

Help Your Colleagues:

Fax Referral to Quitlines

May 25, 2006

Question #1:

Has anyone done evaluation on quit rates of clients that come through fax referral in comparison to general clients?

Question #2:

Has anyone analyzed the cost to generate a fax referral - taking in to account training, systems changes, staff time (including the clinic as well as the quitlines time to contact the client)?

Center for Tobacco Independence Portland, ME

Although the Center for Tobacco Independence has not been able to formally evaluate its fax referral project, there have been some general outcomes noted. One of the most important outcomes is that the project seems to have helped get cessation on the radar screen for providers and clinics as well as the larger issue of tobacco itself. The fax referral system has developed in a way that helps providers begin a dialogue with patients on smoking as well as serving as a reminder to incorporate tobacco treatment into practice. Funding for this project went to implementation of this effort among providers. CTI has some tracking capacity but does not have money for formal evaluation or cost calculations at this point. However, evaluation funding might occur in the future.

CorVasc Bridges Nicotine Dependence Program Indianapolis, IN

The Bridges Nicotine Dependence program was developed at CorVasc MD's four years ago. We are a cardiothoracic and vascular surgery practice. Our market for cessation services is physician offices of all different specialties including, cardiology, pulmonology, podiatry, pain specialist, wound treatment and OB/GYN. We also work hard on PCP and Family Practice offices. Our quit rate for one year is holding between 46-47%, which includes treatment failures. Conversion from referral to enrollment is our issue.

In the past year, we have started doing outpatient office based training to include teaching on the 5 A's and how to implement based on the Clinical Practice Guidelines and our own experience with our practice. Training also includes motivational interviewing techniques to help reduce patient resistance, stages of change, best means to advise a patient, effective components to nicotine dependence treatment and a fax referral system. It is very inexpensive to do given we focus our efforts close to our geographic location. This training serves as excellent marketing for our service and external referrals to our program (outside of CorVasc practice) are currently at 42%.

In my experience, our quit rates have not depended upon whether a referral is on a fax system or by other means such as a nurse calling in referral or a self-referral. The true issue is the quality and consistency of the medical advice. The physician must say clearly and compassionately "You need to quit smoking (using tobacco) and I am making a referral on your behalf to... I expect you to enroll for

assistance.” It is then our job to make our services affordable (though with little or no reimbursement) and of high quality. We must also communicate back to the physician the status of the patient referral and information we obtained so he/she knows what barriers are preventing enrollment. I suggest to the physician to focus on these issues to reduce resistance. We offer a monthly payment plan on a very low service charge. A payment plan is not without challenges, but conversion from referral to enrollment has double this year compared to last.

I spend a significant amount of time chasing referrals for people for whom the MD wants to quit, but readiness is not there. Physician training and education on how to advise and the necessity of them arranging for the referral on the patient’s behalf is paramount for a successful referral.

QuitWorks Boston, MA

Massachusetts has two years of client outcome data for QuitWorks verses self-referred. While there are no differences in 6 month quit rates between the two groups, there are significant differences in the characteristics of two client groups on several important dimensions (e.g. age and stage of change). Until the analyses are complete, however, QuitWorks will not disseminate this information.

JSI has estimated the cost of handling a QuitWorks fax referred caller with provider feedback verses a self-referred caller. The most important factor is not the actual cost or cost difference (as it would vary by quitline provider), but what the cost-sensitive elements are in serving the fax-referral client and provider feedback. These elements include “call-backs” to reach the client, tracking down bad provider information, generating provider feedback reports, faxing, etc.

The costs for a hospital or health center to implement the QuitWorks program can be significant in terms of staff time and provider training. One hospital estimated it cost about \$25,000 in in-kind staff time for the first round pilot/implementation. However, every health center varies in terms of what is done on their part. In Massachusetts, some health centers have all providers trained both in QuitWorks and in the 5A/Rx (2 hours). This alone may be 40-100 clinical person hours just to receive the training.

The process with a single community health center or hospital typically involves multiple steps: initial inquiry and phone discussions (2-5 calls), in person presentation to clinic or hospital decision makers, communications with JSI regarding the actual form modifications and time for a designer (3-5 calls/emails). Some community health centers and hospital integrate the fax referral into the EMR and this takes time. UMass Medical usually handles another 2-5 emails and calls, and typically provides a 2-3 hour on site clinical training. In some cases this may turn into multiple trainings. UMass Medical stays in touch with facilities, tracks progress, and provides troubleshooting. JSI produces individual provider feedback reports and once or twice a year does an aggregate report for the community health center or hospital.

Total time to complete adoption and systems changes can be a minimum of 4 months to over a year, with interactive improvements/-re-education. You should be very cautious about trying to quantify this or estimate costs as a "rule of thumb". It is so specific to each site or institution and to the type/scope of the fax-referral adoption process. Anything other than a broad range/list of "ingredients" of potential steps and who is involved would be misleading. You shouldn't underestimate what is involved if a clinic or hospital takes on basic systems changes. The emphasis should be placed on working with institutions, not just using a fax form.

Resource: QuitWorks website (www.quitworks.org under Tools and Guides): Provides a grid with detailed steps for CHCs or hospitals to implement a fax referral process.

Providence St. Vincent Hospital and Medical Center Portland, OR

Researchers at Providence tested a proactive clinician initiated fax referral system compared to patient initiated self-referral in 17 primary care settings and in two teaching clinics that use a standard electronic

medical record system. The study involved 175 providers that collectively made 496 fax referrals to the Oregon Tobacco Quit Line, generated from the EMR system, between October 2002 and October 2003. The Quit Line was able to contact 59% of those referred and 90% of those contacted accepted a one-time intervention from the Quit Line counselor. An additional 1342 patients had received a brochure prompting self-referral to the Quit Line (documented in the EMR). Of those, 249 called the Quit Line and 94% accepted a one-time intervention.

Cost estimates for the fax referral system were calculated on a "cost per connection" basis. These ranged from \$15 - \$38 per connection in the first year (including start-up costs) and \$4-\$6 per connection in subsequent years. Cost-per-connection estimates in Oregon based only on media campaigns range from \$100 - \$400 per connection.

Data on quit rates for the two groups was not collected.

Reference: Bentz, CJ, Bayley, KB, et al. The Feasibility of Connecting Physician Offices to a State-Level Tobacco Quit Line, *American Journal of Preventive Medicine*, Volume 30, Issue 1, January 2006, Pages 31-37.

Blue Cross Blue Shield of Minnesota BluePrint for Health stop-smoking program Clinic Fax Referral Pilot

Overview

Minnesota's Clinic Fax Referral Pilot is collaboration among seven of Minnesota's health plans (Blue Cross, HealthPartners, Medica, MHP, PreferredOne, UCare) MPAAT, Minnesota Department of Health and Fairview Physician Associates (FPA). The purpose of this pilot is to test the feasibility and effectiveness of directly referring patients who smoke from their doctor's office to telephone-based cessation counseling services, by means of a fax referral. The collaboration is working with FPA, including the Fairview-owned clinics, to implement, at 50 primary clinics in the metro area. The pilot will measure the impact of using either clinic-level financial incentives plus on site technical assistance or, usual care to facilitate the referral process. Incentives and enhanced technical assistance will be used at selected clinic sites only. It is anticipated that this pilot will help Blue Cross and its collaborators to determine the costs, effectiveness and implementation procedures necessary to integrate available smoking cessation counseling resources with primary care medical practices. The FPA Clinic Fax Referral Pilot launched on September 15, 2005. Since the launch more than 1500 patients have been referred, resulting in over 400 stop-smoking program enrollments as of early May.

Centralized Intake and Triage System:

Providers fax, or send an electronic medical record referral, for ALL patient referrals to one central number, Free & Clear (F&C), who then directs referrals to appropriate health plans' telephone-based cessation counseling program. Blue Cross financially supports the central triage of all clinic fax referrals during the pilot.

Member and Health Plan Confidentiality:

The fax referral form and processes meet HIPAA privacy standards. Data will be analyzed at the aggregate level (by clinic) only. Neither individual member data nor data by health plan affiliation will be viewed or analyzed by Blue Cross as part of this pilot study.

Collaboration with Health Plans:

ALL collaborating health plans have agreed to receive fax referrals and contact their members who are interested in telephone cessation counseling services. Collaborating health plans also fax back to the referring medical provider a summary of each client's participation and services. In addition, the collaborating health plans are also providing monthly reports which delineate: aggregate number of fax referrals, by clinic, received; participants reached (aggregate counts, by clinic); for those reached, number enrolled (aggregate counts, by clinic). At six months and then at 12 months the health plans will also provide a report for those enrolled, an aggregate of demographic data (age, gender, pregnancy status, stage of change and education), and number of sessions completed, by clinic.

Collaboration with Fairview Physician Associates (FPA):

Fifty FPA-associated clinics, half of which include Fairview-owned clinics, have agreed to participate in this pilot study. All of the Fairview-owned clinics have Electronic Medical Record (EMR) capabilities. An EMR version of the clinic fax referral form was developed and is now in use with pilot. Use of EMR enables clinicians to directly enroll their patient from the exam room. Other non-EMR clinics are using the paper clinic fax referral form. This study will measure the impact of using either clinic-level financial incentives plus on site technical assistance or, usual care to facilitate the referral process. Incentives and enhanced technical assistance will be used at selected clinic sites only. On September 7, 2005 an orientation was held with the selected clinic sites receiving enhanced technical assistance and incentives.

Wisconsin Fax-To-Quit Manual: A Step-by-Step Guide for Healthcare Organizations

The Fax-to-Quit manual can be found at www.tcn.org/cessation topics and resources/health systems.