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

Cole S, Ahuja T, Koutsenok I, Frankel R, Jadotte Y, Romero C, Sannidhi D, Stein R
November, 2021
CLP 2021 Disclosure: All Presenters

NO CONFLICT OF INTEREST

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

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

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

## Two-Hour Pre-Course

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<td>II</td>
<td>Brief Action Planning (BAP): Core Skills</td>
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<td>III</td>
<td>BAP-MI: Stepped Care Approach (Overview)</td>
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<td>III</td>
<td>Motivational Interviewing for Busy Clinicians</td>
<td>Koutsenok</td>
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<td>IV</td>
<td>BAP-MI in Four Academic Institutions</td>
<td>Stein, Ahuja, Jadotte, Sannidhi/Romero</td>
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## Live Course (2 Hours): Brief Review, Practice of Skills, Q and A

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<td>II</td>
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<td>III</td>
<td>BAP: Small Group Practice of Skills (Groups of 3) (Real Play)</td>
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<td>Plenary Discussion/Q and A</td>
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<td>BAP-MI: Small Group Practice of Skills (3 Groups)</td>
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<td>VI</td>
<td>Plenary Discussion/Q and A/Next Steps</td>
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Two-Hour Pre-Course Didactic

I. Introduction and Overview
   Cole
   05 min

II. Brief Action Planning (BAP): Core Skills
    A. Demonstration/Videos
    B. Presentation of BAP Skills
    Cole
    25 min

III. BAP-MI: Stepped Care Approach (Overview)
     Cole
     05 min

IV. Motivational Interviewing for Busy Clinicians
    Koutsenok
    40 min
    A. Spirit of MI
    B. Ambivalence
    C. OARS
    D. Change Talk/Sustain Talk

V. BAP-MI in Four Academic Institutions
   Ahuja, Jadotte, Sannidhi/Romero, Stein
   40 min

VI. Summary/Conclusion
    Cole
    05 min
Acknowledgements*

Connie Davis
Damara Gutnick
Kathy Reims

Centre for Collaboration, Motivation, Innovation

*for contributions to development of BAP and for several slides in this presentation
BAP: Brief Action Planning

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

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What is Brief Action Planning (BAP)?

General Definition

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

An MI-relevant definition
(For practitioner’s of Motivational Interviewing)

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

- **Core Skills**
  - [https://www.youtube.com/watch?v=w0n-f6qyG54](https://www.youtube.com/watch?v=w0n-f6qyG54)

- **Advanced Skills**
  - [https://www.youtube.com/watch?v=262CjvURVn0](https://www.youtube.com/watch?v=262CjvURVn0)
VIDEO 1
VIDEO 2
“Is there anything you would like to do for your health in the next week or two?”

SMART Behavioral Plan → Elicit a Commitment Statement

“How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?”

“Would you like to set a specific time to check in about your plan to see how things have been going?”
Brief Action Planning: Evidence

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

www.BAPProfessionalNetwork.org
www.CentreCMI.ca
Spirit of Motivational Interviewing

- Compassion
- Autonomy Support
- Partnership
- Evocation
Brief Action Planning (BAP): Uniquely Pragmatic Tool for Telemedicine

- Highly structured, pragmatic, and time efficient
- Intuitive
- Versatile: can be used by wide range of providers across diverse skill levels
- In wide use currently
  Google search = thousands/millions of results (12/2020)
Brief Action Planning (BAP): Uniquely Pragmatic Tool for Telemedicine

- Evidence-informed with emerging evidence-base
  (16 peer reviewed publications to date)

- BAP “relatively” easy to teach/learn/use

- Can be mastered with online learning + zoom sessions
BAP Online Training:
Self-Directed with 4 Teleconferences

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

N=19
Residents/Faculty in Preventive Medicine
Stony Brook Medicine and
UC San Diego Health

July-August 2020
4 sessions (90 min each)
Online Self-Directed Learning + 3 Field Exercises
How Useful Do You Feel This Program Will Be In Your Current or Future Practice?

N = 19
Mean = 4.33
BAP-MI: A Stepped-Care Approach to Health Behavior Change

• Use BAP for patients who are willing/able to make action plans for health

• Use BAP-MI for ambivalent patients not willing/able to make BAP action plans at first
BAP-MI: 3 Steps

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

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

III. Re-probe with Question #1 of BAP (when clinically appropriate as “change talk” increases)
III. Use MI skills for patients unwilling/unable to make action plans w/BAP

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

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

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

(eg smoking, medication nonadherence, exercise, problems at work/home etc)
A Metaphor for BAP-MI: BAP “Bookends” MI
IN BAP-MI, Sometimes, BAP is Sufficient for SMS and HBC

- With engagement/connection
- With Spirit of MI
Sometimes, BAP-MI
Begins with MI and Concludes with BAP
BAP-MI is Adaptable and Flexible: Comes in Many Flavors/Styles
BAP-MI is an approach potentially useful for many patients seen on C-L Services who are ambivalent about....

- Smoking
- Unhealthy use of alcohol
- Unhealthy use of pain or other prescription medications
- Unhealthy use of illicit drugs
- Sedentary behavior
- Unhealthy eating behaviors
- Many other unhealthy behaviors
Motivational Interviewing for Busy Clinicians

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

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I guess you would agree with me that effective treatment of patients with a variety of acute and chronic conditions is impossible without changes in the patient’s behavior?
If you agree, here is the $10 M question:

Why people don’t just change?
You would think . . .

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

and sometimes it does . . . .
Yet so often it is not enough. **Why?**
Common beliefs why people do not change

The problem with them is ...  
- They don’t **SEE** the problem (denial, lack of insight)  
- They don’t **KNOW HOW** to change  
- They simply don’t **CARE**
So, if these explanations are true, there are simple solutions, and you don’t need this lecture

- Give them **INSIGHT** and **KNOWLEDGE**, and they will change
- Give them **SKILLS** *how* to change, and they will do it
- **SCARE** them- make people feel *bad or afraid* enough, and they will change
So, what does it take to make a transition from Contemplation to Action?
What is Ambivalence?

- Ambivalence is having two contradictory thoughts about the same thing (“should I, or I should not…?”)
- Ambivalence is exactly the material that Motivational Interviewing works with
1. Ambivalence is a reflection of my relationship with the PROBLEM

2. Resistance is a reflection of my relationship with YOU

3. Resistance is a result of interaction, not a symptom of any pathology

4. Resistance is the Ambivalence Under Pressure

5. Resistance is indicative of a possible breakdown in the relationship
Assumptions of MI

• Ambivalence is normal

• Motivation is dynamic

• Most people know the solution even if they are reluctant to use it
Motivational Interviewing is a collaborative, person-centered, and directive communication style to elicit and strengthen motivation for change and address the common problem of ambivalence.
VIDEO 3
How Do We Roll with Resistance?

- Avoid arguing for change (you will really have a hard time arguing with me if I do not argue with you)

- Resistance is a signal to respond differently - Shift the direction

- Listen and reflect
VIDEO 4
Effectiveness of MI (1500+ clinical trials)*

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

*Personal communication, Wm Miller, 2020  
www.motivationalinterviewing.org
Fundamental Interactive Communication Skills

OARS

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

Bridge the gap by reflection

1. What the speaker means
2. What the speaker says
3. What the listener hears
4. What the listener thinks the speaker means

SPEAKER

LISTENER
Why the Emphasis on Reflection?

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

- The most effective way to address resistance, explore ambivalence, and elicit internal motivation
- The most difficult skill to master
- Reflections are always statements, not questions
- Drop voice at end of sentence
- Examples of stems:
  - “It sounds like you….”
  - “You are feeling….”
  - “You’re wondering if…”
VIDEO 5
Listen for What?

- Recognizing
- Reinforcing
- Eliciting

Change Talk
Change talk vs. Sustain talk

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

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

- Both are always present
VIDEO 6
Signs of Increasing Motivation for Change

- Decreased resistance
- Decreased discussion about the problem
- More change talk
- Questions about change
- Experimenting
What do you do when you hear “sufficient” CHANGE TALK?

- This indicates significantly decreased ambivalence and potential readiness for change.
- Return to BAP
- “Listening to what you’ve been saying, I wonder if you’d be interested in going ahead and making a plan about your smoking...?”
BAP-MI Education: Medical School and Residencies

- Zucker School of Medicine at Hofstra/Northwell
- Stony Brook Preventive Medicine Residency
- UC San Diego Preventive Medicine Residency
- University of North Carolina School of Medicine
BAP-MI is Adaptable and Flexible: Comes in Many Flavors/Styles
Training First Year Medical Students in Brief Action Planning (BAP)

Taranjeet Kalra Ahuja, DO, MSEd
Assistant Professor of Science Education & Pediatrics
Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

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Curricular Context

- Four-year longitudinal communication skills curriculum

- During the first 7 weeks of medical school, the students learn skills to co-construct a complete history, build trust and empathize

- Subsequent courses build on this foundation with advanced specialized skills
  - One example being Brief Action Planning
Curricular Setting

- Most communication sessions begin with a large-group framing with all 100 students ~30 min

- Students then break off into longitudinal cohorts ~80 min
  - 2 Faculty to 8 Students
  - Small groups focused on skills-based training
  - Role-play with coaching and opportunities for re-practice
What is the curricular focus when BAP is taught?

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

- Learning Objectives of BAP Session
  - Define the spirit of motivational interviewing
  - Define the steps in BAP
  - Appreciate BAP as a tool useful for behavior change to improve health
  - Practice the core skills of BAP

- Prework
  - Web-based Introductory Training in BAP (90 min)
BAP Class Plan (Continued)

- Large Group Session:
  - Framing Lecture on Brief Action Planning ~25 min

- Small Group Session:
  - Faculty Demo of BAP with Debrief
  - Students Provided with Case Vignettes to practice BAP:

  **Initial BAP**
  - Student A plays patient A; Student B plays doctor (10 min)
  - Student B plays patient B; Student A plays doctor (10 min)
  - Debrief with the whole small group (5 min)

  **Follow-up BAP**
  - Student A plays patient A; Student B plays doctor (10 min)
  - Student B plays patient B; Student A plays doctor (10 min)
  - Debrief with the whole small group (5 min)
Reinforcement of Skills

- BAP skill learned and practiced in small-groups with coaching from communication faculty facilitators

- Required to practice with patients in their longitudinal ambulatory clinics

- Assessment Drives Learning!
  - BAP assessed in Objective Structured Clinical Examinations (OSCEs)
True Story!

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

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

- Dr. Joseph Weiner
- Dr. Steven Cole
- Dr. Richard Frankel
- Dr. Alice Fornari
- Faculty and Students at the Zucker SOM at Hofstra/Northwell
Motivational Interviewing (MI) and Brief Action Planning Training (BAP) in Residency: A Longitudinal Model for Preventive Medicine

Yuri T. Jadotte, MD, PhD, MPH
Assistant Professor & Associate Program Director of Preventive Medicine Residency
Department of Family, Population and Preventive Medicine
Renaissance School of Medicine at Stony Brook University
Objectives

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

1. Define the role of the Accreditation Council for Graduate Medical Education (ACGME) in health behavior change counseling training during residency.

2. Explain how Motivational Interviewing and Brief Action Planning can be formally integrated into residency training.

3. Describe approaches for the graduated preparation of resident learners in MI and BAP.
Needs Assessment: ACGME Competencies and the Program Mandate for Behavioral Health Training

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

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

- 2-year Preventive Medicine (PM) residency (PGY2 & 3) + MPH or other relevant graduate degree & coursework
- PM residents train in preventive care:
  - Community medicine → public health
  - Population medicine → population health
  - Clinical preventive medicine (CPM) → health and wellness
- CPM entails
  - Lifestyle medicine
  - Clinical preventive services (i.e. USPSTF screening, behavioral counseling, and chemoprophylaxis)
  - Evidence-based integrative medicine (optional)

**No specific approaches are recommended or required by the ACGME for behavioral counseling training**
Innovation: Longitudinal MI/BAP Training for Junior PM Residents

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

- September-June: 6-month rotation in lifestyle medicine and smoking cessation at VA HPDP
  - VA TEACH (patient health education)
  - MI Training
Innovation: Longitudinal MI/BAP Training for all PM Residents

- September-June annually: Six 1-hour MI Practice sessions (12 total during residency) as part of our Population Health Rounds
  - Akin to floor rounds but with a prevention focus

- Clinical and Community Preventive Medicine course
  - BAP-driven OSCE
Innovation: Longitudinal MI/BAP Training for Senior Residents

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

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


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

A Longitudinal Curriculum in Behavior Change for Preventive Medicine Residency

Deepa Sannidhi MD, Assistant Clinical Professor
UC San Diego School of Medicine
UCSD Department of Family Medicine and Public Health
UCSD Herbert Wertheim School of Public Health

Camila Romero, MD, MPH, Adjunct Professor
UCSD Herbert Wertheim School of Public Health

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Objectives

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

2. Describe the development of a longitudinal curriculum for health behavior change in Preventive Medicine Residency
Context: Push for Lifestyle Medicine Education

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

**July 14, 2010**

**Physician Competencies for Prescribing Lifestyle Medicine**

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

**Box: Suggested Lifestyle Medicine Competencies for Primary Care Physicians**

**Leadership**
- Promote healthy behaviors as foundational to medical care, disease prevention, and health promotion.
- Seek to practice healthy behaviors and create school, work, and home environments that support healthy behaviors.

**Knowledge**
- Demonstrate knowledge of the evidence that specific lifestyle changes can have a positive effect on patients' health outcomes.
- Describe ways that physician engagement with patients and families can have a positive effect on patients' health behaviors.

**Assessment Skills**
- Assess the social, psychological, and biological predispositions of patients' behaviors and the resulting health outcomes.
- Assess patient and family readiness, willingness, and ability to make health behavior changes.
- Perform a history and physical examination specific to lifestyle-related health status, including lifestyle “vital signs” such as tobacco use, alcohol consumption, diet, physical activity, body mass index, stress level, sleep, and emotional well-being. Based on this assessment, obtain and interpret appropriate tests to screen, diagnose, and monitor lifestyle-related diseases.

**Management Skills**
- Use nationally recognized practice guidelines such as those for hypertension and smoking cessation to assist patients in making changes that contribute to healthy behaviors and lifestyles.
- Establish effective relationships with patients and their families to effect and sustain behavioral change using evidence-based counseling methods and tools and follow-up.
- Collaborate with patients and their families to develop evidence-based, achievable, specific, written action plans such as lifestyle prescriptions.

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

---

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

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

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

- Lifestyle Medicine is a core competency of Preventive Medicine. (ACGME Competency MK IV.B.I.c)

- UCSD GPM Residency becomes a site for Lifestyle Medicine Residency Curriculum (LMRC) which allows a path for becoming board certified in Lifestyle Medicine.

- Vigorous curriculum:
  - 40 hours of didactic
  - 60 hours of independent application activities
  - 80 hours of Intensive Therapeutic Lifestyle Change programs
  - 400 patient encounters
BAP and MI practice, practice, practice and application

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

Exposure Track

• BAP curriculum
  • 6 hrs. of virtual/group in-person learning
  • 8 hrs. BAP online course with CME
  • Live zoom practice in break-out groups and integration of LMRC

• Motivational Interviewing
  • MI lecture series
  • Personalized feedback on MI skills

Expert track

• Participation in monthly BAP faculty development group
  ▪ BAP certification

• Psychwire Course on MI

• Experience as mentors during BAP course for the remaining residents

• Practicum Rotations
RACE-MI Curriculum: Practicum

Practical experience:

• SLIM Rotation
  • Shared medical appointment program for patients with Obesity
  • Residents follow a cohort of patients
  • Practice MI skills in small group setting

• Virtual Telemedicine Rotation
  • Behavioral health counseling for chronic disease management
  • Practice MI and BAP skills one-to-one

• Other rotations such as the Diabetes Prevention Project and Ornish Program

• Rotations fulfill practicum requirements for ACPM and LMRC
Testimonials

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

- Marsha-Gail Davis PGY-3

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

- Anastasia Maletz PGY-3


Schultz, K., Griffiths, J., & Lacasse, M. (2015). The application of entrustable professional activities to inform competency decisions in a family medicine residency program. Academic Medicine, 90(7), 888-897.
Motivational Interviewing and Brief Action Planning at the UNC School of Medicine

Curriculum Integration at Three Levels: A Work in Progress

Roy M. Stein, MD
Clinical Professor of Psychiatry
University of North Carolina School of Medicine
Associate Professor Emeritus
Duke University School of Medicine
Key points

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

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

Faculty

Addiction Medicine Fellows

Psychiatry Residents

Medical Students
Addiction Medicine Fellowship

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

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<th>Global Scores (1-5)</th>
<th>Behavior Counts</th>
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<td>Cultivating Change Talk</td>
<td>Simple reflections</td>
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<tr>
<td>Softening Sustain Talk</td>
<td>Questions</td>
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<tr>
<td>Partnership</td>
<td>Seek Collaboration</td>
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<td>Empathy</td>
<td>Affirmation</td>
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<tr>
<td>Emphasize Autonomy</td>
<td>Confront</td>
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Psychiatry Residency

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

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

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

I. Pre-Session

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

II. Zoom Course/Workshop: November 10, 2021 10 AM – 12 noon EST
A. Discuss (and Review) Concepts/Skills
B. Practice Skills in Small Groups with Feedback
BAP-MI: A Stepped Care Approach to Health Behavior Change

2 Hour Zoom Workshop
Cole S, Kousenok I, Stein, R, Ahuja T, Sannidhi D, Romero C, Jadotte Y
Agenda/Learning Goals

I. Welcome
   Cole 10 min

II. Demonstration of Brief Action Planning (BAP)
   Cole/Stein 10 min
   **Goal: Familiarize you with 5 steps of BAP**

III. BAP: Small Group Practice of BAP – Groups of 3
    Stein 15 min
    **Goal: Identify BAP skills for potential use in your clinical practice and teaching**

IV. Plenary Discussion/Q and A
    Faculty 10 min

V. MI: Small Group Practice (3 Groups)
   Stein 40 min
   **Goal: Identify MI skills for potential use in your clinical practice and teaching**

VI. Plenary Discussion/Q and A/Next Steps
    Faculty 30 min
    **Goal: Discuss integration of BAP-MI into your clinical practice and teaching**

VII. Summary/Conclusion
     Cole 05 min
BAP-MI: A Stepped Care Approach to Health Behavior Change

2 Hour Zoom Workshop
What is BAP?

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

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

BAP-MI is a stepped-care integration of evidence-informed skills from BAP and MI for self-management support (SMS) and health behavior change (HBC).
A Metaphor for BAP-MI: BAP “Bookends” MI
IN BAP-MI, Sometimes, BAP is Sufficient for SMS and HBC

• With engagement/connection
• With Spirit of MI
Sometimes, BAP-MI Begins with MI and Concludes with BAP
BAP-MI is Adaptable and Flexible: Comes in Many Flavors/Styles
BAP Demonstration
“Is there anything you would like to do for your health in the next week or two?”

SMART Behavioral Plan → Elicit a Commitment Statement

“How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?”

“Would you like to set a specific time to check in about your plan to see how things have been going?”
Breakout Groups for Practice of Skills (BAP and MI)

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

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

• All are useful for learning new skills
• In last min; write down 1-2 goals for clinical work/teaching
Practice BAP in Groups of 3:

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

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

PRACTICE
Plenary Discussion of BAP Practice

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

- 3 breakout groups
- 40 min to practice
Scenario: inpatient psychiatry consultation

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

******************************

Role-Play Instructions
You’ve completed a thorough evaluation for mood disorder, which is negative. You’re now ready to shift gears and see if the patient will engage with you in discussion of smoking cessation.
Key Points for MI Practice

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

- **D E S I R E** ("want..." "like..." "wish...")
- **A B I L I T Y** ("can..." "could...")
- **R E A S O N S** ("because of...")
- **N E E D** ("need.." "have to..." "got to...")
CHANGE TALK: DARN CATS

- **C** OMMITMENT (“intend...” “going to...”)
- **A** CTIVATION (“ready...” “preparing...”)
- **T** AKING STEPS (“started....”)

![Image of two cats]
SUGGESTED PLAN FOR MI SKILLS PRACTICE: 40 min

- 3 breakout groups (Stein/Koutsenok/Cole)

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

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

- In last min. of group, write down 1-2 goals for your clinical practice/teaching
Scenario: inpatient psychiatry consultation

Consult Request

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

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Role-Play Instructions

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

- What was your experience of MI skills?
- Observations?
- Challenges and Questions?
- Insights?
- How might BAP-MI be useful for Consultation-Liaison Psychiatry?
- Goals?
- Next steps?
BAP-MI: A Stepped Care Approach to Health Behavior Change

Summary/Conclusion

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

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

III. Re-probe with Question #1 of BAP and continue w/BAP (when clinically appropriate)
BAP-MI is Adaptable and Flexible: Comes in Many Flavors/Styles

THANK YOU!
FOR INFORMATION, FEEDBACK or QUESTIONS

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