Electronic referrals: What matters to the users

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NIHI commission

• Conducted from Aug 2010 to Apr 2012
• Evaluate electronic referral (eReferral) implementations
  – Hutt Valley
  – Northland
  – Canterbury
  – Auckland Metro region (entering pilot operation)
  – Waikato
• Four very different projects (and one still taking shape) – with three reported in this paper
  – What have we learnt from the users (clinicians on both ends of the referral process as well as the administrative staff)?
Evaluation methodology

• Evaluation data:
  – Project documentation
  – Visits to key sites
  – Analysis of electronic transactional records
  – Stakeholder interviews (78 clinical, management and operational stakeholders in the first three regions)

• Using these data, for each project, we examined
  – The development approach and lessons learnt
  – The evidence of uptake and acceptance

• Themes that emerge across the regions are also compared and synthesized
The Hutt Valley Solution

- Implemented in 2007
- 30 general practices referring in electronically from Medtech32
- 28 services at Hutt Hospital receiving eReferrals into Concerto
  - 16 service-specific forms, 12 services using a generic form
- Electronic management of workflow
  - GP notified of receipt, triage/decline and FSA
  - Hospital can see list of referrals w/ triage pending
  - Any authorised user can see content on Concerto (e.g. from ED)
Hutt Valley Uptake

- 1000 eReferrals per month in 2008; 1200/mo in 2010
- 56% of total referrals electronic by 2010
- 71% electronic from practices that sent at least one eReferral
Hutt Valley Upsides and Downsides

• **Upsides**
  – Greater transparency
  – Faster turnaround

• **Downsides**
  – IT done once and left
  – Some persistent usability issues
    • Slow attachment opening
    • Difficulty attaching photos
  – Never revisited form content
• From 2009
• Iterative development of clinically most relevant forms
  – Colorectal, Breast, Diabetes-retinal, Diabetes-pregnancy, Diabetes-general, Acute and Generic
• 36 general practices, 29 Whangarei Hospital services
• From Medtech32, to the door of hospital (RMS-Lite)
Northland Uptake

- **Steady uptake**
  - Median 26.5 eReferrals per GP user in 2010
The Canterbury Initiative (CI)

• HealthPathways website initiated in 2009
  – Local agreed method for managing a condition (including referral criteria and fax-able templates)
  – Over 300 pathways by May 2011

• eReferral Management System (ERMS) introduced in July 2010
  – 100+ eReferral forms to support HealthPathways

• GP empowerment
  – GP triaging for community referred radiology (CRR)
  – GPs trained (and paid!) to do skin excisions (GP-to-GP referral)
CI HealthPathway Development & Dissemination

• HealthPathway definition process
  – five 90-minute evening meetings
  – GP and specialists have ‘robust’ discussion
  – The CI facilitator: “… create an environment that enables change. Relationships provide the vehicle to progress.”

• Regular ‘Information Evenings’
• Feedback on declined referrals
  – Highly developed in CRR
• Quantum of funding for community based procedures
HealthPathways Hits

- Used during the weekdays
  - With patient, not as a casual browse on weekend

- Stakeholders indicate substantial demand reduction and more appropriate referral
  - For dermatology, US, colonoscopy

Google Analytics report for May 2011
HealthPathways viewed
eReferral Benefits Perceived by Users

- **Availability & transparency of referral-related data**
  - Visibility of referral data and status

- **Work transformation**
  - Reduced administrative handling
  - GP eReferral triaging teams at Canterbury

- **Improved data quality**
  - Crucial info for triaging, e.g. lab results, is now included by prompting and/or auto-population
  - Legible, consistent, and structured

- **The convenience of auto-population from PMS into the referral forms.**
Gaps Identified by Users

- To support two-way communication between community and hospital
  - “You have no idea what happens on the other end!”
- To further transform triaging workflow at hospital
  - “[eReferral] has not changed processes in hospital; it’s still paper based.”
- Mixed feedback wrt clinical workload impact
  - “eReferral takes more time, creates more workload.”
- Auto-population from PMS data opens issues around data accuracy
  - “So my practice is, prior to writing a referral, just to go through MedTech and ensure those particularly important sessions that I’ve outlined for you are in fact current.”
About eReferrals per se

• Provide transparency
  – Status info and rapid feedback
  – Further gains with deeper electronic workflow

• Acceptable
  – Although not clear that forcing 100% compliance would work

• Unclear
  – Whether to go with many or few forms
  – How much the quality of referral data is improved
  – Whether clinician effort is increased or decreased
Further integration

- Better if the referral workflow continued electronically past the hospital door
- At Hutt Valley the referral goes into their Orion Concerto system
- Allows GP to be aware of referral status beyond receipt
  - Get rid of the ‘black hole’ effect
- Allowed evaluation of impact on time till assignment of priority at Hutt Valley
What have we learned?

• It’s not like upgrading MS Office
• Plan for feedback and iteration
  – Evaluation will identify opportunities for improvement
  – No need to do it all in one go
• Take a wide view to achieve transformation
  – Don’t limit horizon to business as usual
  – Can achieve more if you change workflow (and let funding follow activity)
• Disseminate
  – Each project should contribute to national/international learning
Thank you!

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