

COMMENTARY

Action Planning: A Call To Action

Kate Lorig, MD

Action planning is both a new and an old concept. Goal setting became an important part of mental health interventions as early as the 1960s. For many years, the terms goal setting, contracting, and self-regulation were used more or less interchangeably. More recently, the concept has been termed action planning.¹

Handley et al offer the definition of an action plan “the agreement between clinician and patient that the patient will make a specific behavior change.”² Whereas this is an excellent definition for the use of action plans in a clinical context, it should be noted that patients, once they have the skill, can make action plans on their own. Thus action planning can and does occur outside of the clinic. The advantage of making them in a clinical setting is that this gives the clinician an opportunity to help design the action plan.

Two of the findings in the article by Handley et al reinforce previous findings based on experience that action plans are acceptable to patients. Very few refused to take part in the study. The concept was as acceptable to underserved patients attending safety net clinics as it was to those seeing private clinicians. More importantly, the majority of the patients remembered their action plans 3 weeks later and reported having made a behavior change.

Surprisingly, the authors found that the popular stages of change theory failed to predict either the acceptability of action planning or the carrying out of behavior change.³ This may be due to the fact that action planning, as described by the authors, was heavily dependent on self-efficacy theory. This theory states that one’s confidence in being able to accomplish a specific behavior is a good predictor of actual accomplishment.

Clinicians first asked patients to state their action plan. They then asked them how confident they were that they could accomplish the plan. This second step is taken directly from self-efficacy theory.⁴ It allows both the patient and the clinician to judge the probability of success and, thus, if necessary, change the action plan to assure greater success in achieving skills mastery.

In the study by MacGregor et al,⁵ this step toward self-efficacy, or confidence building, was found to be awkward and time consuming by some of the clinicians. This is not surprising because it is a new behavior for both clinicians and patients. The experience of the Stanford Patient Education Research Center mirrors that found in this study. First attempts at action planning are often awkward. There is a steep but rapid learning curve for both patients and those helping them with action planning. I would urge that this initial awkwardness not be used as a reason to eliminate what may well be the most important part of the action planning process.

It is noteworthy that more than half the clinicians found action planning better than their previous attempts at helping patients to achieve behavior change. In addition, more than 80% said that they would continue using action planning with some patients and a third had told a colleague about action planning. Given the difficulty of getting clinicians to adopt new behaviors, these would seem to be outstanding results.

Many clinicians found that the greatest drawback to making action planning an ongoing part of their clinical practice was time, an average of over 6 min. This can be looked at as a glass half full or half empty. Six minutes is very little time to accomplish behavior change in half of all patients. At the same time, in a busy clinical practice, 6 min add a heavy burden.

It has been our experience that first attempts at action planning are time consuming. For example, in our self-management workshops it takes about 45 min to introduce action planning and to help 10

Submitted 18 January 2006; *accepted* 20 January 2006.

From Stanford University, Stanford, CA.

In this issue, see related articles by MacGregor et al on page 215 and Handley et al on page 224.

to 15 workshop participants make their first action plan. Once they have learned the drill, we find that in subsequent weeks this time can be cut to 15 min. If this same economy could occur in clinical practice, then the time needed for action planning might be reduced to 2 min. We need longer studies where the clinicians, patients, and health care system have continuing experience with the use of action plans. Time may be saved from unnecessary visits or unproductive exhortation of patients.

In summary we, like the authors, patients, and providers in this study, believe that action planning is a valuable tool for achieving health behavior change. This tool can be used in clinical as well as other settings. These studies strengthen the role of self-efficacy in achieving behavior change while bringing into question the usefulness of stages of change. As with any new behavior, the first attempt was a bit difficult and time consuming. We are convinced that these barriers can be overcome with

practice. In short, action planning appears to be a tool that is acceptable to providers and beneficial to patients. Its use should be promoted.

References

1. Lorig K. Patient education. A practical approach (3rd ed). Thousand Oaks (CA): Sage Publications, Inc. 2001.
2. Handley MA, MacGregor K, Schillinger D, Sharifi C, Wong S, Bodenheimer T. Using action plans to help primary care patients adopt healthy behaviors: a descriptive study. *J Am Board Family Med* 2006;19:224–31.
3. Prochaska JO, Velicer WR. The transtheoretical model of health behavior change. *Am J Health Promotion* 1997;12:38–48.
4. Bandura A. *Self-efficacy: the exercise of control*. New York: WH Freeman Co; 1997.
5. MacGregor K, Handley M, Wong S, et al. Behavior-change action plans in primary care: a feasibility study of clinicians. *J Am Board Family Med* 2006; 19:215–23.