Year in Review: Highlights from 2014

Save to myBoK

by Sarah Sheber

The *Journal of AHIMA*'s ongoing web series "HIM Frontlines," explores pressing obstacles that health information management (HIM) professionals encounter in a rapidly changing healthcare environment. Major federal initiativs such as the "meaningful use" EHR Incentive Program, HITECH-HIPAA, and the implementation of ICD-10-CM/PCS—as well as their various stages and deadlines—have challenged practitioners to think creatively to meet all their requirements.

In 2014, even though the ICD-10 implementation date was pushed back another ear to October 1, 2015, coding managers and coding departments remained focused on finding creative ways to keep their coding workforce prepared.

It should come as no surprise, then, that coding-related topics and issues centered on recruiting, training, and retaining coders dominated HIM Frontlines this year.

The Year in ICD-10

Peer-to-Peer ICD-10 Training

While many healthcare providers have looked internally or relied on innovative recruiting methods to get their facilities ready for the new code set, many have looked to outside companies to prepare.

In February, Frontlines featured the peer-to-peer approach to training physicians, and talked to Dr. Gary Huff, MD, CCS, CCDS, AHIMA approved ICD-10 Trainer, an internal medicine specialist. Huff is the CEO of Huff DRG Review Services, a company that provides revenue cycle consulting services and peer-to-peer training for physicians. For example, neurologists would train other neurologists, and surgeons train surgeons. And the physicians that work for Huff don't emphasize code selection. Rather, they concentrate on improving documentation. The last thing Huff would do, he says, is to leave his physician clients with a list of codes to memorize.

"I tell everybody, if you give me a surgeon, and give me his data, I can go through and tell him what he needs to document in 15 minutes. I don't need hours of education with a doctor. Once a doctor, talking to another doctor, reviews his documentation and determines what his data issues are, I can relate this to him in 15 minutes," Huff said.

Coder Training Hub

For Minnesota's Allina Health, the increased need for ICD-10-ready coders is coinciding with the reality that many of the health system's coders are reaching retirement age. With this in mind, Patricia Bower-Jernigan, RHIA, system-wide coding director at Allina Health, increased her coding staff 16-fold over 2013 and 2014.

Bower-Jernigan created a Training Hub to help onboard new coders under a program that pairs new coders with coding mentors.

"For the new coders, boy, it's very intimidating, because everything is new," Bower-Jernigan says. "So we feel that if we can get them well educated in the interview process and how the training takes place, it helps prepare the process of the training itself."

She has also met success by working with local HIM educators and colleges in the area to find qualified recruits.

"There's huge value in working with the educators within your community and partnering with them to identify what's working really well with the newly graduated student on who we get versus where there's opportunity in the classroom setting," she adds.

The 'Grow Your Own Coders' Trend

In 2014, HIM Frontlines talked with founders of two programs that, while unrelated, took a "grow your own coder" approach to filling holes in coder demand.

Rural communities have their own particular set of trouble finding coders, as do many sectors in rural health. Demand is high because, like in many industries, it's difficult to entice professionals from cities and larger population centers to rural communities. This problem is acutely felt in Kansas where few community colleges and technical schools offer HIM programs.

Sherry Farrell, MBA, RHIT, HIM coordinator at Seward County Community College/Area Technical School in Liberal, Kansas, attempted to make a dent in this by recruiting coders straight out of high school. Local high school students who meet Farrell's program requirements can start their coding classes and training while still in high school by taking classes at a community college, online, and by taking anatomy and physiology classes taught by qualified high school teachers. Students can start their junior year of high school and graduate with a coding certificate.

Farrell says that starting a coding career in a rural community does offer advantages and solid experience for later in one's career.

"I tell them in the classroom, 'work in a rural area for a while.' You can get a lot of experience doing that because you can do so many different things."

But the coder shortage transcends population concentration, as it turns out.

Cyndi Thomas, vice president, revenue cycle business development and sales, North Shore-LIJ Health System, is hard at work on a program for her health system that offers coding students a stipend and educational reimbursement in the New York City area.

The program offers students chosen for the program $5,000 to cover the costs of their books and training, plus a $10,000 stipend when they've completed and passed the coding curriculum. The program consists of an intensive thre month-long classroom experience, plus a nine-month apprenticeship where they work with a designated mentor. Once these are done, they are guaranteed a job at North Shore-LIJ Health System as a coder.

"I think that this health system is putting their money where their mouth was. We're asking students to sign a two-year commitment to the health system as a coder," says Thomas, acknowledging that it's unknown how enforceable that will be. "But it tells them we're investing in them, that it wouldn't make us happy if they took this education, went down the street, and worked for another hospital."

Electronic Health Records

With the start of stage 2 of meaningful use, solving problems posed by EHRs was the second most popular subject of HIM Frontlines in 2014.

EHR Directors

In January, Frontlines explored the job of Suzanne Goodell, MBA, RHIA, director of meaningful use at Cone Health. At the time, Gooddell was one of only a handful of AHIMA members that had "meaningful use" in their job title, but it's starting to pop up more and more.

Now that meaningful use has reached the attestation and reporting validation stage, "I'm the one who reads the Federal Registers and keeps up with all of the online news about what's changing and the regulations," Gooddell said. "A lot of the time when we're building for meaningful use or making an adjustment to the build, I have to go back to the federal rules to determine what the specifics are. A lot of the devil is in the details."

Pediatric/Adolescent EHRs

The meaningful use requirement that providers develop a patient portal where patients can view, download, and transmit their health information means that portals must be available for pediatric and adolescent patients. Because the information held in these portals has its own set of privacy and functionality demands, special care needs to be given to their creation.

Anne Tegen, MHA, RHIA, director of HIM, Children's Hospitals and Clinics of Minnesota, discussed these challenges in a two-part Frontlines article. For pediatric EHRs healthcare providers often find themselves on their own when it comes to tailoring their EHRs. Customizing an EHR to reflect a child's needs and status requires special attention for both practicality and safety. For example, weights and measures for babies need to be redesigned to pediatric sizes, as well as doses for medications.

Adolescent patient portals must deal with the thorny issue of deciding the age at which parents are and are not allowed to access their child's health information. For instance, should the provider abide by the legal definition of adulthood, at 18? Or do they make the cut-off age 13, which is when adolescents tend to become more reticent to discuss private health matters with their parents?

Before EHRs it was easier for HIM departments to separate out what an adolescent did and did not want their parent to see of their record.

"So in the paper world it was easy, you just pick up a pink form to write that information on it," Tegen says. "And when you went to release the record, and the parent asks for it, you wouldn't give them the pink form, you'd just give them everything else. They have a right to have it because their adolescent isn't considered legally an adult… it's become very difficult to identify how to separate out that information without causing the physician to do more work."

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