

Victorian State-wide Forum on Electronic Referral

Summary Report April 2004



BACKGROUND

The Department of Human Services funded a range of electronic referral projects through Primary Care Partnerships (PCP) and more recently as part of a number of Hospital Admission Risk Programs (HARP) projects. In response to this activity and the development of the HealthSMART strategy, the sector asked the Department to convene a forum on electronic referral to share what has been learnt and outline future directions. This report summarises selected presentations from the Victorian State-wide Forum on Electronic Referral held on the 5 of March 2004.

E-REFERRAL AT A GLANCE

Primary Care Partnerships as precursor

Electronic referral (e-referral) is being undertaken in many Primary and Community Health agencies throughout Victoria. The foundation for e-referral is the service provider relationship network created by the 32 PCPs, which have been established since 2000. In some areas, such as the Western Metro Region and the Eastern Metro Region, e-referral is well established, with pockets of "best practice" in place. The e-referral systems developed as part of the PCP strategy is based on the state-wide Service Coordination Tool Templates. More than 300 agencies are using the Service Coordination Tool Templates, of which more than 50 are implementing e-referral. The Service Coordination Tool Templates are available in 30 agency software applications including six popular GP clinical applications.

Benefits

E-referral supports a more efficient and comprehensive system by enabling service providers to share and update client service histories, with client consent, to better meet client needs and agency processes. The system increases service provider effectiveness by eliminating the burden of re-capturing basic data, and delivering up-to-date and accurate client service histories. E-referral supports streamlining the making of client appointments, and goes hand in hand with service provider access to the electronic State-Wide Services Directory and other local online directories. E-referral makes life easier for the client because their service histories stay within the system, eliminating the burden of repeating their stories, and releasing more time for receipt of actual services.

Outcomes

Better client information helps service providers create more effective care pathways that can facilitate early identification of client needs and more effective care. This can result in less hospital admissions for clients with complex and chronic conditions. Efficiencies created by e-referral mean more time for face-to-face service provision as well as savings that can be re-invested in human services.

The Challenges

The key is integration – the integration of best practice between agencies and their partners, the integration of different information systems, and the integration of information through electronic messaging as part of a staged implementation for e-referral.

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THE BIG PICTURE

Laying the Foundation for E-Referral

Tracey Slatter, A/Director Primary and Community Health, Department of Human Services

Key message: PCPs as the foundation for e-referral.

Context

Tracey Slatter explained how the PCP strategy, initiated four years ago, had paved the way for e-referral by establishing coordinated care systems throughout Victoria. The PCP strategy was part of a “whole of health approach”, which helps a client access any community-based service. The need for a more holistic approach became clear as statistics revealed that more and more people with chronic and complex health conditions were being admitted to hospitals – something that could be reduced by more cooperative approaches to health care.

“Before the PCP strategy and HARP there was ad hoc coordination,” Slatter said. Client care pathways were limited to a few services and these required assessment and registration at every point. Consumers often had to retell their story. Navigating the service system was challenging. With referrals made on hundreds of agency specific forms, administrative efforts and services were duplicated.

“When providers work together it is easier for consumers to navigate the service system and they receive better coordinated services that improve the continuity of their care across acute and primary care services,” Slatter said.

“Three to four years ago e-referral was a matter of ‘it’s all possible, give it a go’. Now it has been given a go!”

Collaboration

Independent evaluation of the PCP Strategy indicated that partnerships were providing a solid base for collaborative approaches to integrated health promotion activities, and care pathways to better manage chronic disease and joint projects with acute services through HARP. Evidence suggested this was improving the health and wellbeing of Victorians. Through PCPs, service providers were keeping people out of hospital by using the online State-wide Services Directory and by sharing client information, with consent, through the Service Coordination Tool Templates.

Just as member agencies within the PCPs now had “strong links” with HARP (76 per cent of HARP initiatives involve primary care services funding) the PCPs were now positioned to provide a way for hospitals to engage with the Primary and Community Health sector. Increased cooperation and common use of Service Coordination Tool Templates had prepared the sector for the shared best practices, protocols and information involved in e-referral.

“Primary Care Partnerships have provided a systemic vehicle for co-ordinated approaches to care. A growing body of evidence suggests that this is improving the health and wellbeing of Victorians.”

State-wide framework

The state-wide framework for the introduction of e-referral is in place, with three developments – Service Coordination Tool Templates, the State-wide Services Directory and privacy resources.

The Service Coordination Tool Templates, a single state-wide referral tool which fully complies with state and commonwealth privacy requirements: These enabled agencies to collect basic information in the same way, preventing duplication, and enabling other providers to share the information with client/patients consent. The Service Coordination Tool Templates referral forms had replaced 350 other referral forms, Slatter said. Six of the 30 available software programs with Service Coordination Tool Templates are the most popular programs used by GPs.

E-referral using the Service Coordination Tool Templates forms is currently being implemented by more than 50 Primary and Community Health agencies across Victoria, with positive results, Slatter said. “Consumers are saying they’re receiving more care and better assessments and efficiency gains are the agencies’ bonus to reinvest back into service delivery.” An example was Moonee Valley City Council which, by receiving Service Coordination Tool Templates referrals, had saved time for each of its eight assessment officers.

State-wide Services Directory: This electronic directory – a single comprehensive source of information about primary care services - went online in September 2002, enabling service providers to receive the answers to three vital questions: Who are the providers in the region?; What services are available?; and, Would my client be eligible? “This system is currently being enhanced to provide more comprehensive information about services and improved ways to access that information,” she said. The development of privacy resources means that the SCTT complied fully with all state and commonwealth legislation.

Changed practices

Agencies and partners identifying best practices and agreeing on common protocols was “the most important foundation” for the implementation of e-referral, Slatter told the conference. Such protocols contained the agreed ways in which services meet and greet consumers, how they identify their needs, coordinate care and make referrals. And, in order for health information to “follow” the client/patient, “a common approach” to collecting and sharing information was essential.

“To rely on e-referral alone is not enough. You have to think about the practices in your organisations and those of your partners. Find out what best practices exist. Develop protocols with the agencies you work with, and formally implement what is agreed best practice.”

Technology

DHS was investing \$15 million in information and communications technology infrastructure over three years to improve agency capacity to manage and share information electronically, Slatter said. This would connect over 450 Primary and Community Health agency sites to the statewide network for health and give agencies the ability to electronically share the Service Coordination Tool Templates using their own software. As part of the HealthSMART Strategy, Primary and Community Health Branch was working with the Office of Health Information Systems to deliver improved technological integration between its agencies, and between agencies and hospitals; improved client/patient management systems, and practical strategies to encourage GP involvement, such as such as changes to GP software to incorporate the Service Coordination Tool Templates.

TECHNOLOGICAL BACK UP

Support from the Office of Health Information Systems

Fiona Wilson, Director, Office of Health Information Systems, Department of Human Services

Key message: The HealthSMART technology program will provide the tools for the universal application of e-referral

Context

The four-year HealthSMART project aims to implement best practice governance and management, ensure quality and safety, improve demand management and increase the sector's ability to "attract and retain" a highly skilled workforce. The existing complex system – with more than 15 patient administration systems, more than 10 financial systems, more than seven client systems and more than five Human Resources management systems – had created a dependence on proprietary systems and undermined a "whole of government" approach.

Encouraging the change was the "very strong push" from clinicians for systems that will support changing clinical practice and increasing quality and effectiveness. Another was the "volatile" and "fragmented" nature of the IT vendor market servicing the sector's agencies. Further, there was a "significant need" for systems to support increased continuity of care, particularly between hospitals and community-based agencies. "The Health Information and Communication Technology (ICT) environment is complex due to the broad range of functions it must support – there is no "single product" that does it all," Wilson said.

"We are working out a single architecture. The benefit of HealthSMART as a whole is greater than the sum of its individual parts."

Aim

The project's aim was to provide ICT that supports the delivery of high quality, consumer-focused health services through a partnership between healthcare providers and Government.

Opportunity

The project presented the opportunity to bring new generation technologies to health agencies, develop service co-ordination tools current systems can't support, remove dependence on proprietary vendor systems and use e-commerce industry standards. Actions would include replacing obsolete core systems with capable, industry-standard ones; introducing new systems capable of supporting the transformation of health care; refreshing and developing ICT infrastructure; developing a strategic program management structure; and, enabling shared ICT Services by establishing panels to accredit products for core systems.

Project streams

HealthSMART has three project streams – Resource Management Systems (finance and materials, and Human Resources), Clinical (medications management through e-prescribing and investigative services ordering and results reporting) and Patient/Client management systems.

The project would deal with each individual piece to create a whole.

Principles

The project would identify and define the requirements and standards for the new systems, ensuring they optimised agency outcomes. While the project would leverage off the best practice in existing applications, its approach was to minimise internal development and "Buy not Build".

It would identify and adopt national standards where possible, whether taken from internal sources or adopted from "other organizations."

Shared Services

New data centres would provide the basis for shared ICT services. All technological platforms for the agencies will be run out of data centres, which would handle database administration and provide specialist application support. Long-term, the technology would "not just be a set of pipes that takes the message from A to B," Wilson said. "It will also have the ability to do something with the information recorded." Opportunities included shared email services, file storage and an IT advisory service.

Agency responsibility

With purchasing power maximised through Government arrangements, financial support would be conditional on adopting the Health*SMART* strategic approach and principles. Agencies would contribute to implementation costs and be responsible for ongoing support and maintenance costs. Wilson suggested that agency implementation teams focus on individual projects, optimising the use of existing groups to ensure effective engagement to meet project timelines. As she said, "Everyone can't participate in everything at once."

Implementation

The Board of Health Information Systems had overall governance of the Health*SMART* program, and was supported by its three project steering committees; expert project advisory groups made up of business and technical experts, a Chief Information Officer group, and agency project managers and teams (being finalised). It was also preparing a single tender for Patient Management and Client Management systems and setting up expert panels to evaluate products. Implementation involved "involvement from all levels of the sector — users, executives, board members", Wilson said. "Trust is an essential system component."

SESSION 1 PRESENTATION SUMMARY NO.1

Service Coordination Electronic Referral System: Do the BITS & BATS add up?

Jon Hilton, Project Consultant, HARP Information Management and Business Systems Project
Janette Mitchell, Manager, Outer East Primary Care Partnerships

Key message: E-referral has a strong start in the Outer East.

Background

Outer East PCP has 22 member agencies. The original system was conceived in 1997 in consultation with a group of HACC providers in the City of Maroondah (Best Practice Working Group). The pilot began 1997 and went live in June 2002; involved nine agencies; and, generated 156 referrals.

Aims

Improve consumer experience and navigation of the primary health system; more consistent entry points; better capturing and sharing information to reduce duplication; better service coordination (practices, processes, protocols and systems). "E-referral's an integral part of developing this Service Coordination Model," Mitchell said.

Why e-referral

To streamline communication between multiple agencies and agreements with a variety of referral practices; reduce duplication of service; save time for providers.

Evaluation

Web-based deployment successful; "hands on" training and support essential.

Barriers

Technology interface and data re-entry. "No-one was entering GP data," Mitchell said. "We addressed that."

Key features

Web-based for simplicity; technical issues with PKI avoided without compromising client confidentiality; training and rollout complemented Service Coordination implementation; clear, well-developed privacy model; connectivity issues addressed for participants.

Use

Excellent uptake, with 18 agencies set up on system, 15 agencies with selected services 'live', and other agencies and services involved in a staged implementation process; 68 programs/services on-line for receiving referrals; growing engagement of eastern agencies including acute and sub-acute; continuing expansion of services using system within larger agencies.

Next steps

Web based e-referral system with shared data base; provider software able to manage Service Coordination Tool data; provider software linking with external web based referral management; continued work on Service Coordination Tool Templates to support assessment and care planning, and common messaging standards.

Tips

"Ensure you have sufficient agencies on board before you implement [e-referral] and that the participants have signed off around privacy and practice issues."
Janette Mitchell

As there are so many services listed on the online State-wide Services Directory, add the services you use a lot to your computer's Favourites list.

SESSION 1 PRESENTATION SUMMARY NO.2

E-Referral Trial - Workplace and Communication (2 Perspectives)

Brett Wake, Service Coordination Project Officer

Ann-Marie Deeker, Care Coordinator, Box Hill Hospital Emergency Department, Eastern Health

PERSPECTIVE 1 (Brett Wake)

Key message: Take small steps, take it slowly, and involve everybody.

Pilot

February-May 2003. Involved seven agencies including two councils, two Community Health, one GP, the Box Hill Hospital Care Coordinator, ACAS. Featured initial "intensive" workplace support, face to face meetings with practitioners and the use of existing Outer East paper-based document exchange, "to understand what the issues are."

Learnings

Our main learning was that referral is a two way communication," Wake said. Participants were "happy with document sharing" and recognised the relevance of sharing information online. Small steps are good. Identified the need for a regional vision between the Outer East and Central East regions; support for practitioner communication within and outside the system, and frequent use of the system. The hospital sector was a key driver of broad services use.

Second phase

Starting June 2004. Involves 11 participants; hopefully other GP clinics.

System requirements: Easy to use; security (through certification and encryption); an audit trail; management of users, system protocols and reports. The online system needs the ability to fully process referrals; protocol prompts (such as patient/client consent); the ability to attach a SCTT file and fill out the forms on the screen; the ability to make multiple referrals for the same client.

E-referral Benefit:

The Service Coordination Tool Templates referral form has a status history so "at any stage you can track a referral," Wake said. "And every time you make a referral, you receive email notification."

PERSPECTIVE 2 (Ann-Marie Deeker)

"Bite the bullet. There are advantages being in at the ground floor."

Care Coordinator's Main Responsibilities and Clients

Planning for safe discharge; making referrals; networking, whatever is needed. Largely people aged over 70 years; more than 50 per cent over 80.

Slogan

"Meeting the needs of patients with complex needs"

Advantages

Include obtaining a second computer for staff; obtaining broadband connectivity; meeting other practitioners; receiving improved feedback about referrals, and more communication about clients with obvious consumer benefits. "Everyone's talking," Deeker said.

Challenges and a Comparison

Pilot initially very time-consuming; the hospital's lack of its own electronic client record; many clients having "a deep rooted suspicion of new technologies." E-referral was like using today's electric drill compared with yesterday's hammer. "It took a bit of getting used to – you needed to know you could use it safely - but there's no looking back."

Tips

Get over the "scary bitz" - which is about people having different levels of computer literacy. Sure, some participants forgot their pre-Christmas computer training over the New Year break. But once they returned, and received support and encouragement, they could do it!

SESSION 1 PRESENTATION SUMMARY NO.3

Establishing the online Service Directory & E-Referral across Western Metropolitan Region agencies

Simon d'Orsogna, e-Business Manager, Western Region Primary Care Partnerships
Guy Walter, Respite and Activities Team Leader Community Care, City of Moonee Valley

Key message: "Get the business processes right, then the technology."

Aim

Establish Connectingcare.com and e-referral in the region. ConnectingCare is an integrated services directory and e-referral system. It was used because it is proven, relatively cheap, low risk and identified as the best fit with state and commonwealth directions, and privacy legislation requirements.

Timeframe

The project began in March 2002; the technical pilot began at 8 sites in September 2002; regional implementation began in early 2003 with 20 agencies invited.

Participants

By January 2004 the project had 18 e-referral receiving participants, from Melton to Moonee Valley including local councils, HACC providers, Royal District Nursing Service (receiving only), ACAS in Western and Melbourne Health Services, Community Health Services and one large GP practice. Agencies receiving e-referrals are from the Moonee Valley PCP, Brimbank Melton PCP and WestBay PCP (covering Wyndham, Maribryngong and Hobson's Bay LGAs). Community Health services, RDNS and local councils in the Moreland and Hume areas have committed to implement e-referral in 2004.

Success factors

"The three Ps – practices, processes, policies". "The fourth P – passion and a culture of collaboration".

Steps

The first step is a "clear organisational commitment to implementing the Service Coordination reform". Secondly, leadership within teams to review business processes, make the practice changes and document this into the operation plan. We worked intensely on business protocols and established a Best Practice Manual for the region. Finally, register for Public Key Infrastructure (PKI) through Health E-Signatures Australia (HeSA) before implementation and testing.

Technical requirements

In order to send an e-referral to a registered agency you need an internet connection and a browser.

E-referral method

Completing the online Service Coordination Tool Templates or attaching the Service Coordination Tool Templates generated by a client management system so the message is encrypted, sent and decrypted securely. An acknowledgment email is sent back unencrypted, but not containing any client information. Information is deleted from the server at the time the encrypted message is sent. Only registered sites can receive.

Implementation time

Varies with an organisation's readiness, but on average, takes two to four months.

Cost and Use

PCPs currently contribute annual Connectingcare.com subscription fees (\$6,000 annual fee per PCP, plus a once-off joining fee). Implementation costs of e-referral to agencies ranges up to \$5,000 per site. Average e-referrals per month have ranged from 100 to 180 since June 2003.

Advantages

Staff appreciate the ability to: make referrals online; print and post them; and, fax via e-fax. Significant reported increases in productivity and enhanced staff morale have been reported. Anecdotal reports include Community Health Service dietetics staff saying they have twice the time available for specialist assessments and therapeutic intervention. Aged care staff in LGAs were saving more than an hour a week by sending Service Coordination Tool Templates referrals, and sometimes saving up to 10 to 15 minutes for assessment and re-assessment at home visits. Podiatry CHS were gaining time for an additional client appointment each day. Consumers appreciated not having to repeat their histories and have better access to the information they need.

SESSION 2A PRESENTATION SUMMARY NO.1

Electronic Health Messaging

Dr Jeff Urquhart, GP Liaison Officer, Barwon Health

Key message: A good start, with further work required.

Background

Geelong was a good location for piloting electronic health messaging as it provided the ability to liaise between hospital, GPs & specialists. It has a central public hospital, 210 GPs, more than 200 specialists, two predominant software vendors, one main pathology provider, two radiology providers.

Current Projects

Emailed encrypted HL7 discharge summaries (Equery); emailed encrypted HL7 radiology reports (Equery); templates for referral to surgical outpatients and antenatal clinic; the ability to email using PKI (pilot testing).

Radiology Reports & Discharge Summaries

High use of CORDis (80 per cent of summaries completed within 2/24 of patient discharge); Equery v2 simple to set up as already used by pathology in Geelong CORDis. No cost to GPs. Uses FTP. Interfaces with all windows based GP software. No PKI required however will migrate practices to PKI with ver. 3 late 2004. Equery v. 2 pilot phase Feb 2003- July 2003 for discharge summaries. Currently 40 practices (160 GPs) on line (80 per cent); Radiology messages from Agfa RIS commenced in March.

Results

Very stable. Few failures. GP feedback: - decreased staff filing time; no scanning required; consistent interface for checking pathology, discharge summaries and now radiology reports.

Lessons

Initial consultation lacking adequate clinical staff; GP concerns (inadequate consultation about business process with possible increased workload; wanted information prompting and intelligent interface); consultant concerns (too much demographic information; difficult to find important information quickly such as the reason for - and urgency of - referral).

Future (2004)

Emailed encrypted HL7 GP letters from smaller departments using ARGUS (Endocrinology, Neurosciences, Pain clinic, Diabetes referral centre); Roll out other referral templates (Pain clinic, Diabetes referral centre, ACAS).

Other requirements

Set up mail server at division; set up consistent and permanent emailing address standards between hospital GPs and specialists.

SESSION 2A PRESENTATION SUMMARY NO.2

GP Links: implementation issues

Terry Murphy, Informatics Manager, Southcity GP Services

Key message: Key email, interface and security issues need to be resolved before e-referral can work effectively.

Project

Collaborative project between the Ambulatory & Community Services unit of the Alfred Hospital and Southcity GP Services.

Aims

To connect six general practices to the Alfred's Outpatients Department by secure email to trial electronic referral and reporting. This was based on Medical Director, HeSA PKI digital certificates and HeSA's API encryption engine.

Development and Outcome

We achieved successful transmission and reading of PKI-encrypted messages between a Medical Director site and Alfred Outpatients and back again, and successful transmission and reading of PKI-encrypted messages between two Medical Director installations. Technical and business process barriers meant that we could not deliver a practical process to GPs and the final outcome was that the project was shelved.

Summary of barriers

Insufficient referrals for GPs to become familiar with processes; non-universality of trial solution; lack of resources and technical expertise.

Email reply problem

Email referrals should be digitally signed by the GP through the individual PKI certificate (re: HIC standards) with the message encrypted with the receiver's encryption key. Thus the message's Reply-To address will be the GP's individual email address; automatically generated replies will be encrypted with the GP's encryption key.

This means that only that GP, or someone in possession of that GP's dongle, will be able to open the reply. Our solution was to change the Reply-To address in the GP's email client to the practice's general address where staff have access to the practice location certificate enabling message decryption – but this created a problem for GPs using their email for personal and work emails.

Multiple email address problem

This can be a problem. A GP uses other email services from other locations and needs separate digital certificates for each email address. The most desirable solution would be for a single GP dongle (digital certificate) to be able to be associated with a number of email addresses.

In addition, any GP who's ISP's business failed and who was therefore obliged to move to another ISP could be left incommunicado for the time required to obtain digital certificates.

Email management problem

Including the GP's name in the email reply subject line enabled filtering to pre-sort incoming email into personal mailboxes established for GPs. However, while the Medical Director–email client interface allowed the GP to see the mailbox contents to choose messages to view, there are no facilities to move an email from Medical Director to a "Read" or "Archive" mailbox.

This means someone on staff would have to go in to the email client and move email from the GP's personal folder to another location for storage prior to archiving. The issue here is the process by which the GP would indicate which emails have been actioned. The Medical Director interface is excellent in the integration of the emailing facility with the patient database. It is easy to generate referrals and email them. It is easy to view replies (reports, etc.) and to save them to the letters file in the patients' electronic records. But email management needs to be addressed.

Key to e-referral acceptance

The universal application of whatever encryption/decryption process finally gains preponderance is the key to its acceptance. At present GPs and consultants are faced with the spectre of a

multiplicity of systems for secure electronic communication and it is possible to envisage a practitioner with five or more schemes in place to securely communicate with other practitioners. The issues described will be relevant in most e-referral situations in the current environment, regardless of the GP software involved. They will also be applicable to non-GP multi-practitioner practices.

Subsequently we have become aware of a similarly-themed e-referral trial where the encryption process has been taken out of Medical Director by installing the digital certificates direct to the email client, while still utilising Medical Director's email client interface, but this process means that some advantages in the "current" MD-email interface would be lost.

SESSION 2A PRESENTATION SUMMARY NO.3

E-Referral in the South West

Margaret Sinnott, Regional Project Officer, Service Coordination
Bill O'Keefe, Assessment Officer/Care Manager, Timboon & District Healthcare Services
Fiona Torpy, Post Acute Care Regional Coordinator, Wannon

Key message: A simple e-referral system built around the use of a client management system and secure email provides the vehicle for better information sharing between services and more timely service delivery.

Aims

To generate the Service Coordination forms from an existing database.
To secure transmission of these forms using secure email.
To develop agreed referral practice and processes to support e referral.
To trial the system (once established) with local referring partners.

Participants

Timboon and District Health Service, Corangamite Shire, Moyne Shire; South West Healthcare Occupational Therapy and Wannon Post Acute Care Warrnambool.

Focus of Presentation

Wannon Post Acute Care is a major player in South West's e-referral. The service interacts with 33 other service providers and 11 acute care hospitals. It delivered 2031 episodes last financial year and sees great benefits from an electronic referral system.

"We've generated 153 referrals since we started last year and clients have received the service in a timely way, and that's the ultimate goal," said Fiona Torpy

Security

Instead of PKI registration, this project opted for Winzip with password, for attachments.

Benefits

The forms ensure more comprehensive, and "legible, readable, neatly packaged" referrals. Confidentiality is upheld, there is better data collection, less faxing, and reduced duplication by cutting out a host of other forms.

As well, "the form has forced us to collect better information". There is less time spent following up referrals to check whether they were received.

Inter-agency relationships have strengthened. Post Acute Care referral partners are saving time because as e-referral delivers more detailed information, they spend less time on information gathering and more on service delivery.

Challenges

- To get all PCP service providers equipped and trained to receive the Service Coordination Tool Templates in an e-referral form.
- Dealing with the HL7 issues to improve interfaces between databases to prevent double handling of information.
- Improving security using encryption with PKI certificates.

"I want to refer electronically to all 33 service providers, but I have to wait until their staff are trained...and they have the technology to receive them," said Fiona Torpy.

SESSION 2A PRESENTATION SUMMARY NO.4

Connecting with GPs – Implementation of an Electronic Discharge Summary

Dr Susan Sdrinis, Manager, Medical Operations, Peninsula Health

Dr John Siemienowicz, Executive Director, Mornington Peninsula Division of General Practice

Key Message: Successful implementation of Electronic Discharge Summaries required: a multidisciplinary approach to change management; a senior Clinician Champion; and Executive support.

History with the GP Division

Notification Process began in the late 1990s, and the proof of concept work was undertaken at Monash University and funded by the Mornington Peninsula Division of General Practice. Semi-automated processes around notification of admission, discharge and ED attendance were developed. However there were some problems with the process including: identification of local doctor; patient consent; and, limited to GP Division members. Work on Discharge Summaries is ongoing.

Discharge Summary GP Survey

Conducted in Sept 2000 for existing hand-written "Acute" discharge summaries. The issues raised included: legibility; timeliness; accuracy; content; and, mode of delivery.

Established a Memorandum of Understanding (MOU) between GP Division & PH which was signed on 2nd June 2003. The MOU was outcome focused, included a business plan, and detailed joint funding, personnel involvement and behaviour change. The MOU also identified the following outcomes: Quality; GP identification; Referral template; Information sheet.

How do we fix it?

We recognised that a major change was required and that we needed to move to an electronic approach. There were a number of options for over-coming these issues: develop in house; work with the existing Patient Administration Provider; or, purchase off the shelf software. Following a review of the market and options we reached agreement to proceed with Orion in Nov 2001.

What did we implement?

Phase 1 (July 2002 – current) - Electronic Discharge Summary; E-prescribing for discharge medications; Results reporting (with graphing and cumulative views).

Phase 2 (July 2003 - current) - E-prescribing for Inpatients; E-orders for Pathology, Radiology and Allied Health; Event Notification.

How does the summary get to the GP?

Referring or Local doctor must be picked from existing internal doctor table within the system. Preferred delivery mechanism for doctor stored in table [Secure electronic transfer (via Healthlink), Autofax, Hard copy (posted)]. This occurs when summary is triggered as "Final".

Barriers

Doctor identification at registration of patient (QIT). Issues with Healthlink regarding transmission of electronic information to GP practices. Training of GP practices in how to retrieve information

Timeliness

With the implementation of Electronic Discharge Summaries the average time before a GP received a discharge summary was reduced to less than one day. (Minimum = 2 days; Maximum = 29 days; SD = 3.026 days; average completion time = 22 hrs 45mins post discharge).

Factors Contributing to our Success

Working relationship with GP Division; Multidisciplinary approach to Change Management; Senior Clinician Champion; Resource shared by PH and GP Division; Executive & Board Support; Leading (& bleeding!) edge.

Future

Continued review of the Discharge Summary with the GP Division.

Further development of the integrated relationship with the GP Division.

Re-commence the improved electronic event notification via Orion.

Investigate ways of improving information flow both to and from GPs.

SESSION 2B PRESENTATION SUMMARY NO.1

Development of an Information Management Approach for Eastern Health

Jon Hilton, Project Consultant, HARP Information Management and Business Systems Project, Eastern Health

Key Message: Define the rules and standards that underpin communication between acute (including HARP) and high referring primary care services.

Background

Both the Outer East and Central East PCPs are trialling web based electronic referral systems with more than 30 local agencies. The Outer East has built on the Maroondah IT project which began in 1997. This has resulted in software that reflects locally developed protocols and the SCTT tools.

"Benefits of **shared service summaries** include knowledge of the current services the patient is having, especially if the patient's forgotten who the provider is or the details. It's good for numerous things like canceling services when a patient presents to an emergency department and will be admitted. Knowledge of previous services- what worked/didn't work last time they had this problem – is also important. Being able to see presenters to multiple services is good for medication issues, to avoid doubling up on services. They also give the capability for a case manager/GP to monitor the patient and their progress and see if the patient actually has a case manager."

Key Features

Email and web technology have been integrated creating a secure shared data base of referral details incorporating privacy and security legislation and shared between member agencies including local government, community health, acute and sub-acute services and other agencies.

"There's a similarity between the referral models which have been developed by PCPs. The differences are between the systems – the technologies."

Collaboration

"The DHS is aware there are a number of systems [in use by PCPs] and is doing a lot of work around messaging standards as a matter of urgency."

Central East PCP has built on the work of the Outer East PCP and has closely involved the acute sector in its pilots. HARP and ICT funding have now been applied to related projects in the Eastern region. We are all working towards one system to enable effective e-referral and management of client information across sectors in a way that reflects local practice and consumer rights.

SESSION 2B PRESENTATION SUMMARY NO.2

A step or a leap forward into the future

Judi McKee, Manager of ACCESS unit for sub-acute services and ACAS, Peninsula Health – Rehabilitation Aged and Palliative Care Services

Key message: "You need lots of staff training – in IT and a whole culture of change."

Participants

Include ACCESS (Admission into Rehabilitation & Aged Care Inpatient Services), ACAS (Aged Care Assessment Services), ten agencies, GPs.

Aim

The implementation of "one sustainable communications system" throughout the region. This would entail comprehensive assessment at a single point of entry; consistent documentation; enhanced staff skills; client information system to support both front and back end.

Pilot

Two major components. Software development, involving conceptual development, organisational support and promotion within the community to ensure all referrals came through it. Best practice development, involving GP engagement in a six month project to identify best practice.

Learnings

IT was a "critical" success factor. "We are moving towards everyone having a computer".

Protocol

An e-referral protocol created by participants in Frankston and Mornington is being tested. Participants are committed to continue this process until the protocol is agreed between 10 agencies. The protocol covers PKI registration, software rollout, staff training, review of forms, refinement of referral triage and integrating email into the back end.

Tip

Partnership issues usually arose from a "lack of understanding" and this could be resolved through "teams and good technology".

SESSION 2B PRESENTATION SUMMARY NO.3

Service Co-ordination and e-Referral Project

Rebecca Naylor, Manager, Allied Health and Gateway Development, Western Health

Key message: The importance of change management.

Aim

To incorporate the PCP service coordination model and implement e-referral processes into the Western and Melbourne Health HARP initiatives. Building on the regional PCP approach to achieve improved patient care through integration, coordination and improved continuity of care.

HARP projects

Western Health – Complex Needs project, Chronic Disease Management Program (paediatric asthma, COPD, chronic heart disease, angina). Melbourne Health – diabetes-related foot service; falls prevention; COPD, integrated disease management; chronic heart failure; stroke prevention; ED CARE.

Change process

Involves governance structure; project management; e-Business support; local implementation groups; engagement of staff and community.

Challenges

Wide range of disciplines.

High staff numbers.

Large and complex organisations which respond slowly to change.

Staff attitudes.

Expected outcomes

Well functioning partnerships between key stakeholders; improved information flow; improved outcomes for clients; recommendations regarding the process and implications of future implementation of the PCP service coordination tool suite and e-referral processes across tertiary health care settings.

SESSION 2B PRESENTATION SUMMARY NO.4

MEETING THE CHALLENGE OF ACUTE TO PRIMARY CARE E-REFERRALS

Alan Napier, e-Referral Project Manager, Melbourne Health

Key message: Melbourne Health's e-referral pilot was so successful at the Royal Melbourne Hospital that it's being rolled out to the Melbourne Extended Care and Rehabilitation Service (MECRS).

Aims

To shape a new and better referral system in a busy and demanding clinical environment; to assist clinicians to provide more productive, patient focused care; to ensure more timely referrals; more visible, accountable and linked referral and assessment and transfer information; more accessible information for clinicians; better process tracking, & reduced duplication of effort & data entry.

Background

Melbourne Health already had electronic referrals (through the intra-campus HealthPower). It now wanted a referral management system capable of intra-campus and inter-campus referrals; a flexible referral form to meet a range of needs; a system to facilitate process improvement and provide a more effective framework for referral from acute to sub-acute, and to the community.

Initial focus and Development

Improved referral and assessment processes for Aged Care and Rehabilitation, particularly the transfer of acute patients from RMH into sub-acute care at MECRS. Over 18 months Melbourne Health collaborated with i-Health (now owned by iSoft) on the design and implementation of a referral management module within a web-based clinical intranet. The pilot, which ran to Sept 2003, has been successfully deployed across RMH, & rolls out to MECRS in March 2004.

Use and Approach

All allied health referrals, Aged Care and Rehab referrals and assessments are made in the system. PACFU, RDNS, HITH, RITH, CRC among other services are about to be introduced. Community referrals via the system will start soon as part of a combined Melbourne and Western Health HARP Service Coordination Project. Strong involvement of clinicians during the business analysis and design phase. Included a Clinical Project Team, a Change Management Team and clinician focused training with multiple training approaches, and ongoing support ("the most important...and at times the hardest to deliver").

Technical Enablers

A web-based Clinical Intranet framework enabling a patient centric view of clinical information that lends itself to the 'one-stop-shop' approach for patient referrals, assessments, discharge summaries and results. Utilisation of underlying universal indexing of patient identifiers from different campuses created seamless information exchange between acute and sub-acute sectors.

Advantages and User response

Pilot period surveys indicated good acceptance, especially amongst resident medical staff who no longer need to write, fax and phone the TRAC office to confirm referral delivery. Clinicians can find a patient's history and read assessments before a patient even arrives. You can click on the referrals management button and see active and completed referrals.

Learnings

"It is during the pilot period that you learn the most about what works, what doesn't and what needs to be changed or worked around. It is important that time and support is devoted to getting things sorted out in this period before pushing on."

We modified our training, our documentation, or use of system memos, our forms printing and some of the business processes during this period.

Ongoing issues and a Tip

Increasing demand for computers for clinical staff; clinical systems available at the point of care when clinicians need to look-up or enter information; ongoing system support and training for staff, including best practice. During the pilot period, paper based as well as electronic presentation of referrals and assessments must be supported in parallel.

SESSION 3B PRESENTATION SUMMARY NO.1

Implementation of the Service Coordination Tool Templates - current and future directions

Jenk Akyalcin, Senior Project Manager, IM/ICT Support, Primary and Community Health, DHS

Key message: A review of Service Coordination Tool Templates, guidelines and data standards will add to the current suite of tool templates, not replace them.

Key Project

Revision of the Service Coordination Tool Templates guidelines and data standards.

Project start date

July/August 2004.

Aim

The aim is to improve the service response for DHS clients and amend or add to the current suite of tool templates to ensure the final product enhances the practice of all practitioners.

Software Issues

Merging data into Service Coordination Tool Templates; composite documents; making changes to output, saving as RTF/HTML; storing and accessing, filenames.

Process

Rigorous piloting; endorsement through DHS programs, PCPs, practitioners, OHIS, regional consultants

Implementation

Timing carefully planned to coincide with software update cycles to ensure there are not multiple versions of tools in simultaneous use

SESSION 3B PRESENTATION SUMMARY NO.2

Service Coordination Tool Templates "messaging standards" project

Russell McDonell, Technical Operations Manager, Hume Alliance of Rural Hospitals

Key message: The challenge is to "do it once and do it right".

Challenge

The Service Coordination Tool Templates dichotomy. On one hand – really good ideas, process analysis, data requirements. On the other hand – Word Templates.

Issues

Analysing the processes and requirements; getting the data into the databases; pulling the data from the database into a Word document; form or message; transmitting the information from referrer to practitioner electronically; and, pushing the data into the database when it arrives at the other end.

Document Structures

Must be readable by both computers and by people.

SESSION 3B PRESENTATION SUMMARY NO.3

Electronic Referral – Do We Have It Now?

David Ryan, Project Manager, Patient Management Systems, Office of Health Information Systems, DHS

Key message: e-referral not only required integrated technology and messaging, but also shared best practices and protocols.

Snapshot

Ryan said that Primary and Community Health e-referral was based on the Service Coordination Tool Templates data standard, and that this was being used in a “mix of paper-based and partly electronic” document exchanges. Some of the electronic exchanges were web-based; most were secure e-mail based. There were “pockets of best practice”. In other public health sectors (Acute, Sub-Acute, Mental Health) there was no Service Coordination Tool Templates-style single data standard. Referrals were mostly paper-based, with “some” web-based discharge/referral systems.

“True e-referral relies on integration of business processes and data exchange between information systems, both at the data and business logic levels.”

“Many of the projects showcased today have indicated that the lack of integration between the information systems is a major barrier to uptake of ‘true’ e-referral”. Service providers needed to create and receive referrals electronically - as attachments or data - without adversely affecting their data collection or business processes. The solution was an “Enterprise Architecture” consisting of integrated messaging standards, DHS-procurement of information systems, products approved by HealthSMART expert panels, and the creation of data centres to be both information infrastructure portals and repositories for business information and reporting.

Messaging and shared services

Ryan spoke of the review of the Service Coordination Tool Templates data standards, protocols and practices on which shared services and messaging relied. Shared services and messaging also required integration engines (See Beyond DataGate and e*Gate, Cloverleaf, Kestral, HL7Connect, TIBCO etc) which could be built into patient/client management software. However, many existing solutions did not utilise active ‘listening’ and ‘responding’ to messaging. Ryan said HL7 v.2.x would not fully cover the full range of referral information requirements. HL7 and XML (HL7 V.3.x) may be utilised for broader coverage.

Directories

ICT technology had to allow the easy selection of service provider details from a centralised and managed service provider directory incorporating directories such as GPDV’s General Practitioner Registry (GPR), the State-Wide Service Directory (SSD), ConnectingCare.com, and InfoXchange.

Patient/Client management

Systems needed to be able to readily identify a patient/client utilising a matching algorithm, to store local identifiers and to allow for the eventual assignment of a “unique patient identifier” across all health service encounters. Representative advisory groups were defining specifications for the new Patient & Client Management System (specifications such as Access Management – Referrals, Waiting List Management etc). Vendor proposals resulting from the tender process would be evaluated, and panels of preferred products selected.

SESSION 3B PRESENTATION SUMMARY NO.4

State-wide Services Directory

Max Walker, Manager, Information Systems and Services, RRHACS, DHS

Key message: The Statewide Services Directory is being expanded to include more specific information and additional community services.

The Project

The State-wide Services Directory is being enhanced to provide a more comprehensive information about services, and improved ways to access that information

Key Additions

More search criteria, such as area, suburb, opening hours, services provided and the cost of service (whether free or fee-based).

More Methods of Access

Including the internet, API and database copy.

MORE INFORMATION

Electronic copies of material presented at the Forum on Electronic Referral are available on the Department of Human Services Primary Health Knowledge Base (www.dhs.vic.gov.au/phkb).

More information about Primary Care Partnerships and Service Coordination is also available on the Primary Health Knowledge Base.

More information in relation to Victoria's Whole of Health ICT Strategy is available via www.health.vic.gov.au/healthsmart.