



eReferral
Evaluation
Final Report -
Executive Summary

2015

The purpose of this report is to outline the progress of the eReferral Program implementation across three early adopter groups and to provide program recommendations for the future.

September 1, 2014 to
September 30, 2015

EVALUATION SERVICES

RESEARCH PRIORITIES & IMPLEMENTATION

ACKNOWLEDGEMENTS

The eReferral Evaluation Final Report was completed by Evaluation Services, Research Priorities and Implementation in Research Innovation and Analytics. The Evaluation Team would like to acknowledge those who contributed generously with their time and experience.

- Allison Bichel, Executive Director, Provincial Access Team
- Jodi Glassford, Director, Closed Loop Referral Management
- Cindy Norris, Administrative Assistant, eReferral
- Erin Rohl, Communications Advisor, eReferral
- Annabelle Wong, Clinical Design Analyst, eReferral
- Marilyn Flieger, Business Analyst, eReferral
- Bill Burtnik, IT Project Manager, eReferral
- Nicola Brooks, Senior Project Manager, eReferral
- Tanya Christiansen, Project Manager, Alberta Bone and Joint Health Institute
- Grace Bole-Campbell, Director, Path to Care
- The eReferral Evaluation Working Group
- All program staff who assisted in collecting data
- All survey, interview, and focus group participants

This report was prepared on behalf of The Provincial Access Team for:

Jodi Glassford

Director
Closed Loop Referral Management
Calgary, Alberta
Alberta Health Services

Phone: 403-629-1739

This report was prepared on behalf of Evaluation Services by:

Courtney R. Petruik, M.A.

Lead, Evaluation
Evaluation Services
Research Priorities &
Implementation
Alberta Health Services,
780-407-4676

Courtney.Petruik@albertahealthservices.ca

Ashley Drobot, M.P.H.

Research & Evaluation
Coordinator
Evaluation Services
Research Priorities &
Implementation
Alberta Health Services,
780-407-4880

Ashley.Drobot@albertahealthservices.ca

This work is owned and copyrighted by Alberta Health Services (AHS). It may be reproduced in whole or in part for internal AHS use. For any use external to AHS, this work may be produced, reproduced and published in its entirety only, and in any form including electronic form solely for educational and non-commercial purposes without requiring consent or permission of AHS and the author. Any such reproduction must include the following citation:

Petruik, C. & Drobot, A. (2015). *The eReferral Evaluation Final Report*. Alberta Health Services.

eReferral Evaluation Final Report

EXECUTIVE SUMMARY

Introduction

Presently in Alberta most referrals to scheduled health services are done manually through faxing, phone calls or mail (Path to Care Business Case, 2013). Manual systems create problems such as redundancy of work, incomplete referrals, referrals with missing information, lost referrals, and missed appointments, all of which can create delays and have the potential to negatively impact a patient's health outcome. Alberta Health Services recognizes that existing problems with referral processes require immediate resolution and eReferral provides an innovative solution to the problem.

eReferral is Alberta Health Services' first paperless referral solution aimed at improving access to scheduled health services in Alberta. eReferral provides information to users on which reasons for referral providers see, what the wait times are and the referral requirements. eReferral leverages existing information in Alberta Netcare (patient information, diagnostic tests and laboratory results) to populate a referral form, while allowing for new or additional information to be added to the form. Forms that are "in progress" can be saved as a draft (important when a referral cannot be completed in one sitting) and checked for completeness before being sent to a service or provider. All referrals can be managed electronically and tracked in real time (eReferral Website, 2015).

The aim of eReferral is to improve and optimize access to scheduled health services by supporting the development and technological capability across Alberta Health Services (AHS). The purpose of this report is to evaluate eReferral's implementation: to determine what worked well, what could be improved, and to make recommendations for the continued implementation of eReferral.

The eReferral team modelled their implementation strategy around the Alberta Quality Matrix for Health (Health Quality Council of Alberta, 2005) with their goals being to:

1. Improve **efficiency** in scheduled health services by improving, standardizing, and automating business processes
2. Improve **accessibility** and reduce wait times for scheduled services
3. Increase stakeholder **acceptability** by improving awareness and clarity of patient's Path to Care
4. Improved care **appropriateness** through a standardized referral management process and increased adoption of clinical best practices
5. Key performance indicators will help identify access improvement opportunities and determine **effectiveness** of the program
6. Improve **safety** for patients by increasing transparency in the referral process

eReferral was implemented as a limited production rollout within Alberta Netcare for three early adopter groups including: lung cancer medical/radiation oncology, breast cancer medical/radiation oncology, and the hip and knee bone and joint replacement specialties. This evaluation captures data one year prior to the July 14, 2014 eReferral launch and one year after this date.

Evaluation Data

The evaluation data comprises 12 qualitative and quantitative data sources including: Program Metrics, Literature Reviews, Focus Groups, and Surveys.

eReferral Adoption

Key points on eReferral adoption:

- A total of 2078 eReferrals were processed in the first year since eReferral went live.
- On average 37 referrals were processed weekly during this time with a steady increase of the number of referrals and users month over month.
- The submission patterns show the majority of eReferrals were submitted by someone on behalf of a physician
- Most users who start using eReferral continue to use it.
- Prior years' submission patterns show that the majority of breast and lung cancer referrals are sent from surgeons with primary care physicians submitting the remainder.
- For hip and knee joint replacement referrals primary care physicians are primary referral sources with a high referring physician submitting ~ 1 referral per month.
- Breast cancer has shown the greatest adoption of eReferral with 40% of all referrals sent using the tool.
- The breast cancer sites where a Breast Health Clinic referred on behalf of the surgeon had the greatest eReferral uptake.
- Lung cancer and Hip & Knee show the least amount of adoption at 10% and 2% respectively.
- The largest adopters of eReferral for hip and knee sites were PCN referral hubs and large clinics.

Stakeholder feedback on eReferral adoption:

When asked why adoption wasn't higher, it was frequently mentioned by non-users that it was easier to send the referral by fax with less information than it was to use eReferral with its higher information requirements. The current eReferral forms require a certain amount of clinical knowledge to complete. Barriers identified by non-users included:

- eReferral creates more work because it is another system to use (64%),
- It isn't integrated with my current system (EMR) (59%), and
- Lack of familiarity with the system (50%).

Challenges of eReferral adoption:

Overall, eReferral adoption has been increasing but the program has faced contextual challenges that have prevented full uptake of the system. Challenges include: only having 3 early adopter groups, limited access to Netcare, low referral volumes in user groups, eReferral staff turnover, the referral requirements that were automated through eReferral had not been developed collaboratively by sending and receiving sites and were not widely adopted by referring sites prior to automation, and poor integration of eReferral in primary care EMRs. If these challenges are addressed, the program could see improvements in uptake.

Program Implementation across Early Adopter Groups:

A number of strategies and tools are in place to support uptake and success of the eReferral system. Currently, the approach taken by the eReferral team to engage and continue support to stakeholders is well received and effective as shown by survey and qualitative feedback. Continuing to monitor use of eReferral and capture feedback on implementation will serve to provide direction for the eReferral team to continue improvement of the system. Expanding to other services will help current groups observe the

potential effectiveness of the program. Until more groups are on eReferral, duplicate work exists for current users as they use multiple manual and electronic systems to manage referrals.

eReferral stakeholders expressed confidence in the potential success and aims of eReferral. The communication and training strategies have been very well-received by participants. There has been constructive feedback by stakeholders to continue engaging physicians and direct users of eReferral and to expand the system to more groups. The positive feedback on the communication style of the eReferral team is prominent suggesting the continuation of the newsletter and transparent approach to successes and delays of the program.

The users of eReferral stated that the benefits they are experiencing with automation include:

- “Providing wait times and if they are accepting referrals for available physicians/services”,
- “Ability to track referral status”, and
- “Knowing that the referral has been successfully submitted and received.”

The non-users without experience using eReferral state that they would hope that an automated referral system would address the same benefits. Since the perceived and expected benefits of users and non-users respectively are aligned, it is important that non-users are able to understand that the system will deliver on these expectations if they are able to become adopters of eReferral.

The eReferral forms have mandatory fields that must be filled out for successful submission. Data from Alberta hip and knee referral audit has shown that an incomplete referral increases the patients wait by up to 6 weeks. There was an increase in the completeness of eReferrals compared to baseline when looking at administrative data in hip and knee groups in the evaluation per chart reviews. The number of AHS clinics/services aware of eReferral is significant and those using eReferral are eager to see the program succeed. The early stages of implementation in addition to contextual challenges need to be addressed before eReferral can see the success it aims for. The program is well on its way to meeting its desired goals. The successes that the program has seen so far can be attributed to the efforts and determination of the eReferral team and the commitment and dedication of the early adopter groups.

Overall, the eReferral team and stakeholders believe in the work that eReferral sets out to do. The team and stakeholders have set high standards for themselves and the organization and feel what they are doing is the right thing and this motivates their continued engagement. The strategy and approach to eReferral is one that is accepted by stakeholders but may need a shift in the areas of training alignment between Netcare Deployment and eReferral, increased investment in resources to integrate EMRs with eReferral, and improved consistent leadership sponsorship from the organization that can be sustained beyond the limited production roll out.

Although there were challenges throughout implementation, the teams were able to implement eReferral across early adopter groups and have maintained buy-in with these groups and optimism for the future. The eReferral team has voiced their lessons learned in implementation and look forward to continuing the work in the future. The team’s flexibility and adaptability with their stakeholders, their transparent communication, and their attentiveness to stakeholder needs should be continued.

Conclusion:

eReferral has achieved success by increasing uptake and monthly volumes since it went live in July 2014. eReferral has driven the uptake of Netcare, but this remains to be a challenge for eReferral that some potential adopters choose not to use Netcare regularly. Automation has been well-received by early adopter groups with the main challenge for users being the lack of broader spread of eReferral beyond current clinical services and misalignment between eReferral and current clinical EMRs. Aligning EMRs is not an easy feat, but is necessary to realize eReferral's full potential. eReferral has brought awareness to the need for standard referral requirements and has begun working to streamline how referrals are processed provincially, but a plan is required to align EMRs with eReferral. This may take shape by including eReferral in the provincial clinical information system (CIS) planning or by aligning eReferral with the organizational IT strategy.

Furthermore, early adopter clinical areas should be supported to decide how they would like to continue to leverage eReferral. If supported by the organization to expand eReferral beyond the limited production roll out, eReferral should also consider revisiting their implementation strategy to scale out in a more rapid and cost efficient way.

Moving Forward:

eReferral was designed as a limited production roll out, not a pilot. This premise changed over the course of the project. To realize the benefits of eReferral, AHS needs to commit to leadership sponsorship; having clearly set champions who agree to support eReferral among the organization and its key partnerships. Additionally, funding must be secured for the maintenance and expansion of the eReferral program to ensure prevention of further attrition to the future strategic plan of eReferral. Moreover, organizational alignment of eReferral with the broad AHS IT strategy is imperative to enhance credibility of the system and its future with users, potential users and all invested stakeholders. Without these foundations in place, eReferral will not be able to scale out to more services or have a sufficient critical mass of referral types standardized and automated. If sponsorship, funding and IT alignment are not in place, the program as it was originally envisaged will not be realized.