

2017

Barriers and Challenges of Scaling- up eReferral: A Discussion with NAQC's eReferral Workgroup



As of August 2016, 20 state quitlines had fully implemented eReferral¹ with at least one healthcare partner. In addition, 6 state quitlines were actively working to implement eReferral but have not yet completed the work, and 26 quitlines have not yet embarked on the process of implementing eReferral. While opportunities exist to help those quitlines that do not yet have capacity develop the capacity, opportunities also exist to continue efforts with the quitlines that have capacity to scale-up eReferral and expand it to additional sites.

Of the diverse topics discussed during eReferral Workgroup meetings, challenges and barriers that accompany scaling-up eReferral efforts is a frequently discussed topic. While ideally scaling up should be a seamless and natural progression for quitline services, there are several barriers and challenges that persist, impeding efforts to accelerate progress. One key and frequently mentioned barrier and challenge relates to the costs associated with scaling-up eReferral. These costs run the gamut to include fees associated with software and hardware, legal fees associated with Business Associate Agreements (BAA), cost of engaging subject-matter experts and the cost and resources expended on human capital needed to manage and coordinate implementation efforts. While the aforementioned costs are the known costs, other additional costs associated with scaling-up remain unclear and are dependent on the starting points of the health care partner, the organization’s knowledge about eReferral implementation, and existence of a champion spearheading and willing to commit the resources needed to fully implement eReferral.

Organizations that have managed to scale-up with more than one site have developed practices, tactics, tools and templates that they readily share among eReferral Workgroup members to assist others in their attempts to scale-up. The Workgroup also continues to discuss and share efforts on identifying and implementing solutions to address common barriers and challenges associated with scaling-up eReferral. However, one challenge that is ever changing is the ability to quantify the upfront costs associated with eReferral implementation, scaling-up and the cost-sharing model for services offered. Because a “one-size fits all” does not exist for eReferral implementation it is important for all stakeholders involved with implementation to keep an open line of communication and continue to share information and best practices to help other organizations regardless of their starting point.

In 2017, Workgroup members were engaged in a conversation to discuss the core barriers, costs challenges and potential solutions associated with scaling-up eReferral. The following tables represent the outcomes of these discussions with Workgroup members. The tables are segmented by topic area and include specific examples of the challenges faced within that area along with potential solutions that, with the help of NAQC and CDC, could help advance state efforts.

Compliance & Security		
<i>Barrier</i>	<i>Cost Challenges</i>	<i>Potential Solutions</i>
Proving compliance and establishing business associate agreements	<ul style="list-style-type: none"> • Staff time to perform assessments to determine readiness. • Legal fees associated with developing Business Associate Agreements (BAA). • Consultant fees need to prove compliance with Health Information Portability and Accountability Act (HIPAA). • Cost associated with annual renewal 	<ul style="list-style-type: none"> • Establish a federal certification and approval process for the quitline vendors. This will provide health care organizations (HCO) with confidence that the data being exchanged between the HCO and quitline is secure and compliant to a federal standard.

¹ eReferral uses established EHR technology to create bi-directional referrals between healthcare systems and providers of tobacco cessation services such as quitlines.

	of security ID's assigned to entities which are required for systems to be deemed secure/compliant, etc.	
Forms	<ul style="list-style-type: none"> • Staff time to develop individualized forms for each institution • Legal fees for document review to ensure compliance with federal regulations and standards 	<ul style="list-style-type: none"> • NAQC via the eReferral Workgroup can develop and achieve consensus on a template with standard language that can be used and modified by all quitlines. The Texas quitline has developed a template and has agreed to share it with other quitlines.

Integration & Migration		
<i>Barrier</i>	<i>Cost Challenges</i>	<i>Potential Solutions</i>
Assessing the technical capacity of HCO to implement eReferral	<ul style="list-style-type: none"> • Cost associate with purchasing software and hardware needed to implement eReferral • Fees associated with hiring consultants to perform assessments • Staff time and administrative support necessary to coordinate and monitor project 	<ul style="list-style-type: none"> • Identify a list of consultants that speaks the language, understands the systems, and can bridge the gap to help hospital systems with adoption.
Variability of Electronic Medical Record (EMR) and databases	<ul style="list-style-type: none"> • Staff time or consultant fees to perform assessments to determine overall cost of implementing eReferral to healthcare organization • Once cost is determined, determining who will foot the bill 	<ul style="list-style-type: none"> • NAQC could convene EMR vendors to discuss challenges. • Facilitate conversations between EMR vendors and quitlines.
Obtaining leadership buy-in at HCOs	<ul style="list-style-type: none"> • Smoking cessation is not deemed a priority therefore resources are not available for needed updates and improvements. • Time and resources needed to research, identify and cultivate a champion in every organization 	<ul style="list-style-type: none"> • Develop a federal declaration or statement that outlines the evidence and benefits of eReferral for smoking cessation. • Align eReferral with federal certifications, standards and/or quality measures. • Establish a federal incentive program for HCOs that adopt eReferral. • Identify a national level champion (physician, HCO CEO, federal agency head, etc.) to increase awareness and promote concept of eReferral.
Coordinating eReferral across state lines with EMR vendors	<ul style="list-style-type: none"> • Lack of EMR vendor willingness to be flexible, collaborate and coordinate creates cost implications for quitlines seeking to implement eReferral with HCOs across state lines. 	<ul style="list-style-type: none"> • Establish a clearinghouse of possible solutions that all 50 states contribute to so that quitlines know what solutions exist for each EMR vendor.

EMR Vendors		
<i>Barriers</i>	<i>Costs Challenges</i>	<i>Potential Solutions</i>
<p>EMR vendor flexibility (e.g. EPIC is very rigid while eClinical Works and MedTech are more diverse)</p>	<ul style="list-style-type: none"> • Cost associated with developing solutions for each HCOs EMR • Staff time to coordinate implementation efforts • Fees associated with technical consultants to guide implementation efforts and troubleshoot issues • Costs of software and hardware to set-up and establish eReferral • Monthly and annual fees associated with maintaining the eReferral system 	<ul style="list-style-type: none"> • Develop a standard protocol to work with EMR vendors instead of recreating a new model every single time. • Develop an EMR vendor report card that provides estimates on costs for working with each vendor. • Create a centralized place or direct message that goes to one number (1-800-QUIT NOW) where all data is processed, triaged and then sent to the quitline in the caller's respective state.

Sustainability		
<i>Barriers</i>	<i>Costs Challenges</i>	<i>Potential Solutions</i>
<p>Providing and scheduling follow-up to provide continuing education on eReferrals</p>	<ul style="list-style-type: none"> • Staff time associated with coordinating education and awareness efforts • Cost of developing and printing materials for continuing education • Technical consultant to develop materials, tools and resources for education sessions • Cost of Continuing Medical Education (CMEs) credits as incentives for providers to attend 	<ul style="list-style-type: none"> • TX has created animated videos that they share with the HCOs for them to learn how to use the eReferral in their systems along with print materials that can be posted around the institution etc. This video can be shared with quitlines as a template. • Establish a champion at each HCO to promote the benefits of eReferral. • Constant evaluation on barriers to staff and how the QL can help
<p>Continued investment in eReferral systems</p>	<ul style="list-style-type: none"> • Cost associated with updating systems and software to keep up with ever changing technology • Staff time to perform continuous education to ensure continued eReferrals • Staff time and administrative costs associated with following-up and performing outreach to "unreachables" 	<ul style="list-style-type: none"> • Incorporating standardize questions such as "Do you want to be referred?" to ensure patient ownership and buy-in • Incorporating intensive bedside intervention at in-patient HCO facilities • Adopt and adapt practices used in fax referrals...there is a section the patient has to fill out so they expect call. Incorporate this with eReferral.
<p>Reporting requirements</p>	<ul style="list-style-type: none"> • Administrative support to coordinate the completion and submission of reports • Staff time associated with consolidating the data and information necessary to complete reports • Staff time to develop evaluation tools to track outcomes at HCO 	<ul style="list-style-type: none"> • The Center for Medicaid and Medicare (CMS) published required quality measures on tobacco for the inpatient behavioral health populations that could be adapted for eReferral. This will provide an opportunity to encourage physicians to submit eReferrals. • Establish federal measures that

Sustainability		
<i>Barriers</i>	<i>Costs Challenges</i>	<i>Potential Solutions</i>
		allow providers to combine tobacco screening with an order for tobacco cessation treatment.

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For more information about the NAQC eReferral Initiative, contact naqc@naquitline.org.