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Using motivational interviewing and brief action planning for adopting and maintaining positive health behaviors

Steven A. Cole, M.D., M.A. [a,b,*], Deepa Sannidhi, M.D. [c], Yuri Tertilus Jadotte, M.D., Ph.D., M.P.H. [d,e], Alan Rozanski, M.D. [f]

[a] Department of Psychiatry, Renaissance School of Medicine at Stony Brook University, Stony Brook, NY, United States of America
[b] Depaertments of Scientific Education and Psychiatry, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, United States of America
[c] UC San Diego Health, Department of Family Medicine and Public Health, Division of Family Medicine and Division of Preventive Medicine, United States of America
[d] Department of Family, Population, and Preventive Medicine, Renaissance School of Medicine at Stony Brook University, Stony Brook, NY, United States of America
[e] Northeast Institute for Evidence Synthesis and Translation, School of Nursing, Rutgers University, Newark NJ USA
[f] Division of Cardiology, Mount Sinai Morningside Hospital, Mount Sinai Heart, and the Icahn School of Medicine at Mount Sinai, New York, NY, United States of America

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ABSTRACT

Lifestyle medicine practice can be enhanced with interpersonal communication skills to help patients adopt and maintain positive health behaviors, such as improving diet or initiating exercise. We review two approaches that incorporate evidenced-based skills for this purpose: motivational interviewing and brief action planning (BAP). Motivational interviewing involves four processes conducted in a climate of compassion, acceptance, partnership, and empowerment. First, *"engaging"* (or connecting) with patients uses the "relational" skills of active listening and empathic communication. Second, *"focusing"* elicits patients' full spectrum of concerns, expectations, and desires to negotiate a collaborative agenda. Third, "*evoking motivation*," utilizes uniquely innovative skills (e.g., "softening sustain talk" and "cultivating change talk") to increase intrinsic motivation of patients with ambivalence (or resistance) to become more open to choosing healthier behaviors for themselves. Fourth, "*planning for change*," uses collaborative goal-setting skills to help patients specify concrete action plans for health. To this end, brief action planning (BAP) has been developed as a specific pragmatic algorithmic approach, utilizing collaborative "SMART" (specific, measurable, achievable, relevant, and time-based) action planning, encouragement of patient commitment statements, scaling for confidence, problem-solving to reduce barriers for change, fostering patient accountability, and emphasizing follow-up. BAP can be introduced at any point in a patient encounter when patients are ready or nearly ready for change.

Contents

Abbreviations: BAP, brief action planning; BAP-MI, brief action planning-motivational interviewing; CVD, cardiovascular disease; OARS, open questioning, affirmation, reflections, and summaries; SMART, specific, measurable, achievable, relevant, and time-based (plans).

* Corresponding author at: Renaissance School of Medicine at Stony Brook University, Stony Brook, NY, United States of America.
E-mail address: stevecolemd@gmail.com (S.A. Cole).

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An emphasis on disease prevention has led to high awareness regarding the risk factors for cardiovascular disease (CVD). Nevertheless, this awareness has remained insufficient. There has been a marked increase in obesity[1] and diabetes,[2] and a high percentage of Americans are either sedentary or not sufficiently physically active.[3] These risk factors contribute significantly to the risk of developing chronic illnesses as people age. In this era of increasing longevity, health policy points to a critical need for developing and disseminating methods to help patients reverse unhealthy lifestyle habits and/or adopt healthier ones. Many evidence-based behavioral interventions have been introduced for this purpose. Among these, motivational interviewing represents a uniquely innovative method for enhancing patient motivation for behavior change, especially for patients with ambivalence about or difficulty initiating or maintaining healthy lifestyle behaviors.[4] With robust evidence, motivational interviewing is now recommended as a behavioral counseling method by the United States Preventive Services Task Force in numerous chronic disease guidelines.[5]

Clinicians often encounter patients who possess some intrinsic motivation to improve unhealthy lifestyle habits, but lack sufficient "execution skills" to get this done. To this end, brief action planning (BAP) serves as a technique that can be used either as part of motivational interviewing[6] or function as a stand-alone tool to support patient self-management for those patients who are ready or nearly ready for change.[7] In this review, we explore how the concepts and skills of motivational interviewing and brief action planning can be used alone or in synergistic fashion to promote positive changes in high-risk lifestyle behaviors.

Motivational Interviewing

The conceptual framework of motivational interviewing was originally described by William Miller as a method for helping to treat patients with alcohol use disorders in 1983.[8] Over the years, Miller and Rollnick have further developed and broadened the original concepts of motivational interviewing.[4] Motivational interviewing techniques have been increasingly recognized as useful to help patients initiate or improve common lifestyle goals, including exercise, resistance training, nutrition, weight-management, sleep hygiene, smoking cessation, reducing alcohol consumption, or improving adherence to medication prescriptions.

Motivational interviewing consists of four core "processes" as shown in Fig. 1, conducted in an atmosphere promoting partnership, empowerment, and acceptance.[9] *"Engaging,"* the first process of motivational interviewing, resembles widely accepted first principles of communication in healthcare[10–15] emphasizing the foundational relevance of empathic communication to foster rapport and trust in the relationship. "*Focusing,*" the second process, involves negotiating with patients to agree on a domain for exploration and discussion, similar to "agenda" setting in medical practice.[10–15] The third core process, *"evoking motivation*" aims to elicit and strengthen patients' intrinsic (as opposed to extrinsic) motivations for change. *"Planning,"* the fourth core process, helps patients formulate and execute specific action plans. We describe each of these four processes below.

Engaging the patient

The first process, "engaging," emphasizes the foundational importance of rapport and connection. Clinicians help develop patient trust and sense of safety through active listening, open questioning, acceptance, and empathic communication. Fig. 2 shows the four "core" skills of motivational interviewing (OARS: open questioning, affirmation, reflections, and summaries) with examples of how to use them strategically to promote engagement. The foundational skills of OARS are also used in other processes of motivational interviewing as will be described below.

a. Open questioning style

An open questioning style, which includes facilitation and exploration, is encouraged to promote a trusting atmosphere for comfortable and efficient information exchange throughout. Closed questioning is, of course, important in clinical healthcare and motivational interviewing to gather specific information when needed. Early and primary reliance on closed questioning, however, limits potential for full and open conversation and exploration. Some examples comparing closed vs open (preferred) questioning are shown in Table 1.

Use of open questioning style builds trust and connection by encouraging patients to share both their symptoms and related feelings and/or other relevant aspects of their unique personal stories. Open questions, followed by facilitating comments, questions, or gestures ("uh-huh", head nods, "can you say some more?") help patients continue thoughts

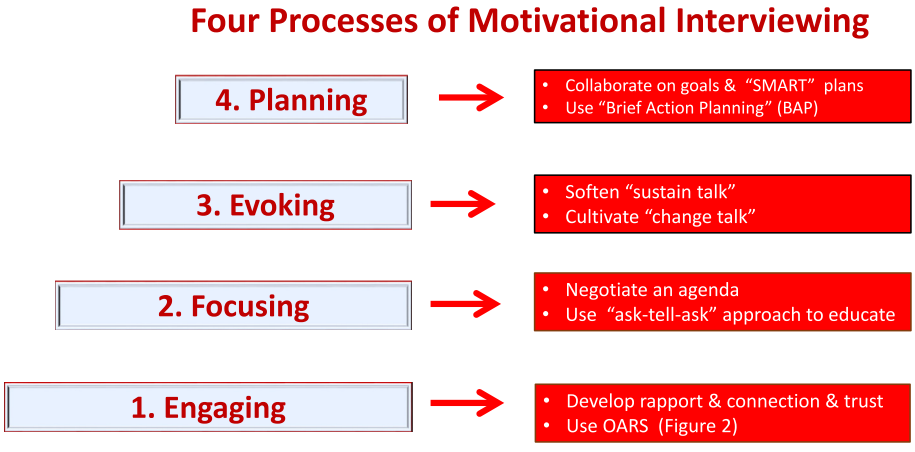

Fig. 1. The four core processes of motivational interviewing.

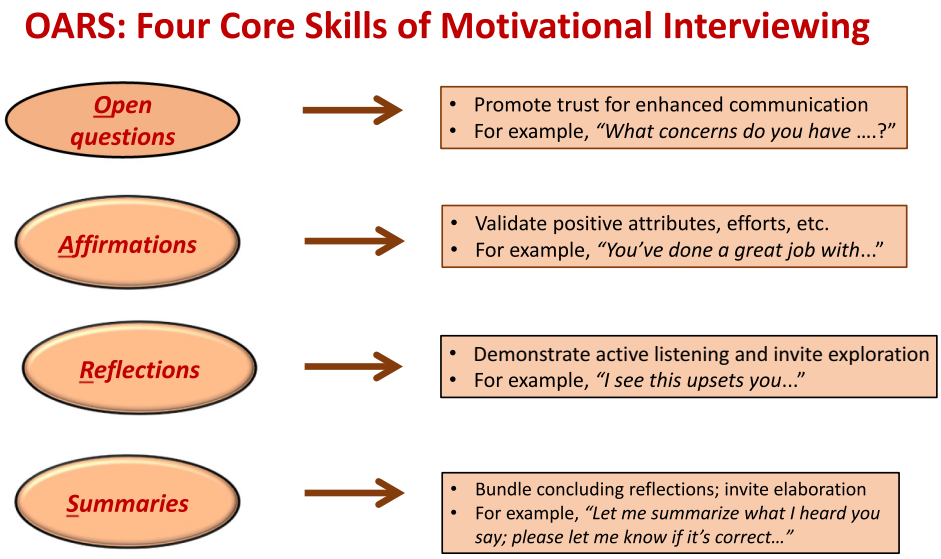

Fig. 2. The four micro-skills for enhancing patient engagement during motivational interviewing ("OARS").

they have begun to express and/or encourages useful exploration. For instance, the clinician might say *"I'd be interested in hearing some more about what you're thinking and feeling about that."* Some open questions may be "grammatically closed" (i.e., technically answerable with one word) but function generatively or conceptually, to "open doors,".[16] For example, "*can you tell me some more about what worries you?"* or "*is there anything you'd like to do for your health?"* are examples of questions that are grammatically closed but function as open questions.

b. Affirmations

Affirmations go beyond and impact patients more powerfully than simple "praise." Affirmations represent clinician comments that acknowledge and validate positive attributes, efforts, or behaviors of patients, especially ones aimed towards facilitating resilience, coping, or adaptation. Affirmations build rapport, patient self-efficacy, and motivation. For example, if a patient reports a ten-pound weight loss, the clinician can affirm this accomplishment by commenting: "*it is really impressive that you've been able to sustain the effort to achieve this*". Most patients, even "difficult" ones, have positive attributes that skilled clinicians should make efforts to identify and validate. For example, *"I know you're discouraged because you keep gaining weight…it's impressive that you understand the health risks of poor nutrition and keep trying to make positive changes."*

To maximize effectiveness, affirmations should be compassionate, genuine, commensurate with patients' actual efforts or positive attributes and used sparingly. Inauthentic affirmations will be heard for what they are – insincere - and undermine relationships. Furthermore, when overused, praise becomes patronizing and ineffective.

Table 1
Comparison of closed versus open questioning.

Patient Statements	Closed questioning (not preferred)	Open questioning (preferred)
"I got so out of breath… I could barely finish that test… I know I should start exercising again."	*"When did you stop exercising?*	*"Can you say some more?"*
"I got so out of breath…I could barely finish that test…I've gained so much weight."	*"How much have you gained?"*	*"What's been hard for you about weight management?"*
"I got so out of breath…I could barely finish that test…I know I should start exercising."	*Are you aware of the risks of not exercising?*	*"Would it be OK for us to talk about the risks of not exercising?"* *

* This is an example of a "grammatically closed" question (that is, one that can be "answered" with one word), which is "functionally" and "conceptually" open, and generative, because it inspires exploration and discovery.

c. Reflections

Patients' responses to open questions provide clinicians with opportunities to facilitate and deepen connection and conversation by reflecting back what they have heard. Effective reflections require and demonstrate active listening. There are many types of reflections illustrated in Table 2. Reflections can be "simple," repeating back the "surface" meaning of what the patient has said; or reflections can be deeper and more "complex" making "a guess about what the person means".[4] Reflections, especially complex ones, in the engagement process build connection and trust, inviting further disclosure and exploration. Complex reflections may re-state what a patient has said with added inferences about what the clinician thinks may motivate the patient's statement, or what the statement may mean emotionally at a deeper level.

Included in Table 2 is an example of a "double-sided reflection." Such reflections cover both sides of a patient's ambivalence, for example the patient's difficulty (or resistance) to change an unhealthy behavior, alongside his/her genuine desire to change in the interest of healthier living. In addition, Table 2 illustrates yet another type of complex reflection, that includes legitimation (e.g., *"lots of people feel the way you do"),* followed by exploration *("What troubles you most about……?*).

Using simple reflections can be relatively easy for motivated learners to integrate into their personal clinical practices. Developing proficiency in the use of complex reflections, however, requires many cycles of practice, and re-practice, with feedback from skilled observers.

d. Summaries

"Summaries" bundle reflections with insights that have been gathered during the patient visit. They serve multiple purposes. In Motivational Interviewing, summaries can selectively and strategically pull together and reinforce threads of change talk, with relative inattention to sustain talk. They can be used to ensure clear communication (and accuracy), tying together numerous discussion themes. Like all reflections, summaries require and demonstrate active listening. They can facilitate transitions to begin exploring a range of patient concerns, as discussed below. A good summary may begin with a statement such as "*let me check to make sure I am understanding you correctly so far….*".

To maximize accuracy and deepen collaboration, effective summaries usually conclude by inviting the patient, with a sense of humility,

Table 2
Types of reflections and related skills.

Patient Statement	Types of Reflection	Clinician response
"I got so out of breath on the test… I could barely finish… I know I need to start exercising; it's just so hard to get started."	**Simple reflection (restatement)**	"I hear you…you know you need to start exercising."
"I got so out of breath on the test… I could barely finish… I know I need to start exercising; it's just so hard to get started."	**Complex reflection (emphasizing motivation)**	"I hear you…you got so out of breath you realize you really need to do something about it."
"I got so out of breath on the test… I could barely finish… I know I need to start exercising; it's just so hard to get started."	**Complex reflection (emphasizing emotional distress to drive change)**	"Sounds like that test got you worried about what could happen if you don't start exercising."
"I got so out of breath on the test… I could barely finish… I know I need to start exercising; it's just so hard to get started."	**Complex reflection (intentionally "amplified" to build motivation)**	"Sounds like something's going to have to change for you to get started on what you know you need to do. I wonder if that's ever going to be possible?
"I got so out of breath on the test… I could barely finish… I know I need to start exercising; it's just so hard to get started."	**Complex reflection ("Double-sided" conveys deep appreciation of both sides of a patient's ambivalence concluding with a "twist" suggesting readiness for active change)**	"You're upset. You're more out of shape than you realized; at the same time, you realize this may be just the right time to get started building a more active lifestyle."
"I got so out of breath on the test… I could barely finish… I know I need to start exercising; it's just so hard to get started."	**Complex reflection (with legitimation & exploration)**	"You're upset. Lots of people feel that way. What's the most troubling part about that?"

curiosity, and partnership, to provide further input, for example: "*Did I miss anything?*" or "*Is there anything that you would like to add or correct?*" or "*What else concerns you?*". After integrating patient's further input, skilled clinicians often then proceed to the second process.

Focusing the agenda

"Focusing," the second process of motivational interviewing, similar to "negotiating the agenda" in medical communication literature, can begin with a question such as: "*You've mentioned several concerns; why don't we decide together where we'll start? What concerns you most?*"?

Physicians may sometimes be understandably tempted to try to "persuade" their patients to engage in healthier behaviors. Indeed, in support of this point of view, a recent systematic review of educational approaches in healthcare found that "persuasion" is often effective, and the authors argue, perhaps under-used.[17] Motivational interviewing research and practice, on the other hand, cautions clinicians to "avoid the righting reflex," especially with patients who are ambivalent about their unhealthy behaviors. Patients with ambivalence, motivational interviewing research demonstrates, typically react negatively to persuasion, confrontation, or even direct "advice," leading to discord in the relationship and, ultimately, decreased likelihood for healthy behavior change.[4]

Motivational interviewing recognizes the importance of sharing expertise. In order to avoid arousing defensiveness, however, motivational interviewing encourages clinicians to use an "ask-tell-ask" (or "elicit-provide-elicit") approach to "persuade with permission."[4] The initial "ask" seeks the patient's permission to discuss a health behavior. For instance: "*is it okay if we discuss your diet?*" Asking for permission in this way, respects and supports patient autonomy in a collaborative style, increasing trust, sense of safety and willingness to be open. If the patient declines, or if the patient demonstrates only "half-hearted" or ambivalent consent, do not proceed with information exchange at that point. If the patient appears reluctant to hear more information, "advice" or "education" will be counterproductive.

For those patients voicing an openness to discussion and exploration, however, clinicians can begin a collaborative process of information exchange and motivational enhancement After sharing ("telling") information relevant to health improvement, in the third step of the "ask-tell-ask" framework, clinicians return to "asking" patients what they think and feel about what they have just heard: "*I wonder what you think about all this ….?*"

Active listening to the patient's responses to this query often provides conversational ingredients for clinicians to actively launch the third process of the motivational interviewing paradigm: "evoking motivation."

Evoking motivation

Ambivalence, or difficulty changing unhealthy behaviors, manifests itself in slightly different, sometimes overlapping forms: emotional distress, discord in the clinician-patient relationship, or deep internal conflict about change. One or more of these forms of ambivalence towards change are common and indeed, "normal," leading typically to denial, rationalization, defensiveness, anxiety and/or procrastination.

Astute observers can detect ambivalence about change by attending to the "language" individuals use when discussing their choices about their own health, wellness, and lifestyle. Motivational interviewing has discovered that individuals express their desires to change versus their proclivity to stay rooted in risky behaviors through their "change talk" and "sustain talk." Motivational interviewing research has demonstrated that clinicians can reliably influence the amount and strength of patients' change vs. sustain talk, and that these changes predict subsequent behavior.[4]

Change talk reflects a person's aspiration for change. It may be reflected by phrases that express desire for change (e.g., "*I would like to start exercising*" or "*I wish I could keep to a regular diet*"), statements of ability to change (e.g., *"I know I can do this if I really decided it was important"*), needs to change ("*I know I need to starting walking,")* or statements that reflect reasons to change (e.g. "*I think I will feel more energy if I get off the sugary stuff*"). The acronym "DARNCATS" categorizes seven categories of change talk as described in Table 3.[4]

Sustain talk reflects a patient's expressed, contralateral desire to stay within, or difficulty leaving their relative "comfort zone" of persistent unhealthy behaviors. Sustain talk includes expression of emotional difficulties or emotional barriers to change. Examples of sustain talk includes statements expressing difficulties to change ("*it's just too hard for me*"), denial (*"I don't believe I'm really at risk – my father smoked till he was 94)"* or references to prior failures and doubts (such as "*every time I try to lose weight, I regain it and then some*").

Working with patients' change talk and sustain talk is the pivotal guiding principle of motivational interviewing. As conceptualized in Fig. 3**,** as the quantity and strength of a patient's sustain talk increases, the balance tips towards maintenance of the status quo. An increase in change talk, on the other hand, tips the balance towards change. *Thus, the central goal of motivational interviewing seeks to increase the amount and strength of a patient's change talk.*

Table 3
"DARN-CATS": Seven types of "change talk" according to Miller and Rollnick.

D	**Desire**	Reflecting a desire for change	"I would like to start an exercise program".
A	**Ability**	Reflecting self-capability	"I know when I get started exercising, I'll be able to walk the three blocks to the library without much trouble.
R	**Reasons**	Providing reasons for change	"I know my shortness of breath will go away if I start exercising regularly".
N	**Need**	Reflecting feeling an obligation to change	"I need to get into shape before my son's wedding".
C	**Commitment**	Reflecting actions that will be taken	"I plan to join my local gym and will hire a trainer before my next medical appointment".
A	**Activation**	Indicating movement towards action	"I feel ready to get started with this program."
TS	**Taking steps**	Indicating steps already taken to change	"I called the trainer yesterday and we're ready to start next week."

Recognizing change talk and sustain talk

Before clinicians can strategically use the technical skills of motivational interviewing to soften sustain talk or cultivate change talk, they must be able to reliably recognize each. Consider Joanne, a 48-year-old female with moderate obesity who comes in for an annual check-up, telling her physician:

> *I have been thinking about going on a diet, but the last time I tried it, it was torture. I gained back all the weight and then some. I wish I could lose weight, but I just cannot follow the rules. It is just so hard for me. Especially at night. I am a big night eater and I also eat during stress. My mother was also heavy, and I saw how it affected her as she got older. I would hate to end up like my Mom. She could not even climb stairs by the time she was 70! However, I just don't feel ready to give this a whirl currently. But I do want to lose the weight. I feel so stuck! Geez, I really need to find a way I can do this.*

Before reviewing Fig. 4**,** which shows Joanne's change talk and sustain talk in different colors, please circle the phrases above which represent change talk and underline the phrases above which represent sustain talk. Then compare your responses to the indicated change talk and sustain talk in Fig. 4**.**

Clinicians who learn to distinguish between change and sustain talk can strategically help their patients to express more change talk and less sustain talk. As Miller and Rollnick point out, those patients who give voice to more and more change talk literally "talk themselves into change".[4]

Softening sustain talk

In general, clinicians strategically "soften" sustain talk with selective inattention, while probing for, reinforcing, and/or exploring change talk. Sustain talk, however, is often associated with strong emotional content which needs to be acknowledged and validated first, to ensure continuing connection and trust. It is always important to let your patients know that you understand their emotional frustrations. When patients feel you do not understand or you minimize their difficulties, you invite "push back," inducing further sustain talk. In the case of Joanne above, "honoring" her distress at early points in the interaction represents one way of softening her sustain talk.

Clinicians must exercise caution and judgment to avoid "too much" resonance and exploration of "sustain talk," because this invites further sustain talk, which in turn encourages "status quo" behaviors. Based on evidence, motivational interviewing principles encourage clinicians to use judgment to acknowledge difficulties, including emotional distress, sparingly but sufficiently before moving towards cultivating change talk.

To both soften sustain talk with empathy and compassion, while beginning to cultivate change talk, clinicians can use "double-sided" reflections. First, clinicians use empathic reflections to communicate understanding and acceptance which softens sustain talk, following by reflections or questions aimed to elicit or reinforce "change talk." In the interaction with Joanne, for example, a clinician could build rapport and cultivate change talk as follows:

> *"I'm getting a clear picture of just how troubling and difficult this whole thing has been for you. I also heard you say quite a bit about why losing*

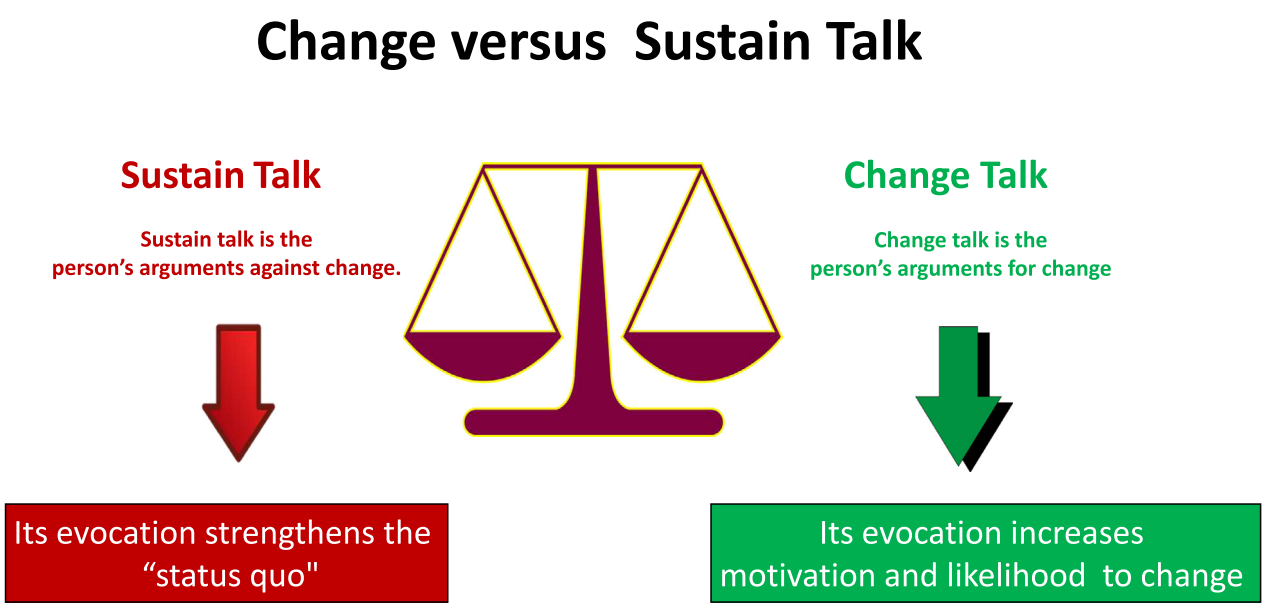

Fig. 3. Importance of focusing on patients' language to evoke motivation. Sustain talk reflects patients' resistance or arguments against change whereas change talk reflects patients desire and arguments for change. Helping patients to increase their change talk helps foster greater intrinsic motivation to change negative health behaviors.

CHANGE TALK (in blue)	SUSTAIN TALK (in red)
I have been thinking about going on a diet, but the last time I tried it, it was torture. I gained back all the weight and then some. I wish I could lose weight, but I just cannot follow the rules. It is just so hard for me. Especially at night. I am a big night eater and I also eat during stress. My mother was also heavy, and I saw how it affected her as she got older. I would hate to end up like my Mom. She could not even climb stairs by the time she was 70! However, I just don't feel ready to give this a whirl currently. But I do want to lose the weight. I feel so stuck! Geez, I really need to find a way I can do this.	I have been thinking about going on a diet, but the last time I tried it, it was torture. I gained back all the weight and then some. I wish I could lose weight, but I just cannot follow the rules. It is just so hard for me. Especially at night. I am a big night eater and I also eat during stress. My mother was also heavy, and I saw how it affected her as she got older. I would hate to end up like my Mom. She could not even climb stairs by the time she was 70! However, I just don't feel ready to give this a whirl currently. But I do want to lose the weight. I feel so stuck! Geez, I really need to find a way I can do this.

Fig. 4. Example of "change talk" (in blue) and "sustain talk" (in red) among the comments made by a patient regarding her thoughts about dieting. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

weight is important to you. Would it be OK if we go back over those reasons why you feel you need to lose weight…. and maybe we can start putting them together so I can understand you better?

Cultivating change talk

There are many ways to cultivate change talk. Clinicians can use skills of "OARS" (see discussion of OARS under the process of engagement) with comments such as *"you said you know you need to stop smoking* (reflection)…*in what ways is this important to you?* (Open question). Using another approach to cultivate change talk, patients can be asked to "look forward," for example, *"Should you ever decide you'd like to stop smoking; I'm wondering how you imagine your life might be different?* (Open question).

Clinicians can also elicit change talk by asking patients to scale the importance of behavior considerations, as exemplified in Fig. 5**.** For instance, applying this technique to Joanne, a clinician could say:

I'm hearing you point to lots of reasons why it is important to you to lose weight…even though it's been so hard. I'm wondering if you'd be willing to give me an idea of about how important it is to you to lose weight… on a scale of 0–10, where 0 means not important at all and 10 is about as important as it could possibly get. What number would you say best shows how important this is to you?

Importantly, regardless of the specific number Joanne provides, the clinician can cultivate change talk by then asking Joanne to explain why she gave that number and not a lower number. For instance, the clinician may ask:

"OK. That's interesting. Despite being so hard, you're actually giving this an importance of 7. That's really high. I wonder why you said a 7 and not a 5 or a 4?"

Patients generally respond well to the importance ruler used in this way. They find it novel, unexpected, and interesting when asked why

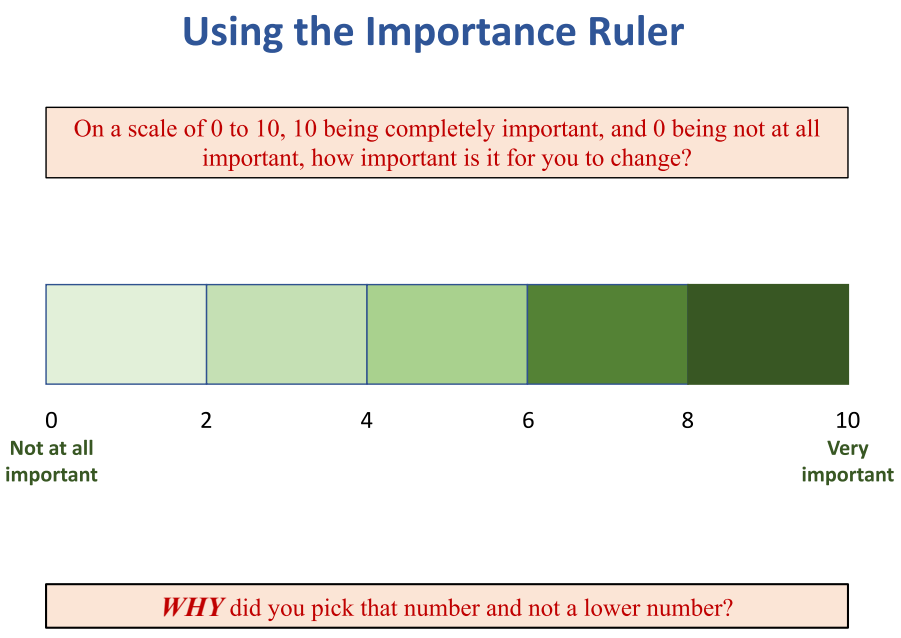

Fig. 5. Having patients scale the importance of behavioral intentions can be used as tool for help patients augment their intrinsic motivation to change.

their confidence level is not *lower* than what they stated. This evokes change talk as patients begin to consider why they did not provide a lower number.

Action planning

If the "evocation" process in the motivational interviewing paradigm has been successful in developing sufficient positive patient language supporting change, the clinician can then move forward towards helping the patient formulate a specific action plan to initiate, improve, or otherwise change towards a desired health behavior. As portrayed in Fig. 6, this step represents a "window of opportunity" emerging from the motivational interviewing process. Increases in motivation or new insights are like seeds. These "seeds" get sufficiently "watered" when clinicians move directly towards helping patients develop a specific action that incorporates a specific goal, expressed or implied in their change talk. The importance of this basic psychological principal cannot be overstated. Tying enhanced motivation to a subsequent specific course of action makes it more likely that the motivation will be sustained. Conversely, if no action plan is developed, or the plan lacks sufficient specificity, there is a greater chance that fledgling motivations or insights evoked during the motivational interviewing process may just turn into a transient insight that is soon forgotten.

Clinicians commonly face the pragmatic challenge of helping patients formulate action plans within the constraints of contemporary time-limited medical practices. To facilitate action planning in time-constrained environments, Cole and colleagues developed an efficient, pragmatic, and flexible algorithm, brief action planning (BAP).[18] Each of the core competencies of BAP respect patient autonomy and is supported by robust evidence.[7] The sequence of brief action planning is shown in Table 4 and discussed below.

a. Eliciting a Behavior Goal

Once a clinician evokes sufficient change talk around a specific domain, BAP encourages probing for a specific behavioral action plan. This can be initiated by asking the patient, Question One, whether he or she would like to do anything for their health in the next week or two, or asking a more directional and context-specific version of Question One: e.g.: *"It sounds like you are voicing some real concerns about… (*e.g.*, smoking, exercise) …I wonder if you'd like to make a specific plan about that?*

If the patient responds affirmatively, the next step is to help the patient make a "SMART" plan, that is specific, measurable, achievable, relevant, and time-based. The more specific the plan, the greater the likelihood of successful follow through. If the patient is unsure about wanting to make a plan, the clinician can offer a behavioral menu of 2–3 varied ideas, including examples of what other patients have successfully proposed. For example: *"one patient I worked with decided to do "X", another did "Y", and a third did "Z"*. In this way, the patient may be offered a few behavioral ideas without feeling pressured. If the patient indicates that they do not want to make an action plan, this should be honored. The clinician is encouraged to leave the door open for change at a later time by asking if it would be okay to raise this question during the patient's next visit.

Table 4
Basic questions and steps of brief action planning.

QUESTIONS	STEPS
1. **Elicit a behavior goal by asking:** *"Is there anything you would like to do for your health in the next week or two?"*	• If "yes", agree on a "SMART" goal. • If "unsure", offer a behavioral menu. • If "no", ask if you can check back with the patient next time.
2. **Elicit a commitment by asking:** "*Just to make sure I understand your plan, would you repeat back to me what you have decided to do?*"	• Eliciting a commitment in the first person predicts subsequent behavior • This question is only asked if patient has agreed to a plan during first step
3. **Assess confidence by asking:** "*How confident do you feel in carrying out this plan on a scale from 0 to 10, where 0 is not confident at all and 10 is totally confident?*"	• Confidence of 7 associated w/ success • If <7, seek collaboration with patient to increase confidence (e.g. ask if patient has ideas or w/permission, suggest ideas).
4. Arrange accountability by asking: *"Would you like to set a specific time to check in about your plan and see how things are going?"*	• Establishing follow-up (with patients collaboration) improves outcomes.

b. Elicit a Commitment Statement by the Patient

Once a SMART plan is collaboratively developed, it is helpful to concretize a commitment on the patient's part by asking the patient to tell back the specific plan. This verbal repetition helps the patient to organize the details of the plan and reveals any misunderstanding regarding what has been planned. First-person re-statement of intent by the patient himself/herself is a powerful predictor of subsequent success.[19] Of interest, the strength of the commitment language itself is correlated with increasing likelihood of successful completion, e.g., a commitment with the language "I will," is more likely to lead to completion than a statement such as "I will try.".[20,21]

c. Assess Patients' Confidence to Actualize Their Health Goals

Realistic action planning is aided by asking patients to scale how confident they are in following through with the plans they have outlined with their healthcare provider. A useful format for

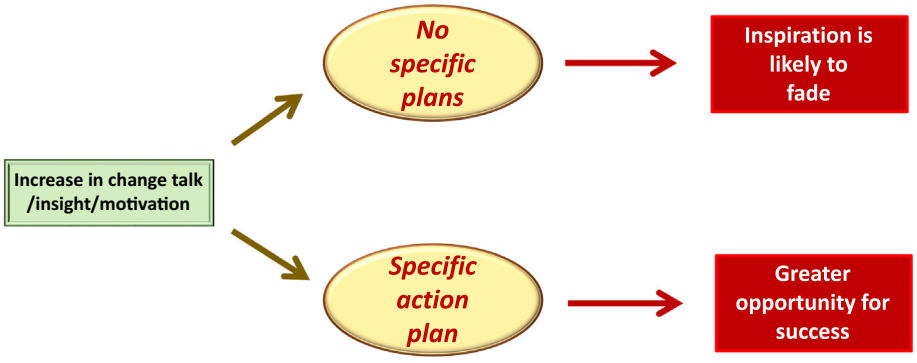

Fig. 6. Increase in patients' level of motivation or new insights represent "windows of opportunity". The likelihood of their leading to change in patient health behaviors is increased if these opportunities are followed by adopting an action plan.

accomplishing this employs a similar approach to the "Importance Ruler" technique described above and schematized in Fig. 5. That is, patients should be asked to scale their confidence to carry out their SMART goals on a 0–10 scale. A confidence level of 7 or greater is associated with higher likelihood of success, reflecting higher self-efficacy.[7] When patients report a confidence level <7, clinicians are encouraged to use a strength-based approach to build self-efficacy (eg "a 6 is great; I wonder if you'd like to discuss ways to reach a 7 or higher which is associated with greater likelihood of success?") With persmission, patients can then be invited to reflect on how they might increase their level of confidence, such as by adopting less ambitious plans, or involving partners or friends in their action planning. Helping patients arrive at a level of confidence where they believe they can be successful is a very important tenet in the successful application of brief action planning.

d. Fostering Accountability

The final step in brief action planning fosters patients' sense of accountability towards their newly developed SMART action plans. This might include arranging for close follow-up with the clinician and/or associated office staff to monitor and encourage patients' progress. Patients can also be asked to consider establishing an "accountability partner", such as one's spouse or a friend, or to foster self-accountability through calendaring or use of self-monitoring phone device or computer software.

Integrative view of behavioral counseling techniques

Besides motivational interviewing and BAP there are many other techniques, some considerably evidence-based, that can be used to foster patient motivation, execution of health goals, and/or maintenance of these goals over the long-term.[20–22] Some of these techniques are shown in Fig. 7.[23,24] For example, patients can be inspired by motivational stories or use of incentives. Execution of goals can be supported using implementation intentions ("if/when" formulations)[25] for which there is a considerable evidence base,[26] or use of time management techniques, which can be very helpful to many patients. Long-term maintenance of health goals (e.g., sustaining a weight loss diet) can be supported by helping patients to make contingency plans (e.g., creating a minimal "floor" of activity when initiating an exercise program), joining a social support group, or gaining assistance in stress and/or energy management issues that may impede one's pursuit of health goals.

Motivational interviewing is particularly effective because it combines various evidence-based techniques with its novel approaches to evoking intrinsic motivation. Similarly, brief action planning combines multiple evidence-based techniques, readily adaptable to busy practice environments. Of note, BAP has potentially broad applicability because it can be used with patients who are ready or almost ready for collaborative planning and therefore, does not require the use of the complete and far more complex motivational interviewing process. Alternatively, BAP can be applied in intermediate steps of motivational interviewing processes, (e.g., even before the evoking stage of this process), if the clinician believes the patient may be ready to discuss action plans at any point. Cole and colleagues have developed a specific integrated BAP and motivational interviewing model (BAP-MI)[27] which is being used and evaluated at several academic medical centers.[28]

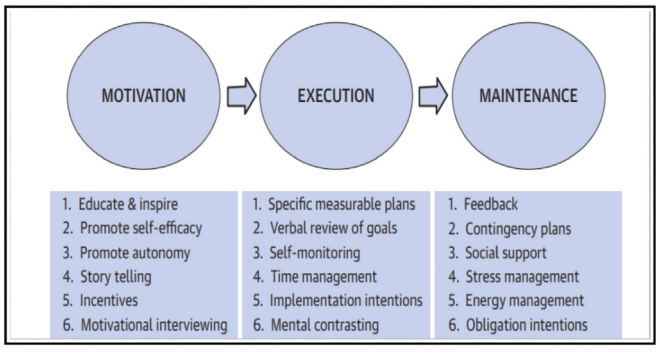

Fig. 7. The three basic components of successful behavioral pursuit (motivation, execution, and maintenance) and examples of techniques used to foster each component.

Learning and using motivational interviewing, BAP, and BAP-MI takes time, patience, and practice. While some of the techniques and skills are relatively easy to understand and use (e.g., use of open questions, simple reflections), developing proficiency in many others such as complex reflections and eliciting change talk in a climate of acceptance, partnership, and empowerment, have been shown to require opportunities for practice of skills with feedback from skilled observers, and re-practice. Importantly, the principles and practices described herein can enhance effectiveness in all walks of life and should be taught more widely at all levels of medical education.

Disclosures

No disclosures.

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