BAP-MI—A Novel, Integrated Model of Brief Action Planning and Motivational Interviewing for Preventive Healthcare

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Abstract

Healthcare practice requires connecting with patients, co-constructing health narratives, and collaborating with them to address the numerous factors that pose challenges to their health. While there have been substantial improvements in healthcare regarding curative medicine, largely driven by both scientific advances and the need to seek medical care created by the pain and suffering of illness and disease, preventive medicine continues to lag in its impact on patient health and wellness. A significant contributor to this lag is the limited amount of time available during the clinical encounter, which constrains patients and clinicians to focus on acute and chronic illness and disease management, rather than the promotion of health and wellness. BAP-MI is a novel, integrated model of

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brief action planning (BAP) and motivational interviewing (MI), two effective interventions for promoting patient self-management and health behavior change. This chapter explores BAP-MI as a pragmatic, integrated approach to the clinical interview and demonstrates how it can be an effective and efficient model for preventive healthcare, with a focus on the medical specialty of preventive medicine and lifestyle medicine. Finally, the chapter proposes a new structure of the clinical interview, "the History of Present Health Status" (HPHS), to provide a guiding template for preventive healthcare. This new template assumes particular importance for clinical encounters that are not focused on understanding or managing a current acute or chronic illness; that is, for medical encounters for which the traditional template of the "History of Present Illness" (HPI) is not relevant or helpful for guiding the co-construction of a meaningful medical narrative.

Keywords

BAP-MI · Brief action planning · Motivational interviewing · Preventive medicine · Lifestyle medicine · History of present health status · Health history · Clinical interview

1 Introduction

Despite significant progress made during the twentieth century toward the reduction of mortality and morbidity, brought about by major successes in medicine (such as vaccines and antibiotics) and public health (such as water use management and injury prevention), challenges to population health and wellness persist. Principally, although tremendous advances have been made in infectious disease epidemiology and management as well as in expanding life expectancy both in childhood and in older ages, the burden of chronic diseases only continues to rise. Specifically, diseases caused by largely preventable factors such as tobacco consumption, poor nutrition, and inadequate physical activity persist and are rising in prevalence (Mokdad et al., 2004; Zhang et al., 2021). While there have been substantial improvements in healthcare regarding curative medicine, largely driven by scientific advances and the need to seek medical care due to the pain and suffering of illness and disease, preventive medicine continues to lag in its impact on patient health and wellness (Jadotte & Lane, 2021a).

A significant contributor to this lag is the limited amount of time available during the clinical encounter. For example, in the United States, clinicians who are tasked with providing primary care for patients usually have 15–20 min per patient visit, after which any additional time contributed toward the visit is no longer reimbursable. This problem is particularly severe when caring for patients with complex medical or socio-behavioral needs (Fiscella & Epstein, 2008). Consequently, this limitation constrains patients and clinicians to focus on addressing or managing the most acute and pressing illness or disease, leaving little time for health promotion

and disease prevention efforts, such as health behavior change counseling for the provision of clinical preventive services (e.g., cancer screenings, preventive medications) and lifestyle factors (e.g., nutrition, physical activity), especially when the patient is otherwise feeling well and currently has no concerning diagnoses. On the other hand, most health behavior change interventions are time-consuming to implement in practice, making them less compatible with the typical clinical encounter, and they are also challenging to learn.

For example, although motivational interview (MI) is a well-known and evidence-based approach for engaging patients, focusing the clinical encounter, evoking change talk, and planning for health behavior change (Cole et al., 2023), it is a complex undertaking that is difficult to teach and learn (Miller & Moyers, 2006; Miller and Rollnick, 2023). Furthermore, even after learning MI skills, implementation research suggests MI interviewing behaviors are even more difficult to sustain in clinical practice. A 2019 scoping and mixed-methods review of MI implementation in health care pointed out that "motivational interviewing (MI) is internationally recognised as an effective intervention to facilitate health-related behaviour change; although, how it is best implemented and maintained in everyday clinical practice is not so clear" (Lim et al., 2019, p. 1). With respect to implementation in primary care practice, another review notes that "motivational interviewing (MI) is an evidence-based counseling approach within primary care. However, MI rarely translates to practice following introductory training programs, and a lack of evidence regarding its implementation persists today" (Langlois & Goudreau, 2024, p. 260).

In contrast to the complexities of learning, teaching, and sustaining MI skills, BAP is an algorithmic, teachable, and efficient approach to support patient self-management, facilitate health behavior change and improve health coaching that is widely used in practice, with a scoping review revealing 143 scholarly publications (Jadotte et al., 2023). Randomized clinical trials are still limited, but preliminary results from a systematic review with meta-analysis show evidence of effectiveness for certain patient health outcomes, such as duration of physical activity and completion of clinical preventive services (Jadotte & Cole, 2023). See the chapter on Motivational Interviewing (MI) and Brief Action Planning (BAP) (Frum-Vassallo et al., 2025) in this handbook for a deeper look at BAP, its theoretical foundations and practical applications in clinical practice and the education of health professionals.

The present chapter focuses on BAP-MI, a novel, integrated model of BAP and MI as two effective interventions that can be useful during the clinical interview for promoting patient health behavior change and patient self-management and that are combined to answer the call for greater emphasis on preventive healthcare, while offering a more efficient approach to the clinical interview given existing time and resource constraints. The chapter explores how BAP-MI can be a useful model for preventive healthcare, with a focus on the medical specialty of preventive medicine and on lifestyle medicine as a foundational clinical approach for health and wellness. While BAP as a stand-alone tool is particularly useful for patients who are ready or nearly ready for change, BAP-MI is an integrated tool appropriate to patients across

all levels of readiness for change, including patients who are deeply ambivalent about making changes in persistent unhealthy behaviors.

Finally, the chapter proposes a new structure for the clinical interview, called "the history of present health status" (HPHS), to provide a better guiding template for preventive healthcare. This new template assumes particular importance for clinical encounters that are not focused on understanding or managing a current acute or chronic illness (i.e. for medical encounters for which the traditional template, the "history of the present illness" or HPI, is not relevant or helpful for guiding co-construction of a meaningful medical narrative).

2 An Overview and Guide to BAP-MI in the Clinical Interview

The earliest formulation of BAP was originally developed circa 2003 by the co-author of this chapter (SC) as an efficient and pragmatic self-management support tool for chronic illness care in the Health Disparities Collaboratives (Cole et al., 2012). With contributions from members of the Motivational interviewing Network of Trainers (MINT), BAP was further defined and shown to align well with multiple other approaches to health behavior change, including peer support and MI (Gutnick et al., 2014). In contrast to BAP alone, BAP-MI represents advanced skills, higher order integration of the skills, and approach of BAP (i.e., the five foundational and three stepped-care competencies, see Tables 1 and 2 below) with higher order advanced skills of MI (Cole & Jadotte, 2023). This integration of MI with BAP is often useful and indeed sometimes necessary for patients with ambivalence and persistent unhealthy behaviors that are relatively refractory to change even with the skillful application of all eight core competencies of BAP.

Both BAP and BAP-MI are grounded in the principles and practice of Motivational Interviewing (Cole & Jadotte, 2023; Gutnick et al., 2014), as well as an approach to clinical interviewing described as "the Three Function Approach" (Cole et al., 2026). Similar to MI's emphasis on four core "tasks"

Table 1 Five Foundational Competencies of BAP

BAP Core Competencies	Examples of How to Apply BAP Core Competencies during the Clinical Interview
1. Elicit patient personal goals	Is there anything you'd like to work on for your health in the next week or two? (Core Question 1)
2. Elicit and clarify SMART plan	Would you like to make a plan about that? (Elicit all 5 aspects of the SMART plan) (Core Question 2)
3. Elicit a commitment statement	Could you repeat back to me what your plan is so that we are on the same page? (Core Question 3)
4. Assess confidence in the plan	On a scale of 0 to 10, 0 being not confident at all and 10 being completely confident, where would you say you land in your level of confidence in this plan? (Core Question 4)
5. Arrange accountability	Would it be helpful to do a check-in on how you are doing with your plan in the coming [week, two weeks, month, etc.]? (Core Question 5)

Table 2 Three Stepped-Care Competencies of BAP

BAP Stepped-Care Competencies	Examples of How to Apply BAP Stepped-Care Competencies during the Clinical Interview
1. Offer a behavioral menu with permission	[Use when the patient does not know how to start addressing his or her identified health goal] Would it be ok for me to share with you some ideas that might be helpful? [List examples relevant to patient history.] I wonder if you'd like to make a plan around one of these example, or if you've thought of something else you want to work on? (Stepped Care Question 1)
2. Support for problem solving	[Use when the patient's readiness for change as assessed by the confidence scale is less than 7.] A confidence of X out of 10 is good. Research suggests that when confidence is 7 or higher people are more likely to achieve their goals. Would you like to see how we might be able to modify your plan to get it up to a 7? (Stepped Care Question 2)
3. Include follow-up	[Include formal follow-up for all plans developed using BAP.] So, how did it go with your plan? …[Affirm success if patients achieve any of their plans, or normalize difficulties if patients have not met specific plans.] Well done! That's quite an accomplishment. Or lots of people have trouble completing…or even getting started on the plans they make. [Ask about next steps.] What would you like to do next?

(i.e., engagement, focusing, evocation, and planning), the Three Function Approach (TFA) is grounded in three MI-consistent core "functions" of clinical interviewing: connection, co-construction, and collaboration. The three functions parallel the four tasks of MI. Following the TFA, and consistent with both the "spirit" and "tasks" of MI, clinicians before all else aim to "connect" with a patient (Function One), using skills of empathic alignment, affirmation, and partnership. Following "connection" (or "engagement" from an MI perspective), clinicians focus patient concerns and negotiate agendas, by "co-constructing" a patient-centered medical narrative using skills of both open and closed questioning to elicit a chronologically grounded health history/health status, weaving in ecological variables such as psychosocial context and patient strengths and resources (Function Two). This foundation serves to guide and inspire productive "collaboration for care" using tools and approaches of shared decision-making, BAP and/or BAP-MI (Function Three) (Cole et al., 2026).

Following establishment of emotional connection (Function One), and supported with the co-constructed health narrative (Function Two), most patients are primed, inspired, and ready to suggest ideas they might like to pursue for their own health or well-being (Function Three). In introducing BAP or BAP-MI, note that BAP Question 1 probes for a patient's readiness for change, as well as helping a patient choose a domain ("any" domain) that they might like to work on for their health in the next week or two. Astute clinicians will note that the logic of Question 1 provides versatility and flexibility for its application across clinical interviewing. While Question 1 is typically introduced following establishment of connection and co-construction of the health narrative, Question 1 can also be introduced much earlier in some clinical interviews, after clinician-patient connection has been established. In this way, Question 1, along with other skills of BAP, can parallel

and/or reinforce the purpose and intent of eliciting, focusing, and understanding patient's concerns, while respecting and partnering with patients as "experts" for collaboration in their own self-care. In this way, BAP and BAP-MI probes or conversations themselves can serve "double duty" as useful elements for both co-constructing health histories and collaborative planning for change.

Linguistically, Question 1 of BAP is a broad, efficient, and effective tool. A "grammatically closed but conceptually open question" (Worley, 2015) or closed generative question (CGQ) (Cole et al., 2026), Question 1 functions clinically as a powerful motivator of change. Patients often affirmatively suggest something they would like to work on for their health, as most people usually can think of something they would like to change in their lives, toward health and well-being. For many patients who are ready, or nearly ready for change (30–70% of patients across disciplines and illness acuity, in the authors and their colleagues' shared experiences), the standard flow of BAP in the clinical interview can be followed sequentially, as shown in Table 1, using the five foundational skills of BAP. The three stepped care competencies of BAP (see Table 2) are often necessary or useful to help patients consider a range of potentially meaningful options for their unique situations ("the behavioral menu"); to work with clinicians to shape ("problem-solve") an action plan to reach criterion "levels" of confidence in their plans (at least "7/10") and for scheduled "follow-up" of a plan, to increase likelihood of goal attainment as well as "stepping up" care from a cross-sectional action plan to longitudinal "next steps" of behavior change over time.

3 When Do Clinicians Need Stepped-Care Skills of BAP-MI to Enrich BAP?

BAP is designed and particularly effective for patients who are ready, or nearly ready for change. Sometimes, all eight core competencies of BAP are not sufficient to launch action planning. This is true especially for patients with significant ambivalence about initiating changes in persistent unhealthy behaviors. In these situations, this chapter suggests that clinicians learn and use BAP-MI: clinicians can "enrich" BAP, using selective higher order, advanced skills of MI to help resolve ambivalence and facilitate health behavior change. Table 3 below provides a capsule overview of one approach to BAP-MI, which selectively embeds skills of MI within the BAP interviewing process itself. In this sense, BAP-MI as described in this chapter can be seen as an "MI-enriched" form of BAP.

4 BAP-MI in Preventive and Lifestyle Medicine: A Curricular and Practice-Based Case Study from a Residency Training Program

Preventive medicine (PM) is the medical specialty that seeks to apply health promotion, health protection, and disease prevention approaches both for individual patients and for populations to optimize health and wellness (Jadotte et al., 2019).

Table 3 Using BAP-MI to Enrich BAP Core Competencies

Core and Stepped-Care Competencies of BAP	Examples of How to Apply the Stepped-Care Elements of BAP-MI during the Clinical Interview
Elicit patient personal goals (Core) and offer a behavioral menu with permission (stepped-care)	Is there anything you'd like to work on for your health in the next week or two? [The patient is not sure what work on, so the clinician offers a behavioral menu with permission.] Would it be ok for me to share with you some ideas that might be helpful? [The patient is still not sure what to work on despite being offered a behavioral menu with permission.] ***BAP-MI stepped-care approach*:** Use MI Importance Scale. Use of the MI Importance Scale generates "change talk," increasing motivation for change (see Cole et al., 2023; Frum-Vassallo et al., 2025). Picking up on a topic or domain the patient has indicated is of "some" concern for change (despite competing ambivalence leading to sustaining behaviors), ask the patient to pick a number on a scale of 1–10, describing the importance of making a change: with 1 being very low importance and 10 being extremely important. After the patient chooses a number, ask why the patient chose the number stated, and not a number much lower. For example, "you said making this change was an importance of 6 to you. I'm wondering why you chose a "6" and not a number much lower, say a "3" or a "2?" This MI question typically generates "change talk," which increases patient willingness to plan for change. Clinicians can explore and reinforce change talk further and periodically probe for readiness by returning to a "context-specific" version of BAP Question 1, perhaps with a summary and affirmation. For example, "I'm hearing you discuss quite a few strong reasons why getting exercise is indeed important to you…you have a really clear and accurate understanding of how this would lower your risk of some worrisome health events and probably increase your sense of well-being. Very impressive. I wonder if you may feel more ready now to make any specific action plan about exercise?
Elicit and clarify SMART plan (Core) and Offer a behavioral menu (stepped-care)	Would you like to make a plan about that? [Elicit all 5 aspects of the SMART plan, and if the patient is not sure how to approach the plan, use the behavioral menu with permission; the patient is still not sure what to do about the collaboratively identified health goal].

(continued)

Table 3 (continued)

Core and Stepped-Care Competencies of BAP	Examples of How to Apply the Stepped-Care Elements of BAP-MI during the Clinical Interview
	BAP-MI stepped-care approach: Use selective MI skills to explore proposed health goals, to generate change talk: Open questions to elicit additional patient reasons for change, ask for clarifications, and use affirmations, simple or complex reflections, and summarizations to elicit change talk about the health goal; then probe for readiness to provide further details of a SMART plan.
Elicit a commitment statement (Core)	Could you repeat back to me what your plan is so that we are on the same page? [The patient is able to elicit most but not all parts of the plan as discussed]. ***BAP-MI stepped-care approach***: Return to the components of the SMART plan, then elicit a commitment statement from the patient. If unsuccessful (e.g., patient expresses ambivalence about a particular aspect of the plan), revisit that aspect and explore how the plan could be modified to be more feasible for the patient; consider assessing confidence in the plan to probe for readiness, despite patient ambivalence, as this scale itself may help elicit change talk that helps address the ambivalence.
Assess confidence in the plan (Core) And Support for problem solving (stepped-care)	On a scale of 0 to 10, 0 being not confident at all and 10 being completely confident, where would you say you land in your level of confidence in this plan? [The patient's confidence is less than a 7, despite collaboratively modifying the plan to make it more feasible or realistic for the patient]. ***BAP-MI stepped-care approach***: Consider revisiting confidence scale to generate change talk. For example: I'm hearing that your confidence in the plan has gone up from a 4 to a 6—with decreasing the plan's scope and adding some accountability. May I ask how come your confidence level is not a 3 or a 2? This should generate change talk as well as highlighting patient's strengths and resources, which the clinician can affirm and explore, the clinician can return to probe for increases in confidence.
Arrange accountability (Core)	Would it be helpful to do a check-in on how you are doing with your plan in the coming [week, two weeks, month]? [The patient is not sure about arranging accountability].

(continued)

Table 3 (continued)

Core and Stepped-Care Competencies of BAP	Examples of How to Apply the Stepped-Care Elements of BAP-MI during the Clinical Interview
	BAP-MI stepped-care approach: Identify and affirm strengths and resources to assist problem-solving. I'd like to hear about how you've been able to reach your goals in the past. What qualities have you been able to rely on to help you get where you want to go? I'd also like to hear about who you turn to for comfort and support? In your family? In the community? [Identify and affirm resources to empower problem-solving and action-planning for health].
Follow-up (Core)	How did it go with your plan? [When asked at a subsequent clinical interview and after an agreed-upon period of implementation of the plan, the patient returns showing ambivalence to change because the plan was not fully successful]. ***BAP-MI stepped-care approach***: Change can be difficult, but it is great that you are trying to make a change, and you were successful at doing (X) part of your plan. [Use MI skills to further co-construct the narrative with the patient about the desired health goal; then probe for readiness by re-visiting the BAP algorithm with the patient from the beginning or at a later step in the BAP algorithm if pertinent and based on the patient's experience with implementing the plan to date; for example, perhaps the main issue is a matter of accountability, or perhaps the issue is that one aspect of the plan was challenging to overcome at this time, etc.]. Determine patient's unique concerns and priorities, as they may change over time. Ask, what would you like to do next? [If patient dialogue contains mostly sustain talk, clinician can "soften sustain talk" by selective inattention, and "cultivate change talk" by exploring potential desires, abilities, reasons, or needs to change (DARN)].

The specialty trains physicians to perform three core functions (i.e., community medicine, population medicine, and clinical preventive medicine) and ten essential services within those three core functions that are critical to public health, medicine, and society writ large (Jadotte & Lane, 2021a). For example, PM physicians collaborate with primary care providers to implement lifestyle medicine

interventions for their patients, a service that requires not only knowledge of the six pillars of lifestyle medicine (i.e., nutrition, physical activity, sleep, emotional wellness, avoidance of risk substances such as tobacco and alcohol, and social connectedness) and the interventions tied to them, but also expertise in and competent application of effective health behavior change techniques in clinical practice (such as BAP, MI, and BAP-MI). Preventive Medicine physicians are also expert consultants for all clinical preventive services (e.g., evidence-based screenings, chemoprophylaxis, and vaccinations) and community preventive services (i.e., evidence-based population-level interventions in the community and in the healthcare system, particularly those that are synergistic with clinical preventive services, such as public health campaigns to increase screening rates and vaccine uptake).

Given this significant role in integrating primary care and public health (Institute of Medicine, 2012), preventive medicine physicians must be not only proficient at health behavior change, they must also be efficient as well, in order to overcome the aforementioned time and resource constraints of health systems and health insurance mechanisms that remain centered on curative rather than preventive care. Facing this reality, many PM residency programs in the United States have adopted MI, BAP, or BAP-MI as methods to prepare their graduates to lead these efforts in clinical and public health practice. What follows is a formative description of how one residency program has structured this training in health behavior change methodologies for its trainees.

The Stony Brook University (SBU) PM residency was established in 1984 and is one of the longest operating PM residency programs in the United States. Residency training in PM consists of the completion of 1 year of preliminary clinical training in another specialty, usually internal medicine, pediatrics, or family medicine, followed by 2 years of training in PM, which includes the completion of a graduate degree in public health, in addition to hands-on work during supervised rotations at various sites, including hospitals, clinics, federally quality health centers, and state or local public health departments. In 2018, the SBU residency program implemented a 2-year comprehensive and longitudinal health behavior change counseling training program to optimally prepare residents to apply these approaches in clinical practice. The program consists of three components designed to be adoptable and adaptable by other PM residency programs, by using a combination of pre-planned online didactics and guided, hands-on, practicum-based live sessions. First, during the first two months of PM residency training, all new residents participate in an intensive "BAP: Core Competencies" course (www.BAPprofessionalnetwork.org) that combines an 8-h online curriculum with self-directed and interactive modules (including didactics, demonstration videos, and "field exercises") that the residents complete independently and asynchronously with 6 h of supervised live practicum sessions with faculty (i.e., 4 sessions of 90 min each). The online modules provide residents with core knowledge as well as basic experiential components they need to actively participate, engage, and benefit from the live practice sessions. The live sessions are delivered by faculty at the host institution as well as faculty working remotely, which facilitates the ease of adoption beyond a given institution.

The BAP core competencies training provides foundational experience with the key elements of BAP including practice using the BAP algorithm in real time, including first through repetition and verbatim recitation of the words in the BAP algorithm until familiarity is established and the resident can conduct a clinical interview using BAP without visually referring to the "BAP Flow Chart"; guided practice with repetition for each of the 8 competencies of BAP, including the 5 core competencies and the 3 stepped-care competencies; and practice using both role play (when a clinical scenario is simulated) and real play (when residents are willing to share their actual health goals as part of the clinical interview process). The "Spirit of MI," emphasizing partnership and autonomy support, is included in both the online course and the face-to-face practicums. At the conclusion of the 8-h online modules, with 6 h of live practicums, residents are expected to reach criterion-levels of BAP competency, as measured by the BAP Checklist (www.BAPprofessionalnetwork.org), which includes proficiency in all eight core skills as well as a score of 4 or 5 on the "partnership" global measure from the MITI (Motivational Interviewing Treatment Integrity) scale (Moyers et al., 2016). The BAP didactics and live practicum sessions are supplemented with a concurrent course in lifestyle medicine (LM) that is modeled similarly using online asynchronous modules (amounting to 32 h of learning of core content) that are completed independently, combined with live practicum LM sessions with faculty feedback. In this way, after the first two months of training, the residents have the requisite knowledge and experience to begin applying BAP as part of their LM clinical practice at different rotation sites.

Second, during the remaining 10 months of the academic year, residents participate in monthly 1-h live practicum sessions that focus on the clinical application of more advanced skills in BAP-MI and MI, building upon what they have learned during the first summer. During these months, the BAP core competencies are enhanced and enriched with selective introduction of the more complex, advanced behavior change skills of MI. A prerequisite for each of these sessions is the concurrent completion of another 8-h self-directed online course entitled "BAP-MI: Advanced Skills" (www.BAPprofessionalnetwork.org). Concepts and skills covered in the advanced online course with didactics, video demonstrations, and field exercises include the core skills of MI ("OARS", which stand for open ended questions, affirmations, reflections, and summarization), the Spirit of MI, the use of relational (i.e., empathy and partnership) skills of MI, recognizing and responding to change talk and sustain talk, the use of the 4 global scales of the MITI (Motivational Interviewing Treatment Integrity Scale) (Moyers et al., 2016), and versatile and flexible use of BAP probes as well as the full BAP roadmap for change, within MI-inspired conversations of change.

Although the Stony Brook University PM residency program integrates these sessions into a unique Population Health Rounds teaching model designed to optimally prepare PM residents to practice the full scope of the specialty (Jadotte & Lane, 2021b), the fundamental and replicable aspects of this training are that the residents must complete all core didactics (for which readily available online modules exist); they must do so as pre-requisites to maximize pedagogic uptake

during the live practicum session; PM faculty must be willing to learn BAP and BAP-MI (which includes basic MI) in order to serve as course facilitators, or to recruit colleagues who can fulfill this role, even if working remotely; and the teaching program must be longitudinal, over at least one full year of residency but preferably during all years of residency in order to achieve criterion-level proficiency (Schwalbe et al., 2014). Optionally, formal assessments of competency in BAP and BAP-MI can be incorporated into the residency curriculum where possible, such as through an objective structured clinical exam (OSCE), or by seeking certification from existing non-profit entities that promote and support BAP and BAP-MI, such as the BAP Professional Network (BAPPN). Models and resources for how to implement this teaching during PM residency have been disseminated and are widely available (Cole & Jadotte, 2023; Jadotte et al., 2023). Experience to date suggests high levels of learner acceptance and appreciation of the learning value of the online trainings in both BAP and BAP-MI, as shown in the Fig. 1 below, courtesy of the BAPPN.

5 The History of Present Health Status (HPHS): A New Structure Proposed for the Clinical Interview in Preventive Healthcare

One of the most significant challenges facing clinicians whose practice focuses on preventive care (such as preventive medicine physicians, health and wellness coaches, positive psychologists, and lifestyle medicine practitioners) is that healthcare is mostly a disease-centric endeavor (Mittelmark et al., 2022). From the education of healthcare professionals to the personal life habits of patients (Jonas, 1982), the mantra of healthcare is inherently oriented toward the prevention,

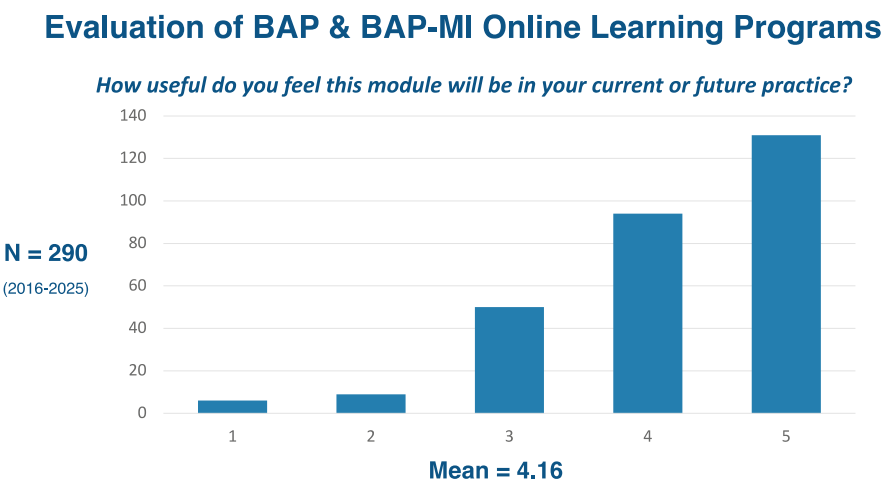

Fig. 1 Cumulative learner evaluations of BAP and BAP-MI online learning programs, from multiple US-based residencies and medical schools, during years 2016–2025

identification (via screening or diagnosis), and treatment of disease and illness. Consequently, all aspects of the healthcare endeavor focus on disease and illness, including during the clinical encounter and the co-construction of the narrative with the patient. For example, the clinical interview names the initial phase of co-constructing the narrative the "history of present illness" or HPI, implying in the linguistic roots of the clinical encounter framework that the narrative of concern (i.e., the narrative worth capturing in the textual data of the clinical encounter documentation) requires the identification of a current illness or ailment (or possibly a disease if it can be diagnosed).

In the HPI, this narrative requires identification of a "chief complaint," or "chief concern," yet another disease-centric framing of the narrative that cognitively dismisses patients without a disease or illness at the time of the clinical encounter. Billing and reimbursement for the clinical encounter requires that clinicians identify both an illness-oriented chief complaint/concern and narrate a history of present illness (Goldberg, 2004), among other factors. If even in the narrative of the patient's clinical history there is no room for health and wellness linguistically, conceptually, or financially, what hope is there to ever help patients achieve optimal health and wellness via the clinical encounter? The current approach to the clinical interview encourages both patients and clinicians to continue to disengage in the ongoing work of health and wellness for prevention whenever illness or disease are absent: studies have shown that physicians tend to provide health behavior change counseling mainly when the patient has a new or acute health problem or health habit trigger (Chernof et al., 1999).

Fortunately, there has been some progress toward redressing this issue. For example, scholars have proposed a restructuring and replacement of the HPI with the chronology of present illness (CPI), which adopts a time-based written format to document the chronology of the patient's symptoms without omission, and to actively map the symptoms, activities performed, and treatments sought within the timeline, while avoiding the traditional prose-style of the HPI (Mazer et al., 2017; Skeff, 2014). This style is congruent with function two in the three function approach, where a key recommended element of co-constructing the narrative is to elicit the chronologically grounded history, but unfortunately this history is still illness or disease-centric, which is much less compatible with preventive care when the patient is neither ill nor experiencing an acute or chronic disease. Since the time-tested adage is that "an ounce of prevention is worth a pound of cure," it would behoove practitioners of preventive care (and the healthcare systems they are embedded in) to seek ways to optimize prevention for the clinical care of patients long before they are ill (i.e., symptomatic) or have a detectable disease. Yet to date, little attention has been given to ways to achieve this goal.

Starting with the linguistic roots of the framing of the narrative within the clinical encounter, one potential approach to addressing this issue is to simply begin by reframing the HPI to the "history of the present health status" (HPHS), replacing the narrow and disease-centric term "illness" with the broader and more inclusive term "health status." This would make conceptual room (for the patient, the clinician, and maybe even the healthcare system) for both illness and wellness in the

co-construction of the narrative of the clinical encounter, such that clinicians would consider connecting with patients with equal vigor and attention when they present with any health goal, regardless of whether this health goal is tied either to an illness or disease, or to a desire to optimize wellbeing even in the absence of a defined illness or disease. It has been the authors' experience in teaching BAP and BAP-MI to preventive medicine residents, as well as in applying these methodologies in clinical preventive medicine practice, that making linguistic and conceptual room in the clinical interview for health and wellness without focus on disease or illness can be beneficial to the formation and maintenance of health behavior change habits for all patients. Combine this with evidence that health behavior change interventions, particularly those of lifestyle medicine, are most impactful on health outcomes when implemented before the incidence of clinical disease (Rippe, 2018), and evidence that successful health behavior change requires long-term engagement and habit formation (including during times without any specific illnesses), there is a case to be made for considering adopting a history of present health status as a framework to advance early prevention.

Table 4 present a sample outline of what the history of present health status could entail and how it may be integrated into a clinical encounter using BAP and BAP-MI, with a focus on clinical preventive medicine practice, including lifestyle medicine. One corollary of this approach that is congruent with BAP and BAP-MI is the idea that the narrative should be driven by a "chief health goal" (which aligns with the purpose, intent, and method of BAP and BAP-MI), thereby respecting the patient's autonomy to choose whether the narrative will be structured around a "complaint" (i.e., an illness or disease) or desire to optimize health and wellness. The authors' clinical experience has shown that there is always a chief health goal that each patient would like to work on, even when there is no chief complaint per se. Similarly, the HPHS helps the PM physician hone in on clinical areas to explore with the behavioral menu at the level of BAP core competency questions 1 or 2, when the patient is ambivalent about a health goal or about what interventions are available to address this goal, respectively. Lastly, this approach to taking the initial portion of the patient's clinical history makes room for the clinician to use the various readiness scales (i.e., the importance scale for connecting with the patient and goal setting, and the confidence scale for assessing for ability to implement a given collaboratively proposed plan), which are key elements of stepped-care in BAP and BAP-MI.

6 Conclusion and Future Directions

BAP-MI is a stepped-care integration of BAP and MI that is designed to facilitate an effective health behavior change counseling approach for patients with ambivalence about changing persistent unhealthy behaviors. The BAP algorithm serves as the backbone that guides the clinician's initial approach to the clinical encounter for all patients with whom rapport is established, but when using BAP-MI, especially for patients with ambivalence about changing persistent unhealthy behaviors, this algorithm is enhanced at strategic points during the clinical encounter to apply MI

Table 4 Outline of the history of present health status (HPHS) and other health-centric modifications of the clinical narrative, in the context of clinical preventive medicine practice

Narrative elements of the patient history during the clinical encounter	Health-centric (modified)	Disease-centric (traditional)
Linguistic framing of the present/initial history	History of Present Health Status (HPHS): does not assume illness is present and makes room for healthy patients to be the subject of the clinical encounter	History of Present Illness (HPI): assumes illness is present which excludes those without current illness
Principal aim of the clinical visit	Chief Health Goal: concern may or may not be based on a disease or illness	Chief Complaint: concern is based on disease or illness
Past medical and other related patient histories	Medical, social, family history, current medications and other health and wellness interventions	Medical, social, family history, current medications
Examples of typical elements to gather in the present/initial history	Nutrition: 24-h multi-pass recall, food frequency questionnaire, ABCD assessment Physical activity: Current physical activities (frequency, intensity, timing) Sleep: Typical weekday/ weekend sleep, perceived sleep quality, red flags Emotional wellness: PHQ-2, PHQ-9, use of past interventions (e.g., yoga) Alcohol use: CAGE, AUDIT 1-2-3, AUDIT 10 screening Tobacco cessation: Ask/advise model Age-appropriate clinical preventive services (i.e. preventive medications, vaccines, screening tests, behavioral counseling)	Disease or illness or symptom onset, duration, intensity, location, radiation (often the emphasis is on a particular "pain" as a chief complaint) Associated symptoms Associated medical conditions Environmental cues chronologically linked with the disease or symptoms

and TFA evidence-based skills (e.g., reflection, empathic alignment, affirmation, eliciting change talk in the health narrative for change, etc.). The authors suggest that preventive healthcare, in particular the medical specialty of preventive medicine and the field of lifestyle medicine, would benefit from development and implementation of a new structural element of the clinical interview, the history of present health status (HPHS), to serve as a template and guide to inspire greater implementation and application of BAP and BAP-MI in clinical practice and in the training of future health professionals. BAP-MI can also be a helpful approach to aid physicians, other clinicians, and all health professionals overcome some of the structural constraints of the clinical encounter, such as lack of time to engage patients in prolonged health behavior change counseling. The integrated approach of BAP-MI can bridge the

knowledge-to-practice skills gaps that persist when trying to learn and apply complex health behavior change methods such as MI. Lastly, the authors believe that the worsening global chronic disease epidemic requires urgent implementation of pragmatic approaches, such as BAP and BAP-MI, to address the health behavior changes necessary to meaningfully impact population health outcomes. It is the authors' hope that this chapter can help advance these aims.

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