

Clinical Coding Capability Framework

Developed on behalf of the Victorian Department of Health

June, 2013

Table of Contents

Table of Abbreviations	3
Background and context	4
How will the Capability Framework be used?	5
What are capabilities?	6
How was the framework developed?.....	7
Background	7
Work and competence.....	7
Competency gaps.....	8
Training issues.....	9
The Capability Framework	10

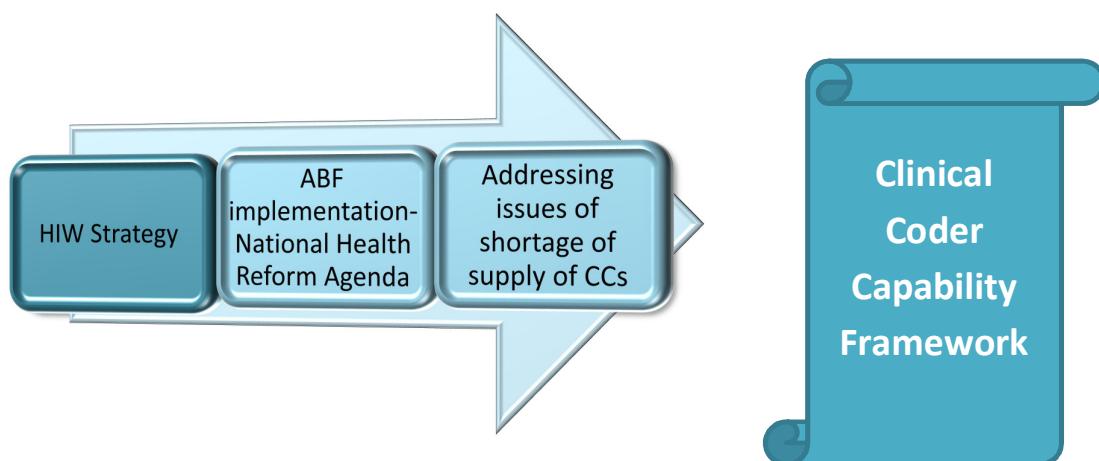
Table of Abbreviations

ABF	Activity Based Funding
CC	Clinical Coders
DACUM	Develop a Curriculum
DH	Department of Health
HCA	Human Capital Alliance
HIM	Health Information Managers
HIW	Health Information Workforce
PH	Pavilion Health
PICQ	Performance Indicators for Coding Quality
TAFE	Technical And Further Education
VET	vocational education and training

Background and context

A consortium led by Central Gippsland TAFE (GippsTAFE) and including Human Capital Alliance (HCA) and Pavilion Health (PH) was engaged by the Victorian Department of Health (DH) to develop a ***clinical coder Capability Framework***. The project commenced in late January 2013, with the project completion date scheduled for mid-August 2013.

The development of a Clinical Coding Capability Framework is a key objective of the overall Health Information Workforce (HIW) Strategy project initiated by DH to address the current and future shortage of HIW in Victoria. The implementation of Activity Based Funding (ABF), as part of the 2011 National Health Reform Agreement, makes it imperative for Victoria to address its current HIW shortage and in particular the supply of clinical coders (CCs) required for the timely and accurate classification of hospital activity. The place of the Capability Framework within the broader strategic initiatives is summarised in the following diagram.



This project's aim is to improve the education of *entry level coders* so that they are work ready competent coders who are employable by health services without the need for extensive supervision.

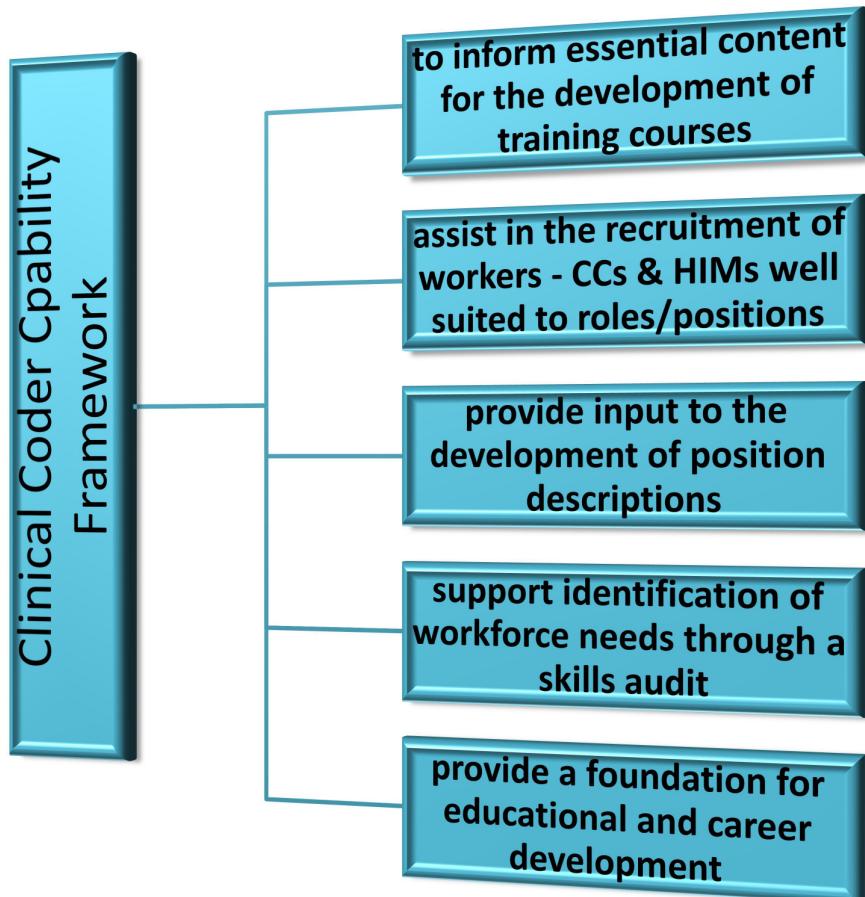
This Framework has been developed to meet industry requirements- informed by the active engagement of relevant stakeholders and organisations.

How will the Capability Framework be used?

The Framework has been designed principally to direct future education and training of the clinical coding workforce, both in terms of content and likely modes of training delivery. In its current form it can serve this purpose immediately given many hospitals in Victoria are already delivering clinical coder training interventions.

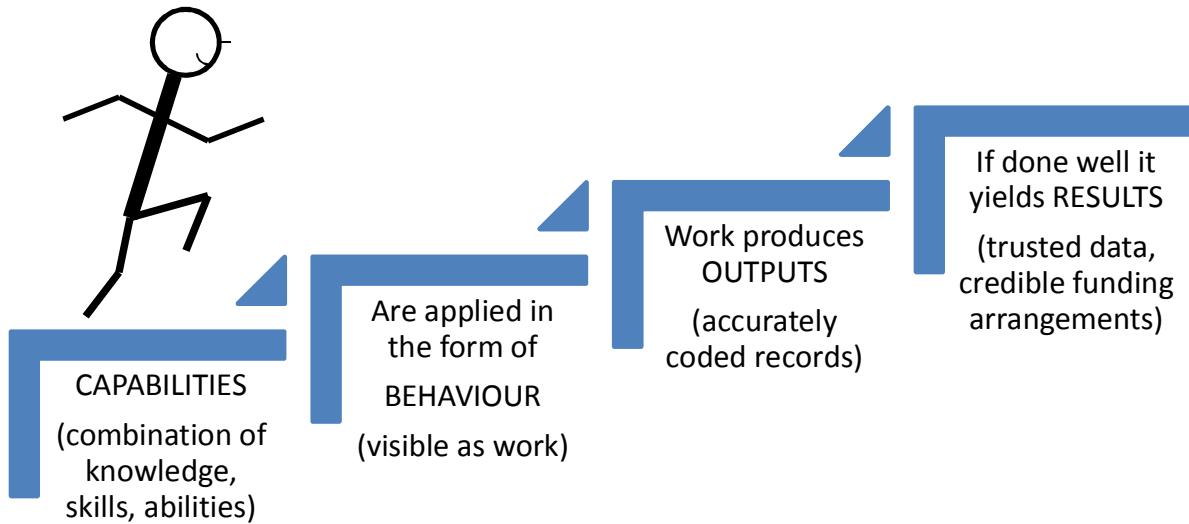
It is not suitable in its current form to support a course which would lead to a formal qualification. It can though strongly inform the basis upon which such courses are designed and validated, being a strong representation of Victoria's needs for clinical coding skill, knowledge and attitudes.

The Framework can also be used for many other human resource purposes besides training and development as shown below.



What are capabilities?

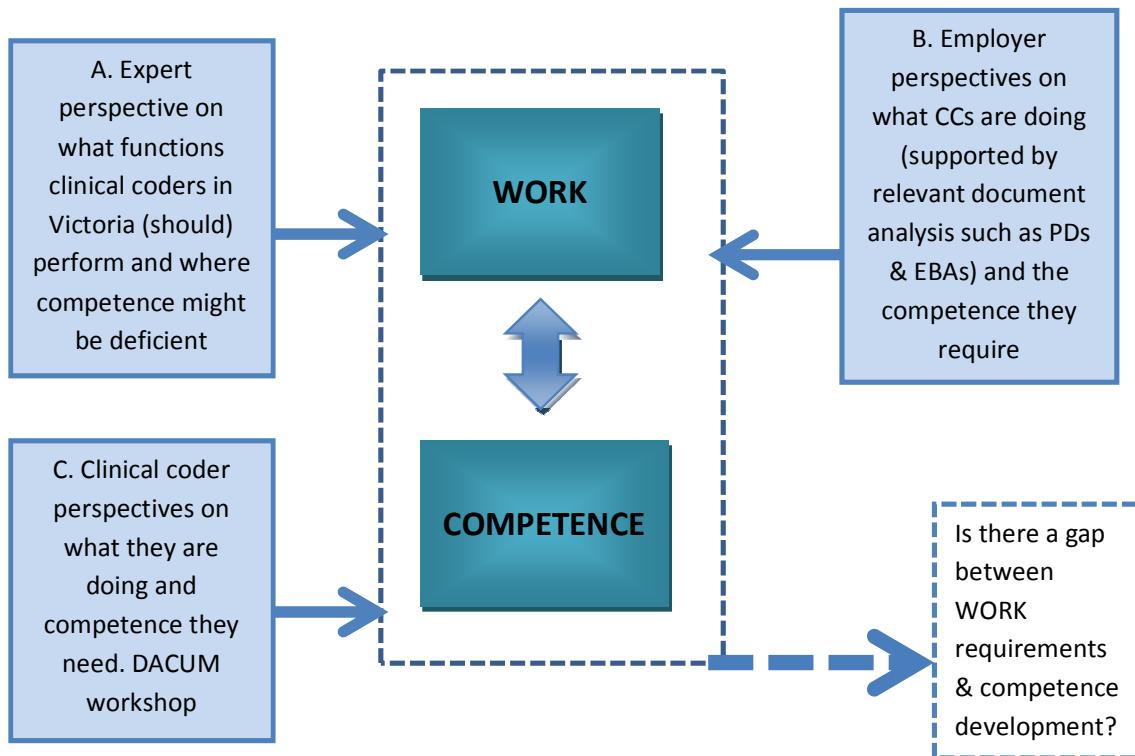
Capabilities define (or describe) the behaviours required to produce the desired outputs = quality (accurate, correct, sound and fully comprehensive) coded records.



How was the framework developed?

Background

Several methods of research were applied to explore the requirements for the Capability Framework, including a literature review, analysis of Performance Indicators for Coding Quality data (PICQ), interviews with a sample of employers (x13), focus group discussions (x3) with expert CCs and training providers, and the conduct of a Develop a Curriculum (DACUM) workshop (x1). The research approach is overviewed in the figure below.



Work and competence

The starting point for discussion of capability or competence (knowledge, skills and attitudes) is the work that CCs are expected to perform. Any discussion of competence is only meaningful in the context of the work they must perform, otherwise the obvious question arises – competence for what? Thus the research required findings to inform:

- An understanding and description of the work that entry level CCs could be expected to be able to perform; and,
- An identification of the competencies (capabilities) required to perform entry level clinical coding work to acceptable industry standards.

A high degree of correlation in the findings from the different research methods (review of the literature, employer interviews, focus group discussions, and conduct of a DACUM workshop) provided confidence that most, if not all, work and capability requirements had been identified.

The DACUM workshop, which started with a ‘blank slate’ conceptualisation of clinical coding work, identified 12 areas of required work / competence as follows:

- Code a Record
- Apply Standards
- Use a Computer
- Access Databases
- Maintain Databases
- Communicate at all levels (clinical/educators/ management/clinical coders/HIMs (Health Information Managers))
- Participate in Internal Audits
- Maintain Privacy & Confidentiality
- Ensure Completeness & Accuracy of clinical coding
- Comply with Workplace Policies & Procedures
- Manage Time & Resources
- Manage Professional Development

The other research method findings largely supported and helped to flesh out the detail in each of these areas of competence. They formed a sound starting point for the drafting of this Capability Framework.

Competency gaps

Current pathways of preparation for clinical coding work — a HIM degree or the Health Information Management Association of Australia (HIMAA) short courses — are generally considered by Victorian employers to be insufficient to provide an entry level standard clinical coder, a stance supported by the literature and an analysis of PICQ data. This has been further impacted by the expectations , requirements and level of the work of clinical coders having increased as of late; the result of greater activity in the areas of Casemix and ABF funding and the audit program which has essentially ‘raised the bar’. The main concerns focused on:

- A lack of knowledge and understanding of clinical processes, in particular of the ‘patient journey’ through particular clinical conditions;
- Lack of clarity surrounding the requirements of the work/role/job function and tasks involved. Interviews with employers and focus group discussions identified a gap between new coders *understanding* of the role and the actual job;
- Poor abstracting skills, not being able to assemble all the necessary data of a record for coding and therefore missing codes;
- Limited skills in identifying high quality sources of medical knowledge (paper and online) and in using these sources to solve coding problems;
- Being able to Identify the impact of coding decisions on Australian Refined-Diagnosis Related Group (AR-DRG) allocation and payment consequences for hospitals; and,
- Poor coder to coder and coder to doctor communication skills.

Training issues

Because of the perceived deficiencies of current training programs, most employers are effectively conducting 'graduate traineeship' like on-the-job, in-house training programs the equivalent in time and effort of a Certificate III or IV level course for new recruits. They are essentially treating pre-vocational training as 'theory', and building onto that with extensive practical learning.

Various stakeholder groups, but especially employers, have advocated the need for placements during training and/or a graduate internship year, where a relationship can be built between a training organisation and health services. This would need to be supported by the development of a specific course for CCs (based on the Capability Framework) the outcome of which would be a specialised clinical coding qualification. It is generally agreed such a qualification is likely to be in the vocational education and training (VET) sector and at a minimum Certificate IV level.

A person when graduating with such a qualification would fit at the 'entry level' into an emerging clinical coding career structure that would allow career development and progress from entry level to senior coder and possibly, with further training, to broader HIW roles.

A copy of the report of this research is available on request from the Victorian Department of Health.

The Capability Framework

This Capability Framework is represented as a Competency Matrix comprising broad capabilities or areas of competence. There are **seven broad areas of capability**¹. Together these capabilities enable the clinical coder to perform their work as an entry level worker. The seven capability areas are:

1. Work effectively in the health system
2. Prepare to work as a clinical coder
3. Abstract clinical information to support clinical coding
4. Assign codes to an episode of care
5. Ensure quality of coded data
6. Manage time, resources and professional development
7. Comply with workplace policies, procedures, and professional requirements

Of course there are other, more generic, capabilities that a clinical coder must possess in order to perform their role satisfactorily. These might be termed 'pre-requisite' capabilities. Chief amongst these would be the pre-requisite skill of 'Use a Computer', which would include navigating basic software (e.g. MS Office, Windows), accessing information on local and shared drives & intranet, using email effectively and accessing and searching the internet. The Capability Framework assumes capability in this area.

The seven capabilities are detailed on the next several pages.

¹ The Capability Framework draws a distinction between 'capability' and 'area of competence', terms which can be used somewhat inter-changeably, and 'unit of competence', which has a meaning located in the formal training system and which requires expression in a particular designated format.

Work effectively in the health system



- Describe the scope, structure and function of the public and private hospital services in Victoria (as a subset of Australia).
- Identify the roles and responsibilities of medical, nursing, allied health and other health workers as they interact with and support the patient during their health care experience.
- Describe the different pathways for management of the patient through non-admitted, emergency, admitted, sub-acute and post discharge services across the various clinical disciplines.
- Explain the scope, structure, roles and responsibilities of a health information service.
- Explain the health information statutory and legislative reporting requirements of a health service.
- Describe the functions of and the data collected within a Patient Administration System (PAS).

Prepare to work as a clinical coder

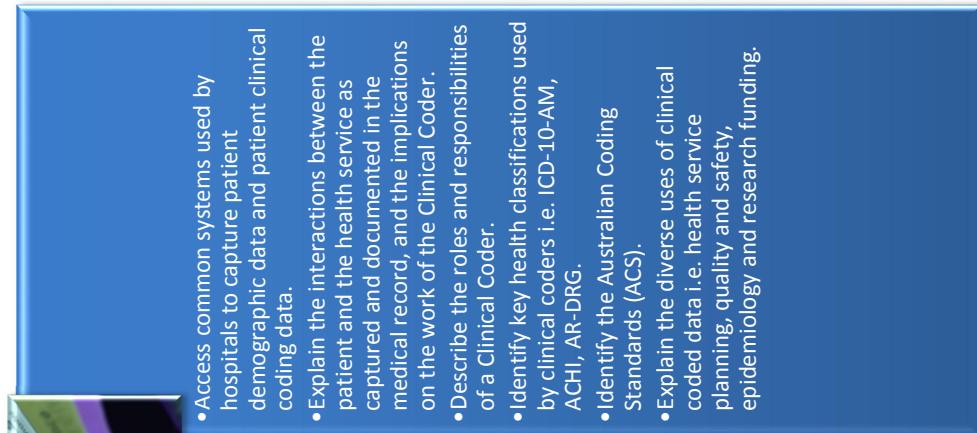


- Access common systems used by hospitals to capture patient demographic data and patient clinical coding data.
- Explain the interactions between the patient and the health service as captured and documented in the medical record, and the implications on the work of the Clinical Coder.
- Describe the roles and responsibilities of a Clinical Coder.
- Identify key health classifications used by clinical coders i.e. ICD-10-AM, ACHI, AR-DRG.
- Identify the Australian Coding Standards (ACS).
- Explain the diverse uses of clinical coded data i.e. health service planning, quality and safety, epidemiology and research funding.

Abstract clinical information to support clinical coding

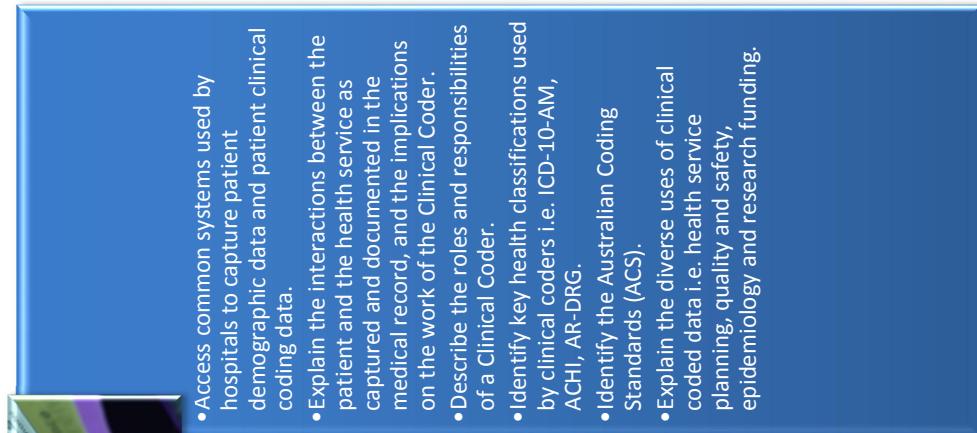


- Use medical terminology.
- Interpret clinical data and documentation including:
 - Common disease conditions and symptoms.
 - Common surgical and medical procedures.
 - Patient related data and documentation.
 - Explain treatment associated with an episode of care and relate to the documentation in a patient's medical record.
 - Utilise clinical information in order to prepare to assign clinical codes.
- Contribute to the completeness and accuracy of the medical record by:
 - Searching for all relevant information in the medical record;
 - Accessing other sources of patient information, e.g. pathology, imaging, operating room or ICU systems;
 - Identifying missing or incomplete documentation;
 - Locating missing or incomplete information, and where available file / append to the medical record;
 - Validating information in the medical record with other databases.



Abstract clinical information to support clinical coding

- Use medical terminology.
- Interpret clinical data and documentation including:
 - Common disease conditions and symptoms.
 - Common surgical and medical procedures.
 - Patient related data and documentation.
 - Explain treatment associated with an episode of care and relate to the documentation in a patient's medical record.
 - Utilise clinical information in order to prepare to assign clinical codes.
- Contribute to the completeness and accuracy of the medical record by:
 - Searching for all relevant information in the medical record;
 - Accessing other sources of patient information, e.g. pathology, imaging, operating room or ICU systems;
 - Identifying missing or incomplete documentation;
 - Locating missing or incomplete information, and where available file / append to the medical record;
 - Validating information in the medical record with other databases.





Ensure quality of coded data

- Evaluate and validate the AR-DRG obtained from the clinical coding process including identifying “error” or inappropriate AR-DRGs.
- Apply an understanding of internal audits by:
 - Preparing records for audits;
 - Clarifying issues for audit;
 - Checking assigned codes and DRGs.
- Communicate with clinical coders, HIMs, clinicians, educators and managers by:
 - Formulating and writing coding queries;
 - Responding to questions as they arise;
 - Using appropriate language (verbal/written) for the intended audience;
 - Managing email communication precisely, appropriately & on time;
 - Participating in meetings (formal & informal);
 - Educating clinicians to use appropriate documentation;
 - Using & pronouncing medical terminology correctly;
 - Comprehending written English;
 - Correctly interpreting handwriting;
 - Seeking and responding to constructive feedback.



Assign codes to an episode of care

- Apply the Australian Coding Standards (ACS) appropriately.
- Access and reference coding conventions embedded in the classifications.
- Assign codes to an episode of care using the following:
 - ICD-10-AM Diseases Index
 - ICD-10-AM Diseases Tabular
 - ACHI Interventions Index
 - ACHI Interventions Tabular
 - Sequence codes according to ACS.
 - Assign prefixes to codes.
 - Enter clinical codes into hospital systems.

Manage time, resources and professional development



- Identify and log into relevant databases.
- Abstract data from a database.
- Run relevant reports to find required data from trusted sources.
- Validate primary and trusted location of information.
- Cross reference with other databases.
- Enter relevant data into appropriate databases.
- Check data entry is accurate & complete
- Recognise data discrepancies
- Report and follow-up data discrepancies to appropriate staff member
- Manage time and resources including:
 - Comply with coding throughput expectations;
 - Seek appropriate assistance when required;
 - Communicate queries and problems in timely manner;
 - Organise resources to enable efficient access;
 - Identify and prioritise tasks and risks;
 - Identify own limitations and recognise own work style;
 - Organise and prioritise own workload.
- Practise team building skills that ensure can work as a valued team member, when required.
- Manage own Professional Development
- Seek and incorporate advice and constructive feedback;
- Access mentors;
- Consult educational resources appropriately;
- Determine knowledge gaps and rectify;
- Undertake ongoing professional development i.e. coding updates, courses, audit programs, grand rounds;
- Participate in network i.e. HIMAA groups, communities of practice, etc.;
- Work independently.

Comply with workplace policies, procedures, and professional requirements



- Access and comply with workplace policies & procedures.
- Apply an understanding of required practices, e.g. OH&S, Fire Safety, Anti-bullying requirements.
- Adhere to emergency codes i.e. Red, Orange, Brown, Blue, Black..
- Comply with workplace guidelines regarding privacy and confidentiality including;
- Managing working environment to maintain privacy of information, including password integrity;
- Disposing of unwanted patient related documents in an authorised manner e.g. assigned security bins;
- Managing conflict of interest in coding a relative, friend or known acquaintance's medical record.