INTRODUCTION

This health practitioners' guide (referred to as the Guide from now on), is based on the HCA Model of Health Change. The Guide is intended to help health practitioners learn and practice the 10 step framework of the HCA Model to achieve greater success in facilitating client self-management and health behaviour change. The principles and techniques contained in this Guide can be used to support behaviour change to prevent or reduce chronic disease risk factors, manage chronic health conditions and improve quality of life.

HCA defines **health coaching** as a practice in which health practitioners apply evidence-based health behaviour change principles and techniques to assist their clients to adhere to lifestyle change and treatment recommendations, so that they can achieve better health outcomes.

The **HCA Model of Health Change** is a system of evidence-based principles and techniques that have been built into a framework that guides health professionals in how to facilitate health behaviour change in their patients or clients, for better health outcomes.

The processes of the HCA Model aim to actively identify and address behavioural, emotional, situational and cognitive barriers to change and build patient skills in decision making, problem solving and planning.

The HCA Model of Health Change bridges the gap between behaviour change theory and practice. It recommends *six foundation knowledge and skill sets* for health practitioners to acquire and provides a *simple 10 step framework* to enable practitioners to engage in three main tasks (see box below). The Model draws on principles and techniques from motivational interviewing, solution-focused coaching and cognitive behaviour therapy. It also integrates numerous theoretical concepts from the evidence-based health behaviour change literature.

The flexible nature of the HCA Model means that it can be used in any clinical health consultation conducted by medical, nursing and allied health practitioners, in chronic disease prevention and self-management programs, and in dedicated face-to-face or telephone-delivered health coaching programs. The Model can also be integrated into group-based education and self-management programs.

Three main tasks for clinicians using the HCA Model of Health Change

1. To provide clients with health assessment, treatment recommendations, and/or health education and referral advice in a way that reduces resistance and increases acceptance of this information. The aim is to assist clients to identify, understand and prioritise health-enhancing behaviour changes aimed at meeting or moving towards relevant clinical targets.
2. To assist clients to decide that it is in their own interests to adopt treatment recommendations and healthy lifestyle changes (given the personal tradeoffs that they will have to make). The aim is to increase client motivation and engagement in pursuing health goals, with an emphasis on those goals with the most beneficial health outcomes for the client.
3. To develop clients' problem solving skills so that they are more systematic and successful in making decisions, planning, initiating and sustaining behaviour changes. The aim is to increase client self-efficacy in engaging in health-enhancing behaviours.

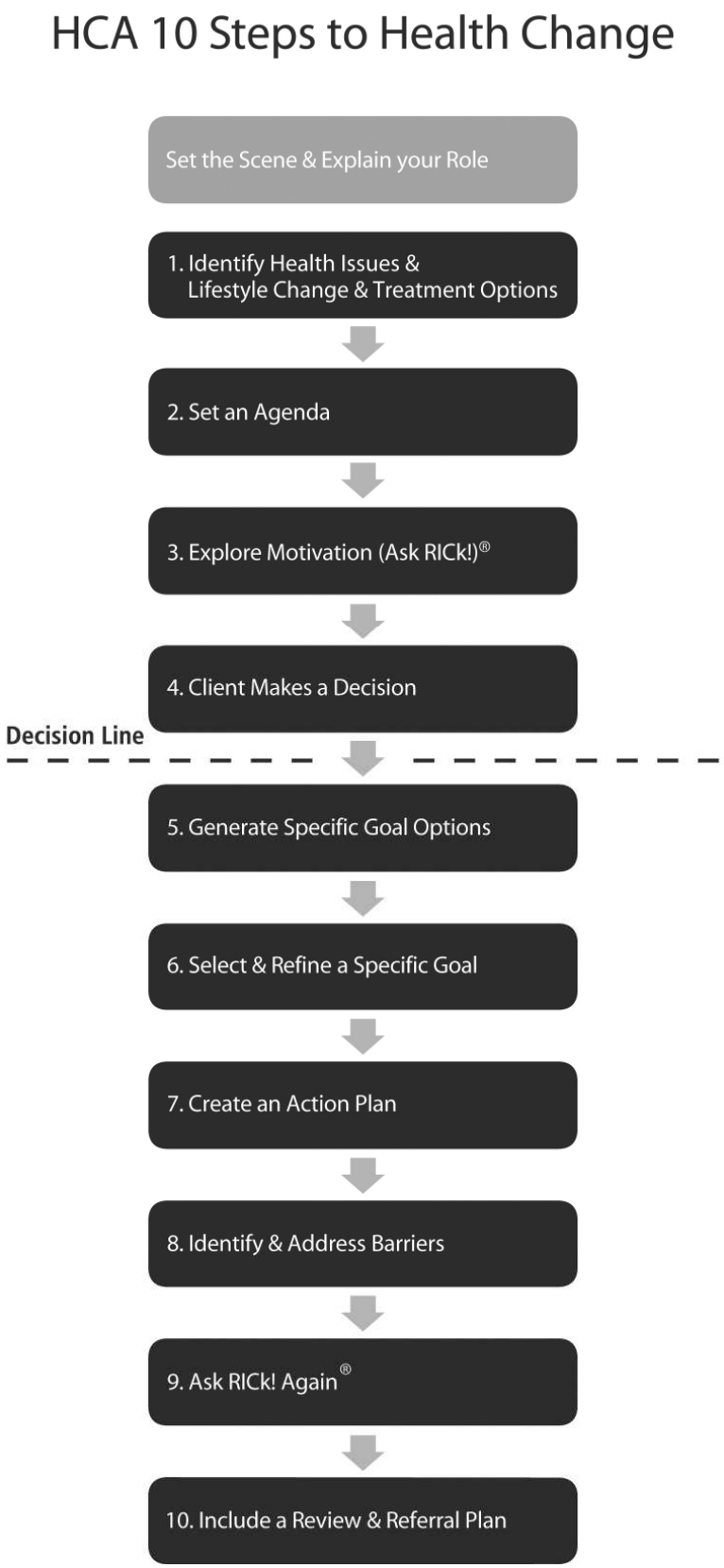
The 10 step framework of the HCA Model allows practitioners to assist clients to identify and prioritise their health changes, increase their motivation, make appropriate decisions and increase their self-efficacy to engage in sustainable health behaviour change. These 10 steps represent ten different points in a health consultation when barriers to change can commonly emerge for a client. Each step provides guidance regarding brief techniques required firstly to check for these potential barriers and secondly to address them.

The HCA 10 Steps help practitioners to systematically ascertain and work with the client's readiness, importance, confidence and knowledge in relation to taking the required actions to better manage their health. This is called the **HCA RICk Principle**, and is summarised by the phrase '**Ask RICk!**'®. Depending upon the client's RICk profile, different health behaviour change processes and techniques are recommended for the clinician to apply.

For a more detailed description of the HCA Model and its theory base, see Appendix B.

HCA 10 Steps to Health Change

The HCA 10 Steps to Health Change are shown in the diagram below and on the reverse side of the title tabs for each of the 10 steps sections in this book. These steps show the processes of facilitating health change in the sequence that the processes naturally occur.



The HCA decision line

There is a decision line built into the flow chart after Step 4. The HCA decision line represents the point in a consultation when a client makes a conscious decision that it is in their own interests to change an aspect of their lifestyle or follow particular treatment recommendations. Not all clients will cross the decision line.

The decision line is a reminder to clinicians that if a client does not perceive that there are benefits in taking action and has not made a firm commitment to do so, then health behaviour change is unlikely to occur or be sustained. Hence, it is unwise to proceed below the decision line into specific goal setting and action planning until the client has articulated their intention to take action.

Above the decision line, the clinician's task is primarily to support motivational and decision-making processes in order to guide the client towards forming an intention to make health-enhancing changes. Below the decision line, the main task is to engage the client in action-orientated processes such as implementation planning and coping planning, and to build and support the client's self-efficacy in relation to their chosen goal/s (see Appendix B for more information about the theory behind these processes).

Above the decision line a brief motivational interviewing approach is used, whilst below the decision line the clinician switches to a solution-focused coaching approach. The relationship between these approaches and the HCA 10 Steps can be seen in the diagram on the inside of the back cover of this book. The Guide follows and expands upon this ten step framework.

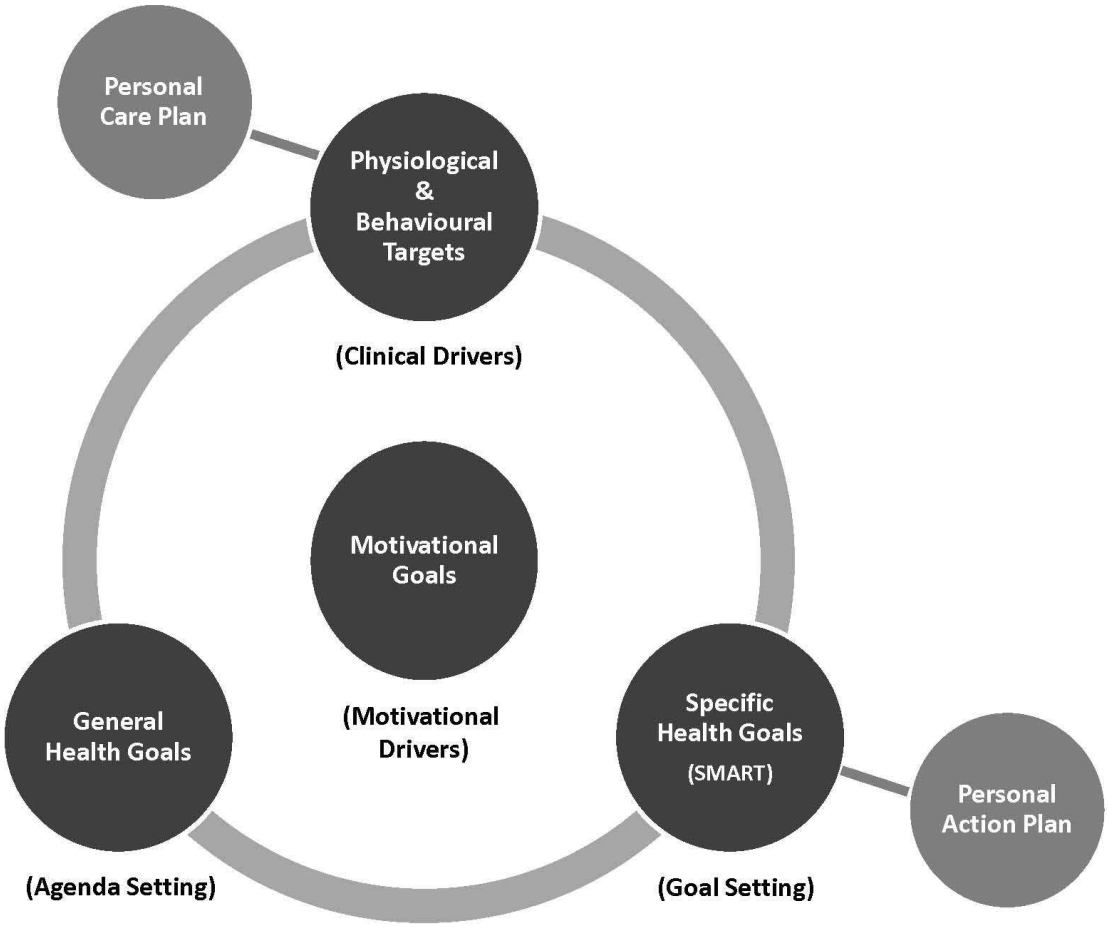
Four types of goals

When applying the HCA Model of Health Change, there are four different types of goals to consider. The diagram on the next page shows the relationships between these goals.

1. **Physiological and behavioural targets** are medical goals (clinical targets) associated with particular health conditions and risk factors (e.g., blood glucose, blood pressure, liver function, kidney function, waist circumference, BMI, bone mineral density as well as physical activity targets, nutritional targets etc.). These evidence-based clinical targets are often contained in care plans written by clinicians. They dictate which general health goals the client will benefit from working on, but do not specify exactly what the client needs to do to achieve their clinical targets. It is the specific (action-orientated) goals that are set with the client that state what actions the client will take to try to achieve the clinical targets.
2. **General health goals** are categories of the types of actions that can be pursued to achieve clinical targets (e.g., taking medications according to prescription, increasing physical activity levels, improving nutrition, engaging in weight management, stress management, pain management, reducing alcohol or smoking, attending medical appointments etc.). These broad categories of actions are what the clinician and client prioritise during agenda setting. It is from within these categories that specific goal options are generated, chosen and set collaboratively with the client as action-orientated goals.
3. **Specific health goals** are the action-orientated goals. These goals are based on carrying out certain actions or specific behaviours (e.g., attending an exercise class three times per week, eating two pieces of fruit per day, getting to bed before midnight each night, attending a series of rehabilitation appointments, completing a series of specific pathology tests etc.). These are the goals that are set collaboratively with the client during goal setting and action

planning processes that occur below the HCA decision line. The actions taken to achieve the specific health goals should impact positively on the client's clinical indicators and move them towards their clinical targets.

4. **Motivational goals** refer to the personal benefits that the client hopes to attain from improving their health outcomes. They are needed because clinical targets are not necessarily motivating in their own right. Motivational goals provide a focus and reinforcement or reward for the client as they begin and sustain movement towards their clinical targets and general health goals (e.g., to be able to attend a grandchild's wedding and not be in a wheelchair, to avoid a second stroke and the subsequent loss of independence, to continue to live independently and hence be able to keep one's pets, to be able to physically access social support and friendship, to feel good about oneself etc.). These motivational drivers are not actually set as goals. However, they are important personal goals that keep the client focused on the benefits they want to achieve by taking action. Clients will benefit from keeping these motivational goals in mind as they actively pursue specific health goals and action plans set in consultations with clinicians using a health coaching approach.



Two types of plans

1. **Care plans** are medical documents that usually summarise a patient's clinical indicators and targets and provide referral recommendations. They usually contain numerous clinical targets and lifestyle goals. Therefore, they can be used as agenda setting tools to assist patients to prioritise their actions and general health goals. The goals in care plans are usually set by clinicians for patients. Whilst patients are often invited to sign their care plans, it is common for people to be unaware of the specific contents of their plan.
2. **Action plans** contain the steps that a client needs to take in order to achieve a specific health goal. The specific health goal should in turn help them to achieve the clinical goals that can be found in their care plan. In some health organisations, care plans are called 'action plans' because they outline for patients what actions they should take in certain situations, for example, if they have an asthma attack. These action plans should not be confused with the type of action plan that accompanies a specific health goal. The latter type of plan focuses on addressing any barriers that might stop the client from achieving specific health goals that they aim to accomplish on an ongoing daily or weekly basis. See Step 7 for more information about these personal action plans.

Above the line processes: information, motivation, decision-making

Steps 1 to 4 of the HCA 10 Steps to Health Change are called 'above the line' techniques. They make no assumptions about the readiness of the client to engage in health behaviour change. If a client understands their health issues, lifestyle and treatment recommendations, is ready to take action and believes that it is personally important to do so, then steps 1 to 4 can proceed quite quickly. However, if the client doesn't meet these criteria at each step, then the clinician is advised not to progress below the decision line into action-orientated goal setting and planning processes.

Step 1 involves making sure that each client knows and understands their health conditions and risk factors (clinical indicators), the consequences of these conditions and risk factors and the actions they can take to address them. This equates to building an agenda for health change. This process identifies the possible things that the client is prepared to do over time to optimise their health outcomes. The range of health issues and actions discussed will depend upon the nature of the consultation, whether profession specific (e.g., physiotherapy, dietetics, occupational therapy etc.), program or disease specific (e.g., diabetes management, CVD rehabilitation, healthy pregnancy etc.) or addressing all of the clients conditions (e.g., general practitioner, nurse practitioner and practice nurse care planning consultations etc.).

Step 1 flows naturally into **Step 2**, choosing a general goal to work on. Generally there will be a number of health issues on the client's agenda that they can address to benefit their health. This step helps the client to prioritise which general health goal/s they will start working on, given the actions that they are already taking. Depending upon the client's clinical indicators and lifestyle risk profile, the health practitioner's role is to help the client to choose health goals that will be of particular benefit to them.

Once a general goal has been chosen to focus on as a priority, in **Step 3** the clinician checks the client's readiness, personal importance, confidence and knowledge in addressing it. The RICk Principle is used as a guide for the practitioner to do this. There are many ways to Ask RICk! The main aim is for the clinician to ensure that the client is actually prepared to work on the chosen issue

and that they perceive there will be personal benefits in doing so. Importance and readiness both need to be relatively high in order to proceed below the decision line. However, it is possible to proceed below the decision line if the client has low confidence in making sustainable changes. This is because the 'below the line' techniques all aim to set suitable goals for the client and to increase or reinforce the client's confidence in taking action.

Step 4 involves checking that a decision has been reached by the client to work on a relevant general health goal. This may become obvious in Step 3, in which case no further questions or clarification will be needed. The client and clinician can proceed across the decision line. However, if the client is ambivalent about taking action (indicated by low to moderate personal importance), the clinician is advised to ask them decisional balance questions. This technique aims firstly to help the client to weigh up the tradeoffs they will need to make in taking action versus the benefits they may gain from that action. Secondly, it aims to help the client to identify an intrinsic motivator for engaging in change. If importance does not increase as a result of these techniques, the client may be invited to revisit Step 2 to choose a different general goal.

Below the line processes: idea generation, planning, problem solving

Steps 5 to 10 of the HCA 10 Steps to Health Change are called 'below the line' techniques. They assume that the client is moderate to high in readiness to engage in health behaviour change, and that they believe there will be personal benefits to gain by taking action.

If the decision line is crossed, **Step 5** involves generating specific options for pursuing the chosen general goal. This can be achieved through the clinician conducting an assessment and presenting alternative treatment options/courses of action, by the clinician offering a 'menu of options', or by collaborative brainstorming and problem solving. The purpose of this step is to generate several specific goal options for the client to choose from and to use as backup options and alternative choices in the future.

Step 5 naturally leads into **Step 6** where the client chooses one of the options to take action on. The clinician's task is to ask a series of questions to assist the client to formulate a behaviour-based specific goal and tailor it to the needs and abilities of the client.

In **Step 7** the clinician and client collaboratively construct an action plan that details the various actions that the client must take in order to achieve their specific goal. The action plan is constructed primarily by listing strategies to address the potential barriers to achieving the goal.

In **Step 8** the clinician helps the client to identify barriers that they may not have immediately considered. In particular these might be behavioural, emotional, situational or thinking barriers. Through discussion and questioning, the clinician normalises the occurrence of these barriers and assists the client to generate strategies to overcome or deal with them. The clinician explains and offers behaviour modification, cognitive change and emotion management strategies for the client to try out as necessary. Relevant strategies are added to the client's action plan.

When the action plan seems complete, in **Step 9** the clinician asks RICk again in relation to the specific goal, given the steps in the action plan. In particular, confidence is used as a gauge for whether or not the specific goal and action plan are appropriate for the client. The goal and plan are adjusted as necessary to ensure that the client leaves the consultation with reasonably high confidence that they will be achieved.

In **Step 10**, the clinician arranges follow-up contact and/or other support as necessary for the client and reinforces a trial and error approach to health behaviour change attempts.

In **review consultations**, the process starts with reviewing and reinforcing the client's behaviour change attempts. The agenda for the session is then collaboratively set by deciding whether to continue to work on the same goal (because the previous plan needs adjustment), change to a new specific goal, or to move on to a new general goal. The rest of the steps are then worked through as appropriate. Actions taken, specific goal attainment and clinical indicators are all periodically reviewed to monitor the client's overall progress over time and to adjust the client's goals as required. Action plans are re-worked as the client confronts barriers to taking action and solutions are proposed to address these.

When a clinician encounters the situation where a client repeatedly presents without taking their planned actions, the question the clinician needs to ask is:

"Is the client 'above the line' or 'below the line' in terms of their motivation and self-efficacy?"

Applying the HCA Model of Health Change flexibly

The HCA Model is not a set program. It is a flexible framework that guides practitioners in facilitating health behaviour change in any clinical practice or health program context, including group sessions. It is a skills-based approach that requires on-going skills development and alignment of clinical systems in order for it to be successfully implemented and embedded into programs.

Whilst the HCA Model of Health Change gives clinicians guidance about which techniques can be used in various situations, the techniques described in this guide are meant to be used flexibly and adjusted to suit individual clients and situations.

If a client is ready, willing and able to carry out the required actions to improve their health, then they may not require much health behaviour change assistance. For example, if a client says "*it's important for me to do this and I will do it without any problems*", then it would be unnecessary to ask a lot of detailed questions about what they need to do to achieve their health goals and how they could increase their confidence. Health practitioners only need to ask probing questions and engage in more detailed health change processes if they think that the client will directly benefit from this. Nonetheless, it is still important to *check* that the client is actually committed to making the changes and is being realistic in their expectations. Asking RICk provides a simple way of doing this.

Some clients will be low or moderate in willingness (importance) and/or ability (confidence) to do what they have been advised to do by health practitioners. These clients will need more in-depth health change support to help them to engage in behaviour change and to problem solve around the things that might get in the way of them achieving their health goals.

Tips for Short Consultations

The time that a clinician has to spend with a client will also dictate the extent to which the clinician is able to act as a change facilitator. For practitioners who have very **short consultations** the HCA Model of Health Change gives guidance as to which techniques would be useful to include to progress the client to the next step in the process of health behaviour change. Usually this will be the first three of the HCA 10 Steps. Subsequent steps can be used in future consultations as appropriate. It is generally better to get clients firmly to the decision line, than for those clients to leave a consultation with detailed plans that they have no intention of acting on. Once a person is committed to taking action, the rest often falls naturally into place.

The HCA 10 Steps are deliberately sequential. They are presented in the order that they need to be considered and worked through with a client. The amount of time spent on each step depends on the individual client and their personal barriers to taking action. The HCA Model provides a framework for clinicians to use their consultation time effectively and efficiently by blending the traditional clinical tasks of assessment, treatment recommendations and health education with health behaviour change processes. In many cases, clinical consultation times can be reduced. By integrating a health change facilitation role into their practice, clinicians can also reduce their 'no show' rates and the number of clients who return again and again without having taken any significant action or improved their health outcome measures. When this happens, it is usually because a solid health behaviour change foundation was not laid in earlier consultations. The client may still be 'above the decision line'.

Core practice principles

Two sets of core practice principles that are used in conjunction with the HCA 10 Step framework are:

1. Client-centred care and communication principles
2. The HCA RICk Principle

Client-centred care and communication principles

Client-centred care from the health coaching perspective is summarised in the table below.

Traditional Care	Client-Centred Health Coaching
• Health professional as expert • Clients commonly advised to pursue multiple complex goals at once • Clients told what to do and personal preferences often not taken into account • Standardised assessment and education • One size fits all solutions • Extrinsic motivators • Clients required to facilitate change without assistance • Doesn't address personal barriers to change • Can create resistance to change • Can cause goal setting overload (too many goals from too many practitioners)	• Health professional experts offer clients evidence-based treatment options and information • Clients are helped to prioritise health goals depending upon clinical and risk indicators and individual circumstances • Clients respected as experts in own lives and as having the right to choose to follow recommendations or not • Individualised assessment and education • Individually tailored solutions to achieve clinical recommendations • Intrinsic motivators • Collaboration and assistance in facilitating change • Identifies and addresses personal barriers to change • Can decrease resistance to change • Number and magnitude of goals to be pursued at any one time will vary to suit each client and their situation

Health coaching represents a qualitative shift in clinical practice compared to traditional clinical service delivery models arising from acute care contexts. When working with people to address chronic conditions and lifestyle change, it is the client who has to take most of the actions, not the clinician. Therefore, a different approach is required. We know from the statistics on patient adherence that simply telling people what their lifestyle and treatment risks and recommendations are doesn't always translate into health behaviour change. Clients also often need assistance to know, choose, plan and do what is required to achieve better health.

Principles and techniques from active listening, motivational interviewing, solution-focused coaching and counselling are used as the basis of client-centred communication when using the HCA Model.

A useful communication technique to avoid building client resistance is:

First <u>ask</u> the client what they already know, then <u>offer</u> them information or ideas as necessary.

This principle applies when providing the following types of information and ideas:

- Offering education about clinical targets
- Offering education about health recommendations
- Offering information about treatment options
- Suggesting strategies to achieve goals
- Suggesting possible barriers to taking action or achieving goals
- Suggesting referral options

The HCA Model uses three main sets of techniques to provide information and suggestions or to generate individualised strategies for clients. They are meant to be used in the order in which they are presented below.

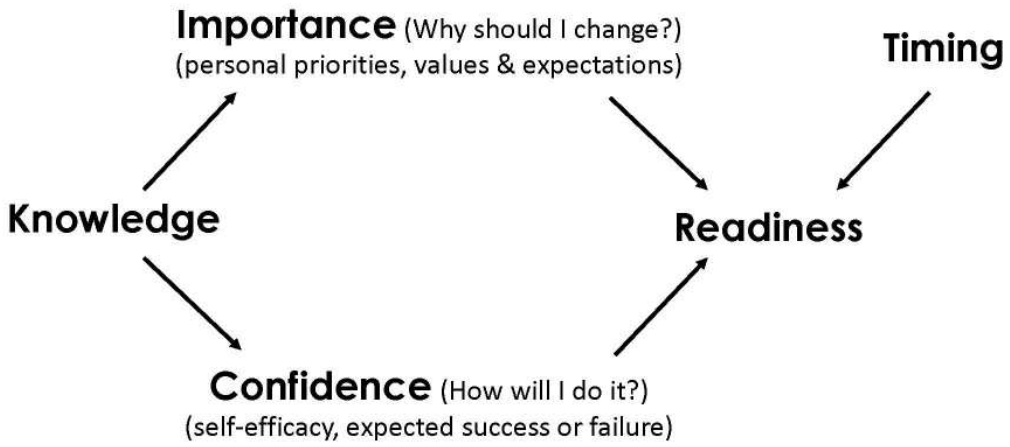
1. The "**Client First**" technique refers to eliciting information from clients to get their input as an equal partner in the consultation conversation, prior to offering them information. This technique can allow novel ideas to be generated by the client, which the clinician could not have thought of themselves (because they don't have access to the same information about the client's life as the client does). The client first technique involves the clinician asking the client questions designed to help them to think about their unique situation, needs and preferences, draw on their own strengths and experiences, and generate their own ideas where possible. It requires the clinician to refrain from offering suggestions until the client has had the opportunity to consider their own knowledge base and strategies. See Step 7 for suggestions about using this technique during action planning.
2. The "**Menu of Options**" technique enables clinicians to offer information, suggestions or advice without receiving a "Yes, but" response from clients. This technique can be used in conjunction with pre-developed goal hierarchies that provide a structured approach to generating ideas (see the annexes to Step 5), or as a way to provide treatment options arising from clinical assessments. The general format for this technique is:
    i) Ask permission to give suggestions: "If you like I can offer some ideas…."
    ii) Provide multiple strategies wherever possible
    iii) Ask the client if they think any of the options might work for them
    iv) Acknowledge that the client might be able to think of something else that suits them better
3. Active **brainstorming** techniques can help clinician and client to collaboratively generate novel, individualised specific goal strategies for achieving general health goals. See Step 5 for more information about using this technique below the decision line.

Another useful communication principle is summed up by the phrase 'WAIT 'til 8'. The acronym WAIT refers to either 'Why Am I Talking?' or 'Why Am I Taking notes?'. We often jump in too quickly with our own suggestions, and don't let clients have the time they need to think of their own ideas. 'WAIT 'til 8' suggests that we should give clients at least eight seconds to respond (and sometimes longer) so that we don't inadvertently cut short their thinking processes. The phrase 'Why Am I Taking notes?' can help clinicians to challenge their own tendency to write down too much detail in client notes. This can interfere with building a good working relationship between clinician and client. See 'Setting the Scene' for more information about documenting consultations.

The HCA RICk Principle

Steps 3 and 9 of the HCA 10 Steps remind clinicians to Ask RICk to check readiness, importance, confidence and knowledge at the general health goal level, and again at the specific goal and action planning level. However, the RICk Principle is meant to be used by clinicians the whole way through the 10 step process. As soon as you detect that any of the four factors is lacking, you need to take action before progressing to the next step.

As a general rule, there is no point in progressing below the decision line if readiness, importance or knowledge is inadequate. Confidence is the main factor that you can work on below the decision line. The relationships between readiness, importance, confidence and knowledge can be seen in the diagram below.



Adapted from Rollnick, Mason & Butler (1999)

This diagram suggests that a client's **knowledge** and understanding of their health conditions and risk factors can impact on how important they think it is to take particular actions. Their knowledge of what to do and how to do these things in a manageable way can also impact on the client's confidence in carrying out the required actions.

Importance in this context refers to a person's personal importance in taking action to address a particular issue. This personal importance partly involves considering the *relative* importance of taking the proposed actions in relation to other priorities in the client's life. Intellectually the client might think that it is important to manage their health condition or improve their clinical and lifestyle risk profile and believe that they 'should' take action. However, considering all of the other things currently going on for them, it might not be a high priority for them to take action on the issue right now. For example, a mother with a chronically sick child may not prioritise her own health concerns, even though she appreciates the importance of maintaining her health. People may also think that achieving the ***outcomes*** of a health goal such as weight management or pain management are very important. However, they may not think it is important to take the ***actions*** necessary to give them the desired outcomes. For example, making small, sustainable, long-term changes will take longer to show results than drastic changes, even though they may provide more sustainable outcomes.

Confidence is closely related to the concept of self-efficacy. This is the person's perception of the extent to which they have the ability to carry out the required actions. However, this concept of confidence does not relate only to the person's physical ability to do the things that they believe

they need to. It also refers to whether or not they think they **will** carry out their plans, given the barriers that might potentially get in the way for them.

Readiness also has a **timing** aspect to it. A client may think that it is important to take action to manage their health, and may have the confidence that they can do what is required. However, temporary circumstances might stop the client from prioritising these actions at the current point in time, or might undermine the client's attempts to take action if they were to try to do this now.

In reality, all of the RICk factors interrelate. See Steps 3 and 9 for different ways to Ask RICk. Keep in mind the following RICk Rules to guide you.

RICk Rules!

#1 - If importance is low:

Ask decisional balance questions to help the client find intrinsic motivators
that make it important enough for them to want to take action

#2 - If confidence is low:

Reduce the magnitude, number or complexity of goals &/or
help the client to identify and address their barriers to taking action

RICk Rule 1 is especially relevant for general health goals such as whether or not to take action to self-manage a chronic disease, lower cholesterol or blood pressure, increase exercise or aim towards a healthy waist circumference target.

RICk Rule 2 is particularly relevant to specific behavioural goals such as engaging in a specific type of physical activity (walking, swimming etc.), eating a specific number of serves of vegetables per day, taking specific medications in accordance with recommendations, attending specific appointments or programs etc.