



January 11, 2013

Submitted Online

Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
Patriots Plaza III
355 E Street, SW
Washington, DC 20201

Re: ONC request for comment regarding draft recommendations for stage 3 of
meaningful use of electronic health records (EHRs) – Docket HHS-OS-2012-0007

Dear Colleagues:

On behalf of the North American Quitline Consortium (NAQC), I would like to thank ONC for the opportunity to provide comments on the draft recommendations for stage 3 of meaningful use, as proposed by the Health Information Technology Policy Committee (HITPC). It is our hope that ONC will include electronic quitline referral as part of its stage 3 recommendations on meaningful use of EHRs. NAQC is committed to working with EHR vendors and eligible providers, hospitals and acute care hospitals to implement a thoughtful, patient-centered and cost-effective process for electronic quitline referral.

BACKGROUND

As you may know, a quitline is a health service that offers telephone support – information, counseling, medication and other support – for people who want to quit using tobacco. Quitlines were first demonstrated to be effective in randomized clinical trials (1), and they are recommended for treating tobacco use and dependence by the U.S. Public Health Service's Clinical Practice Guideline (2). In the U.S., quitlines exist in all 50 states, the District of Columbia, Puerto Rico and Guam (3).

NAQC is a non-profit organization that aims to maximize the access, use and effectiveness of quitlines; provide leadership and a unified voice to promote quitlines; and offer a forum to link those interested in quitline operations. NAQC is comprised of over 400 quitline professionals at state and provincial health departments, quitline service provider organizations, research institutes and national organizations in the United States and Canada. The Consortium enables professionals from these organizations to learn from each other and improve quitline services.

The adoption of quitlines by state health departments occurred very rapidly in the U.S. The first state quitlines were established in the early 1990's. By 2000, over 35 state health departments were offering quitline services to smokers who want to quit. Currently, all 50 states, the District of Columbia, Puerto Rico and Guam have mature quitlines. Each year, state quitlines receive about one million calls; about half of these calls are from tobacco users (10). In addition, quitlines receive over 117,000 referrals annually from health care providers, primarily through fax-referrals (10). The number of referrals from health care providers has grown steadily over the past 5 years and demonstrates the important role quitlines play in supplementing providers' in-office treatment for tobacco dependence.

NAQC's most recent annual survey data show that 52 quitlines have active fax-referral programs with health care providers and hospitals (10). As ONC has begun implementing the HITECH portion of the American Recovery and Reinvestment Act of 2009 and as EHRs have become more prevalent, health care providers and hospitals have begun discussions with quitlines about the importance of moving from fax referral systems to electronic referral systems (that utilize EHRs), and have encouraged quitlines to take action now.

By including electronic quitline referral as part of stage 3 of meaningful use, ONC would facilitate nationwide implementation of these referral systems. NAQC believes a decision to include electronic quitline referral to support the tobacco cessation requirements for meaningful use stage 3 is justified by the points below:

1. Tobacco cessation is a national health priority and should be a priority for ONC's work on meaningful use. Although we have made great progress in reducing by 50% the prevalence of smoking (and thereby reducing the toll of tobacco-related diseases on the health of Americans) since the 1960's, tobacco use continues to be a leading cause of preventable disease and deaths in our nation. Today, national adult prevalence is about 20%, annual tobacco-related deaths number over 430,000, and the annual cost of smoking is estimated at over \$195 billion (2, 7, 8). Although 52.4% of smokers attempt to quit each year, only 6.2% are successful (9). Evidence-based treatment is needed to advance tobacco cessation.

2. Tobacco dependence treatment is both effective and cost-effective. The U.S. Public Health Services clinical guideline on tobacco dependence treatment recommends the use of counseling, FDA-approved cessation medications and social support for tobacco dependence treatment (2). Quitlines are recommended as effective treatment by the clinical guideline. In addition, the guideline recommends that clinicians employ the 5 A's -- Ask, Advise, Assess, Assist and Arrange -- with patients. Research has shown that the return-on-investment (ROI) is high for health care provider interventions (5A's and 5As plus NRT) as well as provider-quitline interventions (5A's plus quitlines and 5A's plus quitlines plus NRT). As shown in the table, 5A's and 5A's plus quitlines have the highest member per month ROI for years 1-5 after treatment (4). Helping patients quit is good business.

Table: Cumulative Health Plan ROI Per Member Per Month (PMPM) by Intervention

	5A's	5A's + NRT	5A's + QL	5A's + Both
Program Cost (PMPM)	\$917K (\$0.41)	\$1,861K (\$0.83)	\$1,515K (\$0.68)	\$2,271K (\$1.01)
ROI (PMPM)				
Year 1	\$(0.34)	\$(0.77)	\$(0.64)	\$(0.37)
Year 2	\$0.67	\$0.15	\$0.39	\$(0.05)
Year 3	\$1.33	\$0.79	\$1.06	\$0.58
Year 4	\$1.71	\$1.17	\$1.44	\$0.96
Year 5	\$1.80	\$1.26	\$1.54	\$1.06

2009, Kaiser Permanente Center for Health Research (Fellows JL et al)

3. Electronic quitline referral has broad applicability, lessens the burden on health care providers who provide tobacco dependence therapy and improves patient outcomes. All eligible health care providers and hospitals have patients who use tobacco but not all providers have the time for or expertise in tobacco dependence treatment to offer intensive therapy to patients. Having evidence-based treatment available via referral to quitlines reduces the burden on physicians and other providers to use precious in-office (or in-hospital) time for intensive counseling. Instead, for most patients, providers can ask patients about their tobacco use, advise them to quit, prescribe medication as appropriate, and refer them to a quitline for continuing treatment. Electronic quitline referral has broad applicability for all eligible providers and hospitals.

As mentioned above, in 2011 quitlines received over 117,000 referrals. We expect that this number will increase dramatically as electronic quitline referral becomes a possibility for a greater number of providers and health systems.

Research demonstrates that by increasing the counseling time for those trying to quit tobacco use we can increase the likelihood of successful quits (2). Providers can supplement the counseling time given to their patients by beginning the tobacco cessation treatment process in-office and then referring patients to quitlines. Such action will improve their patients' outcomes.

4. As a community, the network of state quitlines is building capacity to implement electronic quitline referral programs, and can definitively state that electronic quitline referral is feasible by 2015. Currently, there are 15 organizations that operate all 53 state quitlines (3). Four of these organizations -- Alere Wellbeing, Healthways, JSI Research & Training Institute, Inc (JSI), and National Jewish Health (NJH) -- have begun implementing pilot electronic referral programs between state quitlines and select health care partners' EHRs. These four organizations operate the quitlines for 43 states (3). As Alere, Healthways, JSI and NJH complete their pilot projects and prepare to broaden implementation, over 80% of the state quitlines will have access to the technical capacity to conduct referrals with EHRs.

All four organizations are eager to share their learnings with other state quitlines. For example, Alere and NJH have developed a collaborative data set that specifies standard data elements that will be required for inbound and outbound electronic quitline referrals. They are eager to offer this as a starting place for developing a standard data set for the industry. JSI has offered to support state pilot projects that will demonstrate a closed loop eReferral process between quitlines and their affiliated health care providers using the JSI health information exchange network.

5. The quitline community has a history of collaborative action and will take a standards-based approach to developing electronic referral programs. In 2005, NAQC launched a minimal data set (MDS) for evaluating quitlines that was comprised of standard intake and follow-up questions for quitline clients. State quitlines and researchers worked collaboratively to develop the standard data set. Within 6 months of finalizing the data set, all state quitlines had integrated the MDS into their existing data systems. Over the years, state quitlines have worked with researchers and external stakeholders to modify the MDS and to add optional standard questions. The MDS has become a quality standard not only in the U.S. and Canada, but also in the European Union and Asia.

NAQC plans to take a similar approach with electronic quitline referral. Already, Alere, JSI and NJH are collaborating on standard data elements for their pilot projects. NAQC is establishing a workgroup to build on their collaboration and to develop standard tools that will be needed by quitlines and EHRs, such as data elements that quitlines need to make a referral and the type of acknowledgement and feedback that quitlines will provide to providers. We also will be assessing various interfaces that can be utilized by quitlines to be compliant with security requirements for personal health information.

By including electronic quitline referral as part of meaningful use stage 3, ONC will support clinical decisions and tobacco cessation requirements (for meaningful use) and will facilitate NAQC's ability to collaborate with EHR vendors and eligible providers and hospitals on behalf of state quitlines to develop eReferral standards. Quitlines that are engaged in developing eReferral programs have noted that the single biggest barrier to implementing these programs between health care providers and state quitlines is the lack of a standard document type and interface. Without a national standard, implementation of each individual eReferral program requires the time and effort of IT staff (quitline and health care provider) and the EMR vendor, and results in high costs and great inefficiencies. We recommend that the eReferral process for quitlines follow the same document formats and workflows as referrals made to other health care providers.

Vision for Electronic Quitline Referral

NAQC believes that electronic quitline referral supports tobacco cessation requirements for meaningful use stage 3 and supports clinical decisions to treat tobacco dependence. Our vision extends to all patients age 18 and above who are seen by primary care providers who meet the eligible provider definition under the meaningful use rule or who are seen at eligible hospitals and/or acute care hospitals under the meaningful use rule.

We recommend that all certified EHR systems should be required to build bi-directional capability to send and receive electronic referrals, prescription information and results letters. We encourage the use of a standard document type and interface for eReferrals. We also recommend that all eligible providers and hospitals should be required to implement one or more clinical decision support interventions related to tobacco use cessation. The clinical decision support should guide providers to assess tobacco use in all patients, advise all tobacco users to quit, and intervene with tobacco users who are ready to quit in one or more of the following ways:

- Provide or refer to evidence-based counseling;
- Refer patients ages 18 and older to state quitlines; and
- Prescribe FDA-approved cessation medications, as appropriate.

This intervention is consistent with SAMHSA's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program, which has broad applicability for treatment of alcohol, drug and tobacco problems, and which has been highly successful (11).

COMMENTS ON HITPC PRELIMINARY SET OF RECOMMENDATIONS FOR STAGE 3

NAQC's comments are limited to the preliminary recommendations that are related to the use of EHRs for referral to tobacco cessation quitlines. These include the proposed recommendations listed below:

- SGRP 109
- SGRP 113
- SGRP 130
- SGRP 103
- SGRP 303
- SGRP 304
- SGRP 305

SGRP 109 aims to record smoking status for patients 13 years old or older. The recommendation calls for more than 80% of patients to have smoking status recorded within the EHR. The HITPC document proposes to retire the measure because the threshold is being achieved.

NAQC comment: Although we understand that performance is high and that the threshold has been achieved, NAQC supports maintaining SGRP 109 as part of stage 3 meaningful use. These objectives and measures are an essential first step in assessing tobacco use status of patients. We believe that maintaining the measure will remind clinicians to perform the 5A's. Given the importance of helping patients quit tobacco use, we recommend not retiring the objectives and measures.

Tobacco use screening and intervention is one of the most effective clinical preventive services both in terms of cost and success.(2, 5) The health case for maintaining SGRP 109 is strong. The health goals for the nation – Healthy People 2020 – includes objectives

on provider screening for tobacco status and counseling, further demonstrating the importance of SGRP 109 and the importance of measuring both screening and counseling. Clinical opportunities in this area continue to be missed by some providers. Indeed, a recent article found that only 21% of patients identified as current tobacco users received tobacco cessation counseling and only 8% received tobacco cessation medications.(6) We believe that by maintaining requirement SGRP109, stage 3 of meaningful use will encourage continued high performance on recording smoking status and drive health improvements in this area.

SGRP 113 aims to use clinical decision support to improve performance on high priority health conditions. The recommendations call for implementing 15 clinical decision support interventions related to five or more clinical quality measures for the entire EHR reporting period. Intervention areas include preventative care, chronic disease management, lab and radiology measures and advanced medication-related support.

NAQC comments: NAQC supports SGRP 113 and encourages ONC to require that all certified EHR systems should be required to build bi-directional capability to send and receive electronic referrals (to quitlines and other health care providers), prescription information and results letters. We also recommend that all eligible providers and hospitals should be required to implement one or more clinical decision support interventions related to tobacco use cessation. The clinical decision support should guide providers to assess tobacco use in all patients, advise all tobacco users to quit and to intervene with tobacco users who are ready to quit in one or more of the following ways:

- Provide or refer to evidence-based counseling;
- Refer patients ages 18 and older to state quitlines; and
- Prescribe FDA-approved cessation medications, as appropriate.

Incorporating electronic quitline referral under preventative care will not be burdensome to eligible providers or hospitals. Many eligible providers and hospitals already have established clinical decision support interventions involving quitlines. As mentioned above, 52 state quitlines have active fax-referral programs with in-state providers and hospitals. Through these fax-referral programs, providers and hospitals have established procedures for referring patients to the quitlines. These procedures can be used as a model for electronic quitline referral. A handful of states have pilot projects underway to establish electronic referrals with providers' EHRs. As these pilot projects are completed and move toward broader implementation, we expect that the frequency of clinical decision support interventions on tobacco dependence treatment through EHRs will increase significantly.

SGRP 130 aims to use computerized provider order entry for referral/transition of care orders directly entered by any licensed healthcare professional who can enter order into the medical record per State, local and professional guidelines to create the first record of the order. The recommendations call for more than 20% of referral/transition care orders to be recorded.

NAQC Comment: NAQC supports this recommendation and encourages ONC to include electronic quitline referral as part of the scope of SGRP 130. Based on data from NAQC's most recent annual survey, 98% (i.e., 52) of the state quitlines receive fax referrals from providers and hospitals, 34% receive referrals via email or online and about 10% receive referrals from EHRs (10). In 2011, approximately 1,000 referrals were made by EHR. Although this is under 1% of all referrals (117,714), we expect the number to increase significantly once quitlines move from pilot eReferral programs to broader implementation. We recommend that the eReferral process for quitlines follow the same document formats and workflows as referrals made to other health care providers. We also suggest that SGRP 130 not only require referrals are recorded but also that they are shared electronically with the referred provider.

SGRP 103 aims to generate and transmit permissible prescriptions, including discharge prescriptions, electronically (eRx). The recommendations call for more than 50% of prescriptions written by providers and more than 30% of hospital discharge prescriptions to be transmitted electronically using certified EHR technology.

NAQC comment: NAQC supports this recommendation. As we move forward with meaningful use, electronic transmission of prescription will be important for high quality patient care. About 83% of quitlines provide over-the-counter cessation medications to their callers. Only 2 quitlines provide prescription cessation medications to callers. It will be important for EHRs to have an ability to transmit prescriptions electronically to quitlines so that quitlines can follow-up with callers about their use of prescription cessation medications. Quitlines also may want to request a prescription from a provider for his/her patient. In such situations, eRx would be an efficient way to gain the prescription for callers.

SGRP 303 aims to have eligible providers and hospitals that transition their patient to another setting of care or refer their patient to another provider of care provide a summary of care record for each site transition or referral with specific information. For referrals, the information includes a concise narrative in support of the referral (free text that captures current care synopsis and expectations). It recommends that a summary of care record be available for 65% of referrals. Further, it recommends (as a certification criteria) an ability to automatically populate a referral form for specific purposes, including a referral to a smoking cessation quitline.

NAQC comment: NAQC supports this recommendation and is pleased that quitlines are specifically mentioned in it. Examples of success in automatically populating a referral form for quitline services have been documented. As mentioned under number 3 above, four quitline operators (Alere, Healthways, JSI and NJH) have begun implementing pilot electronic referral programs between state quitlines (CO, IA, MA, ND, NH, WI and WY) and select health care partners' EHRs. The type of information needed from the EHRs for the referral form is minimal and includes patient identification, referring provider identification, patient conditions, medication authorization, and best day to contact patient.

Together, Alere, Healthways, JSI and NJH operate the quitlines for 43 states (3). As these organizations complete their pilot projects and prepare to broaden implementation, over 80% of the state quitlines will have access to the technical capacity to conduct referrals with EHRs. All four organizations are eager to share their learnings with other state quitlines.

As noted above, the single biggest barrier to implementing a bi-directional eReferral system between health care providers and state quitlines is the lack of a standard document type and interface. This results in intensive resources (provider and quitline IT staffs and EHR vendor) being required for each installation. As we move forward with eReferral, standards must be developed to decrease implementation costs, increase interoperability among states, EMR vendors and quitline vendors, and increase the speed with which individual providers and hospitals can use eReferrals for tobacco cessation services.

SGRP 304 is proposed for future stages of meaningful use. It recommends that eligible providers and hospitals who transition patients to another site for care or refers their patients to another provider of care include a number of specific elements as applicable. HITPC poses a question about how we might advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allows for and encourages team based care and includes the patient and their non professional caregivers. A number of priority use cases are identified, including the patient seeing multiple ambulatory specialists needing care coordination with primary care, and a set of questions are proposed (including how access may be managed).

NAQC comment: NAQC will be launching a workgroup on electronic quitline referral in January 2013 and will ask members to consider HITPC's question related to how we may advance the concept of an electronic shared care planning and collaboration tool. We will provide feedback to ONC as it becomes available.

SGRP 305 aims to have eligible providers and hospitals to whom a patient is referred acknowledge receipt of the referral and provide results from the referral to the requesting provider. HITPC asks for comments on the return of test results to the referring provider.

NAQC comment: JSI has developed and is currently using technology whereby the quitline provides acknowledgement and feedback reports (on service utilization and outcomes) to the referring provider. NJH's goal is to have the referring provider receive feedback at various time points throughout the cessation process, including when an eReferral is received or is invalid, at the time a patient enrolls in coaching, if the patient is unreachable or declines enrollment, when medications are ordered for a patient, when a patient completes the program, and when a patient disenrolls for another reason.

NAQC will be launching a workgroup on electronic quitline referral in January 2013 and will ask members to consider HITPC's question related to acknowledging receipt of the referral and providing results from the referral. We will provide feedback to ONC as it becomes available.

In conclusion, NAQC strongly recommends inclusion of bi-directional electronic quitline referral process for EHRs certified for stage 3 of meaningful use and maintenance of SGRP 109 (recording smoking status).

Again, we thank ONC for the opportunity to comment and look forward to its continuing dialogue and work on meaningful use of EHRs.

Sincerely,



Linda A. Bailey, JD, MHS
President and CEO

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