Training Manual
2019

CLEAR ON THE COST:
PATIENTS AND PROVIDERS CO-AUTHORING THE CARE PLANS

Migrant Clinicians Network | **funded by the Robert Wood Johnson Foundation**

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Executive summary

In 2017, Migrant Clinicians Network (MCN), conducted a mixed-methods study focused on patients over 18, who received care at selected Federally Qualified Health Centers (FQHCs) to explore current and best practices for conducting cost-of-care (CoC) conversations and to document optimal methods for training FQHC staff members on this emerging CoC issue. This project was funded by the Robert Wood Johnson Foundation 2016 Initiative, "Optimizing Cost-of-Care (CoC) Conversations Between Clinicians and Vulnerable Patients". In multi-day, on-sites visits to three diverse FQHCs, 85 volunteering patients below 400% of the Federal Poverty Level (FPL) and their agreeing clinicians (NP, PA or MD) and Staff were questioned. The patient's medical encounter was observed by a bilingual interviewer. The study team delivered training modules to sensitize staff and clinicians to CoC concepts and concerns via online training and on-site visits, while assessing what CoC conversation elements were currently delivered and those recalled by patients – triangulating these data with the observer's record. The project explored factors associated with building trust between clinicians and patient populations to support elements of cost-of-care conversations. Study findings explored the value of the CoC conversation's elements by examining what content and scope elements were delivered and recalled. In this one-year study of CoC conversations in primary care experiences for vulnerable patients, the MCN team explored CoC issues for enhancing patient compliance and adherence to clinicians' recommended treatment plans for prenatal care and chronic conditions, which could impact this population's health and FQHC outcomes.

● **Research Objective:** To explore current and best practices for conducting cost-of-care (CoC) conversations in primary care among vulnerable patients, and to document optimal methods for training FQHC staff members on this emerging CoC issue.

● **Study Design:** The research team conducted interviews with patients and providers, and directly observed (shadowing) patients through their clinical encounters. Interviews collected the clinician's and patient's views of what they discussed about cost-of-care. The shadowing interviewer noted what they heard and observed. Patients recalled what they had heard and discussed about CoC in their encounter. We triangulate both the content and comfort of these CoC conversations. Additionally, staff and clinicians were interviewed about the Clinic's training and policy status.

● **Population Studied:** In 12-months, this exploratory research was conducted in four Federally-Qualified Health Centers (FQHCs) in three states, which had existing relationships with Migrant Clinicians Network (MCN), and included detailed interviews for 85 low-income patients, who were over 18, seen for prenatal and chronic conditions, and were below 400% of the Federal Poverty Level (FPL), and the associated clinicians (NP, PA or MD).

● **Principal Findings:** Clinic staff and clinicians typically assumed that others on the care team were addressing CoC concerns of patients and expected that simply confirming insurance status was sufficient to address patients' cost conversation needs. Both patients and providers reported discomfort with conversations about healthcare costs. There were frequent instances of misunderstanding by patients of their financial

responsibility for certain costs. Patients' trust levels for staff and clinicians varied. Clinic workflow prioritized patient throughput rather than proactively exploring patient understanding of costs of copayments and deductibles, out-of-pocket costs for care or medications. Assessment of indirect costs of illness such as lost work time or transportation for treatments was minimal. Communication of patients' CoC issues between staff across the steps of the medical visit was minimal.

- **Conclusions:** The current state of cost-of-care conversations at these observed clinics leads to frequent misunderstandings and unmet CoC needs, which may ultimately increase the work and costs for both patients and their healthcare providers. Clinicians can play a larger role in facilitating conversations about costs with patients, especially those with low health literacy and their patients will trust their insights. This may improve adherence, and thereby outcomes. Administrators and staff can document CoC issues and better support patients' understanding.

- **Implications for Policy or Practice:** There is a need for systematic, patient-friendly, culturally relevant CoC tools for patients, and for insightful CoC staff training that encourages and enables proactive exploration of CoC concerns and integrates principles of shared decision making and patient-centered care. Adapting standard order sets and tracking their covered and remaining costs may be a promising strategy for developing and implementing new approaches to facilitating meaningful cost conversations in these clinics.

The Clear on the Cost training was developed by Migrant Clinicians Network in response to the study findings.

HOW TO USE THE "CLEAR ON THE COST' MANUAL

The initial page of each section provides a brief outline of the section. The second page is a more detailed outline of section. They are numbered separately and can be removed by the trainer and used during the workshop to guide and prompt the training.

The remaining pages are detailed descriptions, intended to be read and studied beforehand by the trainer. They can also be used at the training, according to the trainers' preferences. Some trainers may prefer just an outline in front of him/her during the training; others may prefer more detail.

The following page contains a graphic with the key to how each page is displayed and the use of standard text, bolding color coding, and text boxes.

WORKSHOP SECTION

Prompt on last questions for location or "methodology" (i.e. read it with, give to take home, etc) Presenter asks pair/group to say why this might be effective or not and whether it could be used or appropriate for the clinic. Talk about them in your groups. Report to larger group and discuss.
Include simple signs about health care costs and asking questions, good brochures, good posters including materials in Spanish. On each piece indicate where the material was placed; include lab areas and waiting room signage, posters in bathroom, brochures in exam room, etc., also, low literacy materials, Spanish language and pictorial. (See Appendix A for example)
Refer to handout with ideas for best uses of materials and briefly review it – link to discussion of brochures. (Pick your messages carefully – a few important messages + methods info: variable pharmacy costs, avoid clutter, placement of materials, low literacy, pictorial, simple signs, etc.)

Instructions to the trainer are in normal font.

References to peripheral materials appear in green

Slide 1 Opening

All power point slides are shown in small clip

Introduction to the cost of care: **The purpose of the Cost of Care conversation is better informed patients, who are participating in the clinical decision-making; and are better equipped to engage in self-management recommendation and care plan adherence.**

Text intended to be spoken aloud (or verbatim) by the trainer to the participants is in bold. No other text in the manual appears in bold.

Slide 6 Elements of cost of Care

Elements of Cost of Care
- Cost of Health Insurance Premiums
- Cost of co-payments and deductibles
- Absolute or Relative estimates of the ("direct") cost of procedures and medications
- Other ("indirect") costs of illness (e.g., lost work time, transportation for treatments, etc.)

Text from slides is in a text box.

Refer to the Cost of Care brochure. **You can use this hand-out which lists the various elements and coverage by type of insurance plan.**

Trainer tips including suggestions of processes that work well during actual training sessions will be in blue call out boxes.

Training Schedule

The Clear on the Cost group training briefly orients health center staff to the national data on health seeking behavior vis a vis cost impact. The training provides background information on Migrant Clinicians Network, the Cost of Care research they conducted and the implications for policy development and staff training. The training takes participants through a discussion of cost of care conversation elements and allows participants to practice engaging in CoC conversations.

Objectives: At the end of this training participants will be able to:

- Identify common cost-based barriers to the pursuit of preventive and primary care services
- Identify common barriers to CoC conversations.
- Differentiate the four elements of CoC conversations
- Incorporate coverage/cost assessment into the visit, as it relates to the primary reason for the visit.
- Demonstrate effective communication techniques.

Time: 2 hours; 2 hours of CEU

Audience: Clinic staff, including all clinical staff who provide direct patient care, reception and education staff, eligibility and finance staff and administration.

Design:

Time	*Steps*
Prior to visit	1. Set up visit – Training scheduled
Varies 10 – 15 min	2. Pre-training questionnaire
10 – 15 min	3. Demonstration of a CoC conversation that went poorly and one that went well
Varies 1 – 1.5 hrs.	4. Training using triad system with role playing to include background on cost of care, results of MCN study, elements of cost of care and engaging in CoC conversations.
Varies 15-25 min	5. Post- training questionnaire
Varies 0 – 20 min	6. Post questionnaire clarifying education
15 – 20 min	7. Individual feedback on role playing if requested

Materials Needed

Number/Count	*Material*
Facilitator/Trainer Packet	
Copy for each facilitator/trainer	Checklist
Multiple copies	Sign in sheet
Copy for each facilitator/trainer	Feedback Forms for using in the triad system for role playing
Copy for each facilitator/trainer	Verbal feedback form
Copy for each facilitator/trainer	Participant Packet
Copy for each facilitator/trainer	Health Center Packet
Total number of participants	Name tags
Participant Packet	
Copy for each participant	One from a series of role play scenarios randomly distributed
Copy for each participant	Elements of CoC conversation graphic
Copy for each participant	CoC Brochure
Health Center Packet	
PDF	Patient Education Resources
Electronic copy Word document	Sample health center policy

Set up:

Set up the computer, LCD projector, and test to make sure that the PowerPoint is working. Prepare nametags and sign in sheets and make them available in a prominent place. Set Participant Packet items out so that they can be easily distributed.

Procedure for Triad System for Role Plays

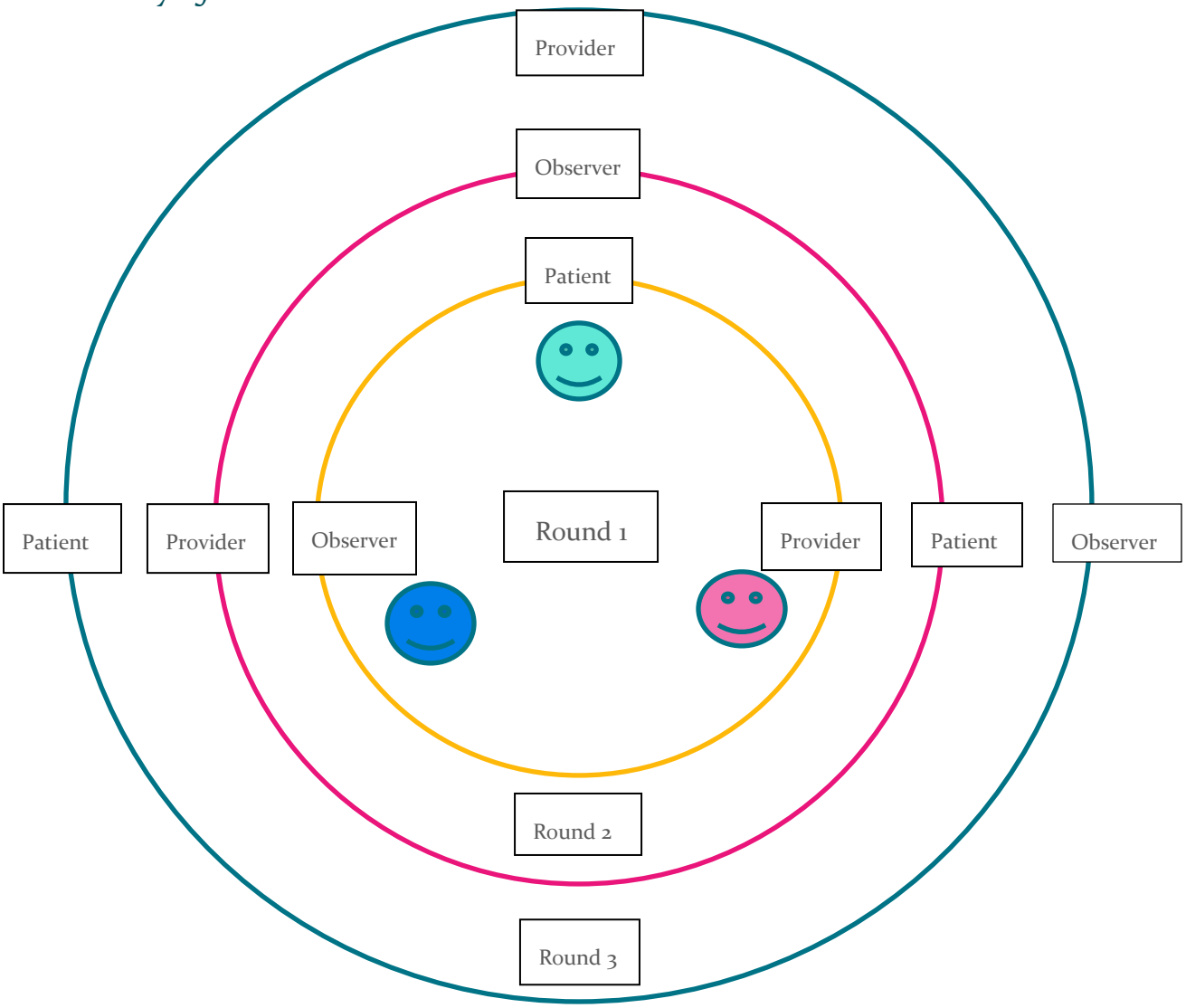
Before you begin the event, count the number of participants and divide by three. This will let you know what the maximum number to set for you participants to count off (example: if you have 6 participants ÷ 3 = 2. You will then start at one end of your participant group and ask them to count off 1, 2. You will then have two groups of 3 participants.) Should you have one participant after the count off that is not part of a triad assign him/her to another group. (example: 16 participants ÷ 3 = 5 triads with one remaining participant) If you have two participant that are not a part of a triad, one of the facilitators can act as the third. (example: 26 participants ÷ 3 = 8 triads with 2 remaining participants)

Provide each participant with a copy of the feedback form. Take a moment to review the form so that the participants are prepared to observe the interaction of the pair that s/he is observing and offer constructive feedback. Then provide each participant with a role-playing scenario. It does not matter if the role play repeats in the same triad. Ask the participants to count off and form their triads.

Once the participants have formed into their triads, ask them to decide who will be the first patient role player and ask that person to raise their hand. The provider in the role play will be the person to their right. Advise them that they will have 5 minutes to act out the role play and then they will take 5 minutes for the third person who observe the role play to provide feedback. For the next round, the provider from the previous role play will be the patient, the observer will be the provider and the first patient will be the observer. They will act out and offer feedback in the same way that it was done for the first role play. Then in the final rotation each member will take the role that they have not had in the previous 2 role play instances.

The following graphic demonstrates the role rotation that will occur within the triad as each participant takes a turn in each of the roles.

Role Playing Rotations Plan



Instructions to Staff and Providers during the Role-playing exercise

We are going to do some role-playing around cost of care conversations that might occur in the health center. Each of you will be the member of a three-person team where you will take turns being the patient, the staff person/ provider and the observer. The role play will be controlled by the patient and each of you will have a character description to help you play the role of a patient when it is your turn.

We asked you to count off according to the number of role-playing teams. So, will all the ones get together, the twos and so on?

Now that you are in your teams, pick who will be the first patient role player. Will you please raise your hand to show us how will be the lead off patient in the role

playing? Great. The person to your right will be the next patient for the second role play.

We will give the patient/provider role players 5 minutes to have a quick conversation based on the character description you have on your sheet. The observer can use the observation sheet to take notes. Observers please make a note of things that went well. If you have an idea about how something might be improved in the conversation, make a note of that as well. We will then take 5 minutes for the observer to comment on the conversation. We will tell you when the 5 minutes are up so that you can shift between role plays and observations.

When offering observations be as specific as possible.

Please start. (time each 5-minute interval and then ask the participants to switch to the next phase until everyone has had the opportunity to play every role)

Switch roles.

Has everyone had a turn in all three roles? Great.

Let's talk about the experience. What did you think of yourself as the provider?

What did you see someone else do well that we should all hear about?

CLEAR ON THE COST TRAINING WORKSHOP

Introduction

Description: This introduction will give participating staff a chance to introduce themselves and their clinic/agency to Clear on the Cost training team, and will give Clear on the Cost team members a chance to introduce MCN, the Clear on the Cost project, and themselves to the staff.

Time: 15 minutes

Time	Activity	Materials needed
5-10 mins	Introductions A. Staff to Clear on the Cost Team B. Clear on the Cost team members to Staff	Sign in sheets Name tags
3 min	Talk about your clinic	
2 min	Participants state expectations of the training Trainers provide purpose of Clear on the Cost Project and of afternoon training	Laptop, projector, PowerPoint presentation

One of the primary objectives of the introduction portion is that each person vocalizes so that they are "warmed up" to participate in further activities. Be sure everyone speaks.

Slide 1: Introduction Slide Clear on the Cost

Have the beginning slide up for people as they get settled. Pass out the participant packets and ask participants to take a moment to make sure that they have signed in and are wearing a name tag.

Slide 2

Clear on the Cost training team members introduce MCN and themselves individually. Ask each person to introduce him/herself by name, position on the health center staff and tell the group something they do to make patients feel comfortable.

If there are many participants, you can limit it to just name.

Slide 3

Describe the work of MCN and the long-standing relation the organization has with federally funded health centers.

Trainer asks clinic staff to refresh his/her memory of what their clinic is like. **Please help us remember some of the specifics of your situation here. I'm going to read a list of statements that may or may not be true of your clinic. Stand up if you feel the statement is true. Stay seated if you think it is false.**

Most of us in the room have been in a cost of care training before.
The center has enough space.
The center has enough staff.
Most of us have lived in (city where training is held) for more than 5 years.
Most staff have worked with migrants for 3 or more years.
We have easy access to hospital care and specialized treatment referrals for our clients.
We see mostly migrants/immigrants.
We see a few migrants/immigrants.
We see more and more migrants/immigrants.
Our clinic has plenty of money.
We have enough bilingual staff.
Most of our patients speak English.
Diabetes is our biggest patient concern/illness.
We've seen some of the same patients for many years.

If you do not want people to sit/stand, you can go around the room and ask each person to agree or disagree. This gives everyone a chance to speak.

On the whole, we drink lots of coffee.
We've had some of the same staff for many years.
[Add one or two more characteristics of this clinic if needed]

Slide 4

Cost of Care Initiative
Robert Wood Johnson foundations

Describe Clear on the Cost Initiative

In 2016, the Robert Wood Johnson Foundation (RWJF) focused resources to ensure that everyone in America has access to affordable, quality health care, especially vulnerable populations. RWJF funded studies focused on testing a diverse range of approaches with diverse populations, to ultimately help inform the development of tools, guides and resources designed to improve patient and clinician communication about costs and high-value care. The MCN Project was one of four funded in this arena.

The Robert Wood Johnson Foundation issued a Call for Proposals in 2016 title "Optimizing Cost-of-Care Conversations Between Clinicians and Vulnerable Patients." This solicitation aimed to fund studies that tested specific messages, best practices, and other principles to be incorporated in resources for improving the frequency and quality of cost-of-care conversations between clinicians and vulnerable patients. Funded studies focused on testing a diverse range of approaches with diverse populations, to ultimately inform the development of tools, guides and resources to improve patient and clinician communication about costs and high-value care. RWJF was particularly interested in prioritizing studies that incorporate rapid testing, message research and high levels of consumer involvement, as opposed to an exclusive focus on extended scientific research and academic publication. The prioritization of rapid testing is a direct response to the imminent need for solutions for this problem. Funded studies focused on preserving and enhancing trust between clinicians and vulnerable patients, given that RWJF saw this as a central factor to improving cost-of- are communication. And, RWJF sought to fund a range of projects across different types of vulnerable patients, types of are settings, and-to the extent possible-geographic areas.

Slide 5

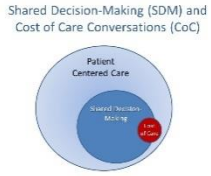
MCN's "Clear on the Cost
Patients and Providers Co-Authoring
the Care Plans

Describe MCN's study: hypotheses and process

Let me tell you a little bit about MCN's project:
The project posited that patients will engage in discussions of emotionally charged issues surrounding CoC if the clinic environment includes:
1. Access to language-appropriate information on possible out-of-pocket expenses;
2. The occasion to discuss emotionally charged financial topics; and
3. Clinicians of all types able to anticipate, recognize, encourage, and participate in these discussions.

To create a clinical atmosphere that facilitates productive CoC conversations, MCN developed a clinic site assessment of appropriate information and multiple opportunities for CoC conversations. They have developed training materials for FQHC clinicians and staff. This effort will shape the content of CoC conversations and provide new information on the optimal training mode for the future. MCN hope to contribute practical solutions to what content and training methods will help to facilitate or to improve CoC conversations between clinicians, their staff members and vulnerable patients.

Slide 6



Shared decision-making (SDM) and Cost of Care Conversation (CoC). Patient center care. Shared decision making. Cost of care

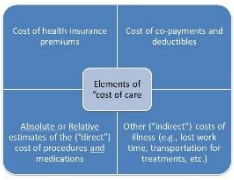
We looked at this within a Shared Decision Making model and designed staff and clinician training, because literature shows that patient adherence and self-management increase, if they are actively engaged in all aspects of decision-making. The literature suggests that while the clinician is often driven by a quality of care standards, the patient is often conflicted between the "seeking wellness" and avoidance of financial catastrophe. Successful Cost of Care conversations are consistent with Patient-Centered Care, when achieved through Shared Decision-making processes.

Slide 7

Elements of "cost of care"

This is a transition slide that will allow the trainer to go into the discussion of cost of care conversations with some basic understanding.

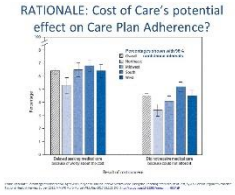
Slide 8



Elements of cost of care. Cost of Health Insurance Premiums. Cost of co-payments and deductibles. Absolute or relative estimates of the ("direct") cost of procedures and medications. Other ("indirect") costs of illness (e.g. lost work time, transportation for treatment, etc.)

The CoC elements are relatively self-explanatory. It is important to highlight that many people are not aware or do not understand that a policy or insurance system has an initial and regular cost to remain in force and the fact that that policy or insurance can have either a deductible or co-pay structure. This Elements of Cost of Care graphic should be distributed as a handout

Slide 9



Rationale: Cost of Care's potential effect on Care Plan Adherence.

Delayed seeking medical care because of worry about cost

Did not receive medical care because could not afford it

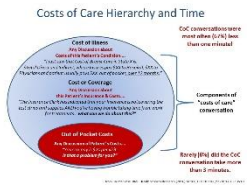
Why are Cost of Care conversations important to adherence? In a CDC study of the 2015 National Health Interview Survey, findings showed:

In 2015, ≈ 6% of people of all ages (20.1 million) in the USA delayed medical care during the preceding year because of worry about the cost. (shown on the left)

Moreover, an estimated 14.2 million (4.5%) did not receive needed medical care because they could not afford it. (shown on the right)

Non-adherence varied by region as shown.

Slide 10



Cost of Care Hierarchy and Time
CoC conversations where mostly (67%) less than one minute
Components of CoC conversation
Cost of illness, Cost of Coverage, Out of Pocket Costs
Any Discussion about
Costs of this Patient's Condition....
"I just saw that Cost of Breast Care in State X is:
$Total Direct and Indirect, where Insures pay $XX to Hospital, $XX to Physicians and patient usually pays $XX out of pocket, over 12 months."
Any Discussion about
this Patient's Insurance & Costs....
"The Insurance Clerk has indicated that your Insurance is not covering the test strips and supplies AND you're having trouble taking time from work for treatments... what can we do about this?"
Any Discussion of Patient's Costs....
"Your co-pay is $20 per visit.
Is that a problem for you?"
Rarely (6%) did the CoC conversation take more than 3 minutes.

Cost of Care include: the Cost of the Illness or Condition, or the Cost of Coverage for the patient, or Out of Pocket Costs for this patient.

Costs can be discussed in relative or absolute terms. Relative cost comparisons ("less than $x, or X% more expensive than currently paying"); or absolute costs ("less than $5, or "our estimate of the medication co-payment costs are $25 per month… Can you handle that?")

Current published research (Hunter, et al, 2016), using recorded conversations in over 1.700 encounters, indicates that these CoC conversations were most often (67%) less than one minute! Rarely (6%) did the CoC conversation take more than 3 minutes.

Slide 11

What is your role in your health center in delivering cost of care conversations?

Early findings suggest that helping each patient understand the costs of health care is generally believed by the patients to be the role of the clinician. Yet, clinicians indicate that the responsibility lies elsewhere. Where does the responsibility lie in your clinical environment? Is it centered in another role? or in your role? Or, is it more likely shared by everyone across the roles, requiring that everyone be sensitive to the patient's needs?

Allow a brief conversation among participants about their experience with speaking to patients about cost.

Slide 12

Role Play Exercise

Role Playing Exercise

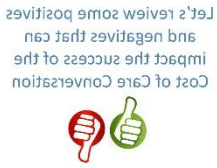
Using the instructions for running the role-playing exercise, give each participant the opportunity to experience each of the roles (provider, patient, Observer)

Slide 13

What, Who, When

Use this time to ask the participants about the interactions in which they engaged and watched. Ask them to describe what they heard that was done well, who had a good strategy, and when in the conversation they were able to insert CoC information.

Slide 14



Let's review some positives and negatives that can impact the success of the Cost of Care Conversation.

Without singling any one participant ask if anyone feels that they did something particularly unhelpful for the CoC conversation.

Slide 15

Front desk staff

A staff person can be a role model for a child and can instantly gain trust and establish rapport to facilitate a Cost of Care conversation. . However…. A staff person may recall that through segregation she could not get services at this site when she was a child…

This slide allows the participants to focus on the importance of making those arriving to the health centers to feel welcome. It also highlights how quickly a negative impression can be left without the person understanding the underlying sentiments of the staff person.

Slide 16

Eligibility staff knows of resources and programs that the family may not be aware of. This positively launches the cost of care conversation… However…Eligibility staff may view use of charitable or public benefits as a weakness, and undermine any CoC conversation…

This slide allows the participants to consider how their own biases can affect the way they address the people arriving at the health center for care. Again, it also highlights how quickly a negative impression can be left without the person understanding the underlying sentiments of the staff person.

Slide 17

Lab staff may be able to explain the unique billing processes of external labs to avoid issues of unnecessary costs of care… However…., Lab staff who are in a hurry, may not focus on the discomfort or concerns of the person in front of them…

This slide allows those participants that think their job is not to engage in cost of care conversations, to see that they can still let the person that the health center welcomes questions and wants to make sure that any concerns are addressed.

Slide 18

Medical Assistant, who "Speaks the patient's language" gains trust and comfort of the patient and may see the hesitation about additional expectations… However…., Medical Assistant who does not know the words for some of the cost of care elements could confuse the patient about her costs.

This slide allows the participants to discuss the critical role that language plays in the clinical visit. Frequently, staff can be capable in conversational language but not as knowledgeable about medical Spanish (or other language). Important the address the idea that "Something is better than nothing." Which is incorrect. Something poorly done is often worse than nothing.

Slide 19

Clinicians are the most influential in the patient's view and may alter the care plan (e.g., treatments or meds) if mindful of the patient's financial situation… However…, a Clinician may feel the patient should get the newest and the gold standard, which may increase non-compliance and poorer outcomes…

Clinicians, (MDs, PAs and NPs), as well as Medical Assistance and others should all be involved. The tendency is to assume that someone else has handled the issue. The Clinician could clarify if a patient is concerned and that adherence is important and refer the patient to the other staff members if they feel that they are likely to have more information. This redirection can maintain the patient's confidence in their clinician, without avoiding the CoC conversation. Any discussion, or recognition of coverage, or out-of-pocket or time costs would be a

CoC conversation. The important point is that your plan of care may not be implemented without this discussion.

Slide 20

Missed opportunities?

In your patient encounter flow, where are missed opportunities for the CoC conversation?

Can we determine the best place and person to initiate the cost of care conversation with the patient in your clinical encounters? As a clinical organization, you may need to develop a policy on where this discussion is going to take place.

Do you have a specific policy? Are there key players, who are most responsible for the CoC conversation in each visit? Can you implement the action as a consistent practice? Are you training every employee to be sensitive and to signal to key players, if issues of cost of care are uncovered? Which are the key players?
What signals have you seen or heard that suggest the cost of care issues have been missed and need to be discussed? What actions by staff or patients disrupted the CoC conversation with a patient that you can recall? Have you periodically discussed these missed opportunities in staff meetings?

Slide 21

Purpose of cost of care conversation
Patient will be: Better-informed and participating in shared clinical decision making
Better equipped to engage in effective self-management and care plan adherence

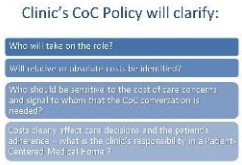
Remember, the purpose of the Cost of Care conversation is better informed patients, who are participating in the clinical decision-making; and are better equipped to engage in self-management recommendation and care plan adherence.

Slide 22

Clinician and Provider Organizations will:
Use time more effectively, in the long-term.
Create shared clinical decision making with patient, that may result in better outcomes
Assist patient in achieving adherence to their care plan, and better self-management

In the long-run, the clinician and the provider organization will operate more efficiently and, in a patient-centered manner, where patients are better able to afford their care plan adherence.

Slide 23



Cllinic's CoC Policy will clarify:
Who will take on the role?
Will relative or absolute costs be identified?
Who should be sensitive to the cost of care concerns and signal to whom that the CoC conversation is needed?
Costs clearly affect care decisions and the patient's adherence – what is the clinic's responsibility in a Patient-Centered Medical Home?

Are there other aspects that need to be included in your policy? Does writing a policy assure that it is being done? How will you check to monitor your success?

Slide 24

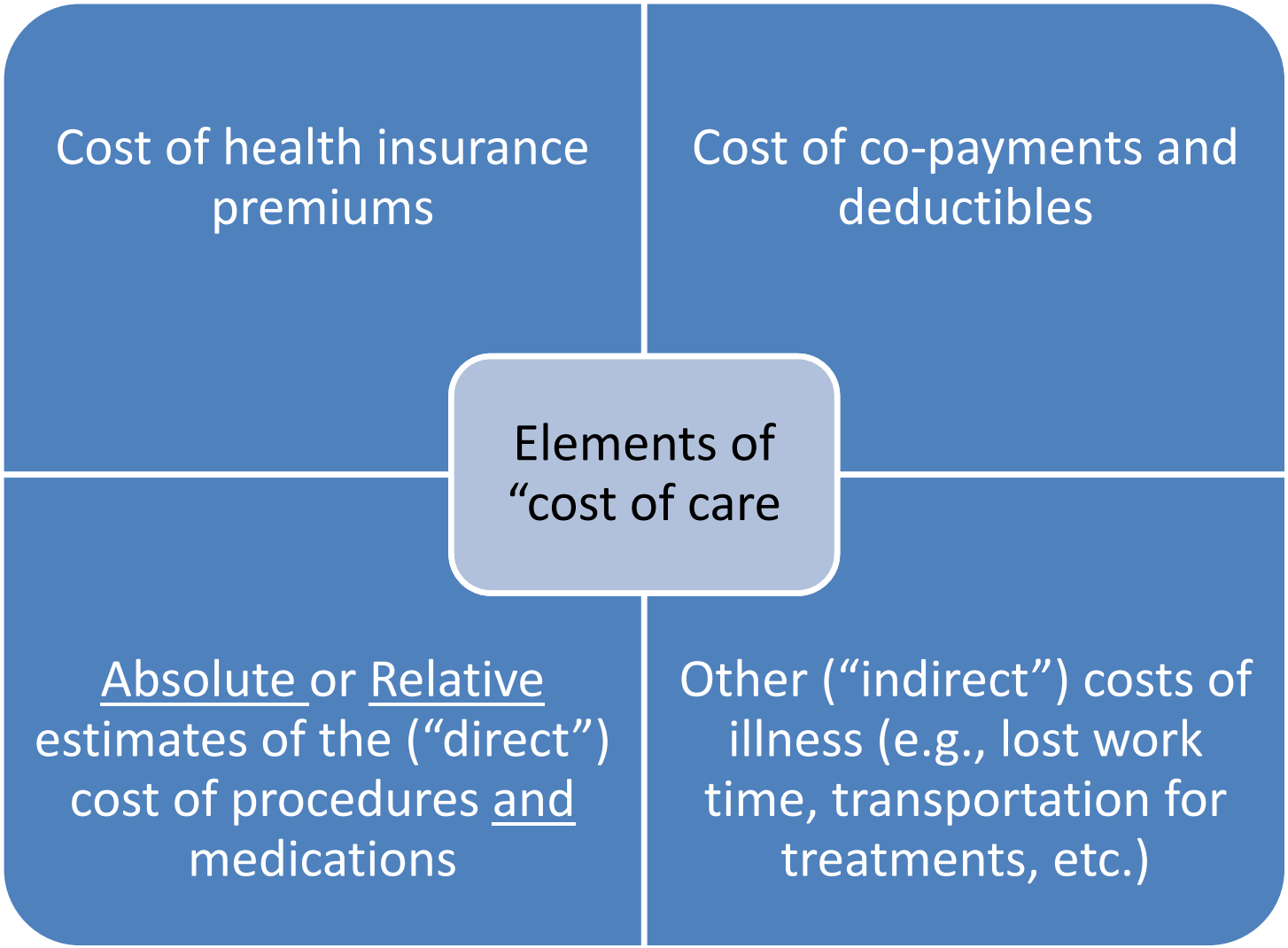
Thank you for your attention…Any questions?

REFERENCES:
QuickStats: Percentage of Persons of All Ages Who Delayed or Did Not Receive Medical Care During the Preceding Year Because of Cost, by U.S. Census Region of Residence — National Health Interview Survey, 2015. MMWR Morb Mortal Wkly Rep 2017;66:121. DOI: http://dx.doi.org/10.15585/mmwr.mm6604a9

Hunter et al., What Strategies Do Physicians and Patients Discuss to Reduce Out-of-Pocket Costs? Analysis of Cost-Saving Strategies in 1755 Outpatient Clinic Visits, BMC Health Services Research (2016) 16:108, DOI 10.1186/s12913-016-1353-2.

This slide allows the presenters/trainers to bring the formal portion of the training to an end and clarify any points of confusion that may remain for any of the participants.

Following questions, the presenters/trainers can review the content of the packet.


Cost of health insurance premiums
Cost of co-payments and deductibles
Elements of "cost of care
Absolute or Relative estimates of the ("direct") cost of procedures and medications
Other ("indirect") costs of illness (e.g., lost work time, transportation for treatments, etc.)

Declaración de política y procedimiento de conversaciones efectivas sobre los costos de los servicios de salud (CoC por sus siglas en inglés) en (Centro de salud)

ANTECEDENTES Y JUSTIFICACIÓN DE LA POLÍTICA

Relación entre los centros de servicios médicos centrados en el paciente y la toma de decisiones compartida.

La toma de decisiones compartida es un sello notable de los centros de servicios médicos centrados en el paciente. El objetivo de lograr conjuntamente el plan de tratamiento de cada paciente y trabajar juntos para manejar la salud y las enfermedades del paciente supone que tanto el paciente como el proveedor (es decir, todo el personal y los médicos) están comprometidos en diseñar ese plan de atención y modificarlo con el tiempo.

La literatura publicada[1] muestra que la adherencia del paciente y los criterios clínicos de la salud de la población mejoran **si los pacientes participan activamente en todos los aspectos de la toma de decisiones. Por lo tanto, tiene sentido que en Centro de Salud. participemos de forma proactiva en el monitoreo de la capacidad del paciente para manejar sus costos de servicios de salud. Esto significa que tenemos que involucrar de manera regular al paciente en las conversaciones sobre los costos de los servicios de salud.**

DECLARACIÓN DE POLÍTICA:

La política del centro de salud es que todos los miembros del personal y los médicos deben involucrar de manera directa y explícita al paciente durante todas las visitas en la exploración de los costos de atención médica. Y aún más si los gastos médicos, el tiempo usado o los costos de transporte para obtener la atención recomendada son un obstáculo para su adherencia exitosa al plan de tratamiento recomendado. Con esto, estamos mejorando nuestro enfoque colectivo centrado en el paciente y la práctica de toma de decisiones compartida que esperamos guíe nuestras interacciones con nuestros clientes.

SUGERENCIAS DE APLICACIÓN:

Contenido de la conversación sobre el costo de los servicios de salud (CoC) - ¿Qué está incluido?

La evidencia sugiere que los elementos de CoC pueden prevenir o retrasar la obtención de una atención médica altamente recomendada. El sentido común sugiere que un plan de atención será menos exitoso, incluso ignorado, si frustra la adherencia al tratamiento de un paciente por no ser sensible a los

múltiples costos implicados en la de adherencia al tratamiento. Esos elementos del costo de la atención incluyen:

A. **Costo de las primas del seguro médico** (primas pagadas por la familia o el empleador)

B. **Costo de co-pagos y deducibles** (pagos directos del bolsillo del paciente al momento de las visitas)

C. Otros costos ("indirectos") **de la enfermedad** (por ejemplo: tiempo de trabajo perdido, transporte para tratamientos, etc.)

Hablar sobre estos elementos del costo de la atención con cada paciente es de importancia crítica para los miembros del personal y los proveedores clínicos en Centro de Salud. Esto mejorará la aceptación de nuestros planes de atención y opciones de tratamiento. También mejorará el cumplimiento y adherencia del paciente al tratamiento y por lo tanto su estado de salud resultante.

El monitoreo constante del uso de conversaciones sobre CoC, así como en la toma constante de signos vitales del paciente, puede mejorar las medidas de salud de nuestra población y la calidad de los resultados de la atención.

Hablar sobre el costo de la enfermedad del paciente nos ayuda a comprender sus necesidades de asistencia, de transporte, de fuentes alternativas para obtención de medicamentos, de servicios de imagen diagnóstica, así como su preocupación por las horas de trabajo perdidas. Esta información mejora nuestra capacidad para involucrar a los trabajadores sociales y a las fuentes de financiamiento externo las cuales el paciente y la familia pudieran no conocer.

Identificar fuentes de seguro médico o cobertura médica es fundamental para facilitar el acceso a nuestros servicios y cubrir nuestros costos de atención. Es crítico reconocer que algunos de estos planes de seguro de salud requieren la participación financiera del paciente y / o de su familia para que los pacientes comprendan su **responsabilidad en los costos de los servicios de salud**. Muchas veces, los pacientes de otras sociedades donde se nacionaliza la atención médica se sorprenden al descubrir que la atención médica en los EE. UU. no es gratuita. En consecuencia, algunos de estos pacientes y sus familias necesitarán asistencia para cubrir esos costos de atención, y podríamos encontrar organizaciones caritativas que puedan brindar este apoyo. Sin la discusión rutinaria sobre las fuentes actuales de seguro médico o los cambios en la cobertura médica, estas necesidades de referencia adicional a otros programas no se descubrirán hasta que se note que las facturas no han sido pagadas y se desencadene una conversación más incómoda. Debido a que estos programas pueden requerir una considerable documentación del paciente para ser elegible, contamos con un especialista que puede ayudar en este esfuerzo. Pero, el personal de esta área no ve a cada paciente en todas sus visitas. **La pregunta de la recepcionista: "¿Ha tenido algún cambio en su seguro médico?" puede ser demasiado pública o dolorosa para revelar la verdad en cada visita. Por lo tanto, todos debemos ser sensibles y estar atentos a las señales de que la cobertura del seguro está en peligro.**

Las conversaciones exitosas sobre el costo de los servicios **de salud son consistentes con la atención centrada en el paciente, cuando se logra a través de procesos de toma de decisiones compartidas.** La literatura[2] sugiere que si bien el médico a menudo se guía por ciertos estándares de calidad en la atención.; el paciente con frecuencia entra en conflicto entre "buscar su bienestar" y evitar una catástrofe financiera conectada directamente a un plan de tratamiento específico. Hablar y cuestionar sobre el plan de atención recomendado, sobre la referencia de imágenes médicas o sobre el plan de medicamentos es una oportunidad crítica para reconocer las barreras financieras del paciente en relación con los costos de bolsillo, los costos de pérdida de trabajo para obtener servicios de imagen médica, las pruebas de laboratorio o los medicamentos. Estar atentos y preguntar sobre el co-pago es una oportunidad para que el paciente revele obstáculos que puedan estar presentes. El cambio a otro centro de imágenes o la elección de elegir una farmacia distinta puede ser central para lograr una adherencia al tratamiento exitosa.

Cuando se discuten nuevos planes de atención con un paciente, se pueden identificar los costos relativos o absolutos. Ya que los protocolos de práctica y ordenes de servicios están estandarizados por los médicos, existe la oportunidad de presentar al paciente un estimado estructurado de los costos esperados por la atención. Sí se está modificando un plan de atención (por ejemplo, una receta nueva), existe la oportunidad de conversar sobre el costo relativo de la atención estimada ("este medicamento nuevo y más eficaz es aproximadamente 50% más caro, pero su co-pago es el mismo"). O bien, se pueden discutir los costos específicos absolutos (este nuevo medicamento, si se compra en nuestra farmacia 340B solo tiene un co-pago de $10, pero en su farmacia local usted dice que paga $15. Entonces, ¡este es un medicamento más efectivo a un costo menor!)

La evidencia[3] de una literatura limitada sugiere que el 67% de estas conversaciones sobre CoC (cobertura de seguro, costo de la enfermedad o costos específicos de tratamiento) tomó menos de un minuto en la visita clínica y solo el 6% tomó más de 3 minutos. Estas conversaciones se pueden incluir de manera eficiente durante la visita clínica en varios puntos.

¿Quién es responsable de la conversación sobre CoC?

Durante la visita o encuentro médico típico, ¿quién debe ser sensible a las preocupaciones del paciente sobre CoC e indicar qué paciente necesita una conversión explícita sobre ello?

Recepcionista: Claramente, la visita médica comienza en la recepción o el registro. Esta es una oportunidad para que la recepcionista confirme que el seguro médico o la cobertura están disponibles, han cambiado o necesitan explorarse para el paciente y su familia. La recepcionista puede identificar que una persona que no se presenta a la cita necesita transporte y puede volver a programar la cita y conectar al paciente con un servicio de transporte. Algunas clínicas pagan por un viaje en Uber, en vez de tener un paciente que no se presenta a la cita, que es costoso para la clínica y, para el paciente también. Estos hallazgos se pueden ingresar en el Registro Médico Electrónico (EMR por su sigla en inglés) más allá de los controles simples del tipo de seguro médico, etc.

Navegador/Consejero financiero o personal de elegibilidad: Redirigir al paciente con el personal de elegibilidad antes de hacer el registro médico es lo que facilitará con mayor probabilidad la

obtención o confirmación de cambios en la cobertura. Sin embargo, la visita con el personal de elegibilidad podría programarse después de la visita a la clínica. En algunas clínicas, las citas por separado con este personal se programan cuando se programa la cita médica, si el paciente revela que no tiene cobertura de seguro médico. Durante esa cita se abordan los programas de financiamiento y sus requisitos, y el personal debe estar atento a las necesidades adicionales que pueden resolverse refiriendo al paciente con los trabajadores sociales o navegadores de pacientes si hay necesidad de un proceso de solicitud complicado. Estas conversaciones tan importantes pueden revelar otros problemas relacionados al costo de la enfermedad, como la necesidad de tener citas fuera del horario de trabajo o durante el fin de semana para evitar la pérdida de trabajo. Tanto la recepcionista como el personal de elegibilidad o el navegador puede darse una idea de estas complejas necesidades, si se mantienen atentos a las sutiles señales del paciente, o si lo preguntan directamente. Esta información se puede ingresar en el EMR además de los controles simples como el tipo de seguro, etc.

Asistente médico: el asistente médico generalmente se enfoca en los signos vitales e identifica el motivo de la visita o cualquier problema con el cumplimiento del plan de tratamiento. Estas son oportunidades excelentes para aclarar si los co-pagos o el costo de la enfermedad interfieren con el cumplimiento del plan de atención. Obtener información sobre los costos específicos que este paciente tuvo durante los servicios de imagen diagnóstica y en la farmacia e ingresarlos en el EMR podría facilitar una consideración más cuidadosa del médico sobre los costos relativos o específicos de la atención que podrían ocurrir si se cambia el plan de atención durante la consulta. Sin la obtención previa de esta información, el médico mismo tendría que reunirla para realizar una comparación efectiva y lograr una conversación beneficiosa.

Personal Clínico - Médico, asistente médico o enfermero(a) practicante: el personal clínico con frecuencia está en posición de impactar más al paciente al recomendar un plan de atención, medicación o examen de laboratorio. Los pacientes asumen que sus consejos son precisos y benéficos. Debido a que los clínicos pueden no tener la información que el asistente médico podría reunir (arriba) sobre los costos actuales para el paciente, muchas veces dudan en ofrecer información específica de costos a sus pacientes. Con el tiempo, si nuestra clínica recolecta y analiza constantemente información sobre el CoC, esta incomodidad para el clínico se llevará a un nivel cómodo. El mantener estos datos en la EMR de cada paciente facilitará este proceso de aprendizaje y aumentará la comodidad de los clínicos.

Las preguntas simples cuando se recomiendan cambios o el inicio de otros componentes del plan de cuidado pueden generar un entendimiento considerable sobre el impacto del costo de la atención para cada paciente y su familia. Algunos ejemplos de preguntas incluyen:

A. "¿Puede usted pagar/cubrir el co-pago por esta visita, este medicamento, este laboratorio?"

B. "¿Puede usted faltar al trabajo por un período de 3 a 4 horas esperando en el centro servicios de imagen médicas del hospital?"

C. "¿Prefiere un co-pago mayor para el servicio de imagen médica en una clínica privada o un copago menor pero un mayor tiempo de espera para los rayos X en el hospital del Condado?"

Empleado de facturación/cajera(o) o empleado de recepción/salida: tanto el empleado de recepción/salida o el empleado de facturación, puede ser la última oportunidad para clarificar directamente con el paciente y su familia si tienen problemas financieros que puedan interferir con la adherencia del paciente al tratamiento recomendado. Aunque su espacio suele ser más público que el de otros miembros del personal, puede ser que algún miembro del personal dependa de ellos para tener la conversación sobre el CoC sobre cobertura del seguro médico, gastos de bolsillo, transporte o pérdida de trabajo. Estas preguntas podrían ser parte de un protocolo de cuestionamiento que se use al final de la visita médica.

Oportunidades adicionales para tener conversaciones de CoC que con frecuencia se desaprovechan:

Solicitar o recoger medicamentos en la farmacia: el personal de la farmacia puede preguntar al paciente si llegar a la farmacia es inconveniente o costoso para él y si el costo de los medicamentos actuales es demasiado alto y que esto pueda evitar que el paciente siga el tratamiento.

Farmacéuticos o técnico de farmacia: tanto el farmacéutico como los técnicos pueden ser sensibles a las señales del paciente sobre los problemas de CoC mientras instruyen al paciente sobre la forma adecuada de tomar el medicamento.

Recepcionista de sala de emergencias y asesores financieros: cuando la clínica está asociada a una sala de emergencias específica, los asesores financieros de estas dos entidades deben involucrar al paciente en una evaluación de su capacidad para pagar los servicios en términos de gastos de bolsillo y sus costos de acceso, transporte y medicamentos. La exploración adicional de la elegibilidad del paciente para la asistencia financiera es claramente una contribución importante de ambos asesores financieros. Una vez más, mientras que el Departamento de Facturación y los consejeros financieros son puntos obvios de la investigación de CoC, todos los empleados deben estar vigilando activamente las oportunidades para ayudar al paciente en los asuntos de CoC y atenderlos directamente.

Record médico electrónico (EMR) y manejo de calidad: el uso significativo del EMR incluiría el resumen descriptivo de los recursos del paciente en términos de costos promedios y rangos de costos para diagnósticos específicos y órdenes estándares. Como se mencionó anteriormente, los costos de tiempo usado durante el encuentro son mínimos, esto con base en los encuentros registrados donde tuvieron lugar las conversaciones sobre CoC. A largo plazo, la adherencia al tratamiento mejorará y los resultados también deberán mejorar. Desarrollar y explorar estas estimaciones a lo largo del tiempo y analizarlas en relación con los resultados obtenidos por clínica en los indicadores de calidad de atención podría ser valioso para la salud de los pacientes y la salud financiera de las clínicas. La capacitación de todo el personal de la clínica con respecto a las conversaciones de CoC, específicamente frases y expresiones sugeridas, exploración confidencial y empatía, debería hacerse por lo menos.

¿Quién asumirá el rol de monitorear que las conversaciones sobre CoC ocurran?

Tal como se explicó en el párrafo sobre política, TODOS somos responsables de realizar y ser sensibles a los cambios en la situación financiera del costo de la atención de nuestros pacientes. En última instancia, el equipo clínico y la administración de la clínica son los responsables de garantizar que, durante la estancia del paciente en la clínica, se obtenga la mayor información posible que pueda resultar en el mejor cuidado de la(s) condición(es) del paciente. Es fundamental mejorar el EMR para solicitar información clave de CoC durante cada visita, y registrar datos factuales que mejoren la información sobre posibles problemas sobre los CoC que pueda tener el paciente. Esto ayudará al personal que posteriormente interactúe con el paciente para lograr una mayor adherencia al plan de atención recomendado por nosotros. Es responsabilidad del equipo de administración y de calidad de la clínica organizar el uso creativo y consistente de esta información, de forma periódica.

Los resultados positivos posibles para nuestros pacientes, sus familias y el **Centro de Salud** son obvios.

Conversaciones efectivas sobre los costos de los servicios de salud en

Centro de Salud

PROCEDIMIENTO SUGERIDO: (PARA SER REVISADO SEGÚN SEA APROPIADO PARA EL CENTRO DE SALUD/CLÍNICA)

#	¿Quién?	¿Qué debe hacer?	¿Cuándo y dónde sucederá esto?	¿Cuál es el resultado esperado?
1	Recepcionista	"¿Algún cambio en su seguro?" Puede ser muy público o muy doloroso para revelarse. Preguntar "¿Tiene una nueva cobertura de seguro?" Puede ser más suave. Prepárese para ofrecer información confidencial al personal de elegibilidad o navegador financiero. Prepárese para retrasar la referencia, seguir la cita médica, o para mantener cita programada por la clínica.	Recepción (área pública) o asistente financiero o navegador (área confidencial).	Detección de dificultades en cuestiones de pagos directos del bolsillo del paciente.
		Registre los resultados en EMR para que el personal que atienda al paciente los conozca y se integren al proceso de atención del paciente.		
2	**Empleado de elegibilidad o navegador financiero**	En un espacio más confidencial revise la situación del paciente y su elegibilidad para programas de cobertura. Hable y cuestione sobre las situaciones de ingresos y de empleo, así como de cualquier situación de residencia que pueda afectar su elegibilidad. Revise el costo histórico de los servicios de salud con proveedores médicos anteriores. Registre los resultados en EMR para que otros conozcan y se integren en sus procesos de servicios de salud.	Asistente o navegador financiero (área confidencial).	Detección de la situación financiera familiar y preferencias para cubrir los costos de bolsillo. Detección de problemas de transporte, farmacia y acceso a laboratorios y sus posibles soluciones.
		Registre los resultados en EMR para que otros conozcan y se integren en sus procesos de cuidados de salud. Refiérase al navegador de pacientes o personal de elegibilidad si es necesario. Incluya una nota en el EMR para concertar una cita después de la visita médica.		
3	**Asistente médico**	Aclare la razón de la visita, obtenga signos vitales. Identifique cualquier problema con la adherencia al plan de cuidado, incluyendo problemas de medicamentos, reacciones, y costos de cuidados de la salud – pagos directos del bolsillo del paciente, costos y dificultades de transporte, co-pagos de farmacia y acceso para recoger medicamentos. Después de que el médico de órdenes, el asistente médico deberá generar estimados de costos de cuidados de salud	En sala de examinación privada (Asegúrese de tener privacidad)	Detección de signos vitales y motivo de visita. Detección de problemas financieros familiares, incluyendo costos directos de bolsillo del paciente que puedan influir con la adherencia al tratamiento. Detección de cualquier preocupación con

		para farmacia, imágenes diagnósticas, laboratorios y costos directos del bolsillo en conjunto con la administración. De ser posible, hable con el paciente..		relación al transporte, la farmacia y el acceso al laboratorio y sus posibles soluciones.
		Registre los resultados en EMR para que otros conozcan y se integren en sus procesos de cuidados de la salud. Refiérase al navegador de pacientes o personal de elegibilidad si es necesario. Incluya una nota en el EMR para concertar una cita después de la visita médica.		
4	**Clínicos - médico, asistente médico o enfermero practicante**	Aclare el motivo de la visita, el diagnóstico y el plan de atención recomendado. Identifique cualquier problema potencial en el cumplimiento del plan de atención, problemas con medicamentos y/o sus reacciones y costos de servicios de salud, incluyendo gastos de bolsillo, dificultades de transporte, co-pagos de farmacia y acceso para recoger medicamentos. Discuta opciones y soluciones. Después de crear ordenes, genere estimaciones de los costos de atención para farmacia, imágenes diagnósticas, laboratorios y los costos esperados de bolsillo del paciente en colaboración con la administración. Hable con el paciente.	En el consultorio privado, confidencial, o donde la privacidad y confidencialidad sea posible.	Detección de signos vitales y motivo de visita. Detección de problemas financieros familiares, incluidos los costos directos del bolsillo del paciente, que puedan estar interfiriendo con la adherencia al tratamiento. Detección de cualquier preocupación relacionada con el transporte, la farmacia y el acceso a laboratorio, y posibles soluciones.
		Registre los resultados en EMR para que otros conozcan y se integren en sus procesos de cuidados de salud.		
5	Empleado de facturación/ cajera(o) o empleado de recepción/salida	Aclare en las notas de EMR o en la cita programada que miembros del personal identificaron problemas potenciales en la adherencia al plan de tratamiento, problemas con medicamentos, reacciones y costos de servicios de salud, incluyendo gastos de bolsillo, dificultades de transporte, co-pagos de farmacia y acceso para recoger medicamentos. Discuta opciones y soluciones. Usando las órdenes creadas para esta visita, genere junto con la administración, estimaciones de costos de la atención de farmacia, imágenes diagnósticas, laboratorios y costos esperados de pago del bolsillo del paciente. Discuta con el paciente.	Empleado de recepción/salida (área pública) o con asistente financiero o navegador (área confidencial)	Resolución de problemas financieros familiares, incluyendo la cobertura básica, el co-pago y las estructuras deducibles. Esté preparado para informar al paciente proporcionando materiales de apoyo sobre los costos directos del bolsillo del paciente (si es que existen), y que pueden impedir la adherencia al tratamiento. Resolución de cualquier problema de transporte, farmacia y acceso a laboratorios y soluciones potenciales.
		Agregue al EMR las resoluciones desarrolladas para este paciente, para que esta información esté disponible en visitas futuras.		

REFERENCIAS:

[1]: *QuickStats:* Percentage of Persons of All Ages Who Delayed or Did Not Receive Medical Care During the Preceding Year Because of Cost, by U.S. Census Region of Residence — National Health Interview Survey, 2015. MMWR Morb Mortal Wkly Rep 2017; 66:121.
DOI: http://dx.doi.org/10.15585/mmwr.mm6604a9

[2]: A.: Cook K, Dranove D, Sfekas A. Does major illness cause financial catastrophe, HSR 2010 45(2) 418–36.

B.: Kelly, RJ, et al,Patients and physicians can discuss costs of cancer treatment in the clinic, J Onc Prac, May 2015, p 1-6.

C.: Ubel PA, Zhang CJ, Hesson A, Davis JK, Kirby C, Barnett J & Hunter WG, Study Of Physician & Pt Comm Identifies Missed Opportunities To Reduce Patients' OoP Spending, HA 35 (4) 20.

[3]: Hunter et al., What Strategies Do Physicians and Patients Discuss to Reduce Out-of-Pocket Costs? Analysis of Cost-Saving Strategies in 1755 Outpatient Clinic Visits, BMC Health Services Research (2016) 16:108, DOI 10.1186/s12913-016-1353-2.

Los términos usados en las conversaciones sobre seguro de salud pueden ser confusos y resultar en que el paciente no busque la atención médica necesaria. Aquí algunos términos básicos:

Copago es un costo fijo que el paciente paga cada vez que visita al médico. El costo restante es pagado por la compañía de seguros.

Deducible es el costo de los servicios pagado por el paciente hasta que llegue a su máximo anual de deducible (gastos de bolsillo) antes de que inicien los beneficios del seguro.

Máximo desembolso anual es la cantidad máximo anual de deducible (gastos de bolsillo) antes de que inicien los beneficios del seguro.

Costos permitidos son terapias, medicamentos y tratamientos específicos que las aseguradoras consideran "permitidos" de acuerdo a la evaluación de su efectividad pueden especificar.

Atención preventiva es la atención antes de que se presenten las enfermedades considerada "efectiva" por los expertos nacionales.

Condiciones preexistentes son características de salud que la persona ya tiene antes del inicio de su cobertura de seguro.

Programas de descuentos de prescripciones médicas

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o llame al **1-844-329-3341**
Comparaciones de precios locales

EasyDrugCard™

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NeedyMeds

needymeds.org
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singlecare

singlecare.com
Regístrese para una membresía gratuita. Descuento para visión y dental

RxAssist
Patient Assistance Program Center

rxassist.org
o llame al **1-877-537-5537**

PPA
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pparx.org
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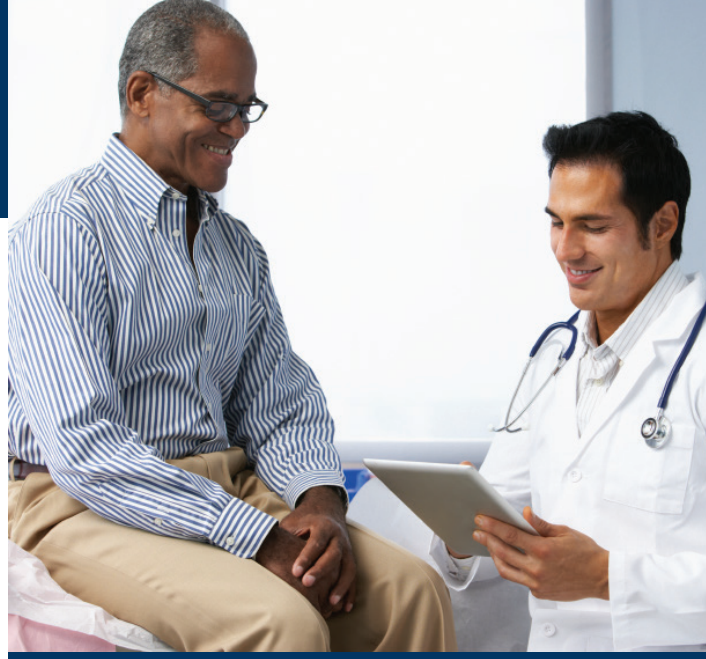

Hablemos del seguro de salud y de los costos de servicios de salud para pacientes

Producido por:

MIGRANT CLINICIANS NETWORK
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Proyecto “Claridad en los costos: pacientes y proveedores creando juntos los planes de servicios de salud” financiado por la Fundación Robert Wood Johnson

CÓMO FUNCIONA UN PLAN DE SEGURO MÉDICO "TÍPICO"