Are quitline referral systems ready for the world of electronic health records?

SEMINAR SUMMARY

Are Quitlines Ready for the E-World?

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In this seminar, presenters from Massachusetts provided a rich overview of the rationale for integrating quitlines into healthcare and EMRs, described the data integration system being used to support their fully electronic referral system with health partners; and highlighted needed quitline service provider capabilities to implement fully electronic referrals.

As described by presenters, the integration of quitlines into healthcare systems and EMRs has the potential to increase our reach and impact, may improve upstream interventions in healthcare, serves as an alternative to costly media promotion and offers benefits to providers, patients, quitlines and the public health. However, in order to keep pace with changes in the healthcare delivery system, there is a need to move beyond the current fax-based system of quitline referral to fully electronic referral systems. In an effort to create a standard terminology and an increased understanding of the various types of referral systems currently in place, presenters defined five stages of quitline referral (with feedback) and how these five stages play out in the manual (fax), hybrid and fully electronic systems.

According to presenters, in order to consider implementing a fully electronic referral system, a quitline must have:

- Operations performance standards
- Real-time access to referral data
- Flexible feedback reporting capability
- Knowledge of:
  - EMR products
  - Meaningful Use tobacco measures
  - Joint Commission proposed measures
  - Knowledge of privacy, security, and consent
- Detailing and training with clinical workflow and EMR fields

To conclude the seminar, presenters shared advice for next steps to consider if one is interested in implementing a fully electronic referral system, a quitline must have:

Q: What are the budget implications we should be aware of?
A: In Massachusetts we were fortunate to already have existing infrastructure. There are three cost items you need to keep in mind:
1. the cost of the interface program that will take data from the EMR to the quitline and back again.
2. we offer this service to systems for free, which means that we pay for the IT technical assistance really. This IT expertise is important – this is the person who works with the health system IT folks.
3. you have to build capacity on the quitline side so that they can receive the data.

C: Yes. I would add a few “capabilities” on the list. I would add funding, as this work is expensive. I would also add expertise and the dedicated time of those with the needed expertise. That includes folks at the quitline vendor level, the health systems level and the EMR level. In Wisconsin our experience has also been that integrating this into the clinical workflow is imperative – they must know about it and it must be easy. We have learned about “EMR alert fatigue” from providers.

Q: What is an on-site detailing service?
A: I’m sure there are several definitions for this but in MA, for hospitals, large provider practices and community-based health clinics, we provide onsite presentation of the program to a broad range of staff (everyone must be present), assessment of readiness, technical assistance with planning, clinical training, EMR work, and 3-month follow up.

Q: Have you seen any difference in conversion rates since the increase in...
electronic referral system:
- Understand the overall eReferral process and how it may benefit your program and participating practices.
- Consider a phased approach for implementation (paper-based, eForms, eReferrals).
- Understand the broader “meaningful use” context.
- Understand the capabilities of your systems.
  - EMR, HIE, QuitLine
- Consider long term implications of IT choices.
  - (3rd party, open source, custom, hosted solutions)
- Engage local resources that can help.
  - Regional extension centers
  - Health information exchanges
  - EMR vendors
  - Public health program leaders

As soon as it is available, a recording of this seminar will be posted to:
http://www.naquitline.org/?page=2011SeminarSeries

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Q: How does a system like this address consent?
A: In MA we depend on the provider to gain consent at the point of care. Some obtain consent and log in an e-signature. We see gaining patient consent as the responsibility of the provider as part of routine patient care.

Q: Are you using any sort of survey or assessment tool to determine a system’s readiness?
A: Yes, we use an assessment protocol to help us determine which referral system options a system is ready to take on. The tool assesses an institution’s readiness – can they share information; are there a certain number of people engaged; do they meet the technical/data requirements? If you would like to see the assessment tool we use, please email me at donna.warner@state.ma.us.

Q: Could we use this type of system to build consumer self-referral?
A: I’m sure but this just isn’t on our plate right now. Our major goal is to improve the provider intervention and so we will stay focused on the systemic changes needed to do so.