How activity-based funding models impact on the clinical coding workforce

Jennie Shepheard

Introduction
The introduction of activity-based funding (ABF) models across Australia has impacted profoundly on the clinical coding workforce, but Clinical Coders (CCs) have not always been included in the plans for implementation. Funding model developers and policy units in all our jurisdictions put a lot of effort into ensuring that hospital managers understand the new system and that changed funding models do not adversely influence the continued viability of a hospital. Little system-wide effort goes into ensuring that the clinical coding workforce is ready and able to function in this new environment. Most of the work with this workforce is in fact retrospective and reactive; a crisis management response rather than a strategic response to a recognised issue. In this article I will discuss the impact on the clinical coding workforce of the introduction of ABF models.

What do CCs do?
CCs are trained to convert clinical statements to code. In Australia this is generally limited to using inpatient medical records to assign codes according to the Australian Coding Standards and the conventions embedded in the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI) classifications. These codes are “grouped” to a Diagnosis Related Group (DRG) using the specification of the Australian Refined Diagnosis Related Groups (AR-DRG) classification. These DRGs and the underlying codes are then used by a wide variety of stakeholders to manage the health system. These cases for use of the coded data include health service planning, epidemiology and research, quality and safety monitoring, and to determine payments from purchasers of health services (government departments, health insurance companies) to providers of health services (hospitals) for the treatment of acute admitted patients.

Clinical coding is a highly specialised skill that, in addition to detailed understanding of the classifications, requires knowledge of clinical documentation and the processes and patient pathways associated with treating patients in our hospitals.

What are ABF models?
The Independent Hospital Pricing Authority (IHPA) is responsible for managing an ABF model for Commonwealth payments to Australian public hospitals according to the terms of the National Health Reform Agreement 2011 (Administrator National Health Funding Pool, 2011). IHPA describes ABF as follows:

ABF is a way of funding hospitals whereby they get paid for the number and mix of patients they treat. If a hospital treats more patients, it receives more funding. Because some patients are more complicated to treat than others, ABF also takes this into account. (IHPA, n.d.)

DRGs are fundamental to acute inpatient episode funding under an ABF model. These, along with many other data elements, create what are referred to as “activity data”. Cost data, also submitted to health departments and IHPA, are analysed along with the activity data to produce relative cost weights for each DRG. A funding model is then developed using the relative cost weights and the available money. Allowances are made for extra payments to support special considerations such as “rural and remote” location in the national model and “hours of mechanical ventilation” in the Victorian and some other jurisdictional models. This process is often referred to as “classify, count, cost” process; classify using ICD-10-AM, ACHI and AR-DRGs, count using admitted patient reporting, cost using costing data.

How has the CC’s role changed following the introduction of ABF models?

Clinical coding workforce requirements
In Victoria, an ABF model for acute inpatients was introduced in 1993. At that time I was working as a CC at the Royal Melbourne Hospital (RMH) where we had an EFT (equivalent full time) of approximately two to cover the clinical coding work. Today, RMH budgets for 24 EFT, comprising of one manager, four auditor/educators and 19 CCs. Of course, this increase has been incremental over more than 20 years but nevertheless represents the explosion that rocked the clinical coding world. From being tucked away in a corner of the Medical Record Department, CCs were suddenly “front and
In a relatively short time frame CCs were catapulted into engaging with clinicians and management where they found themselves not only accountable for the timely completion of coding backlogs but also for the quality, both perceived and actual, of the coded data.

Clinician engagement and financial accountability
In a relatively short time frame CCs were catapulted into engaging with clinicians and management where they found themselves not only accountable for the timely completion of coding backlogs but also for the quality, both perceived and actual, of the coded data. In addition, for the first time they were required to have an understanding of the funding model and the role that clinical coding and DRGs played in that model and to articulate this to various stakeholders. They were not necessarily equipped with the skills and the knowledge needed to hold these conversations, making this either a very threatening or, conversely, a very exciting time for individual CCs. Either way, life became a bit uncomfortable and CCs had to learn how to manage this “personal and professional challenge” (Cook 2016) and make decisions about how to respond and how to survive.

Australian coding standards
Concurrently with the development of ABF models in Australia, the National Coding Standards for Inpatient Data Collections were developed in June 1992. These were published as Volume 3 of the Report of the National Patient Abstracting and Coding Project, which was funded by the Commonwealth Casemix Development Program. These standards have been substantially developed since then and are currently managed by the Australian Consortium for Classification Development under contract to IHPA. The interpretation of clinical coding standards (and conventions embedded in the classification) is the topic of many detailed discussion in coding committees around the country. From a pre-ABF clinical coding environment where the assignment of clinical codes was rarely checked by anyone, CCs in Victoria, at least, now have to undergo extensive internal coder orientation and training when they are employed in order for the hospital to be sure that they are fully conversant with the coding standards applicable to that hospital’s casemix.

Audits of clinical coding
Jurisdictions and private funders have established audit programs to varying extents in order to establish integrity in this new system. External audits became a way of life for Victorian CCs in 1993 and have continued to this day. In the private sector financial penalties may be incurred for failures to comply, and in both the public and private sectors CCs are held accountable for the outcomes of audits.

In time additional staff were appointed to coding teams in Victoria and hierarchies established within these teams. In Victoria now we have roles for coding managers, coder educators, and coding auditors, sometimes all part of the one team and this is the case in other jurisdictions as well. Experienced CCs can work independently, contracting out their services for coding or for auditing. The audit environment feeds into the development of clinical coding standards as well as the development of new codes and index entries as hospital CCs work hard to ensure their choice of code is supported by the classification.

What are the issues associated with these changes for CCs?
Ethical dilemmas
The big issues for CCs relate to the difficulties associated with balancing the financial needs of their hospital by ensuring the coding translates into optimal DRG outcomes, with the requirement that jurisdictions have reliable and accurate data to meet their multiple needs in planning, monitoring, and funding the health services. Robinson et al. (1998) summed this up, saying that CCs found themselves dealing with “new stakeholders with a legitimate and sometimes conflicting interest in coded data”. This conflict continues to this day and is increasingly difficult for CCs to deal with. CCs generally have neither the skills, the tools, nor (often) the moral advocacy from superiors to deal with these issues. Their line managers are under pressure to meet key performance indicators by optimising DRGs to the same level or more than they did the previous year; senior hospital managers are primarily interested in managing increasingly tight budgets; and at a professional body level, CCs and Health Information Managers (HIMs) working in this area do not appear to be organised enough to push back against this pressure.
Professional advocacy
Are CCs strong enough to uphold their professional standing and refuse to bow to undue pressure to optimise or maximise DRG outcomes, or to change coding in response to an adverse indicator outcome? Do they understand the definitions that apply to morbidity coding versus those that apply to mortality coding? Do governing bodies (jurisdictions, hospital management, health funds) understand the role of the CC and the overarching clinical coding standards that govern their work? If not, why not? Who is responsible to address this situation? These are questions that occupy me regularly.

I think we all have a professional responsibility to address these issues. We must recognise clinical coding as a professional activity in its own right, which will result in data that are fit for all purposes rather than skewed to the needs of one-use case. We must rely on our ability to interpret the resultant data in accordance with coding standards and conventions, and to communicate this to the users of the data, rather than resort to changing the data to fit the purpose.

Managers of coding teams could advocate for ethical coding by mandating knowledge of and adherence to clinical coding ethics. They could also advocate for the clinical coding workforce with finance officers and hospital managers by not submitting to unrealistic demands for higher productivity.

Clinical coding committees and developers of the Australian Coding Standards must continue to work to make coding standards clear and transparent with specific instructions where possible. They could also advocate for a code of practice that allows CCs to exercise professional judgement in all aspects of their work. Individual coders could develop a professional self-esteem that allows them to trust their own professional ethics and their own professional knowledge, and to be strong enough to articulate this when necessary.

In summary: why we care!
Clinical coding is a professional activity and CCs are a professional body of workers, eligible for membership of the Health Information Management Association of Australia (HIMAA). As fellow members of HIMAA, we need them to be both protected by and committed to a code of behaviour that is embedded in their, and our, professional ethics. We care because CCs are our fellow workers and we care because clinical coded data constitute a strategic resource that we need to value.

There will always be another version of a funding model, another indicator to be explained, another service plan to be justified. Trying to meet these needs creates an “everybody loses” scenario where the underpinning data potentially lack integrity. We want an “everybody wins” scenario where the underpinning data are safeguarded by a professional, committed and proud workforce.

References

Jennie Shepheard, RMRL, GDipHlthAdmin, CertHlthEco, MPH
Principal Advisor, Health Classification and Coding
Victorian Agency for Health Information
Department of Health and Human Services, Victoria
email: jennie.shepheard@dhhs.vic.gov.au