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National Mental Health eReferral Project Report

PHNs working together to deliver digital solutions
to improve access and coordinated care.





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Acknowledgements

North Western Melbourne Primary Health Network (NWMPHN) acknowledges the peoples of the Kulin nation as the Traditional Custodians of the land on which our work in the community takes place.

We pay our respects to Elders past and present. We also recognise, respect and affirm the central role played in our work by people with lived experience, their families and carers.

We sincerely thank all the individuals who contributed to this project. In particular, we extend our deep appreciation to the members of the Project Advisory Group (PAG), Expert Advisory Committee (EAC), technical vendors, mental health clinicians and general practitioners. Their valuable insights, expertise, and commitment were instrumental to the project's success.

Project Advisory Group

- Adelaide PHN
- Brisbane South PHN
- Brisbane North PHN
- Central Queensland, Wide Bay, Sunshine Coast PHN (Country to Coast)
- Central & Eastern Sydney PHN
- Australian Capital Territory PHN (Capital Health Network)
- South Eastern NSW PHN
- Country South Australia PHN
- Eastern Melbourne PHN
- Gold Coast PHN
- Murrumbidgee PHN
- Murray PHN
- Nepean Blue Mountains PHN
- North Coast PHN
- North Queensland PHN
- Northern Sydney PHN
- Northern Territory PHN
- North Western Melbourne PHN
- Primary Health Tasmania
- South Eastern Melbourne PHN
- Tasmania PHN

- Western Australia Primary Health Alliance
- Western Sydney PHN
- Western NSW PHN
- Western Victoria PHN

Expert Advisory Committee

- Western NSW PHN
- Country to Coast PHN
- Tasmanian Department of Health
- Central and Eastern Sydney PHN
- HealthDirect (Head to Health Service)

Vendors

- HealthLink

Other stakeholders

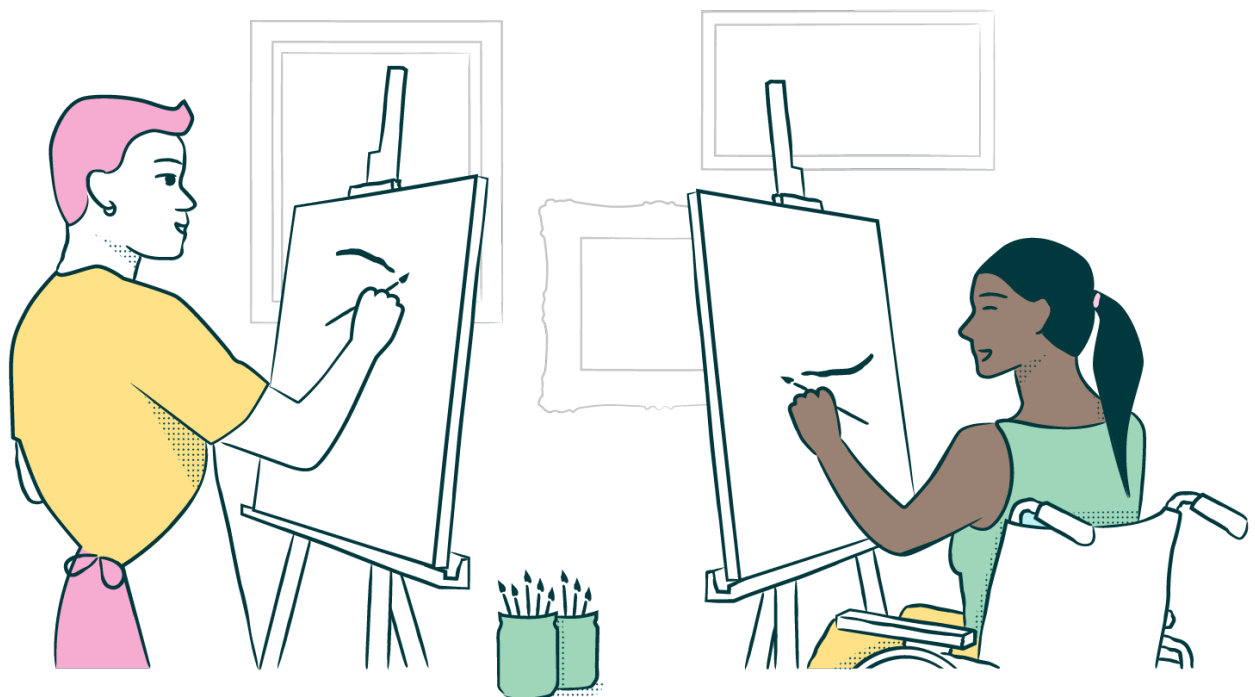
- Amplar Health
- Neami National
- Australian Digital Health Agency (ADHA)
- CSIRO
- Department of Health, Disability and Ageing, Adult Mental Health Services Section (DHDA)

About this report

This report provides a comprehensive account of the National Mental Health eReferral Prototype Project, led by North Western Melbourne Primary Health Network (NWMPHN) in collaboration with PHNs across Australia. It outlines the project's objectives, technical design, staged implementation, and outcomes, culminating in a scalable model for national adoption.

The report highlights the collaborative leadership of NWMPHN, participating primary health networks (PHNs), HealthLink and other key stakeholders in delivering a secure, efficient, and interoperable digital referral solution. It documents the project's achievements, including the delivery of a fully integrated electronic referral (eReferral) system, and presents insights from users across general practice and intake services.

Drawing on quantitative and qualitative evaluation data, the report also captures lessons learned and practical considerations for future rollouts. It is intended to inform ongoing refinement of the mental health eReferral model and guide investment in digital mental health infrastructure across Australia.



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Executive summary

The National Mental Health eReferral Prototype Project set out to transform the mental health referral process by delivering a nationally scalable, digitally integrated referral solution that improves efficiency, enhances user experience, and enables seamless interoperability between health care systems.

Led by North Western Melbourne Primary Health Network (NWMPHN), in collaboration with PHNs around the country, the project responded to long-standing challenges in manual referral workflows, disconnected systems, and limited visibility between general practice and mental health intake teams. Over 12 months, the project delivered a suite of digital tools, including a HealthLink SmartForm, a back end eReferral Manager, a new eReferral Inbox within the Primary Mental Health Care Information System (PMHCIS), a referral tracking function, and an external webform, designed to support timely, accurate, and consistent referrals across the country.

A core strength of the project was the strategic collaboration between PHNs, HealthLink, intake teams, service providers and national advisory bodies. The Project Advisory Group (PAG) and Expert Advisory Committee (EAC) ensured diverse clinical, technical, and operational perspectives were embedded into every phase of the project, resulting in a solution grounded in real-world service delivery and positioned for future national implementation.

The new system underwent alpha and beta testing – involving three and 9 PHNs respectively. This allowed for early testing, iterative improvements, and practical insights into system performance. Evaluation through surveys and interviews with general practitioners (GPs) and intake teams and PHN mental health leads demonstrated clear efficiency gains, and a reduced administrative burden.

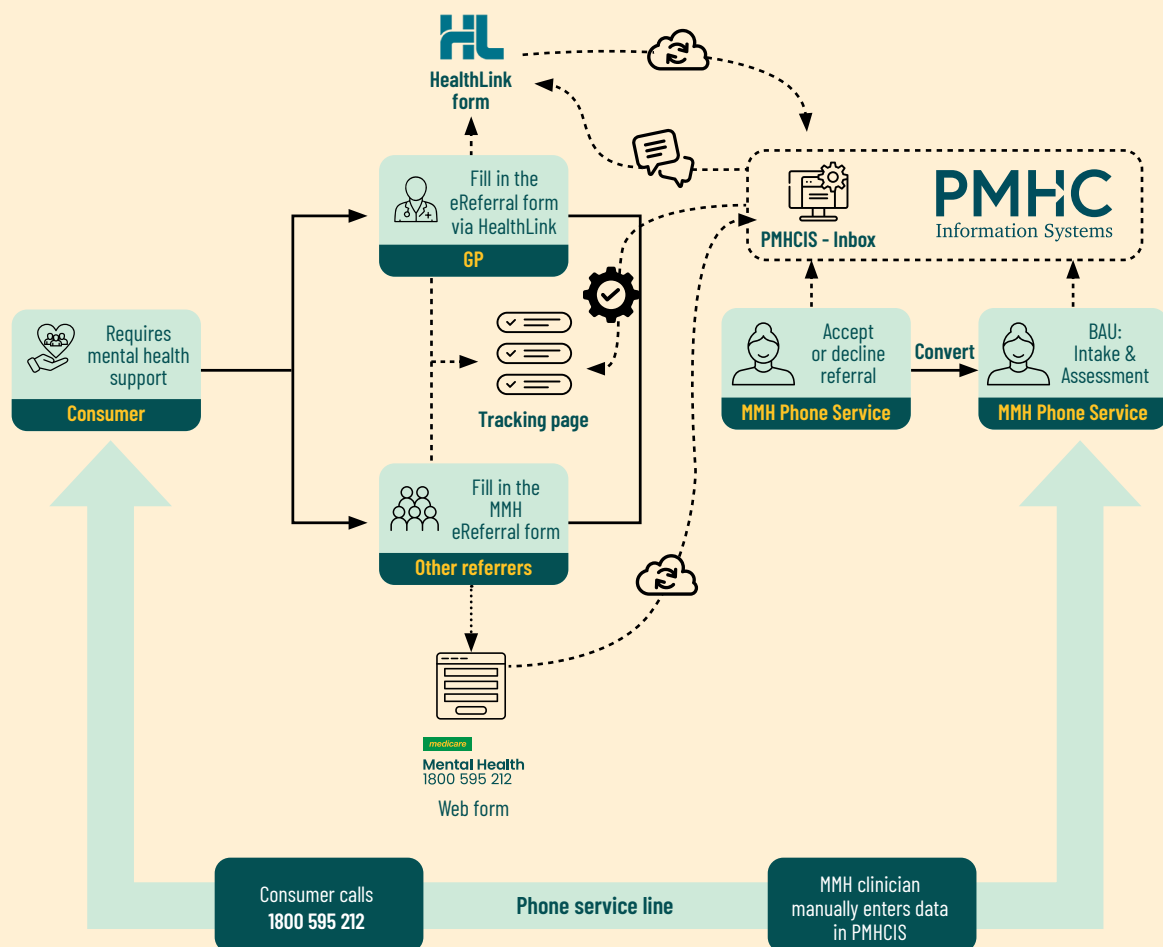
They also revealed positive user sentiment, particularly around automation, referral tracking, and integration into existing workflows. Intake staff reported strong time savings, while GPs valued improved transparency into referral outcomes.

However, the evaluation also highlighted opportunities to improve referral content quality, streamline workflows, and better align GP expectations with intake models.

Lessons from the project included the value of phased implementation, the importance of tailored GP engagement, and the need to balance national consistency with local service context. Collaboration with HealthLink demonstrated that effective vendor engagement, built on flexibility, clear communication and shared timelines, is critical to the success of system-wide digital health initiatives.

Ultimately, the project demonstrated the power of national sector collaboration to address complex health system challenges. It delivered not only immediate value to PHNs, GPs, and mental health services, but has also laid the groundwork for a connected, digitally enabled mental health ecosystem that improves access, drives consistency, and supports better outcomes for consumers across Australia.

eReferral Process



The Primary Mental Health Care Information System (PMHCIS) is a centralised national digital platform developed to streamline the clinical workflow and support mental health intake, assessment, and referral services under the Medicare Mental Health initiative in Australia.

1.

Introduction

1.5 Background and context

On 1 July 2022, the Medicare Mental Health national phone service was launched across all 31 PHNs. It was established to improve community access to mental health support by providing a consistent, streamlined approach to assessment and referral, ensuring individuals are connected with the most appropriate services for their needs.

During the early rollout, it became clear that the existing referral pathways, particularly those involving GPs, were fragmented, inefficient, and heavily reliant on manual processes. Many PHNs identified that fax remained the primary method for submitting referrals into mental health intake services. Faxed referrals required manual re-entry into local systems, creating a significant risk of errors, delays, and data quality issues.

Recognising these shared challenges, a consortium of 11 PHNs came together to develop a high-level project brief that outlined a solution: a modern eReferral system to replace the fax-based process and other non-electronic referral pathways. This proposal was submitted to the Australian Government's Department of Health and Aged Care (now the Department of Health, Disability and Ageing (DHDA)). Approval for the development of a prototype was received in June 2024.

The implementation of the digital referral pathway aimed to:

- enhance the accuracy and timeliness of referral data
- reduce administrative burden and associated costs
- improve the overall efficiency of the referral pathway
- provide the secure transfer of mental health data
- ultimately, support better outcomes for people seeking mental health care.

This report outlines the technical implementation of that vision, detailing the collaborative effort, system design, rollout, and key achievements of the national eReferral prototype project.

1.6 Objectives and desired outcomes

The primary goal of the project was to develop and implement a GP eReferral prototype to streamline referrals into Medicare Mental Health intake services nationwide. The prototype would serve as a proof-of-concept for a scalable, national eReferral solution, addressing long-standing issues with paper-based and faxed referral systems.

The project aimed to demonstrate how digital referrals can improve the efficiency, accuracy, and usability of mental health referral pathways, while enhancing the experience for general practitioners and intake teams.

Objectives

To achieve this goal, the project focused on five objectives.

- **Standardisation:** The development a consensus-built data framework that defined the structure and content of a mental health referral, including a nationally agreed form that captures consistent patient and referrer information.
- **Interoperability:** The design and implementation of a solution that integrated seamlessly with GP software systems via vendor-supported eReferral forms and ensured compatibility with the Primary Mental Health Care Information System (PMHCIS).
- **Efficiency:** The replacement of time-consuming and error-prone manual

processes with an automated referral workflow that improved speed, reduced administrative overhead, and ensured data integrity.

- **Ease of use:** To ensure the eReferral form was intuitive and fitted naturally into existing clinical workflows, minimising disruption for GPs and practice staff.
- **User and consumer experience:** To enhance the experience of referrers and intake clinicians and ultimately improve the journey for consumers accessing mental health support.

Implementation approach

The solution was delivered through two incremental implementation phases:

- Alpha: early-stage, small-scale deployment to test functionality and gather feedback.
- Beta: a broader pilot to validate the solution across multiple PHNs and intake services.

In this set up:

- GPs used a vendor-integrated SmartForm to refer patients directly into the mental health intake service.
- The PMHCIS received and processed the referral automatically via an eReferral inbox function.
- A technical acknowledgement was sent to the GP, along with a tracking link to monitor referral status.

Deliverables

To support these objectives, six outputs were delivered:

- ✓ An eReferral data specification document which captured agreed clinical data requirements.
- ✓ Technical API Specifications for sending, receiving, and processing referrals.
- ✓ A vendor SmartForm implemented via the HealthLink platform.
- ✓ API System Integration between the HealthLink platform and PMHCIS.
- ✓ eReferral Manager Middleware to receive and process referral payloads.
- ✓ Reports to the DHDA and participating PHNs.

Introduction

1.7 Stakeholders involved

The successful delivery of the project relied on strong cross-sector collaboration. As a first step, key stakeholders were assembled to guide the project through all phases, including planning, design, development and implementation. This included forming a dedicated project team within NWMPHN, selecting a capable vendor, and establishing advisory groups with representation from PHNs and other subject matter experts across the country.

NWMPHN project team

The project was driven by a dedicated, multidisciplinary team within NWMPHN. Under the sponsorship of the Executive Director, Insights, Performance and Digital Services, a project leadership team was established, comprising the Technical Development Director and Service Delivery Manager.

The core delivery team included:

- one project officer
- one solution architect
- two full stack developers
- two front-end developers
- one technical business analyst.

This team worked collaboratively, balancing full- and part-time contributions, to ensure delivery against project objectives and timelines. The breadth of expertise required across software development, system integration, and stakeholder engagement highlights the technical complexity and resource intensity of the project.

Vendor partnership

To build the GP-facing eReferral tool, the team engaged a secure messaging vendor. Three were assessed, with key evaluation criteria including:

- usability
- current market adoption
- cost-effectiveness.

HealthLink – part of the international Clanwilliam Group – was selected in August 2024 because of its strong alignment with these priorities. The company was contracted to develop a SmartForm based on agreed technical and clinical specifications.

While HealthLink proved to be a strong partner, technical limitations were encountered. Not all patient details could be pre-populated due to system constraints. Some functional requirements, such as free-text fields under the Initial Assessment and Referral Decision Support Tool (IAR-DST) domains, could not be accommodated and customisation per PHN was technically feasible but would incur substantial costs due to development time.

These constraints informed the scope of the prototype and will help guide decisions in future vendor engagements or system enhancements.

Project Advisory Group (PAG) and Expert Advisory Committee (EAC)

To ensure broad representation and national alignment, a Project Advisory Group (PAG) was established. Invitations were extended to all 29 individual PHNs and alliances, with 28 opting in and nominating a representative. This group played a crucial role in:

- providing subject matter expertise and feedback
- serving as the communication channel to all participating PHNs
- supporting engagement and recruitment for implementation phases.

A sub-group, the Expert Advisory Committee (EAC), was also formed, comprising individuals with specialised knowledge in eReferral implementation and GP mental health referral processes.

From September 2024, the PAG became the central engagement mechanism via monthly virtual meetings, email updates, and collaboration through a dedicated Microsoft Teams space. Though advisory in nature, the PAG was instrumental in identifying PHNs for the alpha and beta implementation phases, based on engagement levels and interest. Phase-specific implementation working groups were also established through the PAG to support local deployment and feedback.

Other stakeholders

The project team maintained regular engagement with broader stakeholders, including:

- Medicare Mental Health Communities of Practice
- DHDA

These interactions ensured alignment with national priorities and facilitated timely updates to key stakeholders.

Additionally, collaboration with the ADHA and CSIRO enabled knowledge-sharing across related initiatives. Engaging with these partners helped situate the project within the broader digital health landscape and informed the team of complementary efforts and potential integration opportunities.

2.

Technical overview

The project delivered a robust, interoperable digital infrastructure for managing mental health referrals from general practice. At its core, the solution consists of multiple integrated components designed to streamline the referral process, improve data accuracy, and enhance the user experience for referrers and intake teams.

2.1 System architecture and components

The system comprises five core technical components:

- **HealthLink SmartForm:** A GP-facing electronic referral form integrated into clinical software. It prepopulates patient information, embeds current version IAR-DST assessments, and securely transmits referrals directly to the PMHCIS. Referrers receive automated status updates via their GP software.
- **External webform:** A web-based version of the SmartForm, designed for GPs without access to HealthLink or for other eligible health professionals. It is accessible via a secure URL and integrates directly into PMHCIS using the same technical infrastructure as the GP-facing SmartForm.
- **eReferral manager:** A back end service with custom Application Programming Interface (APIs) and a database that acts as the integration layer between external referral sources (for example, HealthLink, or the external webform) and the PMHCIS. It can ingest structured data in multiple formats, enabling interoperability with a variety of systems.
- **eReferral inbox:** A new user interface built within the PMHCIS that functions like an email inbox. Intake teams can view, accept, and manage eReferrals, with data automatically populated into the PMHCIS system, eliminating manual data entry.
- **Referral tracking function:** Upon submission, referrers receive a unique URL to track the status of their referral in real time. This feature enhances transparency and closes the feedback loop between referrers and intake services.

2.2 Technical design principles

The eReferral system was built with these technical principles in mind:

- **Interoperability and standards:** The system is designed to integrate smoothly with clinical software, middleware, and intake systems across PHNs. It uses widely adopted healthcare data standards (HL7 and FHIR), and broader industry standards such as RESTful APIs, for compatibility and ease of integration.
- **Security and privacy:** All data transmitted is encrypted and stored securely in line with national digital health privacy standards.
- **Scalability and flexibility:** The modular system design allows for easy expansion, including new referral sources, vendor platforms, or data requirements, without needing to redesign the core system.
- **User-centred design:** Front-end components, including the external webform and the inbox interface, were developed with clinical workflows in mind, ensuring they are intuitive and easy to use for both referrers and intake staff.
- **Reliability and performance:** The backend infrastructure is built using custom APIs and databases developed by NWMPHN's in-house technical team. It is securely hosted to ensure high availability and stable performance across environments.

3.

Key achievements

The project delivered several significant outcomes across technical, operational, and strategic domains. Despite the complexity of the implementation, the solution exceeded expectations in terms of delivery speed, usability, and stakeholder impact.

The following achievements are based on implementation outcomes, stakeholder engagement, and feedback from users, including insights gathered through a survey of participating intake teams and GPs. A detailed summary of survey findings is provided in Section 5.



Timely delivery

Despite the technical complexity, the eReferral system was developed in just four months and successfully released on 7 March 2025. This rapid turnaround, achieved by a small, focused development team, has been widely acknowledged by PHN peers as a rare achievement for a digital health project. One peer described the delivery as "... amazing and almost unheard of for any technical project".



System development and flexibility

The project team successfully developed a sophisticated, interoperable system that integrates with the PMHCIS, thus establishing a robust foundation for future platform integrations. More than a standalone product, the system functions as a flexible service, supporting agility in future digital health solution delivery.



Positive feedback from intake teams

The system demonstrated measurable improvements in usability and efficiency, particularly in reducing manual data entry for intake teams. Feedback from clinicians underscored the value of the solution.

Some examples:

"It's such a great time saver to have the consumer details fly straight in!"

"The content of the e-referral was much better than the content of the referrals we get from GPs on a standard basis."

"I'd say it's really, really positive... definitely putting in a vote of confidence to expand it further."

"I think it's an extraordinary initiative... really accessible - potentially for GPs who don't know how to navigate the mental health system."

While some challenges were noted, the overall sentiment was strongly positive, highlighting the system's practical benefits and potential for expansion.

Key achievements

✓ Capacity-building and technical learning

The project significantly enhanced the project team members' technical capability in delivering digital health projects. Through close collaboration with a secure messaging vendor, the NWMPHN team gained deep insight into:

- vendor engagement best practices
- technical build timelines and complexity
- cost structures and scaling considerations.

This learning has created a stronger foundation for future digital health initiatives.

✓ Additional webform development

Though not a core deliverable, the team leveraged existing capabilities to develop a web-based referral form that can be used outside of standard GP settings.. This was made possible by the technical infrastructure and knowledge gained during the main system build, demonstrating adaptability and value-added delivery beyond original scope.

✓ National PHN collaboration

The project showcased the ability of PHNs to collaborate nationally on the co-design and implementation of shared digital infrastructure. Despite the diversity of local needs, the project successfully delivered a scalable, standardised solution used across multiple PHNs, an important milestone in digital health collaboration.

✓ Demonstrated demand for digital mental health referrals

Over 350 eReferrals were submitted by GPs within the first 2 months of operation which supports the appetite for digital referral pathways in mental health. Additionally:

- 12 PHNs participated in the pilot phases
- other PHNs expressed interest in future adoption.

This demand reflects the relevance and readiness for scalable implementation nationwide.

✓ Strategic alignment and collaboration

The project aligns closely with the ADHA's National Digital Health Strategy 2023–2028, particularly in advancing digital referrals and interoperability in primary care.

Engagement with the ADHA and CSIRO helped ensure strategic alignment, with opportunities for future collaboration on complementary initiatives such as eRequesting and SmartForm-based workflows.

4.

Implementation process

The delivery of the project followed a structured and iterative implementation process over a 12-month timeline. The work was delivered across five key phases: planning, design, technical development, implementation (alpha and beta phases), and national rollout and reporting.

This phased approach enabled progressive delivery, stakeholder engagement, technical iteration, and continuous learning, ensuring that the solution was responsive to clinical needs, technically sound, and scalable.

4.1 Planning (June 2024 – August 2024)

The project commenced with establishing delivery and governance structures. Activities included:

- Establishing the NWMPHN project team
- Convening the Project Advisory Group (PAG)
- Forming the Expert Advisory Committee (EAC) to provide technical subject matter expertise
- Consulting with three vendors and finalising HealthLink as the preferred SmartForm developer.

During this phase, HealthLink's scope of works was refined across six weeks. The EAC and PAG were instrumental in validating early design priorities and implementation risks.

4.2 Design (June 2024 – October 2024)

The design phase focused on defining and validating the national eReferral data specification. Activities included:

- Mapping existing PHN mental health intake forms
- Running consultation cycles through the PAG and EAC to gather clinical, operational, and technical feedback
- Defining form content, logic, and user requirements through meetings, surveys, and stakeholder interviews
- Drafting and refining technical specifications for integration with HealthLink and the PMHCIS.

This collaborative design process led to a nationally agreed referral form and a clear set of technical requirements, forming the blueprint for development.

Implementation process

4.3 Technical development (October 2024 – February 2025)

This four-month period saw the technical build of multiple integrated components that underpin the eReferral service. This included the delivery of the:

- HealthLink SmartForm
- external webform
- eReferral manager
- eReferral inbox
- referral tracking function

Development was led by NWMPHN's internal technical team in close collaboration with HealthLink, supported by regular testing, PAG feedback, and iterative refinement.

4.4 Implementation (January 2025 – June 2025)

Rollout was delivered through a phased approach to support early learning and continuous improvement.

Alpha implementation (January 2025 – March 2025)

The alpha phase marked the first live deployment of the eReferral system. It involved Brisbane South, Nepean Blue Mountains, and North Western Melbourne PHNs and 11 GP clinics. The objective was to test the system in a live environment with a small, supportive user base.

Insights and outcomes:

- Early adoption was slower than expected, with the first referral submitted four weeks after Go Live.
- Adjusting GP engagement strategy from passive expression of interest to proactive outreach significantly improved uptake.
- Weekly cross-PHN meetings enabled shared learning, collaborative problem-solving, and momentum-building.
- Alpha PHNs provided valuable feedback on technical performance and clinical usability, which informed Beta refinements.

Beta implementation (February 2025 – June 2025)

The beta phase expanded participation to an additional nine PHNs, bringing the total to 12, plus 37 GP clinics. Recruitment was facilitated through an EOI process via the PAG.

Enhancements and outcomes:

- Beta phase implementation guidance was refined based on alpha learnings, particularly in GP recruitment and onboarding strategies.
- Weekly drop-in sessions were maintained to support real-time knowledge exchange and PHN collaboration.
- A seven-week delay occurred due to the national rebrand from Head to Health to Medicare Mental Health. All form content and user interfaces were updated accordingly before relaunch.
- Despite the delay, the beta launch (14 May 2025) was smooth and well received, with increasing GP engagement and higher referral volumes.

The PHNs involved in the beta implementation were Adelaide, Brisbane North, Central Eastern Sydney, Eastern Melbourne, Gippsland, Northern Territory, South Western Sydney, Western Sydney, and Western Victoria. Two alpha PHNs – North Western Melbourne and Nepean Blue Mountains – expanded their implementation during beta, and user feedback collected during this period informed the future roadmap.

4.5 National rollout and reporting (July 2025 – September 2025)

The final phase of the project focused on scaling access, evaluating the system, and preparing for wider national adoption. Activities included:

- Dissemination of user feedback surveys and follow-up interviews with intake teams and PHNs.
- Revision of data sharing agreements (DSAs) and service agreements to offer the eReferral system to all PHNs.
- Ongoing support and tailored onboarding for interested PHNs.
- Compilation of key learnings, technical outcomes, and stakeholder feedback into this final report.

By September, two more PHNs – Western New South Wales and South Eastern New South Wales – had included eReferral and webform access in their DSAs, reflecting strong national interest and uptake potential.

4.6 Challenges and solutions

Throughout the delivery of the project, challenges were encountered. These were addressed through agile responses, iterative development, and strong collaboration across internal and external teams.

Challenge	Issue	Solution
1 Vendor scope definition and integration readiness	Finalising the scope of work with the primary vendor (HealthLink) took longer than anticipated, requiring iterative clarification and refinement over a six week period.	The project team maintained close engagement with HealthLink through regular meetings, supported by detailed technical documentation and feedback loops. This collaborative process ensured the final specifications aligned with the project's clinical and technical objectives.
2 Integration of multiple systems with varying data formats	Creating a back end system capable of ingesting data from different systems (SmartForm, webform) and transforming it into the required PMHCIS format.	The development of a custom-built eReferral Manager, including multiple APIs and a new database, enabled flexible data transformation and ensured the system was interoperable and scalable. This allowed consistent ingestion of structured referral data from various sources.
3 Ensuring end-to-end testing between disparate environments	Establishing reliable integration and testing between local testing environment and HealthLink's infrastructure.	The technical team configured a dedicated testing environment and synchronised it with HealthLink's, enabling real-time end-to-end testing. Weekly Q&A sessions and iterative refinement ensured stability and functional integrity prior to live deployment.
4 User interface development within existing systems	Intake staff needed a way to manage referrals without introducing an entirely new platform, requiring seamless UI integration into the existing PMHCIS.	The eReferral inbox was designed and built as an extension of the PMHCIS intake module. The technical team collaborated with front-end developers and intake users to design intuitive workflows and ensure the user experience aligned with clinical processes.

Challenge	Issue	Solution
5 Real-time referral status tracking and communication loop closure	A key user requirement was providing referring GPs with confirmation and ongoing visibility into the status of submitted referrals, something that previously didn't exist.	A referral tracking function was built to generate a secure, real-time tracking URL for each referral. This feature was integrated into the submission process and updated dynamically as referral statuses changed, improving transparency and communication.
6 Branding delay due to national system rebrand	A national rebrand from Head to Health to Medicare Mental Health occurred during the beta phase, requiring updates to all technical and visual components of the eReferral form.	The project team submitted a formal change request to HealthLink, resulting in a coordinated seven week update and re-release of the form. Although it delayed rollout, the update ensured brand alignment and usability for future national adoption.
7 Broadening accessibility beyond GP software	The initial SmartForm was limited to GPs with access to HealthLink's platform, excluding other potential referrers.	Leveraging the same technical infrastructure, the team built a web-based external referral form. This provided broader access to clinicians and services outside the HealthLink ecosystem and demonstrated the adaptability of the core platform.

5.

How do the SmartForm and webform work in practice?

eReferral in action via HealthLink SmartForm



Dr Ngyuen, a GP at a clinic in Melbourne's outer-east, sees a patient, Jim, who reports poor sleep, suppressed appetite and frequent bouts of anxiety.

The GP suggests making a referral to the Medicare Mental Health phone service so that Jim can receive appropriate mental health support. Jim agrees.

Dr Ngyuen's clinic uses Best Practice management software. In it, he opens the HealthLink SmartForm which is linked to Jim's file. The SmartForm automatically prepopulates the form with basic information from the patient record.

Dr Ngyuen adds his clinical notes and conducts an IAR-DST assessment within the SmartForm. Working with Jim, he creates a GP Mental Health Treatment Plan, which he also attaches.

He then presses the tile marked

Submit

Immediately the practice management software receives notification that the material has been received by the intake team, along with a link to a tracking page.

Moments later, Jane, a member of the Medicare Mental Health intake team, sees that the referral has arrived in the PMHCIS eReferral inbox.

She opens it, reads it and accepts it into the PMHCIS intake system for assessment. She does not have to enter any data manually.

Within a short period of time, Jim's referral is assigned to, and accepted by, a mental health service provider with a skillset appropriate to his needs. The service provider contacts Jim, and Dr Ngyuen's tracking page automatically updates to record the development.

How do the SmartForm and webform work in practice?



eReferral in action via webform

Dr Minh is a GP in a solo practice based in a village in the Blue Mountains. One of her regular patients, Ben, attends and discloses that he is having persistent intrusive thoughts about self-harm. This is not the first time Ben has encountered mental ill health, and a Mental Health Treatment Plan is already in effect.

The GP determines first that Ben is not at immediate risk so she does not need to call triple zero. She then tells him that she wants to refer him to the Medicare Mental Health phone service for assessment and support.

Dr Minh does not use a clinical software program that supports the HealthLink SmartForm. Instead she has bookmarked NBMPHN's secure referral webform. She clicks on the link, and records Ben's consent to proceed.

Once she has it on her screen, she:

- Completes the referral, including detailed clinical notes and an embedded IAR-DST report.
- Uploads Ben's Mental Health Treatment Plan.
- Saves a referrer profile to auto-fill future referrals.

After submitting the form she receives confirmation and a secure tracking link. She saves the link and a copy of the completed referral in the patient's file.

The Medicare Mental Health Phone Service Team receives a notification that the referral has arrived in the PMHCIS eReferral inbox.

The referral is opened and all its information is automatically entered into the system. The team member assesses Bens situation and links him into a mental health service provider who is based not far from his home.

Dr Minh receives an update on her tracking page, noting that her patient has been allocated the support he needs.

6.

Impact and benefits

The eReferral system was developed to address key challenges in the mental health referral process by delivering a solution that is efficient, user-friendly, clinically appropriate, and interoperable. To assess how well the project met these objectives, a mixed-methods approach was used, combining quantitative and qualitative data collection.

Quantitative surveys

- *Intake survey* – targeted at Medicare Mental Health or PHN mental health leads and intake teams. A total of 38 responses were received from all participating PHNs.
- *GP survey* – sent to participating general practitioners and practice managers: 14 GPs and 10 practice managers responded.

Qualitative interviews

- To gain deeper insights, semi-structured interviews were conducted with eight intake or PHN mental health leads.



84%

of Intake Teams
say eReferral
reduced manual
data entry

6.1 Feedback

The results revealed a mixed but insightful picture of system performance and user experience. The technical implementation was considered a success, with strong evidence of efficiency gains and ease of use. The main challenges related to the content of the referral form and how the system aligned with local workflows and programs.

System success and user satisfaction

Overall, efficiency gains for GPs and intake teams were achieved, with both groups reporting the system is easy to use and reduces manual tasks. This was more positive with intake team members, 84 per cent of whom agreed that the eReferral reduced manual data entry. One intake lead described the system as

“Brilliant. Love it. That’s a great time saver...”

GPs were also generally positive, though to a slightly lesser extent, with 62.5 per cent agreeing the eReferral was easy to use. The highest-rated feature was the automated referral updates, which were found useful by 100 per cent of GPs who used them, highlighting the strong support for closing the feedback loop. Comments included:

“...the referral was pretty easy to use.”

“When we receive a referral that the GP has done well ... then this process is super-fast.”

Opportunities for improvement: referral form content

Intake teams reported that many GP referrals lacked sufficient detail for clinical assessment or required consumers to repeat their stories. As one intake team member shared,

“The lack of clarity in referrals makes it difficult to identify the appropriate service.”

Just over half of the intake respondents agreed it was appropriate for GPs to complete an IAR-DST assessment, but many highlighted that the absence of domain-level notes limited its usefulness.

On the GP side, fewer than half agreed the form included the right type and amount of information. Only 22 per cent reported using the IAR-DST, citing time constraints as the most common reason for non-use. Some GPs expressed strong criticism of the IAR-DST tool, such as,

“It’s a waste of time and doesn’t change the referral outcome.”

However, others expressed a strong interest in receiving more detailed referral updates.

“It would also be helpful if I was updated regarding the plan for the patient,”

“what services had been allocated, and how often they were being seen, and if the patient engaged with the service.”

This highlights a key tension: intake teams want more detailed information to support triage and allocation, while GPs face significant time pressures. Addressing this will require balancing information requirements with usability, likely through targeted refinement of the referral form.

“It’s still too long and cumbersome to complete the application,”

“There also appear to be numerous unnecessary questions.”

**only
22%**

of GPs used
the IAR-DST

Local context matters: intake team perspectives

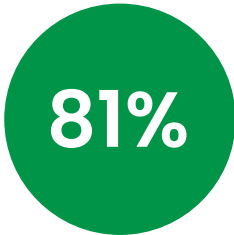
Feedback from intake teams revealed that local service delivery context significantly influenced their experience with the eReferral system and its integration into existing workflows. Notably, those that operated externally as dedicated MMH intake services, where the team functioned as the primary mental health assessment and triage point for PHNs, generally reported more positive experiences.

These appreciated the eReferral role in streamlining data collection and referral management, because the tool complemented their established workflow of conducting comprehensive assessments before allocating services. For these teams, the eReferral effectively reduced administrative burden and supported timely clinical decision-making.

In contrast, internal PHN intake teams using the system as part of broader stepped-care mental health programs faced greater challenges. These teams often had more complex workflows and expectations around completeness and clinical detail. Because they relied more heavily on the information provided by GPs in the referral to directly allocate clients to specific PHN programs or services, they found the content sometimes insufficient to meet their needs. This led to workflow friction, increased need for follow-up contacts with referrers or consumers, and, at times, frustration when referrals lacked the depth of clinical detail or clarity required for timely allocation.

Additionally, the mixed perceptions around inclusion of the IAR-DST and Mental Health Treatment Plans alongside the eReferral reflected these differing operational models. External intake teams, with dedicated assessment processes, were generally more accepting of the IAR-DST as a useful screening tool, while internal teams felt that without detailed domain-level notes, the IAR-DST added limited value and sometimes contributed to duplication of assessment efforts.

This divergence highlights the importance of considering local intake service models and workflows when designing and refining referral systems. Tailoring the eReferral to better accommodate varying clinical pathways and information needs will be critical to maximising system benefits across diverse PHN settings.



81%

say review and
conversion of an
eReferral to PMHCIS
is quick to do

6.2 Outcomes

Overall the project has delivered on its primary objectives achieving the outcomes as described in the table below.

Objective	Outcomes
Standardisation	A consistent national form was implemented and adopted across 14 PHNs. This achievement ensures a strong foundation for future enhancements to better align with local needs.
Interoperability	The system successfully integrates with GP software via HealthLink and the PMHCIS through the eReferral Manager. The webform provides additional access for non-HealthLink users.
Efficiency	There is strong evidence that the eReferral system significantly reduces manual data entry and saves time for intake teams. GPs also experienced administrative efficiency and the automated data entry through the SmartForm improved accuracy of referrals.
Ease of use	Intake teams rated usability highly; GPs found it generally easy to use, though a more streamlined form with less questions may improve adoption further.
User and consumer experience	The tracking function with real time status updates as its closes the communication loop for clinicians. However, limited GP use of the IAR-DST and gaps in referral detail presented challenges for the intake teams.

7.

Lessons learned

Throughout the project, valuable insights have been gained that have informed both the current implementation and future digital health initiatives. These lessons reflect practical experiences related to technology, user engagement, vendor collaboration, and balancing national and local needs. Understanding these factors is crucial for ongoing improvement and successful adoption across diverse healthcare settings.

Staged rollout

The iterative, phased rollout enabled early issue identification and resolution with minimal disruption. Small user groups allowed for easy feedback collection and swift fixes such as inbox bugs and missing UI elements. Agile adaptations, including refining GP engagement strategies, improved subsequent rollout phases.

Quality vs quantity of referral information

GPs and intake teams highlighted that referral issues were more about the quality of information than volume. Clearer, clinically relevant data is crucial to support intake assessments and reduce consumer repetition.

Low GP awareness of Medicare Mental Health services

Some GPs showed limited understanding of Medicare Mental Health intake services, leading to unmet expectations and low adoption. Comments in the survey such as “Be clear about what services can be provided” and “... I’ve referred patients to specifically see a clinical psychologist, and they have been provided with phone calls from a ‘mental health worker’ or a counsellor,” highlight this gap. Clear, targeted communication about services, referral pathways, and IAR-DST roles is essential.

GP engagement remains challenging

Engaging GPs proved difficult across PHNs. Direct clinic outreach and proactive engagement outperformed passive approaches. Face-to-face training was cited as helpful. Tailored, sustained local efforts are necessary to drive adoption and build trust.

Impact of referral tracking on GP behaviour

Providing GPs with real-time referral status updates improved clinical decision-making and referral practices. One GP shared:

“At least now I know quickly if the patient has been rejected or accepted and... can plan for next steps. Previously, with no idea of outcome, it is clinically risky...it was better to refer a patient privately and they would have to save up or miss out on psychologist access.”

This transparency builds trust and changes referral behaviour.

Balancing national standardisation with local needs

Implementing a single national form across diverse PHN contexts exposed tensions between standardisation and local program requirements. Differences in intake processes and GP interactions require flexible implementation approaches.

Vendor collaboration and process adaptation

Delivering a standardised national eReferral form in partnership with an established vendor emphasised the need for flexibility and collaboration. The project team worked within HealthLink's technical framework, which supported a stable and consistent platform while accommodating essential functionality.

Certain customisations, such as detailed notes within the IAR-DST and manual data entry for specific fields (such as healthcare card status), were limited due to the design of HealthLink SmartForm system and the need to maintain interoperability. While some PHNs requested tailored customisations, these options had to be carefully balanced with considerations of cost and system sustainability.

The experience highlighted the importance of defining clear requirements, aligning project schedules with vendor processes, and maintaining open communication to effectively manage expectations and deliver timely updates.

8.

Next steps

As the project enters its broader national rollout phase, continued collaboration between PHNs, HealthLink and other stakeholders remains critical to ensuring the system evolves to meet diverse clinical and operational needs.

Next steps include:

- **Ongoing form refinement:** Continued enhancement of the eReferral form based on user feedback from GPs, intake teams, and PHNs, including improving content quality and usability.
- **Vendor collaboration and expansion:** NWMPHN will continue working with HealthLink to refine the current form and support national onboarding. Opportunities to engage with additional vendors will also be explored to ensure broader reach and interoperability across different clinical systems.
- **Customisation pathways:** Exploration of options for limited customisability of form elements to better accommodate local program requirements, while maintaining alignment with national standards.
- **Form specification updates:** Periodic updates to the technical specification, ensuring it remains clinically relevant, standards-compliant, and aligned with evolving national priorities, including digital health maturity and mental health reform.

- **Implementation support for PHNs:** NWMPHN will provide support to PHNs as they onboard to the eReferral system, offering guidance, training resources, and access to shared learnings from earlier phases.

- **Long-term integration planning:** Investigating opportunities to further integrate the mental health eReferral framework into broader digital health ecosystems, including national infrastructure.

This next phase builds on the project's foundation of collaborative design and shared implementation. It reinforces the goal of creating a sustainable, scalable digital referral system that improves mental health access and coordination across all regions of Australia.

9.

Conclusion



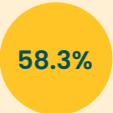
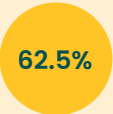
The National Mental Health eReferral Prototype Project has delivered a major step forward in digitally enabling Australia's mental health system. By creating a nationally scalable, interoperable eReferral solution, it has addressed critical inefficiencies in the mental health intake process and laid the groundwork for more streamlined, transparent, and accessible referral pathways.

This achievement was made possible through deep collaboration between PHNs, vendors and national stakeholders, supported by agile development and strong governance. The system's successful design and phased implementation demonstrate the value of co-design and sector-wide alignment in solving complex digital health challenges.

The project identified areas for further improvement, including referral content quality, GP engagement, and local workflow integration. It also established a clear and adaptable foundation for ongoing development. The insights, infrastructure, and relationships built through this project position the system for national scale-up, multi-vendor integration, and future innovation.

Ultimately, the project not only delivered on its core objectives but also proved the power of digital transformation when driven by collaboration, guided by clinical need, and grounded in practical implementation. It offers a replicable model for future initiatives aimed at improving access, coordination, and outcomes across the Australian mental health system.

Appendix A – Quantitative Survey Results

Objective	Intake Teams	GPs
Reduced manual tasks	 84% say eReferral reduced manual data entry	 58.3% say there are fewer manual tasks than previous methods
Ease of use	 72-75% say the system is easy and intuitive (respectively)	 62.5% say the eReferral is easy to use
Improved visibility of referral status		 66% GPs used status messages  100% say they were very or somewhat useful
Quicker than previous methods	 81% say review and conversion of an eReferral to PMHCIS is quick to do  Only 47% agree it takes overall less time. Mixed views due to insufficient GP information causing additional work.	 50% slightly or strongly agree that overall, the eReferral process makes it easier and quicker for GPs
Appropriate referral content	 53% say minimum GP information is sufficient  59% agree that GP completion of IAR-DST is appropriate. Many say the lack of contextual information is a limitation.	 41.7-45.8% agree the form has the right type and amount of information (respectively)  Only 22% used the IAR-DST





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