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Negotiation Training for Case Managers to Improve Older Adult Acceptance of Services

Mobola Campbell, MD, MPH,

faculty in Hospital Internal Medicine at Mayo Clinic. She has been involved in medical education, developing a Health Disparities and Social Justice curriculum for resident physicians. She also has led the Health Equity and Advocacy Clinical Scholars Program

Anne Seltzer, LCSW,

licensed social worker in the Division of Geriatrics at Northwestern University where she facilitates services for older adults who are in need of assistance

Vanessa Ramirez-Zohfeld, MPH,

health services researcher in the Division of Geriatrics at Northwestern University, focused on older adults, caregiver support, and connecting older adults with social services following a hospitalization. She regularly works in the community facilitating full partnership in patient-centered outcomes research

Lee A. Lindquist, MD, MPH, MBA

Chief of Geriatrics at Northwestern University Feinberg School of Medicine, with research focused on connecting older adults and their families to services in order for them to age-in-place safely

Abstract

Purpose of Study: Older adults frequently choose not to accept recommended social support services (e.g., caregiver and home therapy). Social workers/case managers (SWs/CMs) are often caught in the conflict encouraging patients to accept services, but facing resistance. As a result, older adults may experience unsafe home scenarios and hospital discharges. This research sought to examine whether business school negotiation and dispute resolution (NDR) training could ease these conflicts and potentially improve outcomes for both older adults and SWs/CMs.

Practice Settings: Urban health care system (pilot), national case management conference (implementation).

Methodology and Sample: Researchers tailored the NDR training, offered at graduate business schools, for SWs/CMs. Researchers then pilot tested the NDR training at an urban hospital and implemented it with a national cohort of SWs/CMs at a national case management conference. Participants completed a survey that ascertained conflicts, utility of the NDR program, real-world applicability, and future directions.

Address correspondence to Lee A. Lindquist, MD, MPH, MBA, Division of General Internal Medicine and Geriatrics, Northwestern University, Feinberg School of Medicine, 750 N. Lake Shore Drive, 10th Floor, Chicago, IL 60611 (LAL425@northwestern.edu).

The authors report no conflicts of interest.

Results: Eighty-five SW/CM participants, from 22 states, completed the NDR training and survey. Participants reported experiencing conflicts frequently in their workday. Post-NDR training, respondents were very positive about the knowledge gained from the course, specifically noting themes of learning the negotiation basics, tactics (e.g., framing), and integrative strategies (e.g., win-win/expanding to multi-issue discussions). All participants planned to use the NDR skills in the future.

Implications for Case Management Practice: The NDR training program can provide SWs/CMs with formal strategies to facilitate older adults' acceptance of social services while balancing patient autonomy. Learning negotiating techniques can be "win-win" for both older adults' home safety and case manager well-being.

Keywords

communication; continuing education; geriatrics

Over time, older adults face increasing rates of functional loss and require the use of longterm social services in order to live safely in their own homes (Lindquist et al., 2016; Willink et al., 2017; Wolff, Spillman, Freedman, & Kasper, 2016). Although identifying these needs is important, older adults must choose to accept these services (Lindquist et al., 2017; Rajanala, Ramirez-Zohfeld, O'Conor, Brown, & Lindquist, 2020; Tang & Lee, 2010). Research has shown that older adults do not accept social support services because they feel that they are losing independence, dislike burdening others, and distrust support services (Lindquist, Ramirez-Zohfeld, Forcucci, Sunkara, & Cameron, 2018). When older adults do not accept support services, they are more likely to be rehospitalized, face increased morbidity, and endanger themselves and others (Avery, Kleppinger, Feinn, & Kenny, 2010). Often caught in the midst of these conflicts are social workers and case managers (SWs/CMs) who are tasked with arranging support services for older adults—balancing the older adults' right to self-determine/patient autonomy with maintaining patient and community safety.

Many SWs/CMs have been taught motivational interviewing, which is the person-centered strategy of eliciting a patient's motivation to change a specific negative behavior interaction skill through asking open-ended questions, reflective listening, affirming, and reiterating statements back to the patient (Miller & Rollnick, 1991). Although motivational interviewing can be effective in behaviors such as tobacco cessation or medication adherence, a key tenet is that motivational interviewing works best when people are motivated to change their behavior. Often, older adults are not motivated to receive support services, and endanger themselves in trying to maintain their independence. Motivational interviewing usually involves multiple interviews and expanded time needs, which may not always be possible in arranging support services for older adults. As a result, SWs/CMs may face frustration and increased burnout in dealing with at-risk older adults who resist services. Researchers sought to examine alternate means of communication training for SWs/CMs that could potentially be done in a shorter period and with people who may be unmotivated to change.

Negotiation is a process by which two or more parties try to resolve perceived incompatible goals (Carnevale & Pruitt, 1992). Effective negotiators have the ability to persuade others without using manipulations and can maintain a positive atmosphere during tense negotiations (Teucher, Brett, & Gunia, 2013). Most theories of negotiations share the notion of negotiations as a process. A frequently cited and utilized model of negotiation is the Brett model, which has a centralized negotiated outcome and two (or more) people converging through negotiators' interests and priorities as well as strategies and social interactions (Brett & Thompson, 2006). This model concentrates on psychological factors (cognitions and biases, personality, motivation, emotions, and trust) and social–environmental factors (e.g., reputation and relationship, gender, power and status, and culture). Fisher and Ury produced a practical guide to negotiations, *Getting to Yes* in 1981, which used frameworks for preparation (e.g., gaining information, identifying party interests, and alternatives) and tactics (e.g., anchoring and expanding the pie) (Fisher & Ury, 2011). Because negotiation is an established practice of mediation communication, it has become a recognized standard in business and law school curriculums, with dedicated negotiation and dispute resolution (NDR) departments and extensive coursework (DeMarr & De Janasz, 2012). The field of NDR has advanced rapidly from with negotiations specific to content (e.g., professional sports contracting), cross-cultural, power, multiple parties, and form (e.g., in-person vs. electronic) (Druckman, 2004).

Although many law and business schools teach negotiation, most schools of social work and health care do not include negotiation as part of their curriculum. Subsequently, most SWs/CMs do not receive formal training on how to negotiate with older adults and effectively resolve conflicts. This research sought to provide case managers and social workers with NDR skills to overcome conflicts that occur as they advocate for the optimal care of older adults and evaluate their acceptance of NDR in their daily work lives.

Methods

The NDR Training

Didactic Lecture—The NDR training begins with a 30-negotiation lecture modeled after "Negotiations 101" from a university-based graduate business school curriculum. Interwoven in the lecture are case examples related to the conflicts experienced by SWs/CMs and older adults, with instruction on how to use NDR in the real world. The NDR lecture content includes information on the basics of negotiation. For example, negotiations can be distributive, meaning that one party loses and one party wins, or integrative, meaning that both parties "win" by reaching a mutually beneficial decision. Distributive negotiations are usually single issue, where parties argue over one decision. In health care, distributive decisions occur when a case manager states, "You need a caregiver at home," and the older adult agrees or disagrees to it. Single-issue negotiations are strongly avoided because one party always feels a loss, which erodes the relationship. With NDR, people are taught integrative negotiations, sometimes termed "win-win" or "expanding the pie." With integrative negotiations, people are taught to leverage multiple issues. This integrative negotiation is not a flat-out "no" but a collaborative effort to look at multiple issues. Included in the didactic lecture, NDR teaches tactics that can be used to effectively add

issues or respond to disputes (Fischer et al., 2010; Ury, 2007). One example of a tactic is anchoring. Most retail stores use anchoring to convince customers they are getting a sale when they actually may be paying more than what an item costs (e.g., “That hat retails at $40 but today it is half price.” A customer feels it is worthy of a purchase and pays $20 when, in fact, the hat costs $10.) SWs/CMs are taught that they can use anchoring in their daily work, such as arranging caregiver support. “No one wants to go to a nursing home—instead, let’s get you someone to help you at home and keep you out of the nursing home.” Spin is another tactic taught, with using different terminology for caregivers. Instead of arranging a “caregiver” for a hospitalized patient, SWs/CMs can arrange a “personal assistant, chef, driver” all-in-one. Spinning the term “caregiver” or “helper,” which implies disability in the recipient, into an active position that would be used by a busy 50-year-old is more palatable to acceptance.

Role Modeling Activities—Following the lecture, attendees are placed into pairs to resolve a conflict with one being assigned the “SW/CM role” and the other being the “older adult.” Each pair is provided with scripted backgrounds and motivation. An example case study used is where the older adult lives alone and has no family, experiences frequent falls, multiple hospitalizations, and weight loss. The older adult is hospitalized again for a fall, but is very concerned about placement in nursing home (if they accept support). The SW/CM is tasked with negotiating either in-home support (e.g., caregiver/personal assistant) or placement in a senior community. This scenario is very common to the real-world tasks of many SWs/CMs. Pairs are given 20 min to negotiate and practice the tactics that they learned.

After the practice, the moderator then debriefs and walks through possible NDR tactics that could have been utilized. The entire training and practice took about 60 min.

Participants

Initially, the NDR training was conducted with a group of SWs/CMs at a university-based academic hospital. Subsequently, the NDR training was then implemented with a national larger group of SWs/CMs at an annual conference of case managers. In the pilot, SWs/CMs learned about the NDR training through electronic email bursts announcing the program and inviting participants. At the annual conference, participants learned about the training from the paper/electronic programming information (e.g., prospectus and conference program).

Measurement

Participants were asked to complete a survey upon completion of the NDR training. Surveys were considered exempt by the Institutional Review Board because no health information or personal identifiers were collected. Surveys included questions on demoraphics, work history, conflict at work, handling of conflicts, satisfaction with NDR training, acceptance, and perceived benefits of NDR training.

Data Analysis

Qualitative analysis was utilized to evaluate responses from the open-ended questions in the electronic surveys. Responses were analyzed using constant comparative techniques and

grounded theory (Ritchie & Lewis, 2003). Coders independently assessed subject responses for focal themes, and then convened to compare and compile findings, creating a preliminary list of categories and major themes. Identified themes were discussed and refined through a series of coder meetings, during which coders triangulated their perspectives and resolved any identified discrepancies through discussion. The coders organized the content into themes relevant to participants' discussions of how effective was the NDR training (Creswell, Klassen, Plano-Clark, & Clegg-Smith, 2011). Previous research has shown that 8–12 interviews are enough to reach thematic saturation in qualitative studies, which parallels our own experience (Small, 2009).

Results

The survey was completed by 85 participants who identified themselves as social workers (98%) and case managers (2%). The survey response rate was 80.9% (85/105). Respondents were an average age of 36.3 years (range 24–68 years) and had worked in their perspective field (social worker or case manager) for average of 11.3 years (1–40 years), representing 22 states (Arizona, California, Connecticut, Florida, Illinois, Kansas, Massachusetts, Maryland, Michigan, Missouri, North Carolina, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, and West Virginia). Only 3 participants had experience with negotiation. The frequency of times the participants noted conflicts occurring daily: 56 (65.9%); three times weekly: 18 (21.2%); weekly: 8 (9.4%); hourly: 3 (3.5%) (see Table 1).

When asked what conflicts social workers/case managers experienced the most at work, several themes emerged. Participants noted that patients and families resisted accepting services as a key conflict. This included: "Recommending home care/rehab but patients refusing." "Skilled placement that patients are against." A common theme that reflects the teaching in social work schools was the conflict between patient autonomy versus doing what patient needs. *Patient wishes are taught to be paramount yet how can social workers resolve the conflict between autonomy with what needs to be done when patient wishes at discharge do not always result in a safe transition home?* Beside patient-initiated conflicts, respondents noted that conflicts arose from families of patients—either in patient–family interpersonal conflicts (e.g., *families and seniors differ on goals*) or patient–family–medical team disagreements (e.g., *family and medical team not being on the same page*). Respondents also noted conflicts between social workers and physicians/health care providers regarding care plans and goals of treatment. Every respondent noted at least one type of conflict that they experienced in their work.

After completing the NDR training, all respondents were overwhelmingly positive about the knowledge gained from the course, specifically noting themes of learning the basics of negotiation, tactics (e.g., framing), and integrative strategies (e.g., win-win/expanding to multi-issue discussions). Specifically, comments included: *Very positive way to resolve conflict. Useful ways to frame things better, terminology, tactics.* All respondents felt that they would use the negotiation tactics presented. *We are constantly dealing with* "*challenging*" patients. I think this is really something I'll be using a lot. A common theme was that previously respondents would exit the room when patients would decline services.

With the NDR training, respondents felt empowered: *We tend to accept refusals and move on when we should work to overcome it. When patients decline services, it is easy to move to the next patient—this motivates me to advocate more! We tend to leave the room when patients say "no" which is not good but this gives us concrete skills.* Respondents also identified themes that the NDR training would improve their workload as well as better serve their patients. *This will be great for patients and my workload. This has so much potential to improve our workday! Seniors hate change so this will help us (and them!) tremendously! This will empower us with patients and families.* In addition, participants noted that they were not taught negotiation as part of their training and *that this should be taught in our schooling!*

Discussion

Negotiation and dispute resolution training was overwhelmingly accepted by SWs/CMs, with many planning to use it daily with older adults. This project documents the first NDR training of SWs/CMs, specifically designed to reduce conflicts around older adults and their acceptance of support services. NDR training has the potential to lead to meaningful improvement in how SWs/CMs communicate with older adults, as well as improve acceptance of services by older adults. Many older adults resist support services, which often endanger themselves and others. Instead of "accepting no" and documenting refusal of services, SWs/CMs were empowered by NDR training to negotiate with their older adult clients to reach an acceptable solution. Given the prevalence of older adults and demographic trends that point to a growing need of support services in this population, learning how to effectively communicate and negotiate with them is paramount.

Limitations

Although innovative, this study experienced several limitations. There is a lack of collect information on the long-term effects of the NDR training. It would be a worthwhile future endeavor to follow those who completed training, ascertaining whether it improved their self-efficacy, work stress, and other user-centered outcomes. Additionally, it would be useful to see the effects of NDR training on older adults. Specifically, future studies could evaluate whether NDR training of SWs/CMs translated into increased acceptance and utilization of support services by older adults. This study trained and examined only SWs/CMs. NDR training might be useful for professionals in others field (e.g., hospitalists, geriatricians, primary care providers, and nurses) and lay people who interact with older adults (e.g., family caregivers and paid caregivers). Another limitation centers around the complexity of the older adult not accepting services. *The decision to accept services is multifaceted and is more than an unwillingness to change or not trusting others. It also includes factors about finances, living conditions, level of health literacy, and other social determinants of health.* NDR training can help social workers negotiate with patients, but these other issues also need to be taken into account.

Conclusion

In conclusion, this is the first NDR training intervention designed specifically to support SWs/CMs to facilitate acceptance of services among older adults. SWs/CMs felt that

the training was useful and empowering, and would potentially improve their workday. Although ethical implications with patient autonomy were identified, participants felt that NDR training presented a means of communicating with patients to improve acceptance of much needed support services. Further research is needed to determine the long-term effects of NDR training. Ultimately, NDR training has the potential to improve SW/CM well-being and improve the care of the older adults.

Biographies

Mobola Campbell, MD, MPH, is faculty in Hospital Internal Medicine at Mayo Clinic. She has been involved in medical education, developing a Health Disparities and Social Justice curriculum for resident physicians. She also has led the Health Equity and Advocacy Clinical Scholars Program.

Anne Seltzer, LCSW, is a licensed social worker in the Division of Geriatrics at Northwestern University where she facilitates services for older adults who are in need of assistance.

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TABLE 1

NDR Workshop Participant Characteristics (n = 85)

Survey completion rate	80.9% (85/105)
Respondent age (average, range)	36.3 years (range 24–68 years)
Experience in field (average, range)	11.3 years, (range 1–40 years)
State representation	Arizona, California, Connecticut, Florida, Illinois, Kansas, Massachusetts,Maryland, Michigan, Missouri, North Carolina, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, West and Virginia (22 States)
Experience with negotiations	3.5% (3/85)
Frequency of experienced conflicts	
Daily	65.9% (56)
Three times weekly	21.2% (18)
Weekly	9.4% (8)
Hourly	3.5% (3)
Themes of experienced conflicts	
• Patients/families resisted accepting services: *skilled placement that patients are against.*	
• Patient–family interpersonal conflicts*: families and seniors differ on goals.*	
• Patient–family–medical team conflict: *family and medical team not being on the same page.*	
• Autonomy of patient ideology conflict: *Patient wishes are taught to be paramount … (but unsafe).*	
• Social worker/case manager (SW/CM)–medical team conflict: *goals of treatment.*	

Note. NDR = negotiation and dispute resolution.

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