Promote Healthy Behavior With FRAMES Method

To motivate patients, use a nonjudgmental approach that places responsibility for change on the patient.

BY HEIDI SPLETE
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WASHINGTON — The key to motivational interviewing is raising a subject without generating resistance in the listener, Sam Weir, M.D., explained at the annual meeting of the American College of Preventive Medicine.

"People are more likely to change when there is a discrepancy between their current behavior and their goals," said Dr. Weir of the department of family medicine at the University of North Carolina, Chapel Hill.

Once the physical exam and behavioral assessment is completed, summarize the results of the visit for the patient, and consider adding some motivational interviewing strategies, Dr. Weir suggested.

The FRAMES acronym is a quick and easy way to summarize and address preventive medicine issues, Dr. Weir said:

► **Feedback.** Feedback means being nonjudgmental, and saying with a straight face, "You know Mrs. Jones, drinking a six-pack of beer every night is more than most of my patients drink, and it's more than is recommended for your health."

The physician states that there is a discrepancy between the behavior and what is considered healthy, but makes no judgment. Ideally, the doctor would then ask the patient, "What do you think about that?" But when time is at a premium, move on to the next point.

► **Responsibility.** Make a statement reiterating that the problematic behavior, and the patient's reaction to it, is the patient's responsibility.

For example, you might say, "What you do about your drinking is up to you."

► **Advice.** Doctors who avoid the use of the words "should" and "need," when offering advice are less likely to generate resistance in patients.

"I encourage you to consider reducing your drinking" is better than telling the patient she should cut back; the doctor communicates respect for the patient by the way he or she phrases the advice.

► **Menu.** Choices often provide motivation for behavior change. Remind patients that there are many ways to change their behavior, and offer to help them explore their options for doing so.

► **Empathy.** Tell patients that, "It might be hard for you to make this change," because sometimes it is. However, Dr. Weir said that he avoids saying that "it is hard" to change, because for some people it is not, once they make up their minds.

► **Self-Efficacy.** A statement such as, "But I'm confident that when you make up your mind to change, you will be able to do it," reinforces the fact that behavior change starts with the patients, but the doctor believes in their ability to change and will support their efforts when they are ready.

"This FRAMES moniker is a way to give advice about a lot of things in a short period of time," Dr. Weir noted, encouraging physicians to incorporate these principles in written materials, or in other communications with patients.

In his work with medical students, Dr. Weir teaches a 30-second version of FRAMES—a short statement to use with patients that touches all the FRAMES elements, not necessarily in the same order, that can be tweaked to specific behaviors.

For example: "Mrs. Jones, I strongly encourage you to consider quitting smoking. For most people, quitting is the single most important thing they can do to improve their health. The decision to quit is yours, and yours alone. There are many different ways that people can quit, and if you do decide that you want to quit, I'm confident that you can do it. If you decide at some point that you're interested, I'd be very willing to help you look at the options."

Dr. Weir said he encourages medical students to take the FRAMES approach and write their own 30-second versions that they feel comfortable using, as long as they include all the FRAMES elements. "It's like a rosary chain; you need to touch all the beads," he said.

Dr. Weir also explained what motivational interviewing is not. "It is not arguing that a person has a problem and needs to change, it is not giving a solution without the patient's permission, and it is not taking an 'expert' stance," he said.

"[Lack of] knowledge is not as much of a deficit as ambivalence," he added. Patients usually have feelings about their behavior, and it can be important to let them hear themselves talk about these feelings and have the opportunity to reflect on them.

Dr. Weir recalled that as a younger physician, he sometimes felt that his own value as a doctor was negatively affected if a patient continued to engage in an unhealthy behavior.

When using the FRAMES technique, Dr. Weir said he prefers to sit on the small stool found in most exam rooms, with the patient sitting on the table, so the patient's position is higher than his. This arrangement makes him seem less of an expert and more of a collaborator in a patient's decision to change an unhealthy behavior. ■

If Not FRAMES, What About OARS?

The acronym OARS, adapted from the work of William Miller, Ph.D., and Stephen Rollnick, Ph.D., is another way to get the most from motivational interviewing:

► **Open-ended questions.** Motivational interviewing is the strategic use of open-ended questions, which can be the keys to a patient's decision to change a behavior. The goal is to encourage the patient to talk about his or her reasons for change. For example, "What has been hardest for you about living with diabetes?"

► **Affirmations.** Recognize the patient's strengths and express your belief in the patient's ability to change.

► **Reflective listening.** Listen without interrupting and without judgment, and use body language to acknowledge the speaker. Body language includes nodding, facing the patient, and making eye contact.

► **Summarizing.** Recap to make sure the patient has made the point. For example, "Let me see if I understand what you've said so far. You want to stop smoking, but you are afraid that you'll gain weight."

Source: Presented by Betsey LaForge of Blue Cross/Blue Shield of North Carolina at the annual meeting of the American College of Preventive Medicine.

Doctors, Patients May Benefit From Medicare Hospital Database

BY JOYCE FRIEDEN
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WASHINGTON — The new database on hospital quality from the Centers for Medicare and Medicaid Services may herald a new era in patient assertiveness in terms of health care preferences, several experts said at a briefing sponsored by the Alliance for Health Reform.

"We're beginning a change in how doctor-patient relations are established, and [considering] how paternalistic they have been, I think we'll see major changes in the future where they become less that way," said Elliot Sussman, M.D., president and CEO of Lehigh Valley Hospital and Health Network in Allentown, Pa.

"When people come into a community, they'll look at measures like this and say, 'Which are the kinds of places I want to be cared for at, and who are doctors on staff at those places?'," he said.

In fact, such changes have already begun to occur, he added.

"We've seen experiences where people change their doctor relationship because 'I really like Dr. Jones, but he's not on the staff of what seems to be the best hospital. Either he does that or I'm going to find myself a new physician.' "

CMS launched its "Hospital Compare" database on April 1. Available online at www.hospitalcompare.hhs.gov, the database looks at hospital performance on 17 different measures related to the treatment of three conditions: heart attacks, heart failure, and pneumonia. Users can search by hospital name or geographic location.

The data have not shown 'hospitals that are excellent at everything or terrible at everything, but hospitals excellent at one thing and not so great at others.'

Gerald M. Shea, assistant to the president for government affairs at the AFL-CIO, said that the feeling of partnership that comes from empowering consumers should spill over onto the physician side of the equation.

"I could make the argument that there are very serious limits to how much consumers can drive change in the health decision making process," he said. "An equally fruitful strategy would be trying to change the preparation and education of physicians, so they come to this suggesting that a partnership would be a good idea."

In fact, physicians also have much to gain from being able to access hospital quality data, said Margaret E. O'Kane, president of the National Committee for Quality Assurance.

"Physicians have been working in an information vacuum as well—both doctors involved in performing particular procedures in the hospital, and the primary care physicians who are making referrals to specialists," she said.

"We can't underestimate the impact that transparency has on changing everything. I feel very optimistic this will lead to lot of positive changes."

One panelist warned that empowerment does have its limits. Charles N. "Chip" Kahn, president of the Federation of American Hospitals, said that as databases such as Hospital Compare begin adding more measures, "it will be more and more difficult for the average consumer … to figure things out other than, 'This is either an okay place or a dreadful place' and you obviously want to stay away from dreadful places."

In the end, he said, databases like this "are more about using accountability to improve care than they are about consumers making more decisions."

Ms. O'Kane said she was confident that "intermediaries" would rise up to help consumers interpret the database information. And she also had a prediction.

"What we've seen so far is not hospitals that are excellent at everything or terrible at everything, but hospitals that are excellent at one thing and maybe not so great at others," she said.

"As process engineering becomes more core to the hospitals, you'll see hospitals that will break out and be excellent across the board," Ms. O'Kane predicted. ■