



TELEBEHAVIORAL HEALTH CENTER OF EXCELLENCE

Behavioral Health Integration Webinar Series:  
**Diabetes Motivational  
Interviewing in Integrated Care  
Settings**

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## Introducing the Presenter:

# Anthony Fleg, MD, MPH

- 21 years of working with Indigenous communities to improve health.
- Co-founder of the Native Health Initiative (NHI) partnership.
- Primary Care Subject Matter Expert for BH2I.





# Objectives

At the end of this presentation, participants will be able to:

1. Identify key elements of applying Motivational Interviewing (MI) techniques for patients faced with diabetes in integrated care settings.
2. Examine how the use of MI can improve practice and patient outcomes.
3. Incorporate MI to improve practice and patient outcomes as they relate to diabetes care.
4. Apply an Indigenous worldview framework to diabetes care.

# Two Models for Behavior Change

These models will inform us in MI.

- Stages of Change Model
- COM-B Model

# Stages of Change Model: Introduction

- Developed by Prochaska and DiClemente in 1983.
- Also known as the Transtheoretical Model (TTM).
- The model describes behavioral change as an intentional process that unfolds over time and involves progress through a series of stages.

# Stages of Change Model

- **Pre-contemplation**

- Avoidance. That is, not seeing a problem behavior or not considering change.

- **Contemplation**

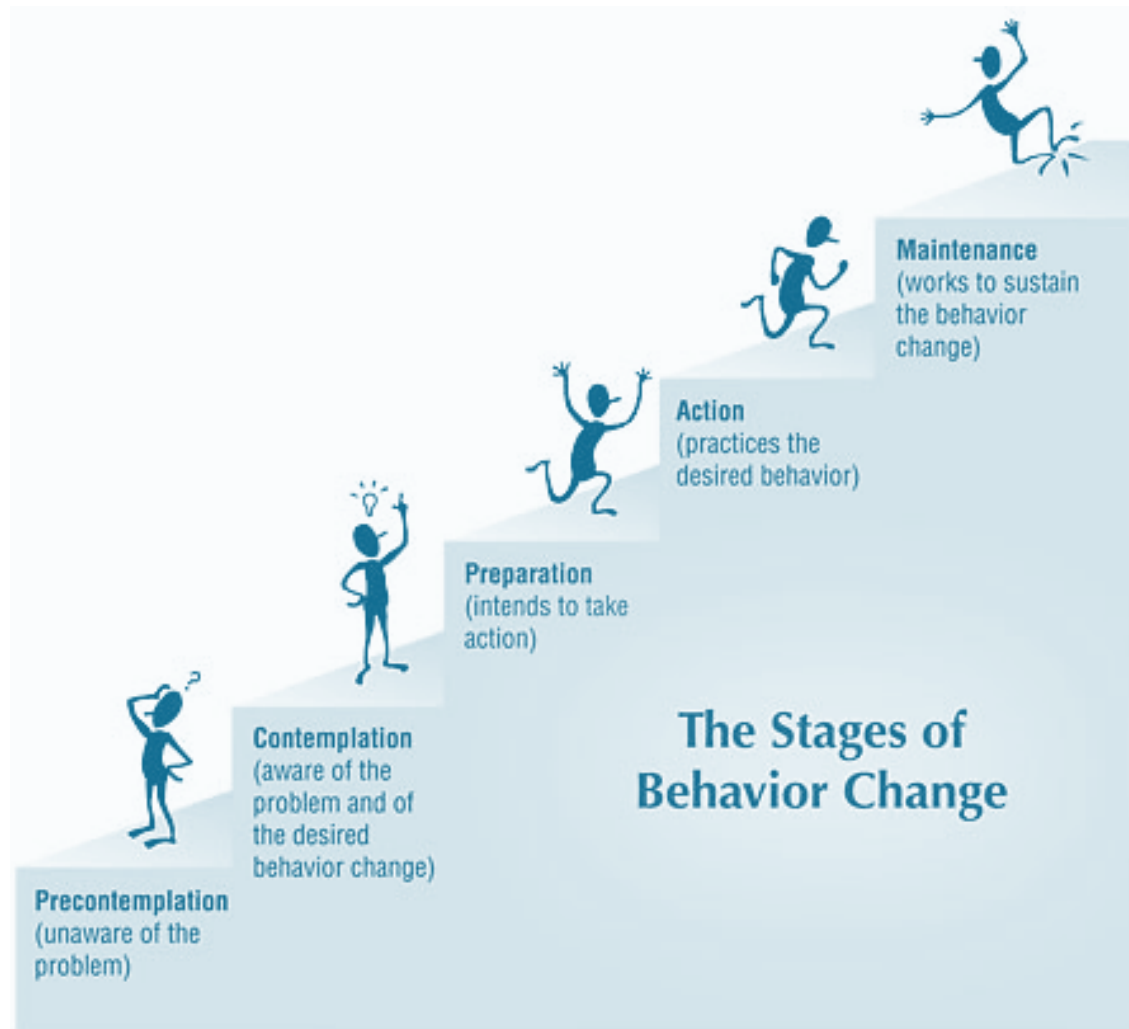
- Acknowledging that a problem exists but struggling with ambivalence.
- Weighing pros and cons and the benefits and barriers to change.

## Stages of Change Model (cont.)

- **Preparation**
  - Taking steps and getting ready to change.
- **Action**
  - Making the change and living the new behaviors, which is an all-consuming activity.
- **Maintenance**
  - Maintaining the behavior change that is now integrated into the person's life.



# Stages of Change Model: Visual



# Stages of Change Model: Versions

- Some versions of this model also include a 6th stage: Relapse.
- Once someone relapses to old behavior, they can return to any of the stages except for “maintenance.”

# Stages of Change Model: Relapse Version

- **Pre-contemplation**

- Avoidance. That is, not seeing a problem behavior or not considering change.

- **Contemplation**

- Acknowledging that a problem exists but struggling with ambivalence.
- Weighing pros and cons and the benefits and barriers to change.

- **Preparation**

- Taking steps and getting ready to change.

# Stages of Change Model: Relapse Version (cont.)

- **Action**

- Making the change and living the new behaviors, which is an all-consuming activity.

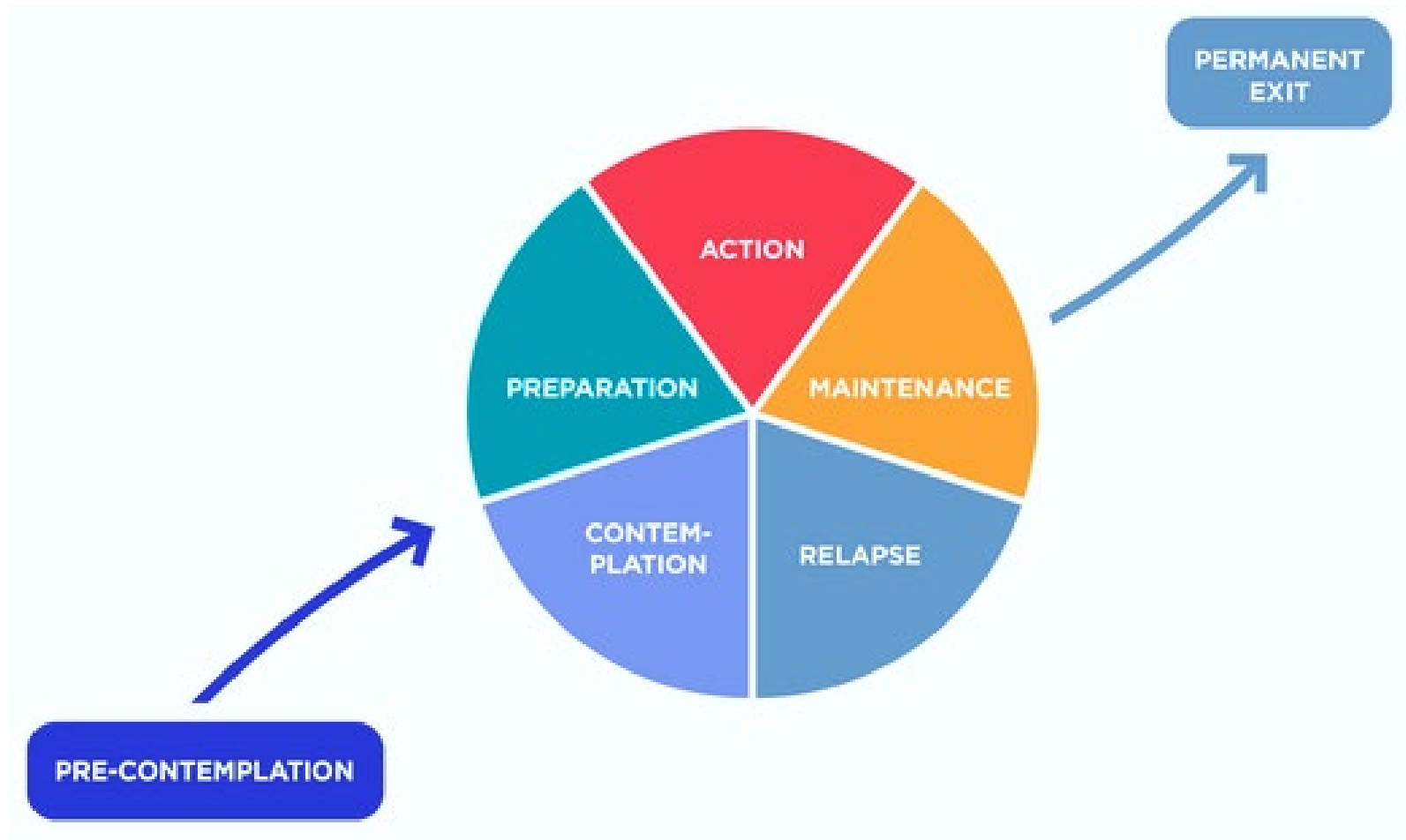
- **Maintenance**

- Maintaining the behavior change that is now integrated into the person's life.

- **Relapse**

- Returning to previous behavior.

# Stages of Change Model: Visual of Relapse Version



# Stages of Change Model: Smoking

- **Pre-contemplation:** I don't think smoking is a health issue for me.
- **Contemplation:** I know that smoking is a health issue, but I don't think I am ready to quit.
- **Preparation:** I am ready to make a quit attempt next month.
- **Action:** I quit smoking 1 month ago.
- **Maintenance:** I quit smoking 6 months ago.
- **Relapse:** I started smoking again last week.

# COM-B Model: Introduction

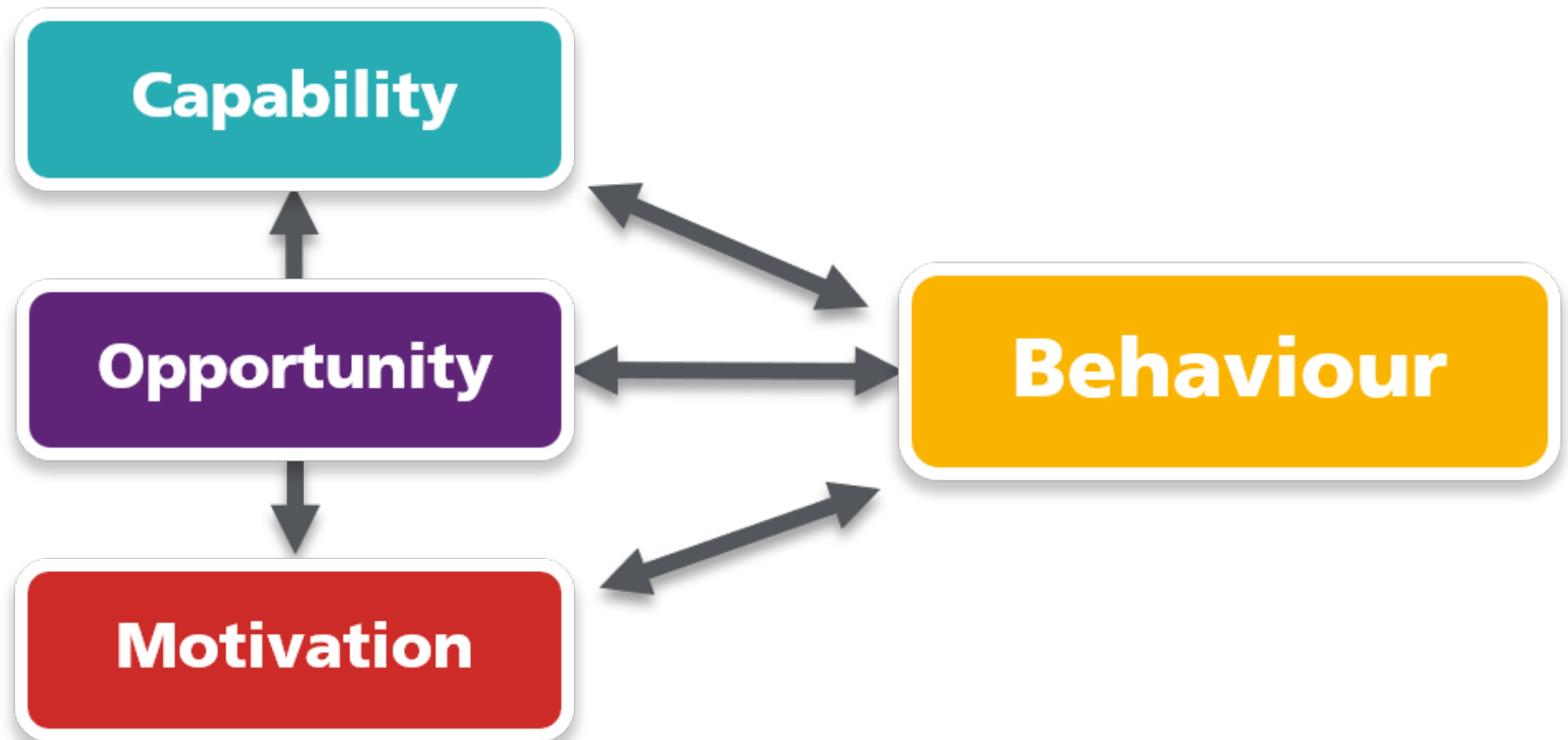
- Developed in 2011 by Susan Michie, Maartje van Stralen, and Robert West.
- The COM-B model for behavior change cites
  - capability (**C**),
  - opportunity (**O**), and
  - motivation (**M**) as three key factors capable of changing
  - behavior (**B**).

## COM-B Model: Key Factors

- **Capability** refers to an individual's psychological and physical ability to participate in an activity.
- **Opportunity** refers to external factors that make a behavior possible.
- **Motivation** refers to the conscious and unconscious cognitive processes that direct and inspire behavior.
- **Behavior** change.



# COM-B Model: Key Factors Visual



# COM-B Model

- This model recognizes that behavior is influenced by many factors, and that behavior changes are induced by modifying at least one of these components.
- The COM-B model is particularly important when considering intervention methods, as interveners need to ensure the sustainability of learned behavior.

## COM-B Model: Smoking

- **C:** Address depression to improve capability to quit smoking.
- **O:** Offer NRT and support group as opportunities that will improve efforts toward smoking cessation.
- **M:** Assess and increase motivation to quit smoking.
- **B:** Behavior change of smoking cessation.

## Using the Models Together → MI

Tom comes in with uncontrolled DM, with poor medication adherence.

- Stages of Change model can help uncover how ready Tom is to make changes.
- COM-B can help us identify what Tom's barriers and opportunities toward change are, so that we can address one or more of these.



## Using the Models Together → MI (cont.)

MI can help move Tom toward action.



## The “Spirit” of MI: Collaboration

MI is a collaborative conversation style for strengthening a person’s own motivation and commitment to change.



## The “Spirit” of MI: Dual Expertise

From clinician-driven and clinician as the expert, MI recognizes “dual expertise” where both patient and clinician bring important tools to the table.

# The “Spirit” of MI: Proven & Effective

- MI is a proven and effective way to:
  - Engage individuals with co-occurring disorders.
  - Develop therapeutic relationship.
  - Determine individualized goals.



# The “Spirit” of MI: Helps Us

- MI helps us
  - Assess the person’s perception of the problem.
  - Explore the person’s understanding of his, her, or their condition.
  - Examine the person’s desire for continued treatment.
  - Expand the person’s perceptions for the possibilities of successful change.

# The “Spirit” of MI: Role Change

- MI represents a complete change in roles; instead of telling a patient what they are doing that is wrong, you are recognizing that
  - **you** don't have to make change happen...in fact, you cannot make change happen.
  - **you** don't have all the answers...and the answers you do have may not be the best anyway.
  - **your** role is to help empower and motivate, not to scare and coerce.



# The “Spirit” of MI: Challenges Us

- It challenges us to avoid the “righting reflex.”

## The “Spirit” of MI: Challenges Us (cont.)

- MI requires clinicians to suppress the initial “righting” reflex so they can explore the patient’s motivations for change.
- It is essential for the clinician to refrain from responding to the client/patient with questions or unsolicited advice.

# The “Spirit” of MI: Acknowledgement

- Takes a strength-based view of our patients and clients, acknowledging that they have the tools and ability to make change (as opposed to needing change to be “prescribed” to them).
- Taken in the context of caring for Indigenous populations, this is particularly important.



## MI and DM

- What do we know about MI for diabetes?

# MI and DM: Impact of Treatment Adherence

- In 2002, Zweben and Zuckoff, in their review of the impact of MI on treatment adherence.
- Overall, adding MI produced significant adherence effects and helped patients move from one level of treatment adherence to a higher one.

## MI and DM: RCT

- Smith West et al conducted an RCT on the usefulness of group sessions for type 2 patients led by clinical psychologists.
- 217 overweight women with type 2 diabetes were randomized to either a
  - group-based behavioral weight control program with supplemental individual MI sessions. Or a
  - weight control program with health education sessions (attention placebo control).



## MI and DM: RCT Results

Women in the MI group lost significantly more weight than those in the control condition at 6 months (-4.7 vs.-3.1 kg,  $P < 0.02$ ).

## MI and DM: RCT Results (cont.)

- This superior weight loss in the MI group was mirrored by enhanced adherence to the treatment program:
  - session attendance.
  - number of weekly self-monitoring diaries submitted.
  - average diary rating.
  - changes in exercise.

# Time to practice together...Begin

## Clinician:

“Mrs. Smith, how interested are you in beginning regular physical activity to help get your diabetes under control?”

On a 1-10 scale, where 1 is “no interest in exercising” and 10 is “great interest in exercising.””

# Time to practice together...Response

**Mrs. Smith:**

“I think I am at a 3 right now.”

# Time to practice together...

What would you say in response to Mrs. Smith?

# Time to practice together...Fixer

Clinician as “fixer”:

“Mrs. Smith, this is critical to improving your diabetes. Why isn’t it more important to you?”

# Time to practice together...Motivator

Clinician as motivator (MI):

“Interesting, Mrs. Smith. Why aren’t you a 1 or 2 on this scale?”

# Ready for acronym overload??

MI for DM in IC.



## MI for DM in IC

- Integrated care (IC) settings give us more options for connecting with patients and for treating the whole person.

## MI for DM in IC: Mrs. Smith

Mrs. Smith shares that she is a

- “3” in terms of beginning to exercise,
- “5” in terms of taking her DM medications more regularly, and
- “7” in terms of addressing her depression.

## MI for DM in IC: Mrs. Smith (cont.)

We know that treating her depression will improve her DM, and she is currently more motivated to address this, so we might prioritize this in our initial treatment plan.

## MI for DM in IC: Behavioral Health

- Often, behavioral health teams bring expertise in MI to the table.
- We might have Mrs. Smith referred from primary care to behavioral health for both depression and for MI related to her adherence to DM meds.

## MI for DM in IC: Support

Bring in community and family support to the MI.

- Is there someone else in their family struggling with the same thing?
- Is there someone in their family doing great with this same thing?
- Is there someone in the family who might want to make this change as well?

# Cultural Considerations

- MI and its focus on “dual expertise” is consistent with culturally centered care.



# Questions?



# Thank you!

Please contact the BH2I T/TA Team for any questions/feedback regarding the presentation at:

[Request Technical Assistance – Behavioral Health Integration Initiative \(bh2itoolkit.com\)](http://bh2itoolkit.com)