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EDITORIALS

BAP-MI: A Novel Stepped-Care Integration of Brief Action Planning and Motivational Interviewing to Optimize Outcomes

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This editorial describes the rationale and development of BAP-MI, a novel, stepped-care integration of Brief Action Planning (BAP) and Motivational Interviewing (MI), 2 evidence-based approaches to self-management support and health behavior change.[1] The authors suggest that this integrative strategy (BAP-MI) may increase the scope of applicability, accessibility, and acceptability across healthcare disciplines, thereby improving outcomes.

MI, initially developed for patients with alcohol use disorders,[2] has evolved into a complex set of behavior change concepts, skills, and attitudes relevant to a wide variety of interpersonal interactions across diverse settings.[3] Defined most recently, as "a particular way of talking to people about change and growth to strengthen their own motivation and commitment,"[3] MI rests on clinical and research foundations in humanistic client-centered counseling,[4] self-efficacy theory,[5] self-determination theory,[6] and empirical sociolinguistics.[7] With respect to its use in health care, MI is evidence based and endorsed by the U.S. Preventive Services Task Force as a behavioral counseling method for many chronic medical conditions.[8] Typically reserved for patients with persistent unhealthy behaviors,[9] the concepts and skills of MI are complex and have proven quite challenging to teach, learn, and integrate with fidelity into healthcare curricula. For example, previous experimental research has shown that workshops as long as 2 full days failed to produce enduring changes in MI skills among clinicians.[10] As a recent qualitative study points out, "motivational interviewing (MI) is internationally recognized as an effective intervention to facilitate health-related behavior change; although, how it is best implemented and maintained in everyday clinical practice is not so clear."[11] Despite widespread interest, medical schools and residencies have not (yet) developed validated pathways or consensus guidelines to help medical students or residents learn and master MI for routine medical practice.

In an early effort, circa 2002, toward diffusing MI into general healthcare, the first author of this editorial developed the precursor of BAP, called "Ultra-Brief Personal Action Planning," a tool and technique based on the principles and practice of MI and designed to facilitate the self-management support component of the chronic care model for healthcare transformation in the *Health Disparities Collaboratives*.[12–14] Qualitative interviews with leaders in high-performing federally qualified health centers support the potential usefulness of this approach for improving overall outcomes.[13] In 2009, the American Medical Association published the tool in a physician resource guide,[15] and a peer-reviewed poster described its use and preliminary outcomes.[16] The first author of this editorial, working alongside other members of the MI Network of Trainers, contributed to further refining and grounding the approach in 8 evidence-informed core competencies.[17] Currently, defined as a "pragmatic, evidence-informed, and versatile MI-

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Table 1. BAP: A Stepped-Care Algorithm

8 Core Competencies of BAP	
Clinicians launch BAP in the presence of good rapport (connection/engagement) and with spirit of MIelements throughout (partnership, autonomy support, and empowerment). BAP simultaneously probes for readiness and begins a collaborative planning process with the (grammatically) closed-ended but generative and conceptually open[26] Question One.	
Five foundational competencies	**1. Question One** ***"Is there anything you'd like to do for your health in the next week or two?"*** Or a context-relevant version of Question One, for example: ***"Now that we've been discussing your interest in exercising more, I wonder if you'd like to go ahead and make a plan about introducing some exercise into your regular routines?"*** **2. Evoke SMART plan collaboratively** If the patient responds positively, they are invited to shape the behavioral idea into a SMART plan (i.e., specific, measurable, achievable, realistic, and time-specific): for example, ***"Would it help to make your plan specific, for example, when you will start, for how long, in the morning or night, how many times a week. . . things like that?"*** **3. Elicit a commitment statement** The patient is then asked to restate the plan and intent (commitment) in the first person: for example, ***"Would it be OK to tell me back what you plan to do, to ensure we're on the same page?"*** **4. Scale for confidence** The patient is then asked to scale their level of confidence (from 0 to 10) in the plan they have already developed (to reinforce and build self-efficacy): for example, ***"On a scale of 0 to 10, where 0 means you're sure you won't be able to carry out your plan and 10 means you're quite sure you'll carry out your plan, about how confident are you feeling?"*** **5. Invite accountability** Finally, the patient is invited to include an element of accountability (e.g., ***"Would you like to build in some ways to check on how you're doing with your plan, that is, by including a friend, family member, calendar entries, or follow-up with our care team?").***
Stepped-care additions, as needed	**6. The behavioral menu** For those patients who express some interest in planning but have difficulty in formulating specific plans, the BAP roadmap suggests that clinicians, with permission, offer a behavioral menu of options for people who would like to hear ideas for change (e.g., ***"Would it be OK for me to share some ideas. . ."***). **7. Problem solving for low confidence** For people whose confidence is <7 in their SMART plan, BAP suggests a collaborative approach to strength-based problem solving, to increase self-efficacy (e.g., ***"You said your confidence in your plan is 6. That's great. A lot higher than 2 or 3. We know plans associated with confidence levels of 7 or more have a greater likelihood of success. Would you be interested in discussing ways to get to a confidence level of 7 or more?")***.
Follow-up	**8. Nonjudgmental follow-up** ***"So, how did it go with your plan?"*** With reassurance, if difficulties were experienced: ***"Lots of people have trouble carrying out their plans."*** With an affirmation of accomplishments: ***"You've done quite a lot. That really shows how important these changes are to you."*** And with an open-ended invitation to continued planning if the patient would like: ***"I'm wondering what, if anything, you'd like to do next?"***

BAP, Brief Action Planning; MI, Motivational Interviewing; SMART, specific, measurable, achievable, relevant, and time-bound.

consistent tool designed to support patient self-management and facilitate health behavior change,"[18] concepts and skills of BAP have been presented since 2010 at many peer-reviewed academic meetings, workshops, and courses across diverse medical specialties and healthcare organizations.[19–24] The authors have recently completed a scoping review that identified 143 articles in health and health care that have reported using BAP, which suggest significant uptake of the approach among disciplines and professions engaged in health behavior change practice.[25]

BAP, most appropriate for patients who are ready or nearly ready for change, requires the presence of good clinician–patient rapport (connection/engagement) as well as adherence to the attitudes and values of the Spirit of MI (i.e., acceptance/autonomy support, equality/partnership, and empowerment) throughout.[1] Table 1 summarizes the BAP road map. The highly structured, flexible stepped-care BAP algorithm lends itself to familiar models of medical education and can be learned in relatively brief episodes of demonstration and observed practice with feedback to standards of proficiency with measurable fidelity. Online (synchronous and asynchronous), interactive, and self-directed training programs have been developed to certify competency, including opportunities for follow-up observed practice and coaching as well as telephonic OSCEs (observed structured clinical examinations).[18,27]

BAP-MI represents a novel integrative, stepped-care model of BAP and MI for routine medical practice to support patient self-management and facilitate health behavior change across the full spectrum of readiness for change. Developed over the last 3 years (2019–2022) by the first author, with contributions from experts in medical communication and MI (as stated in the Acknowledgments section), BAP-MI was designed to maximize feasibility and acceptability for medical practitioners. BAP-MI frames behavior change communication skills in flexible medical algorithms, an approach familiar to healthcare practitioners, with pragmatic applicability to contemporary practice settings. BAP-MI also appeals to clinicians because it conveys a straightforward yet comprehensive conceptual approach relevant to all their patients, including those ready or nearly ready for change as well as patients with ambivalence and persistent unhealthy behaviors. BAP-MI preserves the integrity of the concepts, skills, and the Spirit of Motivational Interviewing, while integrating evidence-informed skills of BAP into a general and readily accessible clinical and learning model with high face validity.

BAP-MI educational programs typically start with basic, foundational BAP core competencies, (including relevant elements of MI spirit), targeted for those patients ready or nearly ready for change. Once trainees use and achieve mastery of BAP core competencies, BAP-MI programs introduce more advanced concepts and skills of MI (e.g., complex reflections, understanding ambivalence, and the linguistic dynamics of strategically responding to change talk and sustain talk) particularly relevant to patients with ambivalence and persistent unhealthy behaviors. Regarding the relationship of BAP to MI, the BAP-MI approach elaborates diverse ways that BAP can flexibly bookend clinical use of MI: (1) for some patients, BAP functions as a stand-alone MI-consistent tool to support patient self-management for patients ready or nearly ready for behavior change; (2) sometimes clinicians probe for readiness for change with Question One of BAP and uncover a need to infuse MI skills into the conversation before returning to the BAP road map to complete an action plan; and (3) sometimes clinicians need to utilize advanced MI skills at the very beginning of a conversation before introducing and completing BAP, which functions then as a pathway into and through the final MI process of planning. Videos demonstrating these diverse pathways are available in the public domain.[28]

Contributors to the BAP Professional Network[29] are actively teaching and evaluating BAP-MI in more than 7 university medical centers. Concepts and skills of BAP-MI, including program descriptions and positive evaluation data, have been presented at recent peer-reviewed medical conferences, workshops, and courses.[24,30–33] Although the research evidence for BAP-MI is still emerging, the pragmatic and flexible algorithmic approach of BAP-MI appears well aligned with the culture of healthcare practitioner learning styles across disciplines and levels of training/expertise. BAP-MI may offer an approach to help disseminate the contributions of MI more broadly into diverse and emerging healthcare environments. These promising early results encourage further clinical and training efforts, along with systematic evaluations of outcomes.

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