Real “meaningful use”
EHRs help patients quit smoking

BY CRYSTAL CONDE
Researchers at The University of Texas at Austin are helping practicing physicians and other health professionals use electronic health records (EHRs) to wean smokers off tobacco. That's important because UT's MD Anderson Cancer Center says patients are 30 times more likely to enroll in tobacco cessation counseling if a clinician refers them than if they merely receive information about services.

Researchers developed the e-tobacco protocol to improve patient referrals to the state-funded Texas Tobacco Quitline, a free, confidential, and 24-hour, 7-day-a-week service at (877) 937-7848. It offers three to five phone counseling sessions and two weeks of nicotine replacement therapy to those referred by a physician or other health professional.

The e-protocol features a comprehensive ask-advisereferral approach to tobacco cessation. At every visit, physicians and other practitioners ask patients 13 years and older whether they use tobacco. If the answer is yes, they advise them to quit as soon as possible and, if the patients agree, electronically refer them to the Quitline.

"The protocol is unique in that it provides an opportunity to refer a patient to an outside source with one click in the

EHR. In the past, all referrals were done with a paper fax," said Shelley Karn, EdD, project manager for the tobacco program at UT-Austin.

In Austin, Lone Star Circle of Care, People's Community Clinic, and El Buen Samaritano Episcopal Mission Clinic adopted the e-tobacco protocol in 2011. Dr. Karn says the preliminary findings are promising.

Before using the e-protocol, health professionals at all three health systems referred only seven patients to the Quitline via fax. Since they began using the e-protocol, they have screened more than 80 percent (285,678) of patients for tobacco use. They identified about 11 percent (31,985) of them as tobacco users, and about 4 percent of them (1,418) said they were ready to stop smoking, a requirement for Quitline referral. Eighty-eight percent of them (1,254) accepted a referral to the Quitline.

Tracy Angelocci, MD, is the chief medical officer for Lone Star Circle of Care, a federally qualified health center with more than 25 Central Texas clinics. She says its 128 physicians, nurse practitioners, physician assistants, and behavioral health therapists use the e-tobacco protocol.

"The e-tobacco protocol allowed us to treat smoking status
as a vital sign — a normal, expected aspect of every patient encounter. We placed it in the EHR workflow where it made the most sense and couldn’t be overlooked. We made it super simple to initiate a referral that required no printing, paperwork, or faxing. It’s just a few clicks in a template,” Dr. Angelocci said.

“With the extensive amount of information a physician must process at every visit to provide the best care and reduce missed opportunities, it can’t all be left to memory and to one person. It is critical to use technology to automate prompts and offload some of that workload to clinical support staff,” Dr. Angelocci said.

Protocol in practice
Dr. Angelocci describes learning to use the e-protocol workflow as “intuitive,” adding it requires minimal training. Cen­tex Systems Support Services — the in­formation technology services vendor for all three health systems — trained physi­cians, nurse practitioners, physician as­sistants, and behavioral health therapists to use the e-protocol. A tobacco cessation counselor from the Seton Tobacco Education Resource Center (STERC) trained medical assistants (MAs). The training included using motivational interviewing techniques to increase the number of patient referrals.

MAs typically use the e-tobacco pro­tocol to record a patient’s smoking status. If they don’t, a pop-up reminder alerts the MA, and he or she cannot complete the patient encounter form. The MAs inquire about a smoker’s commitment to quitting by indicating whether the patient is ready to quit in the next 30 days, thinking about quitting at some point, or not interested at all.

If the patient is ready to quit within the next month, the e-protocol allows a referral to the Quitline for phone-based tobacco cessation counseling or to STERC, a classroom-based, face-to-face cessation program. Both programs offer nicotine replacement therapy.

The e-protocol requires users to make a referral or to document that the patient refused.

“An automated backend business process creates a nightly report listing all patients referred to cessation programs. The report is automatically sent via se­cure email server to enrollment special­ists at each of the two tobacco cessation programs. Specialists then contact the referred patients,” Dr. Angelocci said.

STERC received referrals for about 59 percent of the patients who were ready to quit. Participants in the Seton program attended six cessation classes held at various community sites in Austin. Data show 66 percent of patients remained tobacco free six months after completing the Seton program.

Dr. Angelocci says STERC reached 74 percent of the patients referred to the program. She explains STERC could not contact about one-quarter of patients because they gave the clinic incorrect contact information or out-of-service phone numbers, or they may have moved. To help enrollment specialists reach more referred patients, the clinics added patients’ preferred time of day to call and consent to leave detailed voicemails to the e-protocol. Moving forward, all contact numbers for patients (not just the preferred daytime number) will be added to the protocol.

“It’s important to me that our organi­zation views the protocol as an active project that we continue to improve upon. Even when roles and workflows are studied upfront in an attempt to build a seamless process, there are always lessons learned after implementa­tion,” Dr. Angelocci said.

For a step-by-step guide to integrating the e-tobacco protocol into a medi­cal practice EHR, visit www.yesquit.org/healthcare-providers. The site also fea­tures training videos that teach physi­cians to assess patients’ interest in quitting and guide them through tobacco cessation counseling. The Toolkit Mate­rials link directs physicians to download­able patient brochures in English and Spanish, a patient encounter checklist, Quitline business cards, guides to billing codes and pharmacotherapies, and more.

Meaningful use
The e-tobacco protocol also can help physicians meet Medicare and Medicaid meaningful use EHR program require­ments. To date, the Lone Star Circle of Care has received $2 million in Medicaid meaningful use incentives.

Eligible non-hospital-based physi­cians with at least a 30-percent Medi­caid patient volume can receive up to $63,750 over six years in incentive pay-
ments from 2011 to 2021. Eligible non-hospital-based pediatricians with at least a 20-percent Medicaid patient volume could receive up to $42,500 during the same period.

Health professionals in the Medicare incentive program can earn up to $44,000 over five years for meeting meaningful use criteria from 2011 to 2016. Eligible Medicare physicians in a health professional shortage area can receive a 10-percent increase in incentives.

Stage 1 meaningful use core measures require physicians to record the smoking status for more than 50 percent of patients 13 years or older. In Stage 2, the requirement increases to recording smoking status for more than 80 percent of patients 13 or older.

To achieve meaningful use, physicians also must report on six clinical quality measures, several of which involve tobacco cessation. In Stage 1, physicians can choose a clinical quality measure requiring them to advise smokers and tobacco users to quit, discuss smoking and tobacco cessation medications, and discuss smoking and tobacco cessation strategies. In Stage 2, physicians can opt for a clinical quality measure requiring them to record the percentage of patients older than 18 screened for tobacco use at least once in two years and who received cessation counseling.

For more information about the Medicare and Medicaid meaningful use EHR program, visit the TMA EHR Incentive Program Resource Center at www.texmed.org/EHRIncentive.

TMA has additional resources to arm physicians with tools to promote good health among their patients. (See “POEP Podcast Fights Tobacco,” page 44.)

The TMA Tobacco Cessation Counseling Calculator helps physicians estimate how many patients would benefit from tobacco cessation treatment and determine the potential revenue they could earn by billing for such services. Using the calculator is easy. Physicians or staff members enter contracted fee amounts for each of the codes listed and then enter the number of patients to whom they provide cessation treatment. To access the calculator, visit www.texmed.org/tobacco_calculator.

The Texas Department of State Health Services (DSHS) offers a clinical toolkit for treating tobacco dependence. The toolkit, online at www.dshs.state.tx.us/tobacco/toolkit.shtml, allows physicians and staff members to develop a system that helps ensure they ask every patient at every clinic visit about tobacco use—and document that they did it.

**Saving lives saves money**

Ultimately, the EHR tobacco cessation protocol project could reduce tobacco-related deaths. Dr. Angelocci says. DSHS says more than 24,000 Texans die annually from a smoking-related illness such as cancer or cardiovascular and respiratory disease.

The American Cancer Society estimates a $2,000 reduction over four years in health care costs for every smoker who quits.

TMA's legislative agenda stresses that a healthy and wealthy Texas depends on a sound health care system with robust medical care and effective public health components. The association calls for the state to invest in evidence-based wellness and public health programs that reduce tobacco use.

TMA's recommendations to the Texas Legislature include supporting funding for evidence-based interventions that reduce tobacco use, especially in youth, such as education in schools and the Texas Tobacco Quitline. To read TMA's full legislative agenda, visit www.texmed.org/advocacy.

Fiscal year 2012 funding for the Quitline totaled $848,648, says DSHS Assistant Press Officer Christine Mann. Last year, the Cancer Prevention and Research Institute of Texas (CPRIT) awarded a three-year $950,000 prevention grant to DSHS to fund Quitline services. In 2012, DSHS also received funding for Quitline services from the Centers for Disease Control and Prevention (CDC) that provides an additional $1,157,363 annually for 2013 and 2014.

Ms. Mann says DSHS asked the legislature to maintain the core funding of $848,648 for the Quitline and asked the Legislative Budget Board for about $1.5 million over the next two years to expand Quitline services.

According to Ms. Mann, about 27 percent of Quitline clients surveyed seven months postenrollment said they were tobacco-free. A 2006 Texas study by the Center for Health Research at Kaiser Permanente found that every Texan who quits smoking saves $8,127 in medical costs and lost productivity within the first five years. Assuming 27 percent of the 12,113 clients enrolled in Quitline counseling in 2011 successfully quit using tobacco, the state would potentially save about $26.5 million, Ms. Mann says.

**Moving forward**

DSHS awarded $300,000 in initial funding for the e-tobacco protocol project through December 2011. CPRIT gave UT-Austin a $266,920 grant through August of this year to fund the project.
“We do hope to continue our work to improve tobacco cessation efforts through provider involvement with additional funding,” Dr. Karn said.

Dr. Angelocci says the basic tenets of the e-protocol are applicable to any health system with a customizable EHR.

“The important aspects are the required update of the smoking status at every visit, forced assessment of readiness to quit in smokers, an established cessation referral system that offers the patient options, and ease of initiation of referral. But the workflow specifics could definitely vary. Any protocol needs to be flexible to adapt to existing routines that vary by clinic location, staffing resources, or medical specialty,” she said.

POEP podcast fights tobacco

Physicians can help their patients quit smoking and be paid for it. A podcast from the Texas Medical Association’s Physician Oncology Education Program (POEP) explains how.

“Tobacco Cessation Counseling: Right for the Patient, Good for Reimbursement” focuses on the efficacy of physician interventions, “incident to” services as defined by Medicare, current statistics regarding patient assessment of tobacco use, coding tips, a reimbursement calculator, and the “Five As” of tobacco cessation. The podcast is accredited for 0.5 AMA PRA Category 1 Credits™, including ethics education.

“The key for physicians to effectively promote good health is having a range of resources available for counseling and education,” said Deborah A. Fuller, MD, chair of the TMA Council on Health Promotion and Education, and the Five A’s of tobacco cessation. POEP also offers more in-depth training on tobacco cessation counseling, including tips on motivational interviewing and current pharmacotherapies, in the form of educational modules and podcasts, iPhone apps, and pocket guides. These items are available on the POEP website, www.texmed.org/poep.

The Council on Health Promotion and the TMA Foundation collaborated on the podcast. For more information, email Laura Wells at laura.wells@texmed.org, or call her at (800) 880-1300, ext. 1673, or (512) 370-1673.

TMA, AMA comment on meaningful use EHR program

The Texas Medical Association and the American Medical Association submitted formal comments to the Office of the National Coordinator for Health Information Technology (ONC) on the Health IT Policy Committee’s proposal for Stage 3 of the Medicare and Medicaid meaningful use electronic health record (EHR) program requirements.

Joseph Schneider, MD, chair of the TMA Ad Hoc Committee on Health Information Technology, signed the association’s letter to ONC. TMA’s overarching concerns include the following:

• TMA strongly opposes physicians being measured, incentivized, or penalized based on the actions of patients that are beyond physicians’ control.
• TMA opposes any measures that fracture patient access to records by incentivizing multiple patient portals.