



Workshop Report

e-Diagnostics Program

Version 1.0 — 21 May 2009

Final

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Distribution List

Version	Function	Comments
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Preface

This document has been developed using notes taken during the workshops by NEHTA business analysts and subject matter experts working with the e-Diagnostics Program.

Document purpose

The purpose of this document is to describe the workshops which were convened by the e-Diagnostics program in April/May 2009 with stakeholders of the pathology and diagnostic imaging professions and industries.

Intended audience

The intended audience of this document includes:

- Stakeholders of the pathology and diagnostic imaging industries;
- NEHTA business analysts wanting to become familiar with the pathology and diagnostic imaging industries; and
- NEHTA management and staff involved with development of the e-Diagnostics program of work.

Referenced documents

This document references some artefacts which were discussed during the workshops, including published reports and papers, website material and notes from conversations with stakeholders which have been produced by NEHTA or external organisations and individuals. Some of these artefacts may not be freely available in the public domain.

Details of the documents referenced within this document are contained within the [References](#) section of this document.

1 Introduction

The purpose of the e-Diagnostics Program is to utilise a national e-health approach to deliver solutions to specific business problems of the pathology and diagnostic imaging industries.

A number of workshops were convened with stakeholders of the pathology and diagnostic imaging industries in April and May 2009 in order to gain an understanding of the existing issues and opportunities associated with the Request-Test-Report cycles and to obtain stakeholder input to, and prioritisation of, the program's outcomes and objectives.

Previous workshops convened by the e-Diagnostics Program have demonstrated that there may be advantages in holding separate workshops, which were arranged as follows:

- Workshop for providers of pathology testing 21 April 2009
- Workshop for requesters of diagnostic investigations 23 April 2009
- Workshop for the informatics community and vendors 5 May 2009

This report describes these workshops in terms of attendees, discussion points, outcomes and actions.

Note that additional workshops, for requesters of diagnostic imaging, providers of diagnostic imaging and patients and carers, are expected to be held in July 2009. Those workshops will be described in a separate report.

1.1 Objectives of the workshops

NEHTA's objectives in convening these workshops were as follows:

- To gain an understanding of the existing issues and opportunities associated with pathology and diagnostic imaging;
- To gain an understanding of the existing issues and opportunities associated with the notification of pathology test and diagnostic imaging Results to clinical registries;
- To gain stakeholder input to the e-Diagnostics Program's outcomes and priorities;
- To articulate the vision for e-Diagnostics; and
- To gain the commitment of attendees to be actively involved with the e-Diagnostics Program.

1.2 Expected outcomes of the workshops

- Input to the Environment Scan documents for pathology and diagnostic imaging Requesting, Reporting and e-Notifications;
- A refined list of outcomes, objectives and priorities for the e-Diagnostics Program; and
- A list of volunteers for collaborative participation in the development of e-Diagnostics Program deliverables.

2 Invitations and attendees

2.1 Workshop for providers of pathology testing

In convening this workshop NEHTA sought representation from public and private pathology providers including pathologists, laboratory and IT staff, hospital workers involved with specimen collection and staff from collection centres.

Invitations to attend the workshop on Tuesday 21 April 2009 were distributed Friday 27 March 2009 as follows:

Stakeholder	Organisation	Invitation sent to
Peak Bodies	Australian Association of Pathology Practices	Ann Webb to cascade to members of AAPP
	National Coalition of Public Pathology	Penny Rogers to cascade to members of NCOPP
	National Pathology Accreditation Advisory Council	Suzanne Petrie to cascade to members of NPAAC
	Royal College of Pathologists of Australasia	Beverley Rowbotham to cascade to members of RCPA
Public pathology providers	National Health CIO's Forum	Owen Smalley to on-forward to other members of the NHCIOF to cascade within jurisdictions as appropriate
Private pathology providers	Healthscope	Dougall McBurnie to cascade as appropriate
	Primary Health Care /Symbion Health	Duncan Elliott to cascade as appropriate
	Sonic Healthcare	Alan Lloyd to cascade as appropriate
	St John of God	Paul Mather to cascade as appropriate

Additionally, all members of the Diagnostic Services Reference Group (DSRG) were invited to attend (refer to appendix A for further details).

Attendance at this workshop was as follows:

Organisation	Attendee
ACT Pathology	Charmaine Gray
AIMS	Alan McLeod
Australian Medical Association	Peter Garcia-Webb*
Austin Pathology	Jane Allardice
Consumer Health Forum	Geraldine Robertson*
DOHA (NPAAC secretariat)	Suzanne Petrie

Organisation	Attendee
Healthscope Limited	Dougall McBurnie Achyut Naik
NPAAC	Leslie Burnett
Pathology North - Palms	Simon Holmes
Pathology Qld	Peter Hegarty
PathWest	David Taylor
Qld Health	Graham Dickens
Qld Health (eHealth)	Kate Galbraith
QML Pathology	Duncan Elliott Steve Osborne
RCPA	Lawrence Bott
Royal Hobart Hospital	Andrew Hudspeth
SA Pathology	Chris Reilly*
St John of God Pathology	Paul Mather
Sullivan Nicolaides	Dr Daman Langguth

* members of the Diagnostic Services Reference Group.

2.2 Workshop for requesters of diagnostic services

In convening this workshop NEHTA sought representation from clinical, operational and IT staff involved with the requesting of pathology tests and diagnostic imaging, the receipt of pathology and diagnostic imaging Result Reports and/or the reconciliation of Requests with Result Reports within general practice, medical specialists, public or private hospitals or aged care facilities.

Invitations to attend the workshop on Thursday 23 April 2009 were distributed Friday 27 March 2009 as follows:

Stakeholder	Organisation	Invitation sent to
Peak Bodies	Australian Medical Association	Dr Rosanna Capolingua to cascade to members of AMA
	Australian General Practice Network	David Butt to cascade to members of AGPN
	Royal Australian College of General Practitioners	Dr Chris Mitchell to cascade to members of RACGP
	Royal Australian College of Physicians	Chris Ryan to cascade to members of RACP
Public hospitals	National Health CIO's Forum	Owen Smalley; to on-forward to other members of the NHCIOF to cascade within jurisdictions as appropriate

Additionally, all members of the Diagnostic Services Reference Group (DSRG) were invited to attend (refer to appendix A for further details).

Attendance at this workshop was as follows:

Organisation	Attendee
Australia Commission on Safety and Quality in Health Care	Neville Board*
Australian Medical Association	Peter Garcia-Webb* Steve Hambleton
GP Network NT	Tim Garden
GP Partners	Ann McBryde
Qld Health	Paul Carroll* Anthony Fish Marija Mamic
Royal Australian and New Zealand College of Radiologists	Nick Ferris*
SEAGP Brisbane	Alan Rettke

* members of the Diagnostic Services Reference Group.

2.3 Workshop for the informatics community and software vendors

In convening this workshop NEHTA sought representation from the health informatics community, Standards Australia, NATA, vendors of clinical, laboratory and radiology systems and their industry associations.

Invitations to attend the workshop on Tuesday 5 May 2009 were distributed Wednesday 8 April 2009 as follows:

Stakeholder	Organisation	Invitation sent to
Informatics	Health Informatics Society of Australia	Michael Legg
	HL7 Australia	Klaus Veil
Industry associations	Australian Information Industry Association	Jackie Lack Ian Birks Loretta Johnson to cascade to members of AIIA
	Medical Software Industry Association	Vince MacCauley to cascade to members of MSIA
Vendors	Apollo (Sonic Healthcare)	Alan Lloyd
	Best Practice	Frank Pyefinch
	Cerner	Michelle Davis
	GE Med (Triple G)	Maria Palmer
	Genie	Paul Carr
	HCN (Medical Director)	Lisa Evans

Stakeholder	Organisation	Invitation sent to
	Kestral	Bob Hall Kevin Moynihan
	Medical Objects	Glenn Stephens
	Medipath	Andrew ?
	Omnilab	A Anderson
	PJACC	Philip Allison Tracey Giles
	Symbion Health	Chris Skennerton
	TrakHealth	Generic email address supplied
Other	Standards Australia IT-14	Anne Byatt
	National Association of Testing Authorities	Megan Nelson

Additionally, all members of the Diagnostic Services Reference Group (DSRG) were invited to attend (refer to appendix A for further details).

Attendance at this workshop was as follows:

Organisation	Attendee
ACT Health - INTACT	Michael Cowey
Consumer Health Forum	Geraldine Robertson* Janney Wale*
DoHA eHealth	Geoff Miller
GE Healthcare LIS	Bruce Jones Geoffrey May
Genie Solutions	Paul Carr
Health Informatics Society of Australia	Michael Legg^
Kestral	Bob Hall Grahame Grieve
Mater Pathology Services	Michael Osborne
Medical Software Industry Association	Vince McCauley
National Association of Testing Authorities	Rob Passam Victoria Hauke
Promedicus Ltd	Steven Williams
Qld Health	David Anderson
Royal Australian and New Zealand College of Radiologists	Nick Bradshaw
Standards Australia	Dick Harding

* members of the Diagnostic Services Reference Group.

^ member of the Terminology Services Reference Group.

3 Agenda

Time	Session	Facilitator
8:30am – 9:00am	Coffee on arrival	
9:00am – 9:30am	Welcome and introduction <i>Includes a description of "e-Diagnostics" and an example of what and how we might deliver a solution to a current business problem, using an example problem defined during the clinical leaders workshop which demonstrates the boundaries of NEHTA's role.</i>	Dean Meston
9:30am – 10:50am	Current experiences of Pathology Providers in the Request-Test-Report cycles for pathology and the notification of pathology test Results to clinical registries <i>This session will allow us to understand (at a high level) some of the existing business problems that could be resolved with e-Diagnostics.</i>	Simone Gard
10:50am – 11:10am	Morning Tea	
11:10am – 11:40pm	What is the goal state (vision) for e-Diagnostics from the perspective of Pathology Providers?	Dean Meston / Simone Gard
11:40am – 12:20pm	What are the barriers to uptake of e-Diagnostics?	Simone Gard
12:20pm – 1:00pm	Lunch	
1:00pm – 2:55pm	Key outcomes for the e-Diagnostics Program <i>This session will include a discussion of the outcomes and the rationale for and benefits of each outcome as inputs to the development of the Value Proposition for e-Diagnostics.</i>	Simone Gard
2:55pm – 3:15pm	Afternoon Tea	
3:15pm – 3:45pm	What are the top five priority areas the e-Diagnostics program should focus on for delivery of tangible benefits and what are the expected timeframes?	Simone Gard
3:45pm – 4:15pm	Collaboration model for the e-Diagnostics Program <i>This session will include a discussion of how the group would like to be engaged for specific pieces of work (e.g. volunteer, nomination by professional body etc).</i>	Dean Meston
4:15pm – 4:30pm	Wrap-up, next steps and close.	Dean Meston

Note that the agenda was the same for each workshop, however the agenda items were not covered in the same order to accommodate natural progressions in the discussions at each workshop.

4 Key discussion points

4.1 Current experiences in the Request-Test-Report cycle

The pathology Request-Test-Report cycle refers to the initiation of a request (most commonly by a Physician or GP for the purpose of patient diagnosis or management), the informed cooperation of the patient (at a minimum, for the collection of the specimen being tested), the performance of the requested pathology services by a pathologist and/or pathology provider and the reporting of the test results and/or professional opinion(s) back to the Requester or their nominated delegate (refer diagram 1). A single Request-Test-Report Cycle for a patient may involve a number of medical and non-medical health professionals, health institutions and commercial organisations [RCPA2007].

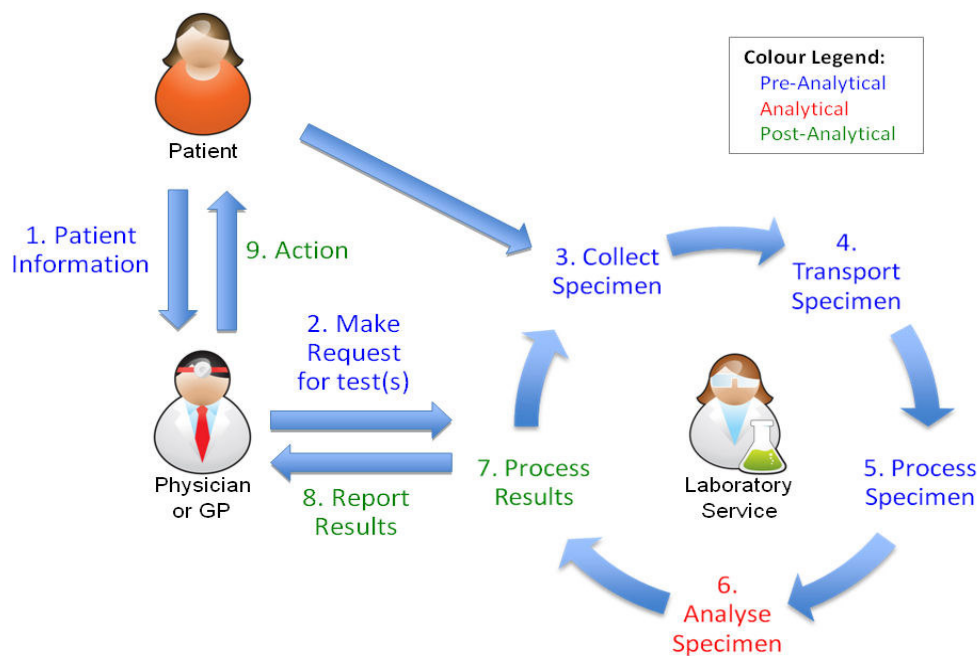


Diagram 1 - The Pathology Request-Test-Report Cycle

The pathology Request-Test-Report cycle described above does not cover the referral of tests between laboratories and/or providers or the notification of test results to clinical registries, nor is it applicable to diagnostic imaging. It does, however, provide a good starting point for a discussion about the day-to-day business problems which could be solved using a national e-health approach. Note that definition of a similar diagram for diagnostic imaging is likely to form part of the e-Diagnostic program of work for the period July-December 2009.

Discussion points regarding the key business problems associated with the pathology Request-Test-Report cycle during the three workshops are summarised below.

Step 1 – Patient Information

- Multiple patient records in a clinical system can cause incoming test Results to be “lost” when matched with an old record, resulting in additional tests being ordered;

- The Australian population is now mobile – a patient’s new clinician needs to rerun tests ordered by previous clinicians in order to establish a baseline;
- Patient consent must be obtained prior to specific tests being able to be performed and reported, however having a patient present at a collection centre does not imply consent to their information being reported, as they may not have been informed by their GP. Consideration of the capture and recording of such consent for an electronic Request is required; and
- HIV testing requires some patient information to be encoded (de-identified), how will this work if unique patient identifiers are implemented?

Step 2 – Make Request for test(s)

- Handwritten Requests are often less complete, sometimes illegible, patient address and contact information may be incorrect, and a Request may use a patient’s preferred names rather than the given names, which may not align with the provider’s or Medicare records;
- Requestors would like to be able to apply a flag to some Requests to enable them to monitor the progress of the Request through the R-T-R cycle, and to be alerted if key events (e.g. specimen collection, Report received etc) do not occur within a pre-defined period of time;
- There are currently no guidelines for clinicians about what a Request needs to look like or what information it needs to contain - a clinician can make a Request on any piece of paper and it will be approved by Medicare as long as it bears their signature;
- For Requests for pathology services which are not funded by Medicare there is no requirement to follow any standard(s);
- With the implementation of electronic systems, there are likely to be mandatory fields that clinicians are unaccustomed to completing;
- A code set for billing in hospitals is required - if a billing code set is inaccurate the request can’t be processed.

Step 3 – Collect Specimen

- Patients will always require a prompt as a reminder of their preparation requirements, contact details and location/directions for collection/imaging centres. This could remain in the form of a paper or could be SMS/email technology;
- There is no way to identify whether the person who presents for a pathology test is the patient that was referred – limited identity checks are performed;
- There are inconsistencies with the recording of information - a collection time will be recorded on a sample but not on the Request form and the process for numbering and recording specimens and request information into the LIS differs between labs;
- A clinician can’t mandate which collection centre a patient goes to;
- In some cases one pathology providers' user interface may be preferred over another. For example, some GPs with a Sullivan and Nicholaides interface use it to complete a request that they then print out on a QML form. This will result in an 'orphan' electronic request being created for Sullivan Nicholaides which will never be processed;
- Approximately 10% (at least) of pathology Requests are not completed as patients don’t turn up for specimen collection;

- If a patient continues to have a choice in which Provider they use, a clinician won't be able to send an electronic request to a specific provider as the patient may never turn up. Implementing a model similar to the e-Prescribing model could help to resolve this;
- When designing solutions – the different jurisdictions need to be considered. For example, if a test is requested in Qld, can it be filled in NSW as the state's legislative requirements may be different?
- State-based clinical registries – if a patient's details are recorded in a registry in one state and they have a test conducted in another state, the original registry should also be updated but this doesn't happen. For example, a NSW patient may have a pap smear in Qld, in which case the Qld pap smear registry is notified rather than (or in addition to) the NSW pap smear registry;
- Designing solutions that follow the current workflow of information travelling with a patient (i.e. paper pathology and/or imaging Requests; imaging Reports etc.) will be very difficult to design, build and implement;
- Although not a legal practice, it is not uncommon in a hospital setting for a doctor to pre-sign a blank Request form that a nurse can complete on behalf of the doctor should they not be available. This process will not be supported with electronic systems and would present a barrier to uptake of electronic ordering in hospital settings;
- Requests should be linked to a patient's unique identifier;
- There is a requirement to match up a sample to a Request;
- Most systems are test based not specimen based. It would be unnecessarily complex to implement systems that were specimen based;
- Labs often assign ID's to specimens but this is an internal process only;
- There needs to be tracking through the process – from specimen collection, identification of containers, transportation and the processing in a lab;
- A radiographer may change a requested test if, on discussing a patient's history with the patient, she determines the requested test is unsafe;
- In Qld the only person who can order a CT is a radiologist – a clinician may "request" a CT but can not "order" one;
- Requestors are not aware of all the safety protocols that need to be fulfilled prior to a test occurring. A radiographer/radiologist will review a patient's history and ask specific medical questions prior to conducting any tests; and
- A decision support system would assist requestors with appropriate ordering of diagnostic imaging.

Step 4 – Transport Specimen

- Specimen transport can be a lengthy process which is not visible to requesters;
- The handover of a specimen collected by the requester is not clearly documented or traceable;
- A HL7 message acknowledgement can be sent already;
- The distance and time taken to transport a specimen can compromise the quality of the specimen, resulting in analysis errors. The lab needs to be made aware of the conditions in which the specimen was

transported, however the recording of such information is not always consistent and is not managed well by any provider; and

- If a specimen is invalid either a report will be sent back to the Requestor or the patient will be contacted directly.

Step 5 – Process Specimen

- If a specimen is sent to separate laboratories the results may be returned directly to the requestor/patient and not to the initial laboratory for review and summary into the one report;
- There are difficulties in getting HL7 messages set up between referring laboratories;
- There needs to be clear protocols in place to manage urgent requests and a process for modifying Request priority during the R-T-R cycle. Knowing where in the process a specimen is would be useful for some tests;
- A specimen will be processed according to lab protocols. If a specimen is received that is not in the right container, does not contain a collection time or is of insufficient quality, it is likely not to be accepted for processing;
- Some lab systems do not allow certain information included on a Request (e.g. clinical information) to be passed through;
- The reason for a test may have an impact on billing;
- There may be privacy issues if a patient's clinical history is included along with specimen information as this information is not required to be reviewed by all lab staff and isn't relevant in some situations;
- There are lab protocols in place to manage urgent requests; and
- It would be beneficial to have an electronic way of managing the status / priority of a test.

Step 6 – Analyse Specimen

- There is no common set of codes for results/tests and the lack of standardisation in receiving systems causes problems for pathology laboratories;
- All errors in collection or transportation of a specimen that were not picked up earlier will be identified in this step; and
- For diagnostic imaging it would be beneficial to see the radiologists' decision points in a process that resulted in an action being taken that was different to the one recommended by the clinician.

Step 7 – Process Results

- Clinical notes are not always passed onto the pathologist reviewing the specimen, and there's no way for a requester to flag that they want a particular –ologist to review a Result before it is reported;
- The status types available are not a problem. There is a problem with the understanding of how they should be used;
- The scope / context of the status needs to be expressed – i.e. one test may be complete but the whole Request is not complete;
- There is an inconsistent use of codes within labs;
- There have been problems around the interpretation of HL7 by labs;
- There are different interpretations of what abnormal means;

- Training should be provided to the receivers of pathology reports; and
- There is a possibility that a requestor could receive results back that were not originally asked for. This could happen if the –ologist identified something additional during their analysis.

Step 8 – Report Results

- No standardised way to notify a clinician of an urgent/abnormal outcome;
- Workflow – business problem. How much notification is needed before a clinician can be deemed as having been 'clinically notified' of a Result? The development of a statement defining the clinical process would assist with this;
- In a Hospital environment:
 - if a doctor orders a test, then leaves and is relieved by another doctor, to whom should the results be sent?
 - if a junior doctor or nurse reviews a result, they have not taken responsibility for acting on the Result (i.e. the senior doctor or specialist needs to see the Result) and do not want the system to send an acknowledgement - there needs to be a way to allow someone to review a result without acknowledging it;
 - in some environments an automated acknowledgement that a Report has been read is generated after a certain period of time.
- There could be various aspects to an acknowledgement (multiple people may be involved) – if this process were to be automated, all of the rules would need to be mapped;
- If a clinician is away on leave or is ill, processes need to be in place to manage the escalation of results so that they are reviewed in a timely manner. Note that these types of rules do not need to be defined externally but should form part of a business's workplace practices. There needs to be clear communication to the industry to set the expectation that this is something they should start working on internally;
- Teaching hospitals – it is common for a senior doctor to have a requirement to review all of the Results which are received by their junior staff. There needs to be mechanisms in place to ensure that all relevant parties receive required information;
- One request could result in many reports. If the tests requested have the same lifecycle they are likely to be reported together. If they don't it is inefficient to wait for other results and reports are often sent back to the requestor as the results are received;
- There needs to be a way to monitor a lab's conformance and compliance to standards;
- All 'final' results are usually deemed 'provisionally final' and if changes are required they are often provided as amendments to the 'final'; and
- There needs to be a way to ensure that all specimens related to a Request are processed and all Results are Reported.

Step 9 - Action

- A process to allow the requester to acknowledge reading a report is required;
- There needs to be clear identification of who has taken responsibility for determining and performing the appropriate patient follow-up in

relation to a Result Report - this isn't always clear where there are multiple 'copy-to' clinicians;

- Classically the concept of Diagnostic Services may, in time, replace the need for specific pathology or imaging, along with the merger of their systems;
- A significant amount of radiology in public hospitals goes unreported (i.e. an x-ray is taken and reviewed and verbally reported, but no official "Report" is issued). For example, one Qld hospital is aiming to improve the rate in which results are being reported from 27 per cent to 50 per cent. An introduction of PACS systems should reduce the incidents of this;
- One significant difference between the reporting of pathology and radiology is that there are two reporting aspects to radiology. Radiology involves both an image and a report. In some cases only one, report or image, is required back by the requestor. There needs to be a way to notify the radiologist of this requirement; and
- In some cases, e.g. breast screening, a patient may present at a radiology clinic without the need for a doctor's referral and Medicare benefits are still payable for the service.

4.2 The goal state

Discussion of the Request-Test-Report cycle at all three workshops ran well beyond the time which was scheduled. Based on the discussion flow at the first workshop (for providers of pathology testing) it was decided to defer a discussion of the e-Diagnostics goal state (vision) to allow the workshop to end on time. For consistency, this discussion was deferred at all three workshops.

The goal state, or vision, is considered essential and will be facilitated by NEHTA in the next few months. Other work will be completed from the workshop which will assist with development of the vision.

4.3 Barriers to uptake of e-Diagnostics

The following barriers were articulated by participants at the three workshops:

- **Unique Identifiers** – IHI, HPI-I and HPI-O are required – there is currently no way to record UHIs in a number of systems due to database structure constraints;
- **Funding** - implementing new/updated systems (or code sets) is likely to be costly (upgrades for software and equipment); who is responsible for paying the Vendor (or provider) to make changes?
- **Availability of resources** to assist with the change/implementation of systems;
- **Privacy Laws** to be reviewed & altered to permit electronic sharing of patient data;
- Commercial considerations – 'vanilla' processes could result in a **loss of competitive advantage** of one provider over another; until specific business/solution requirements begin appearing in tender documents there is no incentive for vendors to change;
- **Terminology** – current terminology sets do not cover all tests; expanded terminology sets need to be implemented in clinical systems to populate the Request; there is no confirmed agreement/direction within the pathology industry that SNOMED CT will be implemented nationally. Use of terminology can't slow down a patient's episode of care;

- **Standards** - Australia has implemented its own flavour of the HL7 Standard. Cerner use NTE segments and comply with international standards, Australia doesn't;
- **Accreditation** - Providers have very little influence on vendors - without CCA processes vendors aren't likely to change their systems;
- Use of **incentives** to drive change – this strategy has proven successful in the past. These incentives need to be multi-level;
- **Computer illiteracy** - some staff can't use computers and/or find writing is faster than typing; this may be reduced as new generations move into the medical profession;
- **Infrastructure** – need reliable and secure broadband;
- **IT support** - who will provide this and who will pay for it? Offsite data backup needed;
- **Roadmaps** - sufficient lead times required to ensure vendors can support changes;
- It's simply not practical (time, money, effort) to move from **legacy systems**;
- **Productivity losses** – a clinician will not adopt e-requesting unless the process is faster than the current manual system;
- Existing **commercial agreements** with vendors and secure messaging providers;
- Existing systems and process are often built around **legislative requirements** (e.g. BreastScreen Queensland) which can make change difficult.

These will form the basis of a risk scoping document which will identify mitigation strategies across the industry.

4.4 Key outcomes for the e-Diagnostics Program

Over the past three years NEHTA's e-Diagnostics Program has met with numerous pathology industry stakeholders, who have communicated their desired outcomes and objectives for e-Pathology. These objectives have been collated and grouped within eight specific outcome areas as follows:

1. Electronic production and delivery of Pathology Result Reports nationally using a single interpretation of HL7 as standard practice;
2. Electronic production, transmission & processing of pathology Requests nationally using a single interpretation of HL7 as standard practice;
3. Improved patient outcomes nationally through effective management of the Request-Test-Report cycle;
4. Improved patient outcomes nationally through use of effective decision support;
5. Improved quality and safety through the national availability of reliable information in clinical systems;
6. Wide-spread adoption of e-Diagnostics within the pathology profession nationally;
7. Broad support exists nationally for the e-Diagnostics Program; and
8. Improved access to pathology information and test results by patients and carers.

This session of the workshops involved robust discussion of these outcomes and their associated objectives and benefits. Participants were asked to clarify and/or correct the objectives already stated, add new objectives and propose

the 'products' which could be delivered by NEHTA in order to assist the industry to meet some of these objectives. Participants were also asked to identify objectives and benefits which are, or are not, applicable to Diagnostic Imaging, with a view to developing a set of outcomes and objectives pertaining to the entire e-Diagnostics Program.

The e-Pathology outcomes and objectives will be updated to incorporate feedback from workshop participants and published on the NEHTA website by 30 June 2009.

4.5 Priority areas for the e-Diagnostics Program

Workshop participants articulated the following priority areas for the e-Diagnostics Program:

Priority Areas	Providers	Requesters	Informatics + Vendors
Communication to stakeholders regarding			
<ul style="list-style-type: none"> Patient identifiers (IHI), including what they are, how will they be used; what needs to be implemented and how it will change existing systems; how will databases be populated and where the data come from; benefits of change; and impacts of not changing. 	✓	✓	
<ul style="list-style-type: none"> Terminology, including guidelines for the use of terminology (including SNOMED vs. LOINC); and what changes are occurring. 	✓		
<ul style="list-style-type: none"> The PIP scheme and how to manage this change. 	✓		
<i>All communications need to be specific to the path industry and written by someone(s) with relevant path industry knowledge.</i>			
Conformance, Compliance and Accreditation Model			
<ul style="list-style-type: none"> Need for NPAAC to come up with Standards and Accreditation requirements for making things happen in the industry – what are the impacts of not changing, what is coming, what is the value proposition, what are the expectations on the adoption of standards and changes to the accreditation process. 	✓		
<ul style="list-style-type: none"> Definition of the business drivers for CCA; who will be responsible for accreditation of PMS vendors; and use IHE Profile to determine whether the CCA model works. 			✓
Secure Messaging Standards			
	✓		✓
Interim Solution – barcoded Requests and Result Reports. Barcode would contain demographic information (patient name/DOB), the tests being performed (using SNOMED ref sets) and a unique Request ID.			
		✓	
Structured Document Template for Requests			
		✓	
Flags for Request Tracking which could be optionally applied by the requester when making a Request to enable:			
<ul style="list-style-type: none"> alert to requester where patient has not presented for specimen collection within x period of time; alert to requester where Result Report is not received within x period of time; status updates sent from provider to requester as Request moves through the Request-Test-Report cycle. 		✓	
Roadmap detailing specific deliverables, specific and guaranteed delivery dates, incentives, support tools, responsibilities, terminology and pathway for adoption.			
			✓

Priority Areas	Providers	Requesters	Informatics + Vendors
Terminology <ul style="list-style-type: none">• Requestable Items (with links to Medicare and Medibank);• Analytes (Reportable Items); and• Fill in the gaps between LOINC and SNOMED			✓
Strategy for uptake which covers how to implement, governance and how to test for compliance			✓
Unique identifiers , including funding to implement, appropriate interfaces (IHE and webservice) and support, and transition pathways between existing and new identifiers			✓

5 Lessons learnt

The following points were noted by the e-Diagnostics Program team in relation to the workshops and will be considered when planning future workshops:

1. The agenda should be realistic in terms of the time required to adequately cover individual items;
2. Invitations should be sent at least six weeks prior to the workshop date to ensure a good representation of stakeholders;
3. Regular communications to stakeholders (e.g. newsletters, information sessions etc) would allow stakeholders to keep up-to-date with NEHTA's broader work program and give participants context for the discussions occurring within a workshop;
4. The role of participants within a workshop should be clearly defined as part of the invitation;
5. Workshops should be held in various cities to ensure access to a broad range of stakeholders; and
6. Convening separate workshops for different stakeholder groups to cover the same agenda is successful in ensuring that different perspectives can be voiced.

References

This section lists the documents which have been referenced within this document.

At the time of publication, the document versions indicated are valid. However, as all documents listed below are subject to revision, readers are encouraged to use the most recent versions of these documents.

[REF]	Document Name	Publisher	Link
[RCPA2007]	Chain of Information Custody for the Pathology Request-Test-Report Cycle in Australia (Guidelines for Pathology Requesters and Pathology Providers)	Royal College of Pathologists of Australasia. Mar 2007.	http://www.health.gov.au/internet/main/publishing.nsf/Content/FDD654D0C46DC374CA2573A0000A9C1A/\$File/ChainInfoCustody.pdf Last accessed 7 May 2009.

Appendix A: Diagnostic Services Reference Group

The Diagnostic Services Reference Group (DSRG) has been established to provide advice to the Stakeholder Reference Forum (SRF), NEHTA Board and CEO. Membership of the DSRG consists of those who are responsible for both implementing and using the deliverables of the e-Diagnostics Program and includes representation from jurisdictions, clinicians, consumers, industry, private health and NEHTA.

Current members of the DSRG are as follows:

Member	Representing
Alan Lloyd	Sonic Healthcare; The Australian Association of Pathology Practices
Chris Reilly	SA Pathology
Dean Meston	NEHTA (e-Diagnostics Program Manager)
Dougall McBurnie	Healthscope Limited
Geraldine Robertson	The Consumer Health Forum (Diagnostic Imaging rep.)
Hugh Greville	NEHTA Clinical Leaders Network
Janine Bevan	The Department of Health and Aging / eHealth Branch
Janney Wale	The Consumer Health Forum (Pathology representative)
Julia Potter	ACT Pathology; The National Pathology Accreditation & Advisory Council
Lawrie Bott	The Royal College of Pathologists of Australasia
Neville Board	The Australian Commission on Safety and Quality in Health Care
Nick Ferris	The Royal Australian and New Zealand College of Radiologists
Owen Smalley (Co-Chair)	ACT Health; National Health Chief Information Officers Forum
Paul Carroll	Queensland Health
Paul Williams	NEHTA (Head of Solution Development)
Peter Garcia-Webb (Co-Chair)	The Australian Medical Association; NEHTA Stakeholders Reference Forum
Philip Dubois	The Australian Diagnostic Imaging Association
Roger Wilson	NSW Health; The National Coalition of Public Pathology