Skilled Knowledge Workers in Short Supply

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This is a demanding time for coders. MS-DRGs and present on admission requirements would have been challenging on their own; however, both came at virtually the same time, straining coders already stretched to meet their job requirements.

Recruitment and retention of coding staff is another concern for organizations. Add to the mix tight operating budgets, heightened compliance concerns, and information systems in transition, and it is very clear why skilled knowledge workers are challenged as never before.

Identifying the Issues

AHIMA polled coding experts to get a firsthand view of the coding environment in "Coding's Biggest Challenges Today." Experts report that even without the new requirements, facilities across the US struggle to hire and retain skilled professionals, achieve high standards of accuracy and productivity, keep reimbursement flowing, and produce data that accurately reflect the quality of patient care provided.

There is no question that coding is growing in complexity. MS-DRGs and present on admission are obvious examples, but the complexity of coding reflects the complexity of medical care and the complexity of reimbursement.

US coders face three major handicaps in performing their work: outmoded classification systems (ICD-9 and its "patches") to code increasingly complex concepts, the Byzantine requirements for reimbursement, and the variability of supporting documentation, an age-old problem, but one that is compounded in the hybrid state of most records.

Clinical Documentation Improvement

That leads us to a very timely discussion of clinical documentation improvement (CDI), a work process that many organizations are putting in place to ensure more complete documentation to support coding and ensure compliance. "Leading Clinical Documentation Improvement" describes several HIM-led programs that allow readers to judge the potential value of such an initiative for their organizations.

In the past our only resource has been people checking documentation. In the years to come the EHR has the potential to ensure that documentation meets a full range of requirements.

This vision underlies AHIMA's initiatives to advance data and record content standards. It is clear that this generation of EHRs does not fully use the power of technology to improve and standardize documentation. We can't blame the technology. Humans must define what documentation is needed, which is the crux of AHIMA's data standards initiatives. This is tough work, and it must be highly collaborative, but it is necessary to realize the big payoffs in the EHR.

A potential step toward standardization may come through the Continuity Assessment Record and Evaluation (CARE) instrument, which is described in "Demonstrating CARE." The Centers for Medicare and Medicaid Services is testing the instrument in hospitals, skilled nursing facilities, long-term care hospitals, home health agencies, and inpatient rehab facilities through 2010. CARE may offer a tool or model for integrating the current set of multiple, nonaligned federal assessment instruments.

Another step forward is reflected in newly approved CCHIT requirements that ambulatory EHRs must be capable of exchanging a continuity of care record. Standardizing the interoperable functions of the EHR is a strong start, but we also need to standardize content within and across EHR systems, including clinical vocabulary and classification tools.

The US also needs to transition to ICD-10. As highly skilled knowledge workers, coders need better classification systems and more sophisticated tools for the complex work they are responsible for.

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