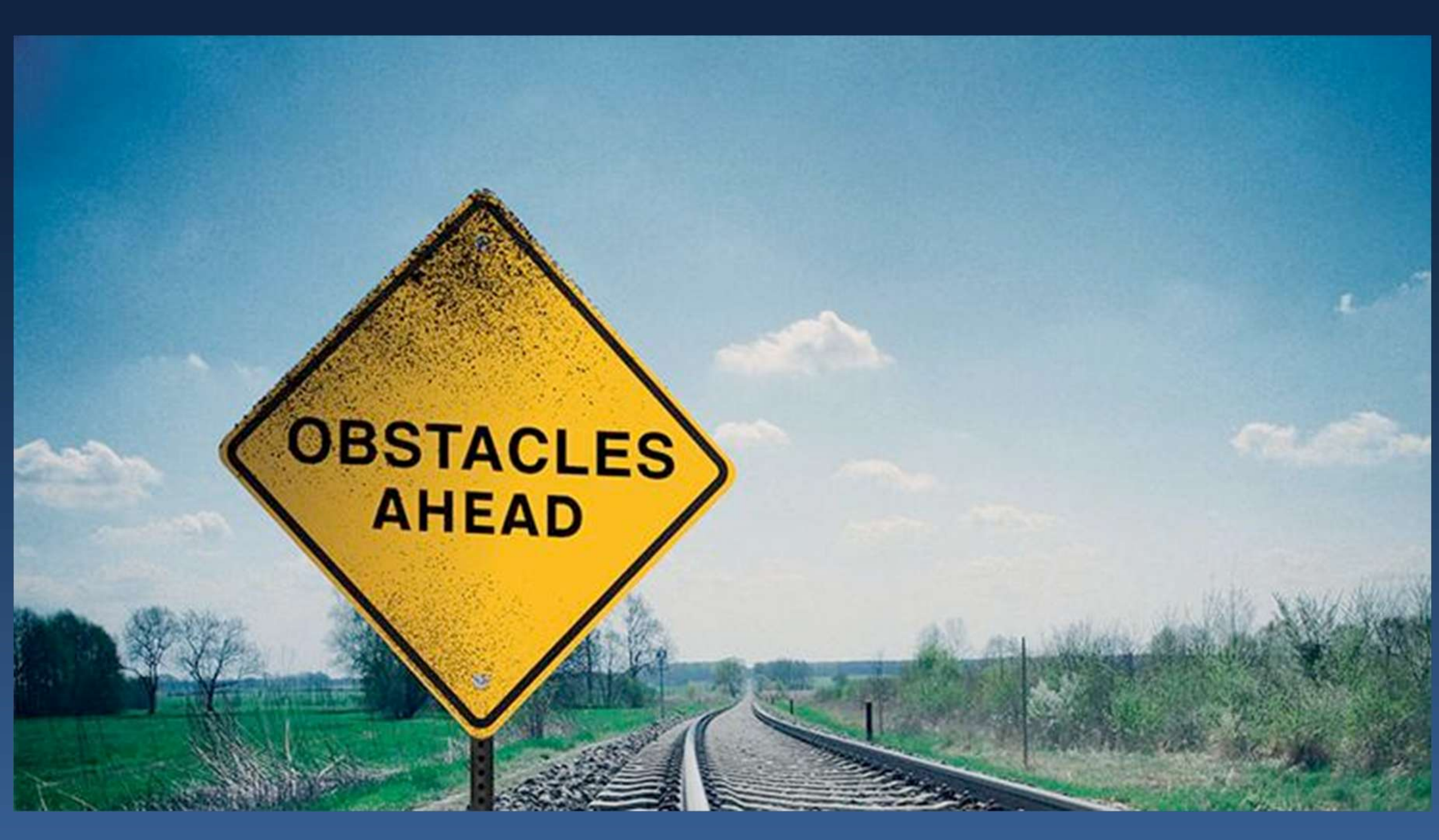
| Shame | | | | | |
|---|---|---|---|---|---|
| I often feel ashamed or embarrassed when other people know about my diabetes. | | | | ✔ | |
| I fear that others will think I am sick or have something wrong with me because I have diabetes. | | | | ✔ | |

# Discussion

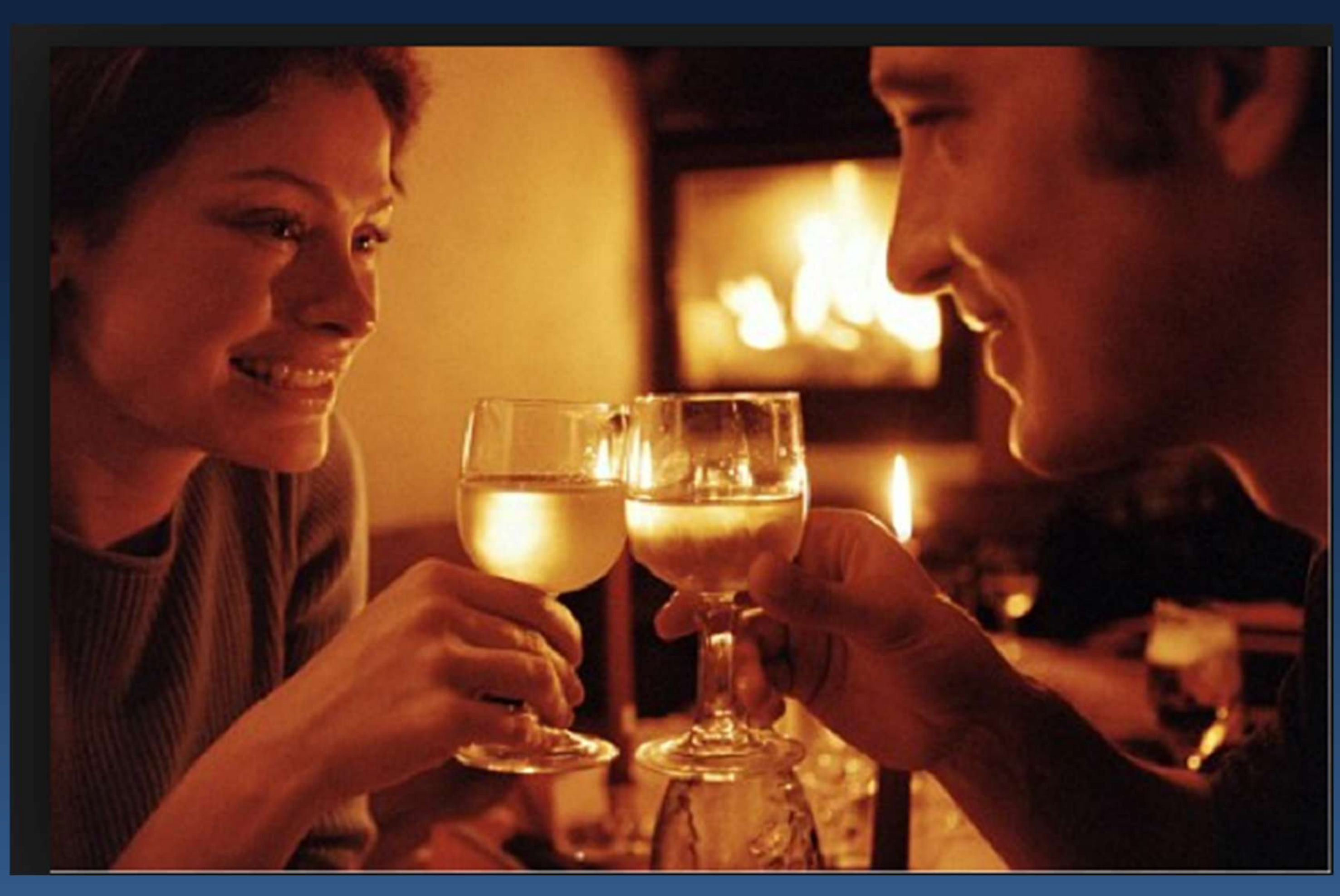
- What was it like to have a DD-focused conversation?
- Was it uncomfortable discussing this side of diabetes?
- Can you see yourself having emotion-focused conversations?
- What are the real-life barriers to using this approach in your practice?

# Time For Lunch!

# Job #1: Identifying the Critical Obstacles



# Job #2: Setting the Mood



# Job #3: Providing Your Patients with New Perspectives

# Job #3: Providing Your Patients with New Perspectives

A. Addressing hopelessness
B. Discussing metabolic results to address discouragement
C. Tackling critical misbeliefs about medications

# A. Addressing Hopelessness and Powerlessness

# Facts and Fictions

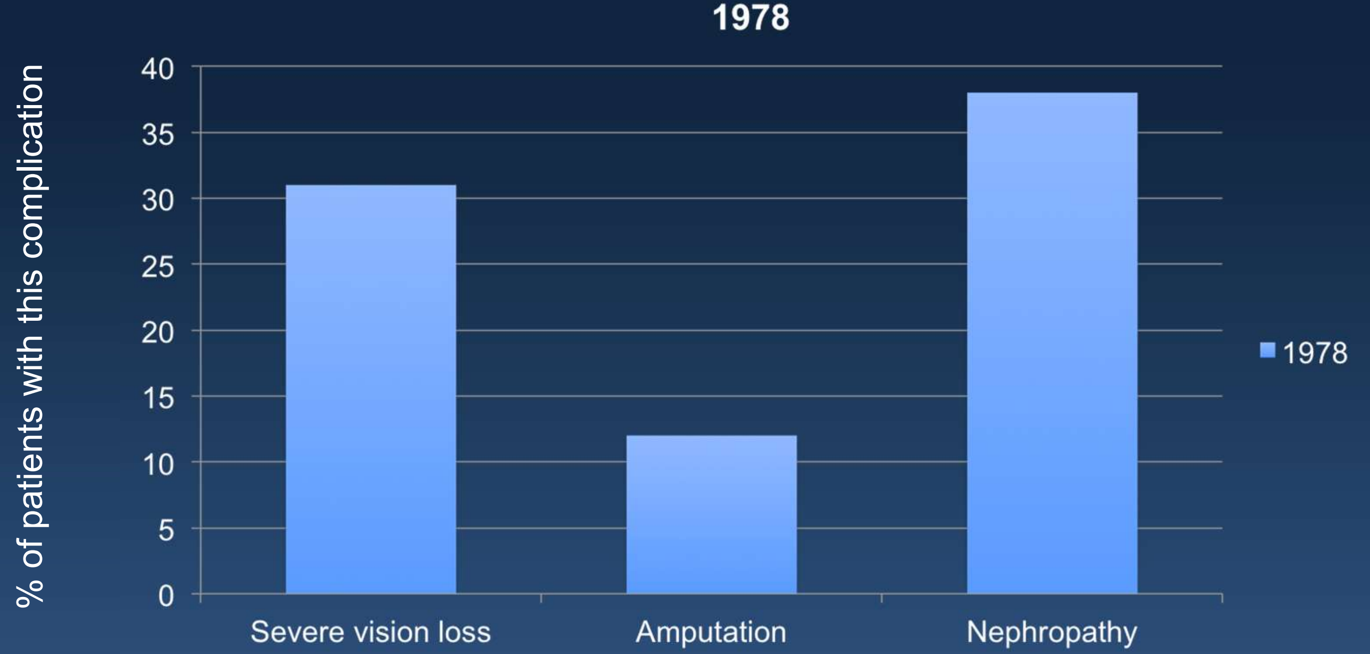
Q. Diabetes is the leading cause of adult blindness, amputation, and kidney failure. True or false?

---

A. False. To a large extent, it is *poorly managed* diabetes that is the leading cause of adult blindness, amputation and kidney failure.

Well-managed diabetes is the leading cause of… NOTHING!

# T1D Complications After 30+ Years




Deckert et al, 1978

# T1D Complications After 30+ Years

DCCT/EDIC Research Group, 2009

# Quiz #7: Avoid Macroalbuminuria over 30 Years with T1D?

1. Mean A1C ≤ 8.1%
2. Mean A1C ≤ 7.5%
3. Mean A1C ≤ 7.1%
4. Mean A1C ≤ 6.5%

**Diabetes Care** Volume 45, November 2022

## Impact of $HbA_{1c}$ Followed 32 Years From Diagnosis of Type 1 Diabetes on Development of Severe Retinopathy and Nephropathy: The VISS Study

*Diabetes Care 2022;45:2675–2682 | https://doi.org/10.2337/dc22-0239*

Arnquist et al, 2022

# Quiz #7: Avoid Macroalbuminuria over 30 Years with T1D?

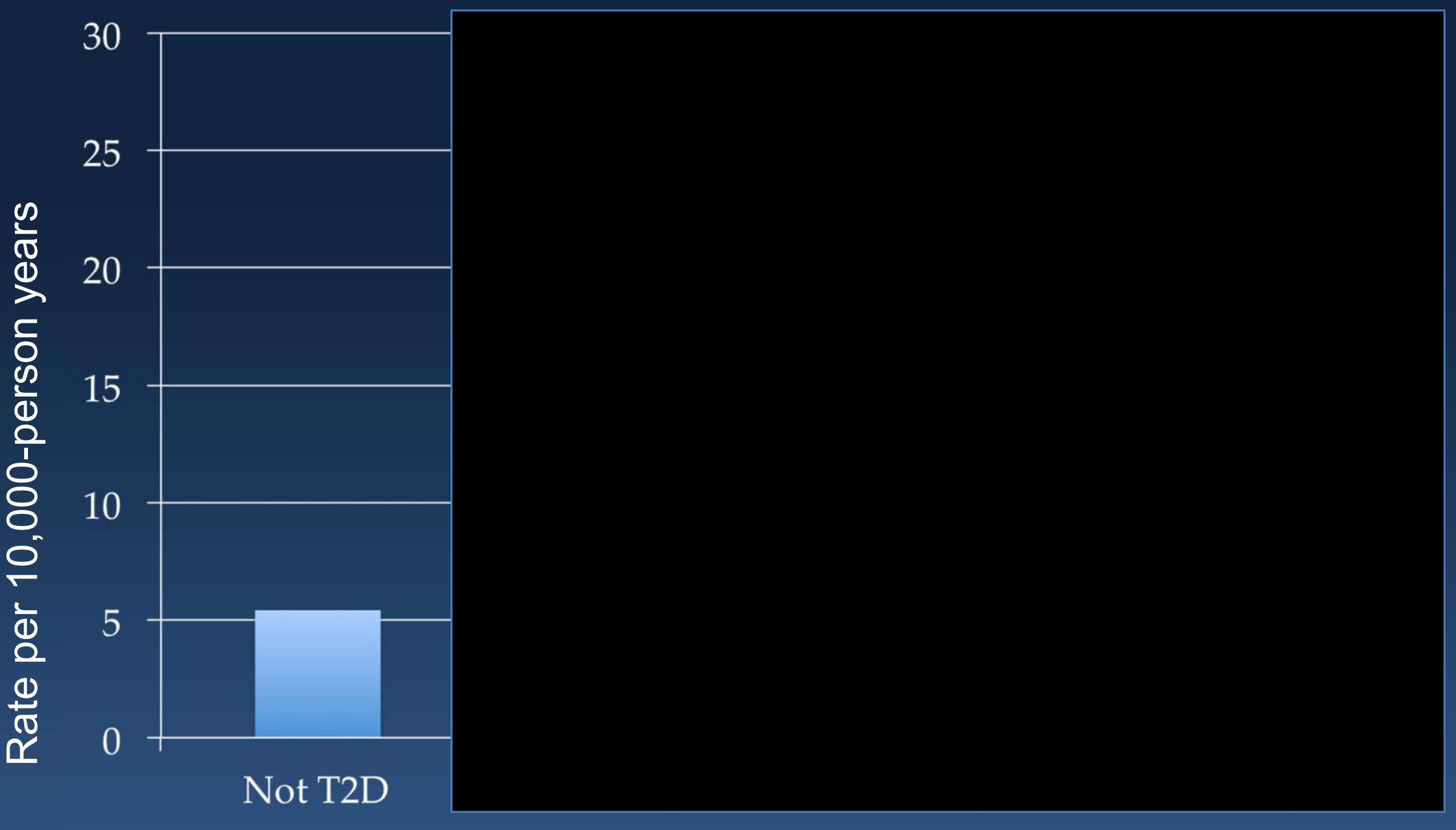
1. Mean A1C ≤ 8.1%
2. Mean A1C ≤ 7.5%
3. Mean A1C ≤ 7.1%
4. Mean A1C ≤ 6.5%

at the 20–24-year follow-up (16). The lowest value for appearance of PDR decreased from 7.6% (60 mmol/mol) to 7.3% (56 mmol/mol) and from 8.4% (68 mmol/mol) to 8.1% (65 mmol/mol) for macroalbuminuria. There may be some uncertainty about these limits

Arnquist et al, 2022

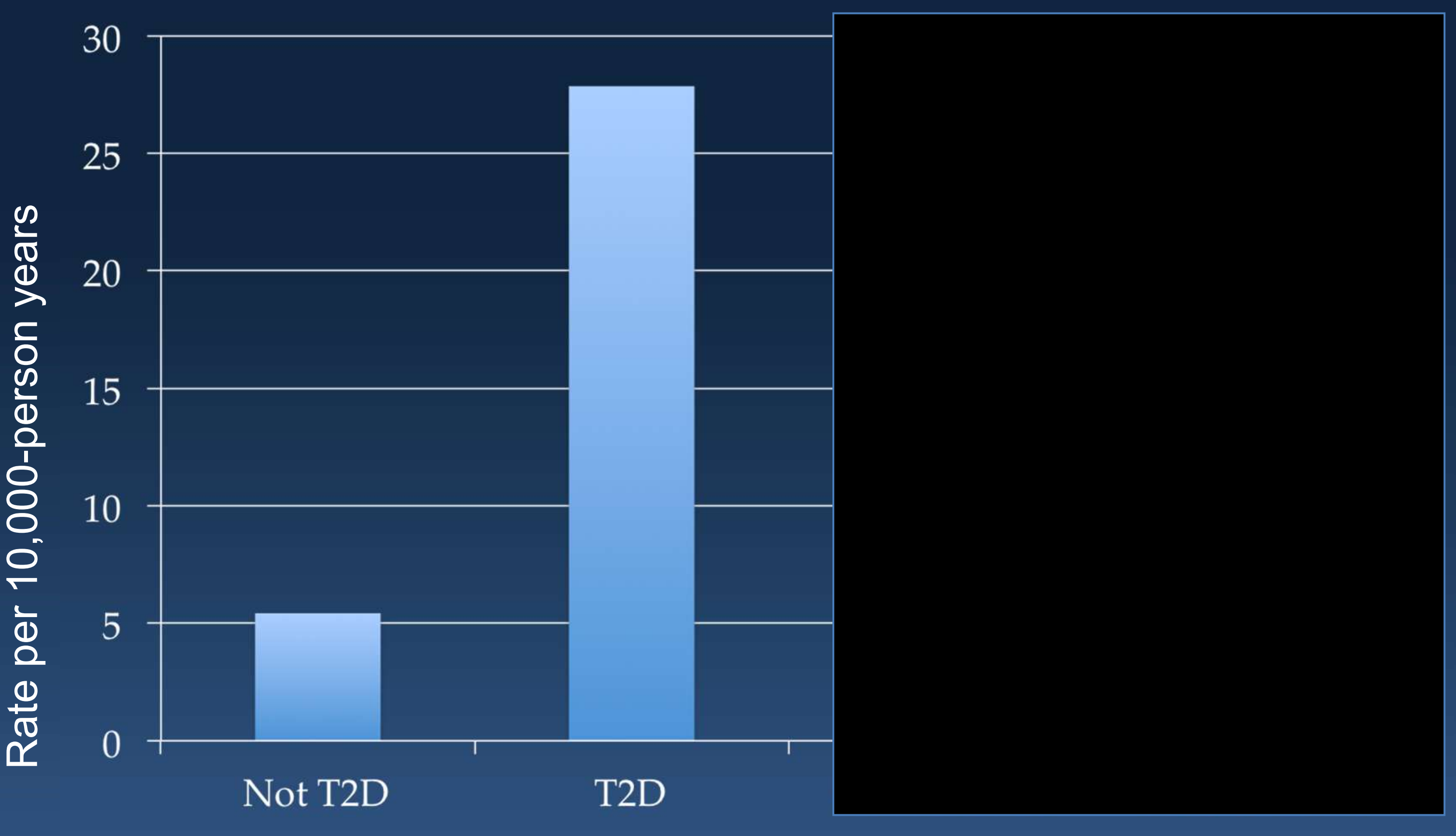
# What About Type 2 Diabetes?

# Heart Attacks in Type 2 Diabetes




Rawshani et al, 2018

# Heart Attacks in Type 2 Diabetes

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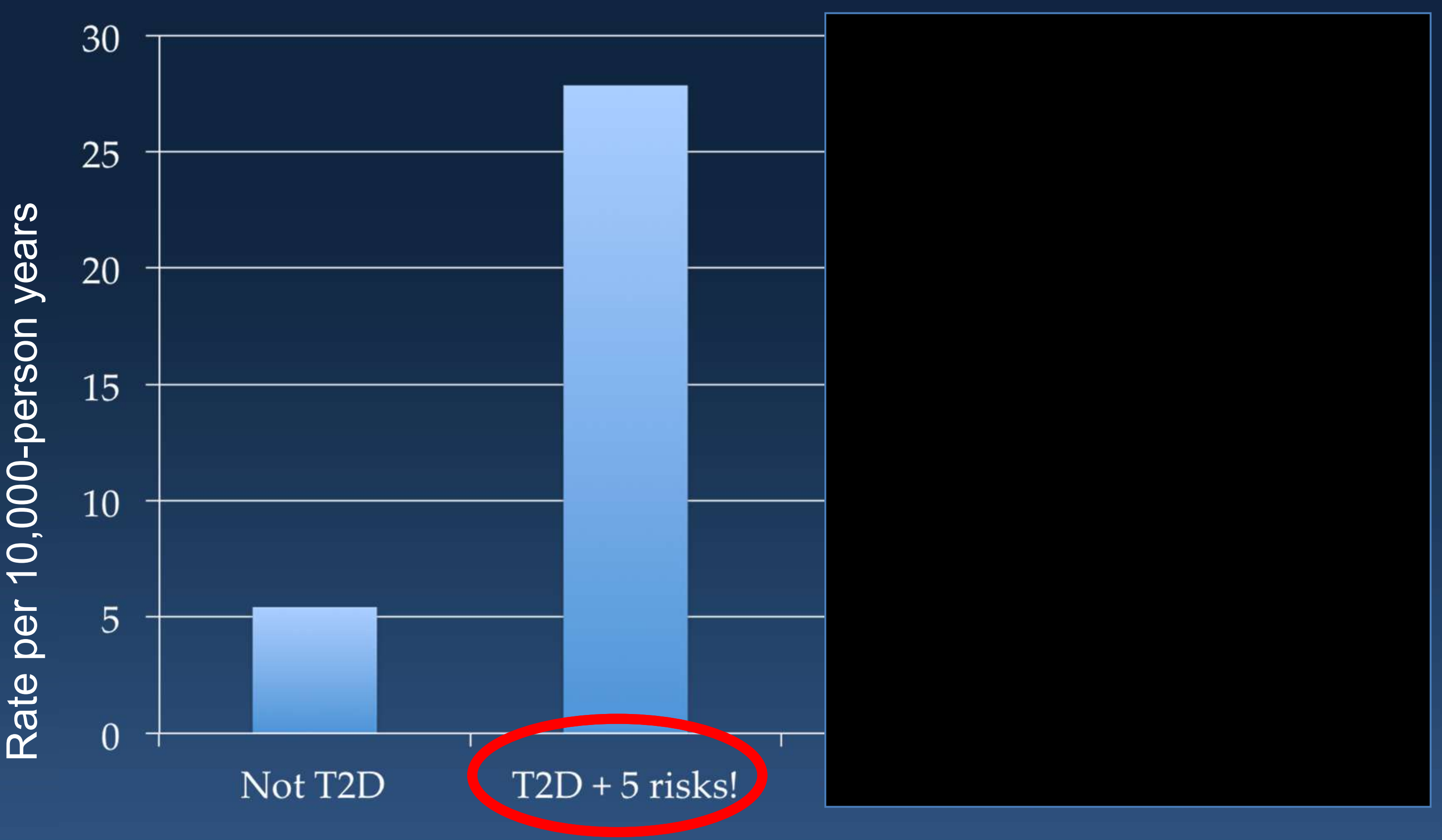
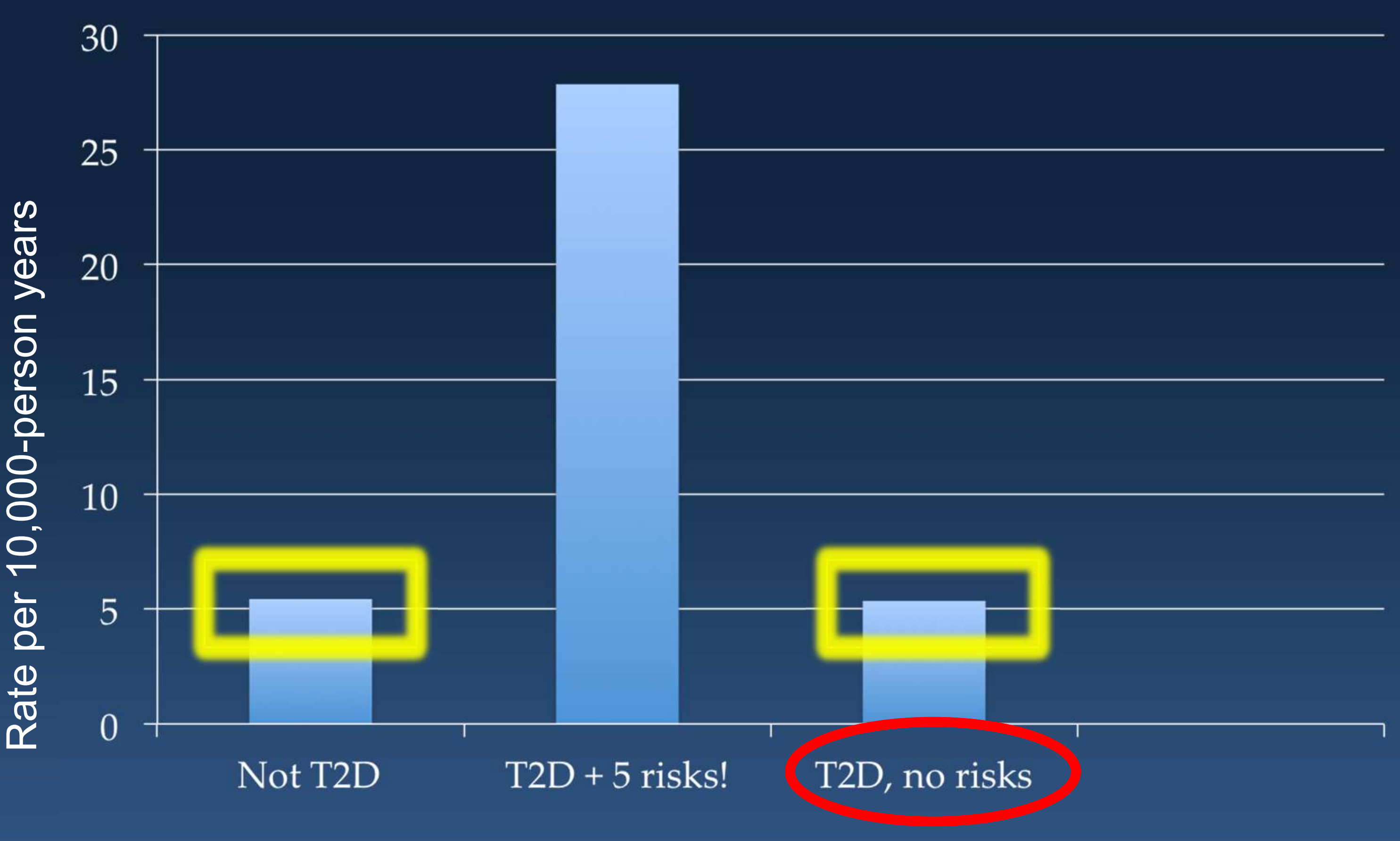



Rawshani et al, 2018

# Heart Attacks in Type 2 Diabetes




Rawshani et al, 2018

# Fact Check

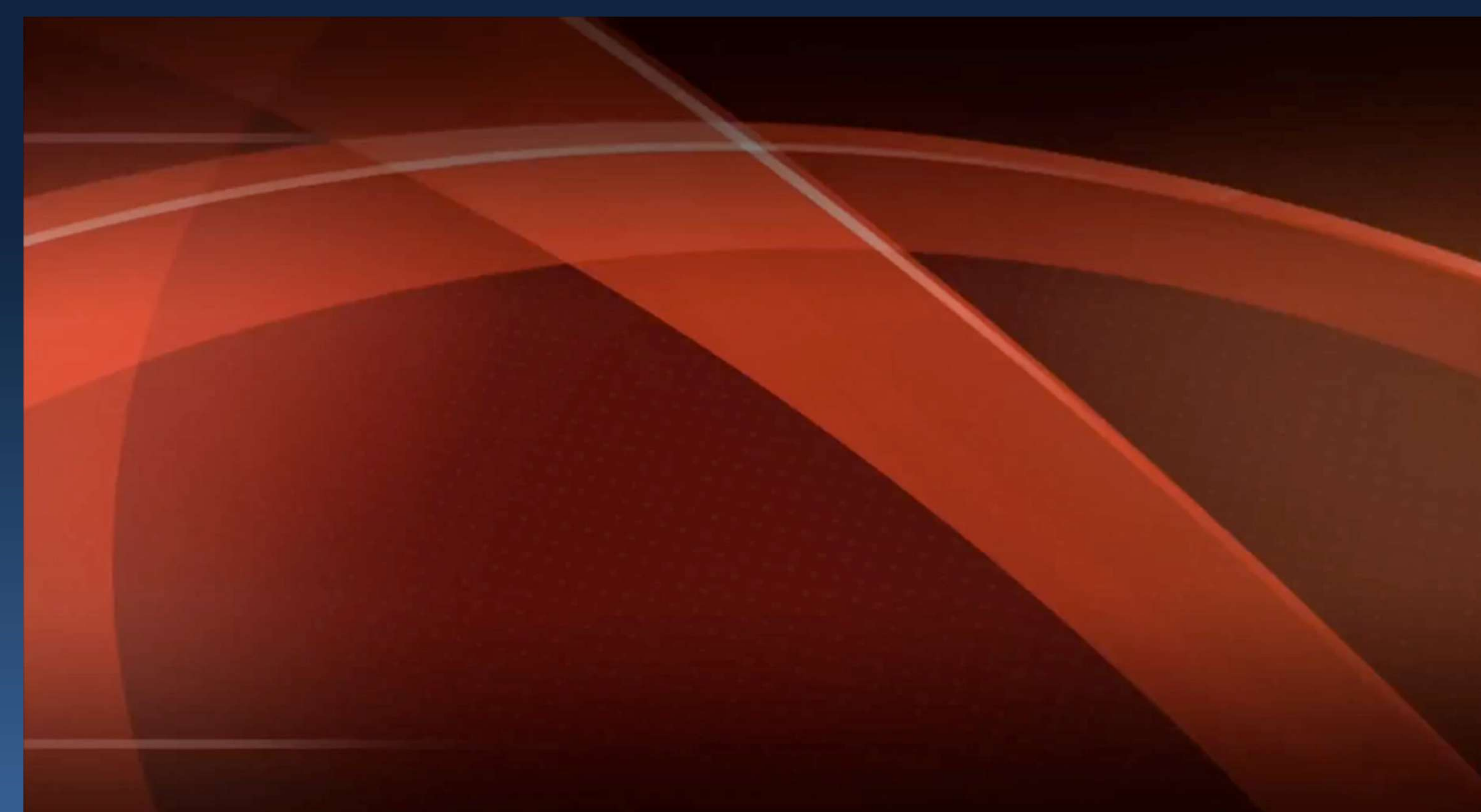
FACTS ✓

This doesn't mean: good care will **guarantee** that you will not develop complications

This does mean: with good care, **odds are good** you can live a long, healthy life with diabetes

# How Could You Use This New Perspective with Your Patients?

# B. Discussing Metabolic Results



# Personalized A1C Feedback

| Reference | Type | Number of subjects | A1C Difference |
|---|---|---|---|
| Chapin et al, 2003 | Chart in medical record, conversation presumed | 127 T2D adults | 0.7%* |
| Levetan et al, 2002 | Laminated poster, then call from educator | 150 T1D/ T2D adults | 0.5%* |
| O'Connor et al, 2009 | Periodic mailed brochures, no discussion | 3703 T1D/T2D adults | 0.0% |
| Sherifali et al, 2011 | Periodic mailed brochures, no discussion | 465 T2D adults | 0.1% |

# Discussing Metabolic Results

- Safe vs. unsafe
  - Not good vs. bad
  - Not high vs. low

# Discussing Metabolic Results

- Safe vs. unsafe
- Promote reasonable expectations
  - "Despite your best efforts, diabetes will often not cooperate."

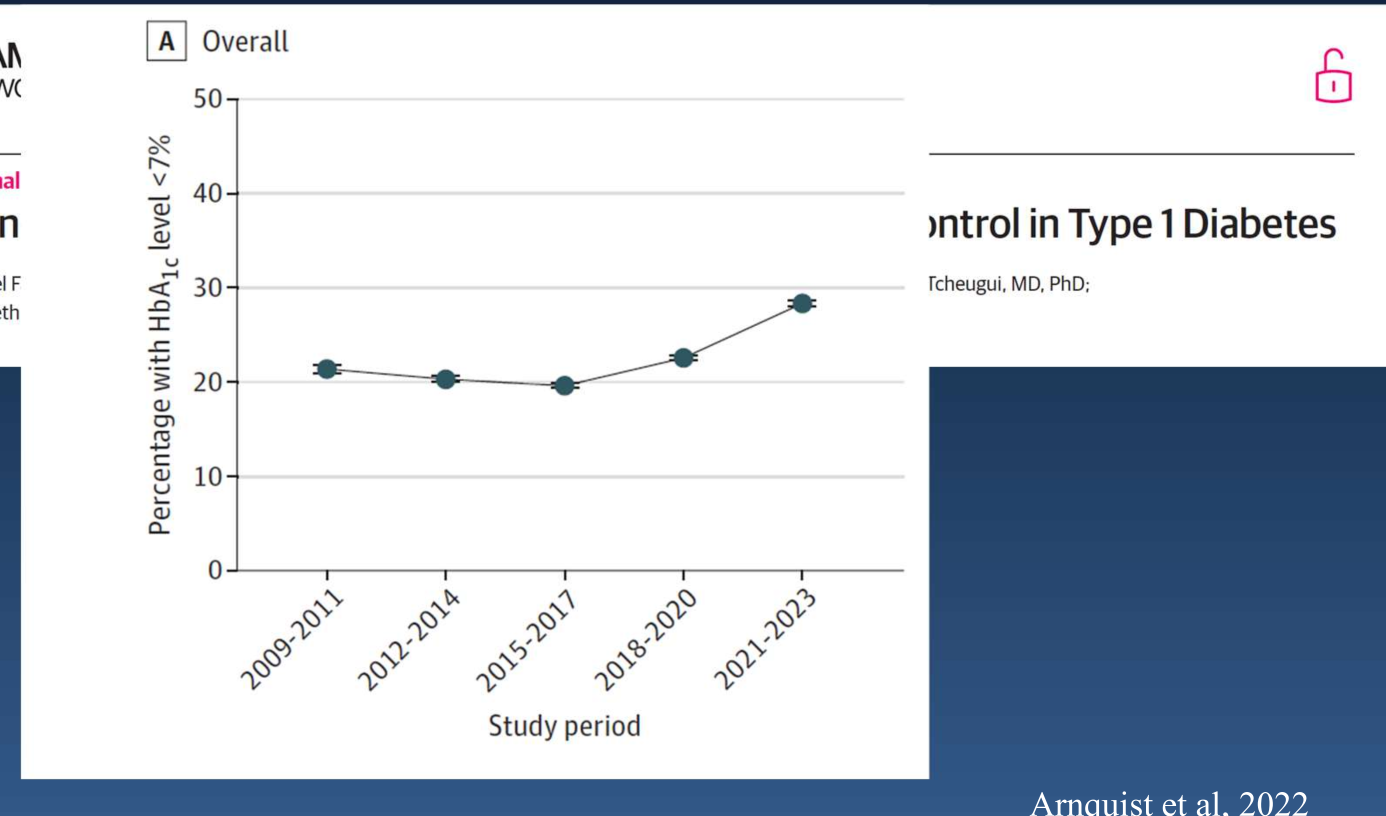
Adam Brown, 2019

# Discussing Metabolic Results

- Safe vs. unsafe
- Promote reasonable expectations
- National and international norms
    - "Just like you, lots of people with diabetes are struggling."

# Quiz #8: How Many People with T1D Achieve an A1C < 7.0%?

1. 8%
2. 18%
3. 28%
4. 38%
5. 48%




Arnquist et al, 2022

# Discussing Metabolic Results

- Safe vs. unsafe
- Promote reasonable expectations
- National and international norms
- Celebrate any and all improvements

# Your Thoughts?

# C. Addressing Critical Misbeliefs about Medications

JAMA Internal Medicine | Original Investigation

# Effect of Reminder Devices on Medication Adherence
## The REMIND Randomized Clinical Trial

Niteesh K. Choudhry, MD, PhD; Alexis A. Krumme, MS; Patrick M. Ercole, PhD, MPH; Charmaine Girdish, MPH; Angela Y. Tong, MS; Nazleen F. Khan, BS; Troyen A. Brennan, MD, JD, MPH; Olga S. Matlin, PhD; William H. Shrank, MD, MSHS; Jessica M. Franklin, PhD

- N = 52,294
- Multiple chronic disease conditions
- Taking $\leq$ 3 chronic disease medications
- Poorly adherent (MPR < 80%) to $\geq$ 1 medication

Choudhry et al, 2017

JAMA Internal Medicine | Original Investigation

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4 conditions:

1. Received nothing

Choudhry et al, 2017

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4 conditions:

1. Received nothing
2. Standard pillbox organizer

Choudhry et al, 2017

**JAMA Internal Medicine** | Original Investigation

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4 conditions:

1. Received nothing
2. Standard pillbox
3. Pillbox strip with toggles

Choudhry et al, 2017

JAMA Internal Medicine | Original Investigation

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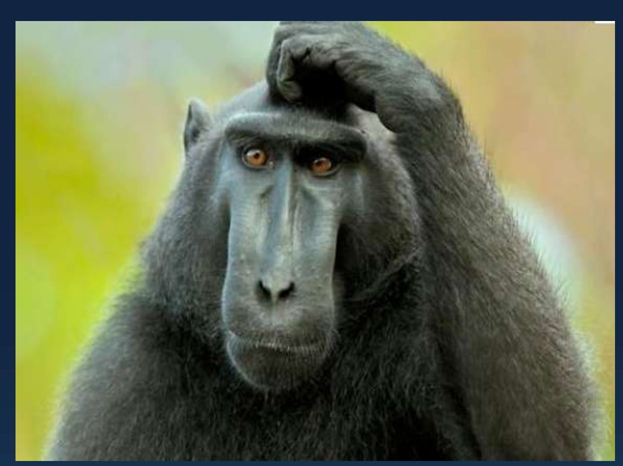
4 conditions:

1. Received nothing
2. Standard pillbox
3. Pillbox strip with toggles
4. Pill bottle cap with digital timer

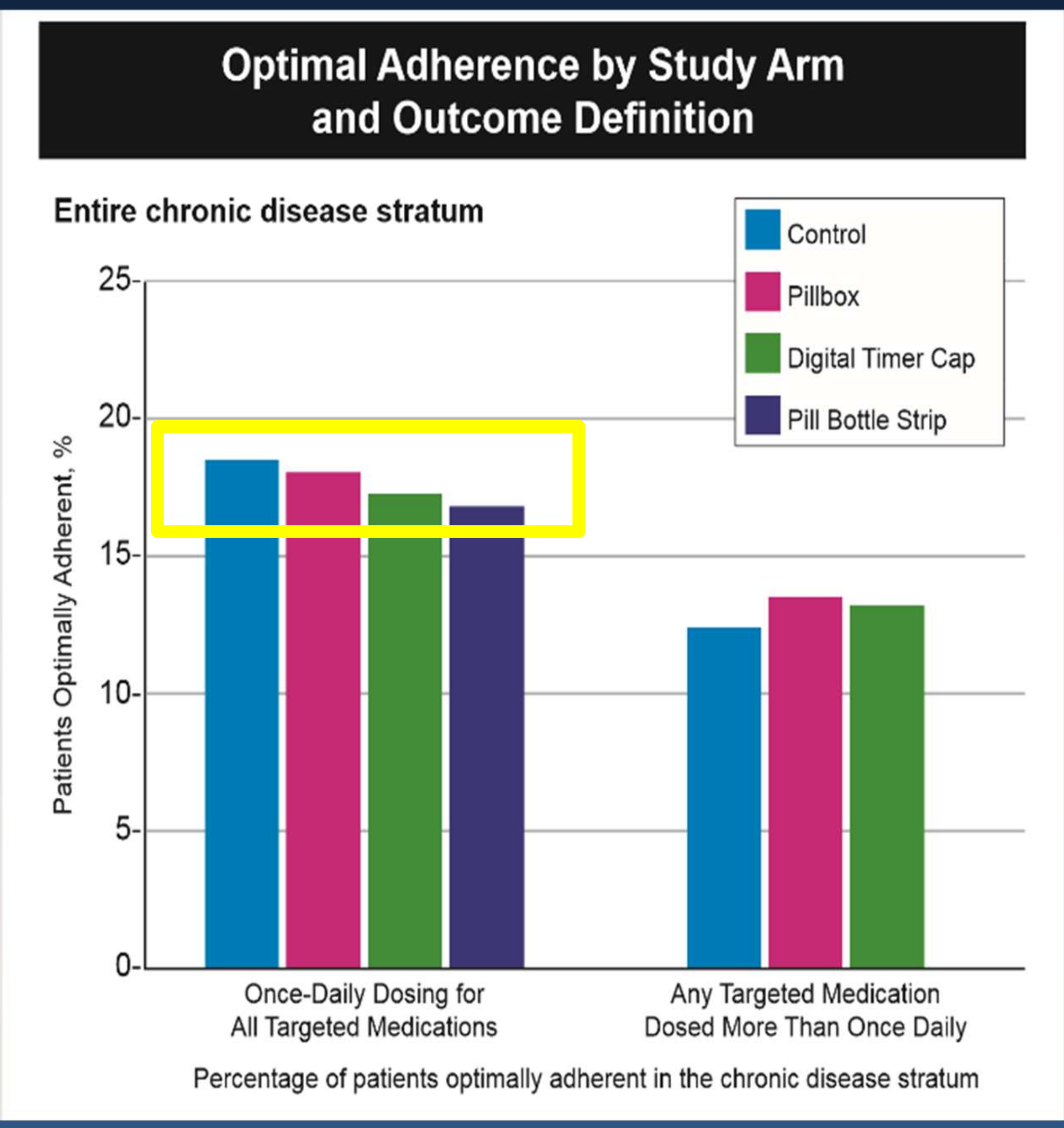
Choudhry et al, 2017

# Quiz #9

Which intervention was most effective in enhancing medication taking over the 12 month period?



1. The standard pillbox
2. The pillbox strip with toggles
3. The pill bottle cap with digital timer
4. None of them worked




"although forgetfulness is the most frequently reported barrier to adherence, this factor may not have been the primary driver of non-adherence in our study population."

Choudry et al, 2017

# Quiz #9

Which intervention was most effective in enhancing medication taking over the 12 month period?

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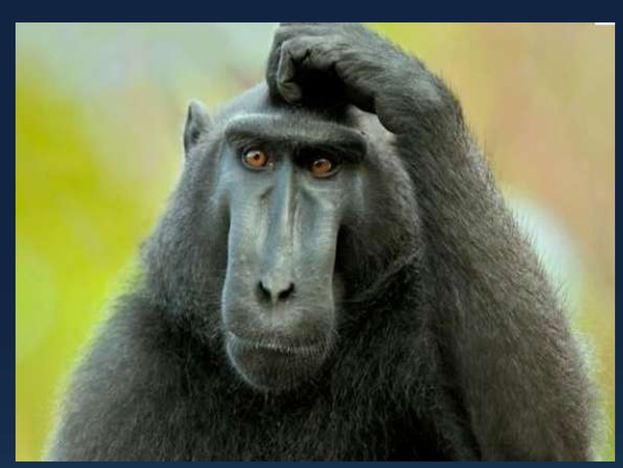


## Lay perspectives on hypertension and drug adherence: systematic review of qualitative research

OPEN ACCESS

Iain J Marshall *clinical academic fellow*[1], Charles D A Wolfe *professor of public health medicine*[1 2], Christopher McKevitt *reader in social science and health*[1]

[1]King's College London, Division of Health and Social Care Research, London SE1 3QD, UK; [2]National Institute for Health Research Comprehensive Biomedical Research Centre, Guy's and St Thomas' NHS Foundation Trust, London, UK

Summarizing 53 qualitative studies, 16 countries

"This evidence… adds weight to the criticism of educational interventions that assume poor adherence is due to patients' failings, either in knowledge or remembering to take drugs. The participants in the studies presented here did not simply have a knowledge deficit but *held alternative explanations for their hypertension;* many deliberately chose to avoid drugs."

Marshall et al, 2012

# CASE 3: Mike's Story

- Age 53, married, T2D for 2 years, works as a firefighter.
- At diagnosis he was prescribed Metformin and told to that he needed to increase his physical activity and stop eating all sweets.
- Has been taking antihypertensive medication and a statin medication daily for 5 years
- Last A1C = 12%

# Let's Ask Mike

"

*What do you like and what do you dislike about those medications you've been prescribed?"*

# And Mike Responds…

*"I just can't keep up all the things I need to do take care of my diabetes, but I sure gave it a good try.*

*For almost a year, I was working out at least two hours a day and taking my diabetes medicines, but still feeling pretty crappy and all the while seeing my numbers go up. So, I said 'screw it' and quit it all."*

# Quiz #10

Which is the most critical contributor to Mike's medication-taking problem?

1. Depression
2. Does not see diabetes care as urgent
3. Competing priorities
4. Sees treatment as ineffective

PROS | CONS

It might be good for me.

But I can’t really tell whether it is helping, it is expensive, I have more important things to take care of in my life, I worry this stuff might be bad for me, and I’m not sure I can trust my doctor’s recommendations anyway.

# Re-Framing the Medication Talk

1. **Come alongside:**
   - **Working together, I'd like to help you live a long and healthy life with diabetes. Sound OK?**
2. **The alert:**
   - **You are in an unsafe place with your diabetes, That can harm you, even if you feel okay.**
3. **Let's get going:**
   - **To help you stay safe, urgent action is needed. Let's start by talking about your medications.**

# Re-Framing the Medication Talk

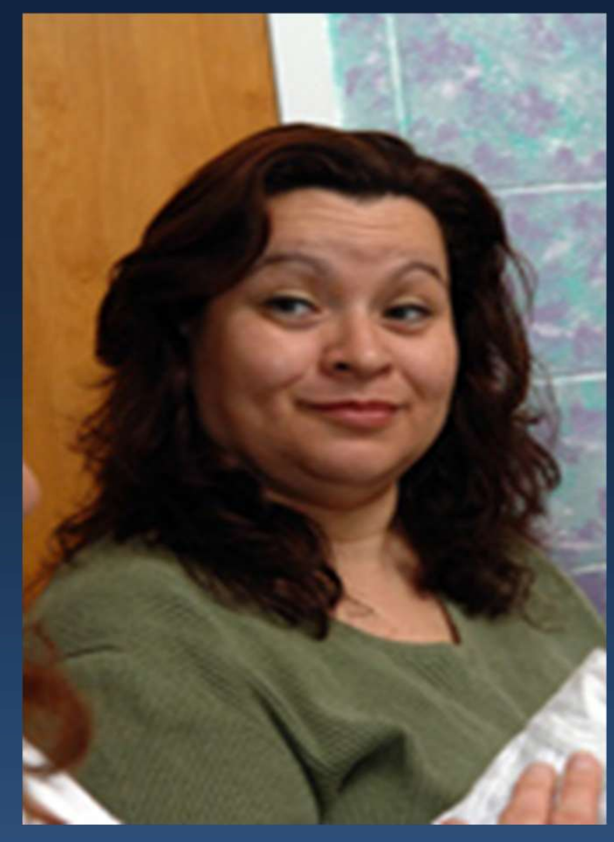
4. **Explore the pro's and con's:**
   - What do you see as the potential benefits of your meds? And what about the potential harm?
5. **Share some new information:**
   - Would you mind if I share with you some important facts about your meds?

# Key Medication "Secrets"

1. Big bang. Taking your meds is one of the most powerful things you can now do to improve your health
2. Working silently. Your medications are working even if you can't feel it
3. Balancing the claims. There are always pluses and minuses, but the minuses are not as big as you think.
4. No blame. Needing more medication isn't your fault
5. Not a health metric. More meds don't mean you're sicker, fewer meds don't mean you're healthier

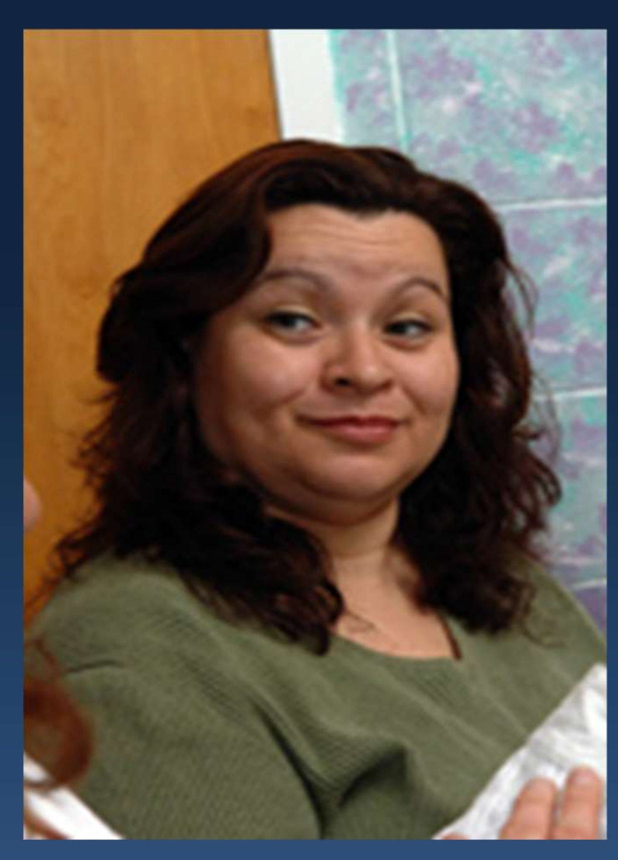
# Carmen's Story

- Age 49 with T2D for 8 yrs.  Lives with husband, 2 teenage sons and mother-in-law.
- A1c is 9.0%, blood pressure is 127/85, and her LDL cholesterol is 95.
- Dutifully checks BGs each morning.
- Currently prescribed 3 OHA's and 2 additional meds for blood pressure.
- Very discouraged that OHA's have "stopped working"
- Declined insulin, tells her HCP that there is no way she can "take the needle".



# Quiz #11: Key Obstacle to Address?

1. Fear of needles
2. Worried that insulin may do more harm than good.
3. Feelings of personal failure
4. Chronically non-compliant to HCP recommendations
5. In denial of diabetes



# Addressing Insulin Misbeliefs

| Obstacles | Discuss |
|---|---|
| **It means I have failed with my treatment** | • No matter what you do, you may need it, because diabetes is "progressive" |
| **Will wreck my quality of life** | • Short-term benefits include better sleep, mood and energy, |
| **Insulin will cause long-term complications** | • Investigate and challenge this belief<br>• Insulin is much more likely to reduce than raise complications risk |
| **Needing more insulin would mean I'm sicker** | • "More insulin doesn't mean you are sicker or are in more danger. We are merely trying to figure out the right amount for your body." |

# Time to Practice #4

Role play: Journalist + Info Intervention

# John’s Story

- 53 years old, T2D for 4 yrs.
- At diagnosis, he reluctantly began metformin, which has gone well.
- SGLT-2 added last year, A1C now at 6.9%.
- However, over last year, blood pressure has risen, now 150/100.
- Weight loss, thanks to his dietary changes and daily exercise, has not improved blood pressure.
- Declines blood pressure meds.

# Bobbie's Story

- 62 years old, diagnosed with T2D one year ago. Retired teacher, lives with husband
- Has declined to start metformin after discussing at last 3 visits
- A1C is 7.8%, increased from 7.2% 6 months ago
- Walks at least 2 miles daily
- Follows a Mediterranean diet, seldomly eats sweets

**Supplements**
March 06, 2013

- Multi-Vitamin (New Chapter Every Woman II): 3 tablets (2 in AM/1 in PM) [*see below for ingredients*]
- Vitamin C (Ester-C): 500 mg each; 2 capsules, 1 in AM/1 in PM
- Last week I changed from Glucosamine (500 mg each) / Chondroitin (333 mg each): 2 capsules, 1 in AM, "Joint Formula" from Mercola.com: 1 capsule in AM [*see below for ingredients*]
- Fish Oil (Garden of Life – Oceans 3): 2 softgels/day; 1 in AM/1 in PM [*see below for ingredients*]
- Red Yeast Rice; 600 mg each; 2 capsules, 1 in AM/1 in PM **(T, T, S, S[1])**
- CoQ10: 60 mg each capsule; 1/day in PM **(T, T, S, S[1])**
- Ubiquinol: 100 mg each capsule; 1/day in AM
- Potassium (75 mg each) / Magnesium (100 mg each); 1/day
- Calcium (500 mg each) / Magnesium (250 mg each); 1/day
- Vitamin D-3: 400 mg each softgel; 3/day x 5 days
- Vitamin D-3: 2,000 IU each capsule; 1/day x 2 days
- Glutathione: 500 mg each capsule; 1/day
- Astaxanthin: (Mercola.com): 4 mg each; 1/day **(T, T, S, S[1])** [*see below for ingredients*]
- Krill Oil: (Mercola.com-women's formula); 1,000 mg/day **(T, T, S, S[1])** [*see below for ingredients*]
- Krill Oil: (Mercola.com); 1,000 mg/day **(M, W, F[2])** [*see below for ingredients*]
- Probiotics: (Mercola.com); 1 capsule/day [*see below for ingredients*]

[1] ***Tuesday, Thursday, Saturday, Sunday***
[2] ***Monday, Wednesday, Friday***

# Journalist + Info Intervention

1. Get the details, stay neutral, listen carefully
   - Assess necessity: “To what degree do you think these medicines would or perhaps wouldn’t help you to get to a healthier place with your diabetes?”
   - Assess concerns: “What worries you about these medications?” “How might you imagine that these medicines could harm you?”

# Journalist + Info Intervention

1. Get the details, stay neutral, listen carefully
2. Summarize and feed back the story you've heard

# Journalist + Info Intervention

1. Get the details, stay neutral, listen carefully
2. Summarize and feed back the story you've heard
3. Ask permission to share new info

# Journalist + Info Intervention

1. Get the details, stay neutral, listen carefully
2. Summarize and feed back the story you've heard
3. Ask permission to share new info
4. Offer info about necessity:
   - Of all the positive steps you could take, we know that taking your diabetes medications is one of the most powerful things you can do to improve your health."
   - "This may surprise you, but your medications are working even if you can't feel it. Looking at how your A1C changes over time can help us to see that."

# Journalist + Info Intervention

1. Get the details, stay neutral, listen carefully
2. Summarize and feed back the story you've heard
3. Ask permission to share new info
4. Offer info about necessity
5. Offer info about concerns:
   - "There are *always* pluses and minuses, but the minuses may not be as big as you think."
   - "Neding more meds than the next person doesn't mean you're sicker or did anything wrong; taking fewer meds doesn't mean you're healthier."

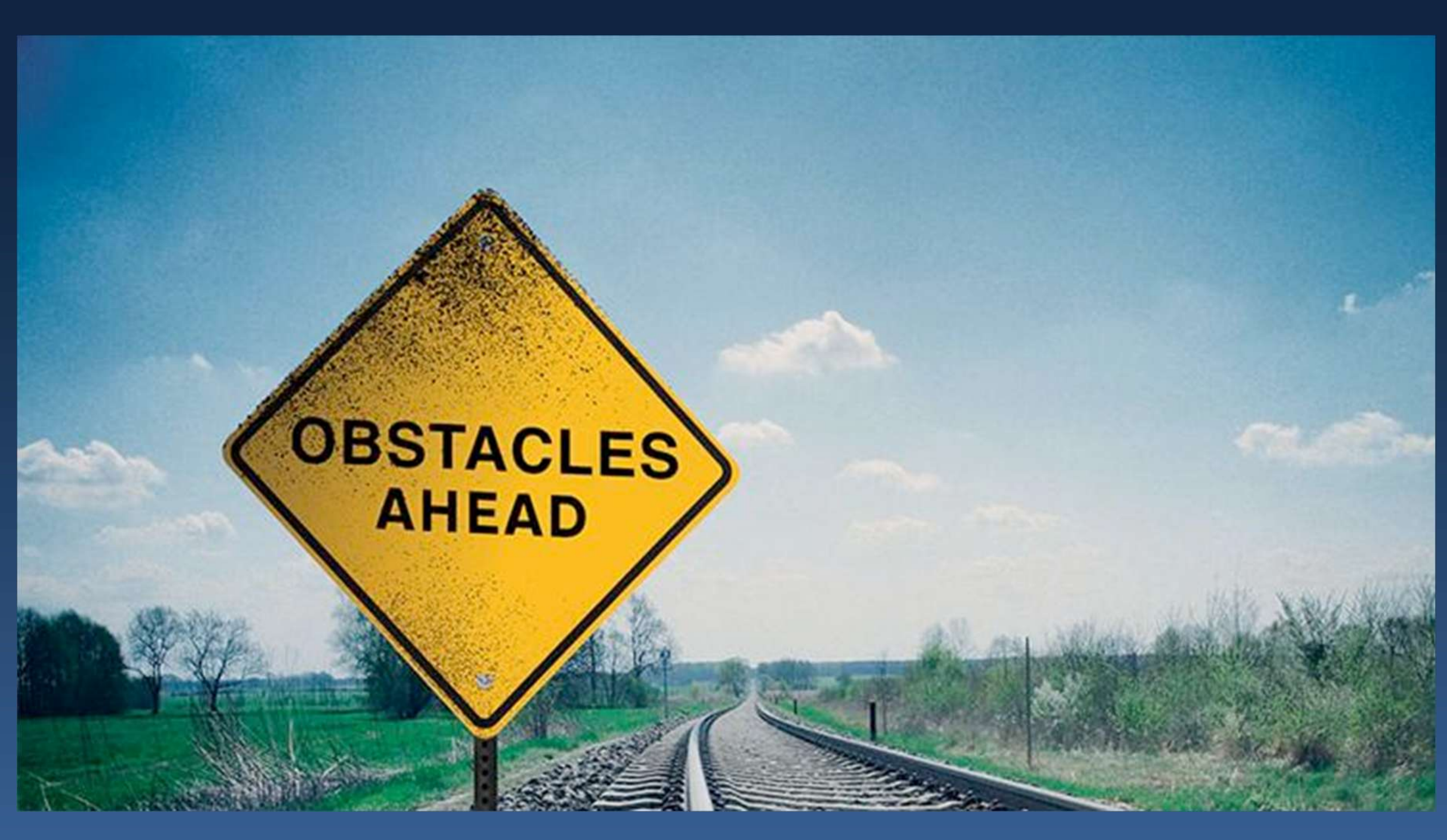
# Journalist + Info Intervention

1. Get the details, stay neutral, listen carefully
2. Summarize and feed back the story you've heard
3. Ask permission to share new info
4. Offer info about necessity
5. Offer info about concerns:
6. Ask for feedback ("What do you think?")
7. Summarize again, then ask "where does this leave you?"

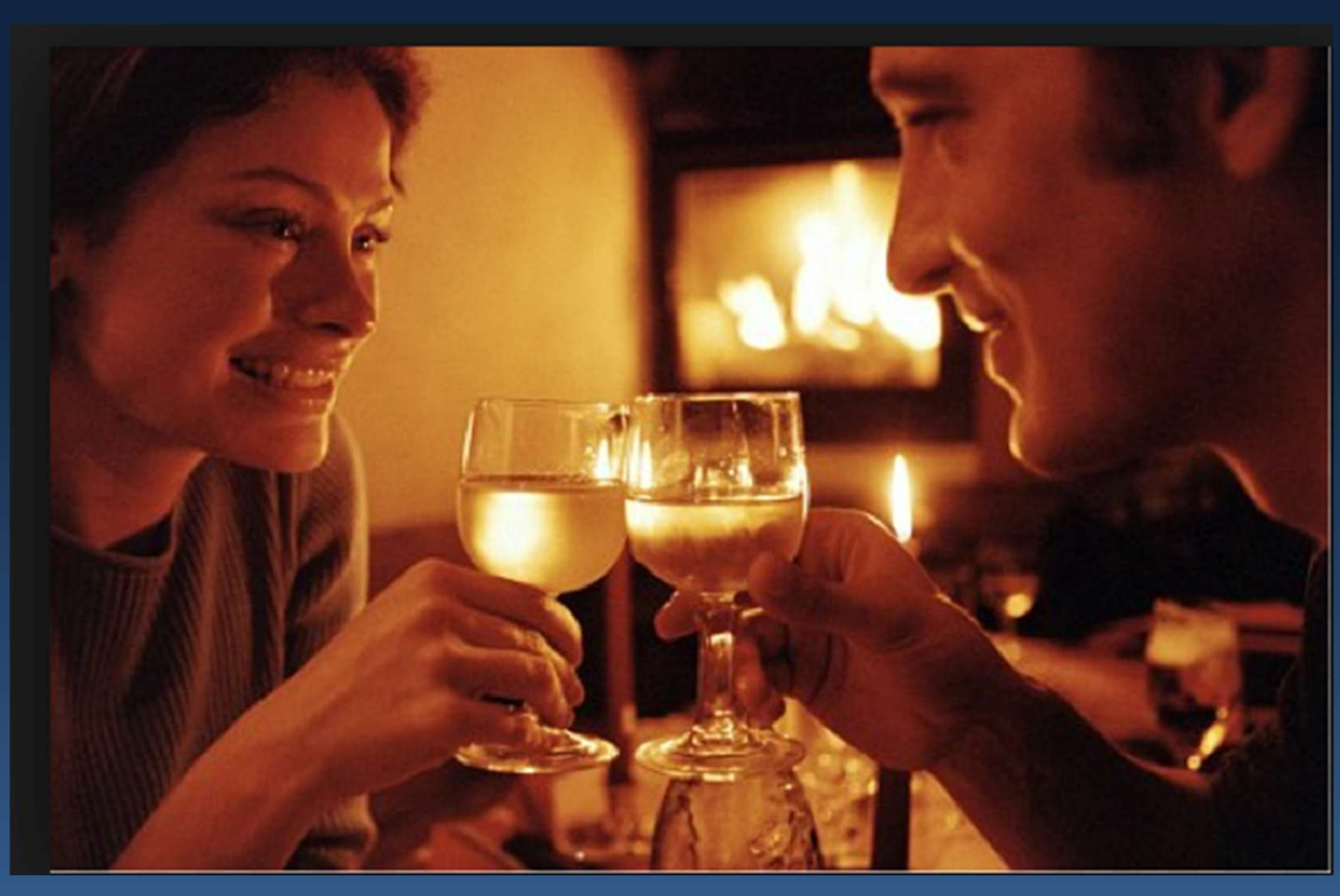
# Questions/Comments

# Time for a Break!

# Job #1: Identifying the Critical Obstacles



# Job #2: Setting the Mood



# Job #3: Providing Your Patients with New Perspectives

# Job #4: Encouraging Behavior Change

# Job #2: Setting the Mood

- THE two key Interventions:
  A. Recognizing/appreciating the patient's perspective (the "journalist" intervention).
     - *Creating an alliance*
  B. Preparing for behavior change (the "journalist-plus" intervention)
     - *Creating/deepening an appetite for change*

# Time to Practice #5

**Can you think of a healthy change you'd like to make in your life, but you just haven't made it yet?**

# Practice #3: Journalist + Activation Intervention

1. Determine an area for behavior change
2. Get the details, stay neutral, listen carefully
    - Why would you want to make this change?
    - How <u>might</u> you go about it, in order to succeed?
    - What are 2 – 3 good reasons to do it?
3. Summarize and feed back the <u>story</u> you've heard

DO NOT OFFER ANY HELP OR ADVICE

# The Approach

1. A specific, meaningful objective
   a. Focus on only 1- 2 behaviors, using the "bang for your buck" approach
   b. Use the patient's interest and expertise
2. A real-world plan for action
   a. Make good use of the environment, not will power.
3. Expect obstacles, and address them
4. Reach for commitment

# Time to Practice

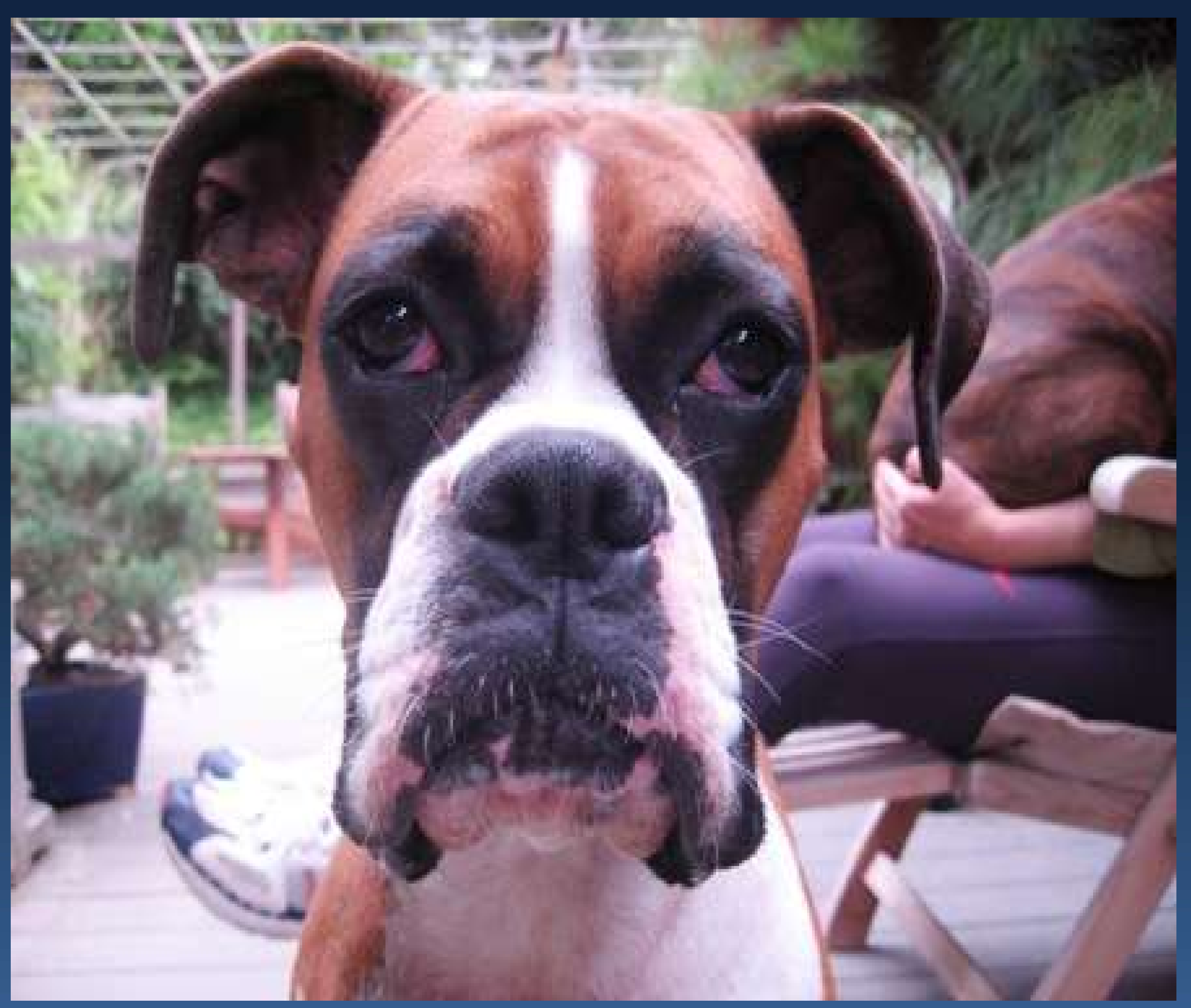
1. A specific and meaningful objective
   – "What is the change you are thinking about? What steps might you need to do to make this happen?"
2. A real world plan for action
   - "You've decided a long walk each day is your first step towards weight loss. So what will you do tomorrow?"
3. Ask about obstacles, and address them
   - "What might get in your way tomorrow or the next day? And let's consider how you might respond."
4. Reach for commitment
   - "So, I think your plan is to do x. Do I have that right?"

# Why This Often Doesn't Work

- Not yet ready (pushing for behavior change too soon)
- The plan is too vague or unrealistic

# Important Considerations

1. Choosing the right moment
2. Limiting the number of actions
3. Make use of the “bang for your buck” approach
4. Focus on actions to start, not stop
5. Make good use of the environment



# What's Next?

- What's one new strategy or approach you will leave here with?
- Given the constraints of real-world practice, what might help to make this STICK for you?

# Conclusion: Four Jobs

1. Identifying the critical obstacles
2. Setting the mood
3. Providing a new perspective
   - You are not alone about feeling this way
   - You are not a bad person (no more shaming!)
   - You are not doomed
   - You *can* feel better and achieve greater success (let's build a doable plan together)

# Conclusion: Four Jobs

1. Identifying the critical obstacles
2. Setting the mood
3. Providing a new perspective
4. Encouraging behavior change

# One Small Step at a Time

# Bringing the assessment and treatment of diabetes distress into the real world of clinical care: Time for a shift in perspective

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**Abstract**

**Aims:** Diabetes distress (DD) refers to the emotional and behavioural challenges associated with managing this demanding chronic disease over time. DD is alarmingly common and it has a significant impact on self-management behaviours and clinical outcomes. Thus, there is growing recognition that DD is a pressing problem that deserves careful attention in clinical care. Translating the application of validated DD assessment and intervention protocols from the research to the clinical setting, however, presents challenges that require a reconsideration of some common assumptions about what DD is, how prevalent it is, how it presents itself clinically, how it might best be assessed and by whom.

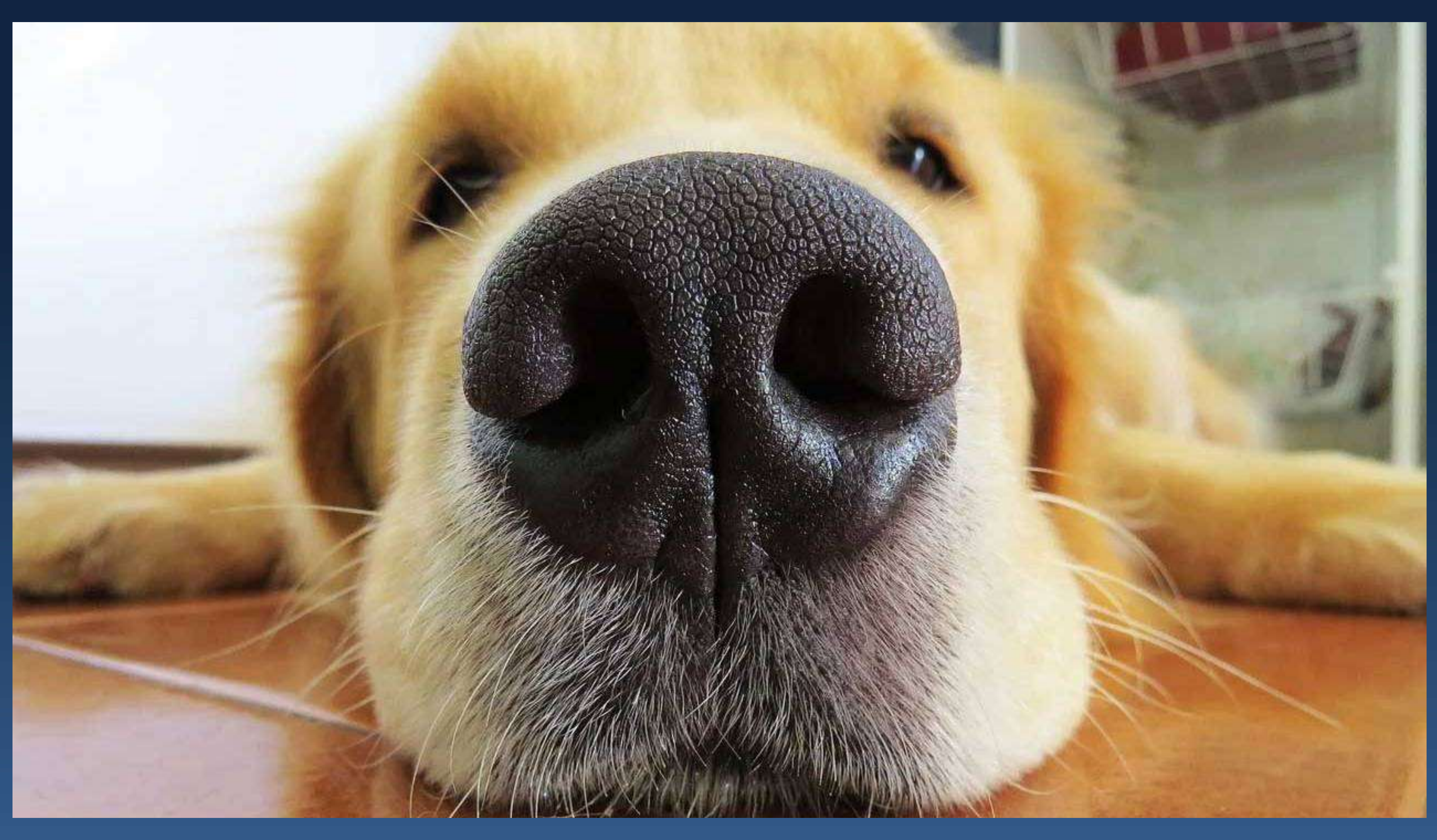
**Methods:** We employed data from six large-scale studies using five common DD measures. Using these data, we review and challenge several common assumptions about DD.

**Results:** These data suggest that, because of its relative ubiquity, DD should not be viewed as a 'co-morbidity' or 'complication' of diabetes and it should not be seen as a mental health/illness 'condition'. Furthermore, we argue that DD assessment should: (1) be accepted as a standard part of comprehensive diabetes care, (2) occur regularly using broad rather than brief screening measures and (3) be addressed directly by diabetes clinicians, rather than exclusively by behavioural specialists.

**Conclusions:** The results form the basis of a series of suggestions to enhance the translation, adoption and implementation of DD knowledge derived from the research setting directly into the real world of clinical care.

Fisher et al, 2024

# Who Won the Quiz Contest?



# Thanks for Participating!

# Behavioral Diabetes Institute

**www.behavioraldiabetes.org**