
Addressing the Most Common Barriers to Implementing Cost-of Care Conversations

Cost-of-Care Conversations Practice Brief #7

Aim / This Practice Brief provides actionable tips for addressing the potential barriers and challenges related to implementing cost-of-care (CoC) conversations in the clinical setting.

What Specific Challenges Exist Related to Implementing these Conversations in Environments Serving Vulnerable Populations?

Research shows that patients in community clinics worry about the costs of their care more than their clinicians realize (1). However, organizations serving vulnerable patients may face unique challenges that can serve as barriers to the routine use of CoC conversations. For example:

- Vulnerable patients – especially low- or fixed-income patients – worry about receiving suboptimal care if they bring up cost concerns with their clinicians (2, 3). See [Practice Brief #6](#) for considerations for holding CoC conversations with vulnerable patients
- The indirect costs of care (e.g., transportation, child care, and lost wages) may pose a greater burden on your low- or fixed-income patients and those with intensive care plans who require more frequent appointments (e.g., patients with a high-risk pregnancy, diabetes, and/or high-blood pressure). See [Practice Brief #2](#) to better understand the indirect costs of care that your patients may be facing
- Patients that live in rural areas may have less ability to ‘shop’ for lower-cost healthcare services because of limited provider availability, as well as challenges and additional costs associated with travel and time off work (4)

Tips /

- Reassure patients that 1) the aim of CoC conversations is to provide them with access to the best care and outcomes, and 2) that these conversations are occurring with all patients. For tips on how to employ empathetic communication with patients, see [Practice Brief #4](#). Using techniques outlined in [Practice Brief #4](#) will help reduce the feeling, reported by low- or fixed-income, vulnerable patients, of being stigmatized. It will also help reduce the chance that patients who might be reluctant to initiate these conversations will have their financial needs overlooked (2)
- Invite CoC conversations with patients using wall posters and fliers that remind and encourage patients to raise cost questions and concerns. This will highlight that every patient is invited to discuss costs and not just those who are facing financial hardship. See [Practice Brief #3](#) for example wall posters and other patient-facing resources that you can use in your practice. Also consider engaging your patients in the development of these resources, to ensure they resonate with your patients and make CoC conversations feel welcome
- Maintain information on helpful resources that you can share with your patients to address their cost concerns (3). Refer to [Practice Briefs #2](#) and [#4](#) for cost resources that you can provide your patients
- Let your patients know about potential indirect costs (e.g., transportation, child care, and lost wages) of receiving care. This will support them in choosing the right treatment option and planning accordingly for their care. For more information on how to assess your patients' indirect costs of care, see [Practice Brief #2](#)
- Identify the competing costs that you patients might be facing (e.g., housing, food, and bills), so that you can better target your care recommendations and refer patients to appropriate cost resources
- Verify whether your organization has navigator(s) and/or social worker(s) on staff who support patients with addressing the costs of their care. Start referring patients to these staff for further assistance

What are the Most Common Barriers Shared by other Clinicians on the Feasibility of Implementing CoC Conversations?

According to a 2018 survey administered to a random sample of 3,000 US American College of Physicians (ACP) members, the most commonly cited barriers to discussing costs relate to insufficient resources such as time, staff, or tools to determine out-of-pocket costs to patients. About 70% of clinicians also cited lack of clinician knowledge (e.g., about costs of medical treatments or patient insurance coverage) as a key barrier (2).

Tips /

- Highlight that CoC conversations can be brief and that preliminary conversations can take less than 1 minute (5)
- Highlight that CoC conversations require a team-based approach and do not rest solely with the clinical staff. For example, non-clinical practice and system staff can support in providing access to cost information and linking your patients to resources (3, 6)
- Establish a clinician champion early who can help drive engagement and buy-in

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- Highlight the importance of CoC conversations in improving patient care and the patient-clinician relationship. See the research presented in [Practice Brief #1](#)
 - Share data and stories on the need and importance of holding CoC conversations with patients. See the [patient stories](#) developed by the Patient Advocate Foundation

What are Some of the Most Common Barriers to Leadership Buy-In?

Leadership across organizations can be protective of clinicians' time due to cost pressures and other competing priorities. Leadership therefore may not be receptive to encouraging CoC conversations unless there is a clear business case (return on investment) and/or impact on patient outcomes.

Tips /

- Share data on the potential to improve patient outcomes through CoC conversations. See the data presented in [Practice Brief #1](#)
- For practice-level leadership, propose a workflow that builds on your organization's existing practices and integrates a team-based approach. You can leverage the example workflow templates shared in [Practice Brief #5](#)
- For organizational-level leadership (e.g., the Chief Medical Officer), tie CoC conversations to your organization's existing priorities such as participation in value-based payment models, quality improvement initiatives, and revenue cycle management

What are Challenges in Educating and Training Staff?

Findings from the University of Rochester Medical Center study highlight that a single 1-hour training tends to be ineffective to spur long-term culture change for the routine use of CoC conversations. The University of Southern Maine grantee found that online training modules allow for longer training periods and greater flexibility for clinicians to attend when most convenient for them. However, lack of financial or indirect incentives for participating in training caused low rates of participation. Effective training can also be complex due to the: 1) distinct roles and responsibilities among different staff in facilitating CoC conversations; and 2) variation in patient needs related to CoC conversations.

Tips /

- Establish and include a clear definition of CoC conversations to ensure that all members of your care team have a shared understanding of expectations. Read Dr. Hunter et al's article for an understanding of different definitions (7)
- Develop and deploy training resources tailored to each member of your care team to establish clear roles (3, 6)
- Hold multiple training sessions to ensure reach across your organization and integrate them into existing training opportunities
- If possible, tie participation to continuing medical education (CME) credits or other financial or indirect incentives (4)
- Provide tips for how to tailor CoC conversations to the varying needs of your patients (8). See **Figure 1** in [Practice Brief #4](#) for 3 types of cost conversations, including specific patient needs and recommendations for the clinician's role to address these needs

For Further Information

This Practice Brief summarizes research funded by the Robert Wood Johnson Foundation and offers practical ways for both patients and care providers to improve the value and frequency of CoC conversations. For the full set of briefs, please see [here](#).

References

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