Brief Action Planning to Facilitate Behavior Change and Support Patient Self-Management

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ABSTRACT

- *Objective:* To describe Brief Action Planning (BAP), a structured, stepped-care self-management support technique for chronic illness care and disease prevention.
- *Methods:* A review of the theory and research supporting BAP and the questions and skills that comprise the technique with provision of a clinical example.
- *Results:* BAP facilitates goal setting and action planning to build self-efficacy for behavior change. It is grounded in the principles and practice of Motivational Interviewing and evidence-based constructs from the behavior change literature. Comprised of a series of 3 questions and 5 skills, BAP can be implemented by medical teams to help meet the self-management support objectives of the Patient-Centered Medical Home.
- *Conclusion:* BAP is a useful self-management support technique for busy medical practices to promote health behavior change and build patient self-efficacy for improved long-term clinical outcomes in chronic illness care and disease prevention.

Chronic disease is prevalent and time consuming, challenging, and expensive to manage [1]. Half of all adult primary care patients have more than 2 chronic diseases, and 75% of US health care dollars are spent on chronic illness care [2]. Given the health and financial impact of chronic disease, and recognizing that patients make daily decisions that affect disease control, efforts are needed to assist and empower patients to actively self-manage health behaviors that influence chronic illness outcomes. Patients who are supported to actively self-manage their own chronic illnesses have fewer symptoms, improved quality of life, and lower use of health care resources [3]. Historically, providers have tried to influence chronic illness self-management by advising behavior change (eg, smoking cessation, exercise) or telling patients to take medications; yet clinicians often become frustrated when patients do not "adhere" to their professional advice [4,5]. Many times, patients want to make changes that will improve their health but need support—commonly known as self-management support—to be successful.

Involving patients in decision making, emphasizing problem solving, setting goals, creating action plans (ie, when, where and how to enact a goal-directed behavior), and following up on goals are key features of successful self-management support methods [3,6–8]. Multiple approaches from the behavioral change literature, such as the 5 A's (Assess, Advise, Agree, Assist, Arrange) [9], Motivational Interviewing (MI), and chronic disease self-management programs [10] have been used to provide more effective guidance for patients and their caregivers. However, the practicalities of these approaches in clinical settings have been questioned. The 5A's, a counseling framework that is used to guide providers in health behavior change counseling, can feel overwhelming because it encompasses several different aspects of counseling [11,12]. Likewise, MI and adaptations of MI, which have been shown to outperform traditional "advice giving" in treatment of a broad range of behaviors and chronic conditions [13–16], have been critiqued since fidelity to

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this approach often involves multiple sessions of training, practice, and feedback to achieve proficiency [15,17,18]. Finally, while chronic disease self-management programs have been shown to be effective when used by peers in the community [10], similar results in primary care are not well established.

Given the challenges of providers practicing, learning, and using each of these approaches, efforts to develop an approach that supports patients to make behavioral changes that can be implemented in typical practice settings are needed. In addition, health delivery systems are transforming to team-based models with emphasis on leveraging each team member's expertise and licensure [19]. In acknowledgement of these evolving practice realities, the National Committee for Quality Assurance (NCQA) included development and documentation of patient self-management plans and goals as a critical factor for achieving NCQA Patient-Centered Medical Home (PCMH) recognition [20]. Successful PCMH transformation therefore entails clinical practices developing effective and time efficient ways to incorporate self-management support strategies, a new service for many, into their care delivery systems often without additional staffing.

In this paper, we describe an evidence-informed, efficient self-management support technique called Brief Action Planning (BAP) [21–24]. BAP evolved into its current form through ongoing collaborative efforts of 4 of the authors (SC, DG, CD, KR) and is based on a foundation of original work by Steven Cole with contributions from Mary Cole in 2002 [25]. This technique addresses many of the barriers providers have cited to providing self-management support, as it can be used routinely by both individual providers and health care teams to facilitate patient-centered goal setting and action planning. BAP integrates principles and practice of MI with goal setting and action planning concepts from the self-management support, self-efficacy, and behavior change literature. In addition to reviewing the principles and theory that inform BAP, we introduce the steps of BAP and discuss practical considerations for incorporating BAP into clinical practice. In particular, we include suggestions about how BAP can be used in team-based clinical practice settings within the PCMH. Finally, we present a common clinical scenario to demonstrate BAP and provide resource links to online videos of BAP encounters. Throughout the paper, we use the word "clinician" to refer to professionals or other trained personnel using BAP, and "patient" to refer to those experiencing BAP, recognizing that other terms may be preferred in different settings.

What is BAP?

BAP is a highly structured, stepped-care, self-management support technique. Composed of a series of 3 questions and 5 skills (reviewed in detail below), BAP can be used to facilitate goal setting and action planning to build self-efficacy in chronic illness management and disease prevention [21–24]. The overall goal of BAP is to assist an individual to create an action plan for a self-management behavior that they feel confident that they can achieve. BAP is currently being used in diverse care settings including primary care, home health care, rehabilitation, mental health and public health to assist and empower patients to self-manage chronic illnesses and disabilities including diabetes, depression, spinal cord injury, arthritis, and hypertension. BAP is also being used to assist patients to develop action plans for disease prevention. For example, the Bellevue Hospital Personalized Prevention clinic, a pilot clinic that uses a mathematical model [26] to help patients and providers collaboratively prioritize prevention focus and strategies, systematically utilizes BAP as its self-management support technique for patient-centered action planning. At this time, BAP has been incorporated into teaching curriculums at multiple medical schools, presented at major national health care/academic conferences and is being increasingly integrated into health delivery systems across the United States and Canada to support patient self-management for NCQA-PCMH transformation. We have also developed a series of standardized programing to support fidelity in BAP skills development including a multidisciplinary introductory training curriculum, telephonic coaching, interactive web-based training tools, and a structured "Train the Trainer" curriculum [27]. In addition, a set of guidelines designed to ensure fidelity in BAP research has been developed [27].

Underlying Principles of BAP

BAP is grounded in the principles and practice of MI and the psychology of behavior change. Within behavior change, we draw primarily on self-efficacy and action planning theory and research. We discuss the key concepts in detail below.

The Spirit of MI

MI Spirit (Compassion, Acceptance, Partnership and Evocation) is an important overarching tenet for BAP. Compassionately supporting self-management with MI spirit involves a partnership with the patient rather than

a prescription for change and the assurance that the clinician has the patients best interest always in mind (Compassion) [17]. Exemplifying "spirit" accepts that the ultimate choice to change is the patient's alone (Acceptance) and acknowledges that individuals bring expertise about themselves and their lives to the conversation (Evocation). Adherence to "MI spirit" itself has been associated with positive behavior change outcomes in patients [5,28–32]. Demonstrating MI spirit throughout the change conversation is an essential foundational principle of BAP.

Action Planning and Self-Efficacy

In addition to the spirit of MI, BAP integrates 2 evidence-based constructs from the behavior change literature: action planning and self-efficacy [4,6,33–36]. Action planning requires that individuals specify when, where and how to enact a goal-directed behavior (eg, self-management behaviors). Action planning has been shown to mediate the intention-behavior relationship thereby increasing the likelihood that an individual's intentions will lead to behavior change [37,38]. Given the demonstrated potential of action planning for ensuring individuals achieve their health goals, the BAP framework aspires to assist patients to create an action plan.

BAP also aims to build patients' self-efficacy to enact the goals outlined in their action plans. Self-efficacy refers to a patient's confidence in their ability to enact a behavior [33]. Several reviews of the literature have suggested a strong relationship between self-efficacy and adoption of healthy behaviors such as smoking cessation, weight control, contraception, alcohol abuse and physical activity [39–42]. Furthermore, Lorig et al demonstrated that the process of action planning itself contributes to enhanced self-efficacy [8]. BAP aims to build self-efficacy and ultimately change patients' behaviors by helping patients to set an action plan that they feel confident in their ability to achieve.

Description of the BAP Steps

The flowchart in **Figure 1** presents an overview of the key elements of BAP. An example dialogue illustrating the steps of BAP can be found in **Figure 2.**

Three questions and 3 of the BAP skills (ie, SMART plan, eliciting a commitment statement, and follow-up) are applied during every BAP interaction, while 2 skills (ie, behavioral menu and problem solving for low confidence) are used as needed. The distinct functions and the

evidence supporting the 3 questions and 5 BAP skills are described below.

Question 1: Eliciting a Behavioral Focus or Goal

Once engagement has been established and the clinician determines the patient is ready for self-management planning to occur, the first question of BAP can be asked: *"Is there anything you would like to do for your health in the next week or two?"* This question elicits a person's interest in self-management or behavior change and encourages the individual to view himself/herself as someone engaged in his or her health. The powerful link between consistency of word and action facilitates development and commitment to change the behavior of focus [43]. In some settings a broader question such as *"Is there anything you would like to do about your current situation in the next week or two?"* may be a better fit, or referring to a more specific question may flow more naturally from the conversation such as *"We've been talking about diabetes, is there anything you would like to do for that or anything else in the next week or two?"*

Although technically Question 1 is a closed-ended question (in that it can be answered "yes" or "no"), in actual practice it generates productive discussions about change. For example, whenever a patient answers "yes" or "no" or something in-between like, "I'm not sure," the clinician can often smoothly transition to a dialogue about change based on that response. Responses to Question 1 generally take 3 forms (Figure 1):

1) **Have an Idea.** A group of patients immediately present an idea that they are ready to do or are ready to consider doing. For these patients, clinicians can proceed directly to Skill 2—SMART Behavioral Planning; that is, asking patients directly if they are ready to turn their idea into a concrete plan. Some evidence suggests that further discussion, assessment, or even additional "motivational" exploration in patients who are ready to make a plan and already have an idea may actually decrease motivation for change [17, 32].

2) **Not Sure**. Another group of patients may want or need suggestions before committing to something specific they want to work on. For these patients, clinicians should use the opportunity to offer a Behavioral Menu (Skill 1).

3) **No or Not at This Time.** A third group of patients may not be interested or ready to make a change at this time or at all. Some in this group may be healthy or
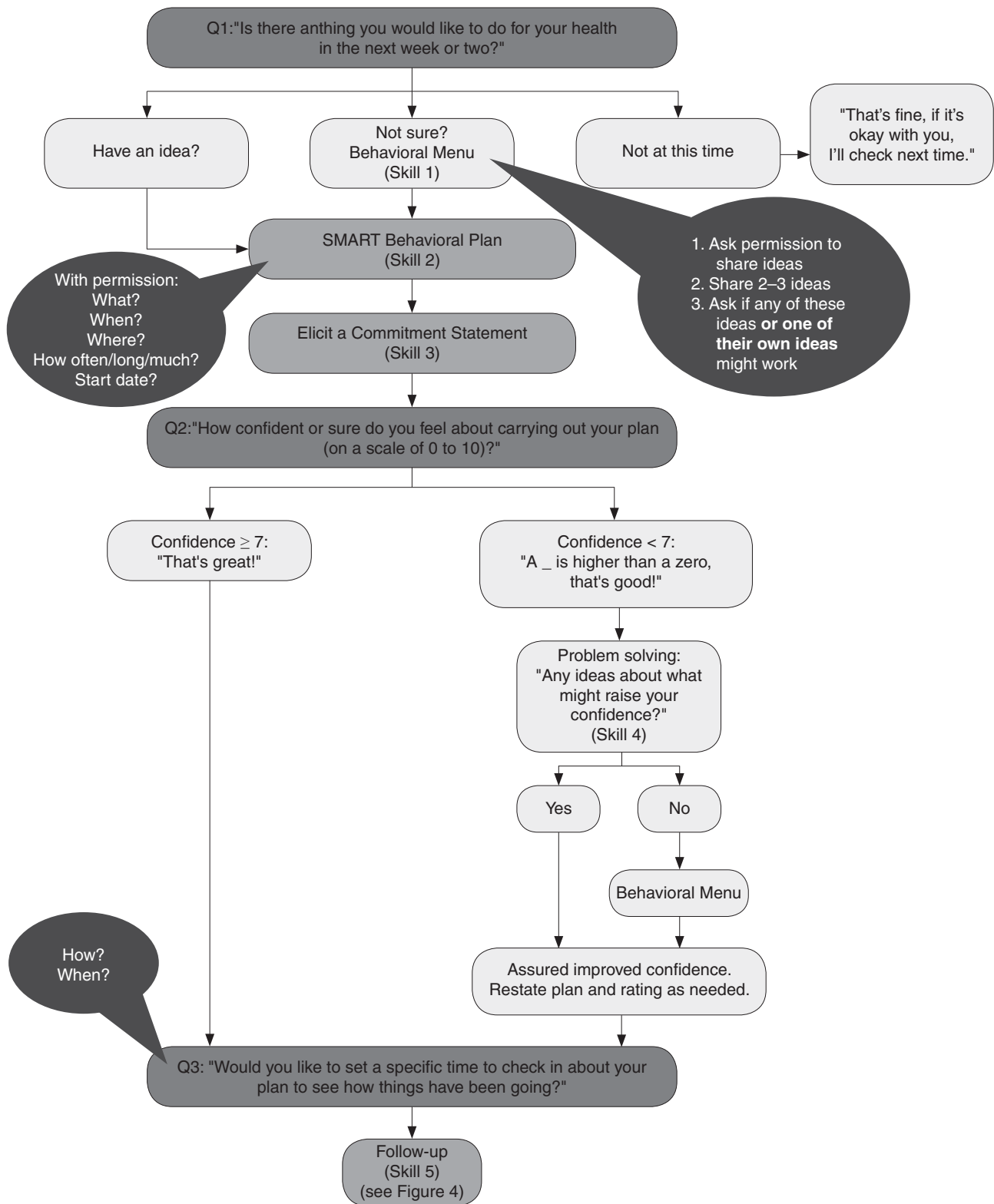
Figure 1. Brief Action Planning flowchart.

already self-managing effectively and have no need to make a plan, in which case the clinician acknowledges their active self-management and moves to the next part of the visit. Others in this group may have considerable ambivalence about change or face complex situations where other priorities take precedence. Clinicians frequently label these individuals as "resistant." The Spirit of MI can be very useful when working with these patients to accept and respect their autonomy while encouraging ongoing partnership at a future time. For example, a clinician may say *"It sounds like you are not interested in making a plan for your health right now. Would it be OK if I ask you about this again at our next visit?"* Pushing forward to make a "plan for change" when a patient is not ready decreases both motivation for change as well as the likelihood for a successful outcome [32].

Other patients may benefit from additional motivational approaches to further explore change and ambivalence. If the clinician does not have these skills, patients may be seamlessly transitioned to another resource within or external to the care team.

Skill 1: Offering a Behavioral Menu

If in response to Question 1 an individual is unable to come up with an idea of their own or needs more information, then offering a Behavioral Menu may be helpful [44,45]. Consistent with the "Spirit of MI," BAP attempts to elicit ideas from the individual themselves; however, it is important to recognize that some people require assistance to identify possible actions. A behavioral menu is comprised of 2 or 3 suggestions or ideas that will ideally trigger individuals to discover an idea of their own. There are 3 distinct evidence-based steps to follow when presenting a Behavioral Menu.

1) Ask permission to offer a behavioral menu. Asking permission to share ideas respects patient autonomy and prevents the provider from inadvertently assuming an expert role. For example: *"Would it be OK if I shared with you some examples of what some other patients I work with have done?"*

2) Offer 2 to 3 general yet varied ideas all at once (Figure 2, entry 5). It helps to mention things that other patients have decided to do with some success. Using this approach avoids the clinician assuming too much about the patient or allowing the patient to reject the ideas. It is important to

remember that the list is to prompt ideas, not to find a perfect solution [17]. For example: *"One patient I work with decided to join a gym and start exercising, another decided to pick up an old hobby he used to enjoy doing and another patient decided to schedule some time with a friend she hadn't seen in a while."*

3) Ask if any of the ideas appeal to the individual as something that might work for them or if the patient has an idea of his/her own (Figure 2, entry 5). Evocation from the Spirit of MI is built in with this prompt [17]. For example: *"These are some ideas that have worked for other patients I work with, do they trigger any ideas that might work for you?"*

Clinicians may find it helpful to use visual prompts to guide Behavioral Menu conversations [44]. Diagrams with equally weighted spaces assist clinicians to resist prioritizing as might happen in a list. Empty circles alongside circles containing varied options evoke patient ideas, consistent with the Spirit of MI (**Figure 3,** Visual Behavioral Menu Example) [44].

Skill 2: SMART Planning

Once an individual decides on an area of focus, the clinician partners with the patient to clarify the details and create an action plan to achieve their goal. Given that individuals are more likely to successfully achieve goals that are specific, proximal, and achievable as opposed to vague and distal [46,47], the clinician works with patient to ensure that the patient's goal is *SMART* (specific, measurable, achievable, relevant and time-bound). The term *SMART* has its roots in the business management literature [48] as an adaptation of Locke's pioneering research (1968) on goal setting and motivation [49]. In particular, Locke and Latham's theory of Goal Setting and Task Performance, states that "specific and achievable" goals are more likely to be successfully reached [47,50].

We suggest helping the patient to make smart goals by eliciting answers to questions applicable to the plan, such as "what?" "where?" "when?" "how long?" "how often?" "how much?" and "when will you start?" [51]. A resulting plan might be *"I will walk for 20 minutes, in my neighborhood, every Monday, Wednesday and Friday before dinner."*

Skill 3: Elicit a Commitment Statement

Once the individual has developed a specific plan, the next step of BAP is for the clinician to ask him or her to "tell

Mrs. Brown is a 64-year-old woman with obesity, poorly controlled diabetes, hypertension and depression. Her physician suspects that non-adherence to her medication regimen is the major reason for her poor disease control. The following interaction takes place toward the end of the visit:

1	Dr	Mrs. Brown, is there anything you would like to do for your health in the next week or two?	Question 1 of BAP
2	Pt	I am not sure what you mean by plan for my health doctor.	Patient needs more information
3	Dr	OK let me clarify. Would it be OK if I shared with you some examples about what some of my other patients with diabetes and high blood pressure have decided to work on?	Ask permission to offer Behavioral Menu
4	Pt	Yes please do.	
5	Dr	OK, well one patient I worked with decided to make some changes in his diet and cut down on his serving of rice, another patient decided she would make a plan around exercising and one patient decided to figure out a way to remember to take her medications. Do any of these ideas sound like something that would work for you or perhaps something else that is important to you comes to mind?	Offer several ideas in various domains and ask if patient has ideas of her own
6	Pt	Well actually, yes. I have gained some weight and I understand that is making my blood sugar go up. I really need to lose some weight. I have a wedding coming up and my dress is fitting too snug. I don't want to be embarrassed.	
7	Dr	That sounds like a great place to start. Do you have any ideas on what specifically you can do to lose weight?	SMART Behavioral Plan
8	Pt	I have been thinking about going back to the gym. I mean I pay for membership every month and just never make it there. It's time that I start going.	
9	Dr	Some people find it helps to get really specific about their plan, what do you think about that?	Spirit of MI, acceptance
10	Pt	Sure	
11	Dr	When would you like to start going?	
12	Pt	I think I can go tomorrow.	
13	Dr	That's great. What time?	
14	Pt	Definitely in the morning, let's say 8 am.	
15	Dr	Wonderful. How long will you stay and what will you do while you are there?	
16	Pt	I can stay for an hour and take a zumba class. I really love zumba and haven't gone in more than a year.	
17	Dr	That sounds like fun. How frequently do you think you can do this?	
18	Pt	Every day.	
19	Dr	Great. Just so that I am sure that I understand your plan, can you please repeat the details of your plan to me?	Elicitation of Commitment Statement
20	Pt	Sure. Starting tomorrow I will start going to the gym every morning and spend 1 hour taking a zumba or some sort of aerobic class.	
21	Dr	That sounds like a great plan. On a scale of 0-10 where 0 is not at all confident or sure, and 10 is extremely sure how sure are you that you will complete your plan?"	Question 2: Scaling for Confidence
22	Pt	Hmm... honestly probably a 5 or a 6. I guess that is not so good.	

Figure 2. Annotated clinical vignette demonstrating BAP and follow-up. In this team-based clinical practice, responsibility for following up with the patient telephonically is delegated to the medical assistant (MA).

23	Dr	Actually a 5 or 6 is a lot more confident than a 0 so that is great. Do you have any idea about how you could modify your plan to increase your confidence to a 7 or more?	Collaborative Problem Solving for Low Confidence
24	Pt	Well truthfully, I think it will be really difficult to do this every day. I take care of my grandson on Tuesdays and Thursdays and I probably won't have the time.	
25	Dr	That's understandable.	
26	Pt	Maybe I should just plan to do this 3 times a week for a start. Let's say Mondays, Wednesdays, and Fridays.	
27	Dr	That sounds like a great idea. What would your confidence be after adjusting your plan like that?	
28	Pt	8. I think that makes it an 8.	
29	Dr	Great. The next step is arranging some way to check in to see how the plan went for you. What would work for you?	Question 3: Arranging Accountability
30	Pt	Perhaps we can do that by phone next week.	
31	Dr	Great idea! How about if my medical assistant Clara gave you a call this time next week to see how things go?	
32	Pt	Yes, that would work for me.	

The following week, Dr. Gutnick's medical assistant calls Mrs. Brown at home to check in.

33	MA	Hi Mrs. Brown, This is Clara, Dr. Gutnick's MA. Dr. Gutnick asked me to call to check in and see how things went with your plan this week. How did it go?	Following up: Using other members of the care team to assist with follow-up.
34	Pt	Well, I did go to the gym a Monday and Wednesday, but I was just too tired on Friday. My grandson really wore me out. Who knew that a 3 year old could have so much energy.	
35	MA	It's great that you had success with your plan on Monday and Wednesday and it sounds like you got a fair bit of exercise with your grandson, too. What would you like to do next?	Recognizing and affirming partial success to increase patient self-efficacy, Spirit of MI, evocation
36	Pt	I really want to continue to do this and fit into my dress next month. I guess I just need to be realistic that Fridays I might be too tired. I will focus on getting to the gym on Mondays and Wednesday and it will be a bonus on Fridays if I am up for it.	
37	MA	Sounds great. How sure are you that you will be able to do this?	Scaling for Confidence
38	Pt	Very sure!	
39	MA	That's wonderful. It sounds like this is a plan that is really going to work for you. Would you like to arrange another check-in to see how it goes?	Affirm strength of confidence
40	Pt	Yes. That would be great. It was really helpful knowing that your were going to check-in. Can you call me again next week?	Arranging Accountability
41	MA	Sure. I can definitely do that.	

Figure 2. *continued*

back" the specifics of the plan. The provider might say something like, *"Just to make sure we understand each other, would you repeat back what you've decided to do?"* The act of "repeating back" organizes the details of the plan in the persons mind and may lead to an unconscious self-reflection about the feasibility of the plan [43,52], which then sets the stage for Question 2 of BAP (Scaling for Confidence). Commitment predicts subsequent behavior change, and the strength of the commitment language is the strongest predictor of success on an action plan [43,52,53]. For example saying "I will" is stronger than saying "I will try."
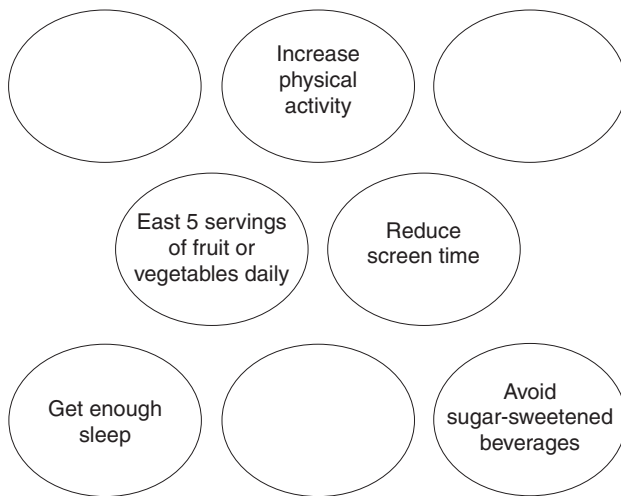
Figure 3. Visual Behavioral Menu Example.

Question 2: Scaling for Confidence

After a commitment statement has been elicited, the second question of BAP is asked. **"How confident or sure do you feel about carrying out your plan on a scale from 0 to 10, where 0 is not confident at all and 10 is totally confident or sure?"** Confidence scaling is a common tool used in behavioral interventions, MI, and chronic disease self-management programs [17,51]. Question 2 assesses an individual's self-efficacy to complete the plan and facilitates discussion about potential barriers to implementation in order to increase the likelihood of success of a personal action plan.

For patients who have difficulty grasping the concept of a numerical scale, the word "sure" can be substituted for "confident" and a Likert scale including the terms "not at all sure," "somewhat sure," and "very sure" substituted for the numerical confidence ruler, ie, "*How sure are you that you will be able to carry out your plan? Not at all sure, somewhat sure, or very sure?*" Alternatively, people of different cultural backgrounds may find it easier to grasp the concept using familiar images or experiences. For example, Native Americans from the Southwest have adapted the scale to depict a series of images ranging from planting a corn seed to harvesting a crop or climbing a ladder, while in some Latino cultures the image of climbing a mountain (*"How far up the mountain are you?"*) is useful to demonstrate "level of confidence" concept [54].

Skill 4: Problem Solving for Low Confidence

When confidence is relatively low (ie, below 7), we suggest collaborative problem solving as the next step [8,51]. Low confidence or self-efficacy for plan completion is a concern since low self-efficacy predicts non-completion [8]. Successfully implementing the action plan, no matter how small, increases confidence and self-efficacy for engaging in the behavior [8].

There are several steps that a clinician follows when collaboratively problem-solving with a patient with low confidence (Figure 1).

- Recognize that a low confidence level is greater than no confidence at all. By affirming the strength of a patient's confidence rather than negatively focusing on a low level of confidence, the provider emphasizes the patient's strengths.

- Collaboratively explore ways that the plan could be modified in order to improve confidence. A Behavioral Menu can be offered if needed. For example, a clinician might say something like: "*That's great that your confidence level is a 5. A 5 is a lot higher than a 1. People are more likely to have success with their action plans when confidence levels are 7 or more. Do you have any ideas of how you might be able to increase your level confidence to a 7 or more?*"

- If the patient has no ideas, ask permission to offer a Behavioral Menu: "*Would it be ok to share some ideas about how other patients I've worked with have increased their confidence level?*" If the patient agrees, then say... "*Some people modify their plans to make them easier, some choose a less ambitious goal or adjust the frequency of their plan, and some people involve a friend or family member. Perhaps one of these ideas seems like a good one for you or maybe you have another idea?*"

Question 3: Arranging Accountability

Once the details of the plan have been determined and confidence level for success is high, the next step is to ask Question 3: **"Would you like to set a specific time to check in about your plan to see how things are going?"** This question encourages a patient to be accountable for their plan, and reinforces the concept that the physician and care team consider the plan to be important. Research supports that people are more likely to follow through with a plan if they choose to report back their progress [43] and suggests that checking-in frequently earlier in the process is helpful [55]. Ideally the clinician
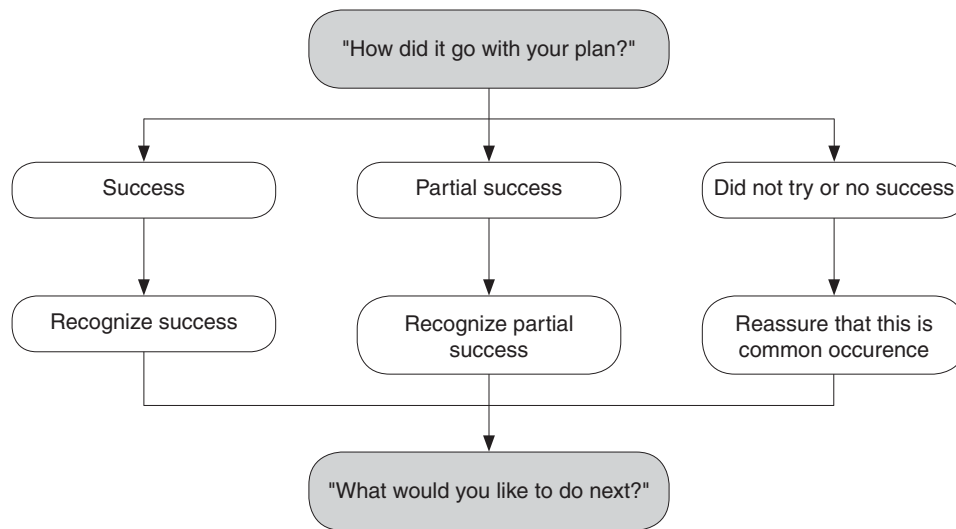
Figure 4. Follow-up on the Brief Action Plan.

and patient should agree on a time to check in on the plan within a week or two (Figure 2, entry 29).

Accountability in the form of a check-in may be arranged with the clinical provider, another member of the healthcare team or a support person of the patient's choice (eg, spouse, friend). The patient may also choose to be accountable to themselves by using a calendar or a goal setting application on their smart phone device or computer.

Skill 5: Follow-up

Follow-up has been noted as one of the features of successful multifactorial self-management interventions and builds trust [55]. Follow-up with the care team includes a discussion of how the plan went, reassurance, and next steps (**Figure 4**). The next step is often a modification of the current BAP or a new BAP; however, if a patient decides not to make or work on a plan, in the spirit of MI (accepting/respecting the patient's autonomy) the clinician can say something like, "It sounds like you are not interested in making a plan today. Would it be OK if I ask you about this again at our next visit?"

The purpose of the check-in is for learning and adjustment of the plan as well as to provide support regardless of outcome. Checking-in encourages reflection on challenges and barriers as well as successes. Patients should be given guidance to think through what worked for them and what did not. Focusing just on "success" of the plan will be less helpful. If follow-up is not done with the care

team in the near term, checking-in can be accomplished at the next scheduled visit. Patient portals provide another opportunity for patients to dialogue with the care team about their plan.

Experiential Insights from Clinical Experience Using BAP

The authors collective experience to date indicates that between 50% to 75% of individuals who are asked Question 1 go on to develop an action plan for change with relatively little need for additional skills. In other studies of action planning in primary care, 83% of patients made action plans during a visit, and at 3-week follow-up 53% had completed their action plan [56]. A recent study of action planning using an online self-management support program reported that action plans were successfully completed (49%), partially completed (40%) or incomplete (11% of the time) [35].

Another caveat to consider is that the process of planning is more important that the actual plan itself. It is imperative to allow the patient, not the clinician, to determine the plan. For example, a patient with multiple poorly controlled chronic illnesses including depression may decide to focus his action plan around cleaning out his car rather than disease control such as dietary modification, medication adherence or exercise. The clinician may initially fail to view this as a good use of clinician time or healthcare resources since it seems unrelated to health. However, successful completion of an action plan

is not the only objective of action planning. Building self-efficacy, which may lead to additional action planning around health, is more important [4,46]. The challenge is therefore for the clinician to take a step back, relinquish the "expert role," and support the goal setting process regardless of the plan. In this example, successfully cleaning out his car may increase the patient's self-efficacy to control other aspects of his life including diet and the focus of future plans may shift [4].

When to Use BAP

Opportunities for patient engagement in action planning occur when addressing chronic illness concerns as well as during discussions about health maintenance and preventive care. BAP can be considered as part of any routine clinical agenda unless patient preferences or clinical acuity preclude it. As with most clinical encounters, the flow is often negotiated at the beginning of the visit. BAP can be accomplished at any time that works best for the flow and substance of the visit, but a few patterns have emerged based on our experience.

BAP fits naturally into the part of the visit when the care plan is being discussed. The term "care plan" is commonly used to describe all of the care that will be provided until the next visit. Care plans can include additional recommendations for testing or screening, therapeutic adjustments and or referrals for additional expertise. Ideally the patients "agreed upon" contribution to their care should also be captured and documented in their care plan. This is often described as the patients "self-management goal." For patients who are ready to make a specific plan to change behavior, BAP is an efficient way to support patients to craft an action plan that can then be incorporated into the overall care plan.

Another variation of when to use BAP is the situation when the patient has had a prior action plan and is being seen for a recheck visit. Discussing the action plan early in the visit agenda focuses attention on the work patients have put into following their plan. Descriptions of success lead readily to action plans for the future. Time spent discussing failures or partial success is valuable to problem solve as well as to affirm continued efforts to self-manage.

BAP can also be used between scheduled visits. The check-in portion of BAP is particularly amenable to follow-up by phone or by another supporter. A pre-arranged follow-up 1 to 2 weeks after creation of a new action plan [8] provides encouragement to patients working on their plan and also helps identify those who need more support.

Finally, BAP can be completed over multiple visits. For patients who are thinking about change but are not yet committed to planning, a brief suggestion about the value of action planning with a behavioral menu may encourage additional self-reflection. Many times patients return to the next visit with clear ideas about changes that would be important for them to make.

Fitting BAP into a 20-Minute Visit

Using BAP is a time-efficient way to provide self-management support within the context of a 20-minute visit with engaged patients who are ready to set goals for health. With practice, clinicians can often conduct all the steps within 3 to 5 minutes. However, patients and clinicians often have competing demands and agendas and may not feel that they have time to conduct all the steps. Thus, utilizing other members of the health care team to deliver some or all of BAP can facilitate implementation.

Teams have been creative in their approach to BAP implementation but 2 common models involve a multidisciplinary approach to BAP. In one model, the clinician assesses the patient readiness to make a specific action plan by asking Question 1, usually after the current status of key problems have been addressed and discussions begin about the interim plan of care. If the patient indicates interest, another staff member trained in BAP, such as an medical assistant, health coach or nurse, guides the development of the specific plan, completes the remaining steps and inputs the patient's BAP into the care plan.

In another commonly deployed model, the front desk clerk or medical assistant helps to get the patient thinking by asking Question 1 and perhaps by providing a behavioral menu. When the clinician sees the patient, he follows up on the behavior change the patient has chosen and affirms the choice. Clinicians often flex seamlessly with other team members to complete the action plan depending on the schedule and current patient flow.

Regardless of how the workflows are designed, BAP implementation requires staff that can provide BAP with fidelity, effective communication among team members involved in the process and a standardized approach to documentation of the specific action plan, plan for check-in and notes about follow-up. Care teams commonly test different variations of personnel and workflows to find what works best for their particular practice.

Implementing BAP to Support PCMH Transformation

To support PCMH transformation substantial changes are needed to make care more proactive, more patient-centered and more accountable. One of the common elements for PCMH recognition regardless of sponsor is to enhance self-management support [20,57,58]. Practices pursuing PCMH designation are searching for effective evidence-based approaches to provide self-management support and guide action planning for patients. The authors suggest implementation of BAP as a potential strategy to enhance self-management support. In addition to facilitating meeting the actual PCMH criteria, BAP is aligned with the transitions in care delivery that are an important part of the transformation including reliance on team-based care and meaningful engagement of patients in their care [59,60].

In our experience, BAP is introduced incrementally into a practice initially focusing on one or two patient segments and then including more as resources allow. Successful BAP implementation begins with an organizational commitment to self-management support, decisions about which populations would benefit most from self-management support and BAP, training of key staff and clearly defined workflows that ensure reliable BAP provision.

BAP's stepped-care design makes it easy to teach to all team members and as described above, team-based delivery of BAP functions well in those situations where clinicians and trained ancillary staff can "hand off" the process at any time to optimize the value to the patient while respecting inherent time constraints.

Documentation of the actual goal and follow-up is an important component to fully leverage BAP. Goals captured in a template generate actionable lists for action plan follow-up. Since EHRs vary considerably in their capacity to capture goals, teams adding BAP to their workflow will benefit from discussion of standardized documentation practices and forms.

Summary

Brief Action Planning is a self-management support technique that can be used in busy clinical settings to support patient self-management through patient-centered goal setting. Each step of BAP is based on principles grounded in evidence. Health care teams can learn BAP and integrate it into clinical delivery systems to support self-management for PCMH transformation.

BAP Resources

Videos

The 3 core questions and 2 of the 5 skills of BAP: www.youtube.com/watch?v=w0n-f6qyG54

An example of BAP involving a patient with osteo-arthritis: www.youtube.com/channel/UCa6qjvuaCA-MrSbIeJz0eRaw

An example of BAP involving a patient with rheumatoid arthritis with doctor offering a behavioral menu and problem solving with the patient for low confidence: www.youtube.com/watch?v=c4cXGW2L1qc

A provider's experience using BAP and the Spirit of MI in a busy practice with an ambivalent patient: www.youtube.com/watch?v=0z65EppMfHk

Website

Centre for Comprehensive Motivational Interventions www.centrecmi.ca: contains the BAP flow chart, education materials, and training tools and resources

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