



Local Public Health e-Referral Toolkit

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Background

Despite great progress decreasing the prevalence of smoking and reducing the burden of tobacco-related illness, tobacco use continues to be a leading cause of morbidity, premature death and high health care costs. Tobacco use prevalence has significantly decreased with policy and cessation and education initiatives. Most tobacco users want and try to quit; as many as 70% of current smokers have expressed a desire to quit smoking.¹ Quitlines are an underutilized but effective resource for evidence-based tobacco cessation counseling or medication strategies.²⁻⁵ Improving systems to refer smokers to Quitlines is an effective tactic to increase the use of Quitlines, resulting in increased quit attempts and the proportion of those attempts that result in cessation success.

70% of smokers have expressed a desire to quit.

Who is the audience for this document?

This toolkit is intended primarily for local public health stakeholders as they consider funding, supporting, or facilitating e-Referral systems between healthcare providers and tobacco cessation Quitlines. Key stakeholders include:

- Public health department tobacco program staff who understand the rationale, approach, development and implementation of e-Referral systems.
- Healthcare providers who seek easy methods to implement an e-Referral system.
- Quitline funders (e.g., state health departments) who share a desire with healthcare providers from their state to make electronic referrals to Quitlines an efficient process.

What is the purpose of this document?

This toolkit provides basic information for key stakeholders to support e-Referral implementation to encourage tobacco cessation. The toolkit answers the following questions:

- What is an e-Referral?
- How does an e-Referral work?
- What are the key development and implementation activities?
- What non-technical issues are worthy of consideration when implementing an e-Referral?
- How is an e-Referral implementation evaluated?

The recommendations and guidelines in this toolkit are based on the implementation experience of Denver Public Health with several Colorado healthcare organizations and resources listed in Appendix 1.

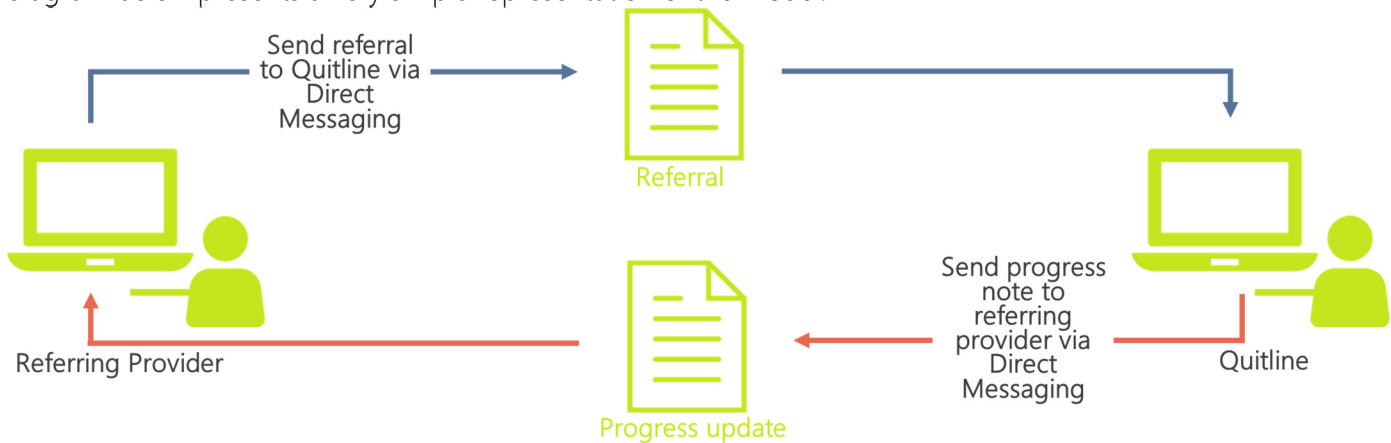
What is an e-Referral?

The term “e-Referral” refers to a closed-loop electronic referral system which transports two types of secure and rapid messages between a provider and the Quitline via Direct Messaging, a HIPAA-compliant framework for transmitting patient information between two entities.

Direct Messaging is very similar to email, except that it is HIPAA-compliant due to an added layer of security and trust-in-identity which operates in the background. (More information on Direct Messaging is available online at <http://www.directtrust.org/about-directtrust/>)

The first type of message allows a provider to send a referral document from the electronic health record (EHR) to the Quitline. The second type of message allows the Quitline to send a progress note back to the referring provider, thus completing the loop. The data elements that should be included in the referral and progress note are described in Appendix 2.

The actual sending and receiving of messages occurs through a Health Information Service Provider (HISP). The diagram below presents a very simple representation of the model.



Why is an e-Referral beneficial?

Most healthcare providers who refer patients to the Quitline use a manual process, which includes faxing a paper-based referral form to the Quitline. Some, but not all, referring providers receive updates on patients through a fax back from the Quitline. The main disadvantages of manual Quitline referrals are time to find and fill out the form, data quality (e.g., wrong interpretation of written phone numbers), and minimal feedback on patient status and progress. Because an e-Referral is automatic, it requires no manual steps and, by being embedded in the EHR workflow, e-Referrals make the referral process faster and easier for providers. By populating the electronic referral form with patient information from the EHR, e-Referral systems improve data quality and increase the likelihood of a successful handoff to referral service provider. Sending information back to providers on the status of a patient creates the opportunity for them to follow up with patients, reinforce and encourage their cessation messages.

The public health benefits of investing time and resources to transform a paper-based referral system to an e-Referral include:



A cost-effective, sustainable means of reaching more tobacco users.



Increased number of referral received by Quitlines.



Increased percent of clients who successfully enroll in Quitline services.



More complete EHR data to improve and coordinate healthcare delivery.

Additionally, providers participating in the [Meaningful Use \(MU\) program](#), a national effort to maximize the use of electronic health data, benefit from implementing an e-Referral system. Electronic referral is one of the requirements of [Stage 2 of MU](#) (a set of standards that a provider must meet). From the EHR, a provider must be able to send electronic referrals for patients and receive progress notes. Often, once a provider has built the e-Referral

infrastructure for a tobacco cessation e-Referral, it can be expanded for referrals to other providers and organizations (e.g., cardiology referrals).

What are the barriers to implementing an e-Referral system?

Implementing an e-Referral system is not without challenges. For any site, one of the greatest barriers to an e-Referral system is lack of time, technical expertise, and resources required to implement and maintain an e-Referral system. Competing demands on a site’s resources, especially technical resources, can cause implementation delays. Barriers arise from EHR customizations to a site’s installation. The months immediately following a new EHR implementation are typically devoted to stabilization and optimization of the EHR; that is not the right time to implement an e-Referral system. Instead, it may be best to wait until the clinical staff are comfortable with a stabilized EHR environment, provider workflows have been established, and users trained.

Another key barrier to e-Referral implementation is failure to account for the human, social, and organizational factors that influence response to a new change in practice. This is especially challenging if the healthcare organization is not committed to tobacco screening and reducing the burden of tobacco within their patient populations. Identifying a cessation champion and selecting implementation sites with high interest in tobacco cessation is recommended.

Who are the stakeholders and what are their roles?

A variety of stakeholders play an important role in an e-Referral implementation. This table describes the responsibility of each stakeholder.

Stakeholder Role	Stakeholder Responsibility(ies)
Quitline Funder	<ul style="list-style-type: none"> • To promote use of technology and the importance of comprehensive tobacco cessation service delivery. • To lead systems change initiatives through partnerships and promotions. • To provide resources to support implementation efforts. • To disseminate e-Referral successes and identify opportunities for alignment.
Quitline Service Provider	<ul style="list-style-type: none"> • To build, maintain, and operate systems, standardize methods, and deploy technology to receive standardized referrals from referral sources. • To build, maintain, and operate systems, standard methods and deploy technology to generate and transmit cessation progress notes (updates) to referring providers.
Healthcare Clinic or System	<ul style="list-style-type: none"> • To make tobacco screening and cessation counseling a routine part of patient care (included in the workflow). See Appendix 3 for an example workflow diagram. • To ensure that tobacco use is properly captured and stored in a structured field in the EHR. • To monitor tobacco screening and referral rates by clinician or delivery unit.
Healthcare Provider	<ul style="list-style-type: none"> • To screen patients for tobacco use, advise patients to quit, and initiate referrals when appropriate (through 5As or AAR)^{6,7}.
Public Health Department	<ul style="list-style-type: none"> • To encourage, convene, and support implementation partners for e-Referral. • To gather data about e-Referral development and implementation successes and lessons learned. • To maintain documentation and recommendations for future implementation efforts.

- To conduct outreach to providers within their community and share e-Referral technology.
- To use readiness assessment tools that identify high readiness healthcare organizations ideally suited for e-Referral.

Health Information Exchange • To facilitate transmission of e-Referrals, acknowledgement messages, and cessation reports (e.g., receive messages and route them to their final destination).

What information does an e-Referral message include?

The e-Referral message includes only the information needed by the Quitline to initiate Quitline cessation services (see Appendix 2). The North American Quitline Consortium has developed a national standard for e-Referral data elements shown in Appendix 1. Information about the patient (e.g., name and gender), how to contact them (e.g., phone number), relevant medical information (e.g., if the patient is pregnant), and the referring provider's name and contact information are included. Information about the referring provider is collected to provide updates through progress notes.

How long does implementation take?

The duration of an e-Referral implementation is impacted by a number of factors. The implementation timeline may range from 10 to 15 weeks depending on the following variables:



- EHR system utilized by the organization
- Existence of a current referral system
- HISP(s) selected
- Presence of an existing or newly required interface engine
- Resource availability (i.e., clinical site, EMR vendor, and HISP(s))

Implementers should also consider additional environmental or temporal factors specific to the time and place in which the project is being run that could impact the timeline. For example, beginning the project in November would introduce resource availability constraints due to the winter holiday season or when another major project is underway with competing demands for resources. Appendix 4 includes an example implementation timeline.

Key considerations for successful implementation and sustained use of Quitline e-Referral

The goal of e-Referral is to improve the efficiency and quality of cessation services offered at a healthcare organization. This is achieved through both technology and organizational change. Investing adequate time and resources to support the technical design of a closed-loop Quitline electronic referral system is a necessary but not sufficient step to its successful implementation and sustained use. Before “going live” with a Quitline e-Referral system, planning teams should focus on more than the technical side; a range of non-technical socio-cultural, organizational, and external influences can dramatically affect whether Quitline e-Referral is well received and widely used⁸⁻¹¹

The goal of effective pre-implementation planning is to increase the “fit” between the Quitline e-Referral system, work tasks and processes, and the socio-cultural milieu. Failure to consider and address these non-technical issues—and how they intersect with the technical aspects of e-Referral—can result in frustration, false starts, ineffective

implementation, lack of spread throughout the organization, and little improvement in tobacco-related patient outcomes.

In this section of the Toolkit we briefly highlight a range of technical and non-technical issues worth considering during the pre-implementation planning phase.

Technical considerations

Informatics projects are prone to implementation failure and e-Referral is no exception. A successful e-Referral implementation must consider technical and non-technical factors.

What technical criteria identify an e-Referral implementation site’s likelihood of success?

To implement an e-Referral, a site must:

- ✓ Have a functioning certified EHR. When an EHR is certified, that means that the EHR offers the technological capability, functionality, and security that is defined by the Office of the National Coordinator (the national health information technology standards organization). This is also referred to as the MU criteria. More information about certified EHRs is available [here](#).
- ✓ Use a workflow that includes tobacco screening and structured EHR capture of tobacco use
 - [Workflow assessment tools](#) can guide this discovery process (see example e-Referral workflow in Appendix 3)
- ✓ Have the capacity to generate a transition of care document (the e-Referral) through Direct Messaging.



A site has a high readiness for implementation if they:

- ✓ Have already successfully attested to Stage 1 of MU (which includes screening and collection of tobacco use).
- ✓ Have already or are currently pursuing Stage 2 of MU (which includes referral functionality using a standard electronic document).
- ✓ Have established connectivity with an HIE.
- ✓ Have an agreement to share data with an HIE and are already sending data to the HIE.
- ✓ Are already sending referrals to the HIE and/or other referral recipients.
- ✓ Are already referring to the Quitline (e.g., fax form or warm handoff).
- ✓ Are already tracking tobacco screening as an internal quality metric.



What lessons learned can expedite implementation?

Engaging in a comprehensive discovery process can ease implementation. One important step in discovery is to document the current state of cessation workflow (i.e., how cessation counseling/referral currently occurs) and dataflow (i.e., how patient tobacco information is captured and stored). Including providers who deliver services and technical experts with knowledge about the EHR and related systems during this discovery phase will ensure the accuracy of implementation planning materials. Information identified in pre-implementation discovery is valuable for implementation planning, often increasing the detail of the activities and accuracy of time and resource estimates. Being including in planning will also improve stakeholder buy-in and implementation experience.

Another important step is assessing a healthcare organization’s technical readiness to implement an e-Referral system by defining the current EHR infrastructure and identifying what functionalities need to be built to achieve the e-Referral ideal state. This information is the foundation for detailed implementation planning that defines how long the implementation will take, how much it will cost, and what resources will be needed. Finally, frequent meetings to

provide status updates and discuss progress and barriers with all stakeholders are recommended throughout implementation.

Non-technical considerations

Simultaneous to planning and designing in line with technical requirements of Quitline e-Referral, teams should also focus on the human, socio-cultural, and organizational side of the equation: what factors meaningfully impact employee response to implementation and how will it impact on the care delivery system change? What external influences outside the control of healthcare organizations might impact implementation and sustained use of Quitline e-Referral.

The following table includes examples of important non-technical influences and indicators worth considering as part of pre-implementation planning.

Key Non-Technical Considerations/Questions	Indicators/Responses/Comments
<p>Sociocultural: Are providers, staff, and patients ready and able to implement Quitline e-Referral?</p> <p>Does this new referral system become integrated into daily practice?</p> <p>Is there a collective commitment and approach to tobacco cessation?</p>	<ul style="list-style-type: none"> • Widespread awareness of Quitline services among providers, staff, and patients • Knowledge of Quitline e-Referral system – processes, workflow, communication (does everyone know the required steps?) • Readiness to change tobacco assessment and cessation practices in line with e-Referral • Collective buy-in and commitment to Quitline e-Referral system • Quitline e-Referral aligns with values and behaviors of practice • Personnel trained on consistent Quitline e-Referral use • Clinical champion helps motivate and reinforce this change • Buy-in from leaders, all providers and staff • Effective, ongoing communications about Quitline e-Referral and follow-up (for providers/staff and patients) • Tobacco assessment and cessation is a shared priority
<p>Organizational: Do organizational structures, processes, and internal policies support making this change?</p>	<ul style="list-style-type: none"> • Quitline e-Referral in line with strategic priorities of health care organization • Supportive, committed leadership • Personnel in place to promote, support, monitor implementation and sustained (consistent) use • Work flow, processes well integrated into existing systems and practices • Ongoing training, feedback and quality improvement • Technical support available
<p>External Environment: What influences outside of the organization might affect successful implementation of Quitline e-Referral?</p>	<ul style="list-style-type: none"> • Coverage expansions or changes related to the Affordable Care Act • National EHR related policy changes or technical standards such as MU • Tobacco assessment and cessation performance measures • National and state funding for Quitline services • Availability of resources to support implementation • Funding model and type of provider/Quitline fee structure

Evaluation: Is the e-Referral system having an impact on tobacco outcomes?

What factors influence Quitline e-Referral implementation and sustained use?

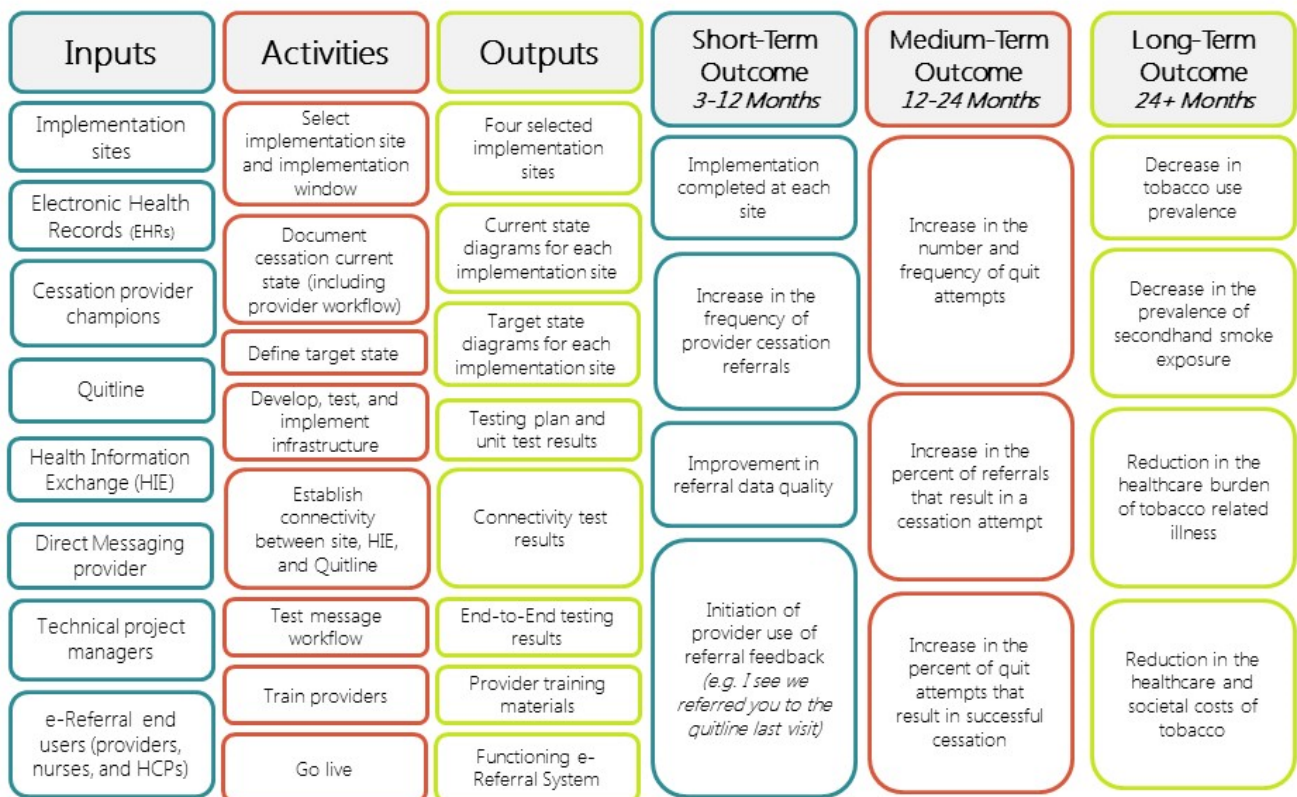
How can the system be improved?

- Technical readiness and capability
- Work flow and process diagrams
- Completeness and quality of tobacco registry data
- Frequency of provider Quitline referrals
- Frequency of quit attempts, proportion of quit attempts that lead to cessation success
- Tobacco use prevalence
- Secondhand smoke exposure prevalence

Evaluation

A combination of quantitative and qualitative evaluation methods can be used before and during implementation to study and understand the impact of an e-Referral implementation. Data collection methods include: reports from an EHR tobacco registry and from the Qutline, surveys, key informant interviews, document review, and documentation of work flow and processes. This information can be used in a formative way for improving “fit” within a practice, and in a summative evaluation of Quitline e-Referral impacts on practice and tobacco-related patient outcomes.

e-Referral Logic Model



The logic model included here can be a helpful tool in evaluating the implementation process and impact and thinking about important evaluation data to capture, monitor, and share.

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Appendices

Appendix 1: Resources

The following resources provide useful information on e-Referrals and health systems change for tobacco treatment.

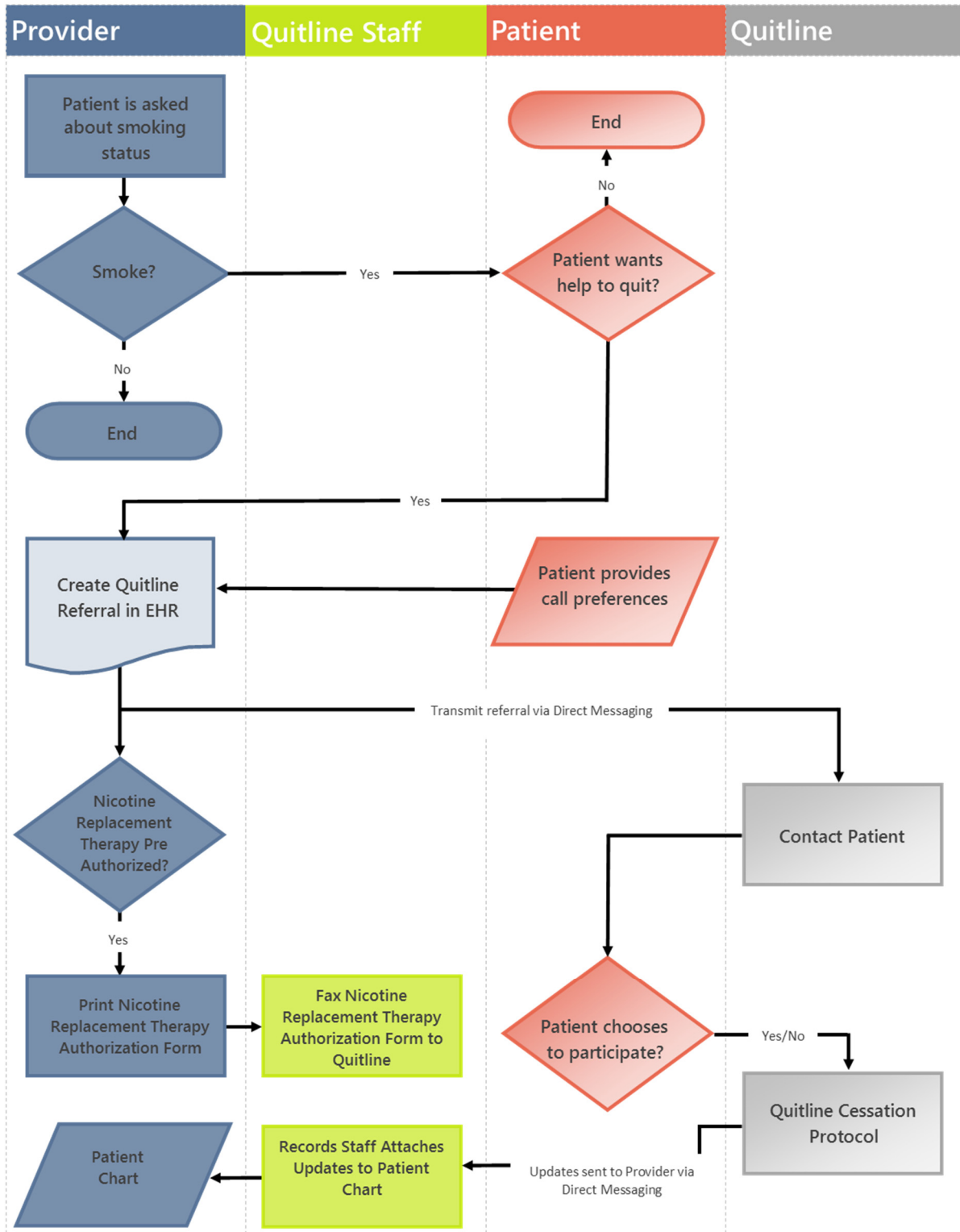
- [Facilitators of Health Systems Change for Tobacco Dependence Treatment: A Qualitative Study of Stakeholders' Perceptions](#)
- [Increased Evidence-Based Tobacco Treatment Through Oklahoma Hospital System Changes](#)
- [NAQC e-Referral Technical Implementation Guide](#)
- [NAQC Quality Improvement Initiative Issue Paper: Quitline Referral Systems](#)
- [NAQC Website: Electronic Quitline Referral](#)

Appendix 2: e-Referral Data Elements

Data Element	Type	Usage	Description
Client	Text	Required	
Referring Entity	Text	Required	
Referral ID	Text	Required	The referral ID is generated by the client's EHR application. Use this ID to uniquely identify the referral in their originating system. Passed back in the response package.
Patient First Name	Text	Required	
Patient Last Name	Text	Required	
Patient Middle Initial	Text	Optional	
Patient EHR ID	Text	Required	
Patient Primary Phone	Text	Required	Format= #####
Patient Secondary Phone	Text	Preferred	Format= #####
Patient Address1	Text	Preferred	
Patient Address2	Text	Optional	
Patient City	Text	Preferred	
Patient State	Text	Situational	Required if no postal code provided
Patient Zip	Text	Situational	Required if no state provided
Patient Race	Text	Optional	TBD
Patient Gender	Text	Optional	M or F
Patient Language Preference	Text	Optional	Values: 0=English; 1=Spanish
Patient Best Time	Text	Required	Period of time that the participant prefers to be contacted. Values to be one of the following codes: <u>Code Description</u> 2) Early Morning 3) Morning 5) Early Afternoon 7) Late Afternoon 8) Evening 9) Late Evening
Patient Best Day	Text	Required	<u>Code Description</u> Anytime Weekdays Weekends
Clinic Name	Text	Required	
Clinic ID	Text	Required	Client to send its own ID; aka REFERRING_PROV_ID
Provider Name	Text	Required	
Provider ID	Text	Required	Client assigns
Clinic Address 1	Text	Preferred	
Clinic City	Text	Preferred	
Clinic County	Text	Preferred	
Clinic Phone	Text	Preferred	Format= #####
Clinic Fax	Text	Preferred	Format= #####
Pregnant	Text	Optional	<u>(Y/N)</u>
Breast Feeding	Text	Optional	<u>(Y/N)</u>
Heart Disease	Text	Optional	<u>(Y/N)</u>
Uncontrolled High BP	Text	Optional	<u>(Y/N)</u>
Comments	Text	Preferred	Any further physician comments.

Appendix 3: Example e-Referral Workflow Diagram

Quitline e-Referral Workflow



Appendix 4: Sample e-Referral Implementation Timeline

Below is a brief outline of a typical project implementation. The project plan should be used as a guide to minimize scope creep, to outline the next steps, and to keep the project on time and on budget.

- Pre Project Kick-Off (week 1)
 - Create draft charter and project plan
 - Create draft data flow and work flow diagrams
 - Identify team members
 - Schedule kick-off meeting
- Project Kick-Off (week 3)
 - Present draft versions of charter and project plan
 - Receive agreement from all key stakeholders for charter and project plan
 - Discuss timelines, roles/responsibilities, and dependencies
 - Present and discuss future state data flow and workflow diagrams
 - Determine weekly team meeting schedules
- Planning (week 4)
 - Finalize and sign off on data flow and work flow diagrams
 - Develop and sign off on communication and training plans
 - Determine method to communicate changes to work plan throughout the process
 - Implement communication plan
 - Initiate technical setup and HISP enrollment (if applicable)
- Build (weeks 5 to 9)
 - Continue technical setup and HISP enrollment (if applicable)
 - Complete build of interface and establish connectivity
- Test (weeks 9 to 11)
 - Test connectivity and review test messages
- Go Live (weeks 11 to 12)
 - Complete training
 - Transition to new process
- Ongoing Monitoring and Project Close (weeks 12 to 15)
 - Establish method for ongoing monitoring of referral process and technology

Appendix 5: Glossary

Term	Description
CEHRT	Certified EHR Technology. EHRs that are certified for MU after being tested and certified in accordance with the certification criteria developed by Office of the National Coordinator (ONC). Hospitals and eligible professionals must use a Certified EHR to qualify for the EHR Incentive Program.
Data	Distinct pieces of information usually formatted in a special way. The term is sometimes used to distinguish machine-readable from human-readable information.
Discrete Data	Data that is distinct and separate (e.g., patient date of birth or phone number). In electronic files, denotes a data field that can be imported or exported separately from all other fields. Text and data files may contain discrete data, whereas image files do not. Discrete data is required for querying and reporting.
Direct Messaging	The overall process of sending and receiving messages via Direct Protocol.
EHR	Electronic Health Record. The terms electronic medical record (EMR) and EHR are often used interchangeably, although technically there is a distinction between the two. An EMR is a computerized medical record designed to replace the traditional paper chart in a provider setting. EHRs are essentially EMRs with the capacity for greater electronic exchange (e.g., following patients from practice to practice, data exchange and messaging between physicians).
EMR	Electronic Medical Record. The terms electronic medical record (EMR) and electronic health record (EHR) are often used interchangeably, although technically there is a distinction between the two. An EHR is more comprehensive in scope than an EMR. See <i>EHR</i> above.
Progress Note	A note that informs a referring provider of the status and outcome of a patient referred to a Quitline for tobacco cessation services.
HIE	Health Information Exchange. Both a verb and a noun to describe the electronic sharing of health-related information among organizations: the actual electronic sharing of health-related information among organizations, or an organization that provides services to enable the electronic sharing of health-related information.
HISP	Health Information Services Provider. A HISP is an independent organization that operates similar to internet email provider, except that it complies with all of the HIPAA privacy and security requirements for PHI. HISPs serve as a "trust agent" that establish a "trust relationship" between a sender and receiver prior to a secure email being sent.
IT	Information Technology. The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
Meaningful Use (MU)	Meaningful Use. Also known as the EHR Incentive Program. An incentive program available through Center for Medicaid and Medicare Services to hospitals and eligible professionals that can demonstrate meaningful use of a certified EHR, as measured by performance on a set of core and elective measures. Initially, providers are rewarded with financial payments for meeting MU criteria, but as program is rolled-out, providers can face financial penalties for noncompliance.
NAQC	North American Quitline Consortium. An international, non-profit membership organization that seeks to promote evidence-based Quitline services across diverse communities in North America. Membership is made-up of more than 400 organizations and individuals from across

	North America. Members consist of organizations and individuals that provide Quitline services, fund Quitlines, conduct research around Quitline-related topics, advance national cessation policies, and work in other areas of tobacco control.
PCP	Primary Care Provider. A health care provider who manages the overall health of a patient, maintains the patient’s medical history, and coordinates care with other providers as needed. PCPs are usually physicians, but can be a physician assistant or nurse practitioner. PCPs are trained in medical disciplines such as family practice, internal medicine, geriatrics, and pediatrics.
PHI	Protected Health Information. PHI is any individually identifiable health information that is created, transmitted, or maintained by a covered entity in any form (e.g., paper, fax, electronic).
Provider	An individual or institution that provides and charges for healthcare services to patients. Individual providers who often refer to Quitlines include physicians, dentists, psychologists, physician assistants, and nurse practitioners. Institutional providers include hospitals, clinics, physician, and dental offices.
Quitline	Telephone-based tobacco cessation services that help tobacco users quit. Services offered by Quitlines may include coaching and counseling, referrals, mailed materials, training to healthcare providers, web-based services, and free medications such as nicotine replacement therapy (NRT).
Quitline Service Provider	An entity that operates a Quitline under contract with state health departments, health plans, and corporations.
Referral Form	A form that is filled out and sent by a referral source to initiate a direct referral; typically includes patient demographics and contact information, reason for the referral, physician/clinic contact information, and authorizing signature.
Transition of Care	The movement of a patient from one setting of care to another, for example, from a hospital or specialist back to a primary care physician. Under MU, a provider who refers, admits or discharges a patient to another provider should include a transition of care record that summarizes the patient’s medical condition. This summary helps ensure the coordination and continuity of health care as patients transfer between different locations (e.g., PCP to Quitline service) or different levels of care.

Appendix 6: e-Referral Workflow Diagram

