Helping Patients Adopt Healthier Behaviors

Thomas Bodenheimer, MD; Connie Davis, MN, ARNP; and Halsted Holman, MD

Assisting patients to improve health-related behaviors is an important responsibility of caregivers, including physicians, nurses, health educators, and counselors. From 1992 to 2000, diet and physical activity counseling took place in < 45 and 30%, respectively, of primary care physician visits by adults with coronary heart disease risk factors.[1] Physicians in primary care seldom have time to engage in such discussions and may be unsure how to discuss behavior change with their patients;[1-3] nonphysicians are generally the appropriate caregivers to assist patients in adopting healthy behaviors.

This article describes a goal-setting method for discussing behavior change with patients in the primary care setting and provides a training guide for clinicians and nonprofessional practice staff. To address the barrier of insufficient time, each primary care practice needs to decide which caregivers—clinicians, nursing personnel, medical assistants, health educators, community health workers, or other patients—can realistically engage patients in goal-setting discussions and whether the activity is best conducted with patients individually or in groups.

Goal Setting and Action Planning

Goal setting is a collaborative process in which patients choose a behavior-change goal. Goal setting takes place after the clinician has assessed the patient's problem, provided necessary information, and engaged the patient in decision making regarding medical or surgical management of the patient's condition. Most patients with chronic conditions or adverse risk factors would benefit from behavior change to implement an evidence-based management plan. Goal setting is a technique to assist patients in working toward healthier behaviors.

One excellent way to initiate a goal-setting discussion is to ask the question used by Stanford Medical School's Dr. Kate Lorig, an international leader in helping patients cope with chronic disease: "Is there anything you would like to do this week to improve your health?" This question allows patients to choose which behavior they are motivated to change and forms the basis for setting a behavior-change goal.

After a patient has agreed on a general goal, the patient and caregivers negotiate a specific action plan to assist in goal attainment. For example, the goal may be to lose 10 lb; an initial action plan may be to substitute water in place of sugar-containing sodas. Goals are more general; action plans are highly specific. Goals may be difficult to attain and occur over a longer period of time; action plans are easier to accomplish. Patients should have a high level of confidence that they can carry out their action plan; success increases self-efficacy (a person's confidence that he or she can make positive life changes).

The following vignette describes how a goal-setting and action-planning discussion might proceed:

Angie, a medical assistant in the private Collaborative Primary Care Associates, asks Jorge Fuentes, "Is there anything you would like to do this week to improve your health?" Mr. Fuentes replies, "I know I'm eating too much, but I can't change that right now. Maybe I could get off my butt and do more exercise." Mr. Fuentes has just made a general exercise goal, but it is neither concrete nor measurable. When Angie asks if he would like to make a specific action plan to achieve the goal, Mr. Fuentes promises to walk 3 miles each day. Angie asks how sure he is that he can go from no exercise to 3 miles each day. On a confidence scale of 0–10, Mr. Fuentes selects a 1. Understanding that success is more important than the amount of exercise, Angie suggests making an action plan with a high chance of success. After a discussion, they agree that Mr. Fuentes will walk for 15 minutes after lunch each Monday, Wednesday, and Friday. Angie promises to call him the following week to see how he is doing with his action plan.

Goal setting involves patients and caregivers agreeing on a general self-management goal, e.g., doing more exercise. Action plans are concrete and specific activities that patients agree to do to help reach their goals, e.g., walking around the block twice on Mondays, Wednesdays, and Saturdays before lunch, or reducing consumption of cookies from three to one per day.[4-5] With nonspecific goals, e.g. to exercise or lose weight, patients cannot evaluate their success and often experience failure. To enhance the likelihood that patients will succeed, clinicians ask patients to estimate, using a 0–10 scale, how confident they are that they can carry out their action plan. Action plans can be adjusted

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so that patients have a confidence level of at least 7 on the 10-point scale that they can succeed. Action plans can be agreed on orally or using a written form, as shown in Figure 1. As with everything in health care, patient preferences must be respected. Some people may not want to set goals or agree on action plans.

Evidence Supporting the Effectiveness of Goal Setting

Studies from non–health-related industries conclude that a specific goal leads to higher performance than no goal or a vague goal such as "do your best." In addition, proximal (short-term and specific) goals are associated with better performance than distal (long-term and general) goals. Setting proximal subgoals (action plans) makes the reward of success come sooner and increases self-efficacy. Increased self-efficacy results in people setting and achieving higher goals, whereas reduced self-efficacy—from failing to achieve a goal—may lead to goal abandonment.[6] In health-related behavior change, self-efficacy is also associated with healthier behaviors.[7]

Several reviews suggest that goal setting and action planning are associated with improved health-related behaviors, although the evidence is not conclusive. A review of 92 studies of diet behaviors found that goal setting or action planning were associated with the eating of less fat and more fruits and vegetables.[8] Another review of 28 studies on diet and physical activity found that 32% of the studies supported the use of goal setting or action planning for adults; the literature for adolescents and children is limited.[9] In one study, low-income patients receiving care in safety-net clinics were able to initiate behavior changes based on action plans as often as higher-income patients in private practices.[5] The American Diabetes Association, the American Association of Diabetes Educators, and the American Heart Association all recommend goal setting as one component of cardiovascular disease risk reduction.

Follow-Up and Problem Solving

One or two discussions resulting in action plans are insufficient to encourage long-term behavior change. Many studies find that regular and sustained follow-up is a necessary component of this method. Follow-up can be conducted by telephone, by e-mail, through Internet-based interactive programs,[10] individually, or in groups. Follow-up includes problem solving related to barriers to success in carrying out action plans. Lack of success on an action plan is translated into "lessons learned" instead of failure. A great advantage to doing action planning in groups, as occurs in the well-established Chronic Disease Self-Management Program,[11] is that patients can "buddy up" and do follow-up and problem solving with each other by telephone.

Caregiver Training for Goal Setting and Action Planning

We have developed, tested, and modified training materials for goal setting and

Date: _____

My Action Plan

I _____ and _____
(name) *(name of clinician)*
have agreed that to improve my health I will:

1. Choose one of the activities below:

☐ Work on something that's bothering me:

_____

☐ Stay more physically active!

☐ Take my medications.

☐ Improve my food choices.

☐ Reduce my stress.

☐ Cut down on smoking.

2. Choose your confidence level:

This is how sure I am that I will be able to do my action plan:

10 VERY SURE

5 SOMEWHAT SURE

0 NOT SURE AT ALL

3. Complete this box for the chosen activity:

What: _____

_____

How Much: _____

_____

When: _____

_____

How often: _____

_____

_____
(patient signature)

_____
(signature of clinician)

Figure 1. Sample Patient Action Plan

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Table 1. Goal-Setting Dialogue

Caregiver:	Your last lab test shows your A1C has gone up to 9.2%. What do you think about that?
Patient:	I don't know. I'm taking my pills. I thought if I took them I didn't have to worry about eating candy and sweets every day; the pills are supposed to protect me.
Caregiver:	What is it you like about eating candy?
Patient:	I love chocolate; it's kind of comforting. I have all these things that stress me out, but I know that chocolate is one thing in my day I will definitely enjoy.
Caregiver:	That makes sense. Is there anything you don't like about eating chocolate?
Patient:	Well, it messes up that sugar. But I don't want to give it up. Like I said, it makes me happy.
Caregiver:	Is there anything else you enjoy doing that reduces your stress but doesn't get your A1C so high?
Patient:	Maybe walking around the block a couple of times.
Caregiver:	Do you want to give that a try?
Patient:	Sure, but I'm not promising to give up chocolate.
Caregiver:	I understand. Let's do a reality check. How sure are you that you can walk around the block a couple of times when you feel stress? Let's use a 0–10 scale: "0" means you aren't sure you can succeed and "10" means you are very sure you can succeed.
Patient:	I can do it; I'm 100% sure.
Caregiver:	Let's try to make this as specific as possible. Rather than walking every time you feel stress, how about walking two times around the block every day after lunch?
Patient:	Well, if I feel stress, that might be OK.
Caregiver:	Why don't we call it your action plan. You will walk around the block two times when you feel the stress coming on. When do you want to start?
Patient:	We'll see.
Caregiver:	Do you want to start this week?
Patient:	That might be nice.
Caregiver:	OK. Why don't we agree that you will walk around the block two times when you feel stress? Could I call you next week to see how it's going?
Patient:	OK.

Table 2. Lessons From the Dialogue

Q: When the patient mentioned an unhealthy behavior (eating chocolate), why didn't the caregiver challenge it, saying that it is unhealthy?

A: When the patient says: "I'm not promising to give up chocolate," the caregiver doesn't make a judgment, but says: "I understand," and moves on. The patient has made it clear that stopping chocolate is not an agenda item the patient is ready to discuss. Challenging the patient about chocolate would be likely to provoke the patient's resistance to the entire process.

Q: Why does the caregiver ask "What do you like and not like about eating chocolate?"

A: This is a Motivational Interviewing technique.[12] Asking "What do you like" about an unhealthy behavior helps to explain why the patient is performing that behavior, which might help in formulating an eventual action plan. Asking "What don't you like" about the unhealthy behavior encourages the patient, not the caregiver, to talk about behavior change. Most people are ambivalent about unhealthy behaviors, and it is often better for the patient to talk about change than for the caregiver to insist on change (which may provoke resistance).

Q: Why does the caregiver say "Rather than walking every time you feel stress, how about walking two times around the block every day after lunch?" What happens?

A: The caregiver is trying to make the action plan more specific. The patient replies, "Well, if I feel stress, that might be OK." That is resistance; the patient doesn't want to make the action plan more specific.

Q: Why does the caregiver say "When do you want to start?" What happens?

A: Same thing: trying to make the action plan more specific. Again, there is resistance: "We'll see" and "That might be nice."

Q: What does the caregiver do about the resistance?

A: The caregiver backs off, "rolls with the resistance," and lets the patient make the final decision on what the action plan is.

action planning and have used these materials with hundreds, if not thousands, of participants, including physicians, nurses, health educators, health professional students, and patients who are peer leaders of chronic disease self-management classes.

Goal setting and action planning can be learned quickly. However, after an initial training, it is essential for caregivers to discuss with each other any problems they are having engaging patients in these discussions. As with any new technique in health care, practice makes perfect.

The initial training can be done in 50–60 minutes and has six parts:

1. The trainer explains goal setting and action planning, using the material just presented in this article (5 minutes).
2. The trainer and a volunteer trainee read aloud a scripted goal-setting dialogue (Table 1). The trainer asks the trainees the questions posed in Table 2 (dialogue lessons; 10 minutes).
3. The trainees are divided into groups of two to practice action plans (20 minutes). They are given the following instructions:
   - One person be the caregiver, the other be the patient.
   - The caregiver asks the question, "Is there anything you would like to do this week to improve your health?"
   - Trainees who are playing the patient role choose an actual problem they themselves are having in their lives. The problem may be health related (healthy eating or exercise) or a psychosocial problem ("I hate my job" or "I never have enough time for myself").
   - The caregiver and patient work out an action plan. The caregiver assesses the level of confidence (0–10 scale) and tries to help the patient make an action plan with at least a 7 of 10 confidence level.
4. The group then reassembles, and trainees are encouraged to talk about the action plans they made and problems they had in making an action plan (15 minutes).

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Table 3. Follow-Up and Problem-Solving Dialogue

Goal setting and action planning will not work without regular and sustained follow-up with problem solving. This process can be done, often by telephone, by medical assistants, community health workers, or patients who buddy-up with one another.

Follow-up (on telephone)

Caregiver: Hello. Is this a good time to talk for a few minutes?

Patient: OK

Caregiver: Do you remember the action plan we talked about in the office last week?

Patient: I was supposed to walk 15 minutes every afternoon. But I didn't do it. I'm scared because we just had a shooting in the neighborhood.

Caregiver: (after discussing the shooting for a few minutes) Would you like to try to make another action plan to do some exercise?

Patient: Yes, I need to do that.

Caregiver: Do you have any ideas what you might do? (This gives the patient the opportunity to suggest an idea; if that doesn't work, the caregiver can suggest a few ideas.)

Patient: My son visits me every week. Maybe he could drive me somewhere, and we could walk together instead of going to McDonald's the way we always do.

Caregiver: Maybe the first action plan could be to ask your son if that is OK. What do you think?

Patient: I'll ask him tomorrow. (Here the caregiver might assess this new action plan with a 0–10 confidence scale. In this case, that might not be necessary.)

Caregiver: That's great. Is it OK if I call you in a couple of days to see what happened?

Problem solving[13]

1. Identify the problem (the most difficult and important step).
2. List ideas to solve the problem.
3. Pick one, and try it for 2 weeks.
4. Assess the results.
5. If it doesn't work, try another idea.
6. Use other resources (e.g., family, friends, or professionals).
7. If nothing seems to work, accept that the problem may not be solvable now.

Table 4. Resources and Information

- Action plan forms in English, Spanish, and Chinese can be downloaded from the Internet at **http://www.familymedicine.medschool.ucsf.edu/community_service/actionPlan.aspx**
- A wealth of information on patient self-management of chronic conditions is available at **http://patienteducation.stanford.edu**
- A monograph titled "Helping Patients Manage Their Chronic Conditions" is available at the California HealthCare Foundation website **www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768**
- The Institute for Healthcare Communication has resources on enhancing the dialogue between patients and clinicians. Available online from **www.healthcarecomm.org**

5. The trainer and a volunteer then read aloud the follow-up dialogue (Table 3). Trainees who played the role of caregiver are encouraged to call or e-mail their partner in a few days to follow up on the action plan and to problem solve regarding barriers (5 minutes).
6. The trainer hands out copies of the materials used in the training (Tables 1–3) and tells the patient how to get more information (Table 4).

Summary

Goal setting with action planning is a useful technique for engaging patients in behavior-change discussions. Some evidence suggests that this technique is effective in improving healthy behaviors. Caregivers can learn the goal-setting technique through a 50 to 60-minute training session.

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Thomas Bodenheimer, MD, is a professor in the Department of Family and Community Medicine at the University of California at San Francisco. Connie Davis, MN, ARNP, is a clinical nurse specialist at FraserHealth in Abbotsford, British Columbia, Canada. Halsted Holman, MD, is a professor of medicine, emeritus, at Stanford University in Palo Alto, Calif.

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