COACHING AND COUNSELING PATIENTS
A Resource from the American College of Preventive Medicine

A Clinical Reference
The following Clinical Reference provides evidence to support the Coaching and Counseling Time Tool.

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1. INTRODUCTION

Unhealthy behaviors such as poor eating habits, sedentary lifestyles, smoking, and alcohol consumption have been estimated to be responsible for approximately 37% of deaths annually in the U.S. [1]

- The combination of two key behaviors—physical inactivity and poor diet—is poised to become the leading actual causes of premature death in the United States.
- 50% of the mortality from the 10 leading causes of death is attributed to lifestyle-related behaviors such as tobacco use, poor dietary habits and inactivity, alcohol misuse, illicit drug use, and risky sexual practices. [2]
- Over half of deaths that occur each year are premature and "preventable" through modification of lifestyle and environmental exposures. [3]
- Many primary care visits (70% in one study) are driven by psychosocial factors that are best addressed through behavioral interventions. [4]

Chronic disease care is a particular concern; approximately 120 million Americans have one or more chronic illnesses, which account for at least 70% of total health care costs. [5,6]

- 25% of Medicare recipients have four or more chronic conditions, accounting for two thirds of Medicare expenditures. [5,6]
- Most patients with chronic conditions are not managed adequately; the burden is magnified by co-morbidities. [7]
- Patients with chronic conditions receive only 56% of recommended preventive health care services. [Parkinson Michael, past president of ACPM, presentation on lifestyle medicine]

Control of major cardiovascular risk factors (hypertension, hyperlipidemia, obesity) and co-morbid conditions (diabetes) has been the centerpiece of guidelines for the prevention of cardiovascular disease.

- But nearly half of patients in the U.S. are not at their target for blood pressure or low-density lipoprotein cholesterol. [8]
- JNC-7 reports only 34% of hypertensives have their blood pressure under control. [9]
- Control of diabetes is also elusive: only 37% people with diabetes have HbA\textsubscript{1c} values at or below the recommended level. [10]

The Burden on Primary Care
Primary care physicians manage the majority of chronic disease problems. [11]

- Managing patients with multiple co-morbid chronic conditions is perhaps the greatest challenge confronting primary care. [12-14]
- A key to improving chronic disease care is to help people with chronic conditions become informed, pro-active patients. Those who are involved in their own care decisions have better health-related behaviors and clinical outcomes. [15]

Motivating Americans to make healthier choices has the greatest potential of any current approach for decreasing morbidity and mortality and for improving the quality of life across diverse populations. [16]

- It is imperative that clinicians address health behavior issues, but asking primary care providers to incorporate behavioral interventions into their practice is controversial.
- Traditional approaches of advice giving and direct persuasion have limited effectiveness. [17]
- Few behavior change intervention studies actually document long-term health outcomes. [18]
- Many barriers in the health care system, and in the individual practices of both patients and providers must be overcome.

But the fact remains that poor health choices are becoming a greater burden on individual health, as well as the health care system, and physicians are not meeting the challenge of helping patients change these behaviors. [19,20]
2. ROLE OF PRIMARY CARE IN BEHAVIORAL CHANGE INTERVENTIONS

Health care providers and their staff play a unique and important role in motivating and assisting patients in making health behavior changes. [21]

- Assisting in improving behaviors and providing self-management tools are important responsibilities. [22]
- Supporting patient self-management is a key element of a systems-oriented chronic care model. [23]

The primary care setting is the obvious place to provide behavioral counseling. [24-26]

- Most clinicians have multiple opportunities to intervene with patients on matters related to health behaviors -- patients < 15 years of age average 2.4 visits per person annually, and those 15 years of age and older average 1.6 to 6.3 visits per year, with visit frequency increasing with age. [27]
- Primary care providers (PCPs) manage the majority of patients with chronic conditions; see 75% of adults at least once a year; the average is 2-3 visits per year. [28]

Patients expect this role; they look to their PCP for preventive health information. [29]

- Most (> 90%) of adult members of health maintenance organizations (HMO) indicated that they expected advice and help in key behaviors, such as diet, exercise, and substance use. [30]
- The public perceives physicians as credible, reliable sources of information regarding health behaviors. [31,32]
- A key function is to clarify misconceptions about health behaviors, for example, the claims surrounding weight-loss diets that seem to imply that fundamental knowledge of dietary intake and human health is lacking. [33]

PCPs generally accept and value this health promotion and disease prevention role. [34,35]

- 72% of practitioners considered it their responsibility to provide some nutrition counseling. [36]
- Many are also interested and able to give tailored physical activity advice and write exercise prescriptions. [37-39]

Clinician advice is a strong incentive for health-promoting action. [29]

- Advice from a physician has consistently been shown to lead to attempts to improve lifestyle behaviors. [40-51],

All prevention-oriented interactions between clinicians and patients have a counseling dimension; i.e., they focus on patient behavior change, whether scheduling a mammogram or beginning a regular exercise regimen. [52]

- There is evidence that the clinician-patient interaction can increase or decrease the likelihood of follow-through. [52]

Unfortunately, physicians often underestimate the power of their role as health behavior change counselors. [53]

According to Greenstone, the challenge is no longer proving that changing health behaviors is effective, but rather in enhancing clinicians’ and the health care system’s commitment to learning how to incorporate counseling interventions into their practices and to deliver specific and compelling messages and strategies to patients. The risks of not changing must be clearly articulated, and a specific plan outlined. [54]
3. RECOMMENDATIONS AND GUIDELINES

A large body of evidence supports the effectiveness of behavioral interventions for lowering the risk of developing chronic disease, as well as for assisting in the management of existing disease. As a result, national guidelines consistently emphasize lifestyle behavior interventions for general health, as well as most disease or high risk conditions. [55-64]

- Healthy People 2010 goals are for 85% of physicians to counsel their patients about physical activity and for 75% of physician office visits made by patients with cardiovascular disease, diabetes, or dyslipidemia to include dietary counseling.

U.S. Preventive Services Task Force (USPSTF) Recommendations
The USPSTF recommends that clinicians:

- Screen all adult patients for obesity, tobacco use and alcohol use, and
- Offer cessation interventions for smokers, and
- Intensive counseling and behavioral interventions to promote sustained weight loss for obese, reduced alcohol consumption in excessive users, and diet changes for all who have hyperlipidemia or other known risk factors for cardiovascular and diet-related chronic disease.


USPSTF recommendations are notable in that they lack an endorsement of behavioral counseling in primary care for physical activity or for dietary improvements in otherwise healthy people.

- They note the benefits of activity and a healthy diet, but cite the lack of randomized controlled trial (RCT) evidence.
- “A” and “B” rated recommendations are usually reimbursed because the evidence is strong, i.e., supported by high quality studies. [see link to pocket guide above for ratings explanations]

“A” Recommendation
- Tobacco Cessation for adult users -- Clinicians should ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.

“B” Recommendations
- Alcohol misuse in adults, pregnant women -- Screen and provide behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
- Diet Changes with hyperlipidemia or other cardiovascular risk factors or diet-related chronic disease -- Provide intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.
- Weight loss for obese (intensive counseling programs only) -- Screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
- Sexual health for sexually active adolescents and adults at increased risk for sexually transmitted infections (STIs) -- Provide high-intensity behavioral counseling to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs.

“I” Recommendations (insufficient evidence)
- Dietary changes in patients without CVD risk factors or diet-related chronic disease -- Evidence is insufficient to recommend for or against routine behavioral counseling to promote a healthy diet in unselected patients in primary care settings.
- Physical activity for all non-obese patients in primary care -- Evidence is insufficient to recommend for or against behavioral counseling in primary care settings to promote physical activity.
- Weight loss (low to moderate intensity) in obese adults -- Evidence is insufficient to recommend for or against the use of moderate- or low-intensity counseling with behavioral interventions to promote sustained weight loss in obese adults.
• Weight loss in overweight (not obese) adults -- Evidence is insufficient to recommend for or against the use of counseling of any intensity and behavioral interventions to promote sustained weight loss in overweight adults.
• Tobacco Cessation for child or adolescent users -- Evidence is insufficient to recommend for or against routine screening for tobacco use or interventions to prevent and treat tobacco use and dependence among children or adolescents.
• Sexual health for non-sexually active adolescents and adults not at increased risk for STIs -- Evidence is insufficient to assess the balance of benefits and harms of behavioral counseling to prevent STIs in non-sexually-active adolescents and in adults not at increased risk for STIs.

Weight Loss Counseling
The Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults from the National Heart Lung and Blood Institute (NHLBI) suggests that the clinical consultations for overweight and obesity include: [61]

• "Patient-centered counseling," -- encourage patient to set goals and express their own ideas for therapy, with input from the healthcare professional.
• A treatment plan that takes into account the patient's readiness for therapy and the patient's ability to comply with the plan.
• Realistic goals, frequent follow-up visits to monitor progress; modifications as needed, and support.

Due to the epidemic of obesity and overweight, a clinical practice that neglects patient nutrition and physical activity patterns is neglecting the leading causes of death for patients. On this basis, routine counseling to promote healthful eating is encouraged by the U.S. Preventive Services Task Force and there is evidence that physician training in nutrition enhances counseling. [3]

Goal Setting
The American Diabetes Association (ADA), the American Association of Diabetes Educators (AADE), and the American Heart Association (AHA) all recommend collaborative goal setting as a key component of cardiovascular disease risk reduction. [65]

Diabetes Self Management Support
The latest evidence-based update of the Diabetes Self-Management Education (DSME) standards from the ADA/AADE Task Force provides the following six principles: [66]
1. Diabetes education is effective for improving clinical outcomes and quality of life, at least in the short-term.
2. DSME has evolved from primarily didactic presentations to more theoretically based empowerment models.
3. There is no one “best” education program or approach; however, programs incorporating behavioral and psychosocial strategies demonstrate improved outcomes.
4. Additional studies show that culturally and age-appropriate programs improve outcomes and that group education is effective.
5. Ongoing support is critical to sustain progress made by participants during the DSME program.
6. Behavioral goal-setting is an effective strategy to support self-management behaviors.

Physical Activity Counseling
The American College of Preventive Medicine (ACPM) takes the position that primary care providers should incorporate physical activity counseling sessions into routine patient visits. [67]

• Effective interventions can be as brief as 2-4 minutes, however, longer sessions may be utilized depending on practice characteristics and patient needs.
• ACPM recommends that physical activity counseling should be covered by insurance benefits, and it encourages professional organizations to offer training in counseling techniques for their members.
The American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Obstetrics and Gynecology (ACOG), the American College of Sports Medicine (ACSM), and the American Heart Association (AHA) all recommend physical activity counseling of some type in the primary care setting. [68-72]

- The U.S. Department of Health and Human Services (DHHS) also encourages physical activity counseling among the goals of Healthy People 2010.
4. PRACTICE PATTERNS – HEALTH BEHAVIOR COUNSELING

Despite the recommendations over the last decade, clinician practices regarding behavior counseling have not improved. [73,74]

- Research has consistently reported that the majority of clinicians do not routinely screen or counsel patients in modifying their health damaging behaviors. [19,75-79,81-84]
- Only 1 in 8 PCPs was even aware of the recommendations for physical activity. [85]

In a national evaluation of physician performance on 439 process indicators for 30 medical conditions plus preventive care, patients received only 55% of recommended care. [86]

- A review of 138 family physicians showed that their patients were up to date on 55% of screening, 24% of immunization, but only 9% of health habit counseling services. [87]

**Self management support**

Clinicians often fail to provide understandable self management education.

- A 2002 national survey found that only 55% of patients with diabetes reported receiving diabetes education. [88]
- In an audio taped study of 336 medical encounters with 34 physicians, the physicians actually devoted an average of 1.3 minutes to giving information, well below their estimate of 8.9 minutes; and 88% of the information provided was in technical language. [89]
- 75% of physicians in another study failed to give patients clear instructions on how to take their medications. [90,91]

**Poor understanding**

Half of patients leave the office visit not understanding the advice given them by the doctor. [92]

- When patients were asked to restate the physician's instructions, they responded incorrectly 47% of the time. [93]
- In another study 50% of patients did not understand how they were supposed to take a prescribed medication. [94]

**Lack of Collaboration**

Clinicians often do not engage in collaborative discussions with their patients.

- In a study of 264 audio taped visits to family physicians, patients' initial statement of their problem was interrupted after an average of 23 seconds. In 25% of the visits, the physician never asked the patient for his or her concerns at all. [95]
- A study of more than 1000 audio-taped visits with 124 physicians showed that patients participated in medical decisions only 9% of the time. [96]
- Half of patients preferred to leave final decisions to their physician, but 96% wanted to be offered choices and to be asked their opinion. [97]
- Patients are more likely to be active participants in their care when their physicians encourage such participation. [98]

**Inconsistent Shared Decision-Making between Providers and Patients**

Knowledge of diagnostic tests, drugs or surgery has been shown to be not much better in those undergoing the interventions than those NOT undergoing them. [99]

- “Pros” concerning the interventions were discussed more than twice as often as “cons”
- Physicians initiated discussions 60-95% of time, offered opinion 80% of time, asked patient’s opinion 45% of time. [99]

Survey of over 400 primary care physicians showed widespread agreement that patients should be informed, especially for lifestyle change and managing chronic conditions (85-90%); less so for screening tests and drug prescriptions (62-64%). [100]

- But shared decision-making was used routinely much less frequently: for lifestyle changes (58%), drug prescriptions and screenings (42%), and imaging and specialist referrals (33%).
- Greatest barriers to such discussions were time and patients difficulty understanding information.
ADVICE AND COUNSELING

Smoking
- About half of smokers reported being advised to quit in the last 12 months but only about 1 in 4 were offered assistance in quitting (despite insurance coverage). [101]
- The odds of receiving counseling did not rise significantly with the number of visits.
- The 2001-2004 National Ambulatory Medical Care Survey showed that 1 in 3 patient charts did not include information about tobacco use, and 4 out of 5 smokers did not receive assistance, and less than 2% received a prescription for pharmacotherapy. [102]

Exercise
- Only 2 in 5 physicians assessed the physical activity status of patients. [103]
- Data show that at best only 1 in 3 [16,17] patients indicated that they had ever received even simple advice to increase activity; others show fewer than 1 in 4. [104-106]
- Likelihood of receiving exercise counseling decreases with age; fewer than 1 in 10 women > 75. [105]
- New patients were counseled more often than established ones; counseling was more frequent when there were diet and exercise brochures in the office. [106]

Even in higher risk, rates are low -- less than 45% of primary care visits by adults with hyperlipidemia, hypertension, obesity, or diabetes mellitus include diet counseling, and only 30% of visits include physical activity counseling. [107]
- In over 137 million patient encounters (NHANES 1999-2000) with a diagnosis of hypertension, nutrition and exercise counseling were provided at 35% and 26% of visits, respectively.
- Patients with more CVD risk factors were counseled slightly more frequently -- 2 risk factors (53% and 32% for diet and exercise, respectively) vs. 1 risk factor (44% and 31%) or no risk factors (30% and 23%, respectively). [108]

Nutrition
- Nonacute visits to PCPs include nutrition counseling only 30–42% of the time and PCPs perform nutrition counseling at visits for cardiovascular disease, hypertension and diabetes mellitus only 25–45% of the time. [109]
- The time spent in nutrition counseling in primary care is usually less than 5 min per patient, with the average time being 1 min. [109,110]

Weight Loss
- Weight loss counseling is included in only 20% to 36% of obesity-related visits with PCPs. [111,112]
- Only 2 of every 5 obese patients are advised to lose weight in regular exams, even when they have chronic conditions made worse by their weight. [112,113-115,117-120]
- Even fewer (< 25%) overweight (not yet obese, i.e., BMI 25.0 - 30.0) had discussed weight with their physician. [121]
- Even when they advise patients to lose weight, physicians often provide insufficient guidance on weight management strategies, possibly because of inadequate counseling skills and confidence. [122]
- Only 33% received specific weight control advice, and 25% were advised to increase physical activity. [123]
- Even with obesity-related co-morbidities, weight loss counseling occurred in only half of visits. [124]

Adequacy of Counseling
- Counseling is most effective when it includes a plan or prescription and follow up, but it often does not include a specific plan.
- Less than 20% of obese patients were given specific weight loss counseling, especially a plan that includes an increase in physical activity. [122,123,125]
- Overweight adults who were advised to exercise and provided a plan were nearly 5 times as likely to meet physical activity recommendations. [126]
Patients want more counseling
Most patients (especially those who are overweight or obese) want more help than they are getting. [127]
• Obese women report much less satisfaction with obesity care than general health care.
• Almost half reported that they had not been given a weight loss strategy; most reported being discouraged with the help from their doctors –3 out of 4 expected only a "slight amount of help" or "none at all" when it came to weight control. [128]

Chronic Disease Counseling
Patients with chronic diseases are insufficiently counseled and educated about the need for lifestyle changes.
• Patients with type 2 diabetes, hyperlipidemia, or hypertension did not receive any type of diet or exercise counseling during more than one half of all visits. [129]

Diabetes – Counseling Rates
The 2002-2004 National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS) showed that counseling/referral for nutrition occurred in 36% of diabetes patient visits and counseling/referral for exercise occurred in 18% of patient visits. [130]
• 1999 BRFSS data showed that counseling was higher in patients with diabetes than without, but still inadequate -- weight loss (50% with diabetes vs. 21% without diabetes), smoking cessation (78% vs. 67%), eating less fat (78% vs. 71%), and increasing physical activity (67% vs. 36%). [131]
• The 2002 Medical Expenditure Panel Survey showed that 73% of adults with diabetes were advised to exercise more versus 31% of adults without diabetes. [132]
• Health professionals advised most patients at risk for diabetes to exercise, suggesting recognition of its importance for disease management. As risk factors declined, fewer patients were advised to exercise, suggesting missed opportunities for disease prevention. [132]

Lack of referral
Very few (2-5%) patients are referred to community resources for behavioral counseling assistance. [133]

Counseling rates not improving
Data from the 1995 to 2004 National Ambulatory Medical Care Survey showed that in 2003/2004, approximately 20% of visits to PCPs by overweight or obese patients included counseling for diet/nutrition, 14% for exercise, and 6% for weight loss. [111]
• Approximately 1 of every 4 visits included at least one of these types of counseling.
• The odds of receiving counseling for any of these services were 18% lower in 2003/2004 than in 1995/1996.

Rates of smoking cessation counseling differ by age group and have declined in the last decade, despite increasing evidence of effectiveness of primary care interventions. [134]
• Time constraints, misconceptions about older patients’ ability and willingness to quit, or doubt about the potential health benefits of smoking cessation in older age groups may explain the lower counseling rates provided to older male patients.
5. BARRIERS TO ENHANCING COUNSELING PERFORMANCE

The most significant barriers at the systems level are: [29,52]

- lack of time with patients,
- lack of training in counseling techniques,
- lack of reimbursement for these services,
- a fragmented approach to care and
- skepticism that health behavior change interventions can make a difference in specific health outcomes.

Time is the biggest obstacle
The average duration of PCP visits by established patients is 16 to 18 minutes. [135,136]

This is not nearly enough time to provide all the preventive services, behavioral counseling and disease management support in the current system.

- Nearly half of PCPs report not having enough time with patients. [137]
- To fully satisfy all USPSTF recommended preventive services, over 7 hours a day for a typical patient load would be needed; and to meet the guideline recommendations for the 10 most common chronic diseases would take at least another 10 hours a day. [138,139]
- The average American family physician would spend between 11 to 18 hours per day delivering preventive and chronic illness care. [140]

The 15- to 18-minute physician visit may be a primary reason why more than 60% of patients with hypertension, elevated cholesterol levels, and diabetes have poor control of their condition. [138]

- Physicians are forced to make choices about preventive services on a case-by-case basis; the patient’s current medical problems usually take precedence over screening and counseling.

PCPs do not have time to engage in behavior-change counseling. [29]

- Nor is there sufficient time to provide evidence-based medicine at every visit for every patient, to make sure that patients understand the evidence, and to assist and encourage patients to incorporate the evidence into their lives. [141]

Multiple agendas contribute to time problems
In a recent study, physicians reported managing an average of 3 problems per encounter; in 37% of all primary care visits, more than 3 problems were addressed. [142]

- In visits with multiple agendas, acute concerns crowd out chronic care management. [143]

Increasing complexity of chronic disease management adds to time problems
Caring for diabetes, for example, is far more complex and time-consuming than a decade ago. [144]

- The greater the number of competing demands in visits with patients with diabetes, the poorer the glycemic control. [145]
- Medication issues and disease monitoring during usual care visits make it difficult to address behavioral issues.

Lack of time limits collaborative discussions and satisfaction
Physicians may fail to provide adequate information and engage in collaborative decision making because they do not have time. [138]

- Length of the office visit is a major predictor of patient participation in clinical decision making [146]; one study found that visits need to be at least 20 minutes to involve patients effectively in decisions. [147]
- Shorter primary care visits associated with lower ratings of patient satisfaction and patient-physician relationship. [148,149]
Lack of training and confidence in behavior change interventions
Physicians’ poor self efficacy and lack of training in behavior change has been shown to obstruct the implementation of lifestyle interventions in primary care. [150-154]

- Few physicians felt very effective in their counseling of smoking, exercise, diet, and weight reduction (25%, 24%, 27%, and 23%, respectively).
- 90% of internal medicine residents were confident in their knowledge about health behaviors, but only 25% were confident in counseling patients. [153]
- Many studies have reported the lack of preparation and confidence in assisting obese patients with weight loss. [24,155-157]
- In another study, more than 90% of physicians were interested in improving their exercise prescribing skills. [158]

Not all patient behaviors are considered equal in terms of the value of intervening, or in the willingness of providers to intervene.
- Smoking cessation interventions are viewed more favorably because evidence of the effectiveness of counseling is stronger, and the process is more straightforward than other behaviors.
- Providers are less confident counseling for weight loss or increasing physical activity; they feel they have much less to offer patients in terms of a specific plan.

Shortage of trained counselors
There is a shortage of clinicians capable of delivering counseling interventions. [52]

- Most physicians have little or no training in counseling, and do not see the time and effort needed for training as worth it.
- And few practices have other staff trained in counseling.
- Providers are unlikely to attempt counseling when they felt unprepared or when patients were uninterested or not motivated.

Lack of effective training programs
Typical passive continuing medical education (CME) methods are not effective for training counseling methods. [52]

- Some professional societies are experimenting with interactive learning on websites but have found that few physicians are currently willing to take advantage of this option.
- Multiple approaches are needed to meet the different training preferences and needs of all involved staff.

Lack of reimbursement is a huge barrier
There is no standard agreed-upon benefit and/or code for counseling as part of routine medical care.

- The lack of benefit standards makes quality control difficult, delivery of services cannot be tracked, and increases vulnerability to fraud and abuse. [1]
- Behavioral counseling is much less likely to happen if services are not reimbursed. [159-161]

Decision-makers (purchasers and medical directors) do not see the value
Counseling is not viewed as distinct from any other conversation between doctor and patient. [52]

- The idea that counseling is a specific service – a protocol-driven interaction that can be effective if delivered correctly and not necessarily by physicians – is a new idea for most decision-makers.

They (decision makers) contend that evidence does not support behavior counseling in routine care.

- The issue of evidence is not straightforward because counseling is not medicine -- evidence comes from disciplines not familiar to health care decision-makers. But the efficacy of counseling is documented in a large number of randomized trials. [52]
- There is a lack of studies of model programs to provide a realistic picture of what it takes to implement counseling.
- The implication is that if evidence were available, counseling programs would be embraced, but the perception of lack of evidence was found to be an excuse for not including counseling. [52]
Lack of an integrated approach to screening and counseling and supportive office systems
A system is needed that helps clinicians and patients address multiple issues in an efficient and productive manner. [162]
- Traditional patient education offers fragmented information and technical skills. [163]
- Patient self-efficacy—confidence to carry out a behavior to reach a desired goal – is not developed. [163]

Chronic care delivery is limited by the lack of office systems to promote the long term process of care. [164]
- Most systems focus on acute needs rather than the on-going process [165]
- Treatment plans focused on isolated conditions rather than entire risk factor profile. [166]

Perceptions of effectiveness:
Many practitioners feel that available evidence on counseling does not apply to them, their patients, or their practices; they believe that research settings do not reflect real world practice. [52]
- Many patients do not believe that changing a particular behavior will benefit them that much. [52]

Physician biases against patients’ motivation or ability to change [167,168]
Cynicism regarding the average patient’s readiness and ability to change well established behavior patterns is widespread. [169,170]
- Physicians often underestimate patient motivation. [171]

Patient misinterpretations
Many underrate their own vulnerabilities; this lowers readiness to change. [172]
- May overestimate the degree of change needed (e.g., amount of weight loss or exercise needed). [173]

Lack of awareness of resources to support behavior change

Disconnect between clinical trial findings and every day clinical practice
A perception that the behavior change literature does not reflect real world primary practice has been cited as part of the resistance to implementing evidence-based strategies. [174-6]
- Integrating these interventions into individual practices requires a process for incorporating and maintaining the strategies and interventions over time. [53,73,177]

Physicians’ resistance to change
Many physicians question the effort required to change their practice systems, and whether it will really enhance patient outcomes. [1]
- There is a lack of established implementation models or strategies for integrating counseling into practice in an efficient manner.
6. STRATEGIES FOR OVERCOMING BARRIERS

DEALING WITH THE LACK OF TIME:

Using a team approach
A team approach is the most commonly recommended and proven strategy to ease the burden on physicians and enhance the care provided to patients.

- Integration of health care staff into practice teams can ease time pressures and improve the quality of life for physicians. [178]
- Clinical staff provide illness care and non-clinical provide wellness and preventive care. [179]
- In larger practices, teams are larger – clinical staff may include physicians, nurse practitioners, physician assistants, nurses, and non-clinical staff may include medical assistants, health educators, behavioral health counselors, pharmacists, other office staff.
- In the smallest practices, teams may consist of only a clinician and one other person, ideally a nurse or health educator, but more likely a medical assistant. [180]

Primary care practices need to be reimbursed adequately to allow the practices to build care teams who can work with physicians to carry out this responsibility. [141]

Extend the clinical visit
Use a post-visit encounter with the coach/counselor to provide education, clarification and counseling. [180]

- The best time to reach patients is as part of their regular clinic visit, expanding the 15-minute visit into a longer encounter, rather than as a separate visit.

Keys to success in this visit include: [181]

- create an individualized approach based on each patient's health risks and habits,
- use other resources (e.g., support groups, registered dietitians), and
- encourage and empower patients to become active participants in change.

Make behavior change the focus of visits
Counseling is more likely to occur when patients make the issue the reason for the visit or explicitly ask for help, OR clinicians view the lifestyle issue (e.g., excess weight) as an exacerbating factor, i.e., “medicalizing” the issue. [111,123,182]

- Making behavior change the focus of visits may also help in coding for reimbursement.

Take advantage of every opportunity
Physicians can impact health behaviors through brief, simple discussions during routine checkups, but only about half are using this opportunity.

- Patients who were asked about their diet were more likely to have changed their fat or fiber intake in the past year than those not asked and were somewhat more likely to have lost weight. [183]

Use group visits for more efficient education and support

- Group visits provide a cost effective method of counseling several patients at the same time; also provide an avenue of support among patients with common conditions. [138,184]

USING A SYSTEMATIC AND ORGANIZED APPROACH:

An office system that integrates lifestyle counseling interventions into routine practice.

- A useful model provides a 4-step plan, beginning with diagnosis and assessment, followed by a series of patient centered counseling sessions in 3-5 minute segments, to guide patients through the behavior change process. [53]
- Considerable effort has gone into developing and testing systems that prompt communications, screening, interventions and follow-up; they have been shown to improve the delivery of appropriate counseling. [185,186]
Office-based quality improvement systems involving some combination of chart prescreening, risk assessment forms, prompts, flow-sheets, reminder/recall systems, patient education materials and redistributing responsibilities among office staff have been shown to increase the rates of providing preventive services. [187]

Use of a Preventive Care Checklist at adult health check-ups that prompted physicians of evidence-based recommendations increased the percentage of patients with up-to-date preventive health services by 23%. [188]

The Put Prevention Into Practice (PPIP) office system is a set of office tools designed to address physician, patient, and system barriers to the provision of clinical preventive services. [189]

- Implementation of the system increased the delivery of selected clinical preventive services after 3 years -- cholesterol screening increased from 70% to 84%, and smoking assessment, from 56% to 80%. [189]

REIMBURSEMENT ENHANCEMENTS:
Receiving reimbursement for preventive services can be facilitated with better understanding of the applicable CPT codes used to bill healthcare services.

- The Agency for Healthcare Research and Quality (AHRQ) partnered with the National Business Group on Health and the Centers for Disease Control and Prevention (CDC) to develop "A Purchaser's Guide to Clinical Preventive Service: Moving Science into Coverage".
- This tool was developed to make it easier for employers and other health care purchasers to develop an evidence-based benefits design for preventive services.
- The purchaser's guide includes CPT codes for the A and B rated USPSTF recommendations. http://www.businessgrouphealth.org/benefitstopics/topics/purchasers/index.cfm

A practical way to pay for chronic care activities is to reimburse physicians for units of service delivered by their team. California’s “Comprehensive Perinatal Services Program” (CPSP) is a good example of a payment mechanism that supports health education and case management services through payments to physician employers. [190,191]

Relevant diagnostic codes for preventive services and counseling can be preprinted on the billing and diagnostic coding sheets and checked off rather than manually documenting the treatment.

- Counseling by itself is a reimburseable activity and can be billed, based on time spent.
- With a diagnosis, examine the possibility of coding for behavior change as part of the management of the disease.
- In other words, “medicalize” the behavior counseling.

CPT codes are available for tobacco and alcohol counseling.

- Some codes are available for physical activity, such as:
  - Pulmonary rehab exercise (4033F), therapeutic exercise for osteoarthritis (4018F), exercise counseling for osteoporosis (4019F), and cardiac rehab (93797).
  - CPT codes generally do not include non-physician services.
- According to the AMA, codes are available for diet change and preventive counseling, but are seldom used and not reimbursed; can bill these services as part of extended visit for chronic disease
- No CPT codes for diet or stress management

The case needs to be made for specific lifestyle interventions (i.e., prescriptions for exercise, diet, stress management, etc) for specific medical conditions (i.e., diagnoses) – so coverage can be defined.

Build the evidence base for behavior change interventions as has been done with smoking.

- In 1997, only 25% of managed health care plans covered any tobacco dependence treatment -- by 2003, nearly 90% did as a result of indisputable evidence of effectiveness. [193]
- By 2005, 72% of states offered coverage for at least one Guideline-recommended cessation treatment. [193-5]

The 2008 Public Health Service (PHS) Tobacco Cessation Guideline update offers a blueprint for changes in health care delivery and coverage for tobacco assessment and intervention as a standard of care in health care delivery, including:

- Providing tobacco dependence treatment as a covered insurance benefit
- Offering training to physicians and nurses to encourage them to counsel patients
- Improving the ability of physicians to document and receive reimbursement for tobacco interventions. [196]

Medicare offers limited health behavior counseling coverage, and only for those with a diagnosed disease – another reason to tie counseling for an older person to a diagnosed condition.

http://www.medicare.gov/Coverage/Home.asp

**ENHANCING TRAINING AND COUNSELING SKILLS**

Continuing medical education (CME) efforts that build clinician skills using interactive, sequential learning opportunities in settings such as workshops, small groups, and individual training sessions appear to have the greatest influence on clinician practices and patient outcomes. [80]

- Even relatively brief physician training along these lines (2 to 3 hours) can improve the delivery of clinical preventive services. [112,112a]

Training may occur by clinicians in the practice or by outside trainers.

- A number of PCPs have successfully trained medical assistants to be health coaches. [180]
- Training may range from 15-minute individual training sessions to 2- hour workshops. [198]

Continuing education for practice staff combined office systems enhancement has been shown to be effective in increasing rates of delivery of preventive care. [197]

Practice change consultants have been shown to improve the delivery of health behavior services in primary care.

- Nurse consultants helped clinicians and staff develop a practice-specific protocol so that they could identify and intervene with the health behavior of their patients. As a result, health behavior delivery was improved. [199]

**Use, and train staff in using, a consistent counseling protocol.**

The USPSTF recommends the "5A's" construct (assess, advise, agree, assist, and arrange-follow up) to provide a unifying conceptual framework for describing, delivering, and evaluating health behavioral counseling interventions in primary healthcare settings. [162]

**Training for Goal Setting and Action Planning**

Bodenheimer and his colleagues at the University of California, San Francisco have developed, tested, and modified training materials for goal setting and action planning and have used these materials with physicians, nurses, health educators, health professional students, and patients who are peer leaders of chronic disease self-management classes. [65]

- 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.
Tools to assist counseling
The Physician-based Assessment and Counseling for Exercise (PACE) program, which utilizes the stages of change theory, provides a valuable framework for exercise counseling. [200,201]

- This program has been shown to be effective in preparing the providers to counsel, and generally acceptable to providers, office staff, and patients. Counseling was provided in less than five minutes by 70% of providers, and most patients reported following the recommendations given. [202]

Two tools, WAVE and REAP, have been developed to help health care providers conduct nutrition assessment and counseling with their patients in a practical and effective manner. [203]

- The WAVE acronym and tool is designed to encourage provider/patient dialogue about the pros and cons of the patients' current status related to Weight, Activity, Variety and Excess.
- The Rapid Eating and Activity Assessment for Patients (REAP) is a brief validated questionnaire that is designed to aid providers in performing a brief assessment of diet and physical activity.
- An accompanying Physician Key aids the provider in discussing the patient's answers and counseling them appropriately. REAP and WAVE can be helpful tools to facilitate nutrition assessment and counseling in the provider office.
- These tools can be used in a variety of ways to discuss nutrition with patients during a clinical encounter in 1-9 minutes.

The Healthy Eating Index also provides a single summary measure of diet quality, thus can be used as the basis for counseling. [204]

BETTER FOCUS IN CHRONIC CARE MANAGEMENT
Make self management support an integral part of chronic disease management
Self-management education for chronic illness is linked to high-quality primary care. [163]

- It requires a new chronic disease paradigm: the patient-professional partnership, involving collaborative care and self-management education.
- Traditional patient education offers information and technical skills; self-management education teaches problem-solving skills.
- A central concept in self-management is self-efficacy--confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems.

Chronic care management

- Is a culturally competent, patient centered approach with interventions tailored to each patient’s unique medical, psychological, and socio-cultural situation.
- Changes the orientation to a chronic care perspective -- a long term, on-going process; the Chronic Care model presents a guide for making this change. [165]
- Includes treatment plans focused on entire risk factor profile rather than on isolated risk conditions.
- Includes the use of registries, multidisciplinary teams, community outreach, interventions that address care transitions, and telephonic outreach have all been shown to improve the quality of care for conditions such as hypertension, hyperlipidemia, diabetes, and coronary artery disease. [169]

New way of thinking - More Conservative Prescribing [205]

- Think beyond drugs
  - Seek nondrug alternatives as first rather than last resort
  - Treat underlying causes, rather than symptoms
  - Look for prevention opportunities, not just treatments
- More strategic prescribing
- Increased vigilance for adverse effects
- Greater caution and skepticism regarding new drugs
- Shared agenda with patients
• Weigh long-term, broader impacts

REFOCUSING EVIDENCE AND GUIDELINES FOR PRIMARY CARE
Clinicians are overwhelmed with clinical practice guidelines and recommendations.
• Greater emphasis needs to be placed on applying guidelines to the type of patients seen in family practice settings—the elderly and those with multiple chronic conditions.
• Disease management and clinical guidelines need to be refocused toward co-morbid illnesses as opposed to single-disease interventions; this is what is seen in primary care, with multiple problems are often dealt with in a single visit. [206]

DEVELOPING RESOURCE NETWORKS
Develop a network of resources to support behavior change.
• Establish community partnerships, teams with other health professionals in the community
• Link to community resources and programs to offer additional opportunities to receive support.
• Identify on-line and telephone support services.
7. THE EVIDENCE FOR HEALTH BEHAVIOR COUNSELING

Unfortunately, the evidence of the effectiveness of counseling interventions in primary care is inconclusive; hence the USPSTF does not recommend routine primary care counseling to increase physical activity, eat healthier, or even to lose weight unless the patient is obese. [18]

- These recommendations form the basis for insurance coverage.

Why is this? Simply the result of evidence.

- The evidence is dominated by minimal interventions. Few studies have investigated the effects of multi-component, multi-provider interventions using proven behavioral techniques with sustained support and sufficient resources.
- There are many factors that seem to increase efficacy but few studies incorporate most of these factors.
- A consistent finding across behaviors is that more intensive interventions, i.e., incorporating the entire 5-A counseling framework, produce better results than brief interventions. [29]

Given the prevalence and impact of unhealthy behaviors, clinicians are still advised to reinforce the importance of healthy behaviors with their patients. (see “Recommendations”)

- And, they are advised to work to improve their counseling skills to assist patients in changing behaviors.

WHAT THE EVIDENCE DOES SHOW

Health Behavior Counseling – can improve behaviors

There is evidence of efficacy for interventions to reduce smoking and risky/harmful alcohol use in unselected patients, and evidence for the efficacy of medium- to high-intensity dietary counseling by specially trained clinicians in high-risk patients.

- There is fair to good evidence for moderate, sustained weight loss in obese patients receiving high-intensity counseling, but insufficient evidence regarding weight loss interventions in nonobese adults.
- Evidence for the efficacy of physical activity interventions is limited. [162]

A systematic review [207] of the effectiveness of counseling to promote a healthy diet among patients in primary care settings found that:

- Dietary counseling produces modest changes in self-reported consumption of saturated fat, fruits and vegetables, and possibly dietary fiber.
- More-intensive interventions were more likely to produce important changes than brief interventions.
- Interventions using interactive health communications, including computer-generated telephone or mail messages, can also produce moderate dietary changes.
- Most studies used a combination of health educators, nurses or dieticians and self-help materials and an office-based organized approach to nutrition counseling

The long-term effectiveness of counseling to promote regular physical activity in the general population is less clear, largely due to a wide range of methods, assessment, patients, etc. [208]

- The efficacy of exercise interventions appears to be enhanced when individualized according to the patient's readiness to change, exercise preferences, or past experiences.

A recent analysis estimated that if the proportion of physicians who provide systematic advice (1-3 minutes) to their smoking patients increased from 60% to 90% would yield an additional 63,000 quitters per year. Coupling the higher advice level with brief (10 minute) counseling assistance would increase annual quitters by a factor of 10 (630,000). [209]
Results of counseling are better when:

- There is more contact – greater intensity results in a more sustained effect. This is well established in the tobacco cessation literature but has also been shown with diet/exercise. [210,211]
  - The Coronary Health Improvement Project (CHIP) is a 4-week course teaching the importance of improving dietary and physical activity behaviors. Behavior improvements were greater at 6 weeks, but persisted up to at least 18 months.
- Counseling is individualized – individualized office-based counseling produced more weight loss than a skill-building approach and cost less than half as much per pound of weight loss. [212]
- The approach is multi-faceted, as in all five steps of the 5A protocol vs. using only a subset of steps. [211,213]

**Collaborative Decision Making – can enhance behavior change**

A participatory relationship between patient and physician is one of the most successful factors promoting healthy behaviors. [214,215]

- Information giving and collaborative decision making have been associated with better adherence to medications, diet, and exercise. [216]
- Patients encouraged to participate more actively in the clinical visit significantly reduced their average hemoglobin A1c levels while controls increased. [217]
- For patients with diabetes, significant associations exist among information giving, participatory decision making, healthier behaviors, and better outcomes. [218-220]
- The more actively the patient is involved, the better the adherence to medications and the greater the chance that the patient engages in healthy diet and exercise. [221,222]

A systematic review comparing collaborative care with usual care in patients with depression showed that depression outcomes were better at 6 months and up to 5 years. [223]

- Better medication compliance was one of the key outcomes that were improved.

Another systematic review found that models of care that focused on quality improvement and collaborative care were more effective than usual care in treating depression in racial and ethnic minority women. [224]

- This review showed that better management of social issues was a key factor in the better outcomes.

Patients who were involved in decisions about their care were nearly three times as likely to be satisfied with their care than those who were not involved in decisions. [225]

A national survey of older adults with diabetes showed the importance of how information was presented and how actively patients were involved in decision-making; both were associated with better overall diabetes self-management. [226]

- Involving older patients in setting chronic disease goals and decision-making were especially important for areas that demand more behaviorally complex lifestyle adjustments such as exercise, diet, and blood glucose monitoring.

**Goal Setting – more effective behavior change**

Studies from non-health-related industries show that a specific goal leads to higher performance than either no goal or a vague goal such as “do your best.” [227]

- Short-term, specific goals are associated with better performance than long-term, general goals. If the feeling of success comes sooner, it increases self-efficacy.
- Self efficacy is associated with goal achievement; Increased self-efficacy results in people setting and achieving higher goals, while reduced self-efficacy—from failing to achieve a goal—may lead to goal abandonment. [228]
- In health-related behavior change, self-efficacy is also associated with healthier behaviors. [228]

Some literature suggests a benefit if patients choose a goal and agree on a concrete action plan that moves toward the goal. [229]
• A review of 92 studies of diet behaviors found that goal setting or action planning was associated with eating less fat, and more fruits and vegetables. [230]
• In another review a third of the studies found a positive effect of goal setting or action planning on diet and physical activity behaviors. [231]

Action planning – increases confidence
According to several studies, when patients can achieve a small success, their self-efficacy (self-confidence in the capacity to make positive lifestyle changes) increases; self-efficacy has been correlated with improved health-related behaviors and clinical outcomes. [232-235]

Team Approach – can improve patient outcomes
Cohesive health care teams have 5 key characteristics: clear goals with measurable outcomes, clinical and administrative systems, division of labor, training of all team members, and effective communication. [236]
• Teams with greater cohesiveness are associated with better clinical outcome measures and higher patient satisfaction.
• Settings in which physicians and non-physician professionals work together as teams can demonstrate improved patient outcomes.
• Barriers to team formation exist, mainly related to personality issues, but taking small steps toward team development can improve the work environment in primary care practices.

A systematic review of 19 studies of the effectiveness of physical activity (PA) counseling in primary care compared interventions by physicians only, by allied health professionals, and combined-provider interventions. [237]
• Interventions that used allied health professionals as adjuncts or alone produced the best long-term results (>6 months).
• More training and more time available to the patient contributed to the difference.

Follow-up – can improve long term outcomes
Patients with diabetes who have regular follow-up have better hemoglobin A1c levels than patients without follow-up. [238]
• The benefits of self-management support for patients with diabetes diminish over time without regular follow-up, and the total time caregivers spend with patients correlates with glycemic control. [239]
• Similarly, regular follow-up is necessary for hypertension management,[240] and it improves outcomes with heart failure. [241,242]

Relationship with physician – can enhance patient self management
Patient trust in the physician has also been associated with improved medication adherence, better health-related behaviors, and continuity of care. [243]

Brief interventions – can have a positive effect
Brief interventions integrated into routine primary care have been shown to have a positive effect on most risk behaviors. [29]

The strongest evidence for the efficacy of primary care behavior-change interventions comes with smoking cessation [18,244] and, to a lesser extent, problem drinking [18,245].
• Some evidence also shows the effectiveness of similar interventions for other behaviors. [18,29]
• However, effective interventions typically use additional resources to assist patients in undertaking advised behavior changes. [244,247]

A health risk appraisal (HRA) with feedback, alone or in combination with single-session counseling by a clinician, is generally not effective in producing behavior change. [248]
Increasing effectiveness with increasing contact time
Even though 1-3 minutes of advice and counseling have been found to double smokers' 6-month quit rates; Increasing total contact time to more than 30 minutes doubles the long-term quit rates.

- Time-intensive interventions and more numerous contacts produce even better effects. [244]

Office systems – can improve delivery of counseling
Office-level system supports (prompts, reminders, and counseling algorithms) have been found to significantly improve the delivery of appropriate dietary counseling by primary care clinicians. [249-251]

- Systematic, routine identification and assessment is the foundation for proactive behavioral counseling interventions. Having a system in place to identify and document tobacco-use status triples the odds of clinician intervention. [244]

Chronic Care Model -- can enhance quality of care
Thirty-two of 39 studies found that interventions based on chronic care model components improved at least 1 process or outcome measure for diabetic patients, such as improved glucose monitoring or medication compliance. [252]

- Eighteen of 27 studies concerned with 3 examples of chronic conditions (congestive heart failure, asthma, and diabetes) demonstrated reduced health care costs or lower use of health care services.

A systematic review of RCTs investigating the effectiveness of disease management programs (DMP) compared with usual primary care showed that DMP had a significantly better effect on patient satisfaction and adherence to the treatment regimen. [253]

- DMP significantly enhance the quality of care for depression. Costs are within the range of other widely accepted public health improvements.

Medication Compliance – can improve disease control
The best improvements in compliance and persistence with medication prescriptions for patients with chronic diseases comes with repeated face-to-face self management counseling with clinicians or other trained staff. [254]

Case Manger Approach – can enhance clinical outcomes
A systematic review of studies that investigated the effectiveness of using case management for major depression showed significant improvements in outcomes. [255]

- More likely to achieve remission after 6-12 months [1.4 times the control group]
- Better medication adherence [1.5 times the control group]
- More likely to achieve a clinical response [1.8 times control]

A case manager approach has been shown to improve overall care (educations, communication, compliance, testing, etc) with other chronic conditions as well. [256]

Planned Visits – can enhance clinical outcomes
Ample evidence, particularly for diabetes, shows that planned visits are associated with improved outcomes, including control as well as clinical events and hospital use. [257-261]

One review of nurse-led programs concluded that nurses "can replace physicians in delivering many aspects of diabetes care, if detailed management protocols are available, or if they receive training." [261]

Self Management Support – can enhance clinical outcomes
Increasing evidence shows that self-management support reduces hospitalizations, emergency department use, and overall managed care costs. [7,232,262,263]

Evidence from controlled clinical trials suggests that focusing on self-management skills is more effective than information-only patient education in improving clinical outcomes and reducing costs. [163]
8. THE COUNSELING PROCESS

Traditionally, physicians have counseled patients to change behavioral habits by providing information depending on their professional credentials (expert power). [264]

- However, research shows that education alone is unlikely to elicit behavioral change. [264]
- Need to move from a traditional advice-giving role to using 'behavior change skills' in a counseling process. A wide range of skills and strategies can be used to facilitate the discussion.
- Individualized behavior change counseling can be effective when simple directive messages fail. [265]

Two keys to effective counseling in family practice are: [266]
1. Using a patient-centered, or collaborative, approach, which allows for advice and planning tailored to the individual, and
2. Continuity of care, which allows the family physician to present and reinforce advice consistently over time.

- Physicians should approach patients with advice and counseling in "ready bits" that fit into the time constraints of regular consultations and make sure these bits are consistent over time and address specific individual patients’ values and barriers. [267]
- Patient-centeredness is promoted by using patients’ expressed readiness to change.

Goal Setting and Action Planning

Goal setting with action planning is also a key part of engaging patients in the process. [212]

- The American Diabetes Association, the American Association of Diabetes Educators, and the American Heart Association all recommend goal setting for cardiovascular disease risk reduction.
- 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 management of the patient's condition. [65]

It is a collaborative process -- patients choose a behavior-change goal. To initiate a discussion about goal setting, ask:
- "Is there anything you would like to do this week to improve your health?"
- This question allows patients to choose a behavior they are motivated to change and forms the basis for setting a behavior-change goal. [268]

After a patient has agreed on a general goal, the patient and caregivers negotiate a specific action plan to assist in goal attainment. [65]

General goals occur over a longer period of time; short-term goals are intermediate goals on the way to the overall goal; action plans are specific steps for achieving specific short-term goals. [65]

- Goals are often perceived as difficult to attain; action plans should be seen as doable.
- For example, a general goal may be to lose 40 pounds, a short-term goal may 5 pounds; an initial action plan may be to substitute water in place of sugar-containing sodas, and walk 20 minutes every day.
- 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).
- Ask patients to estimate, on a 0-10 scale, how confident they are that they can carry out their action plan. They should be at least 7.
- If less than 7, the action plan can be adjusted until the confidence level is 7 out of 10. Action plans can be agreed on orally or using a written form.

Specific goals lead to higher performance than either no goal or vague goals. [65]

- Specific short-term goals are associated with better performance than long-term and general goals.
- Increased self-efficacy results in people setting and achieving goals, whereas reduced self-efficacy—from failing to achieve a goal—may lead to goal abandonment. [269]
• In health-related behavior change, self-efficacy is also associated with healthier behaviors. [29]

**Follow-up and Problem Solving**
Many studies find that regular and sustained follow-up is a necessary component of this method. [See Evidence]
• Follow-up can be conducted by telephone, by e-mail, through Internet-based interactive programs, individually, or in groups. Follow-up includes problem solving related to barriers to success in carrying out action plans. [270]
• Lack of success is translated into “lessons learned” instead of failure.
• An advantage to group programs, as occurs in the well-established Chronic Disease Self-Management Program, is the support; patients can “buddy up” and problem solve with each other by telephone. [232]

**Using a Referral Network**
• For a small practice, without trained staff, implementing the entire 5A framework can be difficult, but the practice’s team does not have to be limited to office staff. [213,271]
• Developing relationships and referral linkages with local, or national (e.g., quit lines) programs to promote healthy behaviors can maximize limited resources and help bridge any gaps in practice services.
• Tobacco cessation programs offer examples for how clinical and community resources can be linked.
• New approaches for linking resources have been tested in practice-based research networks. For more information, go to the AHRQ Innovations Exchange at [http://www.innovations.ahrq.gov/learn_network/resources-for-linking.aspx](http://www.innovations.ahrq.gov/learn_network/resources-for-linking.aspx).
9. STAGE OF READINESS

Patients vary in their readiness to make behavior changes and behavior-change strategies should be tailored to an assessment of "stage of change." [272]

- At any specific time, patients are in one of five discreet stages of change: precontemplation, contemplation, preparation, action, or maintenance.
- Patients move from one stage to the next in the process of change and, in fact, patients may repeat stages several times before they achieve lasting change.

Interventions are best tailored to patients' readiness to change to enhance their progress and use of resources more effectively. [273]

- This requires an accurate assessment of patients' stage of change, followed by specific stage appropriate counseling messages.
- Attempting to promote change when not ready is frustrating and doomed to failure, and it undermines the individual's self efficacy and lowers expectations of health professionals for future attempts. This promotes the vicious cycle of failure and self blame. [274]
- Readiness can be viewed as the balance of two opposing forces: motivation, or desire to change, and resistance to change. [269]

Some clinicians ignore unhealthy behaviors in precontemplative patients. [275]

- This could lead clinicians to avoid all behavior change discussions with patients they believe the patients will fail.
- But in some situations, patients lack motivation because they fear failure.
- The action planning process may still be viable as long as the agreed upon change is simple enough that the patient feels he/she has a high probability of success. [276]
- This may convert some precontemplative patients to the action stage.

Promoting Continuity of Care

Documentation of the patients’ current stage of readiness has been shown to promote continuity of care among providers, which is a key to successful behavioral interventions. [277]

### APPLYING THE STAGES OF CHANGE MODEL TO ASSESS READINESS [274]

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristic</th>
<th>Patient verbal cue</th>
<th>Appropriate intervention</th>
<th>Sample dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>Unaware of problem, no interest in change</td>
<td>&quot;I’m not really interested in weight loss. It’s not a problem.&quot;</td>
<td>Provide information about health risks and benefits of weight loss</td>
<td>&quot;Would you like to read some information about the health aspects of obesity?&quot;</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Aware of problem, beginning to think of changing</td>
<td>&quot;I know I need to lose weight, but with all that’s going on in my life right now, I’m not sure I can.&quot;</td>
<td>Help resolve ambivalence; discuss barriers</td>
<td>&quot;Let’s look at the benefits of weight loss, as well as what you may need to change.&quot;</td>
</tr>
<tr>
<td>Preparation</td>
<td>Realizes benefits of making changes and thinking about how to change</td>
<td>&quot;I have to lose weight, and I’m planning to do that.&quot;</td>
<td>Teach behavior modification; provide education</td>
<td>&quot;Let’s take a closer look at how you can reduce some of the calories you eat and how to increase your activity during the day.&quot;</td>
</tr>
</tbody>
</table>
**APPLYING THE STAGES OF CHANGE MODEL TO ASSESS READINESS**

<table>
<thead>
<tr>
<th>Stages</th>
<th>Description</th>
<th>Support</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>Actively taking steps toward change</td>
<td>Provide support and guidance, with a focus on the long term</td>
<td>“I’m doing my best. This is harder than I thought.”</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Initial treatment goals reached</td>
<td>Relapse control</td>
<td>“I’ve learned a lot through this process.”</td>
</tr>
</tbody>
</table>

Assessing Stage:
How ready are you to try to … [lose weight the right way, begin an exercise program, stop smoking, etc]?
- “When do you want to begin?” – This is the key question. If the answer is anything but “right now” then he/she is not ready, and the counseling shifts from planning to increasing motivation and reducing resistance (perceived obstacles).

Assessing Readiness: One method to begin a readiness assessment is to anchor the patients’ interest and confidence for change on a numerical scale. Simply ask your patients:
- “On a scale from 0 to 10, with 0 being not as important and 10 being very important, how important is it for you to … [lose weight, become more active, etc] at this time?”
- “Also, on a scale from 0 to 10, with 0 being not confident and 10 being very confident, how confident are you that you can … [lose weight, stop smoking, become more active, etc] at this time?”

Another efficient method to assess patient readiness is to use targeted questions, such as:
- “What is hard about … [e.g., managing your weight, smoking, etc]?” This open-ended question acknowledges that the behavior is difficult and conveys an interest for further understanding.
- “How does … [being overweight, unfit, smoking]… affect you?” This question probes the burden of the behavior. Common answers refer to appearance, self-esteem and image, physical ailments, and quality-of-life issues.
- “What can’t you do now that you would like to do if you … [e.g., weighed less, were more fit]?” This question provides useful information regarding expectations and benchmarks for assessing progress.
- “What would you like to get out of this visit regarding your … [e.g., weight, activity habits, smoking, etc]?” This question directly addresses patients’ expectations related to how you can assist them in change.
10. MOTIVATIONAL INTERVIEWING

Motivational interviewing is an approach to counseling and decision making intended to help patients come to their own decisions by exploring their uncertainties. [279]

- The interviewer uses directive questions and reflective listening to encourage the patient to participate. It is about asking the patient provocative questions and discussing the responses, which can help to uncover important self-management issues.
- It generally requires some training, so if practitioners are not able/willing to get this training it might be best to develop an affiliation with someone who is trained in the technique.

Counseling techniques of motivational interviewing: [279-281]

- **Use nonjudgmental, nondirective** questions and comments about the issues, e.g., a high BMI:
  - “Your BMI is above the 95th percentile. What concerns, if any, do you have about your weight?”
  - Next step depends on the response. This differs from a directive style, in which you inform the patient of the seriousness of the condition.
  - “Your BMI is quite high, so it is important to get your weight under control before it becomes a bigger problem. What is your understanding of the potential problems?”

- **Use active listening** to convey sincerity and establish rapport:
  - Nonverbal communication is key; look into their eyes to express empathy.
  - Reflect the patient's emotional tone - shows that you understand how they feel.
  - Framing to show that you understand what your patients are telling you -- “Let me see if I have this right: …”
  - Request clarification and confirmation to acknowledge that they are important partners -- e.g., “Is there anything I left out today?” or “Does that sound right to you?”

- **Use reflective listening** to uncover the beliefs and values:
  - So, it sounds like you have a pretty good understanding of some of the potential health problems. Would you like to talk about some ways that you could get down to a healthier weight? How ready are you to try to make a change or two (1-10 scale)? Are there things that you would like to do to (lose some weight)?

- **Use reflective listening again** to uncover barriers to change:
  - Summarize his/her comments without judgment.
  - For example: “If I heard you correctly, you know you need to get more exercise, but you really don’t like to exercise, so you’re not really ready.”
  - Reflections help build rapport and allow the patient to understand and to resolve ambivalence.

- **Elicit concerns** of patients.

- **Compare values** and current health practices:
  - If the patient values being healthy, then help him/her examine some different types of activities that he/she might enjoy, and be willing to try.

- **Use a shared decision** approach - Evoke motivation, rather than trying to impose it.
  - What might need to be different for you to consider making a change in the future?
  - Could I give you some information about healthy activities [i.e. food choices] to help you think about this?

- **Help patient put together a plan** that is consistent with this/her values.
  - This avoids the defensiveness created by a more-directive style.

- **Make sure he/she understands the plan**:
  - Use the “teach-back method” -- ask patients to explain to you what they have just been told, what their plan is.

- **Close the Encounter**:
  - Summarize: “Let’s look at what you’ve worked through”
  - Show appreciation: “Thank you for being willing to discuss this!”
  - Express confidence: “I know that you can do this!”
  - Arrange follow-up
11. THE 5A’S PROTOCOL

No simple empirically validated model captures the range of intervention components across risk behaviors, but the Five A’s construct—assess, advise, agree, assist, and arrange—adapted from tobacco cessation interventions in clinical care provides a workable framework. [29]

- It was developed by the US Public Health Service for smoking cessation [244], and is the approach to counseling recommended by the USPSTF. [18]

It enables physicians to deliver brief, individually tailored behavior change messages to patients. [282]

- Assess – current behavior, importance of changing it, self efficacy, stage of readiness, social support
- Advise – clear, specific, and personalized behavior change, including information about personal health harms/benefits.
- Agree – collaboratively on the behavior to target (may be several), next steps based on stage of readiness
- Assist – self-help and/or counseling including goal setting and action planning to develop skills, confidence, support to achieve goals
- Arrange – follow-up (in person or by telephone) to discuss progress, barriers, adjusting plan

**Readiness to change** -- used to assure that the counseling provided fits the mindset of the patient and family.

- Stages represent cognitive stages that lead to behavior change. [283]
  - Precontemplation – An individual may initially be unaware of the problem – focus on why the change is important
  - Contemplation – Individual is becoming aware of the problem but still has no plans to address it – stress pros and cons, benefits
  - Preparation – Individual is planning for the new behavior – focus on getting started, steps and goals
  - Action – Finally the individual is beginning the new behavior – focus on strategies for success
  - Maintenance – Encourage continued behavior – anticipate obstacles and prepare for them
  - Relapse – Assist the person to identify what caused the relapse and set goals to resume the desired behavior

Studies have shown that primary care physicians can be trained in the 5A’s approach and can effectively use it to counsel patients in an office-based system. [29,250,284]

**STRATEGIES FOR USING THE FIVE A’S** [29]

**Assessment Strategies**

Ideal assessment strategies for clinical practice settings are feasible, brief, and able to be interpreted or scored easily and accurately.

- Ranges from a few focused questions added before the clinician visit (e.g., "Have you used tobacco products at all in the last seven days? If yes, are you seriously thinking about quitting in the next 6 months? If no, have you used them in the last 6 months?) to more comprehensive tools, such as health risk appraisal (HRA). [See Section _ “Stage of Readiness”]
- An HRA can be a low-cost, easy method to gather data systematically about a variety of modifiable health behaviors and related factors.
- Most behaviors besides tobacco use—such as poor diet, physical inactivity, or risky sex—are complex to assess because clinicians need details about usual practices, both to identify individual candidates for intervention and to measure their progress.
- A brief assessment by telephone in advance of the clinic visit has been shown to produce reasonably accurate results.
Advice Strategies
Clinician advice primarily gives the cue to action, while other health professionals provide the details.

- The clinician is a uniquely influential catalyst for patient behavior change and is best supported by a coordinated system to accomplish and maintain that change.
- Using minor qualifications such as, "As your physician, I feel I should tell you," for an advice message, rather than "You should," is a subtle but powerful way to convey respect for, and avoid undermining, patient autonomy.
- Effective advice has several important elements, including being personalized (to laboratory or physiological test results), normative (compared with results of others), and ipsative (compared with one's previous scores).

How the advice is delivered matters—a warm, empathetic, and non-judgmental style elicits greater cooperation and less resistance.

- A respectful, individualized approach first considers patient interest in change before warning about health risks.
- Emphasize confidence in the patient's ability to change the behavior; acknowledge previous successes in making changes (builds self-efficacy).
- Advice message can be brief (30 to 60 seconds).

Agreement Strategies
Agreement leads to collaboration to define behavior-change goals or methods. Determining stage of readiness helps frame the rest of the intervention.

- If not ready to take action, assistance will aim to bolster confidence and readiness, and address barriers to change.
- If ready to take action, behavioral counseling focuses on goal setting and action planning along with dealing with potential obstacles.

For many behaviors, a few brief questions such as "How important is it for you to..." or "How confident are you that you can..." easily assesses motivation and confidence to change a particular behavior.

- It can engage even a minimally interested patient in a nonthreatening way that may also increase knowledge, self-confidence, and motivation.
- Actively engaging agreement before proceeding with counseling reduces resistance.

Agreement considers the options available for the selected behavior change goals, based on preferences, perceived needs for skill training and support.

Assistance Strategies
Primary care interventions seek to teach self-management and engage problem-solving/coping skills, thereby clearing the path for the next immediate step(s) in the targeted behavior change.

Behavior-change counseling is usually provided by other health care staff within the clinic or outside in the larger health care system or community.

- Assistance techniques vary with the behavior and the patient's needs but include practical counseling (problem-solving skills training) to replace problem behaviors with new behaviors and to tackle obstacles to change.
- Also includes guidance in obtaining support, providing self-help materials, and the proper use of any other medical therapy.
- Behavior-change techniques that may be useful include modeling and behavioral rehearsal, contingency contracting, stimulus control, stress-management training, and the use of self-monitoring and self-reward.

In most primary care settings, behavior change assistance is spread across clinical staff (e.g., clinician, nurse, medical assistant, and receptionist).

- Using diverse, complementary intervention methods improves the feasibility and effectiveness of behavior change assistance.
• In some situations, staff outside the clinical setting provide written and telephone counseling that provides feedback to the provider or medical chart.

Arranging Implementation and Follow-up
Some form of routine follow-up assessment and support is always necessary; it is usually through telephone calls, but may also include repeat visits.
• Simply notifying patients that follow-up will occur, and additional assistance is available if needed, can be a powerful motivator.
• Provides support for the behavior-change plan and helps deal with obstacles sooner rather than later.
• The first four A’s (assess, advise, agree, assist) are usually briefly reviewed taking into account the patient's intervening efforts, experience, and current perspective.

In general, follow-up is best scheduled within a relatively short time period (e.g., one month), although timing varies with behavior (e.g., only a day or two after a quit-smoking date).
• Future contacts are spaced at successively longer intervals to maintain continuity in a gradually reduced manner.

It is important to track individual progress and monitor the effectiveness of the intervention.
12. BRIEF INTERVENTIONS

Brief interventions are those that are designed to fit into everyday practice without system redesigns. Such simple interventions have been shown to produce meaningful changes in a growing number of behavioral risk factors. Generally include only advising patients in a specific behavior change, presenting options and then referring them to a program. [29]

The most basic level of brief intervention consists of a simple statement or two. [285]
- The clinician states that he or she is concerned about the patient's behavior, e.g., drinking, that it exceeds recommended limits and could lead to alcohol-related problems, and the clinician advises the patient to cut down or stop drinking.
- A systematic review of 34 studies found that people who received brief interventions when they were being treated for other conditions consistently showed greater reductions in alcohol use than comparable groups who did not receive an intervention. [286]

Advantages of brief interventions
The advantages of brief interventions are that they:
- are easily incorporated into a family practice
- are delivered by familiar people in a familiar setting
- require minimal, if any, training
- are a lower cost alternative to more intensive treatment

Supplemental handouts may be provided to provide some additional guidance. [287]
- Clinicians can follow up at a later date, either in person, through the mail, or by phone.
- If the brief intervention does not work, clinicians can always recommend a more intensive intervention.

Motivational interviewing can help with reluctant patients
The next step in an office visit for a resistant patient is to add some motivational interviewing. [279]

Effective interventions generally include all of the following: advice, feedback, goal setting, and additional contacts for further assistance and support.
- The elements in effective interventions are generally consistent with the 5 A's (assess, advise, agree, assist, arrange) approach to behavioral counseling interventions adopted by the USPSTF. [29]

Since most effective interventions have been multi-contact ones, they also provide further assistance and follow-up. A few also report tailoring intervention elements to each participant. [288-290]

Advances in delivering brief interventions
Many of the obstacles involved in administering brief interventions—such as finding the time to administer them, obtaining the necessary training, and the cost of the interventions—can be reduced by developing technology.
- Patients can use computer programs in the waiting room or at home, or access interventions over the Internet, which offers privacy and the ability to complete the program at any time of day. [291,292]
- Another option is “video doctor technology,” in which an actor–doctor asks health questions in an interactive computer program. Pilot results of this program indicate that users are more comfortable consulting a doctor in person, but view the “virtual” doctor intervention positively. [293]
13. ENHANCING CHRONIC DISEASE SELF MANAGEMENT SUPPORT

The management of chronic conditions requires a partnership between the healthcare team and the patient living with the chronic condition.

- It is something that most practices and reimbursement systems are not set up to provide.
- And, it is perhaps the greatest challenge confronting primary care physicians. [294-297]

Collaborative Care
Collaborative care appears to be the most effective model for chronic care management because it addresses system weaknesses, particularly those associated with follow-up care. [163,298,299]

- It involves structured care relying more on non-medical specialists to augment primary care.
- It seems well suited to the management of more complicated bio-psychological issues such as depression, which often also have associated co-morbidities.

The Chronic Care Model
The Chronic Care Model is a guide to high-quality chronic disease management within primary care. It recognizes the changes needed to organize health services for people with chronic conditions, and offers a guide for improving practice performance. [300]

- It has been endorsed by the AAFP, along with health care organizations all over the world. [300]
- The model emphasizes office redesign and the use of non-physician staff to provide counseling on self management tasks, follow-up, assuring understanding of instructions, scheduling, etc. [236,301-303]
- The goal is the development of prepared, proactive teams that prepare and partner with informed, activated patients. [7]
- Due to time constraints, physicians have no choice but to create teams, either within the practice or using community resources, along with well written educational materials to help patients modify certain behaviors.

The Chronic Care Model focuses on improving performance in six interrelated components: [7,300]

1) Self management support – the key to effective chronic care
   - To assist patients in becoming better informed and activated self managers
   - Includes providing encouragement and information, teaching specific skills, promoting healthy behaviors, teaching problem solving skills, assisting with emotional support, maintaining regular and sustained follow-up

2) Practice re-design – two elements are required to provide self management support:
   - Planned visits – using a pre-determined agenda; can include individual or group visits, phone calls or emails, internet programs
   - Care teams – identify roles, provide needed training; includes clinicians, nurses, dietitians, social workers, behavioral health professionals, health coaches, exercise therapists, community health workers

3) Decision support -- using evidence-based recommendations and guidelines
   - Chart reminders for recommended services and
   - Electronic record protocols for referrals to specialists

4) Clinical Information Systems – to track care
   - Develop registry – patient list with preventive and chronic care needs and relevant clinical information
   - Team member designated to periodically review, update, identify needed services, reminders to send out
   - Separate registries can be created for patients with the Metabolic Syndrome, or other chronic conditions, or other specific criteria

5) Health care organization – two key elements required to redesign the practice:
   - Leadership – understand and embrace the Chronic Care Model
   - Financing – comprehensive per-patient payments rather than fee for service financing, which usually does not reimburse ancillary services
6) Community Resources
   - Primary care practices can rarely provide all of the services needed for patients with chronic conditions – need to know and encompass local resources to fill the gaps in promoting healthy lifestyles

Self Management

*Self-management* is what patients with chronic conditions do every day: decide what to eat, whether to exercise, if and when they will take medications. [304]

- All patients self-manage; the question is whether they make changes that improve their health-related behaviors and clinical outcomes.
- For patients to make daily decisions and choose actions that favor healthy behaviors, they need to be informed about their chronic condition and activated to take on the role of their own manager.

*Self-management support* is what health care professionals do to assist and encourage patients to become informed and activated. [304] It involves:

- Teaching patients about their chronic condition (helping them become informed), and
- Encouraging them to become activated by including them in medical decisions in a collaborative manner.

Planned visits improve self management

Self-management support happens much easier with planned visits that are focused on self management skills and education. Planned visits are encounters with one agenda: the management of the patient's chronic condition(s). [304]

- Patients must understand that these visits must be focused on chronic care.
- Visits are often scheduled with a care manager (e.g., nurse, health educator) rather than physician.
- They can be done individually or in groups.
14. CHARACTERISTICS OF SUCCESSFUL PRIMARY CARE PROGRAMS

A committee of experts in health behavior and prevention, along with staff from the Blue Cross and Blue Shield Association, Bureau of Primary Health Care and American Association of Health Plans, identified 45 model prevention programs and interviewed their directors. Most (37) were in managed care organizations, and were part of not-for-profit systems (38). [52]

Factors that were consistently found in successful health behavior counseling programs in routine medical care were: [52]

PLANNING
- Followed a model of specific steps.
- Enthusiastic physician support.
- Senior staff leadership in the program.
- A program champion to coordinate.

OFFICE SYSTEMS
1. Program goals outlined in business, strategic and quality improvement plans.
2. Programs supported by internal budgets.
3. Counseling programs fully integrated into care.
4. Clinical information system that identifies patients for counseling, prompts providers, monitors services and outcomes, follows patients over the course of care and provides feedback to both patients and providers.
   - Prompting may be as simple as a sticky note on a chart, or as high-tech as a personalized computer printout at each visit.
   - Follow-up is based on the issue addressed (i.e., less frequent for immunizations, more frequent for smoking cessation).
5. Computer systems linked and integrated.
6. Internal workshops provided to keep up with training needs.

STAFF
1. Committed to providing the services; believe in the value of counseling to patients.
2. Team orientation -- staff know and understand their specific roles and responsibilities.
   - Each step of the process is clearly defined and each staff member is prepared for their part.
3. Physicians’ role in counseling varies -- often provide only brief screening, advice and referral; but their enthusiastic “prescription” of counseling is essential.
   - Nurses, health educators, and other staff provide counseling, coaching and follow up.
   - Information systems specialists and fulfillment and/or mailroom staff target patients for sending out information.
   - Other support staff are responsible for specific tasks -- identifying needs, prompting physicians, entering information, etc.

PROGRAMS
1. Tangible, practical instructions and methods of counseling are provided.
   - Training in counseling methods provided.
2. Use formal protocols, such as the 5A, to deliver prevention services.
3. Systematic follow-up to document effectiveness, track progress, allow necessary adjustments.
   - Includes evaluation of outcomes of counseling (e.g., quit rates for smoking, immunization rates, levels of physical activity, screening rates) to document effectiveness.
   - Some programs gather data on a broader range of measures, e.g., hospitalization rates, cost to provide the program, participant satisfaction and overall health outcomes.
4. Telephone follow-up plays a key role.
5. Have established links with community resources to fill gaps in the practice services.
FOUR KEYS FOR SUSTAINING PROGRAMS IN THE LONG RUN: [52]
1. Continued physician support and organizational commitment, including senior leadership.
2. Monitoring and feedback to senior management.
3. Demonstrated effectiveness in changing behavior, reducing risks and improving health outcomes.
4. Accountability for costs of implementing and sustaining programs.

PROGRAM EXAMPLES

The Pressure System Model
A more efficient counseling model proposed by Katz for the primary care setting. [269]
- It focuses on the balance between each patient’s motivation and resistance to change.
- Clinicians use patients’ barriers and previous failures in behavioral change to reduce resistance to change.
- Two to three questions are used to assess stage, then brief, targeted messages are delivered for each stage.
- Physicians trained in the model were shown to be 1.5 times as likely to provide physical activity counseling, and patients they counseled significantly increased their activity levels. [305]

The “Teamlet” Model
Bodenheimer proposed the teamlet model for addressing health behaviors in primary care. [306]
- A “teamlet” is a subset of a larger team, hence suitable for smaller practices.
- It consists of a clinician and one other person, ideally a nurse or health educator, but more likely a medical assistant.
- A medical assistant would need training in teaching disease-specific skills, goal-setting and action planning, and performing follow-up.

The model has two key features aimed at offloading routine tasks and coaching from the clinician so he/she can focus on the patient’s needs:
1. the patient encounter involves 2 caregivers – the clinician and a health coach (or whatever name the practice wants to use)
2. the usual 15-min visit is expanded to include a pre-visit, post-visit and between-visit follow-up by the health coach.

Medical assistants or other staff are trained in the health coach role – primarily involving behavior counseling and chronic disease self management.
- Prior to the pre-visit clinician and coach agree on clinical goals for encounter.
- Pre-visit: coach discusses with the patient in the exam room the visit agenda, what the patient wants to address, basic history, medication use, indicated chronic disease and preventive services.
- Visit: coach documents clinician orders, advice; fills out forms and provides any other assistance
- Post-visit: coach recaps the clinician’s advice, clarifies any confusion, reviews needs for self mgmt and behavior change, engages in goal setting and action planning, arranges follow-up.
- Between visits: coach calls or e-mails to check progress, problems

To try the program:
Begin with one clinician and two medical assistants; use the approach for 1 or 2 half days a week for chronic care or behavior change visits. [306]
- First step is training the assistants in the coaching role; there are options for training.
- Begin by simply by adding a pre-visit or including the coach in the visit, or add the post-visit.

Group medical visits
The use of group visits is an innovative approach to improve the care of patients with chronic conditions that allows available resources to be used more efficiently. [307]
- May be an alternative to ambitious practice redesign by providing an element of care coordination, and the opportunity to set up patient registries.
May be used in place of or in addition to usual one-on-one primary care. Sessions may last from 60 minutes to several hours and typically include 3-20 patients. They are different than group education, which focus exclusively on self management, exercise and diet, but not medical management or coordination of care needs.

A newer approach to group visits includes both of these; the purpose is for medical management, but providers do not "drive" the care. Using a nondirective approach, patients are offered choices and are included in the decision-making process.

- Most successful group visit programs include an element of between-visit care coordination and case management, typically provided by a nurse or nurse practitioner.

The draw for patients is the better access self management interventions, and the sharing with other patients and learning from their experiences. [307]

- Physicians benefit from the change of pace and the chance to more thoroughly address issues associated with chronic conditions common in primary care.
- Improved satisfaction has been reported for both patients and clinicians, along with better quality of care and reduced emergency department and specialist visits.

Two organizational models were presented:

- 90-minute nurse-practitioner led group visit of 6-9 patients, and
- Preliminary medical assistant visit followed by three patients seen together by the physician in an hour long session.

Standardized materials have reduced the effort needed to develop a curriculum even for underserved and low-literacy populations. [308-310]

- A useful overview of the nuts and bolts of organizing 90-minute shared medical appointments has been published by Bronson and Maxwell, based on experience at the Cleveland Clinic, which has been found to improve both physician backlog and the satisfaction of patients and clinicians. [308]
- An approach for a mini-group visit is described in the paper by Langford et al. [309]

One approach to group visit billing has been to use the office visit Evaluation and Management methods used in standard one-on-one office visits. [307]

**Group behavioral visits**

A different approach to group visits is focusing not on a single disease state but on a specific behavior change. [311]

- 90-minute group visits with small groups of invited patients discuss basic nutrition, exercise, assertiveness and communication skills, but the two main thrusts are goal setting and problem solving.
- Content of each visit is based on the perceived needs of patients; preparation for the group visit is similar to that for any visit.
- Goal setting begins with selecting an achievable goal, confronting the perceived risks and benefits of their behavior, creating an action plan, monitoring and learning how to deal with failures along the way.
- Each patient in the group gets a brief private visit during the group session.
- Billing is based on the content of each individual visit
- Patient response to group visits has been overwhelmingly positive.
- And, there was a minimal financial difference between traditional and group visits, similar to other findings. [312]

**The Action Plan Project**

*From the Department of Family and Community Medicine, University of California at San Francisco School of Medicine*

An evaluation of the effects of training clinicians in the use of a collaborative “action plan discussions” with patients. In this discussion the clinician:
• Asks the patient to set a goal for a behavior they wish to change to improve their health.
• Engages the patient in a discussion of an action plan that can help fulfill the goal.
  o The action plan is concrete and specific; for example, the goal may be to lose 10 pounds; an initial action plan may be to substitute water in place of sugar-containing sodas.
• Once a specific action plan is agreed upon, ask patients to estimate, on a 0 to 10 scale, how confident they are that they can carry out the action plan.
  o If the confidence level was < 7, the plan is revised until the confidence level is at least 7.
• Once the target confidence level is achieved, specifics regarding the action plan (what, when, how often, etc) were recorded on an action plan form. The Action Plan Form: www.familymedicine.medschool.ucsf.edu/research/research_programs/actionPlan.aspx

Clinicians were trained for 45 to 60 minutes, individually or in groups about the goal-setting concept and how to negotiate action plans with patients. Scripted and impromptu role plays were used to demonstrate examples of discussions. Training materials are available: http://familymedicine.medschool.ucsf.edu/community_service/actionPlan.aspx
[bodenheimer@fcm.ucsf.edu]

This project was the first to examine how action planning takes place in primary care. Previously, action plans have been studied in chronic disease self-management classes separate from primary care. [232]

Results showed that collaborative goal-setting can be accomplished during a primary care visit despite several barriers; a majority of clinicians found the action plan concept helpful in discussing behavior change with patients. [313]
• 47% rated the goal-setting discussions as more satisfying than previous behavior-change discussions with the same patient (7% less satisfying).
• 56% reported that the action plan training made it easier to discuss behavior change with their patients (10% harder).
• 74% reported that the training changed the way they discuss health behavior with patients;
• 82% said they would continue to use the action plan with some of their patients
• 87% felt that all primary care clinicians should be trained in goal-setting and action planning
• 33% had already recommended the action plan idea to other clinicians.

The major barrier was time. Two thirds of clinicians reported that they did not have enough time to conduct action plan discussions, or follow-up. [20]
• 59% believed that other caregivers would be appropriate to engage in action plan discussions with patients

Most patients also reacted favorably. Most remembered their action plan 2 to 3 weeks later and over half reported initiating a behavior change based on the action plan. [22]
• The encouraging lesson of the project was the overall positive reaction of both clinicians and patients to the action plan idea. The major discouraging result was that action plan discussions are not feasible for clinicians to undertake as a regular feature of the busy primary care visit.
• The key conclusion is that other caregivers or office staff need to be trained and given time to engage in action plan discussions with patients—in consultation with the patients’ clinician—and to initiate follow-up contact with patients regarding their action plans.

The key findings from this study that are relevant to primary care include: [20,22]
1. The majority of patients and clinicians were able to make behavior-change action plans in the primary care visit,
2. Patients from a variety of clinical settings are willing to engage in the collaborative process, including low income and those in the precontemplative stage of readiness.
3. Clinicians should not assume that lower income patients are less able to engage in collaborative goal setting to promote behavior change.
4. Similarly, patients in the precontemplative stage were engaged in action-plan discussions and carried out their action plans with similar frequency to patients expressing greater readiness to change.

5. Most patients could accurately describe the action plan they made a few weeks later, and over two-thirds of those who could describe their action plan reported making at least some of the proposed behavior changes.

6. Collaborative goal-setting with action planning is a more useful strategy to encourage behavior change for primary care patients than traditional directive advice.

**Brief visit using motivational interviewing**

A brief motivational approach is well suited to the daily practice of a busy primary care clinic, where improved adherence to treatment recommendations is a priority. [279]

- Motivational interviewing techniques provide patients with an opportunity to take a more active role in the change process.
- Use of motivational interviewing techniques by clinicians encourages patients to reflect on and express their own motivation for change.
- The process reduces patient resistance and is usually more satisfying to both patient and clinician.

**Grand Valley Health Plan Program**

A system redesign that integrated health coaches into the practice resulted in more patients being seen by counseling staff, improved access, and improved quality of care. [314]

**Methods**

- Began calling coaching and wellness staff *health coaches*
- Established 15- to 30-minute appointments for coaching staff to provide timely access for patients and PCPs
- Provided targeted training for health counselors and PCPs in the new model and the techniques and skills to implement it
- Half of daily counseling appointments as same-day appointments
- Established evidence-based care guidelines for the delivery of counseling and wellness services
- Focused on services for traditional behavioral health but also on lifestyle and behavior factors that impact patients’ health and management of disease.
- Targets patients with chronic conditions and other at-risk patients.

**Results:**

- Improved communication and coordination of care; counseling and wellness services have become much more integrated.
- PCPs recognizing the benefits of the coaching staff; has also led to positive outcomes and supports the evidence that integration improves quality of care.
- PCPs explain to patients that "this is just how we deliver care to you" when introducing health coaches to patients and asking them to be involved.

**Electronic Medical Record (EMR) System enhancement**

A group of nine primary care practices added an electronic linkage system (eLinkS) to their EMR systems to promote health behavior counseling and to automate patient referrals to community counseling services. [133]

- Patients were offered 9 months of free behavioral counseling at a choice of venues: group counseling, telephone counseling, computer care, and usual care. The counseling was based on the 5A's (ask, address, advise, assess, agree, arrange).
- The eLinkS enhancement prompts clinicians at the point of care to offer counseling to appropriate patients regarding diet, exercise, smoking, and alcohol consumption.
- When the physician comes in to the examination room, he or she calls up the patient's record on the EMR. If unhealthy behaviors have been recorded, the EMR automatically prompts the
clinician to consider counseling and referral services. It generates a list of unhealthy behaviors and asks the clinician if the “Prescription for Health” form should be loaded.

- The form has boxes to check off on the 5A process:
  - whether they advised the patient to change his or her behavior (“advise”);
  - whether the patient was willing to change behavior and seemed engaged in the process (“agree”);
  - whether the patient wanted to be referred outside of the practice to one of the intensive counseling options (“assist”);
  - by what means (telephone contact, office visit, email contact, or none) the patient wanted to follow up with the practice (“arrange”).
- Those who do not agree to outside counseling are “usual care” -- counseling by the clinician, pharmacotherapy, or no intervention).
- Once clinicians and patients agree on a plan, the system electronically sends referrals to community-based counseling organizations, which contact patients to arrange services.
- At any time, the counselor can log onto the Web site to enter follow-up information; the Web site automatically sends progress reports to the EMR for the patient’s clinician.
- Patients referred to an intensive counseling program paid out of pocket or through their own insurance; program developers are working for expanded coverage.

The automated prompts successfully generated patient referrals for counseling services, improved behaviors related to diet and exercise (which in turn led to weight loss), and enhanced quit rates among smokers.

**Computer based intervention**

A computer-based assessment of motivational readiness to increase physical activity and make dietary changes was used. It took less than 10 minutes to complete. On completion of the assessment, a 4- to 5-page individualized, tailored report was printed out. [315]

- A companion report for the patient's physician, which included a brief, bulleted summary of the findings from the patient's assessment (i.e., priority change areas and perceived barriers to change) and provided the physician with patient-specific counseling recommendations.
- Prior to the baseline clinic visit, intervention patients read their report and listed 2 or 3 dietary and/or physical activity self-management goals they wanted to achieve.
- Physicians completed a 3-hour training session on using these lifestyle change goal sheets to provide brief motivational interviewing counseling to help patients change behaviors.
- During a planned visit, patients met with their physician to discuss the patient's tailored lifestyle change goals and plan of action for attaining these goals.

The modest intervention was well accepted and well used by both clinicians and patients. It helped a subset of patients obtain clinically significant improvements in physical activity and weight loss.

- Patients reported support from their physician as the key component of the intervention.
- Weight loss continued for 6 to 12 months, indicating that an approach encouraging modest lifestyle changes can produce sustained benefits over 1 year of intervention.
15. OFFICE SYSTEMS – A KEY TO SUCCESS

A number of studies have documented that two factors are especially important for effective physician-delivered counseling interventions:

1. Skill-building training in counseling methods, and
2. An office system that facilitates delivery of the counseling process. [15,29]

When dealing with a preventive intervention such as smoking or exercise in a busy practice setting, the office system can cue the clinician to carry out the appropriate intervention.

- The use of reminders, counseling and treatment algorithms, follow-up protocols, education material mail outs, and tracking outcomes are all important. [15,29]

Primary care is often conducted within a 15-minute, multi-agenda visit between physician and patient. Such a structure has led to patients being:

- inadequately informed about their chronic conditions and
- passive recipients of medical advice rather than active participants in medical decisions. [15,29]

The result has been poorly informed, passive patients. [15]

Assessing Office Systems
Put Prevention Into Practice (PPIP) from the Agency for Health Care Research and Quality (AHRQ) provides a useful framework for analyzing the office systems designed to deliver patient care. [316]

A collaborative model
The challenge of making patients more active and informed in their own care can be met by three redesigns in office practice systems that encourage collaborative decision-making: [15]

1. Pre-activating patients prior to the visit -- appears to encourage more active patients.
2. Planned visits, with a care manager spending time with patients, individually or in groups, providing behavior counseling and medical management, have been shown to improve clinical outcomes.
3. Regular sustained follow-up, by face-to-face visits, telephone, or electronic means, is associated with healthier behaviors.

Involve Office Staff in a Team Approach
An integrative team approach can enhance patient care. The optimal structure varies with practice personnel but covers the following activities: [15]

- Receptionist -- provide useful information about the practice, including general philosophy, staffing, fee schedules, and written materials.
- Nurses or medical assistants -- obtain vital measurements, including height, weight (BMI), waist circumference, smoking status; provide instruction on and review of food and activity journals and other educational materials; review/score other risk assessments included.
- Physician assistants/nurse practitioners -- monitor the progress of treatment and assume other responsibilities of care.
- Physicians -- coordinate and manage integrating patients’ medical care.

Regular staff meetings discuss office practices and strategies, and to keep up to date with latest guidelines and recommendations. [15]

Patient Medical Questionnaire
Can be mailed to patients and completed prior to the initial visit, completed in the waiting room, or completed with nurse or medical assistant in the examination room. [15]

- Most time efficient is to have it completed before coming in for the visit
- Should include:
  - past participation in obesity treatment programs,
  - a body weight history,
• Some patients may have to work with a physician or nurse to answer the questions.
• An example is available from the Veterans Health Administration clinical weight management program -- the MOVE!23 survey: [http://www.move.va.gov/Move23.asp](http://www.move.va.gov/Move23.asp)

**Other Handouts**

Have questionnaires and handouts to address behavior topics -- weight loss, diet, nutrition, physical activity, medication management, disease self management.


• The VA weight management program - MOVE! has tools, resources, and materials, including an initial patient questionnaire, over 100 patient handouts, modules for conducting group sessions, quick reference guides available free of charge for anyone to use: [http://www.move.va.gov](http://www.move.va.gov)

• For patient handouts, the VA program has many that are available at: [http://www.move.va.gov/Handouts.asp](http://www.move.va.gov/Handouts.asp)

**Identifying Counseling Needs**

A vital sign stamp that includes smoking status has increased smoking cessation counseling and increased smoking cessation rates. [317]

• It has been suggested that a vital sign stamp including height, weight, waist circumference, BMI, blood pressure, physical activity and smoking status might improve the identification of patients at in need of more frequent counseling. [318]

• Disease registries, reminder systems, triggers, and chart prompts can also help.
16. IMPLEMENTING OFFICE SYSTEM CHANGES

The Health Education and Research Trial (HEART) Project was a multicenter trial that evaluated methods to improve primary care practice systems for heart disease prevention in 45 primary care practices in the Midwest. [319]

- 8 factors predicted successful adoption of an office system enhancement: (320)
  - effective leadership;
  - priority setting for preventive services;
  - joint planning by physicians, staff, and office administration;
  - cooperation and teamwork;
  - acquisition of resources for preventive services;
  - increased support and ownership for the planning and implementation process;
  - accomplishment of office systems improvements; and
  - personal changes of physicians or staff (e.g., changing diet, losing weight).

Factors that hindered office system improvements included: [320]
- larger patient load,
- turmoil related to reorganization,
- lack of widespread office routines,
- hospital-affiliated practice,
- poor communication and
- fragmentation within the practice.

Implementation Guide from the PPIP

The Agency for Healthcare Research and Quality (AHQR) developed a workbook on organizing an office system for delivering preventive services, Putting Prevention into Practice (PPIP).

http://www.ahrq.gov/ppip/ppipabout.htm

Outlines an eight-step approach for implementing a program change: [321]
1. Develop a written policy for counseling, including identification criteria for patients to target -- specific diagnoses or types of office visits—diabetes mellitus, obesity, hyperlipidemia, hypertension, prenatal care, health maintenance exams.
2. Perform chart audits to document baseline data, specific needs
3. Outline each person's role and responsibility in the office system to implement the counseling program.
4. Find a champion -- a well-respected and influential office staff member who will be the coordinator of counseling within the office.
5. Develop or adapt tools to implement counseling for each topic area—a screening tool, algorithms or guidelines for specific diagnoses; patient education materials.
6. Set a start date.
7. Meet frequently to assess how things are going and modify the plan as necessary.
8. Resurvey charts and reassess periodically. Revise goals and plans as necessary.

STEPS FOR IMPLEMENTATION

Another program outlined several other steps that were useful: [133]
- Identify health behaviors to target: Review patient population to determine which health risks are most prevalent.
- Develop a local referral network: Some patients prefer one on one counseling, others groups, others self-management through computer-prompted care, others telephone counseling. Find local programs, specialists for referral; also other sources of information and support, especially free services such as smoking cessation Quit Lines.
- Emphasize the benefits of linkages with community organizations: Such partnerships are a "win-win-win": clinicians gain access to tools and resources to help their patients achieve behavior change; community counseling centers can gain access to new patients; and patients can improve their health while clinicians are kept informed of their progress.
• Obtain physician buy-in by emphasizing patient care benefits: Physicians are busy and often resist new care processes. They should be assured that the process will be efficient and will improve quality of care, and ease the burden on them for counseling.
17. IMPLEMENTING A COMPREHENSIVE BEHAVIOR COUNSELING PROGRAM

ASSESS THE PRACTICE
1. Establish a team to assess the practice and develop an implementation protocol

2. Evaluate physician attitudes on expanding behavioral counseling
   - Without their enthusiastic support it is probably not worth the effort and expense
     o Willingness and confidence to counsel patients
     o Perceived barriers for them personally
     o Perceived barriers, needs for the practice
     o Factors that would encourage their participation
   - What role would they like to play in an optimal program?

3. Assess practice readiness to initiate a major coaching plan
   - Identify an internal champion (someone who believes in program, knows the practice, gets along with others, is enthusiastic, and be happy to be a resource during the learning phase)
   - Assess the staff attitudes and perceptions; the organizational climate

4. Assess current practice performance
   - Current practices in behavioral health issues – type and extent of coaching/counseling provided
   - What processes and procedures currently support coaching and counseling?
   - Prepare clinical flow map of patient interactions in practice
   - Assess team approach: review roles of staff members, satisfaction with role
   - What outside resources does the practice currently use?
   - Evaluate counseling assets and needs
     a. Staff counseling experience, skills, confidence
     b. Specific areas of expertise (e.g., smoking, exercise, etc)

5. Assess the clinical information system
   - How well does it identify patient status and needs?
   - How does it prompt for visits, follow-up, counseling to be included in next visit?
   - Does it track patient progress?
   - What outcomes are available for evaluation? Can others be added?

REPORT ON PRACTICE STATUS AND NEEDS (to implement an expanded counseling program)

6. List the status/needs of each aspect of the practice
   - Attitudes and recommendations
     a. Physicians
     b. Other medical staff
     c. Management staff
     d. Other staff
   - Obstacles
   - Counseling services
   - Clinical information system
   - Resources and referrals

PLAN THE PROGRAM

7. Develop the intervention specifics
   - Identify each step in the clinical flow of the counseling process:
     a. Identification/documentation of patients’ counseling needs (both lifestyle and self management) – information system
b. Communication with patients
  c. Assessment of patient needs, preferences, stage of readiness, confidence)
  d. Counseling strategies 5A protocol, motivational, dealing with resistance)
  e. Referrals
  f. Follow-up protocols (calls, mail-outs, visits)
  g. Evaluation – outcomes to be included (patient behaviors and feedback, staff feedback, costs, etc)

8. Determine Staff Roles and Responsibilities
   • Involve physicians in designing their roles in providing counseling.
     a. Depends on other responsibilities, preferences, needs of the practice
     b. Physician roles vary – most commonly involve setting the stage for counseling – providing brief information and advice, assessing readiness and confidence, referring to trained staff member or outside resource for counseling, describing follow-up protocol
   • Identify an internal champion (someone who believes in program, knows the practice, gets along with others, is enthusiastic, and be happy to be a resource during the learning phase)
   • Identify staff roles and responsibilities
   • Identify referrals needed and develop the referral network – high quality local programs, nationally available programs and materials that address the specific needs (e.g., for smoking cessation – local therapists and group support programs, national quit lines)

PREPARE FOR COUNSELING

9. Develop the counseling protocols
   • Decide which issues to address, which to refer
   • Identify counseling staff – areas of focus
   • Identify guidelines, strategies to follow, assessments to use
   • Determine training needed, where to obtain
   • Identify tools and materials to support counseling roles
   • Develop follow-up protocols, outcomes to evaluate for each counseling area

DEVELOP AN IMPLEMENTATION PROTOCOL

10. Design the protocol
    • Establish a timeline
    • Set goals for the practice
    • Arrange for information system enhancements if needed
    • Establish orientation schedule
    • Prepare staff handouts -- roles and responsibilities, procedures, etc
    • Arrange for training
    • Present implementation plan to staff

From Ref 52: Center for the Advancement of Health. Integration of Health Behavior Counseling in Routine Medical Care, April, 2001, Washington, DC
18. RESOURCES

TOOLS
Action Planning
Action plan forms in English, Spanish and Chinese:
http://www.familymedicine.medschool.ucsf.edu/community_service/actionPlan.aspx

Example of an action plan:
http://clinical.diabetesjournals.org/content/25/2/66/F1.expansion.html

Example of goal setting dialogue:
http://clinical.diabetesjournals.org/content/25/2/66/T1.expansion.html

Problem solving dialogue:
http://clinical.diabetesjournals.org/content/25/2/66/T3.expansion.html

Guidelines and tools for self-management are available from the:
Institute for Healthcare Improvement:
http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Tools

For guidance in implementing a physical activity counseling program:

Patient-centered Assessment and Counseling for Exercise and Nutrition. www.paceproject.org

PATIENT CENTERED MEDICAL HOME
Creating a Patient Guide for a "Medical Home” Practice Center for Advancing Health

SELF MANAGING CHRONIC CONDITIONS
Information on patient self management of chronic conditions:
http://patienteducation.stanford.edu

Improving Chronic Illness Care Website
http://www.improvingchroniccare.org/tools/criticaltools.html

Monograph: “Helping Patients Manage Their Chronic Conditions” from the California Healthcare Foundation:
http://chcf.org/topics/chronicdisease/index.cfm?itemID=111768

TRAINING
Wellcoaches, Inc offers training programs for fitness coach, health coach, and wellness coach.
www.wellcoach.com

Institute of Lifestyle Medicine, Harvard University Medical School has classes in coaching lifestyle behavior change:
http://www.instituteoflifestylemedicine.org/courses_lectures.asp
http://www.activedoctors.org/

UCSF Medical School training program guide for clinicians and nonprofessional practice staff discussing behavior change in primary care:
http://clinical.diabetesjournals.org/content/25/2/66.full#T1#T1
Training curriculum for health coaches
http://familymedicine.medschool.ucsf.edu/cepc/pdf/HealthCoachTrainingCurriculumMay08.pdf

The Institute for Healthcare Communication has resources on enhancing the dialogue between patients and clinicians
www.healthcarecomm.org

EDUCATIONAL MATERIALS
AHRQ has also developed printed materials to inform patients and prompt them to request appropriate preventive services and track their results: of particular note is a new pair of checklists, for men and for women over age 50, listing daily steps to good health as well as appropriate preventive medicines and screening tests. All of these resources are available electronically at:
http://www.preventiveservices.ahrq.gov

ORGANIZATIONS
For the integration of research findings into medical practice:
The Institute for Healthcare Improvement
  • Uses a model that requires identification of what needs improvement and the use of the "Plan-Do-Study-Act" cycle to test and implement modification.

For changing health and social policy to improve health:
The Canadian Health Services Research Foundation (CHSR)
  • Works with policymakers and other end-users of research in formulating research questions to aide in the design of research that is relevant to decision-makers in health plans or policymakers and to facilitate the ability of decision-makers to incorporate research in decision-making.

PROGRAMS
http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=133375

Integration of Health Behavior Counseling in Routine Medical Care, From the Center for the Advancement of Health. April, 2001, Washington, DC
  • Project was a report based on three sets of interviews to better understand the factors that influence how and why health behavior change strategies can be (are) implemented into routine medical care: 1) practicing clinicians, national and academic leaders, and researchers, 2) directors of successful and innovative prevention programs, and 3) directors and key staff of the National Institutes of Health, medical professional societies, other government agencies, and voluntary health organizations.
### TABLE 1. GOAL SETTING AND ACTION PLANNING – SAMPLE FORM

1. Problem: 

2. Achievable goal: 

3. How convinced are you that this is the right goal for you?  

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- Totally unconvinced
- Unsure
- Somewhat convinced
- Very convinced
- Extremely convinced

4. Solutions:  

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5. Choice of solution: 

6. Steps to achieve solution:  

   a)  
   b)  
   c)  

Confidence ruler: How confident are you that you can reach your goal?  

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- Totally unconvinced
- Unsure
- Somewhat convinced
- Very convinced
- Extremely convinced

Source: Fam Pract Manag © 2008 American Academy of Family Physicians
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