BAP-MI:
A Stepped-Care Approach to Health Behavioral Change for C-L Psychiatry

Cole S, Ahuja T, Koutsenok I, Frankel R, Jadotte Y, Romero C, Sannidhi D, Stein R

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ACADEMY OF CONSULTATION-LIAISON PSYCHIATRY

Advancing Integrated Psychiatric Care for the Medically Ill

CLP 2021 Disclosure: All Presenters

NO CONFLICT OF INTEREST

With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the parties listed above (and/or spouse/partner) and any for-profit company which could be considered a conflict of interest.

Objectives

After participation in this workshop, participants will be able to:

1. Describe and demonstrate the core skills of Brief Action Planning (BAP);
2. Explain the Spirit of Motivational Interviewing (MI);
3. Explain MI concepts of Ambivalence, OARS, and Change/Sustain Talk;
4. Discuss use of MI for ambivalent patients not ready/willing to make plans w/BAP;
5. Describe the BAP-MI stepped care approach to health behavior change; and
6. Integrate BAP-MI into clinical care and teaching on C-L services.

Agenda Overview

Two-Hour Pre-Course

I.	Introduction and Overview	Cole	05 min
II.	Brief Action Planning (BAP): Core Skills	Cole	25 min
III.	BAP-MI: Stepped Care Approach (Overview)	Cole	05 min
III.	Motivational Interviewing for Busy Clinicians	Koutsenok	40 min
IV.	BAP-MI in Four Academic Institutions	Stein, Ahuja, Jadotte, Sannidhi/Romero	40 min
V.	Summary/conclusions	Cole	05 min

Live Course (2 Hours): Brief Review, Practice of Skills, Q and A

I.	Plenary: Brief Review of Core Concepts and Skills		15 min
II.	Plenary Discussion/ Q and A		15 min
III.	BAP: Small Group Practice of Skills (Groups of 3)	(Real Play)	20 min
IV.	Plenary Discussion/Q and A		10 min
V.	BAP-MI: Small Group Practice of Skills (3 Groups)		30 min
VI.	Plenary Discussion/Q and A/Next Steps		25 min
VII.	Summary/Conclusion		05 min

Two-Hour Pre-Course Didactic

I.	Introduction and Overview	Cole	05 min
II.	Brief Action Planning (BAP): Core Skills	Cole	25 min
	A. Demonstration/Videos		
	B. Presentation of BAP Skills		
III.	BAP-MI: Stepped Care Approach (Overview)	Cole `	05 min
IV.	Motivational Interviewing for Busy Clinicians	Koutsenok	40 min
	A. Spirit of MI		
	B. Ambivalence		
	C. OARS		
	D. Change Talk/Sustain Talk		
V.	BAP-MI in Four Academic Institutions	Ahuja, Jadotte, Sannidhi/Romero, Stein	40 min
VI.	Summary/Conclusion	Cole	05 min

Acknowledgements*

Connie Davis
Damara Gutnick
Kathy Reims

Centre for Collaboration, Motivation, Innovation

*for contributions to development of BAP and for several slides in this presentation

BAP: Brief Action Planning

Steven Cole, MD
Professor of Psychiatry, Emeritus
Stony Brook University School of Medicine and
Clinical Professor of Scientific Education
Zucker School of Medicine at Hofstra/Northwell

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What is Brief Action Planning (BAP)?

General Definition

Brief Action Planning (BAP) is a highly structured and pragmatic, versatile Motivational Interviewing (MI) consistent tool designed to help people change and to support self-management for health and well-being.

What is Brief Action Planning (BAP)?

An MI - relevant definition

(For practitioner's of Motivational Interviewing)

Brief Action Planning (BAP) is a highly structured, evidence-informed roadmap that can be flexibly applied to help guide the transition from evocation into and through the process of planning.

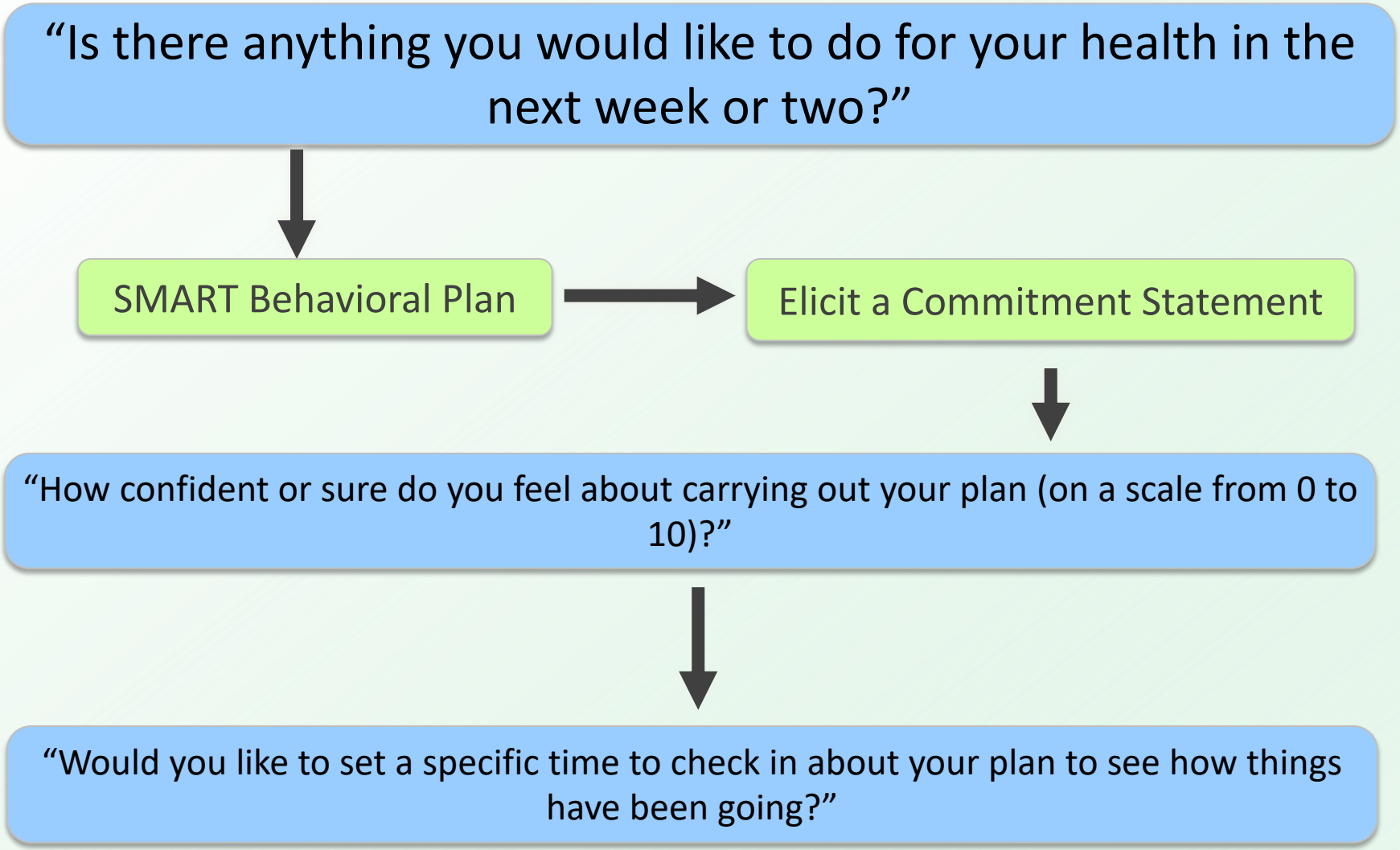
BAP Demonstration Videos

- Core Skills
  - https://www.youtube.com/watch?v=w0n-f6qyG54

- Advanced Skills
  - https://www.youtube.com/watch?v=262CjvURVn0

VIDEO 1

VIDEO 2


"Is there anything you would like to do for your health in the next week or two?"
SMART Behavioral Plan
Elicit a Commitment Statement
"How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?"
"Would you like to set a specific time to check in about your plan to see how things have been going?"

Brief Action Planning: Evidence

- Spirit of Motivational Interviewing: Patient– Centered
- SMART Behavioral Planning
- Elicit Commitment Statement
- Collaborative problem–solving to reach confidence level = 7

Gutnick, D, et al: Brief Action Planning to Facilitate Behavior Change and Support Patient Self- Management. JCOM. 1:17-29, 2014.
www.BAPProfessionalNetwork.org
www.CentreCMI.ca

Spirit of Motivational Interviewing

- Compassion
- **Autonomy Support**
- **Partnership**
- Evocation

Brief Action Planning (BAP): Uniquely Pragmatic Tool for Telemedicine

- Highly structured, pragmatic, and time efficient
- Intuitive
- Versatile: can be used by wide range of providers across diverse skill levels
- In wide use currently

  Google search = thousands/millions of results (12/2020)

Brief Action Planning (BAP): Uniquely Pragmatic Tool for Telemedicine

- Evidence-informed with emerging evidence-base
  (16 peer reviewed publications to date)
- BAP “relatively” easy to teach/learn/use
- Can be mastered with online learning + zoom sessions

BAP Online Training: Self-Directed with 4 Teleconferences

- 8 hours of CME (Stony Brook Office of CME)
- Includes core concepts, high definition videos, self-assessment tests and real world field exercises to practice skills
- Meets ACGME Core Competency Objectives (Interpersonal Skills +)
- Certification of Individual Competency Available

Brief Action Planning: Evaluations

N=19

Residents/Faculty in Preventive Medicine

Stony Brook Medicine and

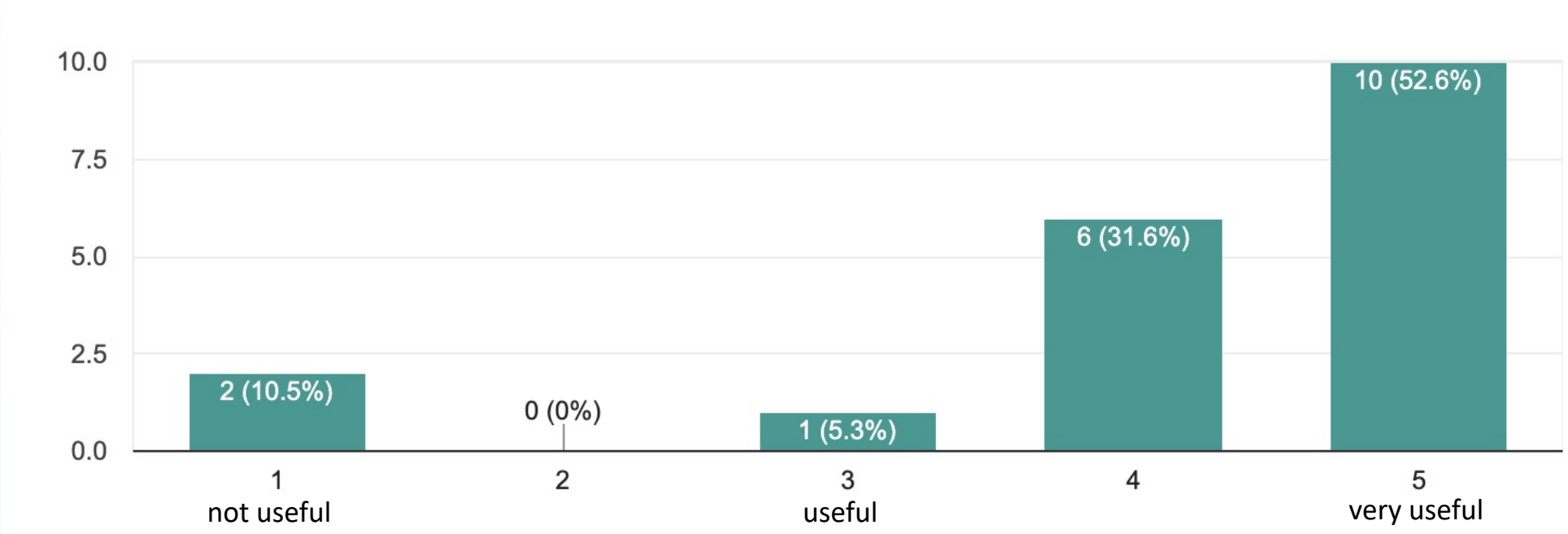
UC San Diego Health

July-August 2020

4 sessions (90 min each)

Online Self-Directed Learning + 3 Field Exercises

How Useful Do You Feel This Program Will Be In Your Current or Future Practice?



N = 19

Mean = 4.33

BAP-MI:
A Stepped-Care Approach to Health Behavior Change

- Use BAP for patients who are willing/able to make action plans for health
- Use BAP-MI for ambivalent patients not willing/able to make BAP action plans at first

BAP-MI: 3 Steps

I. Probe with Question #1 of BAP (when clinically appropriate) and continue w/BAP (if OK)
Use with Spirit of MI, and only when there is good engagement (connection)

II. Use MI skills for ambivalent patients unable/unwilling to make action plans with BAP

III. Re-probe with Question #1 of BAP (when clinically appropriate as “change talk” increases)

BAP-MI: Step Two

III. Use MI skills for patients unwilling/unable to make action plans w/BAP

- align empathically (engage/connect) throughout
- elicit patient's concern/story (w/MI Spirit)
  - Emphasize past success, affirm strengths or….
  - *"Should you decide to make any change in your life, what would that be?"*
  - *"Should you decide one day to make this change, (eg stop smoking), what do you think your life will look like?"*
- recognize/accept/respond to ambivalence
- elicit, recognize, respond (reinforce) change talk throughout

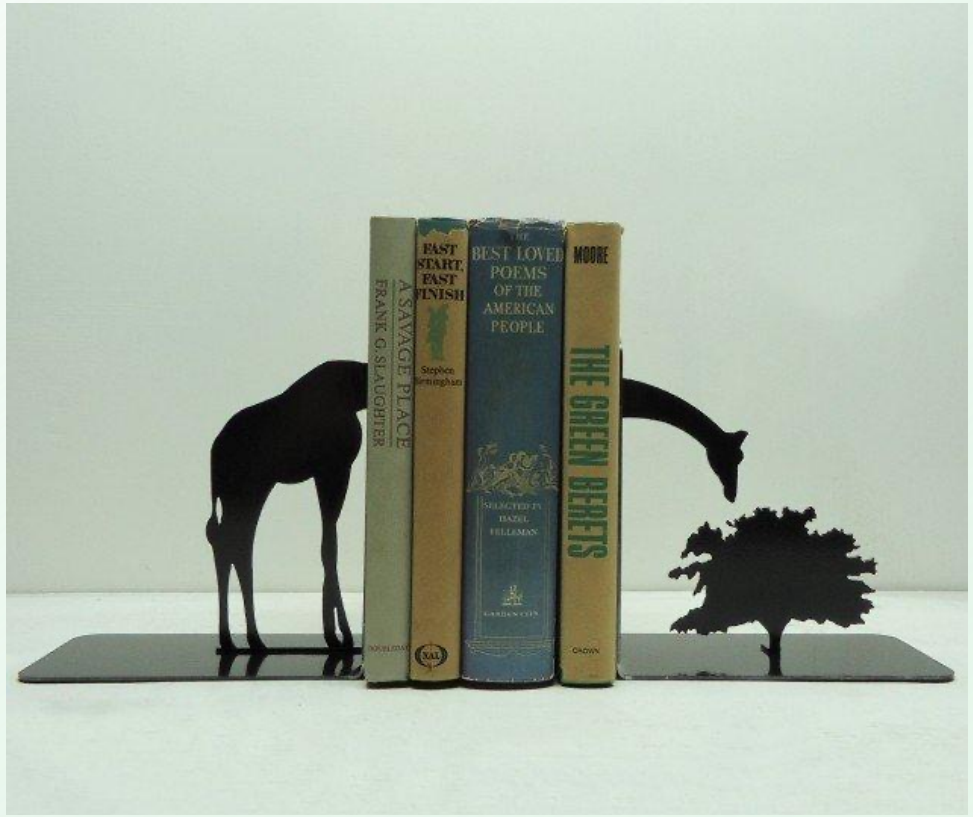
BAP-MI: Step Three (The “Pivotal” Question)

IV. Re-Probe with BAP Q #1 (when clinically appropriate as “change talk” increases)

- *“Given what I hear you saying now….*
  - *“… Is there anything you’d like to go ahead and do about …(this concern) we’ve been discussing?”*
  - *“….Would you like to make a plan about ….(this concern we’ve been discussing?”*

  (eg smoking, medication nonadherence, exercise, problems at work/home etc)

A Metaphor for BAP-MI: BAP "Bookends" MI



IN BAP-MI, Sometimes, BAP is Sufficient for SMS and HBC

- With engagement/connection
- With Spirit of MI

Sometimes, BAP-MI
Begins with MI and Concludes with BAP

BAP-MI is Adaptable and Flexible: Comes in Many Flavors/Styles

BAP-MI is an approach potentially useful for many patients seen on C-L Services who are ambivalent about….

- Smoking
- Unhealthy use of alcohol
- Unhealthy use of pain or other prescription medications
- Unhealthy use of illicit drugs
- Sedentary behavior
- Unhealthy eating behaviors
- Many other unhealthy behaviors

Motivational Interviewing for Busy Clinicians

Igor Koutsenok, MD,
Professor of Psychiatry
University of California San Diego, Department of Psychiatry

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I guess you would you agree with me that

Effective treatment of patients with a variety of acute and chronic conditions is impossible without changes in the patient's behavior?

If you agree, here is the $10 M question:

Why people don’t just change?

You would think . . .

- That having had a heart attack would be enough for someone to quit smoking and exercise more.
- That hangovers, damaged relationships, would be enough to convince people to do something about their drinking or drug use
- That being diagnosed with diabetes will be enough to someone to start a diet and medication
- That time spent in the jail or prison would dissuade someone from re-offending

and sometimes it does . . . .

Yet so often it is not enough.

Why?

Common beliefs why people do not change

The problem with them is ...

- They don't **SEE** the problem (denial, lack of insight)
- They don't **KNOW HOW** to change
- They simply don't **CARE**

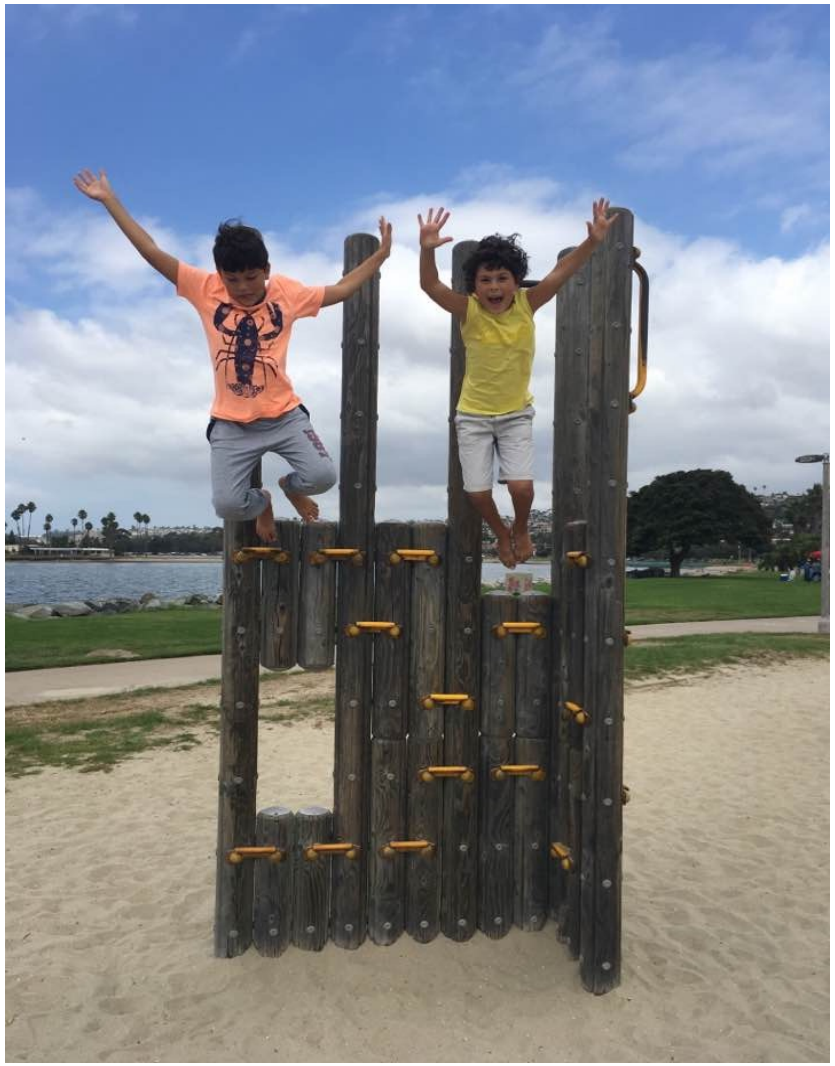
So, if these explanations are true, there are simple solutions, and you don't need this lecture

- Give them **INSIGHT and KNOWLEDGE,** and they will change
- Give them **SKILLS** *how* to change, and they will do it
- **SCARE** them- make people feel *bad or afraid* enough, and they will change

So, what does it take to make a transition from

Contemplation

To Action



What is Ambivalence?

- Ambivalence is having two contradictory thoughts about the same thing (“*should I, or I should not…?)*
- Ambivalence is exactly the material that Motivational Interviewing works with

Ambivalence vs. Resistance?

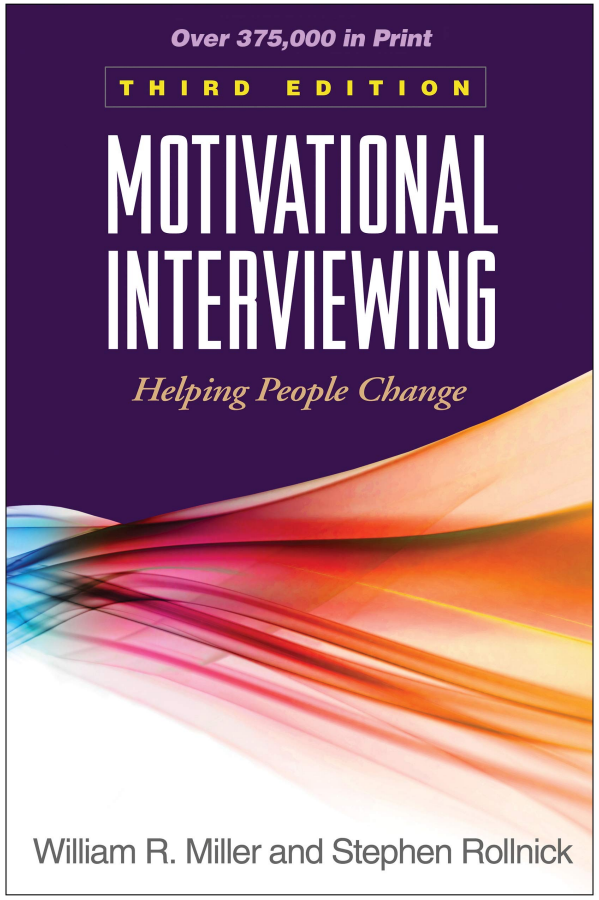
Rolling with Resistance: Wrestling vs. Dancing

1. Ambivalence is a reflection of my relationship with the PROBLEM
2. Resistance is a reflection of my relationship with YOU
3. Resistance is a result of interaction, not a symptom of any pathology
4. Resistance is the Ambivalence Under Pressure
5. Resistance is indicative of a possible breakdown in the relationship

Assumptions of MI

- Ambivalence is normal
- Motivation is dynamic
- Most people know the solution even if they are reluctant to use it

What is Motivational Interviewing?



Motivational Interviewing is a collaborative, person-centered, and directive communication style to elicit and strengthen motivation for change and address the common problem of ambivalence.

VIDEO 3

How Do We Roll with Resistance?

- Avoid arguing for change (you will really have a hard time arguing with me if I do not argue with you)
- Resistance is a signal to respond differently - Shift the direction
- Listen and reflect

VIDEO 4

Effectiveness of MI (1500+ clinical trials)*

- For:
  - Medication adherence
  - Diet and exercise
  - Addictions treatment and gambling
  - Eating disorders
  - Co-occurring disorders
  - Adults and youth in criminal justice system

*Personal communication, Wm Miller, 2020

www.motivationalinterviewing.org

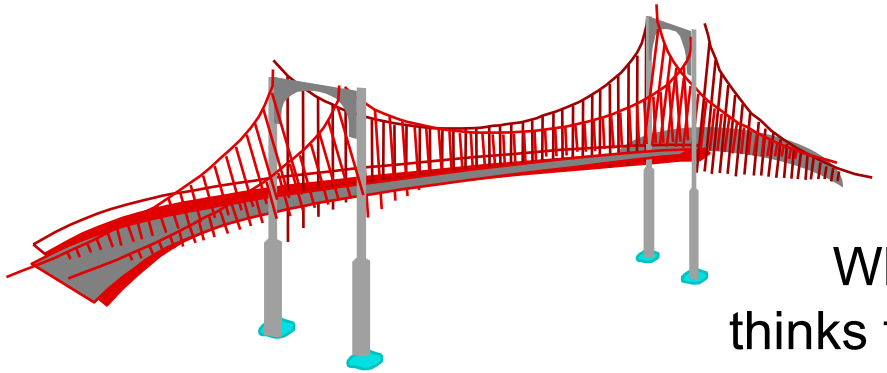
Fundamental Interactive Communication Skills

OARS

- Open-ended questions
- Affirmation
- Reflective listening
- Summarize

Reflections

Bridge the gap by reflection



What the speaker means

1

SPEAKER

2

What the speaker says

What the listener hears

3

4

What the listener thinks the speaker means

LISTENER

Why the Emphasis on Reflection?

- Get more and more valid info with reflections than with questions
- Patients feel listened to, *heard* and *cared* about
- Therefore, they are willing to disclose more and better info
- Speaks about what's on his or her mind rather than answering what is on doctor's mind
- Less lying

Reflective Listening

- The most effective way to address resistance, explore ambivalence, and elicit internal motivation
- The most difficult skill to master
- Reflections are always statements, not questions
- Drop voice at end of sentence
- Examples of stems:
  - “It sounds like you….”
  - “You are feeling….”
  - “You’re wondering if…”

VIDEO 5

Listen for What?

- Recognizing
- Reinforcing
- Eliciting

Change Talk

Change talk vs. Sustain talk

- Change talk is everything that the patient says in favor of movement in the direction of change. Significantly predictive of real behavioral change.

- Sustain talk is what they say that favors the status quo. Significantly predictive of NO CHANGE

- Both are always present

VIDEO 6

Signs of Increasing Motivation for Change

- Decreased resistance
- Decreased discussion about the problem
- More change talk
- Questions about change
- Experimenting

What do you do when you hear "sufficient" CHANGE TALK?

- This indicates significantly decreased ambivalence and potential readiness for change.
- Return to BAP
- *"Listening to what you've been saying, I wonder if you'd be interested in going ahead and making a plan about your smoking…?"*

BAP-MI Education: Medical School and Residencies

- Zucker School of Medicine at Hofstra/Northwell
- Stony Brook Preventive Medicine Residency
- UC San Diego Preventive Medicine Residency
- University of North Carolina School of Medicine

BAP-MI is Adaptable and Flexible: Comes in Many Flavors/Styles

Training First Year Medical Students in Brief Action Planning (BAP)

Taranjeet Kalra Ahuja, DO, MSEd

Assistant Professor of Science Education & Pediatrics

Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

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DONALD AND BARBARA ZUCKER SCHOOL of MEDICINE AT HOFSTRA/NORTHWELL

Curricular Context

- Four-year longitudinal communication skills curriculum
- During the first 7 weeks of medical school, the students learn skills to co-construct a complete history, build trust and empathize
- Subsequent courses build on this foundation with advanced specialized skills
  - One example being Brief Action Planning

Curricular Setting

- Most communication sessions begin with a large-group framing with all 100 students ~30 min
- Students then break off into longitudinal cohorts ~80 min
  - 2 Faculty to 8 Students
  - Small groups focused on skills-based training
  - Role-play with coaching and opportunities for re-practice

What is the curricular focus when BAP is taught?

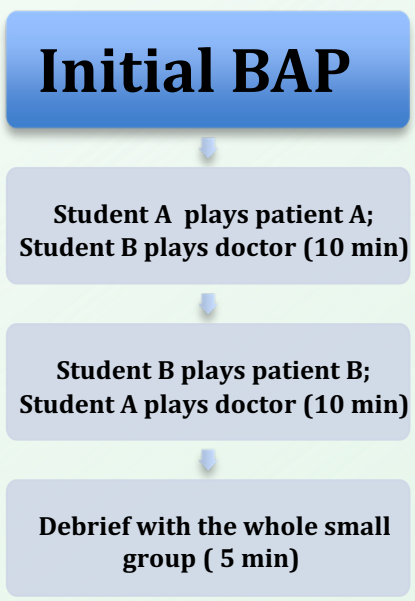
- Brief Action Planning is taught in last course of MS1 year
- Students are in Pulmonary/Cardiology/Nephrology course
- Students clinical experience is Internal/Family Medicine

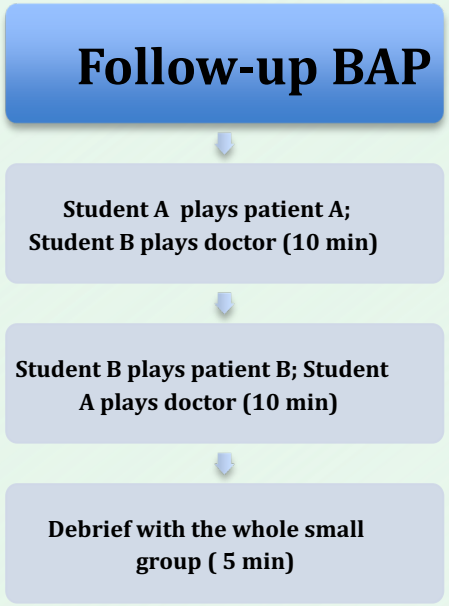
BAP Class Plan

- Learning Objectives of BAP Session
  - Define the spirit of motivational interviewing
  - Define the steps in BAP
  - Appreciate BAP as a tool useful for behavior change to improve health
  - Practice the core skills of BAP
- Prework
  - Web-based Introductory Training in BAP (90 min)

BAP Class Plan (Continued)

- Large Group Session:
  - Framing Lecture on Brief Action Planning ~25 min
- Small Group Session:
  - Faculty Demo of BAP with Debrief
  - Students Provided with Case Vignettes to practice BAP:





Reinforcement of Skills

- BAP skill learned and practiced in small-groups with coaching from communication faculty facilitators
- Required to practice with patients in their longitudinal ambulatory clinics
- Assessment Drives Learning!
  - BAP assessed in Objective Structured Clinical Examinations (OSCEs)

True Story!

- An MS1 student practiced the skills of BAP in his outpatient medicine office after learning about it in a classroom session and was able to successfully collaborate with a patient on their journey towards smoking cessation. He was so pleasantly surprised that he was able to help a patient at this stage of his learning.

- The student from this story just graduated from psychiatry residency in June 2020!

Acknowledgements

- Dr. Joseph Weiner
- Dr. Steven Cole
- Dr. Richard Frankel
- Dr. Alice Fornari
- Faculty and Students at the Zucker SOM at Hofstra/Northwell

Motivational Interviewing (MI) and Brief Action Planning Training (BAP) in Residency: A Longitudinal Model for Preventive Medicine

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Department of Family, Population and Preventive Medicine
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Objectives

At the conclusion of this presentation, participants will be able to:

1. Define the role of the Accreditation Council for Graduate Medical Education (ACGME) in health behavior change counseling training during residency.
2. Explain how Motivational Interviewing and Brief Action Planning can be formally integrated into residency training.
3. Describe approaches for the gradated preparation of resident learners in MI and BAP.

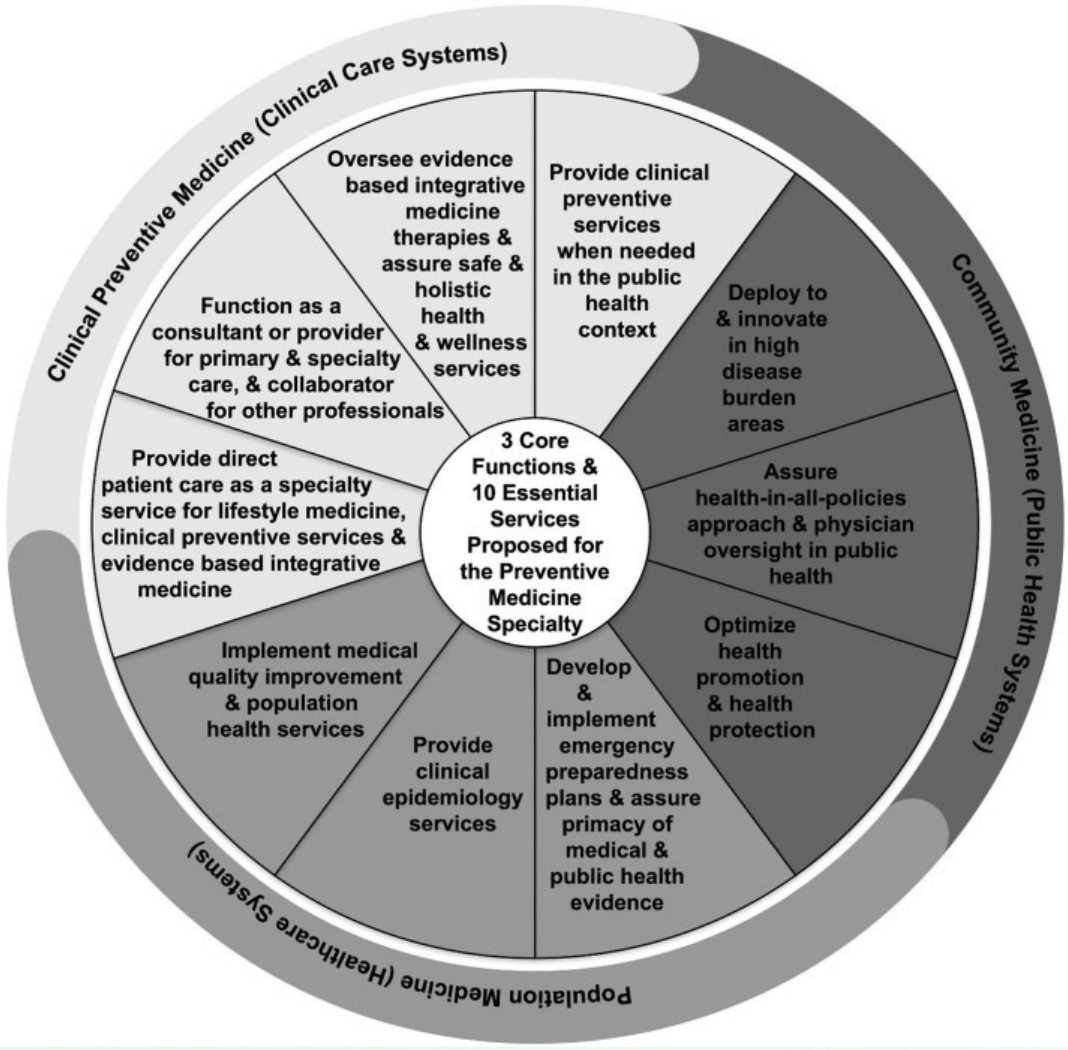
Needs Assessment: ACGME Competencies and the Program Mandate for Behavioral Health Training

- **Medical Knowledge Competency**. IV.B.1.c)*Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences*, as well as *the application of this knowledge to patient care*. (Core)

- **Interpersonal Communication and Skills Competency**. IV.B.1.e).(5) For programs with a concentration in public health and general preventive medicine, *residents must demonstrate competence in counseling individuals regarding the appropriate use of clinical preventive services and health promoting behavior changes*, and providing immunizations, chemoprophylaxis, and screening services, as appropriate. (Core)

Needs Assessment: The Preventive Medicine Specialty Practice Context

- 2-year Preventive Medicine (PM) residency (PGY2 & 3) + MPH or other relevant graduate degree & coursework
- PM residents train in preventive care:
  - Community medicine → public health
  - Population medicine → population health
  - Clinical preventive medicine (CPM) → health and wellness
- CPM entails
  - Lifestyle medicine
  - Clinical preventive services (i.e. USPSTF screening, behavioral counseling, and chemoprophylaxis)
  - Evidence-based integrative medicine (optional)
- ***No specific approaches are recommended or required by the ACGME for behavioral counseling training***

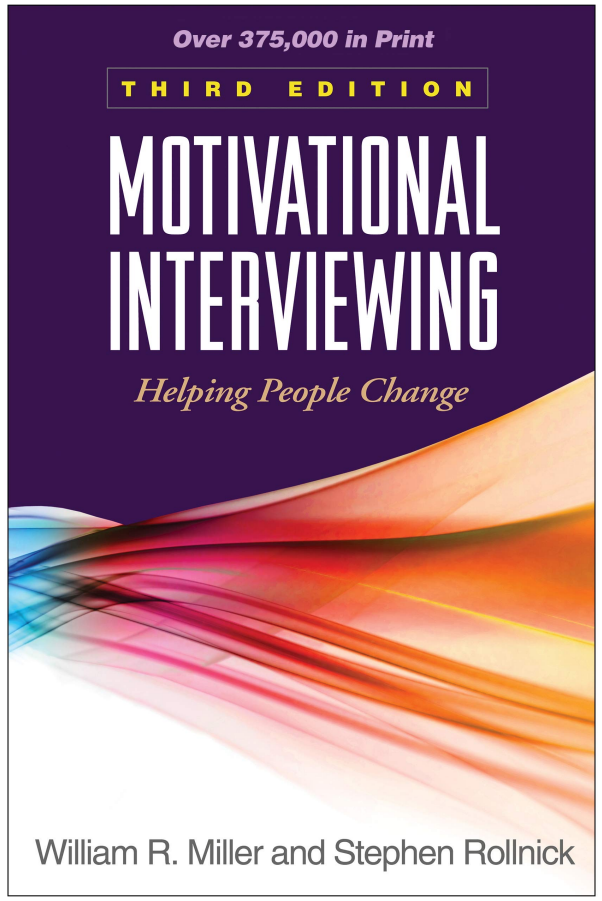


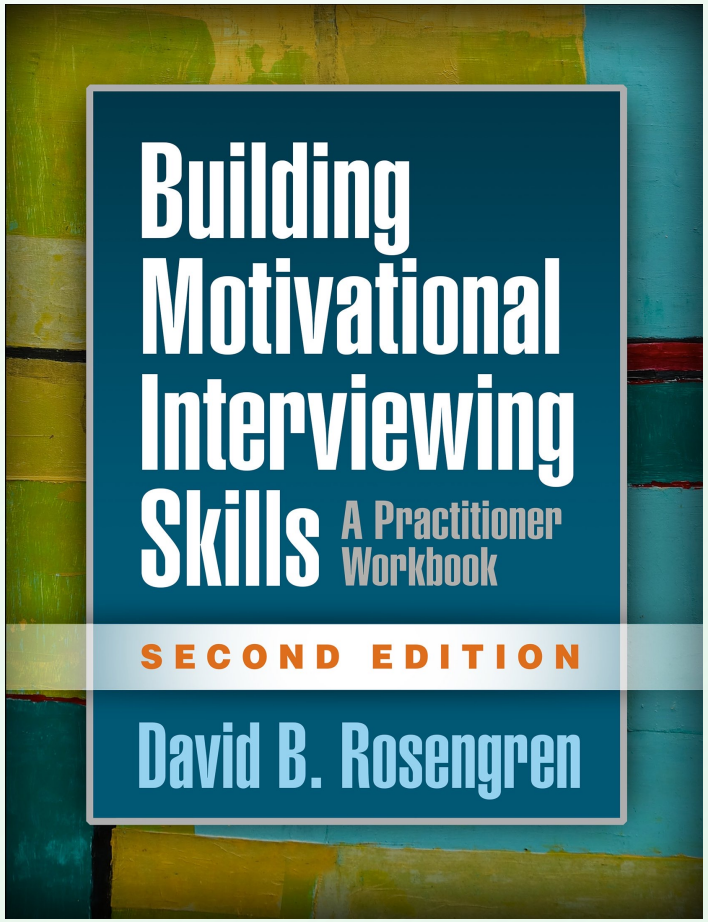
Innovation: Longitudinal MI/BAP Training for Junior PM Residents

- July and August: completion of the online BAP (CME-level) Online Course + 4-hour guided BAP skills training
  - Concurrent completion of a 32-hour (CME-level) online core competencies module in lifestyle medicine from the American College of Preventive Medicine (ACPM)

- September-June: 6-month rotation in lifestyle medicine and smoking cessation at VA HPDP
  - VA TEACH (patient health education)
  - MI Training

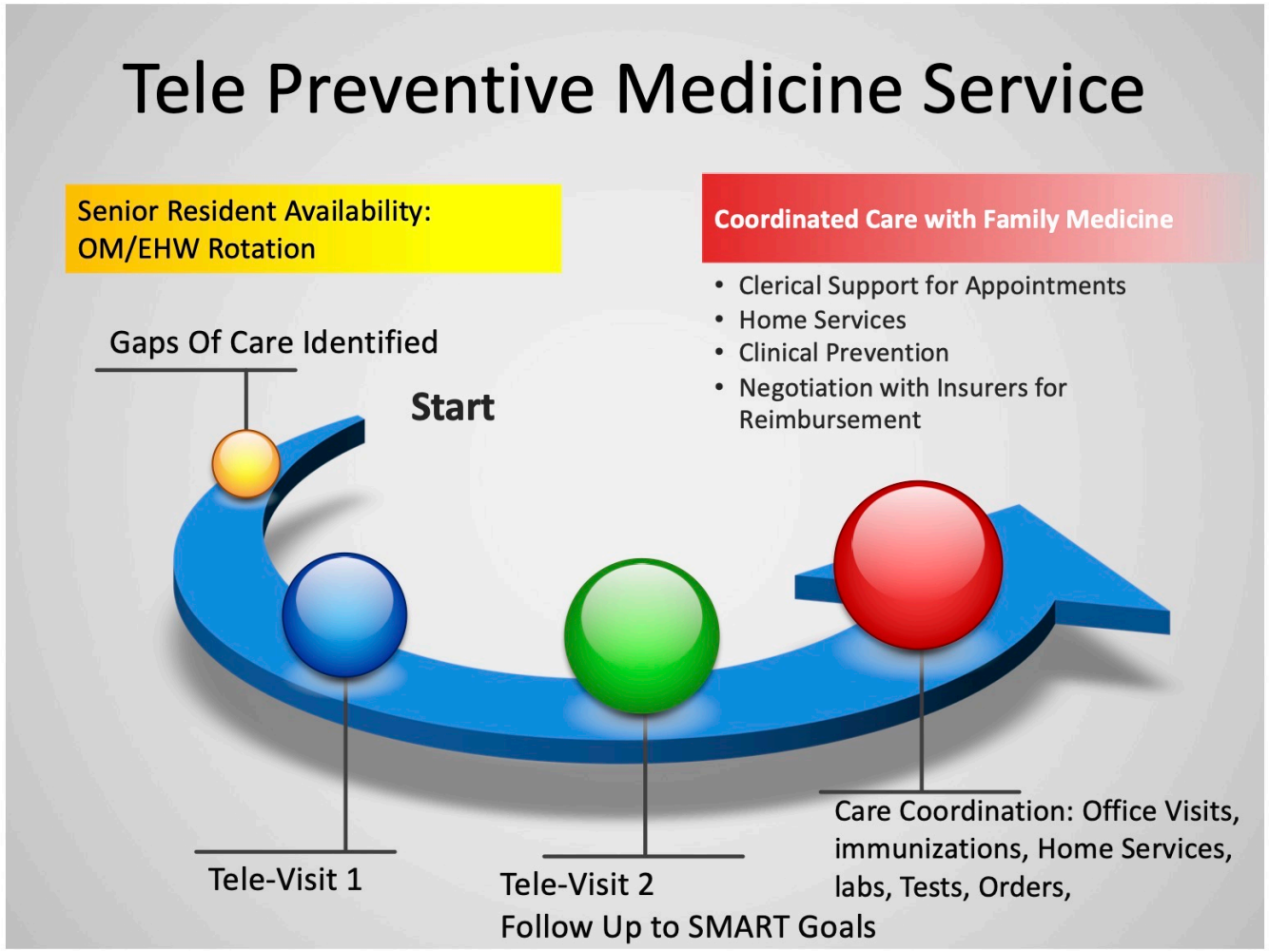
Innovation: Longitudinal MI/BAP Training for all PM Residents





- September-June annually: Six 1-hour MI Practice sessions (12 total during residency) as part of our ***Population Health Rounds***
  - Akin to floor rounds but with a prevention focus
- Clinical and Community Preventive Medicine course
  - BAP-driven OSCE

Innovation: Longitudinal MI/BAP Training for Senior Residents



- 3-month rotation in Tele-Preventive Medicine (TPM) service
  - Culminating "chief resident"-level experience in CPM and Population Medicine
  - Indirect resident supervision
  - Resident-led management of both clinical and population aspects of the service

Summary

- ACGME program accreditation requirements for Preventive Medicine residencies mandate formal health behavior change training without specifying the required counseling skills or recommended pedagogic approach.
- The Stony Brook Preventive Medicine residency program has adopted and embedded MI and BAP in a longitudinal approach to teaching health behavior change counseling skills.
- Evaluation of the educational effectiveness of this pedagogic approach for health behavior change training is ongoing.

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Residents Achieving Competence and Expertise in Motivational Interviewing (RACE-MI)

A Longitudinal Curriculum in Behavior Change for Preventive Medicine Residency

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Objectives

1. Understand the role for health behavioral counseling training in Lifestyle Medicine.

2. Describe the development of a longitudinal curriculum for health behavior change in Preventive Medicine Residency

Context:
Push for Lifestyle Medicine Education

AMA resolution 2017: 1) it recognizes 15 competencies of lifestyle medicine and urges physician to offer evidence-based lifestyle interventions as the primary mode of preventing and treating chronic disease; and will work to assist physicians via medical societies and medical organization to address lifestyle factors as the primary strategy for chronic disease prevention and management. 2) AMA supports policies to incentivize and/or provide funding for the inclusion of lifestyle medicine and social determinants of health in medical education.

10 Primary Care Competencies for the Prescription of Lifestyle Medicine

July 14, 2010

Physician Competencies for Prescribing Lifestyle Medicine

Liana Lianov, MD, MPH; Mark Johnson, MD, MPH

» Author Affiliations | Article Information

JAMA. 2010;304(2):202-203. doi:10.1001/jama.2010.903

Box. Suggested Lifestyle Medicine Competencies for Primary Care Physicians

Leadership

Promote healthy behaviors as foundational to medical care, disease prevention, and health promotion.

Seek to practice healthy behaviors and create school, work, and home environments that support healthy behaviors.

Knowledge

Demonstrate knowledge of the evidence that specific lifestyle changes can have a positive effect on patients' health outcomes.

Describe ways that physician engagement with patients and families can have a positive effect on patients' health behaviors.

Assessment Skills

Assess the social, psychological, and biological predispositions of patients' behaviors and the resulting health outcomes.

Assess patient and family readiness, willingness, and ability to make health behavior changes.

Perform a history and physical examination specific to lifestyle-related health status, including lifestyle "vital signs" such as tobacco use, alcohol consumption, diet, physical activity, body mass index, stress level, sleep, and emotional well-being. Based on this assessment, obtain and interpret appropriate tests to screen, diagnose, and monitor lifestyle-related diseases.

Management Skills

Use nationally recognized practice guidelines, such as those for hypertension and smoking cessation, to assist patients and lifestyle

Establish effective relationships with patients and their families to effect and sustain behavioral change using evidence-based counseling methods and tools and follow-up.

Collaborate with patients and their families to develop evidence-based, achievable, specific, written action plans such

Help patients manage and sustain healthy lifestyle practices, and refer patients to other health care professionals as needed for lifestyle-related conditions.

Use of Office and Community Support

Have the ability to practice as an interdisciplinary team of health care professionals and support a team approach.

Develop and apply office systems and practices to support lifestyle medical care including decision support technology.

Measure processes and outcomes to improve quality of lifestyle interventions in individuals and groups of patients.

Use appropriate community referral resources that support the implementation of healthy lifestyles.

Establish effective relationships with patients and their families to effect and sustain behavioral change using evidence-based counseling methods and tools and follow-up.

Collaborate with patients and their families to develop evidence-based, achievable, specific, written action plans such as lifestyle prescriptions.

Help patients manage and sustain healthy lifestyle practices, and refer patients to other health care professionals as needed for lifestyle-related conditions.

Context: Lifestyle Medicine Curriculum

- Lifestyle Medicine is a core competency of Preventive Medicine. (ACGME Competency MK IV.B.I.c)
- UCSD GPM Residency becomes a site for Lifestyle Medicine Residency Curriculum (LMRC) which allows a path for becoming board certified in Lifestyle Medicine.
- Vigorous curriculum:
  - 40 hours of didactic
  - 60 hours of independent application activities
  - 80 hours of Intensive Therapeutic Lifestyle Change programs
  - 400 patient encounters

BAP and MI practice, practice, practice and application

- LMRC requires behavioral change counseling skills not congruent with most resident's past training
- Collaboration with internationally recognized MI/MINT trained experts were key to practicing and refining these skills
  - Individualized feedback on MI skills from Dr. Koutsenok
  - Tailored BAP skills training program from Dr. Cole

RACE-MI Curriculum: Tracks

Exposure Track

- BAP curriculum
  - 6 hrs. of virtual/group in-person learning
  - 8 hrs. BAP online course with CME
  - Live zoom practice in break-out groups and integration of LMRC
- Motivational Interviewing
  - MI lecture series
  - Personalized feedback on MI skills

Expert track

- Participation in monthly BAP faculty development group
  - BAP certification
- Psychwire Course on MI
- Experience as mentors during BAP course for the remaining residents
- Practicum Rotations

RACE-MI Curriculum: Practicum

Practical experience:

- SLIM Rotation
  - Shared medical appointment program for patients with Obesity
  - Residents follow a cohort of patients
  - Practice MI skills in small group setting
- Virtual Telemedicine Rotation
  - Behavioral health counseling for chronic disease management
  - Practice MI and BAP skills one-to-one
- Other rotations such as the Diabetes Prevention Project and Ornish Program
- Rotations fulfill practicum requirements for ACPM and LMRC

Testimonials

Learning BAP has provided me with a precise and effective tool to engage in conversation with my patients about lifestyle change. The language is simple but also effective at inquiring about my patient's interests in making lifestyle changes in a curious and non-judgmental way.
- Marsha-Gail Davis PGY-3

BAP is a goal setting technique that empowers patients to make small but significant changes towards health. With each successful goal towards health accomplished the patient is emboldened that they actually can make changes towards a healthier future. Created based off of a Motivational Interviewing foundation BAP is deceptively simple and can easily be fit into the end of an office visit. Patients are incredibly receptive and leave feeling good about themselves and what they want to accomplish. I wish I had learned this in medical school and am excited to see how it impacts my patients going forward.
- Anastasia Maletz PGY-3

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Schultz, K., Griffiths, J., & Lacasse, M. (2015). The application of entrustable professional activities to inform competency decisions in a family medicine residency program. *Academic Medicine,* 90(7), 888-897.

Motivational Interviewing and Brief Action Planning at the UNC School of Medicine

Curriculum Integration at Three Levels: A Work in Progress

Roy M. Stein, MD
Clinical Professor of Psychiatry
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ACADEMY OF CONSULTATION-LIAISON PSYCHIATRY

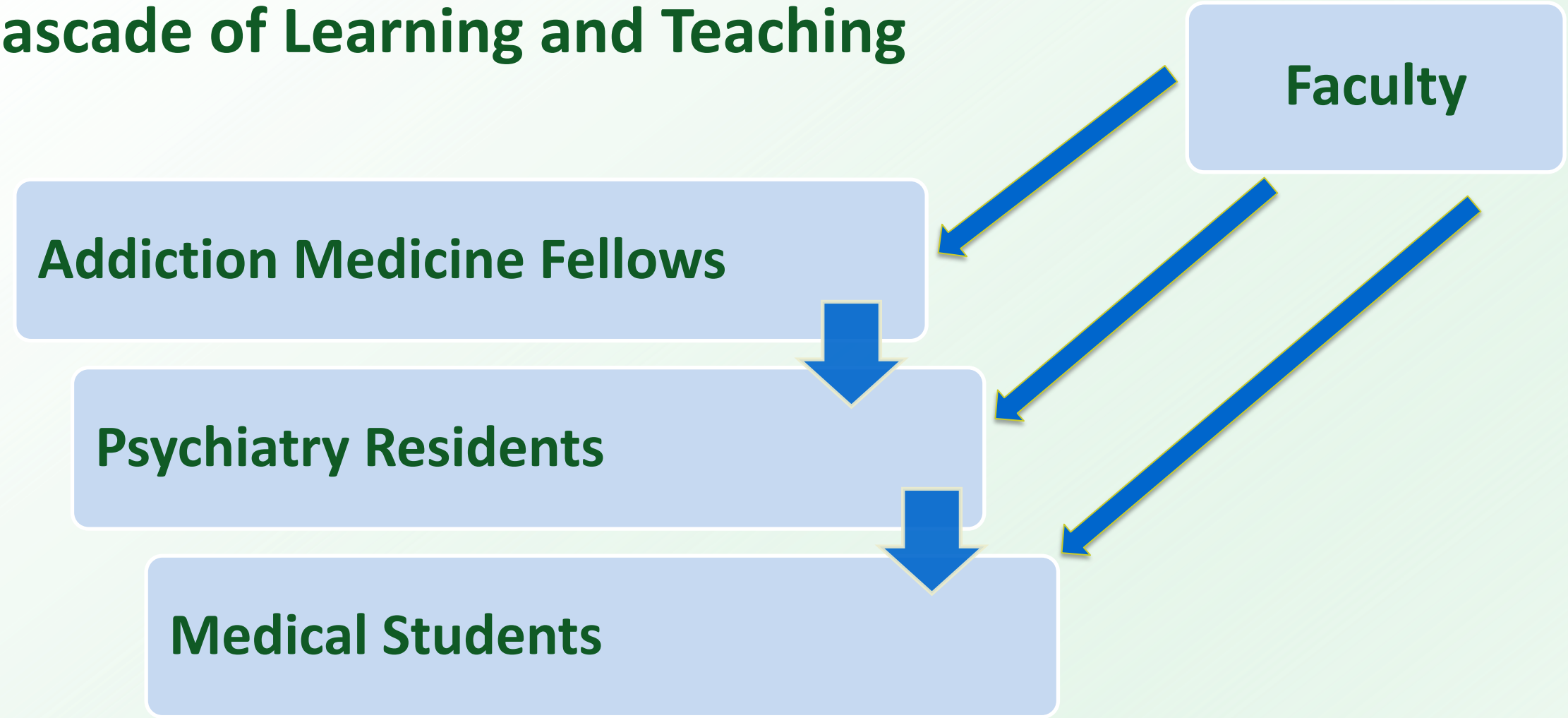
Advancing Integrated Psychiatric Care for the Medically Ill

Key points

- Teaching MI/BAP to multiple levels of learners with goal of broadening and amplifying uptake and application of skills.

- Assessment and feedback re: MI skill development using a structured instrument with recorded patient interviews.

Cascade of Learning and Teaching



Addiction Medicine Fellowship

- 6-8 fellows per year
- Multiple specialties (Psych, FM, IM, EM, Ob-Gyn, Prev Med)
- Multiple sites: clinics, inpatient detox, inpatient consults
- 4-hour MI orientation workshop
- Required patient recordings for coding with Motivational Interviewing Treatment Integrity (MITI 4.2)
- Monthly coaching with MITI feedback.

MI Treatment Integrity Scale MITI 4.2 (casaa.unm.edu)

Global Scores (1-5)	Behavior Counts	
Cultivating Change Talk	Simple reflections	Complex reflections
Softening Sustain Talk	Questions	Giving Information
Partnership	Seek Collaboration	Persuade with Permission
Empathy	Affirmation	Persuade
	Emphasize Autonomy	Confront

Psychiatry Residency

- MI and BAP incorporated in didactics in years 1, 3, and 4
- PGY1: 6 hours of MI/BAP didactic + skills practice
- PGY3-4: Refresher sessions on MI/BAP.
- PGY3-4: Resident elective in Addiction Psychiatry Clinic with direct supervision and coaching in MI/BAP, MITI coding of recorded patient sessions.

Undergraduate Medical Education

- Small group MI practice sessions with standardized patients and Addiction Medicine (AM) fellows as group leaders.
- Psych residents reinforce MI skills with MS3's on psych rotation.
- Addiction Psychiatry elective includes clinical experience and supervision in use of MI/BAP.
- Extra MI/BAP training for Addiction Medicine Interest Group

Observations

- Standalone workshops without follow-up have minimal impact.
- Teaching skills at multiple levels reinforces learning and practice.
- Observed practice (live or recorded) is essential. (Would your piano teacher rely on your verbal description of your playing?)
- Inpatient consult service is ideal setting for practice, supervision, and recording of extended MI sessions.
- BAP fits well in fast-paced clinical settings.

Summary/Conclusion

I. Pre-Session

A. BAP - Core Concepts and Skills
B. MI - Core Concepts and Skills
C. BAP-MI: A Stepped Care Approach to Health Behavior Change (many flavors/styles)

II. Zoom Course/Workshop: November 10, 2021 10 AM – 12 noon EST

A. Discuss (and Review) Concepts/Skills
B. Practice Skills in Small Groups with Feedback

BAP-MI: A Stepped Care Approach to Health Behavior Change

2 Hour Zoom Workshop

Cole S, Kousenok I, Stein, R, Ahuja T, Sannidhi D, Romero C, Jadotte Y

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Advancing Integrated Psychiatric Care for the Medically Ill

Agenda/Learning Goals

I.	Welcome	Cole	10 min
II.	Demonstration of Brief Action Planning (BAP) ***Goal: Familiarize you with 5 steps of BAP***	Cole/Stein	10 min
III.	BAP: Small Group Practice of BAP – Groups of 3	Stein	15 min
	Goal: Identify BAP skills for potential use in your clinical practice and teaching		
IV.	Plenary Discussion/Q and A	Faculty	10 min
V.	MI: Small Group Practice (3 Groups)	Stein	40 min
	Goal: Identify MI skills for potential use in your clinical practice and teaching		
VI.	Plenary Discussion/Q and A/Next Steps ***Goal: Discuss integration of BAP-MI into your clinical practice and teaching***	Faculty	30 min
VII.	Summary/Conclusion	Cole	05 min

BAP-MI: A Stepped Care Approach to Health Behavior Change

2 Hour Zoom Workshop

ACADEMY OF CONSULTATION-LIAISON PSYCHIATRY

Advancing Integrated Psychiatric Care for the Medically Ill

What is BAP?

Brief Action Planning (BAP) is a highly structured, efficient and versatile Motivational Interviewing (MI) consistent tool designed to help people change and to support self-management for health and well-being.

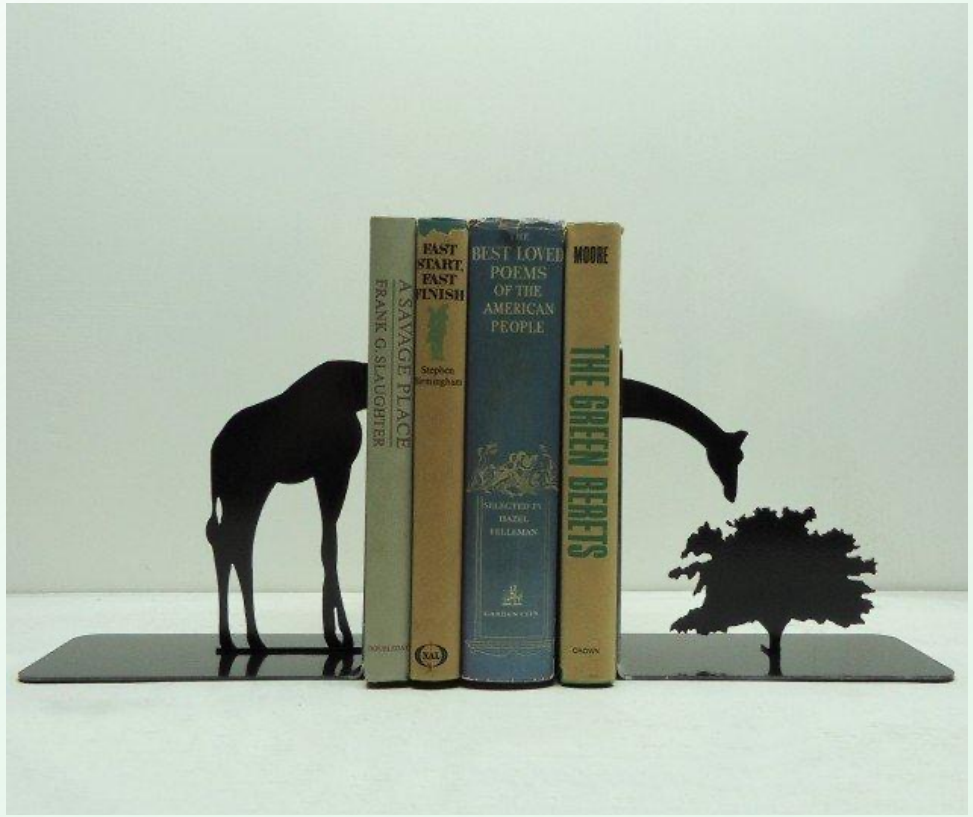
What is MI?

Motivational Interviewing (MI) is a collaborative, person-centered, and directive communication style to elicit and strengthen motivation for change and address the common problem of ambivalence.

What is BAP-MI?

BAP-MI is a stepped-care integration of evidence-informed skills from BAP and MI for self-management support (SMS) and health behavior change (HBC).

A Metaphor for BAP-MI: BAP "Bookends" MI



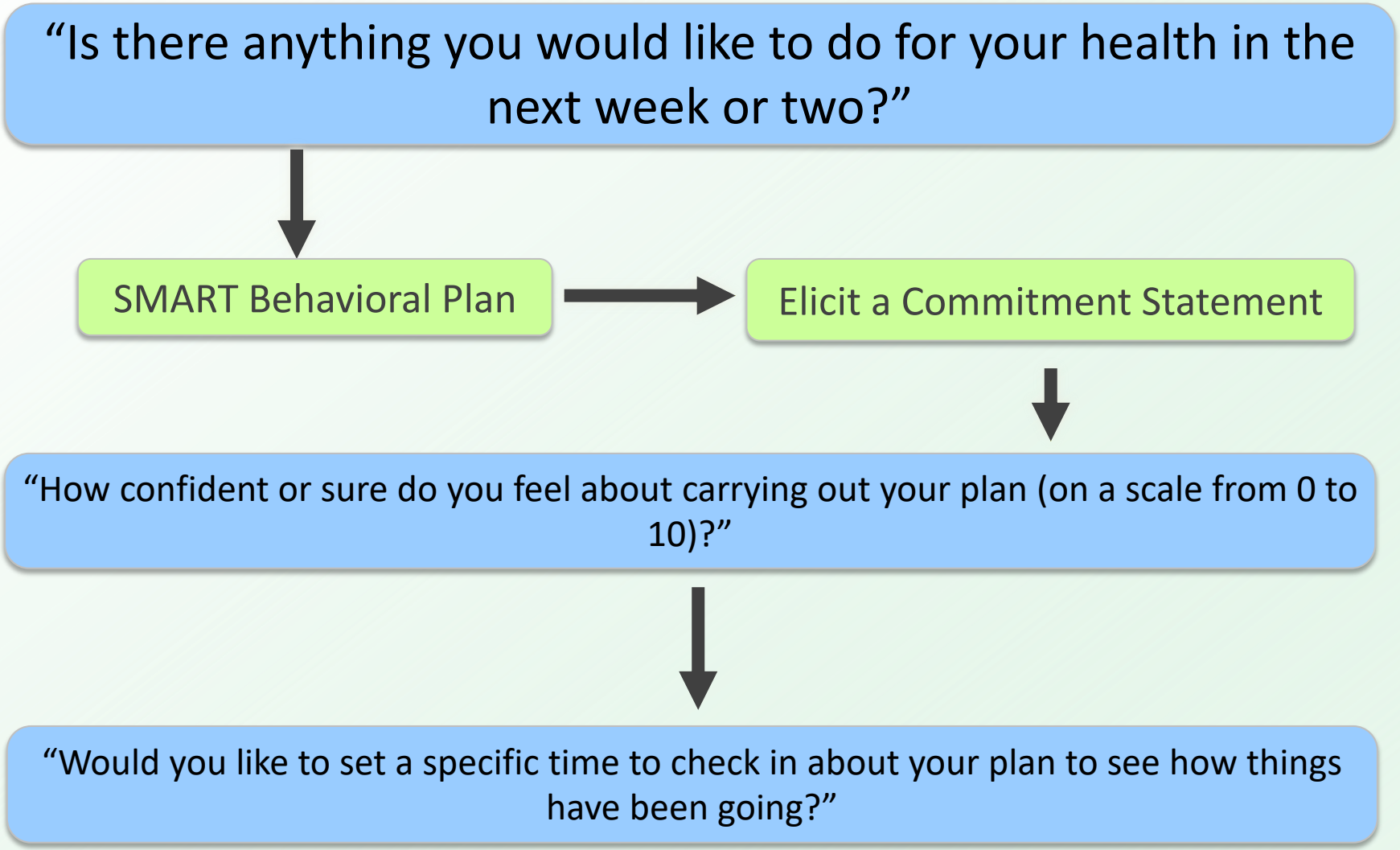
IN BAP-MI, Sometimes, BAP is Sufficient for SMS and HBC

- With engagement/connection
- With Spirit of MI

Sometimes, BAP-MI
Begins with MI and Concludes with BAP

BAP-MI is Adaptable and Flexible: Comes in Many Flavors/Styles

BAP Demonstration


"Is there anything you would like to do for your health in the next week or two?"
SMART Behavioral Plan
Elicit a Commitment Statement
"How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?"
"Would you like to set a specific time to check in about your plan to see how things have been going?"

Breakout Groups for Practice of Skills (BAP and MI)

Learning in limited time: Not everyone will get to practice all skills

- Symbolic modeling (discuss interventions/imagine what you would do)
- Vicarious modeling (watch interventions/ imagine what you would do)
- Participant modeling (practice yourself)

- All are useful for learning new skills
- In last min; write down 1-2 goals for clinical work/teaching

Practice BAP in Groups of 3:

- Introductions (brief – 1-2 min total)
- We suggest real-play
- One person asks BAP questions (“clinician”)
- One person makes a plan for themself (“patient”)
- One person observes and provides feedback/suggests opportunities for re-practice
- SWITCH ROLES in 4-5 minutes, (if possible); (recall: multiple methods of learning)

- Use final minute to write down 1-2 goals for future practice/teaching
  (we’ll give a 2 min ”warning”)
- Total time in breakout group = 15 minutes

BAP

PRACTICE

Plenary Discussion of BAP Practice

- What was your experience of BAP?
- Observations?
- Challenges?
- Insights?
- Goals?

MI SKILLS PRACTICE

- 3 breakout groups

- 40 min to practice

Scenario: inpatient psychiatry consultation

Consult Request

43 year-old admitted with unstable angina. MI was ruled out. Cardiac cath → stent placement. 20+ pack-year smoking history. Pt understands smoking risks, but doesn't want to discuss quitting, and declines referral to smoking cessation clinic. Seems down. Please evaluate for depression and try talking to patient about smoking cessation.

****

Role-Play Instructions

You've completed a thorough evaluation for mood disorder, which is negative. You're now ready to shift gears and see if the patient will engage with you in discussion of smoking cessation.

Key Points for MI Practice

- align empathically (engage/connect) throughout
- OARS
  - open questions
  - affirmations
  - reflections
  - summaries
- elicit patient's concern/story, maintaining MI Spirit
- recognize/respond to ambivalence
- listen for, reinforce, and evoke change talk throughout

CHANGE TALK: DARN CATS

- **D** ESIRE (“want…” ”like…” “wish…”)
- **A** BILITY (“can…” “could…”)
- **R** EASONS (“because of….”)
- **N** EED (“need..” ”have to…” “got to…”)

CHANGE TALK: DARN CATS

- C OMMITMENT (“intend…” “going to…”)
- A CTIVATION (“ready…” “preparing…”)
- T AKING S TEPS (“started….”)

SUGGESTED PLAN FOR MI SKILLS PRACTICE: 40 min

- 3 breakout groups (Stein/Koutsenok/Cole)

- Very brief introductions (10-15 seconds each)
- One facilitator serves as simulated patient
- Participants work as “teams” to practice MI skills to interview “patient”

- One participant volunteers to begin MI conversation with the “patient”
- The volunteer calls “time-out” to:
  - Consult with other group members and then continue; or
  - Ask the ”patient” to back up to any point, to re-do a segment; or
  - Pass the “interviewer” baton to another group member
- Suggest multiple participants take turns to interview; (multiple methods of learning)

- In last min. of group, write down 1-2 goals for your clinical practice/teaching

Scenario: inpatient psychiatry consultation

Consult Request

43 year-old admitted with unstable angina. MI was ruled out. Cardiac cath → stent placement. 20+ pack-year smoking history. Pt understands smoking risks, but doesn't want to discuss quitting, and declines referral to smoking cessation clinic. Seems down. Please evaluate for depression and try talking to patient about smoking cessation.

****

Role-Play Instructions

You've completed a thorough evaluation for mood disorder, which is negative. You're now ready to shift gears and see if the patient will engage with you in discussion of smoking cessation.

MI

PRACTICE

Plenary Discussion of MI Practice

- What was your experience of MI skills?
- Observations?
- Challenges and Questions?
- Insights?
- How might BAP-MI be useful for Consultation-Liaison Psychiatry?
- Goals?
- Next steps?

BAP-MI: A Stepped Care Approach to Health Behavior Change Summary/Conclusion

I. Probe with Question #1 of BAP and continue w/BAP (when clinically appropriate)
Use with Spirit of MI, and only when there is good engagement (connection)

II. Use MI skills for patients unable/unwilling to make action plans with BAP

III. Re-probe with Question #1 of BAP and continue w/BAP (when clinically appropriate)

BAP-MI is Adaptable and Flexible: Comes in Many Flavors/Styles

THANK YOU!

FOR INFORMATION, FEEDBACK or QUESTIONS

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