Healthcare Pricing Office

Clinical Coder Resources

The Evolving Role of the Clinical Coder

A qualitative study carried out by the HPO

October 2019

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Acknowledgements

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Executive Summary

Timely and accurate HIPE data collected by trained clinical coders in acute public hospitals is key to inform the health services and is central to the success of the Activity Based Funding (ABF) funding model for acute hospitals. The coder's role is evolving to encompass new technologies and increasing demands on the data.

Clinical coders are in short supply both in Ireland and internationally and it is critical that skilled clinical coders are not lost from the system due to the recruitment or retention issues.

With clearer job specifications for the different HIPE roles and with a clear management structure within those HIPE departments the evolving role of the coder can be seen as an opportunity for retention and recruitment of clinical coders. This project looks at current staffing in HIPE and provides a number of conclusions and observations to inform HIPE staffing policy.

The Irish Government committed to the introduction of ABF for hospital care in 'Future Health: A Strategic Framework for Reform of the Health Service' (2012)[1]. In addition in 2017, the all-party 'Sláintecare Report'[2] proposed a ten-year plan for reform towards universal healthcare and recommended the continuation of ABF.

The Pavilion Report (2016)[3] was commissioned to assess the validity of the data underpinning ABF model. The review demonstrated that the quality of HIPE was sufficiently sound to provide a platform for ABF in acute hospitals and the report provided a number of recommendations. This project is following up on one such recommendation with regard to clinical coding workforce structures.

The role of the HIPE clinical coder in Irish hospitals is evolving and although their primary role is in the clinical coding, their brief has broadened beyond the HIPE office.

The HIPE department should be seen as an attractive place for people to work with good opportunities for development and career progression. In turn retention of staff will be supported by a clear career path within the department. It is important that for coder retention that HIPE staff have opportunities to apply for more senior positions with additional specialised duties e.g. audit, mentoring, reporting etc *within* HIPE. With a clearer career path visible within HIPE, it makes joining and remaining in HIPE more attractive to potential candidates, leading to a stable and experienced HIPE workforce.

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1   Future Health – A Strategic Framework for Reform of the Health Service 2012 – 2015, Department of Health, November 2012, https://health.gov.ie/wp-content/uploads/2014/03/Future_Health.pdf

2   Sláintecare Report, Houses of the Oireachtas Committee on the Future of Healthcare, May 2017, https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

3   National Audit of Admitted Patient Information in Irish Acute Hospitals, September 2016, Pavilion Health

Key Recommendations[4]

1. Role(s) of the Clinical Coder

Clearly defined roles for the different levels of clinical coder required in the hospital and the group.

Job specifications to be prepared by HPO/HSE.

2. HIPE Team Structure

Develop a team structure to support professional and personal development with clearly define roles and responsibilities.

3. Recruitment & Retention

Clearly defined structures with nationally agreed job specifications to provide a clear route for progression are required.

4. Coder Education

Core HIPE training needs to be mandatory.

HIPE training function to be resourced and supported locally in conjunction with the HPO.

5. Data Quality & Audit

HIPE data quality and auditing function needs to be resourced locally and supported by management.

Clinical support for the role of HIPE and HIPE data quality is required at hospital level.

6. Communications

Clearer roles and responsibility will lead to more efficient HIPE teams working together in a cohesive way.

Increased visibility of the HIPE function within the hospitals will lead to increased engagement.

7. EHR / Source Document

Engagement with clinicians through regular meetings, increase clinicians understanding of HIPE and ABF will lead to better source information available for clinical coders.

Access to high quality, timely electronic and hard copy source documentation to be made available to HIPE coders.

8. Environment & Resources

Ensure coders have a good working environment, close to coding colleagues. Recommendations for a minimal technical requirement for HIPE staff (Table 2).

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4 For detailed challenges, risks and recommendations please see Table 3 (p22).

Introduction

Timely and accurate HIPE data collected by trained clinical coders in acute public hospitals is key information to inform the health services and is central to the success of the Activity Based Funding (ABF) funding model for acute hospitals currently being rolled out in Ireland. These clinical coders are trained and supported both by the HPO and locally in hospitals and hospital groups. The quality and timeliness of the data is constantly under review. With the advances in technology, the advent of the Electronic Health Record (EHR) and the roll out of ABF the role of the clinical coder has come under the spotlight. These skilled staff now have more demands on them than ever, and not simply in meeting the shorter deadlines.

The role of the HIPE clinical coder in Irish hospitals is evolving and although their primary role is with clinical coding, their brief has broadened to include; clinician engagement, HIPE data reporting, documentation improvements, engagement with IT, finance and management in hospitals. This is in addition to the on-going responsibilities of HIPE data quality, audit, training and mentoring. With this evolution of the role and the added burden of shorter deadlines (a discharge must be coded within one month of discharge) the demands on the clinical coder are increasingly expanding beyond the HIPE Coding Office.

This project, prompted by recent reviews of HIPE and the advent of ABF is a timely review of the role of this key hospital staff member; to look at how this job role is evolving; how HIPE Departments are evolving and how best to support the HIPE function within the system to ensure timely and accurate HIPE data is available.

> **HPO Project Team**
> - **Ms. Deirdre Murphy, Head of HIPE and NPRS**
> - **Ms. Maureen Lynn, Business Manager/Project Manager**
> - **Ms. Marie Glynn, Head of Clinical Coding Education**
> - **Ms. Jacqui Curley, HIPE Coding Manager**

The Pavilion Report (2016)[5] highlighted the lack of career structure for experienced clinical coders, with just over 70% having coding experience for more than 5 years. The ABF Implementation plan 2015-2017 made a number of recommendations around staffing[6]. While a number of Model 4 hospitals have made significant progress with the structure of their HIPE coding teams, the project team found that the HIPE department structures and line management in some HSE Hospitals can be flat and appear to be under resourced in terms of a career path and support. A clinical coder requires support and on-going education from the hospitals and the wider system in order to have sufficient skilled and experienced clinical coders working and retained within the system.

An increased focus on HIPE data to monitor service quality is now recognised in many hospitals. However in other sites, where there are vacant posts and resourcing issues, the time for dedicated data quality work is limited. The importance of continuous effective data quality review and auditing must be recognised by hospital management and clinical coders alike.

It is important that for coder retention that HIPE staff have opportunities to apply for more senior positions *within* HIPE. In addition potential promotion is an important issue in the retention of these specialised staff. With a clearer career path visible within HIPE, it makes joining and remaining in HIPE more attractive to potential candidates.

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5   National Audit of Admitted Patient Information in Irish Acute Hospitals, September 2016, Pavilion Health.

6   At time of writing, September 2019, a new ABF implementation is in preparation for 2019-2022

Background

The Irish Government committed to the introduction of Activity Based Funding (ABF) for hospital care in 'Future Health: A Strategic Framework for Reform of the Health Service'[7]. The Policy document 'Money Follows the Patient Policy Paper on Hospital Financing'[8] was published by the Department of Health in early 2013. Central to this was the creation of a single office to bring together the activity (HIPE) data and the costing data in preparation for ABF. This became the Healthcare Pricing Office (HPO).

> 'Therefore, it is appropriate that the HIPE system would be maintained as the standard classification and coding system on which future universal prospective payment systems would be built' (p 32. MFTP Policy Paper 2013).

In 2014, the HPO was established within the HSE to support the implementation of ABF across the Irish hospital system. Since then, it has worked with the Hospital Groups to implement ABF, guided by the 'ABF Programme Implementation Plan 2015-17'[9]. That implementation plan made a number of recommendations with regard to increasing the clinical coding staff nationally in addition to the establishment of a group managers' role. This was in recognition of the central role that HIPE data plays in the implementation and on-going development of ABF.

In 2017, the all-party 'Sláintecare Report'[10] proposed a ten-year plan for reform towards universal healthcare and recommended the continuation of ABF. The Government committed to the on-going implementation and expansion of ABF in the 2018 'Sláintecare Implementation Strategy'[11] and the importance of data collection, analysis and management.

> 'In the future, a strong approach to data collection, analysis and management will underpin the delivery of our health and social care services.' *Sláintecare Implementation Strategy* p32.

7   Future Health – A Strategic Framework for Reform of the Health Service 2012 – 2015, Department of Health, November 2012, https://health.gov.ie/wp-content/uploads/2014/03/Future_Health.pdf

8   Money Follows the Patient Policy Paper on Hospital Financing. Department of Health. February 2013. https://health.gov.ie/blog/publications/money-follows-the-patient-policy-paper-on-hospital-financing/

9   Activity-Based Funding Programme Implementation Plan 2015 – 2017, Health Service Executive, May 2015, https://health.gov.ie/wp-content/uploads/2015/07/ABF_Implementation_Plan_20_05_2015.pdf

10 Sláintecare Report, Houses of the Oireachtas Committee on the Future of Healthcare, May 2017, https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

11 Sláintecare Implementation Strategy, Government of Ireland, August 2018, https://health.gov.ie/wp-content/uploads/2018/08/Sl%C3%A1intecare-Implementation-Strategy-FINAL.pdf

HIPE is the principal source of national data on discharges in acute hospitals and ABF represents a major change in the way hospitals are funded and replaces the previous arrangement in block allocation. HIPE clinical coding teams across all acute public hospitals provide this HIPE data.

HIPE Nationally

- **~ 1.7 Million Inpatient and Day case HIPE Discharges each year**

- **39 ABF Hospitals, 56 HIPE returning hospitals in total**

- **99% Coverage**

- **~280 Clinical Coders**

- **~30 HIPE Managers**

- **HPO, hospitals, and hospital groups undertake audits and data quality reviews of HIPE data**

- **HPO trains and supports all HIPE staff nationally in clinical coding, in audit and data quality**

- **HPO provides data quality and audit tools for use in hospitals**

The Project

In late 2016 and early 2017, Maureen Cronin, Head of Acute Finance ABF/HPO, along with the HPO project team undertook a series of clinical coder engagement meetings with hospitals outlining the impact of ABF on hospital funding and clinical coding. The results and recommendations of the 2016 *National Audit of Admitted Patient Information in Irish Acute Hospitals Report* (Pavilion Health 2016) were also discussed with particular reference to the structure of HIPE coding departments and the risks to the collection of hospital activity data around coder recruitment and retention. These have been longstanding issues and risks within HIPE. In a previous review of HIPE procedures in 2004, the issues of coder recruitment and retention were highlighted as on-going and central issues for both the central office and for hospitals (*Towards Best Practice in the Coding of Morbidity Data*, Bramley Reid 2004)[12].

> Retention of coders is a key issue and a career pathway or promotional opportunities are important factors in establishing a stable, experienced, educated and skilled work force.[13]

In the absence of a recognised HIPE clinical coder career pathway the issues of coder retention, recruitment and on-going education are issues for the system to overcome to ensure timely and accurate HIPE data produced by an appropriately trained and stable workforce.

> **Pavilion Report Recommendation 10**
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> **In hospitals <u>where Clinical Coder staffing is greater than 5 Whole Time Equivalents</u> (WTE) a workforce structure and common job specification be designed as follows:**
>
> - **Trainee Coder**
> - **Competent coder**
> - **Senior coder (internal auditor/on the job trainer/mentor**
> - **Manager**
> - **Quality Control Manager**
>
> **Pavilion Report 2016**

The annual HPO national HIPE Staffing Survey identifies staff resources in HIPE by Hospital. In order to look behind these figures this qualitative Coding Resources Project was embarked on by the HPO.

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12 Towards Best Practice in the Coding of Morbidity Data. A review of clinical coder training programs and data quality audit procedures within the Hospital In-Patient Enquiry Unit, ESRI August 2004 A consultancy report for the Economic and Social Research Institute, Dublin. Prepared by: Michelle Bramley and Beth Reid, The University of Sydney. Australia

13 Establishing the feasibility of accreditation of clinical coder training in Ireland through action research. Deirdre Murphy. MSC Final thesis. TCD. 2010

Methodology

In December 2017, the HPO embarked on a scoping exercise to address the staffing issues described earlier. The purpose of the scoping exercise was to achieve a much richer analysis of requirements and resources by meeting people at the coal face who could describe their current situation and what the main issues are around HIPE with particular focus on HIPE staffing, responsibilities and HIPE department structures. Maureen Cronin, *Head of ABF and the HPO*, sent a letter to all group CEOs informing them of the project. (Appendix 1)

Hospitals visited represented a good spread across hospital model, voluntary, non-voluntary and hospital group (Appendix 2). Fifteen site visits were conducted between December 2017 and October 2018.

The project manager arranged each meeting with the relevant staff in each site; all HIPE staff were welcome to participate. The meetings took approximately an hour and a half. Staff attending included a mix of clinical coding managers, clinical coders, accountants and hospital managers and focused on the roles of the HIPE coder and HIPE manager. A document was read out by the HPO at the start of the meeting to set out the purpose of the project (Appendix 3). The results of the most recent HIPE coder staffing survey for the hospital being visited were also available and discussed.

Findings and recommendations are presented in this report under these common themes which emerged through the study.

1　Role of the HIPE Clinical Coder

2　Staffing and Structures

3　Recruitment and Retention

4　Training

5　Data Quality

6　Workplace environment and resources

7　Medical Records and EHR

8　Communications

Findings

1. Role of the HIPE Clinical Coder

The clinical coder analysis and translates the relevant chart information and the medical terminology into numeric code and performs an essential function in providing quality, accurate, and uniform medical information and hospital activity data for use throughout the health service. While this report is reviewing the work of clinical coders we also considered the roles of HIPE managers both at hospital and group levels.

> - A clinical coder can read the clinical record and make decisions about the appropriate codes to assign, based on the clinical documentation.
> - A clinical coder understands the structure and use of a statistical classification.
>
> Source: ACS Appendix B Clinical Coders' Creed (see Appendix 5)

The role of the HIPE clinical coder in Irish hospitals is evolving and although their primary role is in the clinical coding as described above, their job description has broadened to include:

- Clinician engagements
- Reporting
- Documentation improvements
- Engagement with IT, finance and management in hospitals

This is in addition to the on-going responsibilities of HIPE data quality, audit, training and mentoring. With this evolution of the role and the added burden of shorter deadlines (a discharge must be coded within one month of discharge) the demands on the clinical coder are increasingly expanding beyond the HIPE Coding Office. The expectation is that a coder will continue to code 7,000 discharges per year within one month of discharge, and also carry out these additional duties.

This development of the coder's role is an opportunity for clinical coders and HIPE departments to evolve and for job roles to be developed in different areas. This will open up opportunities for personal and professional development with increased responsibility and career opportunities. With the advent of the EHR, technological advancements and new ways of working, clinical coders' roles need to reflect these changes.

Currently the Irish system uses the Australian modification of the World Health Organisation's disease classification (ICD-10-AM) for diagnoses and the Australian Classification of Health Interventions (ACHI) to code procedures. Australian Coding Standards (ACS)[14] provides guidance on the application of codes. The Irish Coding Standards (ICS) developed and published by the HPO further guide and support HIPE.

The project found that HIPE staff are now required to be experts not only in clinical coding and the classifications but to have knowledge of service delivery, reporting, data management etc. The findings of this project illustrate how these changes are happening across the country and have implications for HIPE data provision, quality and timeliness and for the successful implementation of ABF nationally.

With this evolution in the role of the HIPE team, the HPO project team found that there is huge disparity in the role of the clinical coder and the role of their managers across the sites visited. Some standardisation of these roles will be helpful as the HIPE function develops within the system.

2. Staffing and Structures

There is currently no standard structure for a HIPE coding department. The only guide in place is that a hospital will have a WTE clinical coder for every 7,000 discharges. Most hospitals will have a HIPE manager.

The project found that the HIPE team within the hospital can fall under various departments across hospitals, including medical records, finance and I.T. This further emphasises the breadth of HIPE within the system and the multiple tasks associated with HIPE staff. Therefore coders are not recognised from a national perspective as being associated with one particular department. In one hospital visited the HIPE Manager has a dual role managing Medical Records and the HIPE department.

Many HIPE Departments visited reported a pressure to meet deadlines. The staffing resources and structures are not in place to allow a focus on audit, data quality, clinician engagement and the expanding role of HIPE within the hospitals. The HPO project team agree that a standard management and staffing framework is required to support all aspects of the clinical coding team's work, specifically in the areas highlighted above and also to increase the visibility of HIPE in the Hospital. Increased visibility leads to increased awareness and hopefully increased engagement. In all hospitals that the HPO visited there is an acknowledgment regarding the significance of the clinical coder role.

The importance of having a career structure within HIPE was raised in relation to staffing structure both within the HIPE office and the hospital. It is evident that there is lack of uniformity on the clinical coding staffing and support structures across HIPE departments and hospital groups.

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14 ICD-10-AM/ACHI/ACS © Copyright Commonwealth of Australia 2012, Eighth Edition. Used under licence.

One hospital reported:

New job descriptions have been drafted and new contracts have been re-issued to include additional duties such as audit, ensuring that timelines are met, engagement with clinicians, data quality, completion of all mandatory and DIT training[15]. Coders that have been upgraded to a more senior grade are required to have completed all the mandatory training, and have completed or have undertaken to complete the DIT training course and take on additional responsibilities. Posts are also subject to performance review. HPO Comment: This is an indication of best practice.

A strong HIPE Department within a hospital raises the profile and value of HIPE data and also the work of the clinical coders and will serve to embed the HIPE system as a critical function for the hospital and the hospital groups. Many hospitals report a growing awareness of the HIPE function, including data quality and audit, data management and reporting, data reliability, increased value to data users and service improvement. With a well-structured HIPE department this visibility can be raised which will improve the profile of HIPE and those staff working within it. A stable, well resourced, effective and skilled team will in turn serve to ensure data quality assurance. Increased visibility will strengthen the HIPE team and help with retention of coders with recognition of their roles and a career path to follow. It will also help with communication which will be discussed later in this report.

Children's Health Ireland (CHI) is in a unique position in that the three hospitals currently have individual HIPE departments within each hospital. Currently, CHI comprises of three voluntary hospitals; Our Lady's Children's Hospital, Temple Street Children's University Hospital and Tallaght University Hospital Paediatrics. As of 1st January 2019 the hospitals are one legal entity operating from three locations. CHI will be a separate legal entity to the HSE and will be funded under Section 38. In the interim CHI are overseeing the integration of the three children's hospitals.

The HIPE resources will subsequently merge over the next few years with the addition of two satellite units. One of the satellites opened in 2019 is located at Connolly Hospital and will be an Outpatient and Urgent Care Centre. The HPO will work with the CHI in supporting this process. Expected activity discharge numbers and complexity in CHI will determine how the new structures might look.

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15 The HPO in partnership with The Technology University of Dublin (TU Dublin), formerly DIT, provide a training course which leads to a Professional Development Certificate in Clinical Coding. See under Section 4. Training for more information.

The Pavilion Report (2016) highlighted the lack of career structure for experienced clinical coders, with just over 70% having coding experience for more than 5 years. The ABF Implementation plan 2015-2017 made a number of recommendations around staffing. A number of Model 4 hospitals have made significant progress with the structure of their HIPE Coding teams. The Project team found that the HIPE department structures and line management in some hospitals can be flat and appear to be under resourced in terms of a career path and support.

The project team heard that it can be challenging for a coder that is at the same grade as their colleagues to take a lead in data quality and/or mentoring new staff, although all coders are involved in quality and are all very aware of the importance of data quality. Standardised structures are being explored by the HPO and these will be discussed later in this report.

> **Group HIPE Managers and clinical coders**
>
> The 2014 – 2017 ABF implementation plan proposed a group HIPE Manager for each hospital group, seven in total with additional group clinical coders. A number of group HIPE Managers and group clinical coders have yet to be appointed. Group Managers that are in post advise that the position is new and still developing. HPO were advised that as there is no legislation in relation to the groups and in the absence of a line management function, the group HIPE Manager is largely relying on the co-operation of the hospitals. The project team were advised that the group clinical coders in post are working on auditing and coding of backlogs.

The governance issues around the Hospital Groups are proving challenging for hospitals in particular where the previous groupings no longer operate and management structures are not aligned to the new Hospital Groups. Until such time as the Groups become statutory this lack of clarity may continue.

> The Group HIPE Manager in one Hospital Group with a wide geographical spread described their role as evolving at the time of the project visit. The group V coders report into the local HIPE Manager at the hospital where they are based, with a *dotted line* connection to the Group HIPE Manager. The grade V group coders have a dual role: audit and coding of backlogs. The group manager is involved in the recruitment process for new coders, looking at the complexity in each of the hospitals, working with the various directorates and also holding education sessions for the managers.

To ensure that HIPE Departments will operate to the standardised framework it is critical that hospitals recognise the risks associated with delayed recruitment for new or replacement posts. The clinical coding role is specialised and a lead in time is required for training in all aspects of the job including coding, auditing, data quality review and reporting.

A standard structure will also provide a career pathway for clinical coders and will help with the retention of staff within HIPE. Table 1 below lists some possible roles and responsibilities to support HIPE within hospitals. Roles, responsibilities and structure will be dependent on the size of the hospital.

Table 1: Possible HIPE Department Roles and Responsibilities

HIPE Dept. Roles	Clinical coding duties	Other duties
HIPE Manager	Recommend some coding each week.	Manage HIPE department Reporting Engagement Clinical Documentation Improvement
HIPE Quality Manager	~50% coding duties	Audits Data Quality review Performance Indicators for Coding Quality (PICQ™ Audit Tool) Review
HIPE Training Manager	~50% coding duties	Mentoring new staff Supervising on-going education of new staff Training all staff
HIPE Team Leader	~50% coding duties	Mentoring New staff Supervising on-going education of new staff Training all staff Data Quality review PICQ™ review
Experienced Clinical Coder	100% coding duties significant experience (> 2 years) Proven track record of continuous education	Participate in data quality and training activities
Entry Level Clinical Coder	100% coding duties	Participate in data quality and training activities
HIPE Chart Officer	No coding duties	Chart retrieval

3. Recruitment and Retention

The Clinical Coder is a specialised role with extensive on-going training with continuous on-the-job experience important in the development of the skilled clinical coder. With this being such a specialised role requiring on-going training and with their work open to continual scrutiny it is not a role that suits all administrative staff. The box below lists typical aptitudes for a clinical coder.

The Clinical Coder

- Adheres strictly to confidentiality policies in relation to patients' information

- Has attention to detail and accuracy

- Performs precise and detailed work

- Has good communication skills and is able to communicate with a range of staff across the hospital and the broader system.

- Concentrates, sits and reads for extended periods of time

- Analyse, abstracts and interprets information

- Has initiative, problem solving and detection skills

- Has a pro-active approach to seeking information

- Will apply standards, guidelines and policies

- Is able to work well under pressure and prioritise own work

- Can work independently and also as part of team

- Is a self-directed learner

- Is willing to continually update skills and knowledge

- Understands the data and its importance and takes responsibility for their own work

- Is required to be open to and comfortable with peer review and auditing.

Recruitment needs to done with the typical aptitudes listed above in mind so those staff applying are aware of the commitment involved. Clear job specification at the recruitment stage will help to ensure the right person is appointed who will be engaged, interested and committed to this challenging role.

Hospitals reported that funding of additional new posts is challenging and that there are delays in getting approval for backfills. It is reported that on promotion, within the HIPE system, in some instances it is not possible for the successful candidate to take on all their new duties where there is not a backfill for their vacated clinical coder post.

The HPO team were advised by hospitals visited that it takes a minimum of three months to recruit replacement posts under National Recruitment Service (NRS). Often backlogs can occur when a coder leaves and is not replaced promptly. The recruitment process necessitates that the posts must be advertised internally first and there are also delays around internal staff being released to take up a post. In voluntary hospitals, the recruitment process is somewhat more streamlined.

A common view expressed among the hospitals visited is that the panel system does not work for recruitment to the specialised clinical coding positions. Filling a clinical coder post from a generic panel is not ideal as the person identified may not have the aptitude, skills, commitment or willingness to undertake this complex role (see box 'The Clinical Coder' above).

It is important that for coder retention that HIPE staff have opportunities to apply for more senior positions *within* HIPE. In addition potential promotion is an important issue in the retention of these specialised staff. With a clearer career path visible within HIPE, it makes joining and remaining in HIPE more attractive to potential candidates.

Clinical coders are in short supply both in Ireland and internationally and it is critical that skilled clinical coders are not lost from the system due to shortfalls in the recruitment process and career structures available.

4. Training

HIPE clinical coder education is essential, but currently not mandatory for the HIPE clinical coder role. In Ireland, new HIPE coders typically come from administration roles and will usually have no formal medical background or training. The advantage of having administration staff in these roles is that they must rely on the medical record information presented to them in the source document and will not make any assumptions on diagnoses etc. It can take up to two years to fully train a new HIPE coder in all aspects of HIPE coding from chart extraction, anatomy and physiology, the classifications, uses of HIPE data, reporting etc. A coder at entry level will undergo the HPO structured foundation HIPE clinical coder training programme and the individual is expected to undergo continuous in-house training and mentoring while gaining on-the-job experience.

As in hospitals, HPO recruitment of clinical coder trainers with the relevant skills and experience has proved difficult leaving the burden of training on a small team. With the increase in technologies to allow for web based delivery and sessions being recorded the HPO work to ensure all coders are trained and supported with a calendar of training published every month. This training is only available

to staff currently working within a HIPE department, as on-the-job experience is essential to the training. HPO are considering what other technologies, tools and pathways could support the training.

> The success of the training delivered depends upon the commitment and competence of the clinical coder and support from their line manager. It is therefore essential that a prospective clinical coder and hospital management understand the basic knowledge and skills required as well as the on-going commitment ahead of recruitment.

All clinical coders working in HIPE at all levels of experience require on-going structured training from the HPO and within their hospital's HIPE department.

Monitoring training requirements at hospital level is important to ensure all working clinical coders of all levels are equipped with the skills required in their role. A training log is kept in some hospitals and also within the HPO training division. This is an important training tool for *Training Needs Analysis* and for planning. Clinical coder training and mentoring is a critical function that must be supported both within the HIPE department and the wider hospital management.

The HPO offers a Training & Mentoring Course to senior clinical coders who train and mentor as part of their role. The course supports the establishment of structured training programmes within hospital HIPE Departments for clinical coders at all levels of experience. The course provides participants with the skills to perform *Training Needs Analyses*, devise training plans and develop, implement and evaluate training.

The course aims to address the recommendations in the Pavilion Report in relation to a reduction in the amount of time that it takes to train a new coder.

> **HIPE Clinical Coder Certification**
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> Since 2015, the HPO in partnership with The School of Computing, College of Sciences and Health at the Technology University of Dublin (TU Dublin), formerly DIT, provide a training course which leads to a Professional Development Certificate in Clinical Coding. All clinical coders working within HIPE can apply to take the certification course which is held once a year over 6 months. There is a final examination and the overall pass mark is 80%. The Certificate in Clinical Coding is at Level 6 on the national framework of qualifications (NFQ). This accredited clinical coder education provides a recognised training program for clinical coders to enhance the role of clinical coding as a skilled profession within healthcare. At time of writing, upwards of 130 clinical coders from 39 hospitals have successfully undertaken the course.
>
> The HPO are currently in discussions with TU Dublin with regard to developing an advanced course building on the certificate, leading to a diploma. This course will cover advanced clinical coding with a second module choice of 'Audit & Data Quality' or 'Training & Mentoring'.

The project team found that in some hospitals not every coder is in a position to continually up-skill due to competing work priorities. Coders who have not attended training for some time need to be supported by senior management to engage in continuous training. This is particularly an issue in some of the smaller hospitals where the coder has a multiplicity of roles, including that of a manager and mentoring of new staff.

> The HIQA report '*Review of information management practices in the Hospital In-Patient Enquiry (HIPE) scheme*' (October 2018) reported that "advanced coding skills training needs to be enhanced as some gaps have been identified in this area by the HPO." (HIQA, October 2018, p65)

The importance of continuous and structured clinical coder training both in hospital and at the HPO must be recognised by hospital management and clinical coders alike. Although the training is currently not mandatory it is critical that all coders take part at all levels relevant to their role.

The HPO HIPE Clinical Coder Education Programme is listed in Appendix 4. These courses are available to all HIPE staff currently in post.

5. HIPE Data Quality

> Quality data and information refers to data and information that are; relevant, accurate and reliable, timely and punctual, coherent and comparable, accessible and clear.[16]

In 2017 the HPO published the *HIPE Data Quality Strategy* document which sets out the purpose and objectives for HIPE Data Quality. This strategy document sets out the approach and requirements for the HPO and hospitals to perform HIPE Data Quality Surveillance and HIPE Coding Audits.

The project team found that there is an emphasis on HIPE data quality in all hospitals. All HIPE managers interviewed showed an understanding on the impact that quality data has in the provision of timely accurate healthcare data. It is recognised that the workload is no longer just focused on maintaining coding levels and meeting the monthly deadlines. All HIPE coders are aware of ABF and the requirement for quality activity data. Use of the HPO HCAT© (HIPE Coding Audit Toolkit)

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16 Source: Guidance on a data quality framework for health and social care, HIQA, 2018 page 11

and the Checker© data quality tools is frequently cited.[17] There is an emphasis that HIPE coding is about good quality data and clinicians are beginning to recognise this and their role in the provision of this data. One hospital visited reported that the clinical coding department has a strong relationship with the Quality Service Information Directorate.

The ABF Implementation Plan 2015-2017, the Pavilion Report and the recent HIQA report on HIPE; *Review of information management practices in the Hospital In-Patient Enquiry (HIPE) scheme*, HIQA October 2018[18] all recommend increasing the number of audits and HIPE auditors to support a national audit programme and implementing a standardised HPO Audit process. The number of HIPE Auditors in the HPO has increased and hospitals are being audited more frequently, the aim of the HPO is to audit each ABF hospital at least once every two years with targeted audits where the requirement arises. The HPO are recruiting additional clinical coding auditors.

Specific data quality roles within HIPE departments are being developed and resourced in some hospitals. In 2018, the HPO developed a HIPE Coding Audit course for experienced coders this course is now being delivered regularly by the HPO. Clinical coders who have completed the initial course were given the opportunity to present their completed projects. This is important as HIPE staff have to present information on HIPE data to their own hospital staff. HIPE Data Quality and Audit expertise is a critical function that must be developed and supported within the HIPE department.

Coders are engaging more with the clinicians and coders are sometimes invited to meetings with clinical specialties and in some cases coders attend Grand Rounds and the Multidisciplinary Team meetings (MDTs). Audits by the National Office of Clinical Audit (NOCA) have brought more clinicians into the HIPE data quality realm.

An increased focus on HIPE data to monitor service quality is now recognised in many hospitals. However in other sites, where there are vacant posts and resourcing issues, the time for dedicated data quality work is limited. In hospitals where the HIPE manager has a dual role, the resources are not there to give dedicated time to data quality. The importance of continuous effective data quality review and auditing must be recognised by hospital management and clinical coders alike.

The Pavilion Report recommends the use of existing quality tools so that errors can be corrected in a timely manner. With HIPE data employed across many platforms for quality improvement, policy, planning, KPIs and funding it is important to quality assure this important national data set. HCAT©, the Checker© and the PICQ™ (Performance Indicators of Coding Quality) data quality assessment tool are some of the tools available to hospitals.

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17 At the time of the study the PICQ™ (Performance Indicators of Coding Quality) had not been implemented.

18 *Review of information management practices in the Hospital In-Patient Enquiry (HIPE) scheme*, HIQA October 2018.
    https://www.hiqa.ie/reports-and-publications/health-information/review-information-management-practices-hospital

PICQ™ is a commercial clinical coding data quality tool developed and supported by Pavilion Health, Australia. PICQ™ was rolled out at the end of 2018 and helps hospitals further monitor and improve the quality of their HIPE data and ensure compliance to the Australian and Irish Coding standards.

6. Work Place Environment & Resources

The workplace environment can impact employee morale and productivity both positively and negatively (Herzberg[19]). In the hospitals visited by the HPO there is widespread variation on the quality of working accommodation provided for coders. It is optimum that the HIPE coders be accommodated in one location, with access to the medical record, to include both hard copy and EHR systems. Some HIPE departments do not have dedicated accommodation and coders may be located in several locations, some sharing with other departments. Close proximity of HIPE team members allows for information transfer and discussion on cases amongst the clinical coding team. This encourages continuous learning and consistency in clinical coding. This will also encourage healthy communication that in turn supports team building, information exchange and data quality. It is important that the HIPE department is easily accessible to relevant hospital staff. This will aid with the visibility of the HIPE function within the hospital.

Hospitals that have put resources into upgrading their coder's accommodation appear to have improved the morale of the staff in the clinical coding department.

Mobile coding is the process where the clinical coder will interrogate the patient chart on the ward. This type of coding was discussed at all the sites visited and while it is operational in some hospitals, the lack of a designated workspace for a clinical coder to work on a ward seems to be the main drawback in this being implemented on a more wide scale basis.

In some coding departments clinical coders have access to two work screens so that that the HIPE portal can be open and coders can access other applications such as MNCMS, PAS and laboratory systems.

As part of this project the HPO working with HPO IT have developed a recommended specification of minimum technical requirement for HIPE staff. Table 2 below gives the current full specification of minimum requirements for HIPE Coders.

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19 Herzberg, Frederick; Mausner, Bernard; Snyderman, Barbara B. (1959). *The Motivation to Work* (2nd Ed.). New York: John Wiley

Table 2

Minimum Technical Requirements for HIPE coders

Hardware/Computer

HIPE coders need access to a personal computer or a laptop capable of:

• running Microsoft Windows.

• connecting two monitors and extending the desktop between them. Two screens are needed so that the coders can access the ebook/electronic copy of the coding classification and other hospital systems while simultaneously accessing the data entry system. Each monitor should be at least 28 inches wide.

• using a USB headset. Coders take part in on-going frequent training courses delivered via WEBEX/SKYPE or similar. HIPE staff need a personal headset with a microphone connected to their computer via USB.

• connecting to the internet. An internet connection is needed so that coders can research medical terminology and concepts, in addition to accessing national and international coding standard documentation.

Software

HIPE coders require the following software on their computers.

• Google Chrome browser minimum version 72

• Microsoft Skype for Business

• Microsoft Office standard

• Electronic Copy of the coding classification in use (provided by HPO)

• Access to EHR systems within hospital

• Access to shared network drives for shared working

• PDF printing software

• Email access

• Sound card

7. Medical Records and the EHR

The source document for the HIPE clinical coding process is the patient's medical record, be it in hard copy chart form, an EHR or a combination of sources. As described above the dual screen system, where available is proving invaluable for coders as patient information is increasing available through electronic systems.

The use of the EHR is increasing with many elements of the patient's medical record now being stored electronically. Clinical Coders need to review multiple systems to access information with regard to each discharge to be coded. Coders now need to be able to navigate these systems and become familiar with this new data landscape. Training in reviewing the EHR will now need to be part of clinical coder education in addition to training received on reviewing paper charts. This is an area that requires review by the HIPE team both in hospitals and at the HPO. The HPO are currently trialling a training tool for coders to use the EHR. This tool contains a bank of anonomised medical records for coders to train on.

> Recommendation 12 of the Pavilion Report includes:
>
> HPO needs to build an online database of coded anonymous medical records with questions about the correct codes, the answers and explanations of why those are the correct codes. This database should be available to clinical coders for independent learning, and to hospitals for on-the-job training, as well as for use in HPO courses.

In all hospitals visited there was support with chart retrieval from a non-coding staff member to assist. The process of making the charts available to the coders appears to work well. The number of hours allocated to chart retrieval varies depending on the size of the hospital and number of charts to be retrieved but varies from 2 hours per day to 2 WTE staff. In the main, this role is from the administration staff. In one hospital retrieval of charts is a porter's function.

Updating the PAS/IPMS is not within the remit of the clinical coder although they must verify that the information that is downloaded to the HIPE Portal from the PAS/IPMS is correct before submitting the HIPE record. Chart administrators at ward, clinic and directorate level are responsible of ensuring that patient documentation is filed appropriately in the patient record.

> One hospital visited is implementing, on a pilot basis initially, a new electronic based *paper light* patient based record system for Paediatrics and Dermatology. The patient's chart will be collected following the patient discharge scanned by a commercial company which is based 200km away. The process for destruction at the time of the HPO Visit had not been finalised. Staff including coders will be able to access patient records 24/7 directly at the point of care.

8. Communication

Communication is critical for any system to operate to an optimum. For HIPE this communication is necessary with all stakeholders within hospitals, groups, the HPO and the wider HSE.

In the hospitals visited, the coders have involvement with a number of committees. The overall consensus is that clinical engagement has improved. There is some inconsistency on the level of engagement with ABF, although many managers reported having representation on the ABF committees. HIPE managers also reported participation in Medical Records committees, Sepsis committees, and Mortality committees. There is also participation in Grand Rounds and MDTs (Multidisciplinary Teams).

As the chart documentation is central to the work of the coder it is critical that all clinicians understand the value of good records not only for patient safety and recording of a patient's episode but also for good abstraction and coding for HIPE data. HIPE managers usually deliver a brief presentation at the induction day for NCHD's. However not every hospital has the resources to provide training for the NCHD's.

The Pavilion Report highlights the importance of increasing the visibility of coding managers and clinical coders. Some hospitals have newsletters where coding issues can be highlighted. The consensus is that there are good communications with the Clinical Nurse Specialists but more engagement with the clinicians is required. Mobile coding on wards has made the clinical coders more visible with the Nursing Staff.

HIPE *Coding Notes* which is a newsletter circulated quarterly by the Healthcare Pricing Office is an important information source and communication tool for those involved in HIPE. It is important that all involved read each edition to keep abreast of developments in HIPE. *Coding Notes* alerts users to developments and updates in HIPE coding, articles of interest that have arisen from a HIPE audit or other data quality reviews and new classifications guidelines, coding queries and training alerts. *Coding Notes* is circulated to all the coding community and clinical coders are invited to submit articles of interest.

Challenges, Risks & Recommendations

The challenges for HIPE Departments include but are not limited to; meeting the monthly deadlines while maintaining data quality, manpower resource issues, the delays in the recruitment process for recruiting replacement posts, lack of promotional opportunities/pathways for experienced coders or pathways for coders within hospitals, and union issues in relation to upgrading posts. Other concerns raised included an embargo on Grade 4's producing reports, lack of progress on ABF, and raising awareness of ABF with the clinicians. It was recognised that it is not possible to have an even job split of 50% non-coding HIPE duties and 50% coding as the coding element takes precedence due to the pressure of deadlines.

The draft ABF Implementation Plan 2019-2022 recognises that the number of experienced clinical coders overall has been reduced in recent years partly due to retirements and transfer of staff to other areas within the hospital. This new plan recognised that additional senior HIPE coder positions for hospitals with changes to their structure as discussed in this report, are required to fully staff the HIPE function.

To ensure that HIPE Departments will operate to an optimum, structures as suggested in Table 1 of this report will ensure best practice for HIPE and coder retention and recruitment. It is critical that hospitals recognise the risks associated with delayed recruitment for new or replacement posts. The clinical coding role is specialised and lead in time is required for training in all aspects of the job including coding, auditing, data quality review and reporting. A standard structure similar to those proposed in Table 1 will provide a career pathway for clinical coders and help with the retention of staff within HIPE. Table 1 in this report lays out the possible roles and responsibilities for HIPE departments in hospitals of different sizes. While 'one size doesn't fit all',Table 1 offers options for different types and size of hospitals. The HSE are currently working with the trade union Fórsa on a job evaluation of Grade IV clinical coder roles. The outcome of this will inform future developments in this area.

Many hospitals will be different, for example a small hospital may just need a HIPE Team leader who would lead on mentoring and data quality whereas a bigger hospital would need separate roles for data quality, mentoring & training, reporting and data management

During the course of this project it has become clear that the role of the clinical coder is evolving. The clinical coder is expected to take responsibility for their data, for its quality and timeliness. The clinical coder needs to be able to progress within their role for both personal and professional advancement. There are opportunities to evolve roles for coders as their experience and knowledge builds. These specialised staff needs to be encouraged and supported to develop in order to support the HIPE system. The HIPE department can be seen as an attractive place for people to work with good opportunities for development, learning and career progression. In turn retention of staff will be supported by a clear career path within the department.

Table 3 below summarizes some of the challenges, risks and recommendation arising out of this project.

Table 3 – Challenges, Risks and Recommendations

Theme	Challenge	Risk	Owner of Risk	Recommendation
Role of the Coder	Currently there is disparity in the coder's role. Different coders are doing different jobs, no uniformity.	Coder not supported throughout hospital leading to poor returns. Coders do not stay in the position as without a clear role there is dissatisfaction for the clinical coder with no incentive to stay	Hospitals	Clearly defined roles for the different levels of clinical coder required in the hospital and the group HPO to work with HSE on Job specifications for each HIPE role.
HIPE Team Structure	Where no team structure exists roles are not clearly defined and clinical coders are not clear on their role or potential roles.	Deadlines are not met and data quality is not monitored. Work is not evenly distributed.	Hospitals Hospitals	Develop a team structure to support professional and personal development Clearly define roles and responsibilities
		Coders do not receive support in terms of mentoring or education.	Hospitals/HPO	
		Audit and DQ activities are not managed	Hospitals	
		The HIPE department does not meet all the needs of the hospital and/or the group.		
		Trained coders leave if there is no prospect of development or promotion.	Hospitals	

Theme	Challenge	Risk	Owner of Risk	Recommendation
Recruitment & Retention	There is a nationwide shortage of coders. With the lack of clarity in the role(s) HIPE is currently not attracting people to the roles. Staff are not staying because there is little or no chance of advancement	People will not apply to join HIPE when jobs are advertised if the job is not attractive and has no prospects	Hospitals	Clearly defined structures with nationally agreed job specifications to provide a clear route for progression which will encourage people to join the HIPE Team and to be retained as a supported member of a clearly defined team
		Staff will leave HIPE for promotion or more varied roles	Hospitals	
Coder Education	Identification of training needs nationally	Poor data quality and inefficiency – including resources required for sending cases back to hospitals for review by the HPO. Hospital resources correcting cases that are sent back for review	HPO/Hospitals	A training management system would allow the HPO to perform a national training needs analysis in planning training for HIPE Clinical Coders
	Access to distance learning for HIPE clinical coders	Clinical Coders unable to avail of or participate in training resulting in poor data quality	HPO/Hospitals	Some components of the Clinical Education Programme could be made available on-line to facilitate self-paced learning but resources are required to build online training modules and record training sessions. Hospitals and HPO require IT resources to facilitate this
	Resourcing and Staffing the HIPE training function at Hospital level	Poor data quality and inefficiency due to lack of training	Hospitals	HIPE training function to be resourced locally

Theme	Challenge	Risk	Owner of Risk	Recommendation
Coder Education	Currently it is not mandatory for HIPE clinical coders to participate in HIPE Training	Training needs not addressed in a timely manner at a local level leading to inaccurate data and/or inappropriate funding	Hospitals	Core HIPE training needs to be mandatory and participation needs to be as prescribed by the HPO
	Clinical coder training records are not always kept locally	If clinical coders do not participate in HIPE training this can reduce the accuracy of HIPE Data	Hospitals	Each Hospital HIPE Department to maintain clinical coder training records locally
		Prevents Training Needs Analysis being carried out locally	Hospitals	Regular Training Needs Analyses required locally to manage and support HIPE.
	The HPO are not in a position to make medical records available for use at training courses	Abstraction skills cannot be taught, practiced or assessed at training courses	HPO	eHRoI tool which is currently being trialled, if suitable could be used to teach and assess abstraction kills
Data Quality & Audit	Resourcing and staffing of data quality function at hospital level	Lack of confidence in HIPE data	Hospitals	HIPE data quality and auditing function to be resourced locally
	Data quality and audit function not prioritised by hospital management	Incorrect ABF funding	Department of Health	Management to ensure that HIPE data quality strategy is implemented • Use data quality tools • Conduct chart based audits • Apply national coding guidelines

Theme	Challenge	Risk	Owner of Risk	Recommendation
Data Quality & Audit	No dedicated time for data quality activities	Poor data quality	HPO/Hospitals	Engagement of all HIPE Staff in data quality and audit function
	Lack of engagement of all HIPE staff in data quality and audit	No measure of data quality	HPO/Hospitals	HPO to provide training on HIPE data quality and audit
		No improvement in data quality	HPO/Hospitals	Adherence to Standards for ethical conduct in clinical coding
		HIPE staff unaware of data quality issues	HPO/Hospitals	Clinical support for role of HIPE and HIPE data quality at hospital level
EHR / Source Document	The EHR/Source document must contain accurate, legible and accessible information to support the collection of the activity data by clinical coders.	Charts illegible and / information incomplete.	Hospitals	Acceptance of any new EHR system requires correct planning and change management
		EHR is not easily accessible		
	Coders should be able to access patient electronic records at the point of care	Coders not given access or training to full EHR		Good communication and training is essential
	Clinicians need to understand what is required to ensure accurate data is recorded.	Information in the chart is not adequate and incorrect or incomplete information is reported.	Hospitals	Engagement with clinicians through regular meetings increase clinicians understanding of HIPE and ABF

Theme	Challenge	Risk	Owner of Risk	Recommendation
EHR/Source Document	Ensure that there is adequate support for chart retrieval and storage of documentation	PAS is not updated prior to HIPE Coder receiving the chart Results are not back in time to meet coding deadlines	Hospitals	Process for retrieval and storage of electronic information should be clear to all HIPE coders
	Clinical coders have timely access to all parts of the patient's record.		Hospitals	
Communications	HIPE Coding Departments do not meet and discuss relevant issues regularly	HIPE is not known outside of the HIPE office and the data will not be regarded as trustworthy	Hospitals	Regular Team meetings for HIPE departments. Buy in for HIPE by all relevant sections of the hospital Increased visibility of the HIPE function within hospitals leading to increased engagement and support
	HIPE team members not involved in other work in the hospital – in Grand Rounds, MDT meetings, Finance, Reporting, Patient Safety, and Quality improvement	HIPE's central role in ABF is not understood or supported	Hospitals	Include HIPE staff in Grand Rounds, MDT meetings, Finance, Reporting, Patient Safety, and Quality improvement Committees
Environment & Resources	Coders not in a single location with adequate access to chart, paper or electronic records.	Coders make errors in coding due to isolation from colleagues.	Hospitals	Ensure coders have a good working environment close to coding colleagues

Theme	Challenge	Risk	Owner of Risk	Recommendation
Environment & Resources		Communication inadequate within HIPE department.	Hospitals	Coding environment should be undisturbed in so far at this is possible. Coders need to be supplied with 2 PC screens and headsets
		Trained clinical coders leave due to poor or under resourced working conditions.	Hospitals	Good access to medical records
Group Coder Managers/Group Coders	Role of the Group Lead Coder is across the groups	Group lead is largely relying on the co-operation of the hospitals which makes the role more difficult to define in terms of leadership	Groups / New Regional Health Bodies	Role needs to be more clearly defined with a consistent approach Proposed geographic alignment of community healthcare organisations and hospital groups will influence the future of this role.

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9. PICQ™ (Performance Indicators of Coding Quality) (Page 12)

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Appendix 1

Letter to Group CEOs informing of the project

Dear CEO

RE: HIPE Clinical Coder Resources within the ABF Hospitals

As you are aware in late 2016 and early 2017, I along with my colleagues from the HPO HIPE Team undertook a series of Clinical Coder engagements around the country outlining the impact which ABF has had on hospital funding and clinical coding. I also discussed the results and recommendations of the 2016 *National Audit of Admitted Patient Information in Irish Acute Hospitals Report* (Pavilion Health 2016[20]).

The purpose of the Pavilion study was to assess the validity of the data underpinning the HSE's ABF model and among its conclusions was that while the overall quality of the HIPE Data is sufficient to move forward there is a need to develop and resource a national quality data improvement agenda that reduces variations in clinical coding practice between the hospitals.

Recommendation 10 of the Pavilion Report is a proposal on staffing:

"In hospitals where Clinical Coder staffing is greater than 5 Whole Time Equivalents (WTE) a workforce structure and common job specification be designed as follows:

- Trainee Coder
- Competent Coder
- Senior Coder (internal auditor/on the job trainer/mentor)
- Manager
- Quality Control Manager"

(*Reference: Pavilion Health 2016, National Audit of Admitted Patient Information in Irish Acute Hospitals, National Level Report, Page 14*)

Deirdre Murphy, Head of HIPE at the HPO, together with her team and the HPO Business Manager, Maureen Lynn are embarking on a scoping exercise to address the issues within this recommendation.

An annual national HIPE Staffing Survey has just been completed which identifies staff resources in HIPE by Hospital. However a much richer analysis of requirements and resources is needed for us to seek to implement Recommendation 10. This will involve analysis of hospital complexity and existing structure of HIPE Departments.

In order to inform the process, we will now engage at hospital level, and meet with the relevant HIPE team members in your group and your hospitals to assist us in this exercise.

We look forward to working with you on this important initiative. Please do not hesitate to contact me if you require clarification on this project.

Yours sincerely,

Maureen Cronin
Assistant Chief Finance Officer
Head of Acute Hospital Finance – ABF/HPO

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20 Full report available at www.hpo.ie

Appendix 2

Hospitals Visited for the Project

Hospital	Date Visited	Met with	Notes
UL Hospital Group	01.12.17	HIPE Group Manager, Planning and Performance Finance Manager	Group Manager Post currently undergoing recruitment
New Children's Hospital	10.01.18	CFO ABF Accountant Management Accountant	As of January 2019 the Children's Hospital has its own legal entity
Tallaght University Hospital	30.01.18	CFO ABF Accountant HIPE Manager	
St. James's University Hospital	13.02.18	HIPE Co-ordinator MIS Manager IT Manager	HIPE reports into MIS Department
St. Vincent's University Hospital	21.02.18	ABF Accountant HIPE Manager	
Regional Hospital Mullingar	16.03.18	Finance Manager HIPE Manager	
Beaumont Hospital	09.04.18	Director of Finance HIPE Manager	Group post on hold at time of meeting
University College Hospital Galway	21.05.18	HIPE Group Manager Finance Manager	Obtained overview of the HIPE Coding Structures for Saolta
University Hospital Waterford	09.07.18	ABF Accountant HIPE Manager	HIPE manager has a regional remit with more than 1 group
University Hospital Kerry	25.09.18	HIPE/Medical Records Manager HR Manager	
South Infirmary Victoria University Hospital, Cork	26.09.18	CFO Hospital Accountant Assistant Administrative Services Manager HIPE /Casemix Co-ordinator	
Cork University Hospital	26.09.18	HIPE Manager	
Mercy University Hospital, Cork	26.09.18	HIPE Manager	
South Tipperary General Hospital (Clonmel)	19.10.18	General Manager Finance Officer	
Mater University Hospital	13.11.18	Director of Finance HIPE Manager	

Appendix 3

Introductory note for each meeting

As you are aware in late 2016 and early 2017, Maureen Cronin along with some of the HPO HIPE Team undertook a series of Clinical Coder engagements around the country outlining the impact which ABF has had on hospital funding and clinical coding. Maureen also discussed the results and recommendations of the 2016 *National Audit of Admitted Patient Information in Irish Acute Hospitals Report* - The Pavilion Report

The purpose of the Pavilion study was to assess the validity of the data underpinning the HSE's ABF model and among its conclusions was that while the overall quality of the HIPE Data is sufficient to move forward there is a need to develop and resource a national quality data improvement agenda that reduces variations in clinical coding practice between the hospitals.

Recommendation 10 of the Pavilion Report is a proposal on staffing:

"In hospitals where Clinical Coder staffing is greater than 5 Whole Time Equivalents (WTE) a workforce structure and common job specification be designed as follows:

- Trainee Coder

- Competent Coder

- Senior Coder (internal auditor/on the job trainer/mentor)

- Manager

- Quality Control Manager"

We are embarking on a scoping exercise to address the issues within this recommendation.

An annual national HIPE Staffing Survey has just been completed which identifies staff resources in HIPE by Hospital. However we are hoping for a much richer analysis of requirements and resources by meeting people at the coal face who can really describe to us their current situation and what are the main issues around HIPE with particular focus on HIPE staffing, responsibilities and HIPE department structures (as described in the Pavilion Report).

We have been doing our own thinking around this and are happy to share some initial thoughts we have that may help build a framework for us to start to develop a well-resourced HIPE function nationally.

There is a lot of movement currently with Groups recruiting HIPE managers and coders and these initiatives are to be welcomed – it is important that everyone works together at local hospital, at group and at national level and that we are all working to the common goals of providing high quality, timely and accurate HIPE data for the system and that we support, resource and develop the dedicated HIPE staff across the system.

We look forward to our meeting today and have some questions that we hope will encourage discussion and debate

We will report back to you on our findings both here and nationally in the coming months, and while we have to make it clear that we cannot sanction any upgrades or new staff we are more than happy to consider all proposals, ideas and issues raised here today.

Appendix 4

HPO HIPE Clinical Coder Education Programme

Course	Venue	Audience	Duration
Intro to HIPE 1	HPO	New Clinical Coders	1 day
Intro to HIPE 2	WebEx	Clinical Coders that have attended Introduction to HIPE 1	2.5 hours
Coding Skills I	HPO	Held within two weeks following the introduction to HIPE II	2 days
Coding Skills II	HPO	Held 1 month after Coding Skills 1 focusing on clinical coding, clinical coding guidelines and HIPE portal training	3 days
Coding Skills III	HPO	Clinical coders who have completed Coding Skills II, aims to consolidate training and work experience	3 days
Coding Skills IV	HPO	All clinical coders to provided clinical and coding information on specialty areas such as Endoscopies and Neoplasms	Half to one day
Refresher Course	HPO	Experienced Clinical Coders to update their knowledge	Held on demand
Anatomy and Physiology Courses	HPO	Focused on the anatomy and physiology presented by an expert speakers	On demand
HIPE Training and Mentoring Course	HPO	Specialised HIPE Training and mentoring course for experienced HIPE staff	5 Days & Project work
HIPE Coding Audit Course	HPO	Specialised HIPE coding audit course for experienced HIPE staff	3.5 days & project work
Certificate in Clinical Coding at level 6 on the national framework of qualifications	HPO	All clinical coders working within the HIPE System not based on grade or supervisory level	5 assessments & Coding examination

Appendix 5

ICD-10-AM/ACHI/ACS

CLINICAL CODERS' CREED[21]

Although new codes are introduced regularly, on the whole the ICD-10-AM classification structure remains constant over time. Codes and coding standards need to change to try and keep pace with medicine, but ultimately, clinical coders will often need to make decisions which are based on their **experience and common sense** as well as the resources available to them.

When you look at what clinical coders do objectively, they assign numbers from a structured, classification system to complex, ever-changing medical concepts which are not documented in a standardised way – no wonder it can be difficult! To revisit the fundamental skills of the clinical coder:

- A clinical coder has a thorough, working knowledge of medical science and terminology.

- A clinical coder can read the clinical record and make decisions about the appropriate codes to assign, based on the clinical documentation.

- A clinical coder understands the structure and use of a statistical classification.

The important features of these three points are **medical science, make decisions and structure**.

- Medical science is complex and forever changing.

- Decision-making is subjective.

- Structure of the classification is static.

The point is, no matter how much one might hope there will be hard and fast rules to solve all our coding problems, it remains that no amount of rules will ever replace the educated judgments that clinical coders make about specific cases based on the...

Clinical Coders' Creed

These things are the fundamentals of the art and science of clinical coding:

    Clinical documentation

    Communication with clinicians

    Coding standards

    Conventions

    Classification experience

    Common sense

    s**C**ience of medicine

All this serves to highlight the considerable and often forgotten skills of clinical coders.

Decisions in coding based on **Sailing the Seven Cs with the Clinical Coders' Creed** will ensure assignment of a code that is as good as possible – the work of a competent clinical coder.

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21 Source: Australian Standards for ICD-10-AM/ACHI 8th Edition. Australian Health Services Research Institute (AHSRI), University of Wollongong, Independent Hospital Pricing Authority (IHPA). Sydney Australia. 2013