Introduction to Health Coaching
A Toolkit for Physiotherapists
# Table of Contents

- Introduction
  - Background
- Health Behaviours
- Health Coaching
- Behaviour Change
- Facilitating the Change Process
  - The Therapeutic Alliance
  - Communication
  - Motivational Interviewing
  - Behaviour Change Techniques
- Identifying Achievable Goals
  - Bridging Patient Goals and Outcome Measures
  - Cultural Competence
- Active Learning
- Personal Accountability
- Considerations Specific to Physiotherapy
  - Brief Interventions
  - Longer-term Interventions
- Resources
- Appendix 1: The PT-BCT Checklist
- Appendix 2: Personal Decision Guide
- Appendix 3: OA Go Away
- Appendix 4: HealthChange Methodology
- Sources
- Acknowledgements
Self-management supports an active role for patients with chronic conditions by enabling patients to learn to manage their symptoms, maintain independence, and achieve a better quality of life. Health coaching is emerging as an effective means to promote and support self-management. Health coaching helps patients “gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals.”

A recent systematic review of the health coaching literature concluded that it can be effective in improving a patient’s lifestyle behaviour and self-efficacy and has resulted in patients achieving better overall physical and mental health. Health coaching has also been shown to facilitate improved weight management and increased physical activity, and has been associated with improvement in factors affecting cardiovascular health, pain management in cancer patients, and adherence to self-management and lifestyle changes in patients with diabetes.

The physiotherapy profession is well suited to incorporate health coaching. Physiotherapists are health-care professionals who “promote, restore and prolong physical independence by enhancing a client’s functional capacity. Physiotherapists encourage clients to assume responsibility for their health and participate in team approaches to health service delivery.” Physiotherapists treat a wide range of patients with acute and chronic conditions; physiotherapists see them on a regular basis and provide personalized care. They provide education on risk factors for prevention and management of a condition, prescribe exercise and physical activity to achieve and maintain independence or function as well as physical techniques to manage stress and cardio-respiratory symptoms. Given the current and growing prevalence of chronic conditions, patient demographics will include patients with one or more risk factor, or who are in the early or advanced stages of a chronic condition either in addition to, or as the primary reason, they are consulting a physiotherapist.

This Toolkit is not intended to be a comprehensive guide to health coaching but will provide an introduction to the essential components, along with resources to guide physiotherapists wishing to explore this approach.

Background

More Canadians are living with chronic conditions than ever before. Over one in five Canadian adults live with one of the following chronic diseases: cardiovascular disease (CVD), cancer, chronic respiratory disease (CRD), or diabetes. In addition, musculoskeletal disorders (MSD) are the most common reason for repeated visits to a physician, with chronic low back pain among the most common reasons for physician consultations among people under 60 years of age in Canada.

Chronic conditions are detrimental to a patient’s quality of life and are an increasing economic burden on society. Each is associated with four risk factors or health behaviours - smoking, unhealthy eating, physical inactivity and harmful use of alcohol. Obesity and hypertension may also contribute to the onset of a chronic condition. Similarly, these risk factors may impact quality of life and health in older adults and contribute to the onset of frailty.

The health cost and economic burden of smoking, obesity and alcohol abuse are well reported in the literature. Physical inactivity is increasingly being recognized as a major factor in the onset and progression of illness and chronic disease. A recent Canadian study concluded that, as well as a higher number of physician and specialist visits, patients who are physically inactive spend 38% more days in hospital than active people.

Addressing these risk factors can alter the effects of chronic conditions on the patient, and on their use of health-care resources. To do so, the focus of care shifts from the condition to the patient and the complexity of changing health behaviours.

Physiotherapy Alberta + College + Association has developed the Introduction to Health Coaching for Physiotherapists Toolkit to provide physiotherapists with a clinical resource to promote self-management strategies in patients with chronic conditions.

Physiotherapy Alberta - College + Association | Introduction to Health Coaching for Physiotherapists
Health Behaviours

Patients living with chronic conditions make decisions about their health and manage their symptoms daily based on their understanding of their condition, their activity level or capacity, their self-care requirements and family/social responsibilities. They rely on health professionals for support, for collaboration to achieve health goals, and for education on self-management.

Health behaviours are complex and ultimately manifest as the culmination of multiple factors, including:

- Personal (e.g., motivation)
- Social (e.g., family influence, social media)
- Environmental (e.g., living situation, built environment)
- Institutional (e.g., access to resources) influences

Additionally, improving or changing health behaviours may not always be seen as a priority. People generally do not experience the consequences of poor health behaviours immediately, or they may be focussed on other more immediate concerns. Despite these barriers, health behaviours are modifiable and within the patient’s control.

As a result, behaviour change is dynamic, variable, and neither linear or chronological in nature. Many people are ambivalent about making any changes - the desire to change is countered by the desire to stay the same. Health coaching recognizes this tension and targets the coaching strategy to the patient.
Health coaching is patient centred. The patients’ perspective and values drive the process of behaviour change, allowing them to develop skills in self-management and the confidence to apply these skills independently.

It is a collaborative process. The health coach explores patients’ knowledge and understanding of their conditions or their associated health status, their current and past experiences, and their readiness to make changes to health behaviours or lifestyle. Have they tried other strategies or approaches? Do they know how, or are they ready, to set goals or are there other priorities to address? With those who are ready and able, the coach works with the patient as they prioritize their goals - the behaviours they want to change or improve - helping them find ways to meet them, or, in some cases, to set more achievable goals. With those who, for various reasons, are ambivalent about or not ready for behaviour change, the health coach explores and resolves the perceived barriers to change helps them to take the next step towards change.

Health coaches:

• Support the patient in problem solving how to overcome and learn from any obstacles he/she encounters in achieving goals and facilitates the selection and use of “markers,” or indicators, that will help measure patient progress.
• Acknowledge and respect patients’ autonomy so patients learn to be personally accountable for aspects of their own care and build intrinsic, or internal, motivation, and a sense of self-efficacy, or belief in their own ability to be successful in achieving a goal.
• Do not identify problems and/or tell the patient what to do; health coaches are supportive, “well-informed guides,” and are neither directive nor prescriptive.
• Facilitate and guide the patient’s change process.
• Help the patient identify his/her own achievable goals for change.
• Facilitate an active learning process for working towards goals.
• Help patients be accountable for and monitor, their own progress.
Behaviour Change

Health coaching for behaviour change begins with assessing the patients’ readiness to change and their level of engagement to follow through on the goal.

The coach will focus on the dynamics of change - what patients know and understand about their conditions, and what they wish to change, but also what they see as the pros and cons for making (or not making) changes and how that change will affect their day-to-day life. For example, while the patient recognizes that a change will be beneficial, there may be negative associations that reinforce their ambivalence - what else are they changing, what will they lose when they make the change? Previous experience is also a factor - is this the patient’s first attempt at making a change, or have they tried multiple times unsuccessfully? How confident are they in their ability to make and sustain a change?

Success in making and sustaining a change in a health behaviour is determined by resolving ambivalence and facilitating a belief in one’s ability. These two concepts have been termed “decisional balance” and “self-efficacy” and are described below.

Decisional balance is a health coaching tool that can be used to help patients quantify their ambivalence and visualize how they see the implications of making an identified change. During goal identification, it clarifies any discrepancy between the patient’s stated goal and their actual situation. It will also assist in determining their readiness to change a health behaviour. Decisional balance is discussed further in the section on identifying achievable goals.

Self-efficacy is a patient’s confidence in his or her ability to successfully make and sustain a behaviour change. It is affected by a number of factors, including whether it is the initial attempt to make a change, whether he or she has had repeated (and possibly unsuccessful) attempts in the past, and by emotional and psychological state.

Self-efficacy is critical for achieving positive outcomes in health behaviour change in patients with a range of chronic conditions, such as osteoarthritis, chronic pain, and COPD. It is also essential for those living with a chronic MSD, such as non-specific low back pain.

Self-efficacy can be fostered in a number of ways, such as:

- Mastering a task: Achieving goals will build and reinforce patients’ belief in their self-efficacy. While a failure may undermine that sense, setbacks can also reinforce the value of sustained effort. For example, reframing a setback as achieving a percentage (e.g., 25%) of a defined goal can be a reinforcement to continue. “Normalizing” the occurrence of setbacks will also help the patient build self-efficacy.
- A vicarious experience: Seeing others similar to oneself achieving a goal. This can reinforce a belief that patients do have the capacity to master a task. However, patients must not perceive or feel they are being compared unfavourably to others.
- Verbal persuasion: Support for, or confidence in the patient’s capacity expressed by an influential person, such as a health coach or a health care professional, can enhance self-efficacy.

The Transtheoretical Model (TTM) of change is an integrative, biopsychosocial model that describes the process of intentional behavior change. It describes a series of stages patients move through when modifying or changing a behaviour. The principles of decisional balance and self-efficacy are used in health coaching to help determine the patient’s current stage and the appropriate coaching strategy to facilitate the process.
TTM views change as a five-stage process, not a single action or decision and integrates the patient’s current status with the patient's intention to change. Change is frequently non-linear, and regression to previous stages, or re-cycling through the current stage, is part of the overall process, as shown in Figure 1.

The Five Stages of Change in TTM

- **Precontemplation**: Patients who are not intending to make changes within the next six months. For example, they may not understand the issue/consequences or may have other personal priorities that take precedence. In some cases, previous attempts to change a behaviour have been unsuccessful and the patient lacks confidence to try again.22

- **Contemplation**: Patients who intend to take action within the next six months. For example, they may have just been diagnosed with a chronic condition, or they have just identified a health behaviour they would like to change, or their life circumstances are such that it is possible to make a change now, or within the next six months.22

- **Preparation**: Patients are now ready to take action within 30 days, and have begun taking small steps towards their goal, a healthier lifestyle.22

- **Action**: Patients who intend to take action within the next 30 days and have already begun, but it is not yet part of their routine. For example, they may have begun to exercise, but not on a regular basis.22

- **Maintenance**: Patients who have made changes in behaviour in the last six months. They may be following a regular home routine or are participating in a group activity.22

**Figure 1.** Transtheoretical Stages of Change Model.29 Used with permission.
Facilitating the Change Process

The relationship between the health coach and the patient is critical for a successful collaboration in planning and achieving a behaviour change. Behavioural change interventions require trust, thoughtful and non-judgmental communication that respects the patient’s autonomy, and a process that is appropriate to their knowledge, motivation and capacity.

The Therapeutic Alliance
The skills employed in health coaching are congruent with those of physiotherapists as described in the therapeutic alliance in physiotherapy. Both stress the importance of setting collaborative goals, setting tasks aligned with those goals, and the importance of an interpersonal, trusting bond between the patient and the health-care professional. Research has identified that being present, receptive, committed, and genuine were necessary conditions for a positive physiotherapy therapeutic relationship. These conditions reinforce actions that establish connections with the patient, through acknowledging the patient as a patient by meeting them as a partner, validating their experiences, and individualizing treatment to the needs of the patient.

Health coaches consistently demonstrate empathy and a respectful manner that builds a non-judgmental, collaborative relationship. They show respect for the patient and their unique perspective, feelings and values and maintain an attitude of acceptance, but not necessarily approval or agreement. Using verbal and non-verbal messaging to communicate that they understand the patient’s situation will reinforce collaboration and concordance in setting goals.

Communication
Thoughtful communication is an essential element in health coaching. It can facilitate and support the patient’s consideration of, and decision to make a change in health behaviour. The health coach seeks to learn the patients’ knowledge or understanding of their condition, the goals they would like to achieve, and the factors that will affect achieving them (both positive and negative). The health coach then provides information that is targeted to the patient’s understanding, needs and personal situation.

Communication in health coaching strategies includes:

- **Asking, not telling**: Open ended questions communicate that the coach values the autonomy of patients as a partner and encourages a discussion of their concerns about their condition, what they would like to change, and when and how this might happen. Examples include, “What do you see as your biggest challenge?”, “What have you tried in the past?”, “Would you like to know more about...?” or “How do you think you could...?”

This also helps the coach learn about his/her patients’ level of health literacy - what they understand about their condition. The coach can then target any evidence-based information to provide regarding their level of understanding and needs.

- **Active listening**: The health coach is aware of his/her own body language and non-verbal cues that let patients know they have the coach’s attention. (e.g., making eye contact, mirroring postures, nodding to acknowledge comments). Being open-minded and non-judgmental. The health coach avoids making negative comments, criticism and/or correcting the patient, seeking only to clarify the patient’s perspective (e.g., “It sounds like you have...”, “Am I correct in thinking that...” rather than “You shouldn’t...” or “you need to...”)

- **Reflective listening/responses**: Repeating, restating or clarifying the key points in what patients have said communicates to patients that the health coach has heard them, values their concerns and wants to understand their point of view. It may also help the patient gain an additional perspective to reflect on as they consider making a change in behaviour.

- **Maintaining a respectful manner**: Communicating a positive regard for the autonomy of patients will allow a discussion of their situation without overwhelming them with information. For example, when patients identify a specific concern, the health coach first explores what the patients know already, and then inquires if they are interested in knowing more.
By responding to the specific question or issue, rather than providing a global explanation of the whole topic, patients are enabled to review their situation and make decisions based on their understanding and new learning. As in all aspects of care, thoughtful communication improves compliance and is an important factor in improved outcomes.33

Motivational Interviewing

Motivational Interviewing (MI) is one methodology used effectively in health coaching. MI is a “collaborative, person-centred form of guiding to elicit and strengthen motivation for change,” and like all other professional skills, requires training and practice. Within health coaching, MI is used to assess the readiness of patients for change, build on their ability or capacity to make a change, and to set realistic goals.

MI focuses on “evolving and strengthening” the client’s own verbalized motivations for change.35 Its guiding principle is that the patient articulates the arguments for change, not the professional.37 Arguments, or reasons, for change are classified as “change talk.” Conversely, reasons for maintaining the status quo are classified as “sustain talk.” The focus of MI is to explore those reasons, resolve the ambivalence to change and guide the patient as they shift to “change talk.”35

MI integrates common communication strategies under the following set of principles:

- It requires the physiotherapist to adopt an empathic style that is accepting and a belief that ambivalence about change is normal.34
- Using MI techniques helps the patient recognize discrepancies between their stated goals and their current situation, avoids arguments (“rolls with resistance”) and supports self-efficacy. “Rolling with resistance” acknowledges any negative comments and reframes them by, for example, restating them as a neutral reflection, or by providing information that may shift the patient’s perspective.36
- It requires the physiotherapist to remain focused on the goals and values of patients – it is not a series of questions intended to convince them to change behaviour, or to pressure them into making a change that the coach has identified as important.20

Although training in MI is recommended, Rolnick et al provided family physicians an introduction to the core strategies,37 and recommended the use of:

- The guiding style
  - Open ended questions that ask the patient to consider how and why he or she might change
  - Using reflection or other means to show empathy and encourage discussion
  - Asking permission to provide evidence-based information; ask what more information might mean to them (e.g., “would you like to know more about?”, i.e., effects of physical inactivity, weight gain or chronic condition diagnosis, or “what do you think that (information) means for you?”)
  - Building on patients’ strengths, such as:
    - Setting the agenda by asking them to select the issue or problem that is their priority.
    - Assessing their ambivalence to change – what are the pros and cons? Is change a possibility?
    - Determining what the importance of making a change is. If its importance is not high, supply information for further review, recognizing their autonomy in decision making.
  - Exchanging information- elicit what the patient understands, provide information on potential results of not changing (both positive and negative), elicit their understanding of any personal implications of making a change, as well as not making the change.
  - Responding to patients’ language - as in active listening.
  - Use open-ended questions. When patients engage in “change talk,” which suggests they are thinking of change (e.g., “I should...” “I want to...” or “I know it would be better if I...”) the coach’s response might be to say “You feel that...” or “How do you think you might...” that encourages more discussion about change. When they use “sustain talk,” indicating preoccupation for the status quo (e.g., “I enjoy...” or “I have never succeeded in...”) the coach attempts to move the conversation towards change, using questions such as “What do you see as drawbacks to...?”, “What would happen if...?” or “How might things be different if...?”

MI requires training to learn the skill and achieve competency to practice. The Resources Section provides links to opportunities for training and online resources in MI, including a webinar on MI by D. Gross, PT, PhD and Joanne Park, OT, PhD hosted by Physiotherapy Alberta College + Association.

Behaviour Change Techniques

Behaviour change interventions include all the components of a health coaching strategy. Behaviour Change Techniques (BCTs) are the active and measurable components.36 These techniques offer a broad range of tools a health coach can employ to facilitate health behaviour change at any stage in the process of behaviour change. Similar to MI, BCTs can prompt reflection, identify barriers or obstacles to change, build self-efficacy and help implement or maintain a behaviour change. For example, an active learning strategy may use problem solving (a BCT) in conjunction with other BCTs such as goal setting, self-monitoring, behavioral prompts, cognitive coaching, and reinforcement to achieve a goal.

BCTs may be behavioural, cognitive or motivational and can be implemented throughout the behavioural change process. Recent research suggests that combining BCTs that facilitate self-regulation, defined as the physical skills and function, or the “how to,” with communication that addresses the underlying motivation, the “why,” supports maintaining a new behaviour over time.37 For example, an older adult may cite maintaining independence as their primary goal because they enjoy travel, while a younger person may focus more on resuming a particular sport or activity, because he or she is looking forward to a tournament. For the former, BCTs may be targeted to prompting graded exercise and identifying barriers, while for the latter, pacing and visualization may be most effective.

“Active” or behavioural BCTs, such as pacing and self-regulation, which encourage symptom self-management, have been shown to be more effective than “passive” or cognitive techniques, such as education and advice, for maintaining physical activity in people with OA.36 Similarly, BCTs such as graded activity, self-monitoring, recording activity outcomes, or planning and implementing environmental changes are effective for increasing physical activity and for healthy eating.37

Appendix 1 is the PT-BCT Checklist, developed in 2014 by Harman, MacRae, Vallis and Barrett,38 and is used with permission. The checklist includes BCTs specific to physiotherapy practice and were selected from Abraham and Michie’s taxonomy of BCTs.39 The BCTs and their descriptions in the checklist relate to chronic MSD disorders, but are applicable to other areas of physiotherapy practice.
The strongest predictor of success in health coaching is how the goals are set.\(^ {40}\)
To bridge the gap between intention and behaviour, any goal must be specific to
the patient’s personal preferences and ability, recognize potential obstacles and
plan strategies in advance to overcome them.\(^ {41}\)

The health coach recognizes that throughout the change process,
the patient’s readiness to change and their resulting decisions
and actions will be influenced by both their decisional balance and
self-efficacy.

There are several tools available to ascertain readiness to change.
For example, the Likert scale (1-10) can quantify both how
important making the change is to the patient and how confident
he or she is that the changes can be made. Patients’ responses
will give a strong indication of the value they attach to the change
and their readiness to make that change.\(^ {27}\)

Additional tools to evaluate or monitor decisional balance include:

- The “Readiness Ruler” (Figure 2), is also a 10-point scale that
can be used throughout the coaching process and beyond to
weigh decisions about the importance of making a change and
confidence in their ability to make that change.

- The Ottawa Personal Decision Guide (OPDG) is a take home
guide that is valid across populations and is included in
Resources Section of this document. The coach may provide it
as part of the consultation with the patient. The OPDG walks
the patient through the process of identifying problems,
weighing the pros and cons for each risk and benefit,
identifies available support and clarifies the approach the
patient prefers.\(^ {32}\)

- An Adapted OPDG, for use with indigenous populations, is also
included in the Appendix 2.\(^ {33}\)

Lower scores in the tools assessing decisional balance suggest the
patient is likely either in the Pre-contemplation or Contemplation
stage within the TTM model. Pre-contemplators may rate
importance of change at three or lower. These patients are more
likely to speak more about reasons not to change - the cons - than
the benefits for making a change - the pros. By contrast, the
reverse occurs for patients in the Action or Maintenance stages:
they tend to speak more about the pros for maintaining the
change than the cons.\(^ {44}\)

Similarly, there is evidence that there is a strong correlation
between self-efficacy scores on the tools and the patient’s stage
within the TTM. Scores on the Likert scale or the Readiness Ruler
are lower in the pre-contemplation stage than in the maintenance
stage.\(^ {44}\)

Along with the observations about the patient’s understanding
of their condition, their health beliefs and their social and family
support, the scores for both decisional balance and self-efficacy
assist the health coach to determine the patient’s stage in the
TTM and to plan the appropriate health coaching approach.
Goal: increase physical activity

Coaching approach

Examples of potential BCTs to select from PT-BCT Checklist

Pre-contemplation
May be unaware of the benefits they might gain by increasing physical activity, have other priorities that take precedence, or have barriers such as location or a lack of equipment to engage in a physical activity. They may not recognize the gap between their goal and their current status.

Discussions on benefits of physical activity, explore cons, barriers of making a change, as well as pros and cons of not making a change. Problem solving, if appropriate, including whether this is the right time in the patient’s life to make a change in this area.

Providing information on behaviour – health link, prompting intention formation, prompting self-monitoring of behaviour.

Contemplation/Preparation
May feel the cons of (barriers to) physical activity outweigh the pros. May have pre-conceptions for what is required or may have not been successful in past attempts.

Discuss potential benefits of physical activity, explore cons and engage in problem solving to resolve cons/barriers, as well as the pros and cons of not making the change. Encourage reflection on intrinsic reasons for goal by exploring what will change in the patient’s life by making a change, and/or past successes, as well as the contributing factors.

Role modelling, providing information on the approval of others, prompting visualization, facilitating internal reinforcement.

Action
Has begun to increase activity but it is irregular.

Confirm benefits of regular physical activity, problem solving for barriers, support self-efficacy in keeping schedule, routine, and contingency planning for occasions when activity is not possible.

Pacing, agreement to behavioural contract, positive feedback.

Maintenance
Regular participant

Support self-efficacy, discuss value of variety of activities, social support

Setting graded activity, stress management, review of behavioural goals, internal reinforcement

Table 1.

Table 1 demonstrates how a health coach may approach collaborative goal setting with patients at various stages and/or readiness to change when “increased physical activity” was the first goal the patient selected. NOTE: BCTs are suggestions only and will be selected as appropriate to the patient.

Bridging patient goals and outcome measures

Patients’ goals are specific to their personal situation or needs. However, in the clinic, the physiotherapist’s assessment goals or intervention measures may not address the patient’s goals directly. A study comparing patient goals and clinical outcome measures used in chronic low back pain found that patient goals were not directly tied to the clinical outcome measures used for pain or for recording the patient’s clinical improvements. For example, while treatment was progressed or adjusted based on changes in range, strength, or other outcome measures, patients’ goals (and their own measure of success) were their ability to resume a specific activity. Health coaching is an excellent tool that can be used to bridge the patient’s goals to the outcome measures used by physiotherapists to measure progress, providing the goals are aligned and the physiotherapist is able to articulate how the goals support one another. Throughout the health coaching relationship, the focus is on patients setting and achieving their goals, with the health coach facilitating the patients’ ability to identify and solve problems, and respecting their autonomy.

HealthChange(R) Australia is a methodology that promotes behaviour change to support self-management. The physiotherapist in the video in the link below describes how she incorporates health coaching principles within physiotherapy management of a woman with an acute ankle injury, and is used with permission:

https://vimeo.com/healthchange/review/83546314/3d15a2bd8

Cultural competence

Cultural competence is the ability to communicate effectively and respectfully with people from different backgrounds. In health care, it has been defined as “acknowledging and incorporating the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.” The term also refers to ethno-cultural, gender and/or gender identity and expression, sexual orientation, age, disability, income, and educational level differences.

Health-care professionals have the same implicit biases as the general population. Implicit biases are those a person may not be conscious of; the “stereotype-confirming thoughts that pass spontaneously through one’s mind, and that can lead to discrimination.” Implicit biases may even exist regardless of the person’s expressed values. Research shows that biases in health care can result in poorer health outcomes, as well as reduced adherence to health care in targeted populations. Biases do not have to be overt – they can be expressed through “micro-aggressions - brief, verbal or non-verbal expressions that may or may not be intentional, but convey a derogatory or hostile attitude.”

The following are examples of strategies for incorporating cultural competence within health coaching:

- Be aware of how your personal status (e.g., gender, race, physical abilities or health, income, sexual orientation, education etc.) may predispose you to implicit biases, such as your expectations for health behaviours in others
- Reflect on your own implicit and explicit biases
- Develop and use an inclusive assessment form
- Provide culturally specific examples to communicate concepts
- Link goals to culturally informed roles and expectations
- Provide links to appropriate community supports for follow up
As the steps are accomplished, patients (especially those in the initial stages of behaviour change) gain self-efficacy and learn they have the ability and capacity to succeed in other situations.

Whether a goal is focused on physical activity, a functional goal or a social activity, it must be stated in the patient’s own words and be meaningful to them. For example, the patient who has stated broadly that his or her goal is to “increase their level of physical activity”, may further elaborate that he or she misses going to her/his weekly walking club and would like to re-join. This goal has meaning and value to them. Their statement “I would like to rejoin my walking group” may be further broken down into “I would like to walk for 30 minutes at a moderate pace so I can rejoin my walking group with confidence”.

In the ensuing discussion, the patient expresses concern about their endurance, as he or she has been diagnosed with osteoarthritis and feels his or her legs are getting weaker and knees are stiff lately. Together the physiotherapist and the patient consider the actions required to resume distance walking and work out a strategy that prioritizes the steps and is achievable. Steps the patient proposes might include getting stronger, improving stamina, and/or buying better footwear. The coach uses open ended questions to help them prioritize the steps and decide on an action plan (e.g., “what gives you the most difficulty?”, “which of these would you like to work on first?”)

The health coach also recognizes that the means or activities to meet the desired goal for “increased physical activity” will be more successful if it is the patient’s preference or choice - this may include whether this is done independently or with a peer group, as an example. Similarly, some patients prefer non-competitive activities, while others gain from being part of a competition. In some situations, it may be that formal physiotherapy treatment is the patient’s choice and the optimal means to achieving the goal: the health coach is attuned to this as well.

Table 2 illustrates a patient-led plan for increasing physical activity. In this case, the health coach used the SMART model of goal setting to facilitate the process.

Goal setting includes talking about managing any setbacks that may happen such as the possibility that patients may encounter obstacles (e.g., time constraint, symptom flare) or that their situation may change (family or work requirements) and ensuring that this is a part of the change process. The coach will reinforce to the patient that behaviour change is not always straightforward. If a patient finds he/she has fallen short of a goal, the patient and the health coach will look at contributing factors together, and will either revise the plan or problem solve to overcome the obstacle. The underlying message is that both sustained effort and problem solving are valuable tools in achieving self-efficacy, and will be applicable to future situations.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Specific</th>
<th>Measurable</th>
<th>Action oriented</th>
<th>Realistic</th>
<th>Time dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>What would you like to accomplish and why?</td>
<td>What specific steps can you take?</td>
<td>How will you measure your progress? How often will you follow your plan?</td>
<td>What actions will you need to take?</td>
<td>Is this doable?</td>
<td>What is your timeframe? When will you start?</td>
</tr>
<tr>
<td>I want to exercise more so I have more energy</td>
<td>I will begin with daily walks</td>
<td>I can go every day either before 10:00 or after 3:00 and walk for 15 minutes. Each week I will increase the time by five minutes.</td>
<td>I will add it to my calendar four days of every week and log my walk times.</td>
<td>I can walk outside in good weather or to go to the mall other days.</td>
<td>I will walk four days a week for a month starting next Monday.</td>
</tr>
</tbody>
</table>

Active Learning

Successful health coaching strategies use a patient-initiated agreement on goals and tasks. Within the trust built by the therapeutic alliance, the overall goal is broken down into manageable steps.
In the case of the patient whose goal is to return to their walking group, the plan may include recording pacing progress and problem solving about potential flare-ups (BCTs). Self-monitoring encourages perseverance, and a visible record provides information on self-efficacy. It may also reveal where a barrier occurs or if the goal itself requires modification. Depending on the patient’s preference, the coach may recommend tools such as a written log or a diary, wearable technology, or an online program. Examples of each tool can be found in the Resources section of this document.

Patients carry out the actions in the plan, with the coach following their progress and providing feedback in person, by phone or by email, depending on the patient’s needs and preferences. Health coaches may also schedule “booster” sessions to review progress and modify actions with the client and provide feedback and encouragement in person.

With support from the health coach, patients finalize their plan, and the coach provides a means for recording the actions supporting the progress towards and achievement of the goal.
Considerations Specific to Physiotherapy

With support from the health coach, patients finalize their plan, and the coach provides a means for recording the actions supporting the progress towards and achievement of the goal.

Of the four identified risk factors in chronic conditions, physical inactivity is the health behaviour most associated with current physiotherapy practice. However, physiotherapists may also have a role in smoking cessation and are often asked questions regarding nutrition. Similarly, while weight loss is not a primary goal in physiotherapy practice, physiotherapists may be part of an obesity management team and participate in coaching and facilitating increasing physical activity as well as assessing mobility, balance, and physical function in this population. In recent years, physiotherapists have also participated in the management of sleep hygiene and stress management. The following section demonstrates the application of the principles of health coaching to clinical physiotherapy practice, with examples from the literature.

Physiotherapists may incorporate health coaching principles as brief interventions within traditional physiotherapy treatments, or in some cases, may use health coaching as a stand-alone intervention to assist with chronic disease management (depending on the physiotherapist, the patient served and the practice setting).

**Brief interventions**

Physiotherapists may gather information about health behaviours in the initial assessment as follows:

- Including a question about physical activity can generate a discussion about the patient’s knowledge of the health benefits of physical activity, as it applies to their reason for consulting a physiotherapist. Part of a brief coaching intervention may include sharing information about the health benefits of, for example, short bursts of “incidental physical activity,” or prompt a discussion about Canada’s Physical Activity Guidelines. Physiotherapists may also consider linking the patient to HealthSteps™, a free online and app-based coaching program to help patients increase their activity level.

- A question about smoking (amount, frequency) may generate a discussion on awareness of the health benefits of changing that behaviour, perceived obstacles for quitting and how patients might overcome them, as well as building the physiotherapist’s understanding of why a person values smoking or why they smoke. Throughout, the physiotherapist maintains a non-judgmental attitude. If patients indicate they are interested in receiving more information, the physiotherapist can provide a link to Alberta Quits, a free self-management program offered by Alberta Health Services. The physiotherapist may also offer to provide information on other formal programs in the area if the patient is interested.

- When a patient presents to physiotherapy, and obesity may be a contributing factor to their diagnosis, the physiotherapist may request permission to discuss their weight. Then, using a coaching approach, the physiotherapist explores their understanding of their weight and weight management specific to their current situation. If the patient expresses interest, the physiotherapist may provide access to online resource such as My Health Alberta’s online learning module for weight management, or initiate a referral to a community dietician or a formal program in the community.

- Restful sleep is a challenge for many patients with chronic conditions and not getting enough can be detrimental to their overall health. The assessment may include a question about sleep patterns and if appropriate, the physiotherapist may inquire if the patient would like more information. My Health Alberta provides an online module on strategies for improving sleep patterns. The physiotherapist may determine that a coaching approach to a program of sleep hygiene within their treatment plan is appropriate, or refer the patient to their physician or a community program.

- Similarly, if the patient identifies stress or anxiety during the assessment, such as concern about work performance or relationships, the physiotherapist may inquire about steps the patient has already taken and/or interest in information about stress management. With an affirmative response, the physiotherapist may provide the My Health Alberta link. Similar to the approach to sleep hygiene, if the physiotherapist has training in stress management, he or she may consider using a health coaching approach to address that within the treatment plan or refer the patient to a formal program.
Alternately, when the patient’s comments related to changing a health behaviour are couched with negatives, or “wishes” (“I would but I have no time,” “It’s too hard” etc.), the physiotherapist may use reflective listening to explore their rationale and offer to work with them to develop a plan when the patient chooses to do so. For example, the physiotherapist may suggest patients reflect on their use of personal strengths in past situations and how this might apply to the current situation.19

**Longer-term interventions**

A longer-term health coaching intervention may result from the earlier conversation during the assessment or be introduced as an option in the physiotherapy treatment plan.

Here, the physiotherapist asks patients what concerns them most about their current condition and what they think are the main issues. This message communicates a respectful approach and recognizes the patient’s autonomy in self-management but may also help the physiotherapist determine how to focus the physiotherapy assessment.

The physiotherapist introduces the concept of a collaborative relationship in setting goals and action plans for self-management, with the physiotherapist providing evidence-based information, collaborating on setting achievable goals, developing the action plan, as well as giving feedback and guidance on the chosen goals and strategies. The patient carries out their action plan, tracks their own progress and meets with the physiotherapist to review successes or lapses as part of an active learning process (what works/what doesn’t?) for self-management.

When the assessment is complete, the physiotherapist offers the patient the options for care, whether self-management strategies or traditional physiotherapy interventions. For those patients who choose traditional management, the physiotherapist may incorporate a health coaching approach for the education component of the treatment plan, using discussion of health behaviour change and an active learning process. In either situation, the physiotherapist documents the assessment findings, selected interventions, progress and outcomes.

Appendix 4 is a description by a physiotherapist of their strategy to introduce a patient to behaviour change and self-management. It is used with permission of HealthChange Australia, a methodology that uses behaviour change to support and promote self-management in health care.

Depending on the clinical setting, health coaching can be a team strategy or practiced by the physiotherapist independently. In some situations, a certified health coach is part of the team. Regardless of the setting, the physiotherapist practices health coaching in collaboration with other team members (including the patient) to support the achievement of the goals the patient has established.

Several studies illustrate how physiotherapists have implemented various health coaching strategies for health behaviour change in different practice areas.

Patients with MS, at any level of disability, improved their level of physical activity through an innovative program that helped them select an activity that had value to them. The physiotherapist interspersed bi-weekly home visits to patients with MS with texts, emails and online patient support groups. The patients in the program perceived it as supportive and enabled them to adopt new health behaviours.55

Patients with non-chronic LBP who received telephone coaching in addition to their usual physiotherapy showed significant improvement in the Patient Specific Functional Scale and in recovery expectation.56

Patients with chronic LBP who identified personal challenges in managing their LBP, and were supported in goal setting and evidence based strategies to achieve them, showed significant improvement in a number of measures, including pain, disability, fear avoidance, quality of life self-efficacy.57
Resources

**Behaviour Change Information**

Health Change Australia offers an extensive selection of resources, tools and publications.

Physiopedia has published an extensive review of health coaching including a review of apps that physiotherapists can incorporate within a coaching strategy.

Alberta Health Services has adopted the work of Health Change Australia and is in the process of training their staff in the methodology. They provide additional information about the methodology and theoretical foundations.

Motivational Interviewing Webinar for Injured Workers, presented by Joanne Park, OT, PhD, Douglas Gross, PT, PhD, outlines the technique of motivational interviewing and research regarding the effectiveness of the technique, when working with injured workers.

HealtheSteps is a free online coaching program available to anyone interested in improving health behaviours. It was developed at the Lawson Health Research Institute at Western University.

**Tools**

Readiness Ruler is available from the centre for evidence-based practice. It can be used in the assessment of decisional balance and self-efficacy.

Ottawa Personal Decision Guide was developed at the Ottawa Health Research Institute. It is protected by copyright but is “freely available to use, provided you: a) cite the reference in any documents or publications; b) do not charge for or profit from them; and c) do not alter them except for prefilling them for a specific condition/decision as necessary”.

The Culturally Adapted OPDG (Appendix 2) was developed to support decision making by Indigenous women and is thought to have broad application. PDF

OA GO AWAY (Appendix 3) was a self-management tool for increasing physical activity and exercise in patients with OA of the hip or knee.

**Apps to support health coaching**

Myhealth - Pain Care

A 2019 study, by Yang et al, found that an “app APPS-based self-management program appears to bring additional benefits to physiotherapy for patients with CLBP. Self-management is a potential approach for people with CLBP”.

Accupedo Pro pedometer

A 2014 study by Glynn et al found that a simple smartphone app improved physical activity in a primary care population.

**Additional Training**

This toolkit is intended to introduce readers to the concepts that underly health coaching and equip them with beginner-level skills. Physiotherapists wishing to advance their skills in this area are encouraged to seek additional training. The list below includes organizations that offer additional training in coaching and motivational interviewing. Physiotherapy Alberta does not endorse any training programs. Physiotherapists are encouraged to fully investigate all training options for themselves to determine the program that best addresses their learning needs.

- Excel Academy
- Change Talk Associates
- Alberta Home Visitor Network
- AIM Alberta
- The Monarch System

* Please note this is not an endorsement of these courses by Physiotherapy Alberta.
## Appendix 1: The PT-BCT Checklist

<table>
<thead>
<tr>
<th>#</th>
<th>BCT name</th>
<th>0</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Behavioral</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Setting graded activities or exercises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Physiotherapist modeling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Prompting physical skills acquisition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Providing graded exposure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Shaping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Providing positive reinforcement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Prompting patient modeling/social comparison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Role modeling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Relaxation training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Pacing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Prompting homework</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Cognitive</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Providing general information on behavior-health link</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Providing information on consequences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Providing information on other’s approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Prompting intention formation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Cognitive restructuring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Prompting visualization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Providing stress management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Prompting barrier identification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Problem solving/maintenance/dealing with flare ups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Planning social support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Motivational</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Motivational interviewing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Prompting specific goal setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Seeking agreement to a behavioral contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Prompting self-monitoring of behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Prompting review of behavioral goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Facilitating internal reinforcement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Providing feedback on performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Providing booster sessions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PT BCT Companion Document

Behavioral techniques

1. Setting graded activities or exercises\textsuperscript{1-3}
   - Collaboratively identifying important/relevant, suspended/ restricted activities
   - Explaining treatment rationale
   - Establishing a baseline activity tolerance
   - Collaboratively setting quotas (approx. 80% of baseline)
   - Instructing patient to complete selected activity to predetermined quotas
   - Assessing response and collaboratively adjust quotas

2. Modeling by the Physiotherapist\textsuperscript{1,4-5}
   - Physically demonstrating a movement, activity or behavior
   - Verbally describing a personal situation, experience, self-assessments or movements

3. Prompting Physical Skills Acquisition\textsuperscript{6-8}
   - Providing knowledge of back biomechanics, fitness principles
   - Encouraging practice of basic skills required to achieve a goal (voluntary activation of muscles, coordination of motor skills, strength, endurance, flexibility and aerobic fitness)
   - Encouraging the chaining of basic skills to perform advanced or applied skills
   - Encouraging generalization of advanced skills to activities associated with pain and or disability
   - Encouraging exercise progression
   - Identifying exercise cues for correct performance such as indicating where a stretch should be felt.
   - Incorporating immediate therapist monitoring, “how does it feel?”
   - Confirming knowledge, abilities and skills through physical performance and consideration of the purpose of an exercise, “What are we trying to do?”

4. Graded Exposure\textsuperscript{9}
   - Measuring levels of fear avoidance
   - Collaboratively establishing a hierarchy of feared activities
   - Educating on fear avoidance, neuroplasticity, exposure therapy and / or safety of the tasks
   - Prompting gradual and systematic exposure in a graded fashion to activities in the individual fear hierarchy
   - Progressing to the next feared activity when the patient’s fear avoidance concerning the previous activity has been decreased

5. Shaping\textsuperscript{10}
   - Providing immediate feedback to an individual through visual, auditory, sensory/tactile or proprioceptive means to correct physical movements, activities, behaviors and identified cognitions
   - Used closely with technique 3, prompting physical skills acquisition.

6. Providing Positive Reinforcement\textsuperscript{1,2,10}
   - Identifying individual patient reinforcers
   - Providing immediate, positive and external reinforcement of movements, activities or behaviors that are associated with short term goals which are correctly performed (praise, visual feedback, physical encouragement)
   - Used closely with techniques 3 and 5, to create the desired movement or behavior.

7. Prompting Patient Modeling/Social Comparison\textsuperscript{1,4}
   - Encouraging patient demonstration of a movement, activity or behavior to other patients in a group setting and critiquing those performed movement patterns for “observational learning”
   - Encouraging patients to verbally describe a personal situation, experience, self-assessment or movement
   - Relating experiences, scenarios, comments from other comparable patients outside the class and using them as examples

8. Role Modeling\textsuperscript{1,4}
   - Educating patients on how to be an example of healthy behaviors to others with chronic pain in a clinical, home or work setting
   - Encouraging and/or providing opportunities for patients to persuade others of the importance of adopting or changing behavior in a clinical, home or work setting
   - Identifying others who exemplify attitudes, behaviors and using them verbally, in pictures, real life observation or video to explain a concept (sports icons, other individuals)
   - Identifying a patient within the treatment program who exemplifies the desired beliefs, attitudes, behaviors being encouraged and then using their situation to explain a concept either through verbal description or physical demonstration

9. Relaxation Training\textsuperscript{11}
   - Educating on the role of relaxation (break pain-tension-pain cycle, deal with stress, means of dealing with their pain)
   - Assessing and practice breathing
   - Practicing the application of relaxation (progressive relaxation, guided fantasy)
   - Educating on the application of relaxation in “risk” situations and everyday settings outside the clinic

10. Pacing\textsuperscript{2,12}
    - Educating on the over-activity-under-activity cycle
    - Educating on activity scheduling, reducing speed of activities, scheduling breaks, maintaining a constant pace or separating tasks into manageable components, setting quotas
    - Educating on gradually increasing activity levels without significant increases in pain
    - Prompting pacing practice especially during “at risk” activities (home or clinic)
11. Prompting Homework
- Encouraging practice of activities, movements, behaviors or monitoring and challenging of cognitions outside the clinical setting, often outlining what exercise, how to determine the amount and frequency.
- Providing written materials, verbal instruction and encouragement concerning the performance of established activities outside the clinical setting.
- Encouraging the use of cues to remind patients to practice (time of day, alarm on watch or computer).
- Encouraging the patient to outline a plan, either verbally or in writing, to perform homework.

Cognitive techniques

12. Providing General Information on the Behavior Health Link
- Providing education concerning the relationship between behavior and health (importance of maintaining or increasing activity).
- Providing information on the facts about the relevant condition, such as prevalence and persistence of LBP, and what behaviors may result due to this condition.

13. Providing Information on Consequences
- Providing information focusing on the “benefits and costs of action or inaction,” performing or not performing the behavior.

14. Providing Information about Others’ Approval
- Providing information about the effect of other’s approval or disapproval on their behavior, influences of their society.
- Providing guidance on how to maintain a behavior such as performing exercises, despite the disapproval of others.

15. Prompting Intention Formation
- Encouraging the patient to consider making positive behavioral changes and what that might look like.
- Encouraging the patient to make a “behavioral resolution.”
- Giving patients the opportunity to make changes by leaving the choice up to them such as telling them they can stay and perform exercises, or go home early, let patients chose a course of action.
- Prompting the patient to consider ways of fitting exercise and activity into their lives.

16. Cognitive Restructuring
- Providing education concerning pain and its meaning, hurt does not equal harm, the role of maladaptive thoughts and emotions.
- Providing education on the neurophysiology of pain.
- Reassuring patients that despite their pain, there is nothing seriously wrong.
- Prompting patients to demonstrate their understanding of pain.
- Prompting examination of thoughts concerning movement, activities, and behaviors.
- Educating on how inaccurate thoughts may interfere with improvements in their behaviors through vignettes and examples (may be used with techniques 2 and 7, modeling by the physiotherapist and prompting patient modeling/social comparison).
- Prompting the challenging of cognitions.
- Prompting the focus on function or goal accomplishment, instead of pain.

17. Visualization
- Prompting the envisioning of the “risk” environment or setting when performing physical activities within the clinic.
- Prompting the patient to “see” themselves successfully completing a feared or “risk” activity, movement or behavior in a variety of settings from the clinic to the work or home environment.

18. Stress Management
- Educating on the impact of stress on physical movements, function and pain perception.
- Educating on means of dealing with stress (this may include the use of techniques 9, relaxation, 10, pacing and 16, cognitive restructuring).

19. Prompting Barrier Identification
- Encouraging the identification of future problems or specific obstacles to performance that may prevent goal attainment such as a lack of time, “increased pain (flare-ups), fearful thoughts and decreased social support.”
- Encouraging the identification of obstacles in writing.
- Encouraging the consideration of the home, work and social environment when developing a list of potential barriers.

20. Problem Solving/Maintenance and Dealing with Flare-ups
- Providing education on flare-ups and indicating that they are normal and not a sign that back symptoms are worsening.
- Providing education on coping strategies to deal with identified barriers (may include techniques 9, 10, 18: relaxation, pacing, stress management).
- Encouraging activity resumption as soon as possible after a flare-up and stressing the importance of having a plan in place to resume activity.
- Prompting cognitive problem solving by collaboratively developing strategies to cope with identified barriers or flare-ups (setting criteria for visiting health care providers, maintenance and progression of their home exercise plan, activity modification or use of techniques 9 and 10, relaxation and pacing).
• Prompting problem solving with focus on physical and functional activities
• Prompting the selection of a preferred course of action and record a personal maintenance plan to deal with flare-ups or barriers
• Reviewing the personal maintenance plan to clarify or collaboratively modify as necessary to ensure the patient is prepared to deal flare-ups or barriers
• Relaying to the patients that physiotherapy support is available to assist with taught self-management strategies as required after discharge
• Prompting maintenance by reminding patients of their newly acquired knowledge and problem solving skills (Techniques 21, planning social support, 23, prompting specific goal setting, 25, prompting self-monitoring of behavior, 26, prompting review of behavioral goals and 27, facilitating internal reinforcement may also be highlighted)
• Prompting the application of newly acquired knowledge to everyday situations

21. Planning Social Support
- Prompting the consideration of how others could alter behavior to provide help and/or instrumental social support
- Prompting the establishment of a “buddy” or social support system for maintenance or improvement of current activity levels or behaviors

Motivational techniques

22. Motivational Interviewing
- Determining a patient’s readiness to change
- Discussing the decisional balance if the patient is not ready to change
- Prompting change using the decisional balance tool and discussion of replacing maladaptive behaviors
- Discussing other techniques to achieve desired behavior (self-monitoring, shaping, recognize and reject negative stimuli, recognizing reinforcers)

23. Prompting Specific Goal Setting
- Determining relevant activities that are either decreased or avoided due to pain and disability
- Collaboratively setting specific, measurable, achievable, realistic and timely goals that will include the frequency, intensity, and duration of the outlined decreased or discontinued activities. Additionally, one of the following must be included, the where, when, how or with whom must be specified
- Planning a time for collaborative goal review
- Prompting the patient to consider and identify exercises that may be relevant for their specific goal setting, “You’re going to like this one … Those of you that find this one difficult…”

24. Establishing a behavioral contract
- Prompting the signing of a written contract witnessed by another that outlines the expected behavior

25. Prompting self-monitoring of behavior and cognitions
- Prompting the maintenance of a record of completed activities, exercises or behaviors through either a diary or questionnaire completion
- Prompting the monitoring of the occurrence and challenging of maladaptive cognitions and behaviors
- Encouraging patients to pay attention to what they are doing and should be doing in class as well as at home, a “self-check in”
- Encouraging patient monitoring through a regular check in with the physiotherapist.

26. Prompting review of behavioral goals
- Encouraging the patient to reconsider previously set goals and intentions at regular intervals

27. Facilitating Internal Reinforcement
- Educating on the activities, movements, behaviors or cognitions to be reinforced
- Educating on the importance of taking credit for achievements, “you must be very pleased with your progress”
- Highlighting goal achievements, performance improvement, increases in function or duration of activities while decreasing the frequency of positive reinforcement from consistent, to occasional to complete withdrawal
- Prompting the identification and use of internal reinforcers (self-praise, small treats, recording and recognizing progress, a night out, a new pair of shoes)
- Confirming new knowledge and skills acquisition (may be used with technique 28, providing feedback on performance)
- Confirming skills application reasoning, “What should I do?” “What do you do if you are asymmetrical?" “When and why should you do this exercise?”
- Managing expectations, “Some of you may not notice a change for six months but stick with it, and change will occur”
- Can be used with Technique 8, prompting role modeling

28. Providing Feedback on Performance
- Providing summarized feedback on performance after reviewing goal achievements through observation, use of outcome measures, review of patient documented data on activities, movements, exercises, behaviors or cognitions
- Identifying discrepancies between set goals and achieved performance, or discrepancies in relation to the performance of others
• Collaboratively discussing performance and making recommendations for future performance and goal setting
• Discussing in a group format, a summarized version of patient performance in general, “at the beginning of the class this was the most difficult exercise for all of you but now you are all performing it perfectly”
• Often used with techniques 7, prompting patient modeling/social comparison and 27, facilitating internal reinforcement

29. Booster Sessions¹
• Planning follow-up sessions beyond the period of direct patient care at short, medium or long-term follow-up time frames
• Performing follow-up care through “phone calls, one-on-one or group sessions at short, medium or long-term follow-up time frames”

REFERENCES
Appendix 2: Personal Decision Guide

Adapted Ottawa Personal Decision Guide: For People Making Health or Social Decisions

There are four steps: 1 2 3 4

1. Clarify your decision
What decision do you face?

Why are you making this decision?

When do you need to make a choice?

Where are you with making a choice?
- Not yet thought about the options
- Thinking about the options
- Close to making a choice
- Already made a choice

2. Explore your decision

<table>
<thead>
<tr>
<th>Reasons to Choose this Option (Benefits / Pros)</th>
<th>How much it matters Use 0 to 5 ★s</th>
<th>Reasons to Avoid this Option (Risks / Cons)</th>
<th>How much it matters Use 0 to 5 ★s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option #1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option #2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option #3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which option do you prefer? □ #1  □ #2  □ #3  □ Unsure

How motivated are you to take action
- Not Motivated 0 1 2 3 4 5 Very Motivated

How confident are you that you can take action?
- Not Confident 0 1 2 3 4 5 Very Confident

List things that may get in the way of doing this:

List things that may help you to do this:
Support

<table>
<thead>
<tr>
<th>Who is involved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who else can support you?</td>
</tr>
<tr>
<td>Which option do they prefer?</td>
</tr>
<tr>
<td>Is this person pressuring you?</td>
</tr>
<tr>
<td>How can they support you?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What role do you prefer in making the choice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Share the decision with _</td>
</tr>
<tr>
<td>□ Decide myself after hearing views of _</td>
</tr>
<tr>
<td>□ Someone else decides _</td>
</tr>
</tbody>
</table>

3 Identify your decision making needs

<table>
<thead>
<tr>
<th>Certainty</th>
<th>Do you feel sure about the best choice for you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Do you know the benefits and risk of each option?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Values</th>
<th>Are you clear about which benefits and risks matter most to you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support</th>
<th>Do you have enough support and advice to make a choice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

4 Plan the next steps based on your needs

✓ Things you would like to try

A. Certainty
If you feel unsure about the best choice for you:
□ Working through the steps below may help.

B. Knowledge
If you need to know more:
□ Find out more about the options and the chances of the benefits and risks.
□ List your questions.
□ List where to find the answers (e.g. library, care provider, counsellor).

C. Values
If you need to think about what matters most to you:
□ Review the stars in the balance scale to see what matters most to you.
□ Talk to others who have made the decision.
□ Read stories of what mattered most to others.
□ Discuss with others what mattered most to you.

D. Support
If you need support:
□ Discuss your options with a trusted person (e.g. care provider, counsellor, family, friends).
□ Find help to support your choice (e.g. funds, transport, child care).

If you feel pressure to make a certain choice:
□ Focus on the views of others who matter most.
□ You can share your guide with others.
□ You can ask others to try this guide. See where you agree. If you disagree on facts, agree to get more facts. If you disagree on what matters most, consider each other’s view.
□ Find a trusted person to help you and others involved.

Other ideas and plans:

Adapted Ottawa Personal Decision Guide © 2014 Jull & Minwaashin Lodge; Adapted from O’Connor, Stacey, Jacobsen. Ottawa Hospital Research Institute & University of Ottawa, Canada.
Appendix 3: OA Go Away

OA GO AWAY

People with OA who are physically active feel much better than those who aren’t active. Exercise can help make your OA symptoms go away!

This is how to use the OA GO AWAY:

Step 1: OA GO AWAY Journal

Complete once per month.

To create a personal diary of how your OA is affecting your daily function and health and how you are managing it.

Step 2: OA GO AWAY Goals & Action Plan

Complete once per month. Check in every 2 weeks to make sure you are on track.

To set personal goals and an action plan to improve your OA.

Step 3: OA GO AWAY Exercise Log

Four copies, complete one per week.

To keep track of the exercise/physical activity that you do each day as recommended by arthritis guidelines, Health Canada and your physiotherapist.

Instructions

Instructions for how to complete the Journal, Goals & Action Plan, and Exercise Log are located at the end of this booklet.

ONLY FILL OUT WHAT YOU WANT TO FILL OUT
### My OA GO AWAY Journal

Complete once per month. Answer questions based on the past week.

#### Top 3 Activities that are difficult due to my OA that I would like to improve
(e.g. walking, stairs, getting up from chair, laundry, shopping, gardening, playing with grandkids…)

<table>
<thead>
<tr>
<th>Difficult Activity 1</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Difficult Activity 2</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Difficult Activity 3</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

#### Other possible impacts of my OA

<table>
<thead>
<tr>
<th>My Sleep</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Pain</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Mood</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Stiffness</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Energy</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Swelling</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe</td>
<td></td>
</tr>
</tbody>
</table>

#### My Fitness and Weight measures

<table>
<thead>
<tr>
<th>Last week I did: (write the number)</th>
<th>Rate (circle)</th>
<th>Rate (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 excellent</td>
<td>1 excellent</td>
</tr>
<tr>
<td></td>
<td>2 very good</td>
<td>2 very good</td>
</tr>
<tr>
<td></td>
<td>3 good</td>
<td>3 good</td>
</tr>
<tr>
<td></td>
<td>4 fair</td>
<td>4 fair</td>
</tr>
<tr>
<td></td>
<td>5 poor</td>
<td>5 poor</td>
</tr>
</tbody>
</table>

**Vigorous Aerobic activity**

**Moderate Aerobic activity**

**Light Aerobic activity**

Health Canada recommends 150 minutes of moderate to vigorous aerobic activity per week; for OA start with light activity & progress.

Strengthening exercises on ____ days (e.g. weights, theraband, bike, yoga)

Health Canada recommends strengthening exercises on 2 days per week.

**Weight** _____ lbs/kg  **Waist** _____ cm/inches

#### Treatment for my OA symptoms

<table>
<thead>
<tr>
<th>Medications</th>
<th>How much</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dose</td>
<td># / day</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Treatments**

(supplements; physio; heat/ice; massage; acupuncture)

1.  
2.  
3.  
4.  

Date __________
## My OA GO AWAY Goals & Action Plan

Complete once per month; check in every 2 weeks.

| **Goals:** related to ‘Top 3 Activities that are difficult due to my OA’  
(e.g. get up from sofa without pain; walk to store without stopping) | **Action Plan: Exercise/Activity**  
(include what, how often, how much/how long; when; where) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal #1</strong></td>
<td>Aerobic exercise</td>
</tr>
<tr>
<td></td>
<td>Strengthening exercise</td>
</tr>
<tr>
<td><strong>Goal #2</strong></td>
<td>Range of motion/stretching exercise</td>
</tr>
<tr>
<td><strong>Goal #3</strong></td>
<td>Balance exercise</td>
</tr>
</tbody>
</table>

| **Goals: Other**  
(e.g. lose weight, improve mood, correct my flat feet) | **Action Plan: Other**  
(e.g. change diet; see social worker/psychologist; buy orthotics) |

---

**How will I make sure I stick with my Plan?**
# My OA GO AWAY Exercise Log

**Complete weekly**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
</table>

### A. Aerobic activity/exercise
(e.g. walking; biking; dance; swimming/aqua fit; exercise class)

- **Mins**
- **Int**
- **Intensity:**
  - 3 = vigorous
  - 2 = moderate
  - 1 = light

Aim for _ ___ minutes for _ ___ days per week

1.

2.

3.

4.

**My weekly total # minutes of moderate to vigorous intensity aerobic activity:**

### B. Strengthening exercises
(e.g. wt’s; theraband; gym; bike)
_for specific exercises refer to ex routine log_

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Total Days</th>
</tr>
</thead>
</table>

1.

2.

**My weekly total # days I did strengthening exercises:**

### C. Range of motion/ stretching exercises
(e.g. physio ex’s; yoga; tai chi)
_for specific exercises refer to ex routine log_

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Total Days</th>
</tr>
</thead>
</table>

**My weekly total # days I did range of motion (ROM) or stretching exercises:**

### D. Balance exercises
(e.g. physio ex’s; yoga; tai chi)
_for specific exercises refer to ex routine log_

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Total Days</th>
</tr>
</thead>
</table>

**My weekly total # of days I did balance exercises:**

### Comments
(e.g. did something get in the way of my exercise routine?; did I make any changes to my medications or other treatments for my OA?)
**My OA GO AWAY Exercise Log**  
Complete weekly

Copy for second week

**REMINDER:** check-in with your Action Plan – to see if you are on track

**My OA GO AWAY Exercise Log**  
Complete weekly

Copy for third week

**My OA GO AWAY Exercise Log**  
Complete weekly

Copy for fourth week
Instructions

My OA GO AWAY Journal

Complete once per month

For all of the questions, think of how you have been in general for the last week, and write what you would like to keep track of.

Top 3 Activities that are difficult due to my OA that I would like to improve

List on the lines provided, in order of priority: 1 to 3 activities that are important to you, that are difficult, painful or impossible because of the OA of your hip(s) or knee(s), and that you would like to do better. (e.g. walking; stairs; getting up from chair/toilet; standing; bending/squatting; lifting; kneeling; getting in/out of bath/bed; putting on socks/shoes; tying laces; chores/housework; shopping; gardening; intimacy; volunteer work).

Describe in the space provided: each activity in as much detail as possible.
- include a time frame (e.g. how long it took to walk to store)
- include if you need to use an aid (e.g. cane; brace; railing; reacher; raised toilet seat; ice grippers)
- include how many breaks you need or how you had to modify the activity (e.g. how many times you sat down on way to store; need to take stairs 1 step at a time)

Rate the level of difficulty of each challenge for you, by circling a number from 1 (easy) to 5 (extremely difficult).

Other possible impacts of my OA

My Sleep

Describe in the space provided: your sleep on average in the last week. (e.g. trouble getting to sleep; trouble getting comfortable in bed; sleep disrupted by pain; unable to lie in certain positions; lack of deep sleep; need to take sleeping pills; average number of hours of sleep).

Rate the level of quality of your sleep according to the scale by circling a number from 1 (excellent) to 5 (poor).

My Mood

Describe in the space provided: your mood on average in the last week. (e.g. feel happy, sad; calm, peaceful; irritable; stressed; annoyed; worried; nervous; frustrated; down in the dumps; depressed; variation of mood).

Rate: Level of Quality: rate your mood according to the scale by circling a number from 1 (excellent) to 5 (poor).

My Energy

Describe in the space provided: your energy on average in the last week. (e.g. tired; worn out; full of pep; need to take a nap; low motivation to do things; based on your normal physical / mental / spiritual energy level).

Rate: Level of Quality: rate your energy according to the scale by circling a number from 1 (excellent) to 5 (poor).

My Pain

For each affected hip / knee:

Describe in the space provided: your pain on average in the last week. (e.g. location; sharp; dull; aching; burning; shooting; throbbing; constant/intermittent; unpredictable; at rest/with activity/at night; duration).

Rate your pain over the last week with a number from 0 (no pain) to 10 (worst pain you can imagine) Write the number on the line beside the Left (L) or Right (R) hip or knee.
My Stiffness
For each affected hip / knee:

Describe in the space provided: your stiffness on average in the last week (e.g. stiff after sitting too long; stiff in the morning when I get up; stiff at movies)

Rate your stiffness over the last week with a number from 0 (no stiffness) to 10 (extreme stiffness) Write the number on the line beside the Left (L) or Right (R) hip or knee

My Swelling
For each affected knee:

Describe in the space provided: your swelling on average in the last week. (e.g. swollen, puffy, hot, warm, red, feeling of fullness, location of swelling)

Rate your swelling over the last week with a number from 0 (no swelling) to 10 (extreme swelling) Write the number on the line beside the Left (L) or Right (R) knee. (i.e. it is impossible for you to tell if your hip is swollen)

My Fitness and Weight Measures

Last week I did: Record how many minutes in the past week you did aerobic activity of vigorous; moderate and light intensity (e.g. walking, hiking, swimming/aqua fitness, biking, dancing, cross country skiing, cardio machines, exercise class, etc.) To achieve general health benefits Health Canada recommends that adults should accumulate 150 minutes of moderate to vigorous aerobic physical activity per week in bouts of 10 minutes or more. For those with arthritis who are starting a new aerobic activity it is recommended to start with light activity and gradually increase your intensity and minutes. Going from no activity to some activity will help your OA.

- **Vigorous- Intensity** physical activities will cause adults to sweat and be ‘out of breath’. Activities like: jogging, cross country skiing, swimming, etc. Your heart rate should be 70-85% of your maximum rate.
- **Moderate- Intensity** physical activities will cause adults to sweat a little and breathe harder. Activities like: brisk walking, bike riding, etc. Your heart rate should be 50-70% of your maximum rate.
- **Light- Intensity** physical activities will get your heart rate up a little and your breathing will feel easy.
- Record how many days in the past week you did Strengthening exercises (e.g. weights, theraband, gym machines, aqua fitness, yoga, tai chi, cycling, Physio exercises, etc.) Stronger muscles will help take some stress off of your hips and knees and will help decrease pain.

Weight

Step on your scale and record your weight in lbs or kg.

Waist

This is a measure of the fat stored around your waist. A high range means you are at risk for high blood pressure, high cholesterol, type-2 diabetes, heart disease and stroke, and your OA pain may be worse.

**How to use a tape measure**
1. Stand in front of the mirror and remove clothing/belts from around your waist
2. Place the tape measure around your waist at the level of your belly button.
3. Take 2 normal breaths. After the second breath out, tighten the tape around your waist. The tape should fit comfortably snug around the waist without depressing the skin. Be sure that tape is not twisted and is parallel to ground. Now take the reading on the tape.

**Normal Measurements**

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Men's waist</th>
<th>Women's waist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>inches</td>
<td>cms</td>
</tr>
<tr>
<td>European/Caucasian; Sub-Saharan Africans; Eastern Mediterranean; Middle Eastern</td>
<td>&lt; 40</td>
<td>&lt; 102</td>
</tr>
<tr>
<td>South Asian; Malaysian; Asian; Chinese; Japanese; Ethnic South &amp; Central Americans</td>
<td>&lt; 35 ½</td>
<td>&lt; 90</td>
</tr>
</tbody>
</table>
**Treatments for my OA symptoms**

**Medications**

List all pills or creams/ointments you took for your OA symptoms last week. These include those prescribed by your doctor (e.g. anti-inflammatories pills such as Celebrex or Naprosyn; creams such as Pensaid; narcotics such as Tramadol) and those you take without a prescription or ‘over the counter’ (OTC) (e.g. Tylenol; Advil; Aleve; Voltaren Emugel cream; Capsaicin cream). These can also include medications you take for other OA symptoms (pills for sleep and mood)

**Indicate**
- How much you take (dose for each pill)
- How often you took each pill/cream per day and/or the total in the last week.

**Other treatments for my OA**

List any other treatments you have used in the past week to help relieve your OA pain (e.g. supplements such as glucosamine, chondroitin; vitamin D, physiotherapy; heat/ice; massage; acupuncture; chiropractic; osteopathy; etc.)

**Indicate** how many times per day or per week you used each treatment in the last week.

---

**My OA GO AWAY Goals & Action Plan**

1. **Goals # 1, 2, 3:** Review your OA GO AWAY Journal ‘Top 3 Activities that are difficult due to my OA’. Write down 1 to 3 personal Goals related to these difficult activities (e.g. Goal # 1: ‘I want to be able to walk to the corner store without having to stop because my left knee hurts’)

2. **Goals (other):** if you have other goal(s) not related to functional difficulties, write it down here. (e.g. ‘I want to lose 10 lbs by Xmas’; ‘I want to improve my mood’)

**GOALS SHOULD BE SMART:** Specific; Measurable; Achievable; Realistic, Time sensitive.

3. **Action Plan: Exercise/Activity:** Write down your Action Plan in terms of what exercise/activities you plan to do to help you achieve your goals. List each activity next to the type (aerobic; strengthening; range of motion/stretching; balance). Be specific and specify exactly what the activity is; and where; when; how often and how long you will do it. (e.g. Aerobic exercise: I plan to go 1 hour aquafit classes at Dovercourt pool on Tuesdays and Thursdays from 3 to 4 PM; Range of motion/stretching exercise: I will spend 10 minutes doing the 4 hip ROM exercises that my Physio showed me, for 10 repetitions each, every evening before I go to bed)

4. **Action Plan: Other:** write down what you plan to do to help you achieve your ‘other goals’. (e.g. next week I will make an appointment to see a dietician’; ‘I will see the social worker at the Arthritis Society every 2 weeks for the next 6 months’)

5. **How will I make sure I stick with my plan?:** can you think of any obstacles that may get in the way of doing what you plan to do? (e.g. in the winter it is sometimes hard to walk outside) If so, think of ways to overcome these? (e.g. on the bad snow days I will walk in the hallways or I will purchase ice grippers for my boots so I won’t have to worry about slipping)
My OA GO AWAY Exercise Log Instructions

Complete Daily or Weekly

Write the Month and Dates and Days of the week in the top boxes:

A. Aerobic activity/exercise (must be minimum 10 minutes sessions):
   (e.g. walking, hiking, swimming/aquafit, biking, dancing, cross country skiing, cardio machines, exercise class etc)
   In the grey box write your goal for the week: how many minutes and/or days this week would you like to aim to do aerobic activity?
   - List the aerobic activities you will do this week in boxes 1-4
   - Each day you do one of these aerobic activities check it off in the boxes
   - include the # of minutes you did this activity in the top half of the square and the intensity in the bottom half as either 3 (vigorously) or 2 (moderate) or 3 (light)
   - At the end of the week: Total the number of minutes for each activity of moderate to vigorous intensity activity (rated 2 or 3)
   - Add up your weekly total number of minutes for all moderate to vigorous activity and compare this to the recommendations from Health Canada

B. Strengthening
   (e.g. weights, theraband, gym machines, aquafit, yoga, tai chi, cycling, physio exercises, etc)
   In the grey box write your goal for the week: how many minutes and/or days this week would you like to aim to do strengthening exercises?
   - Each day you do a session of strengthening exercises check it off in the boxes
   - At the end of the week: total the number of days you did strengthening exercise sessions
   - Add up your weekly total number of days you did strengthening exercises and compare this to what is recommended by Health Canada
   *For specific exercises you may want to keep track of these on the ‘Exercise Routine Log’

C. Range of motion (ROM)/stretching
   (e.g. physio exercises; yoga; tai chi; aquafit)
   In the grey box write your goal for the week: how many minutes and/or days this week would you like to aim to do aerobic activity?
   - Each day you do a session of Range of Motion or stretching exercises check it off in the boxes
   - At the end of the week: Add up your weekly total number of days you did ROM or stretching exercises and compare this to what your physiotherapist has recommended
   *For specific exercises you may want to keep track of these on the ‘Exercise Routine Log’

D. Balance
   (e.g. include yoga; tai chi; physio exercises)
   In the grey box write your goal for the week: how many minutes and/or days this week would you like to aim to do aerobic activity?
   - Each day you do a session of balance exercises check it off in the boxes
   - At the end of the week: total the number of days you did balance exercises and compare this to what your physiotherapist has recommended
   *For specific exercises you may want to keep track of these on the ‘Exercise Routine Log’

NOTE: some activities can be recorded more than once (e.g. aquafit class qualifies as aerobic, strengthening, ROM and balance type exercise)

Comments: write any comments that are related to your activities this week (e.g. ‘sick on Tuesday, unable to go to aqua fit class’ or ‘I took an 2 extra tylenol Friday because I had more pain’)

Physiotherapy Alberta - College + Association | Introduction to Health Coaching for Physiotherapists
My OA GO AWAY Exercise Routine Log (optional)

This chart is to be used if you wish to keep track of the individual exercises that are part of your ‘exercise routine’ such as your ‘physio exercises’ or the particular exercises/machines you do at the gym. These can be ROM, stretching, strengthening, or balance exercises. If you wish you may record the weight you used or the number of repetitions and/or sets.

<table>
<thead>
<tr>
<th>Specific Exercise</th>
<th>date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4:
HealthChange Methodology

Tips for Physiotherapists using HealthChange® Methodology

We do more than manual therapy!

How often do clients have an expectation that passive treatment will “fix” them? Explaining your role at the beginning will lay a good foundation for the rest of the consultation. Sample script: “Have you seen a Physiotherapist before? What was the experience like? I work a little different from some Physios.” Highlight the difference between “passive” (hands on) and “active” (patient takes action, develops skills, learns to problem solve) treatment. Explain you can help them with “what” to do and also “how” to do it in a manageable way for their circumstances. Then ask “How do you feel about that?” if the client chooses to pursue manual treatment first, that gives you an opportunity to discuss the possible contributing factors and ask the client about the potential benefits of managing these factors and the consequences of not managing them.

Assess the client as well as the condition

Ask the client what they think are the main issues before launching into an assessment. This may enable you to save time by performing a more targeted assessment. Asking the client what they think are the main issues, will allow you to spend more quality time on the things impacting on their pain or function (e.g., difficulty performing tasks at work) rather than conducting a 30 minute assessment. Sample script; “What do you feel are the main issues impacting on your pain or function?” Asking RICK about self-management strategies and exercises will save you from wasting time on talking about issues the client is not motivated to engage in.

Pen ownership

Inviting the client to write down what was discussed can increase the success rate up to ten times! Sample script: “That pen and paper is there for your own use if you come up with some good ideas. It is just a matter of remembering things when you leave this consultation.”

Messy Head Syndrome!

How often do clients (and even ourselves) feel overwhelmed with the many changes that need to be made to manage their pain or improve their function? Outlining general categories or areas to work on over time will help the client to prioritise and focus on one item at a time. Sample Script: “Working on all of these issues is too much to consider in one go. Is there one area that you feel you would benefit the most from working on it?”

‘Messy head’ may also be the result if clients don’t understand or feel that they have control of pain triggers. Encourage a systematic, problem solving approach to set up a positive expectation. If clients can’t identify what influences their pain, explain how ‘BEST’ can be used as a framework to think about the different types of pain triggers. Behaviours – Do they plan activities thinking about what loads their tissue? How do they habitually move or perform tasks? Emotions – explain how stress influences the pain response. Situations – Does the pain vary with different situations? For example, increased pain in the morning might be due to position, inflammation or stiffness overnight. Thinking – Do they avoid exercise/activity because of concerns about causing more damage? BEST can also help you to identify enablers for dealing with pain triggers.
Assume unsteady until proven ready!

Make no assumption that just because a client has turned up to an appointment they are ready to take on an active role! It does mean that we have an opportunity to assist them with prioritising and managing their musculoskeletal health. For example, use summaries of evidence-based treatment options of common conditions to inform the client about possible treatment pathways. Possible script for acute low back pain: “Research shows the most effective treatment is to individualise the recommendation to ‘stay active’ and assist your understanding of the problem; passive treatment and medication are often helpful; however complete bed rest is harmful.” Then ask “What do you think you would get the most benefit from today?” Ask the client what benefits they hope to get out of making changes rather than simply telling them. This allows you to assess their knowledge and also increase rapport and trust. Sample script: “Everyone would like to be pain free however this requires some time and effort to keep your body balanced and healthy. What benefit do you think you would get if you were to learn how to use your body more efficiently?”

Offer a menu of options

We all like to feel that we have choice. Being able to choose from a menu reduces resistance and increases client readiness. Rather than giving clients one option at a time, offer a menu of strategies or suggestions. Sample script: “Here is a list of strategies to manage neck pain at work/home. Would any of these options suit you?”

If you fail to plan, you plan to fail!

Even if the client knows what to do, are they confident that they will go out and do it? Asking the client what may get in the way and what they need to do in order to achieve their goal will increase their likelihood of success. Scheduling in time to learn new skills or exercise regularly requires thought and planning.

Watch out for over-doers!

The body finds it hard to adjust to big changes so increasing activity or exercise by 50% or more for example would be difficult to sustain. Encouraging clients to start off with making 10% or manageable changes is more realistic and sustainable in the long term. Once they have adjusted to this change, encourage them to increase by another 10%.

What you track is what you get!

Focusing solely on pain can be demotivating. Ask the client how they will know they are improving to help them focus on the positives and keep them persisting over time. Use a variety of tracking measures such as range of movement, functional ability, their feeling of control or energy levels. Encourage repetition and skill development by tracking activities in charts, by accumulating objects in a jar over the day and/or by reviewing progress with video clips taken on a phone (if possible).

Trial and Error

Encourage a trial and error philosophy. Remind clients that it is not them that failed if a strategy has not worked. Sample script: “Remember if the strategy does not work it is not you that failed, it is just the strategy. So keep a note of what does and doesn’t work and we can discuss this at the next consultation”.

Compiled by Caroline Bills, Manipulative Physiotherapist and HealthChange Associates Senior Training Facilitator
Sources

31. Hutting N, Johnston V, Staal JB, Heerhens YF. Promoting the Use of Self Management Strategies for People with Persistent


Acknowledgements

The Introduction to Health Coaching was developed by Physiotherapy Alberta College + Association with the following advisory committee members, and thanks them for their contribution and commitment to the project outcome. Project lead was Carol Miller, Consultant in Knowledge Mobilization for Physiotherapy Alberta.

Cari Cooke has been a Physiotherapist for 24 years working with neurological and geriatric populations. Previous experiences as a clinician, program coordinator, research assistant, and clinic owner have all lead to her current passion of working with persons with Parkinson's disease as a consultant for the Parkinson Association of Alberta. She has certifications in PWR! Moves, Neurodevelopmental Therapy (NDT) for hemiplegia and gait, LSVT/BIG and Urban Poling.

Neera Garga is a University of Toronto graduate and has been practicing for 19 years with a focus on neurological populations. Currently she is working at the Glenrose Rehabilitation Hospital treating stroke, MS and general neurological clients in the outpatient clinic. In addition, she is a team member of the Glenrose spasticity and adult stroke clinics. Prior to moving to Edmonton 8 years ago, she worked in Calgary at the MS clinic (OPTIMUS - Foothills Hospital) and was the physiotherapy consultant for the Parkinson Society of Southern Alberta.

Cindy Grand is a change maker fueled by good coffee and a passion for patient centred care. She worked in sports/orthopedics for 14 years and then on the Provincial Bariatric Resource team, a multidisciplinary team supporting providers of care for patients with obesity for 5 years. She completed her Master of Public Health and is Prosci Change Management Certified, has her HealthChange Associates Peer Training levels 1&2 and has completed Foundational Training in Cognitive Coaching. Cindy has had the honor of being a lecturer at the University of Alberta for physiotherapy and interdisciplinary students. You can currently find her in a temporary role of Implementation Lead on the Walter McKenzie Campus Connect Care Implementation Team before she returns to the Integration & Innovation Team within the Provincial Primary Health Care Program, AHS.

Dr. Maxi Miciak is the Cy Frank Fellow in Impact Assessment at Alberta Innovates and an adjunct associate professor in the Faculty of Rehabilitation Medicine, University of Alberta. Her research interests involve developing, implementing, and evaluating practices that impact the quality of the patient-practitioner therapeutic relationship, including how health services and policies support this relationship. Most notably, she developed a pragmatic framework of the therapeutic relationship in physiotherapy to support physiotherapists in taking meaningful action when developing positive relationships with patients. Her appreciation for the therapeutic relationship developed over 13 years working in private practice and on interdisciplinary rehabilitation teams supporting people with a diverse range of musculoskeletal conditions, chronic pain conditions, mild traumatic brain injury, and psychological dysregulation (e.g. depression, post-traumatic stress).

Clare Smith graduated from University of London, Kings College, with BscPT in 1993. She has spent the last 25 years working in many aspects of Acute Care, but specializing in Cardiorespiratory physiotherapy in Paediatric and Adult populations. The last 18 have been spent working with truly dedicated teams involved with the care of people with Cystic Fibrosis, from bedside care, to support in daily life and finally into clinical research.

Review panel

The draft document was circulated to a review panel composed of researchers, educators and clinicians. Their comments and recommendations were invaluable to the project outcome.

Dr. Sinead Dufour
Assistant Clinical Professor
School of Rehabilitation Science
Adjunct Faculty
Michael G. DeGroote School of Medicine
McMaster University

Jim Millard BSc PT, MClS(Manipulative PT) 2010, FCAMT
Clinical instructor/lecturer Western University
Physiotherapist, Lifemark Health Group
Co-founder and Facilitator COMPASS Interactive Workshops

Todd Wolanshy PT (Clinical Specialist – Seniors’ Health)
Physiotherapist + Program Facilitator
Rural Allied Health, Calgary Zone
Alberta Health Services
Clinical Assistant Professor, University of Alberta

Resources

The PT-BTC checklist is used with thanks and with the permission of the developers, Katherine Harman, PT PhD, Dalhousie University and Major Marsha MacRae, BscPT MsCPT, CFB Stadacona.

Physiotherapy Alberta thanks Janet Jull OT Reg, PhD, Queens University, who provided the Adapted Ottawa Personal Decision Guide, which has recently been released for clinical use.