Eas-e-Referrals

Partnership for improved referrals between General Practice and the Illawarra Shoalhaven Local Health District

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Case for change

Poor patient experiences including delayed access to services
Average length of time between referral and first specialist appointment is 4.5 months (2 months of which is a delay in contacting the service)

Incomplete referral information, administrative burden and difficulties effectively processing referrals
40% of GP referrals to specialists arrive without pathology results (and other key clinical information)

Resources directed away from patient care
In 40% of initial consultations, allied health and nursing staff spend up to 10 minutes on the phone chasing pathology results

Goal

Improve patient journeys & service efficiency associated with referral processes between General Practice & the Illawarra Diabetes Service

Objectives

Improve the quality and completeness of referrals so that:

i. the proportion of specialist referrals containing appropriate test results increases from 60% to 80% by May 2015, and

ii. the proportion of initial educator and dietitian appointments during which information must be followed up (at the expense of time spent on patient care) is reduced from 40% to 20% by May 2015

Streamline patient journey, reducing the average time between referral and first specialist appointment from 4.5 to 3 months

Method

To fully understand and prioritise the issues and root causes, the following methods were used :

- Patient / Carer interviews
- Data analysis
- Process Mapping
- Manual Data Gathering
- Observation of processing & triage
- Stakeholder interviews
- Root cause analysis
- Issues prioritisation

To develop and prioritise the most appropriate solutions, the following methods were used:

- Best practice review
- Literature search
- Solutions design workshop
- Stakeholder interviews / meetings
- Brainstorming
- Multi-voting

Diagnostics

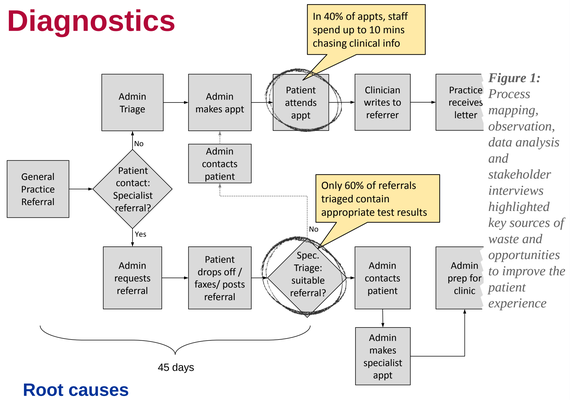


Figure 1: Process mapping, observation, data analysis and stakeholder interviews highlighted key sources of waste and opportunities to improve the patient experience

Root causes

1. No formal, consistent referral process in place
2. Limited general practice understanding of referral process and requirements
3. General Practice clinicians' preference / skill
4. Patient forgets, or is unaware of requirement, to bring referral documentation to consultation
5. No direct, secure communication between general practice & service
6. Patient lacks understanding / motivation
7. Process designed to avoid 'check in' on arrival

Planning and implementing solutions

Five primary solutions:

1. Standardised electronic referral template
2. Electronic transfer of referral using secure messaging
3. Enhanced definition of services
4. Define & communicate process for patients
5. Phased roll out to enable fine tuning

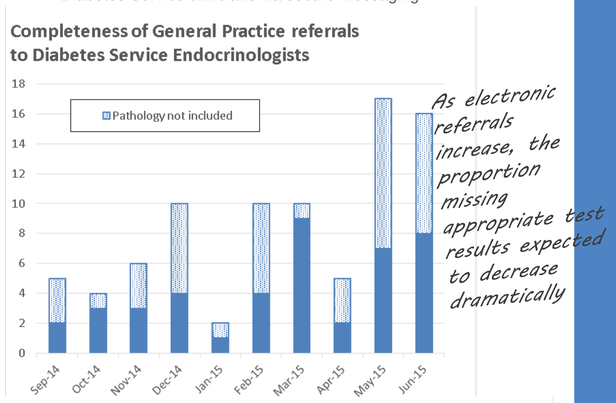
Key implementation strategies:

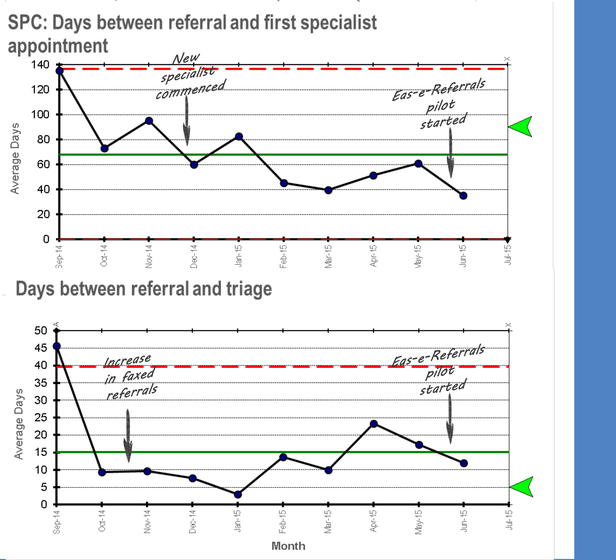
- Ensure comprehensive testing of new processes, both technical and administrative
- 'Package' solutions for easy implementation; new template incorporates enhanced definitions and send capability.
- Reward adoption: users will receive confirmation referral has been received and advice on status of referrals
- Use Phase 1 to showcase ease and benefits
- Ensure communications align with other integration communications, eg health pathways
- Co-deliver brief technical/process training and clinical education

Progress and results to date

The project is currently in the Implementation phase with the first electronic referrals recently received by the Diabetes Service. Specific progress to date includes:

- Referral template developed & installed on 6 pilot practices' clinical software
- Secure messaging infrastructure available & tested at Diabetes Service & practices
- Brochure available at point of referral to explain services and support patients
- 13 practices recruited to participate in pilot and ready to commence transmission of Eas-e-Referrals
- 52 items of correspondence sent to general practice from Diabetes Service clinicians via secure messaging





Sustaining change

Key strategies to enhance sustainability include:

- Embed responsibility and process knowledge in existing roles within the Diabetes Service and the PHN
- Facilitate access to ongoing technical support through the PHN and ISLHD
- Align project indicators with LHD Ambulatory and Primary Health Care Division key result areas and PHNs strategic plan and local indicators
- Integrate / align with Health Pathways implementation, going live September 2015
- Continue liaison and linkages with other integration project including HealtheNet and PCeHR
- Continue to leverage the PHN's focus and expertise in eHealth

Conclusion

Several opportunities to transfer learnings and processes have been identified:

- The project has been positioned as a first step to implementing improved and standardised referral pathways between General Practice and specialist services across the Illawarra Shoalhaven Local Health District.
- Opportunities identified to build on and integrate improved referral processes with the District Access and Referral Service.
- Communication and planning will become increasingly integrated with the Health Pathways project, strengthening the implementation of both projects across the area.

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