CLINICAL CODERS' SOCIETY OF AUSTRALIA INC

Key Challenges facing Clinical Coders

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There are a number of current and future challenges that Clinical Coders are facing:

- Telecommuting
- Recruitment
- Potential of offshore workforce
- Contract Clinical Coding (Australia) workforce
- Ongoing assessment of Clinical Coders in the workplace
- Rural and remote workforce
- Contract (Australia) auditing
- Auditing of Clinical Coders without feedback provided to the individual
- Traineeships
- Qualification bias
- Technology
- Role design and future re-design
- Health classifications and terminologies
- Timing and currency of national coding advice
- Education
- Workforce and work environment.

Telecommuting

The COVID-19 pandemic has accelerated many organisations ability to allow Clinical Coders to telecommute, i.e. work from home. This initiative facilitates local workforce work/life balance and is seen as an incentive for those organisations that offer this workplace arrangement. The expectations and proportion of telecommuting has changed significantly during and post pandemic. Telecommuting capacity has also been of benefit for Clinical Coders and health organisations where flexibility has been needed for carer leave, sick leave due to pending reporting of COVID-19 test results, school closures or teacher strikes.

It is the differences between workplaces that impact the profession and individuals which Clinical Coders should be aware of, such as:

- Not all workplaces allow or can support telecommuting (paper clinical records).
- Differences in expectations organisations have for Clinical Coders to return to the workplace after fulltime telecommuting during the pandemic.
- There are differences in the "amount" of telecommuting that organisations offer. For example, maximum 3 days a week for a fulltime position, or 100% telecommuting.
- Inequity in access to technology provided by the employing organisation to enable Clinical Coders to work from home – some organisations provide laptops and screens whereas others don't.

- Telecommuting can reduce networking and sharing of information between Clinical Coders. This can have a particular impact if the Clinical Coding team is spread nationally. State localisation in regard to data can be critical. It can be difficult to share this information if Clinical Coders do not have regular face-to-face interactions. Working remotely can be extra challenging for new staff who would normally benefit and learn about the organisation from working alongside staff that know the workplace, workplace routine and organisational processes.
- For some individuals, telecommuting can be very isolating. Some people (any profession) thrive in environments where there is regular face-to-face interaction.
- Reduced ability to train/share information with novice/trainee Clinical Coders. If all the senior Clinical Coding team telecommute, this can impact support and knowledge transfer to junior Clinical Coders.
- Some Clinical Coders have limited information technology (IT) knowledge and problem-solving skills. This means that when they then experience IT issues this can result in frustration and downtime/lost productivity in order to work out these issues.

We recognise that workforce access to quality and consistent National Broadband Network (NBN) and utilities such as electricity has been challenging for many in recent times due to flood, fire and cost of living. Pandemic measures such as lockdowns and home schooling have also impacted work related access of NBN and technology for telecommuting due to competing family requirements.

Recruitment

The recruitment of Clinical Coders is being impacted by a number of issues identified by Clinical Coders. These issues have the potential to reduce capacity to fill positions and will impact future workplace planning and limit career progression.

These issues include:

- Inconsistency in coding tests requirement to be completed during the recruitment process. Some organisations require applicants to undertake a coding exam (which may be different between facilities) whereas others don't.
- Restricted recruitment opportunities where eligibility to apply for vacant positions is limited to current jurisdictional employees. This reduces the available pool of qualified skilled applicants and reduces skill development across health sectors.
- Number of positions being offered as temporary versus permanent. Where positions are temporary, this limits the capacity for Clinical Coders to apply as their origination workplace may not release the Clinical Coder for temporary positions and learning opportunities.

Potential of offshore Clinical Coding

Offshore clinical coding is a reality that other countries have already had to face. Organisations may decide to access this service due to lack of workforce, financial reasons and other factors. Clinical Coders have concern about the privacy of this information being viewed from an offshore location and what mechanisms are in place for investigation and/or prosecution.

The impact and factors of utilising an offshore workforce can include:

- Reduced use of local workforce.
- Security and access compliance in regard to information required to perform role in a non-Australian environment.

- Differences in understanding of local coding requirements.
- Reduced access to seek clinical clarification in regard to queries.
- Technology and infrastructure requirements.
- Need for strong and robust data quality assurance processes.
- Lack of management control.
- Knowledge, application and ongoing education of the Australian implementation and requirements for ICD-10-AM/ACHI classifications.
- Although the ICD-10-AM classification is used in many countries other than Australia, not all editions are necessarily regularly implemented, and thus offshore Clinical Coder may not always have updated knowledge and skills in current edition.

Contract Clinical Coding (Australia) workforce

Due to workforce shortages of experienced Clinical Coders (also see Traineeships), some organisations have starting utilising a contract workforce which may or may not be located locally.

There is also the situation of where contract staff do not have the appropriate skills to code the casemix complexity relevant to the contracting organisation. This deficit may not be known or identified until after the work has been completed and auditing of the data identifies issues.

There are some downstream impacts of this similar to offshore clinical coding, such as:

- Reduced use of local workforce.
- Differences in understanding of local coding requirements.
- Reduced access to clinical staff to seek documentation clarification in regard to queries.
- Often the contact Clinical Coders don't code extended length of stay admitted episodes of care – these are left for the facility staff to code.
- If the contracted staff are used infrequently, the fixing of errors or provision of audit feedback is difficult.

Ongoing assessment of Clinical Coders in the workplace

Assessments of Clinical Coding knowledge to assist in identify training and education needs has always been a part of the profession. It is a key component of staff development and improvements – when undertaken with clear intent, feedback and follow up action.

Anecdotal feedback from Clinical Coders has identified that some organisations have started requiring Clinical Coders to undergo 8-hour examinations without a clear indication of what the intent of the assessment is.

Assessment of Clinical Coders in such a way does not allow for learning and development of knowledge and skills as an individual or a group. It does in effect have a reverse effect and has the potential to foster a negative working environment.

Rural and remote workforce

Clinical Coders who work in rural and remote locations face not only all the challenges included in this paper but also others unique to their environment. Typically operating on a solo basis and often for multiple facilities spread over a large distance, specific challenges for this dedicated group of Clinical Coders include extremely limited access to any form of face-to-face education or day to day

support, quality auditing and professional development opportunities. Most rural and remove facilities do not have electronic records, so physically travelling long distances to these facilities presents additional considerations/risks such as vehicle access/use, travel time (and overnight stays at the rural and remote location) and contact with road hazards (native and agricultural animals).

Contract (Australia) auditing

The use of contract Clinical Coding Auditors is increasing in the Australian health sector, as previously mentioned, partly due to lack of workforce, finance and other factors. It is becoming increasingly recognised that for contracted auditing services there is a difference between collaborating with external experts for organisation gain (financial, knowledge and skills) and filling vacant positions (short term gap stopping).

The challenges that the use of a contract auditing workforce presents includes:

- Contract auditors not having knowledge of local coding protocols and requirements – and even jurisdiction requirements at times.
- Auditing utilising coding requirements from facilities/jurisdictions other than the facility being audited.
- Often as the contract coders are not on site with the Clinical Coders but telecommuting, there is minimal opportunity for knowledge sharing and clarification.
- Reduced opportunities for local Clinical Coders to develop skills and knowledge in auditing.
- Some contract auditing services are used for uplift auditing only – not to assist in data quality and/or accuracy or identify education opportunities for Clinical Coders.
- Lack of quality focused auditing – typically contract auditing has other objectives.

Auditing of Clinical Coders without feedback provided to the individual

As with assessment of staff, auditing of Clinical Coding staff is a key component in education and self-development. But this can only occur when the results of any audits undertaken are fed back to the Clinical Coding team – both individually and as a group.

Feedback such as from auditing allows for Clinical Coders to celebrate good practice, learn of areas for improvement, seek education and overall improve data quality.

To only audit for financial gain, without feedback to Clinical Coders is organisationally self-limiting as it will not allow the organisation to learn, improve and prevent any mistakes being repeated.

Traineeships

While there are some organisations that have realised the importance and value of offering traineeship positions for recently qualified Clinical Coders, there is still a significant short fall in the number of available traineeship positions.

It can often take someone who has recently completed the Clinical Coding course a number of years to find a trainee position or an organisation that provides mentoring. The majority of advertised Clinical Coding positions require experience.

This deficit in succession planning not only applies to traineeships but also for the coding workforce in general. Lack of support for and provision of training of Clinical Coders to progress to team leader and manager roles is another area of concern.

Recent feedback from Members has identified that some Clinical Coders who completed the Certificate IV in Clinical Classification qualification have moved away from Clinical Coding due lack of available trainee/mentored positions. Others have advised that they have been told by prospective employers that they need greater than 2 years' experience in order to apply and secure a clinical coding position. It has been noted that trainee positions are not often advertised and are rarely offered as part-time positions.

Managing the expectations of those undertaking Clinical Coding qualifications is an area where there needs to be improvement. Those that undertake the Clinical Coding qualification expect that they will be able to obtain a position on completion of their qualification and get a return on the financial investment they have made by undertaking the training. This is not always the case.

There would also be benefit in the development of a standardised tool to assist in ensuring a trainee is the right fit for an organisation's trainee program and/or the organisation. There can be expectations and/or workplace requirements for and of the trainee that it would be beneficial to identify prior to commencing a program.

With the national qualification moving to a Diploma of Clinical Coding, the impact and/or need for trainee positions is not yet known. It will be approximately two years before this can be assessed. The two-year course timeframe will also impact the pool of potential trainees available. This has been raised as a concern going forward.

Some organisations have previously employed trainees while simultaneously training the trainee as they undertake the introductory coding course. Whether this will still be able to be offered in light of the qualification change is to be confirmed.

There is also a growing understanding that 'trainee' positions need to include more than only newly qualified Clinical Coders. Trainee/mentored positions also need to encompass auditing, data reporting and Clinical Documentation Specialist roles as these current positions are also play a key part in the process of clinical coding.

Without a serious commitment to providing traineeships positions (of all types) that are supported by a mentor, Clinical Coding will continue to face a growing workforce crisis and increase the use of and reliance on contract and overseas coding.

Qualification bias

All Clinical Coders are required to successfully complete the national qualification via a Registered Training Organisation (RTO). The attempt to bias qualifications based on a specific organisation is not only unfair and immoral, but also workforce limiting.

The national qualification for Clinical Coding has recently moved from Certificate IV in Clinical Classification to a Diploma in Clinical Coding. There is some concern in the industry that the increased cost to undertake this qualification may impact the number of people undertaking this qualification.

There is also an increasing concern amongst Clinical Coders that Health Information Managers are moving into the space of Clinical Coders. Though Health Information Managers have a university qualification, they may not have the practical and applied expertise to function in a clinical coding role.

Clinical Coders need to be recognised as professionals in their own right.

Technology

The range and amount of technology impacting Clinical Coding is increasing and becoming more complex.

Clinical Coders now need to be able to use a range of different applications, often many are required to code a single episode of care, such as electronic medical record, pathology system, operating room application.

But it is also how technology is currently, and will be, used in the future and this impact on clinical coding that needs to be considered. Technologies such as computer assisted coding, the development of classifications that are information technology dependent and artificial intelligence will change the way Clinical Coding is done in the future. The Clinical Coding workforce needs to be ready for this (also see Role design and future re-design). Some Clinical Coders are concerned that in the future the role of clinical coding will be reduced to that of a data validator or data entry clerk.

Role design and future re-design

The role of a Clinical Coder has changed over time and will continue to do so. While many facilities still have paper medical records, the days of Clinical Coder coding from paper medical records using paper classification books for most is a thing of the past.

In light of all the challenges listed above, the Clinical Coding workforce of the future is going to look very different to what it does now. As a profession, there needs to be a national conversation and work done to look at re-designing the role of Clinical Coder so that it is sustainable and continues to be recognised as required.

Clinical Coders have a vast array of knowledge and skills. They play an important part in many organisations – many of which are not hospitals. Analysis of key role responsibilities and future needs is urgently required.

Health classifications and terminologies

The increasing complexity of current health classifications (ICD-10-AM/ACHI/ACS), pending implementation of new health classifications (e.g. ICD-11) and the increasing integration of health terminologies (e.g. SNOMED-CT) into electronic health records is changing the landscape that Clinical Coders work and interact with.

Mapping between health classifications and terminologies, development of applications (app's) to assist clinicians to select the "correct" term and increasing use of technology is and will continue to impact Clinical Coders to a degree not seen before in this profession. It is essential for Clinical Coders

to be part of the conversation about the current and possible future uses and applications of classifications and terminologies (also see Role design and future re-design) as coding related roles will be essential for real time data analysis.

Timing and currency of national coding advice

With the recent pandemic, the release and currency of national coding advice has been highlighted. National coding advice can increase coder burden relating to coding volume, auditing and education needs. Clinical Coders realise that the past two years have been a unique situation but there is a belief that more active contact with the Clinical Coders on the front line would assist in identifying data and knowledge gaps, concerns and emerging issues that need to be addressed. There is also a belief amongst Clinical Coders that it would also assist the system managers to have an increased and real-time understanding of the impact of national coding advice and code changes to data for reporting and analysis.

The number, frequency and impact of related national coding changes has led in some situations to 'dummy' coding in order to meet timelines. This will impact the accuracy of data and resource analysis.

Education

There is a growing dependence on the 'outsourcing' of education for Clinical Coders. With there being a number of organisations offering education material for Clinical Coders at a cost. Not all organisations purchase access to this education for all Clinical Coding staff to attend, so there can be differences in who can access what education. There is also no oversight of the education being provided at a national level, so there is the potential for differences in education content and quality.

While Clinical Coders appreciate access to any and all education, they have also noted a:

- Lack of dedicated education positions to support the current Clinical Coding workforce.
- Lack of the provision/opportunities for education during work hours with there being expectation that mandatory education is done in a Clinical Coders own time.

Workforce and work environment

The workload and expectations being required of Clinical Coders continues to increase.

Along with an increased importance on clinical knowledge, there is an increasing requirement for knowledge relating to funding, safety and quality influencers such as Activity Based Funding/Management and Hospital Acquired Complications.

Clinical coding workplaces are experiencing issues such as:

- Coding quantity versus quality – and often quality is the greater pressure point.
- Quotas and/or key performance indicators – both financial, caseload and throughput.
- Requirement for optimisation of financial outcome.
- Reporting and investigation of Hospital Acquired Complications.
- Increasing pressure placed on Clinical Coders to meet reporting timelines for those using the coded data, for example requirement for rapid turnaround of coding to meet deadline for Activity Based Funding/Management analysis for a particular clinical specialty.

- Fear of losing jobs to Health Information Managers, artificial intelligence and/or offshore Clinical Coders. Often Clinical Coders feel that they can't speak up about their concerns due to job insecurity.
- Fairness remuneration compared to administration roles – there needs to be recognition that Clinical Coders have a unique skillset.
- Equity of pay rates between jurisdictions, health organisations, public and private sectors.
- Unclear career progression provisions based on years of service or skill level within jurisdictional industrial awards/enterprise bargaining agreements.
- Presence of ad hoc arrangements at the health district level in some jurisdictions which can lead to non-meritorious position appointments.
- Differences in management styles – micromanagement is still an issue that is often raised.
- Concern that the role of Clinical Documentation Improvement Specialists are only for those with a Health Information Manager or Nursing background and not Clinical Coders.
- Erosion of tasks that were once part of a Clinical Coders role, for example the use of clinical staff to submit queries to clinicians and Clinical Documentation Improvement Specialist undertaking coding audits.
- Position Descriptions not fully accounting for the increased complexity of the coding job.
- With the increasing public/private shared care model for delivery of health care (especially during the COVID-19 pandemic), this is impacting Clinical Coders. Along with the challenges of adapting to and managing patient administration and medical record systems external to their own organisation, some Clinical Coders have had to rapidly upskill as a result of expanded/more complex case mix in a short space of time.
- Need for representation of Clinical Coders as a cohesive profession at a jurisdictional and national level. Clinical coding is a highly specialised and skilled profession. Currently, clinical coding is included in administrative work streams of staff but would best be its own work stream.

These issues and others are impacting Clinical Coder day-to-day workloads, work/life balance and mental health.

With an increasingly aging workforce, all of the above issues identified are influencing Clinical Coder workforce planning – some positively and others negatively for both the short and long term. An example of this is how telecommuting is assisting to keep some experienced staff in the current workforce longer (flexibility, able to employ staff from wider geographical locations without relocation costs) but the impact of challenges for trainee positions may result in workforce shortages in the future.