Behavior-Change Action Plans in Primary Care:  
A Feasibility Study of Clinicians

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Purpose: Collaborative goal-setting—with clinician and patient together deciding on concrete behavior-change goals—may be more effective in encouraging healthy behaviors than traditional clinician-directed advice. This study explores whether it is feasible for clinicians to engage patients with coronary heart disease (CHD) risk factors in collaborative goal-setting and concrete action planning during the primary care visit.

Methods: Primary care clinicians were trained in goal-setting and action planning techniques and asked to conduct action plan discussions with study patients during medical visits. Clinicians’ experiences were documented through post-visit surveys and with questionnaires and semistructured interviews at the end of the study.

Results: Forty-three clinicians and 274 patients with CHD risk factors participated in the study; 83% of the patient encounters resulted in a behavior-change action plan. Goal-setting discussions lasted an average of 6.9 minutes. Clinicians rated 75% of the discussions as equally or more satisfying than previous behavior-change discussions, and identified time constraints as the most important barrier to adopting the goal-setting process.

Conclusions: Collaborative goal-setting between clinicians and patients for improved health behaviors is viewed favorably by clinicians in primary care. Time constraints could be addressed by delegating goal-setting to other caregivers. (J Am Board Fam Med 2006;19:215–23.)

Coronary heart disease (CHD), the leading cause of mortality in the United States, is strongly associated with modifiable behaviors including physical inactivity, poor diet, and tobacco use. Seventy-seven percent of the US adult population engages in a low level of physical activity, 58% are overweight, 23% use tobacco, and 53% have more than one of these risk factors. However, physicians inconsistently provide health behavior-change advice to their patients. From 1992 to 2000, diet and physical activity counseling took place in fewer than 45% and 30%, respectively, of primary care visits by adults with CHD risk factors. Physicians in primary care seldom have time to engage in such discussions and may be unsure how to discuss behavior change with their patients.

The research presented here describes a method for engaging patients in behavior-change discussions within primary care: goal-setting with action planning. This process is based on the emerging collaborative model of patient care. In this paradigm, patients set a goal for a behavior they wish to change, and clinicians engage patients in a discussion of an action plan that can help the patient fulfill the goal. The action plan should be concrete and specific. With nonspecific action plans, eg, to exercise or lose weight, patients cannot evaluate their success and often experience failure. To enhance the likelihood that patients will succeed with their action plan, clinicians ask patients to estimate,
on a 0 to 10 scale, how confident they are that they can carry out the action plan, and help patients make an action plan that patients feel they can accomplish.

The theoretical basis for action planning is the concept of self-efficacy developed by Bandura. Self-efficacy refers to a person’s confidence that he/she can carry out a behavior necessary to reach a desired goal. Patients are encouraged to choose action plans with a high probability of success because success in making a behavior change, no matter how small, increases patient self-efficacy. In several studies, increased self-efficacy has been associated with improved health-related behaviors and clinical outcomes.

Action plans have been studied in chronic disease self-management classes separate from primary care practice. Patients attending those classes may be more motivated to adopt healthy behaviors than the average patient. A study of action plans in primary care has a greater likelihood of observing the action plan process among patients at both higher and lower levels of motivation. This article provides the first-ever detailed look at how action planning takes place in primary care; these observations may help to guide future research on the impact of action planning on clinical outcomes.

The present study examines the feasibility of collaborative goal-setting and action planning between primary care clinicians and patients with CHD risk factors, including diabetes, hyperlipidemia, hypertension, overweight, and/or tobacco use. This article presents data on the feasibility of clinicians engaging in action plan discussions with their patients in the primary care setting. A companion paper describes how patients responded to the action plan discussions. The research questions addressed in this article focus on the perspective of the clinician in the goal-setting process and include the following: Is it feasible for clinicians to engage in collaborative goal-setting using action plans with their patients with CHD risk factors during the busy primary care visit? Do clinicians find this method more or less satisfying than their previous behavior change discussions?

Methods

Clinician Recruitment and Training

Between November and December of 2003, we recruited 4 safety-net health centers and 4 private practices, all members of the University of California at San Francisco (UCSF) Collaborative Research Network, a practice-based research network, by contacting the medical directors of each practice. Practices were selected because they provided diversity in clinic setting (private and public) and size, had many English-speaking adult patients with cardiovascular disease risk factors, and were not currently involved in similar interventions. Practice size ranged from small (2 full-time equivalent clinicians and 145 patients per week) to medium-sized (14 clinicians and 1500 patients per week). At each site, research staff presented the study to clinicians during regular meetings. Clinicians who attended the meetings were invited to participate in the study; at each site, most were interested in participating whereas some were not. Although some clinicians were familiar with motivational interviewing techniques, none had engaged patients in action plan discussions. Clinicians who agreed to participate were trained for 45 to 60 minutes, individually or in groups, and were presented with a description of the goal-setting concept and how to negotiate action plans with patients. Scripted and impromptu role plays were used to demonstrate examples of goal-setting discussions. Training materials are available on request.

Conducting Goal-setting Discussions with Study Patients

Clinicians were asked to undertake goal-setting discussions and to use the action plan form (Figure 1) with at least 6 of their patients who would be enrolled by research assistants at the site. It was emphasized that clinicians should engage in goal-setting discussions with study patients only if such discussions seemed appropriate. The action plan form was designed to elicit information on the health behavior domain the patient felt was most important to address. Clinicians were asked to encourage patients to identify a behavior that could be altered to improve their health. The action plan form includes several domains that patients can choose from: physical activity, food choices, taking medications, smoking, stress, and an open-ended category (“work on something that is bothering me”). Once a specific action plan was chosen by the patient, the clinicians were asked to assess the patient’s level of confidence in achieving the action (using a 0 to 10 scale) and to reset the action plan with the patient if the confidence level was less than
7. Once this target confidence level was achieved, specifics regarding the action plan (what, when, how often, etc) were to be recorded on an action plan form. The study was approved by the UCSF Institutional Review Board.

**Patient Recruitment**

Trained research assistants reviewed patient charts to determine eligibility for patients with upcoming appointments with study clinicians. Patients were eligible for the study based on the presence of CHD risk factors including diabetes, hyperlipidemia, hypertension, overweight (clinical note indicating obesity), tobacco use, or a diagnosis of coronary heart disease. Exclusion criteria included limited English proficiency, planning to be out of the area during the period of the study, or having severe mental or terminal physical illness. Patients who agreed to participate were interviewed by a research assistant immediately before their clinician

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**Figure 1. The Action Plan Form**

![Action Plan Form](www.familymedicine.medschool.ucsf.edu/research/research_programs/actionPlan.aspx)
visit. An action plan form was clipped to enrolled patients’ charts along with a questionnaire for clinicians to complete immediately after the visit.

**Clinician Follow-up**

For each enrolled patient, clinicians were asked to fill out a brief post visit questionnaire to measure their own satisfaction with the action plan discussion, to estimate the time required for the discussion, and for visits in which an action plan discussion did not take place, a brief explanation. A sub-set of clinicians was also asked to audiotape the study visits if the patient had provided consent for the audio recording. The goal-setting portion of these recordings was timed by one member of the research team (CS) to determine the length of the discussions.

Within 6 weeks of the study’s conclusion, the research team met with clinicians at each site, individually or in small groups. Each clinician was asked to anonymously rate the acceptability of the goal-setting method, using a 1-page questionnaire. During the follow-up meetings, the research team also conducted semistructured interviews with clinicians using open-ended questions to elicit their impressions about the goal-setting process. These group interviews were audiotaped, transcribed, and coded for themes associated with the implementation of action plans by 3 researchers (KM, SW, CS) separately, with discussion of results to achieve agreement.16

Data were entered into an Access database. All statistical analyses were performed using the SAS statistical software package (SAS Institute, Inc.). χ² tests were conducted to determine whether differences existed between safety net and private practice clinicians in their questionnaire responses.

**Results**

**Clinician Characteristics**

Forty-three clinicians from the 8 primary care sites participated in this study. Nineteen clinicians practiced in safety net settings and 24 in private practices. Sixty-seven percent were women and 88% were white. Two of the clinicians were nurse practitioners and 2 were physician assistants; the rest were physicians in family practice or internal medicine. The average number of years in practice was 14 (range 5 to 35) for private practice clinicians and 15 for safety net clinicians (range 3 to 32 years).

**Goal-Setting Discussions**

Research assistants approached 375 patients for the study. Of these, 40 were ineligible because of the exclusion criteria (11%), 61 refused (16%), and 274 (73%) enrolled in the study. We enrolled 128 patients from safety net clinics and 146 from private practices. Seventy percent were non-white (33% African American, 16% Asian, 10% Latino, and 11% mixed or “other”) and 64% were women. The mean age was 52.3 years (S.D. = 12.7), and 42% had completed a high school education or less at the time of the study. All had chart or clinician confirmation of one or more CHD risk factors, with 86% having multiple risk factors. More extensive information on patient demographics, disease characteristics, enrollment and patient outcomes are described in a separate paper.15

Two hundred twenty-eight patients (83%) had goal-setting discussions with their clinician resulting in an action plan. The percentage of patients making action plans with their clinician on the day of the study visit was nearly identical (82% versus 84%) for safety net versus private practice settings.

**Clinician Reports following the Goal-Setting Discussions**

Clinicians completed post visit questionnaires for 92% of enrolled patients (Table 1). For the 38 visits with completed questionnaires that did not result in an action plan, clinicians cited: “not enough time” (39%), “patient too ill” (29%), and “lack of patient interest” (13%) as reasons for not engaging in a goal-setting discussion. Reasons for not completing an action plan were different between safety net and private practice settings (\(P = .03\)). Safety net clinicians cited patients being too ill as the major reason for not completing an action plan whereas private clinicians reported lack of time as the main factor. The average amount of time for the goal-setting discussions was 6.9 minutes in safety net settings and 6.8 minutes in private practice (range 1 to 20 minutes in both settings). Seventeen of the 43 clinicians agreed to audiotape one or 2 study visits, resulting in recordings of 22 visits. The time of the goal-setting portion of these visits measured from the audiotapes was similar to the discussion times estimated by clinicians.

Forty-seven percent of clinicians rated the goal-setting discussions as more satisfying than previous behavior-change discussions with the same patient; 28% found the discussions equally satisfying. Only
7% found goal-setting discussions to be less satisfying than previous discussions, with no significant differences identified between private and safety net practice settings (P > .05).

**Poststudy Clinician Follow-up**

Most clinicians (91%) returned the 1-page questionnaire at the end of the study and more than half (67%) also participated in the poststudy semistructured interviews. Fifty-six percent of clinicians responding to the questionnaire reported that the action plan training made it easier to discuss behavior change with their patients; 33% found using action plans to be the same, and 10% found it harder. Seventy-four percent reported that the training had changed the way they discuss health behavior with patients; 82% said they would continue to use the action plan with some of their patients after the study; 87% felt that all primary care clinicians should be trained in goal-setting and the use of action plans; and 33% reported they had recommended the action plan idea to other clinicians. Most (59%) believed that other caregivers would be appropriate to engage in action plan discussions with patients (Table 2).

Two thirds of clinicians responded that “inadequate time” was a major barrier to conducting action plan discussions (Table 3). Clinicians also cited difficulty with the research methodology or the action plan form as a barrier (39%); examples included having to deal with an additional piece of paper, remembering to engage in the action plan discussion, using the 0 to 10 confidence scale, and negotiating the behavior-change goals. Quotes from the poststudy interviews (Table 3) shed light on clinicians’ views regarding the action plan technique.

**Discussion**

Despite evidence that shared decision making can improve health-related behaviors, only a handful...
Table 2. Clinician Post-study Questionnaire Responses

<table>
<thead>
<tr>
<th>Question</th>
<th>Private practice (N = 21)</th>
<th>Safety net (N = 18)</th>
<th>Overall (N = 39)</th>
<th>Private practice</th>
<th>Safety net</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In general, do you feel that action plans make behavior change discussions:</td>
<td></td>
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<tr>
<td>Easier?</td>
<td>52%</td>
<td>61%</td>
<td>56%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>The same?</td>
<td>43%</td>
<td>22%</td>
<td>33%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Harder?</td>
<td>5%</td>
<td>17%</td>
<td>10%</td>
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<tr>
<td>b. Did the study change the way you like to discuss health behavior with patients?</td>
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<tr>
<td>Yes</td>
<td>62%</td>
<td>89%</td>
<td>74%</td>
<td></td>
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<tr>
<td>No</td>
<td>38%</td>
<td>11%</td>
<td>26%</td>
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<tr>
<td>c. Did you use action plans with patients outside the study?</td>
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<tr>
<td>Yes</td>
<td>76%</td>
<td>72%</td>
<td>74%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>24%</td>
<td>28%</td>
<td>26%</td>
<td></td>
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<tr>
<td>d. Have you recommended the action plan idea to other clinicians?</td>
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<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>43%</td>
<td>22%</td>
<td>33%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>57%</td>
<td>78%</td>
<td>67%</td>
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<tr>
<td>e. Will you continue to use the action plan with some of your patients?</td>
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<tr>
<td>Yes</td>
<td>81%</td>
<td>83%</td>
<td>82%</td>
<td></td>
<td></td>
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<tr>
<td>No</td>
<td>19%</td>
<td>17%</td>
<td>18%</td>
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<tr>
<td>f. Should all primary care clinicians be trained in the use of action plans?</td>
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<tr>
<td>Yes</td>
<td>86%</td>
<td>89%</td>
<td>87%</td>
<td></td>
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<tr>
<td>No</td>
<td>14%</td>
<td>11%</td>
<td>13%</td>
<td></td>
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<tr>
<td>g. Do you think Action Plans can be helpful in encouraging behavior change?</td>
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<tr>
<td>No</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Rare patients</td>
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<tr>
<td>Some patients</td>
<td>67%</td>
<td>67%</td>
<td>67%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most patients</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
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<tr>
<td>h. What is the barrier that makes it most difficult to use Action Plans in primary care visits?*</td>
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<tr>
<td>Time</td>
<td>67%</td>
<td>65%</td>
<td>66%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Methods†</td>
<td>38%</td>
<td>41%</td>
<td>39%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
<td>0%</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>5%</td>
<td>29%</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Do you think it would be more appropriate for other caregivers to engage patients in goal setting since physicians have very little time?</td>
<td>Yes</td>
<td></td>
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<td></td>
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<tr>
<td>Yes</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>52%</td>
<td>67%</td>
<td>59%</td>
<td></td>
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<tr>
<td>j. If “Yes,” what type of caregiver would be appropriate?</td>
<td></td>
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<tr>
<td>Health Educators</td>
<td>67%</td>
<td>67%</td>
<td>67%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>29%</td>
<td>33%</td>
<td>31%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>57%</td>
<td>61%</td>
<td>59%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td>29%</td>
<td>39%</td>
<td>33%</td>
<td></td>
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</tbody>
</table>

* More than one barrier was identified by some clinicians.
† Methods refers to difficulties associated with using action plan forms and engaging in collaborative discussions.
of studies have examined one central component of shared decision making—collaborative behavior-change goal-setting—to determine its feasibility in the primary care setting.\(^{18-23}\) None of these studies systematically examined clinicians’ attitudes or satisfaction regarding collaborative goal-setting techniques.

This study explored 2 research questions. Is it feasible for clinicians to engage in collaborative goal-setting, using action plans, during the busy primary care visit? Do clinicians find this method more or less satisfying than their previous behavior-change discussions?

Table 3. Sample Clinician Quotes from Post-Study Semistructured Interviews

<table>
<thead>
<tr>
<th>Topic</th>
<th>Quotes</th>
<th>Practice Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>“... that was the big inhibition for me—the time factor. When patients come here they often have four or five issues, and you can’t add another thing.”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“... it’s difficult when it’s busy and it’s difficult not to be directive. Being directive doesn’t take much time.”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“... [the action plan] helped me prioritize that as opposed to the 16 other priorities ...”</td>
<td>Safety net</td>
</tr>
<tr>
<td>Resources</td>
<td>“It would be kind of nice to have an appointment just to talk about the action plan.”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“Anything that adds more paper is a problem.”</td>
<td>Safety net</td>
</tr>
<tr>
<td></td>
<td>“[The action plan] made it more real and achievable for patients to set goals ... and by doing that and calling them back a week later it was extremely helpful for them. ... It would be really nice if we could continue that. We don’t have the resources to do that.”</td>
<td>Private practice</td>
</tr>
<tr>
<td>General comments</td>
<td>“It would be hard to totally let [the action plan] be patient-driven.”</td>
<td>Safety net</td>
</tr>
<tr>
<td></td>
<td>“I get to the point where I say, ‘The action plan is you’re going to take a lipid-lowering medicine, you’re going to take it for 4 weeks, here’s the lab slip.’”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“The emphasis on getting patients to assume some responsibility for their own care is good.”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“... paring down to one thing, pin it down, that was a shift for me.”</td>
<td>Safety net</td>
</tr>
<tr>
<td></td>
<td>“[The action plan] really gives you a chance for buy in and I found it’s more successful to give them a chance to talk about their health and what’s important for them, so I like it.”</td>
<td>Safety net</td>
</tr>
<tr>
<td></td>
<td>“When a patient didn’t do the action plan I was flummoxed. I didn’t know what to do next.”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“I really felt like [the action plan] impacted the way I did health education with lots and lots of patients ...”</td>
<td>Safety net</td>
</tr>
<tr>
<td></td>
<td>“I felt disappointed when patients did not reach their goals, even if they only did 50%.”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“If an action plan comes up naturally in a visit then it’s a good idea.”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“I like the concept, but most doctors, and probably myself, will do [action plans] for a while and then go back to the old pattern of yelling at the patients to change their behaviors—because that is how we were taught.”</td>
<td>Private practice</td>
</tr>
<tr>
<td>Other caregivers</td>
<td>“I think [the action plan] would be much better for the non-clinician to do, because of time.”</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td>“I think it would be empowering for our nurses to do action plans when they’re not busy doing other stuff.”</td>
<td>Safety net</td>
</tr>
<tr>
<td></td>
<td>“... if we had our nurse and MAs trying to do [action plans] it would slow things down even more.”</td>
<td>Safety net</td>
</tr>
<tr>
<td></td>
<td>“All those medical assistants, health educators, social workers, that would be awesome if they could do action plans before or after the visit.”</td>
<td>Private practice</td>
</tr>
</tbody>
</table>

http://www.jabfm.org 221
ated by conducting research in a busy medical prac-
tice. Clinicians may have felt pressure to initiate an
action plan with a “study” patient for whom a
recruitment and consent process had just been
completed. Clinicians may have given the interac-
tions even higher satisfaction ratings had they been
able to choose when and with whom to use the
action plan method. Few patients per clinician were
enrolled in the study and clinicians may not have
achieved mastery of the new skill. One clinician
commented “. . . I need more repetition, practice to
truly incorporate it into routine patient care.” The
brevity of the training sessions necessitated by the
clinicians’ busy schedules may not have allowed for
uptake of this new counseling method. Most im-
portantly, there are competing demands for clini-
cians’ time. 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.24

Clinicians expressed greater acceptance of goal-
setting in the poststudy questionnaires compared
with their responses immediately after the goal-
setting discussion. Perhaps the rushed atmosphere
of primary care practice occasioned more negative
responses toward anything that takes more time,
whereas the calmer atmosphere of a meeting con-
ducted outside of clinical time allowed clinicians to
reflect more positively on the new behavior-change
method. The clinicians in the study seemed to have
a general desire to find new ways to help patients
achieve healthy behaviors. A report of focus groups
with primary care clinicians managing patients with
CHD risk factors found agreement “that one is
more likely to be successful by beginning with what
the patient perceives as a priority.”5

A major barrier was the time it took to engage in
goal-setting discussions—an average of 6.9 min-
utes. With continued practice, clinicians may be-
come more facile with the technique. A related
barrier is the lack of time for sustained follow-up
on patients’ action plans; regular follow-up is an
essential element of successful behavior change.25
These barriers could be addressed by delegating
goal-setting discussions and follow-up to other
caregivers, a concept endorsed by the majority of
clinicians. A greater percentage of clinicians in
safety net settings endorsed the delegation of action
planning; this may represent the reality that, com-
pared with private practices, safety net clinics usu-
ally have nurses, social workers, and health educa-
tors available. For private practices to involve these
caregivers, patients would probably need to be re-
ferred to hospital outpatient facilities where these
personnel work; such referrals constitute yet an-
other barrier for both private clinicians and pa-
tients. Moreover, few health plans pay these care-
givers for their time.

Limitations
This study was exploratory in nature and therefore
has the limitations associated with preliminary
work. Participating practices and clinicians were
self-selected and possibly more inclined than their
peers were to engage in a collaborative paradigm.
The research protocol encouraged clinicians to
hold goal-setting discussions with patients enrolled
in the study rather than with patients for whom
behavior change was an important issue in the pri-
mary care visit. We did not assess preintervention
knowledge of, attitudes toward, or experience with
shared decision making, which might have affected
clinicians’ opinions on the feasibility and accept-
ability of the goal-setting technique.

Conclusion
Although unhealthy behaviors are a leading cause
of coronary heart disease mortality, physicians fre-
cently fail to provide effective behavior-change
counseling to their patients.4 Collaborative goal-
setting—with clinician and patient together decid-
ing on behavior-change action plans—has been
shown to be a promising technique for assisting
patients to improve physical activity and diet.20–23
The study reported here finds that a sample of
primary care clinicians who volunteered to engage
in goal-setting discussions with patients with car-
diovascular risk factors had generally positive atti-
dudes toward this behavior-change technique.
However, lack of time in the multiagenda primary
care visit was a significant barrier to holding these
discussions and sustaining this paradigm in prac-
tice. Most clinicians were favorably disposed to
deleagating the goal-setting process to other mem-
bers of the primary care team. Future interventions
need to be tested in primary care settings to deter-
mine whether non-physician caregivers, in partner-
ship with physicians, can engage in behavior-
change discussions using goal setting, to make this
tool a realistic and sustainable component of pri-
mary care practice.
References


