**Policy Statement and Procedure for   
Effective Cost of Care Conversations in ??? Clinic**

**POLICY RATIONALE AND BACKGROUND**

***Relationship to Patient-Centered Medical Homes and Shared Decision-making.***

Shared Decision-making is a hallmark of Patient-Centered Medical Homes. This goal of collaboratively achieving each patient’s treatment plan and working together to manage the patient’s health and illnesses, assumes that both the patient and the provider (i.e., all staff and clinicians) are engaged in designing that care plan and modifying it over time.

Published literature1 shows that patient adherence and clinical metrics of population health improve **if patients are actively engaged in all aspects of decision-making. Therefore, it makes sense that we at ??? Clinic should be proactively engaged in monitoring the patient’s capacity to handle their costs of care. That means we need to engage the patient in Cost of Care conversations, routinely.**

**POLICY STATEMENT**

**It is the Policy of ??? Clinic that all staff members and clinicians should explicitly and directly engage the patient during each visit to explore their costs of care issues and whether these medical expenses or the time or transportation costs to acquire recommended care are an impediment to their successful adherence to our recommended care plan. In doing this, we will add to our collective patient-centeredness and practice the shared decision-making that we expect to guide our interactions with our clients.**

**IMPLEMENTATION SUGGESTIONS**

***Content of the Cost of Care (CoC) Conversation – What’s included?***

Evidence suggests that elements of costs of care can prevent or delay the patient’s acquisition of even highly recommended care. Common sense suggests that a care plan that frustrates a patient’s compliance because it is not sensitive to their multiple costs of adherence will be less than successful, if not ignored. Those elements of the cost of care include:

1. **Cost of health insurance premiums** (premiums paid by family, or employer)
2. **Cost of co-payments and deductibles** (out-of-pocket fees that share the cost of visits)
3. **Other (“indirect”) costs of illness** (e.g., lost work time, transportation for treatments, etc.)

Discussing these elements of cost of care with each patient is critically important for every staff member and each clinical provider in ??? Clinic. This will improve the acceptability of our care plans and treatment choices. It will also improve patient’s compliance, and their resulting health status.

Consistently monitoring the use of CoC conversations, just like consistently taking vital signs, can improve our population health measures and quality of care outcomes.

Discussing the patient’s cost of illness helps us understand their needs for transportation assistance, their need for alternative sources for imaging and pharmacy, and their concern for missed work hours. This information improves our ability to engage social workers and external funding sources of which patient and family may not have been aware.

Identifying sources for health insurance or medical coverage is fundamental to facilitating access to our care, and covering our costs of providing care. Acknowledging the reality that some of these health insurance plans require the financial participation of the patient and / or their family is critical to their gaining an understanding of their **responsibility for the costs of care**. Often patients from other societies where healthcare is nationalized are surprised to find that healthcare in the US is not free. Still some patients and their families will need assistance in covering those costs of care, and we might find charitable organizations who can provide this support. Without the routine discussion about current sources of health insurance or changes in coverage, these needs for additional referral to other programs will not be uncovered until after bills are not paid and more awkward conversation must occur. Because these programs may require considerable eligibility documentation, we have specialists that can assist in this effort. But, they do not see each patient at each visit. **The receptionist’s inquiry of “Any changes in your insurance?” may be too public, or too painful to uncover the truth at each visit. Therefore, we all need to be sensitive and alert to signals that insurance coverage is in jeopardy.**

Asking if the expected copayment is burdensome may create an opportunity for the patient to reveal potential barriers. The literature2 suggests that while the clinician is often driven by quality of care standards and focuses their attention there, the patient is often conflicted between the “seeking wellness” and avoidance of financial catastrophe that is attached to a specific care plan. **Successful Cost of Care conversations are consistent with Patient-Centered Care, when achieved through Shared Decision-making processes.** Questioning whether a recommended care plan, imaging referral, or medication plan is feasible is a critical opportunity for being sensitive to the patient’s financial barriers to out of pocket costs or work loss costs for gaining desired images, laboratory tests, or meds. Switching to a different imaging center or pharmacy may be crucial to achieving successful adherence.

When new care plans are discussed with a patient, the relative or absolute costs can be identified. Because practice patterns and order sets are frequently standardized by clinicians, there is an opportunity to present the patient a structured delineation of their expected costs of care. If a care plan is being modified, (e.g., a new prescription), there is an opportunity to provide a conversation of the relative cost of care estimate (“This new, more effective medication is about 50% more expensive, but your copayment is the same.”). Or, absolute specific costs can be discussed, (“This new medication, if purchased from our 340B Pharmacy is only $10 copay, but at your local pharmacy you said you were paying $15. So, this is a more effective drug at a lower cost!”)

Evidence from limited literature3 suggests that 67% of these cost of care conversations (about insurance coverage, cost of illness, or specific treatment costs) took less than a minute in the clinic visit, and only 6% took more than 3 minutes. These conversations can be efficiently woven into the clinical visit, at several points.

***Who is Responsible for the Cost of Care Conversation?***

During the typical Medical Visit, or encounter, who should be sensitive to the cost of care concerns and signal to whom that an explicit CoC conversation is needed?

Receptionist: Clearly, the medical visit begins at the check-in desk. This is an opportunity for the Receptionist to confirm that health insurance or programmatic coverage is available, changed or needs to be explored for this patient and family. The receptionist may identify that a no-show needs transportation, and might re-schedule the appointment and connect the patient to a transportation support. Some Clinics pay for an Uber ride, rather than incurring the no-show, which is costly to the clinic, and ultimately to the patient. These findings can be entered into the Electronic Medical Record (EMR) beyond simple check-offs of type of insurance, etc.

Eligibility Clerk or Financial Navigator / Counselor: Re-routing the patient to the Eligibility Clerk before the medical check-in is the most likely outcome to facilitate gaining or confirming changes in coverage. However, the Eligibility Clerk might be scheduled after the clinic visit. In some clinics, separate appointments with Eligibility are scheduled when the appointment is being made, if the patient reveals that they have no insurance coverage. Eligibility Clerks address the financing programs and their requirements, and also need to be alert for additional needs that can be met through referral to Social Workers, or Patient Navigators, if a complex application process is needed. These crucial discussions may uncover other cost of illness issues, including the need for after-hours or weekend appointments to avoid work loss. Either the Receptionist, the Eligibility Clerk, or the Navigator may gain insight into these complex needs, if they are alert to subtle signals from the patient, or specifically inquire. These findings can be entered into the Electronic Medical Record (EMR) beyond simple check-offs of insurance type, etc.

Medical Assistant: The Medical Assistant usually focuses on the vital signs, and identifying any problems in the care plan adherence, or the reason for the visit. These are great opportunities to also clarify whether the copayments or cost of illness are interfering with that care plan’s adherence. Getting information about the specific costs that have been incurred by this patient at the imaging center and the pharmacy and entering these into the EMR could facilitate the clinician’s careful consideration of the relative or specific costs of care that might occur, if a change in care plan or script is suggested in the encounter. Without this information, the clinician will have to gather these data points to conduct an effective comparison and fruitful conversation.

Clinician – Physician, Physician Assistant or Nurse Practitioner:Clinicians are frequently in the position to influence the patient the most by recommending a care plan, medication or laboratory test. Patients assume their advice is accurate and for their benefit. Because Clinicians may not have the information that the Medical Assistant could collect (above) about current costs to the patient, they are often hesitant to offer specific cost information to their patients. Over time, if our clinic is consistently collecting and discussing cost of care information, this discomfort for the clinician will resolve to a comfortable level. Maintaining these data in the EMR of each patient will facilitate this learning process and increase clinicians’ comfort.

Simple questions when recommending changes or initiation of the care plan components will garner considerable insight about the impact of the cost of care for each patient and family. Examples include:

1. “Is your co-payment for this visit, this medication, this lab comfortable?”
2. “Will it be possible for you to be away from work for the time frame of 3 to 4 hours waiting at the hospital imaging center?”
3. “Would you prefer a larger co-pay amount at the Private Imaging Center, or waiting longer for the x-ray at the County hospital?”

Check-out Clerk or Billing Clerk:Both the Check-out Clerk and the Billing Clerk, if not the same individual, may be the last opportunity to clarify directly with the patient and family whether they are experiencing any financial concerns that might interfere with the patient adhering to the recommended care plan. Although their space is usually more public than many of the other staff members, it may be that others rely on them to handle the Cost of Care conversation about insurance coverage, out-of-pocket expense, transportation or work loss. These questions could be part of a script used in the closing moments of the medical visit.

***Additional Opportunities for CoC Conversations that are Often Missed:***

Pharmacy Check-in or Pick-up:Pharmacy Clerk can inquire during check-in whether coming to the pharmacy is inconvenient or costly, and whether the current medications are too costly to potential prevent adherence.

Pharmacists or Pharmacy Technician: Both the Pharmacist and Technicians can be sensitive to the patient’s signals of Cost of Care issues while they are engaged in instructing the patient about appropriately taking the medication.

Emergency Room Clerk and Financial Counselors: When the clinic is associated with a specific Emergency Room, the financial counselors of these two entities should engage the patient in an examination of their ability to pay for their care in terms of out-of-pocket expenses and their costs of access, transportation and medications. Additional exploration of the patient’s eligibility for financial assistance is clearly an important contribution from both financial counselors. Again, while the Billing Department and Financial Counselors are obvious points of CoC investigation, all employees should be actively watching for opportunities to assist the patient in the CoC issues and engage them directly.

Clinical EMR and Quality Management: Meaningful use of the EMR would include the descriptive summary of patients’ cost of care means, medians and ranges for specific diagnoses and standard order sets. As noted above, the time costs in the encounter are minimal, based on recorded encounters where costs of care conversations took place. In the long run, adherence will improve and outcomes should improve as well. Developing and exploring these estimates over time and discussing them in relation to the clinic’s performance in quality of care metrics could be valuable to the patient population’s health and the clinic’s financial health, too. Training of everyone in the clinical environment regarding suggested phrasing, confidential exploration and empathetic Cost of Care Conversations should be annual if not more frequent.

**Who will take on the role of monitoring Cost of Care Conversation Occurrence?**

As the policy discussion above relates, EVERYONE is responsible for conducting and being sensitive to changes in the cost of care situation of our patients. Ultimately the Clinical team and Clinic Management are responsible for assuring that the patient’s flow through each visit garners the best information that can result in optimal care of the patient’s condition(s). Enhancing the Electronic Medical Record to prompt for key CoC information during each visit, and recording factual data for the subsequent players’ knowledge about potential CoC issues that might reduce adherence to our recommended care plan, is critical. Organizing consistent creative use of this information, on a periodic basis, is the responsibility of the Quality Management and Clinic Management teams.

The potential positive outcomes for our patients, their families and the clinical organization are obvious.

***SUGGESTED PROCEDURE: (TO BE REVISED AS SEEN APPROPRIATE FOR ??? CLINIC)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **#** | **Who?** | **What will you do?** | **When and Where will this happen?** | **Expected Outcome?** |
| 1 | **Receptionist** | “Any changes in your insurance?” may be too public, or too painful to uncover the truth. Asking “Do you have new insurance coverage?” may be gentler. Be prepared to offer confidential referral to the Eligibility Clerk or Navigator.  Be prepared to delay the referral to after the medical appointment to maintain the clinic’s schedule. | Front Desk (public area)  or  Financial Assistant  or  Navigator (confidential area) | Detection of out-of-pocket cost of care issues, if present. |
| Record findings in EMR for others to know and assimilate into their care processes. | | |
| 2 | **Eligibility Clerk or Navigator** | In a more confidential space, review the patient’s situation and eligibility for various programs of coverage.  Review income and employment situations, as well as residence, which affect eligibility.  Review historical cost of care with prior medical providers.  Record findings in EMR for others to know and assimilate into their care processes. | Financial Assistant  or  Navigator (confidential area) | Detection of family financial situation and preferences for covering the out-of-pocket costs of care issues, if present.  Detection of transportation, pharmacy and laboratory access concerns and potential solutions. |
| Record findings in EMR for others to know and assimilate into their care processes. Referral to Patient Navigator or Eligibility Clerk if warranted. EMR note to set up appointment after medical visit. | | |
| 3 | **Medical Assistant** | Clarify the reason for the visit, obtain vital signs.  Identify any problems in the care plan adherence, including medication issues, reactions,  and costs of care – out of pocket expenses, transportation costs and difficulties, pharmacy co-payments and access for pick-up.  After clinician creates orders, generate estimates costs of care for pharmacy, imaging, laboratories and expected out-of-pocket costs in collaboration with management. Discuss with patient, if possible. | In confidential examination room, where confidentiality is possible. | Detection of vitals and reason for visit.  Detection of family financial issues, including the out-of-pocket costs of care issues, if present that may be interfering with adherence.  Detection of any transportation, pharmacy and laboratory access concerns and potential solutions. |
| Record findings in EMR for others to know and assimilate into their care processes. Referral to Patient Navigator or Eligibility Clerk if warranted. EMR note to set up appointment after medical visit. | | |
| 4 | **Clinician – Physician, Physician Assistant or Nurse Practitioner** | Clarify the reason for the visit, diagnoses, and recommended care plan.  Identify any potential problems in the care plan adherence, including medication issues, reactions, and costs of care – out-of-pocket expenses, transportation costs and difficulties, pharmacy co-payments and access for pick-up concerns and discuss options and solutions.  After creating orders, generate estimates of costs of care for pharmacy, imaging, laboratories and expected out-of-pocket costs in collaboration with management. Discuss with patient. | In confidential examination room, where confidentiality is possible. | Detection of vitals and reason for visit.  Detection of family financial issues, including the out-of-pocket costs of care issues, if present that may be interfering with adherence.  Detection of any transportation, pharmacy and laboratory access concerns and potential solutions. |
| Record findings in EMR for others to know and assimilate into their care processes. | | |
| 5 | **Check-out Clerk or Billing Clerk** | Clarify in EMR notes or scheduled appointment staff members’ identified potential problems in the care plan adherence, including medication issues, reactions, and costs of care – out-of-pocket expenses, transportation costs and difficulties, pharmacy co-payments and access for pick-up concerns and discuss options and solutions.  Using created orders in this visit, generate estimates of costs of care for pharmacy, imaging, laboratories and expected out-of-pocket costs in collaboration with management. Discuss with patient. | Check-out or Front Desk (public area)  or  in  Financial Assistant  or  Navigator (confidential area) | Resolution of family financial issues, including basic coverage, copayment and deductible structures. Be prepared to educate the patient with handouts about the out-of-pocket costs of care issues, if present, that may be interfering with adherence.  Resolution of any transportation, pharmacy and laboratory access concerns and potential solutions. |
| Add to EMR notes any resolutions developed for this patient, so this information is available in future visits. | | |
|  |  |  | | |

**REFERENCES:**

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.