

The Five A's Construct for Clinical Counseling on Excess Bodyweight

Adapted from *Evaluating Primary Care Behavioral Counseling Interventions: An Evidence-based Approach*. Background Article. Originally in *Am J Prev Med* 2002;22(4):267-84. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov>

Background

The Five A's construct (ask, advise, assess, assist, arrange) was originally developed by the National Cancer Institute to guide physician intervention in smoking cessation. The U.S. Public Health Service used the A's construct to report on high-quality, controlled clinical trials in tobacco cessation, many conducted in primary care settings to test brief, feasible population-level interventions. The A's construct has also been applied to brief primary care interventions for a variety of other behaviors. The following terminology is used to describe minimal contact interventions for WatchWT that are provided in the physician office setting:

- **Ask:** Ask about/assess bodyweight and factors affecting choice of behavior change goals/methods.
- **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms/benefits of excess bodyweight.
- **Assess:** Assess specific nutrition (i.e. measure RMR), physical activity, and psychosocial constructs. Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
- **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change.
- **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Rationale and Strategies for Implementing the Five A's

The content of each step in the Five A's construct necessarily varies from behavior to behavior, but clinical intervention targeting any behavior change can be described with reference to these five intervention components. While we promote the idea of a unifying construct to describe behavioral counseling interventions across behaviors, we acknowledge that the type and intensity of behavior change strategies needed may vary by the complexity of the change, whether the behavior is being added or deleted, and by individual factors. Our brief description of each "A" of this unifying construct uses selected examples to detail current options and challenges in providing behavioral counseling interventions for patients with excess bodyweight.

Ask: Because behavioral risks are largely invisible and are rarely the main reason for seeking clinical care, explicit systems for behavioral risk-factor assessment in clinical populations serve two purposes. First, they identify all those in need of some intervention for a given behavior (e.g., sedentary or underactive individuals vs. already active).

Second, they gather data needed to target (e.g., group) those needing different interventions and, if warranted, to individualize (i.e., tailor) brief interventions for maximum effectiveness or health benefit. Depending on the behavior, groups are targeted for intervention by factors such as current practices (e.g., sedentary lifestyle vs. active lifestyle), intention (e.g., intending to reduce bodyweight vs. not), readiness to change the eating and/or activity behavior (e.g., soon vs. not), and presence of medical/physiological factors defining treatment options (e.g., pregnant vs. not). Within target groups, moderating factors such as age, gender, ethnicity, physiology, comorbidity, or health literacy can help clinicians personalize the intervention. Such assessment for intervention individualization may be delayed to a later point in the A's process (see Assess section). Assessment can also identify contraindications to intervention, such as general promotion of physical activity in the presence of a recent morbidity or the safety and appropriateness of specific nutrition recommendations.

Systematic, routine assessment is the foundation for proactive behavioral counseling interventions, particularly to realize their public health potential. For instance, having a system in place to identify and document Body Mass Index (BMI) increases the odds of clinician intervention [1, 2]. Adequate assessment can help the clinician consider patient priorities and medical risks, particularly among those with multiple behavioral risks (diabetes, cardiovascular disease, etc.). Little research currently exists in effective methods for prioritizing among competing behavioral risks, but ongoing work by the Behavior Change Consortium, sponsored by the National Institutes of Health, may help address these issues.

Ask Strategies: Ideal assessment strategies for clinical practice settings are feasible, brief, and able to be interpreted or scored easily and accurately, and they enhance intervention appropriateness and effectiveness. Assessment ranges from a few focused questions added before the clinician visit "Have you thought about reducing your bodyweight? If yes, are you seriously thinking about losing this weight in the next 6 months? If no, have you attempted to lose weight in the last 6 months?"

Challenges for behavioral assessments include the tension between accuracy and feasibility. To be practical, many tools are abbreviated to require as little patient and clinician time as possible; thus, good evaluations consider both accuracy and applicability for any assessment approach. One approach to the demands of a more lengthy assessment is to obtain brief assessment by telephone in advance of the clinic visit. This has been shown to produce reasonably accurate results. However, these assessments rely on self-report and recall of customary behavior, and these can suffer from lapses in individual memory, errors in estimation, and the imprecise mapping of self-reported activities to meaningful, physiologically related measures. Overall, when reliable biological markers are available for comparison, self-reported health behaviors and risk factors tend to underestimate the proportion of general-population individuals considered "at risk." Microlife Medical Home Solutions has developed a patient self-assessment questionnaire that is feasible and utilizes questions that have proved accurate in assessing various psychobehavioral constructs

related to weight management. The purpose of the questionnaire is to aid the clinicians during the brief intervention.

Advise: As discussed above, clinician advice establishes behavioral issues as an important part of health care and enhances the patient's motivation to change. Such advice is most powerful when personalized by specifically linking the behavior change to the patient's health concerns, past experiences, family, or social situation, and tempering it with the individual's level of health literacy. Clinician advice primarily gives the cue to action, while other health professionals and media provide the details. In this scenario, the clinician is a uniquely influential catalyst for patient behavior change and is best supported by a coordinated system to accomplish and maintain that change. Simply advising the patient to reduce bodyweight may engage the patient to change a given behavior but repeat studies have indicated that this will not result in short or long-term weight changes [3]. Therefore, a supporting program accompanying the advisory information is more influential to the patient promoting weight change. WatchWT focuses the clinician's efforts towards advisory information and utilizes support staff to provide the details.

Feedback from current or previous assessments can help personalize health risks and health benefits as well as enhances motivation for change. Well-delivered advice supports the patient's self-determination. Using minor qualifications such as, "As your physician, I feel I should tell you," for an advice message, rather than "You should," is a subtle but powerful way to convey respect for, and avoid undermining, patient autonomy.

Advice Strategies: Effective clinician advice has several important elements. Personalized feedback can be biological (laboratory or physiological test results), normative (compared with results for others of the same age, race, and gender), or ipsative (compared with one's previous scores). How the clinician's advice is delivered matters—a *warm, empathetic, and non-judgmental style elicits greater cooperation and less resistance, particularly for patients not currently interested in change.*

A respectful, individualized approach first considers patient interest in change before warning about health risks or trying to convince the patient to take action. Helpful clinician advice also emphasizes the clinician's confidence in the patient's ability to change weight management related behaviors (i.e., building self-efficacy), and reassures the patient that there are multiple ways to approach successful change and sources to support the eating behavior and physical activity behavior change once it is undertaken. Acknowledging a patient's previous success in making changes can also boost the patient's confidence. Even considering all these elements, advice messages can be compactly constructed and short (30 to 60 seconds), particularly when coupled with additional assistance. Some clinicians are reluctant to advise patients because people seeking clinical care are not consciously seeking medical advice about their excess bodyweight. However, well-delivered advice is actually associated with improved patient satisfaction and with improved behavioral risk factors.

Assess & Agree: Here the patient and clinician "come to common ground" on area(s) where behavior change is to be considered or undertaken. When both agree that change is warranted, they then collaborate to define behavior-change goals or methods. The importance of collaborative care and patient agreement in a course of action was not explicit in the original Four A's model, but medical thinking has shifted over recent decades to greater patient participation

in many aspects of medical care. This is an important component to patient-centered care.

Increasingly, treatment decisions are based on clinician-patient agreement after considering treatment options, consequences, and patient preferences. Shared decision making is specifically recommended by the US Preventative Services Task Force for preventive services that involve conflicting or highly individualized risk-benefit trade-offs. Similarly, a collaborative approach that emphasizes patient choice and autonomy is critical in behavioral counseling intervention, where the patient retains ultimate control.

Patient involvement in decision making about behavior change offers important benefits, even when decisions involving competing risks and benefits are not the overriding concern. Patients who are actively involved in health care decisions have a greater sense of personal control. Also, patient involvement in decisions promotes choices based on realistic expectations and patient values, which are important determinants of patient adherence. Patient-centered approaches in which the patient and clinician mutually agree on specific changes may require less visit time than provider-centered ones.

Assess & Agreement Strategies: Additional assessments will help frame the rest of the intervention. For example, the American Dietetic Association recommends clinicians measure resting metabolic rate when developing individual nutrition plans for weight change [4]. In addition, a questionnaire assessing lifestyle factors, weight goal expectations, and physical activity will help the clinician tailor the nutrition and activity plan for the patient. Once the plan is developed and the patient is in agreement with the plan assessing patient confidence will validate the plan.

A brief question such as "How confident are you that you can follow the nutrition/activity plan" easily assess a person's motivation and confidence to change eating and activity behavior, and quickly identify the most promising avenues for further assistance. This type of open-ended exchange can engage even the minimally interested patient in a nonthreatening way that may also increase knowledge, self-confidence, and motivation.

Actively engaging a patient's agreement before proceeding with further behavioral counseling can also prevent resistance. Agreement considers the multiple treatment or intervention options available to help the patient achieve selected behavior change goals. For instance, patients can select home-based or wellness center options to increase their activity levels and the choice of a wide variety of approaches (meal replacements, packaged foods, meal preparation, etc.) to improving diet. Moreover, for each of these changes, patients can often choose between reliance on self-help and more intensive clinic methods such as the WatchWT Advanced program, based on preference and perceived need for the more intensive skill training and higher levels of social support that clinic-based and group counseling provide. For people with multiple behavioral risks, agreement is needed about which behavior change(s) to tackle first.

Assist: In providing assistance, the clinician or other health care staff offers additional treatment to address barriers to changes, increase the patient's motivation and self-help skills, and/or help the patient secure the needed supports for successful behavior change. Effective primary care interventions seek to teach self-management and engage problem-solving/coping skills, thereby enabling the patient to undertake the next immediate step(s) in the targeted behavior change.

WatchWT provides a didactic outline for providing evidence-based nutrition education to patients. The focus of the intervention is towards energy balance, reading food labels, and portion control. As emphasized earlier, additional assistance through effective behavior-change techniques need not be provided directly by the primary clinician solely within the context of a physician visit. Clinicians may provide assistance through mid-level providers or ancillary clinic staff (i.e. medical assistants) or may refer to other health care staff (i.e. dietitians or behavioralists) within the clinic or outside in the larger health care system or community.

Additional assistance within or outside the patient visit produce better outcomes than minimal-contact, advice-only treatment. For example, even though 1-3 minutes of advice and counseling have been found to increase eating and physical activity behavior as indicated by self-report data [5], time-intensive interventions and more numerous contacts produce even better effects. Increasing the total contact time in an intervention (time per intervention X number of contacts) from the minimal 1 to 3 minutes to more than 30 minutes produces better patient outcomes. WatchWT facilitates 2-13 sessions based on the need of the patient and the resources in the clinician's office.

Assistance Strategies: Assistance techniques vary according to the behavior and the patient's needs but include practical counseling (problem-solving skills training) to replace the problem behavior with new behaviors and to tackle environmental and physiological barriers to change. Assistance also can include direct support from the health care provider/team, guidance in obtaining social support from friends and family, the provision of self-help materials to support self-change efforts, and the provision or prescription of appropriate medication or medical devices (e.g., pharmacotherapy for weight reduction, MedGem for metabolic assessment, and bariatric surgery for certain weight loss regimens). Other effective behavior-change techniques include modeling and behavioral rehearsal, contingency contracting, stimulus control, stress-management training, and the use of self-monitoring and self-reward. All of these topics are covered in the WatchWT Advanced program.

Involving a variety of staff and using diverse, complementary intervention methods improve the feasibility and the effectiveness of providing further behavior change assistance. In addition, reduces the time burden on the physician to improve patient outcomes. Studies have demonstrated that physicians can act as monitor of a more comprehensive weight reduction program and this improves patient outcomes [6, 7]. Telephone counseling and well-developed self-help materials provide additional channels for efficiently delivering effective interventions. Computer-driven interventions will someday offer direct, interactive personalized contact through computer kiosks or the Internet that bypasses use of office staff and resources. Within certain health care environments, such as managed care and health maintenance organizations, staff outside the clinical setting undertake written and telephone counseling that can result in feedback to the provider or medical chart.

For settings with few of these options, the delivery of appropriate behavior change assistance is more feasible if intervention activities are spread across clinical staff (e.g., clinician, nurse, medical assistant, and receptionist). The WatchWT program promotes the use of medical assistants in delivering patient education and encourages the provider to act more as a monitor or manager of patient's care delivery team.

Arrange: Arranging follow-up challenges us to reconceptualize behavioral risk factors as chronic problems that change over time. No matter how intensive the initial assistance, some form of routine

follow-up assessment and support through repeat visits, telephone calls, or other contact is generally deemed necessary in behavior change interventions. For one thing, follow-up contacts provide the opportunity to evaluate and adjust the weight management plan. Usually, this is accomplished by briefly repeating the first four A's (assess, advise, agree, assist) to update the behavior-change plan, taking into account the patient's intervening efforts, experience, and current perspective. Follow-up allows for support of behavior-change maintenance and relapse prevention for those who have already made some significant improvement of their body weight. In general, follow-up is best scheduled within a relatively short time period (e.g., one month), although the timing can be geared to provide support for a specific event. WatchWT promotes a 4-week follow-up after the initial intervention. After the initial intervention follow-up, future contacts are often spaced at successively longer intervals to provide needed support and continuity in a gradually reduced manner. WatchWT provides an algorithm that assists in determining the appropriate timeline for a respective patient based on weight change.

Arranging Implementation and Follow-up: Behavioral interventions can involve "stepped-care" approaches, similar to those used for hypertension management, with the need for referral to more intensive treatment or outside resources determined after evaluating response to briefer, less-intensive interventions during follow-up. Simply notifying patients that follow-up will occur seems to be a powerful motivating factor, communicating that the behavior change is important and that follow-up assistance will be available if needed. Clinical staff can systematically arrange follow-up assessment and support through repeat clinical visits, telephone calls, or other methods of contact between the patient and the health care system. Completion rates for follow-up and outside referral are important implementation process measures.

Recent advances in health communications can assist both clinicians and patients as they engage in appropriate adjustment of the behavior-change plan. For example, interactive computer programs coupled with the capacity for individually tailored output can track individual progress and adjust health promotion strategies to respond to the individual's preferences, rate of progress, and changing environments. The diversity of populations that clinicians serve increases the importance of adjusting weight reduction plans to the culture, social circumstances, and economic status of clients. WatchWT helps the provider tailor a plan based on the physiology, attitude, social support, and current behaviors of the patient. By using the WatchWT system, the clinician will be able to efficiently and effectively offer an evidence-based weight reduction program that models the 5 A's for successful behavior change.

Additional References:

1. Jackson, J.E., et al., *Trends in professional advice to lose weight among obese adults, 1994 to 2000*. J Gen Intern Med, 2005. **20**(9): p. 814-8.
2. Galuska, D.A., et al., *Are health care professionals advising obese patients to lose weight?* Jama, 1999. **282**(16): p. 1576-8.
3. Franz, M.J., et al., *Weight-loss outcomes: a systematic review and meta-analysis of weight-loss clinical trials with a minimum 1-year follow-up*. J Am Diet Assoc, 2007. **107**(10): p. 1755-67.
4. ADA. *Adult Weight Management Evidence-Based Nutrition Practice Guideline*. 2007.
5. Sciamanna, C.N., et al., *Who Reports Receiving Advice to Lose Weight?: Results From a Multistate Survey*. Arch Intern Med, 2000. **160**(15): p. 2334-2339.
6. Pritchard, D.A., J. Hyndman, and F. Taba, *Nutritional counseling in general practice: a cost effective analysis*. J Epidemiol Community Health, 1999. **53**(5): p. 311-6.
7. Bowerman, S., et al., *Implementation of a primary care physician network obesity management program*. Obes Res, 2001. **9 Suppl 4**: p. 321S-325S.