Collaborative Goal-Setting Training

It is easy to train caregivers to have goal-setting discussions with patients. Training consists of 1) two people reading one or more goal-setting dialogues with as much enthusiasm as possible, 2) explaining the "lessons" listed under each dialogue, and 3) having pairs of people do action plans with each other (see Personal action plan instructions).

If you want to use action plan forms, they can be downloaded in English, Spanish and Chinese from www.action-plans.org. You may or may not want to use the forms. You may or may not want patients to sign their action plan. Be flexible.

For all action plans, follow-up is key, in person, by phone, e-mail. Follow-up involves asking how it's going with the action plan, seeing if patient wants to change the action plan, helping to problem-solve barriers to success in the action plan, and arranging the next follow-up encounter.

Dialogue #1: patient is ready to change

Doc: I think we've talked before about things you could do to improve your cholesterol [use diabetes, or blood pressure, heart problems -- whatever the patient's problems are]. We've talked about eating better, doing more exercise, stopping your cigarettes, taking your pills more regularly, and reducing the stress in your life. Is there anything you would like to do that would help to improve your cholesterol?

Patient: I think I need to lose weight. Doc, when I come in here next month I'll be down 20 pounds. I promise you.

Doc: Would you mind if we do a reality check? How sure are you that you can really lose 20 pounds in one month. That's not easy to do. Let's use a 0 to 10 scale: 0 means you aren't sure you can succeed and 10 means you are very sure you can succeed [have a prop available to show patient]. How sure are you that you can succeed?

Patient: well, doc, maybe it's a 3 out of 10.

Doc: let's think of an action plan that has a greater chance of success. Are there ways you might change your diet or increase your exercise so that you can lose some weight?

Patient: I love cheese. I'll stop eating any cheese. Then I'll lose weight.

Doc: on the same 0 to 10 scale, how sure are you that you can stop eating any cheese.

Patient: maybe it's 5 out of 10.

Doc: I really want you to succeed. Let's try an action plan that you feel sure you can do. Any ideas?

Patient: if I eat only one slice of cheese twice a week, I think I can do it. 8 out of 10.

Doc: Great. That will be your action plan. When do you want to start?

Patient: I'm starting right now.

Doc: OK. Why don't we sign this agreement that you will only eat one slice of cheese twice a week, starting now. I'll sign here, and you can sign over here.

Patient: signs.

Doc: someone will be calling you in about a week to see how you are doing with your action plan. Take this copy home and put it on your refrigerator to remind you. Also, we'll discuss it when you come back in a month.

Lessons:

Start the discussion with an open-ended question such as “Is there anything you would like to do to improve your cholesterol?” or “Is there anything you would like to do this week to improve your health?” Feel free to use the action plan form to give people a list of possible things to work on.

It’s best if the patient suggests an action plan. But if the patient says, “Doc, you tell me what to do,” then make a few suggestions to help the patient.

Trying to get an action plan with a confidence level of at least 7 out of 10 is best, because we want patients to succeed.

Try to make the action plan specific: what, how often, for how long, when start? This is not always possible.

Action plans can be continuous behavior change (I will walk 15 minutes after lunch on Mondays, Wednesdays and Fridays) or a one-short action (I will go to the Yoga class to see if a like it).

Dialogue #2: patient is ambivalent

Doctor Goode: It looks as if your HbA1c has gone up to 9.2 in the lab test we just did. What do you think about that?

Patient: I thought I was doing fine. I'm taking my pills and they seem to be working OK. If I take my pills, then I don't have to worry about eating my Hershey bars because the pills protect me.

Doctor Goode: what do you like about eating Hershey bars?

Patient: it really tastes good. And it reduces my stress. When I feel stress, I eat and I feel relaxed.

Doctor Goode: that makes sense. Is there anything you don't like about eating chocolate?

Patient: well, it messes up that Hemoglobin thing. But I'd rather have that Hemoglobin at 9.2 than feel that stress.

Doc: is there anything you could think of that might help reduce your stress that wouldn't get your HbA1c so high?

Patient: maybe I could walk for two miles a day to get the stress out of my body.

Doc: We could call that your action plan. Do you want to give it a try?

Patient: sure, but I'm not promising to give up my Hershey bars.

Doc: I understand. Let's do a reality check? How sure are you that you can walk 2 miles a day? Let's use a 0 to 10 scale: 0 means you aren't sure you can succeed and 10 means you are very sure you can succeed . How sure are you that you can succeed?

Patient: I guess a 3 out of 10

Doc: let's try to make the action plan easier to accomplish. Any ideas?

Patient: well, I could walk two times around the block every time I feel stress.

Doc: on a 0 to 10 scale, how sure are you that I can do that?

Patient: Oh, it's a 10, slam dunk.

Doc: 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 work.

Doc: OK, so we're agreed that you will walk around the block two times every time you feel that stress coming on. When do you want to start?

Patient: We'll see.

Doc: do you want to start this week?

Patient: that might be nice

Doc: OK. So you feel that you can walk around the block two times every time you feel stress. Is it OK if the medical assistant calls you in a week to see how it's going?

Patient: no problem.

Lessons:

The technique: "What do you like about eating Hershey bars?" and "What don't you like about eating Hershey bars?" is a motivational interviewing technique. The first question gives some information about the reasons for the unhealthy behavior and also shows that the doc is not being judgmental about the behavior. The second question allows the patient to do the change talk him/herself, which is much more effective than having the caregiver asking/telling the patient to change.

When the patient says: "I'm not promising to give up my Hershey bars," and the Doc says: "I understand," that is about expressing empathy, not arguing with an unhealthy behavior, and not trying to change something the patient is not ready to change.

0-10 confidence scale. If the action plan is 2 miles a day and the patient fails, nothing is gained. If the action plan is around the block twice and the patient succeeds, self-efficacy (confidence) increases and the patient feels more confident he/she can make other changes.

The doc – trying to make the action plan more specific -- asks: "When do you want to start?" Patient: "We'll see." Doc: "Do you want to start this week?" Patient: "That might be nice." That is resistance on the part of the patient, ambivalence toward making the change. Doc "rolls with the resistance" and backs off; doesn't include starting time in the action plan.

Dialogue #3: patient needs to deal with social problem
before being able to think about other health issues

Doc: Now that we've discussed your blood pressure pills, I'd like to ask you a question: are there any problems you are having in your life that are really bothering you?

Patient: it's my daughter. She's 37 and she still lives at home and she's an alcoholic and she brings people into the house and they get violent. It scares me.

Doc: no wonder your blood pressure is so high. That's a tough problem. Have you thought about what you might want to do about it?

Patient: I've got to get her out of the house. If she weren't there, things would be so much better. I know that wouldn't help her but it sure would help me. But I don't know how to do it?

Doc: do you have any ideas how you might do it?

Patient: I need to get the courage to tell her that she's got to move out. I've never even told her.

Doc: maybe the first step is to sit down with her and tell her. That could be your action plan to start working on this problem.

Patient: OK. I'm going to sit her down.

Doc: Would you mind if we do a reality check? How sure are you that you can get up the courage to tell her that you want her to leave? That's not easy to do. Let's use a 0 to 10 scale: 0 means you aren't sure you can succeed and 10 means you are very sure you can succeed. How sure are you that you can succeed?

Patient: well, doc, maybe it’s a 3 out of 10.

Doc: let's think of an action plan that has a greater chance of success. Do you have any ideas?

Patient: maybe if she comes in here and I talk to her with you being here to help me.

Doc: I'd be happy to help. What do think are the chances that she would come to the visit?

Patient: I think it's 8 out of 10. If I tell her that you wanted her to come to talk about my health she'd come.

Doc: When do you want to talk to her about coming to an appointment with me?

Patient: this week, before Saturday.

Doc: Great. That will be your action plan. Why don't we sign this agreement that before Saturday you will ask your daughter to come to an appointment with me. We'll make the appointment now, for next week. I'll sign here, and you can sign over here.

Patient: signs.

Doc: I'll see you next week. If for some reason something comes up, someone will call you to see how you are doing with your action plan.

Lesson:

If the patient has a social problem that prevents him/her from dealing with diabetes or HBP or overweight, it makes no sense to do an action plan on diet or exercise. The action plan is best related to the patient's main problem.

Personal action plans instructions

People would break down into pairs. One person be caregiver (physician, nurse practitioner, or medical assistant); one person be patient. Then switch roles.

Caregiver starts out: "Is there anything in your life you would like to work on to become healthier or to make your life more satisfying? It could be a new job, a new place to live, healthier behaviors, or reducing stress."

Discussion to arrive at an action plan.

Caregiver assesses confidence to achieve action plan with 0 to 10 scale. Try to re-negotiate action plan such that confidence level is 7 out of 10 or higher.

Try to make action plan as specific as possible. It can be a one-shot action plan (e.g. "I will go to the yoga class once to see how I like it.") or an on-going action plan ("I will stop drinking cokes and drink water instead.")

Make a follow-up plan to call or e-mail each other to see how action plan is going and to problem-solve barriers to achieving action plan.

Frequently Asked Questions (FAQs)

Is there any evidence that action plans work?

There is no research evidence demonstrating in a randomized controlled trial that action plans by themselves improve health status or health-related behaviors. However, there are two randomized controlled trials demonstrating that patient self-management education classes -- *of which action plans are a prominent part* -- improve patient's health compared with controls. One study is by Kate Lorig and associates at Stanford showing that patients with a variety of chronic illnesses in self-management classes, that included action plans, reported better control of their symptoms, improved self-efficacy, an improved feeling of well-being, and fewer hospitalizations and emergency department visits compared with controls -- these findings persisted 6 months after the classes were completed and some of the improvement persisted for two years [1,2]. The second study, by Anderson, Funnell and colleagues at Michigan found that people with diabetes who attended empowerment (problem-solving and goal-setting) classes, that included action plans, had improved HbA1c levels compared with controls [3].

What is self-efficacy?

Self-efficacy means the confidence that one can carry out a behavior necessary to reach a desired goal [4]. In self-management training, patients may be asked to estimate their confidence on a 0 to 10 scale that they can achieve their action plan. Self-efficacy theory holds that the successful achievement of the action plan is more important than the plan itself. If a physician tells a patient to walk one mile each day and the patient fails to do so, little is accomplished except a sense of failure. If a physician and patient collaboratively agree that exercise is desirable and the short-term action plan succeeds, the patient may later propose a revised action plan to exercise more or improve the diet [4].

In analyzing why self-management classes improved patients' feeling of well-being and reduced hospital and emergency department use, the main variable associated with these outcomes was improved self-efficacy as measured by a series of questions called a self-efficacy scale. Kate Lorig makes the simple statement that "People who feel confident that they can improve probably can; people who don't feel confident that they can improve probably can't."

It is because of the importance of self-efficacy; it is more important that the action plan succeeds than what the specific action plan is. The purpose of the action plan is to build self-efficacy.

Why should the action plan be specific?

Experience, especially the many long years which Kate Lorig has spent doing action plans with patients, shows that action plans have the best chance of success if they are specific: what, when, how long, how often. For example, "I will walk on Monday, Wednesday and Friday after lunch for 15 minutes, starting tomorrow." Sometimes people will say: I don't have time to exercise. One can say: "What are some ideas you have to fit exercise into your schedule?" Making the plan very specific may make it easier for people to fit it into their schedule.

What if the patient isn't interested in making any behavior change?

Some patients may not be ready for any action plan. One cannot force an action plan on a patient. Many behavior change theorists use the "stages of change" concept developed by Prochaska and others for smoking cessation and are applying this concept to all health behavior change [5]. People can be in the pre-contemplative, contemplative, readiness, action, and maintenance stage of change with respect to a particular behavior. Those in the pre-contemplative stage may not be ready for an action plan. For those patients, one can say, "As your physician, I want you to know that eating a good diet and doing exercise are the best ways to control your diabetes. I am available to help with these things and I am confident that you will be successful when you are ready."

It is important not to be rigid in using stages of change. People who are not ready for one behavior change may be ready for a different behavior change. Someone not ready to stop smoking may be ready to do exercise. An excellent question to avoid the trap of prematurely categorizing a patient as “pre-contemplative” is to ask: “Is there anything you would like to do this week to improve your health?”

In addition, it is important to divide readiness into importance and confidence. If it is important to a patient to get diabetes under control, and patient is confident that he/she can succeed, then the patient is ready. Pre-contemplative patients may be not-ready because they don’t see the diabetes as important, or because they are not confident that they can improve the diabetes [6]. The discussions to have with patients are very different when importance is the problem vs. when confidence is the problem. It is often possible to make a very simple action plan with people even if they don’t seem particularly ready to make a change.

There are ways in which a clinician or health educator can discuss healthy behaviors with patients that can help move them from a less-ready to a more-ready stage. Such techniques are explained in detail in the excellent book "Motivational Interviewing" by Miller and Rollnick and the Rollnick et al book “Health Behavior Change” [6,7]. A key lesson of motivational interviewing is most people performing unhealthy behaviors are ambivalent -- they like the behavior and don't like it at the same time. If a clinician or health educator tells people not to do a certain thing, that may push the patient into the "I like that behavior" stance. In contrast, if one tries to bring out the patient's ambivalence, it may be possible to assist the patient to embrace the "I don't like that behavior" position. One way to do this is to ask, "What do you like about eating french fries?" and "What do you not like about eating french fries." There may be clues that will help to direct the discussion into an eventual action plan. For example, if the patient eats high-fat foods to reduce stress, one could discuss other ways to reduce stress and perhaps develop an action plan on stress reduction that did not reduce high-fat foods but allows the patient to succeed at something, improving self-efficacy, and perhaps later moving to a stage of greater readiness to change diet.

Doesn't motivational interviewing take too long?

Yes, the full version of motivational interviewing cannot be done in a primary care visit, and also takes considerable training to master. However, there is a short version of motivational interviewing called "brief negotiation." Agreeing on an action plan with a patient is an example of brief negotiation. If the patient is ready for making a change, the negotiation is relatively simple, coming up with an action plan that the patient is confident can succeed. If the patient is not ready, the negotiation may take longer and may or may not be possible in a primary care visit. Some take-home lessons of brief negotiation are:

If you are told what to do there is a good chance you will do the opposite.

Encourage patients to say things that you usually tell them.

Help patients to talk themselves into making a change. Sometimes this can be done by asking a pair of questions: "What do you like (not like) about ___?" or "What are the advantages of keeping things the same?/What are the advantages of making a change?"

What are some ways to initiate discussions with patients about action plans?

One might ask the patient's permission to have the discussion: "Would you be willing to spend a few minutes discussing your diabetes?" or "What questions do you have about your diabetes?" or "I have the results of your HbA1c, which is 9.5." (Explain what that means). "What do you think about this?" Or "Is that a concern to you?"

If the patient is willing to have the discussion, one might say: "There are a number of things you might do to improve your diabetes. One is diet, another is exercise, another is checking your blood sugars, and another is taking medications. Would you be interested in working on any of these things? Or do you have another idea?"

Why is it important to have the action plan in writing?

The main reason to put the action plan in writing is to make certain that the patient understands what the clinician and patient have agreed upon. Schillinger and colleagues have shown that in explaining a new concept or recommendation to a patient, only 12% of the time does a physician ask the patient to repeat what the clinician recommends in order to determine whether the patient understands. They also found that "closing the loop" (i.e. physicians asking patients to repeat their recommendation) was associated with lower HbA1c levels in diabetic patients [7]. Putting the action plan in writing is one way to "close the loop" to make sure patients understand what the action plan is. Asked the patients to repeat back their understanding of the action plan would also be an excellent idea.

References

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