



IMPLICATIONS FOR PRACTITIONERS

Brief Negotiation Program for Promoting Behavior Change: The Kaiser Permanente Approach to Continuing Professional Development

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ABSTRACT **Background:** Behavior change counseling is one of the most difficult and constant challenges faced by health providers. It has a significant impact on clinical outcomes as well as patient and provider satisfaction. By encouraging patients to participate in a partnership with health care professionals, Brief Negotiation offers techniques to motivate behavior change successfully. We review the key components of Brief Negotiation and describe how one large group model health maintenance organization was able to identify key staff members, develop educational opportunities and implement Brief Negotiation system-wide into standard care practices.

Objectives: To expose a maximum number of health care professionals to a recommended model of behavior change counseling; to increase the satisfaction and confidence of health care professionals in counseling for behavior change; and to increase the likelihood of improved patient health outcomes.

Method: Two departments created one-day, two-day, six-hour and one-to-two-hour skill-based programs targeted to physicians, nurse practitioners, care managers, clinical health educators, behavioral medicine specialists, physical therapists, pharmacists and medical assistants. Practice protocols, strategic departmental alliances and intranet sites complemented the educational interventions.

Results: Over 1000 health care professionals have been exposed to the Brief Negotiation model in over two years. A mailed survey to graduates of the one- and two-day programs indicated that 67% of physicians and 79% of other health professionals felt more confident about working with patients on behavior change after having attended the Brief Negotiation program.

Conclusions: System-wide professional development requires multiple exposures to the

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Brief Negotiation model, considerable resources for curriculum development, training time and follow-up, and credible clinical trainers. Questions remain about the amount of training needed for long-term clinician behavior change and for improved health outcomes in patients.

KEYWORDS *Behavior change, clinician-patient communication, continuing medical education, counseling, training, motivational interviewing.*

Introduction

Ask health professionals what comes to mind when they think about working with patients who should be making a behavior change and you will often hear feelings of frustration, hopelessness, even futility; anger at being unable to get patients to make and sustain needed behavior changes, sometimes in life-threatening situations. Health professionals are often ill-equipped to counsel about behavior change, yet counseling is required in many patient encounters: to stop smoking, to take medications, to pursue prescribed mobility exercises, to stop taking drugs, to soak an injured limb, to avoid lifting, or any number of other behaviors that complement the medical intervention. Much of medical care *is* counseling about behavior change.

Background

Kaiser Permanente (KP) is a non-profit group model health maintenance organization serving over 6 million members throughout United States. The Northern California region serves 3 million members with over 4000 physicians and 30,000 employees at 32 medical offices. To prepare health professionals better for behavior change counseling, two departments, Physician Education and Development, and Regional Health Education, created a comprehensive strategy to prepare health professionals for this important work by introducing Brief Negotiation. The context for this work began in 1997 when the Northern California Region began to redesign the delivery of primary care to adults to reflect an interdisciplinary team-based model called Adult Primary Care (APC). Teams consist of physicians, nurse practitioners, nurses in extended roles, clinical health educators, behavioral medicine specialists, physical therapists and medical assistants. Each team is responsible for the delivery of primary care to 20,000 members.

APC represents a significantly different way of delivering care, so attention and resources have been applied to identify learning needs and enhance practice skills of the team members so that they may do their jobs well in a collaborative fashion. One of the strategic skill areas that was identified was working with patients on behavior change. It was believed that strengthening this practice skill could increase provider and patient satisfaction, improve practice efficiency as

well as improve health outcomes. The Northern California Region selected the Brief Negotiation model as its standard.

Brief Negotiation Model

In *Motivational interviewing* (1991), Miller & Rollnick made a case for working with behavior change in a radically new way. They proposed that a patient's motivation (and on the other side, resistance) was strongly influenced by the relationship between the patient and provider. A show of empathy and collaboration sets the stage for the patient to find his/her own reasons to change. Once rapport is established, the provider customizes his or her approach based on the readiness of the patient to change. The provider facilitates the patient's exploration of the inherent ambivalence that comes with the anticipation of change: wanting to stay the same while desiring to change.

Studies of motivational interviewing suggest that patients are more likely to consider change (and take steps to change) when resistance is lowered and ambivalence is explored (Miller *et al.*, 1988; Bien *et al.*, 1993; Rollnick & Miller, 1995.) Studies across a variety of settings have shown similar results (Saunders *et al.*, 1995; Stott *et al.*, 1995; Rollnick, 1996; Handmaker *et al.*, 1999).

Since 1992, the Northwest Region of Kaiser Permanente's Center for Health Research (CHR) has incorporated principles of motivational interviewing into research studies of behavior change within health care. This adaptation was soon referred to as Brief Negotiation to differentiate it from the more lengthy therapeutic model. Studies of the application of this model suggest that a brief clinical intervention can produce better outcomes than simple advice (Butler *et al.*, 1999), can lead to reductions in dietary fat intake, and can increase clinician satisfaction (Berg-Smith *et al.*, 1999). As word about the appropriateness of this model spread to a variety of settings within Kaiser Permanente, CHR staff were asked to train clinicians in the Brief Negotiation model in other KP regions. Beginning in 1997, Physician Education and Development and Regional Health Education developed curricula for one-hour, four-hour, six-hour, one-day and two-day programs to facilitate the dissemination of the Brief Negotiation model as the "standard of care" for behavior change counseling.

Objectives

The central tenet of the Brief Negotiation model is that clinicians can't change their patients' behavior—only patients can. This is a shift in the balance of power from the traditionally defined clinician–patient relationship, in which the clinician tells the patient what to do and how to do it, and the patient is supposed to do it. Given this change in philosophy, the program is designed to:

- expose a maximum number of health professionals to a recommended model of behavior change counseling;
- increase the satisfaction and confidence of health professionals in counseling for behavior change; and
- increase the likelihood of improved patient health outcomes.

The program derives from the following related principles.

- *Stages of change*: most people pass through several stages of commitment to making a change on their way to achieving change. Whether patients are in the stage of precontemplation, contemplation, preparation, action or maintenance, clinicians need to match their responses appropriately to each patient's stage of readiness (Prochaska & DiClemente, 1982).
- *Reactance theory*: if people are told what to do, many will do the opposite. Therapists, parents, and clinicians are familiar with this phenomenon, which is also labeled resistance. By implication, lecturing and preaching are counter-productive in persuading patients that behavior change is necessary (Brehm & Brehm, 1981).
- *Change talk*: people's beliefs are more influenced by what *they* say than by what others say to them (Bem, 1972). To encourage change talk, health professionals invite patients to discuss their motivations and desires for change. For instance, a physician could ask, "What do you not like about smoking?" "What would have to happen for you to consider taking your medications on a more regular basis?"
- *Confidence matters*: confidence in one's ability to change predicts attempts to change, persistence, success, and actual health status. Therefore, one goal of such interactions becomes building people's confidence in their efficacy (Bandura, 1977). For example, a clinician can help enhance the confidence of someone who is not ready by saying "I am confident that when you are ready to begin taking your medications on a regular basis, you will find a way to do it."

Methods

Just as Brief Negotiation suggests how to work with patients' resistance and readiness for change, we are following those principles in helping clinicians learn to use this model in their clinical practices. Training in the use of this model is offered to a range of clinicians through several modalities (see Table 2). As in all effective education for adults, every effort is made to render the training relevant, practical, and highly interactive. As much as possible, participants are given the chance to say the words and use the skills. Roughly 20% of each training is didactic and 80% features experiential learning. Skills are practiced in the form of exercises, role-plays, coaching by trainers and by fellow participants, and the use of professional actors playing typical patients.

Considerable time and resources have supported curriculum development,

Table 1. Components of the Brief Negotiation model

Model component	Elements of component
Setting the stage	Establish rapport, define the time available for the visit, explicitly ask the patient's permission to discuss the behavior issue, listen reflectively, and negotiate the agenda for the visit.
Information exchange	Style matters: demonstrate empathy and a collaborative, non-judgmental attitude. Communicate clearly and succinctly. Present the facts and provide education.
Assessing readiness to change	Express concern; elicit patient's response to your news. Assess the patient's readiness to change by asking him or her to choose a number on a scale of 0–10 where "0" is not ready and "10" is very ready. Acknowledge the patient's choice, explore that choice, and respond based on the patient's stage of readiness.
Closing the visit	Summarize what the patient has said. Express confidence in the patient's ability to make the change, and confirm the next steps to be taken.

training of trainers, writing practice protocols based on the Brief Negotiation model, time for clinical staff to attend training, and developing supplementary services to reinforce the skills, such as mentoring programs and online discussions.

Description of Programs

Stand-alone Training Programs

- *The one-day program:* 400 + participants to date. A six-hour, off-site program targeted primarily to physicians and nurse practitioners: offers interactive didactic sessions and coached practice using actors as patients.
- *The two-day program:* 345 participants to date. Through didactic sessions, interactive exercises, and case study role-plays with personal coaching, participants learn to apply the model in a variety of patient scenarios and settings. Targeted primarily to clinical health educators, physical therapists, pharmacists and care managers.
- *Team program:* 180 participants to date. A three-session, six-hour training in the Brief Negotiation model for the 30-member APC teams. Trainers are a physician from each facility partnering with another clinician, such as a behavioral medicine specialist (psychologist or social worker) or clinical health educator. This training builds on each team's strengths by incorporating practice scenarios using their own patients, and identifies ways in which the model can be used and reinforced in that team's practice.

Table 2. Programs offered to various target groups

Target audience	One/two-day program onsite	Multi-session facility-based program	Modules within an existing program	Instruction at peer group meeting	Distance learning (multiple sites)	Mentoring program
Physicians	X	X	Group Appointment training		X	
Nurses	X	X	Chronic disease care manager training		X	
Clinical health educators	X	X	Group Appointment training	X	X	X
Behavioral medicine specialists	X			X	X	X
Physical therapists	X	X			X	X
Medical assistants		X				

Training Programs as Part of Existing Programs

- *Group Appointment training*: a training program for health professionals who are doing Group Appointments. Group Appointments are co-led physician/provider clinical interactions with patients in a group setting. Brief Negotiation principles of empathy and patient collaboration are showcased and reinforced as important tools for this clinical setting.
- *Chronic disease care managers*: 155 participants to date. Two- to 14-day training programs for care managers responsible for the care of patients with asthma, diabetes, heart failure and complex chronic conditions. These feature a section on incorporating the Brief Negotiation philosophy and strategies into care management. Practice protocols for treatment are written to reflect the Brief Negotiation model.
- *Clinical health educators (CHEs)*: 70 CHEs in adult primary care provide one-on-one behavior change counseling as well as facilitate group visits. The basis for their work with patients is the Brief Negotiation model. They attend multiple-day trainings (depending upon the focus of their unit) on the CHE role, disease management and HIV counseling. All of the CHE practice protocols reflect the Brief Negotiation model. Eleven of the 70 CHEs are trained to observe and coach peers in the CHE role, including the use of the Brief Negotiation model with patients. CHEs are seen as the “experts” in Brief Negotiation on the APC team and often are in the position of reinforcing the use of the model with other team members.
- *Behavioral medicine specialists*: a half-day adaptation of the Brief Negotiation model for psychologists and social workers who serve as behavioral medicine specialists on the APC team. A select group of regional sub-chiefs of behavioral medicine has asked to be prepared as mentors in Brief Negotiation so they can train their colleagues in each facility and on each APC team. This training will incorporate the principles of Brief Negotiation with other communication issues specific to the work of the behavioral medicine specialists.

Results

Over 1000 health professionals have been exposed to the Brief Negotiation model. Whether the program was one day, two days, two hours or six hours, participants rated the program “quite good” to “excellent” (mean = 4.3 on a 5-point scale). Over 90% said that they “would recommend this program to a colleague.” Through mailed surveys to graduates of the one- and two-day programs (57% and 41% respective response rates), 67% of physicians and 79% of other health professionals reported that they felt more confident about working with patients on behavior change after having attended the Brief Negotiation program.

Discussion

Implementation of the program has focused on three items: fidelity to the model, training logistics and long-term behavior change.

We recognized that we must balance the severe constraints on clinicians' time with our desire to enhance their counseling skills. This involved considerable discussion and deliberation to define the essential behaviors of the Brief Negotiation approach. Was it establishing rapport, assessing readiness? What skills would lend themselves most to increased satisfaction or improved outcomes? How much time should be spent on exploring ambivalence, as opposed to sharing health information? How much time could we set aside for practicing these behaviors? We continue to debate whether 8 or 16 (or more) hours of training are sufficient to see changes in clinicians' behavior. We tinker with different designs as we gain experience over time. Long-term evaluation will help us determine how much is enough. These results will have major implications for the amount of exposure required for staff and patients to experience change over time.

Once key skills were identified, creating learning opportunities for the skills became the next challenge. Credibility of the trainers is crucial: they must be able to teach, model and give realistic examples of Brief Negotiation in their practices. All the training programs are co-taught by a clinician who uses the Brief Negotiation model in practice and a professional educator/trainer. It has not been easy to find skilled clinicians who can also train. Trainers have participated in a combination of two-day train-the-trainer programs, worked as apprentices with skilled trainers and received individual coaching and feedback. As the skill levels vary with trainers, we are challenged by the effort that is required to produce quality instruction. Ideally, we would like to incorporate periodic continuing education for the trainers.

Our experience shows that we required multiple exposures to the Brief Negotiation model before we could say we understood and practiced the model. Since starting the program dissemination in 1997 we have found that our personal experience is similar to that described by other clinicians: they may have seen a one-hour presentation, then attended a one- to two-day program and still found it difficult to incorporate the skills in their practice on a regular basis. For this reason, we designed the facility-based Brief Negotiation Team Training. In this way, the APC team members are exposed to the model with colleagues with whom they have day-to-day contact. The context provides cues to behavior change, a shared language and opportunities for reinforcement and problem-solving with challenging behavior change cases. A survey of program graduates indicated a strong desire for follow-up to reinforce skills and problem-solve. Options being considered include facility brown bag seminars, online discussion groups and specialty-based follow-up programs. An existing intranet website for clinicians contains Brief Negotiation program descriptions, and bimonthly case studies and clinical tips. We are piloting an online discussion group where

clinicians discuss the use of the model in clinical practice. Work is underway to evaluate the long-term efficacy of the Brief Negotiation model in this medical care setting.

Conclusions

The intent of disseminating the Brief Negotiation model is to change the day-to-day practice and culture of medical care. Clinicians have rated the program highly and felt more confident about working with patients on behavior change. In this collaborative approach practitioners find themselves able to step back and allow patients to make the important decision to change or not change. Practitioners trained in Brief Negotiation express relief and an appreciation for the difficulties inherent in making behavior changes. Some patients have expressed surprise when invited to discuss their own changes in this way. This approach is well suited to the future as patients become better informed and more inclined to take an active role in their health care decisions.

Using the Brief Negotiation philosophy, Kaiser Permanente chose to implement this program system-wide in a series of discrete, incremental steps based on clinicians' own expressed desire to change the way they practice. This strategy has demonstrated the success of engendering familiarity and interest as opposed to generating resistance, as follows region-wide mandates. Challenges remain: determining how much training of health professionals is enough, providing for the maintenance of clinicians' behavior change, and developing an evaluation methodology that measures the efficacy of our efforts with staff and patients. KP is committed to state-of-the-art medical care, including what is known and tested about successful practices with patients considering change. We believe that Brief Negotiation offers considerable strength in improving clinician and patient satisfaction. Time will tell if this approach offers successful, long-term behavior change for clinicians and patients alike.

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