Enhancing eReferral Capacity: A Strategy for Increasing Cessation among Priority Populations and Encouraging Health System Change

Abstract: Through Meaningful Use, the federal government requires healthcare organizations to demonstrate increased efficiency of Electronic Medical Records (EMRs). This has created a demand for quitlines to replace current fax referral with eReferral systems in which healthcare organizations can make a patient referral directly from the EMR to the quitline and receive a feedback report to the EMR. Eleven service providers operate the 53 state quitlines. Five service providers have the capacity to conduct eReferrals and six do not have the capacity. This project will engage the six quitline service providers that do not have the capacity for eReferral in an 18-month project to develop capacity.

The overall goal of the project is to deliver effective quitline services to more smokers, especially those in priority populations, by establishing a national capacity to implement eReferral systems between state quitlines and healthcare organizations. We will establish six state teams that include a quitline service provider (that does not have eReferral capacity), the state quitline funder and a healthcare organization that serves priority populations. These teams will receive technical assistance on implementing eReferral and their progress will be monitored. Three products will be developed and disseminated during this project: a technical tool on implementing eReferral, a resource on developing successful eReferral partnerships, and a series of case studies documenting the challenges and successes of the six state teams. The evaluation will assess state team success on eReferral, number of referrals, reach to priority populations, national capacity for eReferral, and development and dissemination of products.

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Overall Goal and Objectives

The overall goal of the project is to deliver effective quitline services to more smokers, especially those in priority populations, by establishing a national capacity to implement electronic referral ("eReferral") systems between quitlines and health care organizations (i.e., healthcare centers and institutions such as hospitals).

This project is closely aligned with the focus of the Pfizer IGLC and Smoking Cessation Leadership Center RFP in that it focuses on improving the competence of health professionals (i.e., quitline and healthcare professionals) and the performance of healthcare systems (i.e., enhancing the capacity of both quitlines and healthcare organizations to conduct eReferral) so that more smokers receive effective cessation treatment. This project aims to go beyond educating health professionals to address the system changes needed within healthcare organizations to identify smokers and refer them electronically to quitlines as well as the system changes needed within quitlines to receive an eReferral and provide an electronic feedback report. In addition to quitlines, this project will include healthcare organizations that serve populations disproportionately burdened by smoking (i.e., priority populations), such as those with chronic mental illness, substance abuse disorders, other chronic diseases, low socioeconomic status (SES), and racial/ethnic minorities. These groups have been identified by Pfizer and SCLC as populations of special interest. The project is designed to have an impact on important national targets, including Healthy People 2020 objectives TU-4.1 (increase smoking cessation attempts by adult smokers) and TU-5.1 (increase recent smoking cessation success by adult smokers). As the ability of healthcare organizations to refer patients to quitlines via electronic medical records (EMRs) expands, we anticipate that quit attempts and cessation successes will also increase.

This project also is closely aligned with the goals of the North American Quitline Consortium (NAQC). Since 2004, NAQC's mission has been to maximize the access, use, and effectiveness of quitlines. This project will help further the mission. In addition, this project will help NAQC make progress on two goals: 1) for all quitlines to achieve equity in treatment service rates and outcomes for priority populations as compared to majority population; and 2) for all quitlines to have the capacity to conduct eReferral by 2016, consistent with the date set by the Office of the National Coordinator (ONC) for implementation of the Health Information Technology for Economic and Clinical Health Act and adoption of EMRs by the health care sector. NAQC has been working on eReferral for over three years, supporting the progress of state eReferral pilot projects and creating resources for the field. Progress and challenges are described in the Technical Approach section.

Objectives:

1. Provide training and technical assistance on implementing eReferral systems to 6 state teams, each comprised of the funder of the state quitline, the quitline service provider and a healthcare organization.
2. Include a healthcare organization that serves a high proportion of priority populations in each of the six state teams.
3. Increase the number of referrals from the selected healthcare organizations to the 6 participating state quitlines by 10%, approximately 1,250 smokers.
4. Increase the number of states with eReferral pilots underway or completed from 8 to 14.

5. Increase the number of states that have successfully implemented eReferral from 5 to 11.
6. Increase the number and percentage of state quitline service providers who are engaged in eReferral projects from 5 to 11 and from 45 percent to *100 percent*, respectively.
7. Develop three resources on implementation of eReferral, including a technical tool, a guide for developing successful eReferral partnerships between quitlines and healthcare organizations, and a series of six case studies.
8. Disseminate resources and lessons learned to all state health departments, quitline service providers and the healthcare community. Maintain these resources on NAQC's website as an enduring product of the project.

Technical Approach

Structure of Quitlines, Growing Demand for eReferral and NAQC's eReferral Workgroup

Although the first statewide quitline was launched in 1992, it was not until 2004 that a complete national network of state quitlines existed in the U.S. The network includes 53 quitlines based in each of the 50 states, the District of Columbia, Puerto Rico and Guam. State agencies, most often the health department, fund and administer the state quitlines. Quitline service providers are contracted by the states to operate the quitlines. Currently, 11 service providers operate the 53 state quitlines in the U.S., including four service providers that operate quitlines for more than one state.[1]

Through its recent Meaningful Use initiative, the U.S. federal government has begun providing substantial financial incentives for healthcare organizations to adopt electronic medical records (EMRs) and use them in ways to improve quality, safety and efficiency. These incentives are having their desired effect – 72% of physicians in outpatient practices and 42% of U.S. hospitals reported using EMRs in 2012.[2] As the federal government requires healthcare organizations to demonstrate increased efficiency of EMRs, there is a growing demand from healthcare organizations for quitlines to replace current methods of referral (i.e., via fax and email) with eReferral systems in which healthcare organizations can transmit a patient referral directly from the EMR to the quitline and receive a feedback report from the quitline directly to the EMR. Implementing eReferral not only improves the quality and number of referrals that quitlines receive from healthcare organizations, but it also encourages system changes within the healthcare organization by creating organization-wide procedures for identifying smokers, advising them to quit, assessing their readiness to quit, providing initial treatment (as time allows), and referring them to the quitline. The quitline then engages the patient in a longer course of treatment and sends a feedback report to the referring healthcare organization. This new system of eReferral strengthens cessation services and makes them more available to smokers who would like to quit.

In 2012, NAQC established a workgroup on eReferral for states, service providers and healthcare providers interested in implementing eReferral systems. The workgroup has served as a learning community on eReferral, where members can share approaches, challenges and solutions. Currently, the workgroup includes seven states (California, Massachusetts, New Hampshire, Oklahoma, Texas, Vermont and Wisconsin), three healthcare providers (American Association of Pediatrics, Denver Health and University of California medical system), and four service providers (Alere, California Smokers Helpline, National Jewish Health and Roswell Park). MaineHealth, which recently launched an eReferral project, will join the workgroup at its next

meeting. The workgroup has developed a number of resources, including a white paper on referral programs, case studies and webinar presentations[3], which will be used as background and training materials for the proposed project. The workgroup is completing a technical guideline (table of contents is included as an appendix) which will serve as an important training material for the project. Although both a state funder and service provider are involved in quitline eReferral programs, the effort to build the technical capacity falls to the service provider. For this reason, the project focuses on ensuring that every state quitline service provider gains experience and develops capacity in implementing eReferral systems.

Assessment of Need

According to NAQC's annual survey, quitlines received 1.3 million calls from tobacco users, friends and family, healthcare providers and others in 2012, and provided treatment to 530,000 tobacco users (i.e., quitlines treat about 1.2 percent of all tobacco users in the U.S.).[4] CDC has set a goal for quitlines to provide treatment to 8 percent of tobacco users each year.[5] There is a substantial gap between current level of treatment services (1.2 percent) and this best practices goal (8 percent). Increasing the number of referrals for quitline services nationally is likely to increase the number of quit attempts and cessation successes as well as to decrease the prevalence of tobacco use.

Since 80 percent of smokers see a physician each year,[6] healthcare centers and institutions have been important venues for beginning cessation treatment with a referral to the quitline for follow-up care. The importance of the referral relationship has been has been growing as a result of the Health Information Technology for Economic and Clinical Health Act, which has accelerated the adoption of electronic medical records (EMRs) by health care providers. As the ability of health care providers to refer patients to quitlines via EMRs expands, there has been a growing demand for quitlines to have the capacity for eReferral. Adoption of EMRs by healthcare organizations is likely to have a positive impact on national Healthy People objectives such as increasing quit attempts and cessation success. If state quitlines have the capacity to conduct eReferrals, the impact of EMR adoption on these Healthy People objectives will be increased substantially and progress will be accelerated toward the goal for quitlines to treat 8 percent of tobacco users each year. A recent study supports this assertion, finding that physician referral to quitlines and patient acceptance rates of quitline treatment services were higher for eReferral (13.9% and 4.9%, respectively) than for fax referral (0.3% and 0.15%, respectively).[7]

In 2012, quitlines received 171,379 referrals. All 53 quitlines offered fax referral for healthcare providers, 18 offered referral by email or online, but at that time only one quitline offered referral via EMRs.[8] Through a telephone assessment of service providers (conducted by NAQC in December 2014-January 2015), NAQC has confirmed that five of the 11 service providers that operate the 53 state quitlines are engaged in eReferral pilot projects (Alere Wellbeing, California Smokers Helpline, MaineHealth, National Jewish Health and Roswell Park). The remaining six service providers will need to develop eReferral capacity to maximize the number of smokers referred to quitlines by healthcare organizations. These six quitline service providers are the focus of the proposed project.

From discussions with states and service providers, NAQC has learned that many states and service providers have not yet initiated eReferral activities due to a lack of familiarity with

what an eReferral is (i.e., the content that is transmitted from the EMR to the quitline and from the quitline to EMR) and *how* to implement it (the IT programming and platforms that allow transmission between data systems). NAQC's eReferral workgroup (which includes leading-edge states, quitline service providers and health care providers that are engaged in eReferral pilot projects) has expertise in building eReferral systems, has developed a white paper on eReferral[9] as well as a dozen case studies on their pilot projects[10], and is in the process of completing a technical guideline on implementation of eReferral systems.[11] Through the proposed project, we will make training and technical assistance available to quitlines not yet engaged in eReferral, using the expertise that exists among NAQC staff, experiences states and service providers, and a technical consultant.

Members of NAQC's eReferral workgroup experienced many challenges as they launched eReferral pilot projects during the past three years. The challenges were often related to either the technical nature of eReferral (i.e., complexity of the project, need for highly specialized staff and cost) or establishing successful relationships with healthcare institutions to engage in eReferral (i.e., competing IT priorities, systems change, workflow issues, customization needs and cost). We anticipate that quitlines that begin to work on eReferral will experience many of these same challenges. This project will use training and technical assistance to address challenges, as described in the Project Design and Methods section.

Since 2009, quitlines have been assessing the types of populations who use quitline services and have been seeking ways to better reach priority populations. According to NAQC's annual survey, quitlines provide treatment to African American tobacco users and Native American tobacco users at nearly the same rates as the majority population. However the proportion of Asian/Pacific Islanders, Hispanics/Latinos and tobacco users with low SES who are treated by quitlines is lower than the majority population. NAQC does not have national data on the treatment rates for tobacco users who have mental health illnesses, substance abuse disorders, and have chronic diseases. Research has demonstrated that compared with self-referred smokers, smokers referred to the quitline by health care providers are more likely to be non-white, less educated and have public insurance like Medicaid[12]. This finding indicates that quitlines may improve the reach of their services to priority populations by engaging in referral partnerships with healthcare providers who serve these populations.

As shown, there is a need to: a) increase the proportion of tobacco users who receive treatment from quitlines from the current proportion of 1.2% toward the CDC goal of 8%; b) increase the number and proportion of quitline service providers that have the capacity to conduct eReferral from 5 to 11 and from 45% to 100%, respectively; c) provide technical assistance, training and written resources to help in establishing relationships with healthcare organizations and developing a technical capacity for eReferral; and d) increase the reach of quitline services to priority populations.

The primary target audiences for this project are the six state quitline service providers that currently are not engaged in eReferral (American Lung Association, Avera McKennan, beBetter, Information and Quality Healthcare, Telemedik, and University of Arizona's Smokers Helpline) , six state agencies that fund them (Illinois, South Dakota, West Virginia, Mississippi, Puerto Rico and Arizona), and a healthcare organization within each state that serves priority populations (to be selected during phase one of the project). The 6 state teams (including the state funder of the quitline, quitline service provider and health care organization) that

participate in the project will benefit most from this project. However it is noteworthy that as a result of this project, *every* quitline service provider will have experience and the capacity to conduct eReferral. This outcome will strengthen the national cessation enterprise. State agencies that fund quitlines and healthcare organizations also will benefit from the lessons learned and resources developed through this project (see dissemination section, below). Based on 2012 NAQC annual survey data, we estimate that 1,250 tobacco users will be referred through this project and will benefit directly. We anticipate this number will expand greatly as eReferral is implemented across all state quitlines and with multiple healthcare partners.

Project Design and Methods

NAQC proposes to establish a national capacity among state quitlines for engaging in eReferral with healthcare organizations. This capacity will greatly increase the quit attempts and cessation success, especially among tobacco users from priority populations; will strengthen partnerships and collaborative endeavors between quitlines and the healthcare sector on cessation treatment; and will advance system changes in the healthcare sector and quitlines. This 18-month project, slated to begin in May 2015 and end in October 2016, will focus on six state teams.

State team selection process

To ensure that every quitline service provider has the capacity to implement eReferral, NAQC conducted a telephone assessment of service providers in December 2014-January 2015. The assessment confirmed that five of the 11 service providers that operate the 53 state quitlines are engaged in eReferral pilot projects (Alere Wellbeing, California Smokers Helpline, MaineHealth, National Jewish Health and Roswell Park). Many of these service providers will serve as experts for this project (see letters of support in appendix). Five of the six remaining service providers that do not have eReferral capacity have agreed to participate in the project, including American Lung Association, Avera McKennan, beBetter, Information and Quality Healthcare and University of Arizona Smokers Helpline (see letters of support in appendix). Telemedik, the service provider for Puerto Rico, was not able to gain approval before the proposal due date. NAQC anticipates that territorial staff will have approval to participate by the start date for the project and has assumed they will participate. If approval is not received, we will move forward with five "official" state teams and will continue to encourage Telemedik to participate informally by attending training webinars and moving forward as much as they are able.

Table. State quitline funder and service provider teams

STATE	QUITLINE SERVICE PROVIDER
Arizona	University of Arizona (ASHLine)
Illinois	American Lung Association
Mississippi	Information and Quality Healthcare
Puerto Rico	Telemedik
South Dakota	Avera McKennan
West Virginia	beBetter

The project will have four phases. The phases are described briefly below and in more detail in the work plan.

Phase one: Foundation and assessment activities (months 1-4)

NAQC will notify the state teams and experts as soon as we learn whether the proposal has been approved for funding. If successful, we plan to launch the project in May 2015 with internal meetings for NAQC staff, a kick-off meeting with SCLC and Pfizer, and kick-off meetings and webinar training with the state teams. During this phase, a healthcare organization that serves a high proportion of priority populations (e.g., community health center, public hospital, behavioral health center, etc.) will be selected and join each state team, and the strengths and weaknesses of each team will be assessed. This information will be used to tailor training and technical assistance to specific needs of the state teams.

Phase two: Building eReferral capacity (months 5-12)

Based on the experience of the eReferral workgroup, six months is an adequate time to build eReferral capacity. In this project, we have set aside eight months to achieve this milestone to accommodate end of the year holiday schedules and ensure adequate time for all state teams to be successful. The focus of this phase will be on delivering training and technical assistance adequate for each team to build eReferral capacity.

Phase three: Demonstration period (months 13-16)

During this phase, the six state teams will demonstrate and improve their capacity for eReferral, thus achieving the primary goal of creating national capacity for eReferral among all state quitline service providers. The focus will be on identifying problems and inefficiencies in the process, collecting data and compiling lessons learned for dissemination to the broader field.

Phase four: Dissemination and evaluation (months 17-18)

NAQC will develop a final report in collaboration with the state teams. Lessons learned and recommended next steps will be reflected in the final report. Completed case studies, the technical tool and the resource for successfully engaging healthcare organizations in eReferral will be posted to the NAQC website and shared electronically with the cessation and tobacco control communities as well as healthcare sector (through associations and societies as well as national partners including SCLC, the Office of the National Coordinator (for Meaningful Use), Centers for Disease Control and Prevention, National Institute of Health, and others). We will ask SCLC to partner with us on dissemination. A PowerPoint and manuscript will be developed.

Addressing known barriers and facilitators through the design of the project

Priority of eReferral and Costs: Two of the significant barriers quitlines have experienced in engaging healthcare organizations on eReferral have been competing priorities within healthcare organizations and the cost of IT programming to build a connection between the healthcare organization and the quitline. NAQC has set aside funding for each state team to help elevate the priority of the eReferral project and to defer from the overall cost of implementing eReferral. Each state team will decide how to allocate these funds in collaboration with NAQC

(and in compliance with requirements of Pfizer). These funds may be allocated for IT programming to lessen the overall cost borne by the healthcare organizations, if an incentive is needed to engage the healthcare partner. The funds may also be used by the service provider to lessen its overall expenses to build eReferral. State teams will have opportunity to discuss options during the bimonthly state team conference call meetings.

An existing referral relationship between the healthcare organization and the quitline serves as a facilitator for developing a successful eReferral partnership. For this reason, NAQC will encourage state teams to select a healthcare organization that already is providing fax or email referrals, when possible. If qualified healthcare organizations (i.e., those with a high proportion of priority populations) do not have an existing referral relationship with the quitline, such a relationship will be developed during phase two of the project, as a first step towards establishing eReferral. By doing this, the healthcare organization will begin to make the necessary systems changes such as identifying smokers within medical records, advising they quit, and referring them.

Technical expertise: There are two topics on which state teams will need technical assistance: 1) strategies for establishing successful partnerships between the healthcare organization and quitline; and 2) knowledge and guidance on technical issues related to meaningful use standards, HL7 versions 2 and 3, the consolidated CDA and interoperability. Members of the NAQC eReferral workgroup have the expertise to provide technical assistance on strategies for partnering with healthcare organizations to impart general knowledge on meaningful use standards, HL7 issues and interoperability. They will serve as experts for the project. To ensure that the state teams have access to the technical expertise needed to plan for and implement eReferral, NAQC has included a technical consultant as part of the project team. The technical consultant will provide guidance to the state teams on solutions to implementing eReferral between the specific state quitline data system and the healthcare partner's EMR.

The consultant will provide 155 hours of consultation that includes the following services:

- Leading five webinar presentations for state teams. The webinars will be conducted every other month and will follow the chapter topics from the new Technical Guideline on eReferral that NAQC is developing (25 hours of time);
- Providing technical assistance to individual state teams on challenges they encounter in developing eReferral capacity (90 hour of time);
- Coordinating and consulting with the project manager (20 hours of time); and
- Reviewing and commenting on a technical tool that will be developed by the project manager (20 hours of time).

This level of technical consultation will be very helpful for overcoming major challenges, but not sufficient for building eReferral systems. Each state team will need to supplement the technical consultation provided through the project with on-site IT expertise.

Resources to support eReferral activities: The development of a technical tool and resource will be spearheaded by the project manager. The technical tool will include the

PowerPoint presentations and audio files from the webinars, with a text accompaniment that describes the content of each presentation and includes sidebars on challenges and solutions in implementing eReferral based on the experience of the state teams. The second product, will highlight strategies for establishing successful partnerships between quitlines and healthcare organizations. This resource will reflect the lessons learned from the six state teams as well as the members of the eReferral workgroup. These two products, together with case studies developed by state teams, will be disseminated to relevant professionals and their societies and associations. They also will be posted on NAQC's website. NAQC will maintain these products on its website and will continue to disseminate them to quitlines and healthcare organizations after completion of the project.

Evaluation Design

The approach for evaluating this project will utilize both quantitative and qualitative data related to achieving the goals and objectives set forth in this proposal. The primary focus will be on determining whether all six state teams were able to implement an eReferral system and transmit referrals through the system during the project period. Quantitative and qualitative information will be collected. A secondary focus of the evaluation will assess the satisfaction of state team members with the training and technical assistance provided during the project, the strengths and weaknesses of the project; and key lessons learned, next steps and recommendations.

Data sources will include standard quantitative data from the quitlines as well as qualitative data from members of the state teams regarding various aspects of the project.

Quantitative Data Sources

Quitlines are data-oriented and have adopted standard data sets for collecting information on referral sources, client demographics and smoking history as well as outcomes. The Minimal Data Set (MDS)[13], developed by NAQC in 2005, provides standard questions asked at intake and at 7-month evaluation and offers a rigorous approach to evaluating tobacco cessation quitlines. The MDS was adopted by all quitlines in North America by the close of calendar year 2005. Since that time, NAQC has collected aggregate results on key MDS variables to monitor quitlines and share their progress with the broader tobacco control community.

Each state quitline will report the following types of MDS data on referrals from the health care partner to the quitline:

- Number of fax referrals (start date will vary; end date will be month 16)
    - Number of referrals who register for services
    - Demographics of referrals (age, gender, race/ethnicity, education level and type of insurance (uninsured, private, Medicaid)
    - Special descriptors, if available (LGBT designation, behavioral health factors, chronic disease factors)
    - Nicotine dependency level
    - Number and types of services delivered
    - Quit status
- Number of eReferrals (start date will vary; end date will be month 16)

- Number of referrals who register for services
- Demographics of referrals (age, gender, race/ethnicity, education level and type of insurance (uninsured, private, Medicaid)
- Special descriptors, if available (LGBT designation, behavioral health factors, chronic disease factors)
- Nicotine dependency level
- Number and types of services delivered
- Quit status

The data described above will be used to determine whether we met objectives 1, 3-6.

In addition, each health care partner will be asked for a description of its patient demographics as part of the review and selection process in phase one of the project. The health care partners' demographic profiles will be used for the evaluation. This information will provide context about reaching priority populations for objectives 2 especially, and also 1, 3-6.

The project manager will conduct a survey of all 11 service providers who operate quitlines in the U.S. to determine: a) whether they are engaged in eReferral activities; b) if so, the names of the states in which they are developing eReferrals and the status of the activities (eReferral capacity being built or eReferral transmissions being received and sent); and c) the names of their healthcare partners. Survey monkey will be used for this activity. The data will be used to determine whether we met objectives 4-6.

Administrative files will be used to describe the number of training and technical assistance sessions, topics covered, who led the session and who participated in the session. This will contribute to describing our activities and success with objective 1 as well as determining how well engaged each team member was in the project. Administrative data from the project also will be used to describe our activities and success related to objectives 7 and 8 (development of resources and dissemination).

Qualitative data sources

A secondary focus of the evaluation will assess the satisfaction of state team members with the training and technical assistance provided during the project, the strengths and weaknesses of the project; and key lessons learned, next steps and recommendations. A survey of state team members will be used to collect this information. Prior to fielding the survey, all project participants (state team members, experts from the eReferral workgroup, consultant and staff) will be engaged in a discussion on these topics via conference call. This conference call will help NAQC staff determine key strengths and weaknesses of the project and also will stimulate the thinking of state team members prior to the survey. The survey will be fielded using survey monkey.

Amount of change expected

During the project period, we expect that at least 5 of the 6 state teams will be successful in implementing eReferral systems. As a result, the full national network of quitlines will have the capacity for eReferral with healthcare EMRs (possibly with the exception of Puerto Rico). We also expect that at least 6 states will have new eReferral projects underway, referrals will increase by 1,250 and that there will be an increased understanding of how to develop

successful eReferral partnerships among public health agencies, quitline service providers and healthcare organizations.

The resources developed during the project will focus on the two key barriers to eReferral, namely technical knowledge and strategies for quitlines to engage healthcare organizations in eReferral. We anticipate that these resources together with the dissemination activities will result in launch of an increasing number of eReferral projects in the years after the projects completion, as quitlines and healthcare organizations continue to develop eReferral partnerships. Over time, we expect significant increases in the number of referrals and rate of quitline treatment of smokers, especially in priority populations. NAQC plans to continue its work in supporting eReferral activities through training and technical assistance until every quitline has multiple eReferral partnerships with healthcare centers.

Determining if target audience was fully engaged in project

NAQC will determine the level of engagement among the target audience using quantitative and qualitative data. The quantitative data will focus on who attended webinars and state team meetings. From this, we can determine the level of engagement of each individual, types of team members, and each state team. We also will use the qualitative survey, examining participants' satisfaction with the project and their perspective on the project's strengths and weaknesses, key lessons learned and recommendations.

Dissemination

Dissemination is a key component of this project. Through dissemination activities, NAQC will:

- Ensure that tobacco control, cessation, quitline and healthcare institutions and providers are aware of the project, achievement of milestones throughout the project, and have access to the final products and resources developed through the project;
- Promote key resources developed during the project to professionals who will be implementing eReferral systems via electronic means;
- Make presentations to influential organizations; and
- Provide enduring products, including a peer-reviewed journal article and a webpage with e-resources on NAQC's website.

The project manager will compile a list of key dissemination contacts, including national healthcare and medical associations and societies, national tobacco control and cessation organizations, state tobacco control programs, quitline service providers and other opinion leaders.

During phase two of the project, the project manager will provide information about the launch of the project to the contacts on the dissemination list. As milestones are achieved, additional communications will be sent to the contacts. Key resources developed during the project will be disseminated to the list, with sample text for inclusion in a newsletter or on a website. Conferences in tobacco control and healthcare will be considered as venues for making presentations about the project and one or more will be selected based on timing and availability of NAQC travel funds. In addition, NAQC will seek to make presentations to important stakeholder groups via webinar or in-person meetings. A manuscript will be

submitted for publication. All final products from the project will be maintained on NAQC's webpage on eReferral.

Detailed Workplan and Deliverables Schedule

Phase One – Project Foundation and Assessment

Key Activities

Month one:

1. Set up financial reporting process, administrative processes and processes for collecting data and reporting on project outcomes. Project website is set up. Timelines and project details are disseminated to project team.
2. Project kick-off meeting will be held with SCLC and Pfizer.
3. State teams are notified of project and a state team participant contact list is developed and distributed to the full project team.
4. Core knowledge webinar presentation on selection of health care partners and strategies for building successful partnerships with health care organizations is developed.
5. State team knowledge and capacity assessment survey tool is developed and survey is conducted. Assessment results are utilized to finalize training webinar schedule, identify high priority topics and draft technical assistance plan.

Month two:

1. Core knowledge webinar presentation on selection of health care partners and strategies for building successful partnerships is conducted.
2. Individual conference call meetings are conducted to develop and finalize technical assistance plan and funding stipend plan with each state team.

Month three:

1. State teams complete selection of healthcare partners and provide data on patient demographics to demonstrate priority population reach.
2. Core knowledge presentation on Meaningful Use and the Technical Approach to eReferral is developed.

Month four:

1. Core knowledge webinar presentation on Meaningful Use and the Technical Approach to eReferral is conducted.
2. Provide up to three hours technical assistance on Meaningful Use and the technical approach to eReferral, or other topics as needed, to each state team.
3. Develop draft template for case studies and data collection and reporting plan to share with teams.

Deliverables:

Project timelines, priorities and activities are finalized and disseminated.	May 1, 2015 – June 30, 2015

State team assessment is conducted.	May 1 – June 30, 2015
Health care partner selection and partnerships training webinar is conducted.	May 1, 2015 – June 30, 2015
Technical assistance plans and funding stipend plans are finalized for each state team.	June 1 – 30, 2015
Health care partners are confirmed, and data on health care partner reach among priority populations is reported.	June 1, 2015 – July 31, 2015
Meaningful use and technical approach to eReferral webinar training is conducted and technical assistance is provided.	July 2015 – August 31, 2015

Phase Two – Building eReferral Capacity

Key Activities

1. Individual state team meetings will be conducted via conference call bimonthly to develop plans for implementing eReferral, address challenges and technical issues specific to individual state teams and assessing each state team's progress.
2. Data will be collected, reported and analyzed by state teams and project manager. Qualitative and quantitative data and experiences will be captured throughout this phase in the case study template for each state team.

Month five:
1. State teams initiate fax referral between the quitline and the health care partner if it does not already exist.
2. Core knowledge webinar presentation on Content of eReferrals is developed.

Month six:
1. Core knowledge webinar presentation on Content of eReferrals is conducted.

Month seven:
1. Provide up to three hours technical assistance on Meaningful Use and the technical approach to eReferral, or other topics as needed, to each state team.
2. Core knowledge webinar presentation on Structure, HL7 and Interoperability is developed.

Month eight:
1. Core knowledge webinar presentation on Structure, HL7 and Interoperability is conducted.

Month nine:
1. Provide up to three hours technical assistance on Structure, HL7 and Interoperability, or other topics as needed, to each state team.

Month ten:
1. Core knowledge webinar presentation on Message Transport and Message Delivery is developed.

Month eleven:
1. Core knowledge webinar presentation on Message Transport and Message Delivery is conducted.

Month twelve:
1. Provide up to three hours technical assistance on Message Transport and Message Delivery, or other topics as needed, to each state team.
2. Technical tool outline and the resource for successfully engaging health care partners in eReferral drafts will be developed. The technical tool will include presentation notes and slides, Q&A and deep learnings notes, webinar audio files, etc.
3. Initial dissemination activities are conducted.

Deliverables:

Bimonthly individual state team training and technical assistance meetings are conducted.	September 2015 – April 2016
Data is reported monthly and utilized in the case study drafts. Case studies are updated as data and learnings are available.	September 2015 – April 2016
Content of eReferrals webinar training is conducted and technical assistance is provided.	September 2015 – November 2015
Structure, HL& and Interoperability webinar training is conducted and technical assistance is provided.	December 2015 – January 2016
Message Transport and Message Delivery webinar training is conducted and technical assistance is provided.	February 2016 – April 2016
Technical tool outline and resource for engaging healthcare partners in eReferral drafted and shared.	March 2016 –April 2016
eReferral will be underway in all six state teams.	April 2016

Phase Three – Demonstration Period
Key Activities
1. State teams report data on a monthly basis and work to complete the case studies.

Month thirteen:
1. Core knowledge webinar presentation on Refining Your eReferral System After Implementation is developed.

Month fourteen:
1. Core knowledge webinar presentation on Refining Your eReferral System After Implementation is conducted.

Month fifteen:
1. Provide up to three hours technical assistance on Refining Your eReferral System After Implementation, or other topics as needed, to each state team.
2. Data and lessons learned compiled from state teams.
3. Technical tool and resource for engaging health care partners in eReferral is completed and disseminated.
4. Additional dissemination products are created (including an abstract and PowerPoint presentation for a conference, and a manuscript for journal publication).

Deliverables:

eReferral continues for all six state teams.	May 2016 – July 2016
Data are reported monthly and utilized in the case study drafts. Case studies are completed for each state team.	May 2016 – July 2016
Data and lessons learned from states, service providers and health care partners are compiled and drafted.	June 2016 –July 2016
Technical tool and resource for engaging health care partners in eReferral is completed and disseminated.	June 2016 – July 2016
Dissemination products, including an abstract and PowerPoint presentation for a conference and a manuscript are created.	June 2016 – July 2016

<u>Phase Four – Dissemination and Evaluation</u>
Key Activities

Month sixteen:
1. Final webinar with all project participants to debrief on the project is conducted. Satisfaction survey is developed and conducted.

Month seventeen:
1. Final project report and products will be completed and disseminated to SCLC and Pfizer, and on NAQC website. NAQC map will be updated.
2. eReferral project results will be presented to NAQC members and other key stakeholder groups.
3. Manuscript will be submitted to at least one journal.
4. Final project materials and resources will be disseminated to the tobacco control, cessation and health care communities.

Month eighteen:
1. Project closedown activities.

Deliverables:

Final webinar with all project participants to debrief on the project. Satisfaction survey is developed and conducted.	August 2016
Final project report and products will be completed and disseminated to SCLC and Pfizer, and on NAQC website.	September 2016
eReferral project results will be presented to NAQC members and other key stakeholder groups.	September 2016
Manuscript will be submitted to at least one journal.	September 2016
Final project materials and resources will be disseminated.	September 2016

REFERENCES

[1] North American Quitline Consortium. List of Service Providers. Posted online at http://map.naquitline.org/reports/operators/. Accessed January 20, 2015.

[2] North American Quitline Consortium. Resources on Electronic Quitline Referral. See Quality Improvement Initiative Issue Paper on Referral Programs and State Pilot Projects for Developing eReferral Capacity. http://www.naquitline.org/default.asp?page=EQR Accessed January 21, 2014.

[3] North American Quitline Consortium. Electronic Quitline Referral webpage of resources. http://www.naquitline.org/?page=EQR. Accessed January 26, 2015.

[4] North American Quitline Consortium. Annual Survey of Quitlines – 2012. See report posted online at http://www.naquitline.org/?page=2012Survey . Accessed January 26, 2015.

[5] Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs — 2014.Atlanta: U.S. DHHS, CDC, NCCDPHP, OSH, 2014, page 51.

[6] Centers for Disease Control and Prevention. National Health Interview Survey; http://www.cdc.gov/ nchs/nhis.htm; accessed: December 2, 2013.

[7] Adsit RT, Fox BM, Tsiolis T, et. al. Using the electronic health record to connect primary care patients to evidence-based telephonic tobacco quitline services: a closed-loop demonstration project. TBM 2014;4(1). doi:10.1007/s13142-014-0259-y.

[8] North American Quitline Consortium. Annual Survey of Quitlines – 2012. Report posted online at http://www.naquitline.org/?page=2012Survey. Accessed October 21, 2014.

[9] North American Quitline Consortium. Resources on Electronic Quitline Referral. See Quality Improvement Initiative Issue Paper on Referral Programs and State Pilot Projects for Developing eReferral Capacity. http://www.naquitline.org/default.asp?page=EQR Accessed January 21, 2014.

[10] North American Quitline Consortium. State Case Studies on Developing eReferral Capacity. http://www.naquitline.org/?page=EQR. Accessed January 21, 2015.

[11] North American Quitline Consortium. Table of Contents for the Technical Guideline on Developing eReferral Systems is attached as an appendix.

[12] Song G, Landau, AS, Gorin TJ and Keithly L. Real-world impact of quitline interventions for provider-referred smokers. AmJPrevMed 2014;47(4):392-402.

[13] North American Quitline Consortium, Minimal Data Set webpage. http://www.naquitline.org/?technical. Accessed January 26, 2015.