



A Strategic Asset

Health Information Management Association of Australia (HIMAA)

Submission on the

**COAG Independent Review of Accreditation Systems within the
National Registration and Accreditation Scheme for health
professions**

Discussion Paper February 2017

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Document Information

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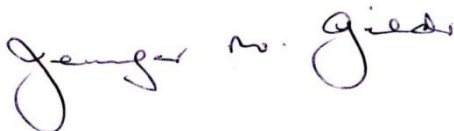
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This document will be reviewed upon feedback from COAG's Australian Health Ministers' Advisory Committee.

National COAG Health Care Accreditation Submission

HIMAA welcomes this opportunity to contribute to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professions Discussion Paper of February 2017 (the Review).

The Health Information Management Association of Australia Ltd (HIMAA) is the peak professional body for health information management (HIM) professionals in Australia. It has been serving the health information management profession since 1949. HIMAA is committed to improving the health of all Australians through professional information management.

Health information management professionals contribute to the health outcomes and delivery of the healthcare system through best practice health information management. Recognised occupations include Health Information Managers (HIMs) and Clinical Coders (CCs).

As the profession's peak organisation, HIMAA provides national advocacy on issues of strategic importance, and national standards for practice quality and safety. The Association strives to promote and support our members as the universally recognised specialists in information management at all levels of the healthcare system.

HIMAA also provides competency standards for the delivery of education and training across the learning life of the HIM practitioner. At the tertiary level, HIMAA has been accrediting university degrees in health information management against its Entry Level HIM Competency Standard since 1992.

At the Vocational Education and Training (VET) level HIMAA delivers education and training in Clinical Coding through distance learning in Australia and overseas, and Continuing Professional Development activity for graduates at VET and degree levels nationally through online activity and its internationally recognised annual conference, and locally through its regional branches, networks and special interest groups. HIMAA is by far the largest provider of national VET in Clinical Coding and is recognised by industry as the standards setter in this occupation.

HIMAA's Professional Credentialing Scheme offers quality assurance to the profession and to employers on individual currency of credentials through continuing professional development and quality improvement activity. Participants in this scheme are eligible to bear the post-nominals CHIM (Certified Health Information Manager) or CHIP (Certified Health Information Practitioner) depending on their level of HIMAA membership.

HIMAA is a member of the International Federation of HIM Associations (IFHIMA), and a mutual recognition of certification agreement exists with fellow IFHIMA member association CHIMA in Canada.

It is on the strength of this authority that HIMAA presents this submission to COAG's Australian Health Ministers' Advisory Committee.

Accreditation: The Inclusion on Non-frontline Non-clinical Professions in the NRAS

The Review states that:

"The establishment of NRAS merged over ninety different Acts of parliaments into a single National Law which was then promulgated across all states and territories and applies a consistent and common approach to the regulation of health practitioners and to the accreditation functions." (p.2)

The NRAS does not, however, include non-frontline health care professions such as HIM, even though HIM professionals are as important as frontline healthcare practitioners in the delivery of health care services to the Australian community. Patient privacy and the

confidentiality of their information in the hospital system is of central ethical as well as practice concern to the HIM professional. The quality, integrity, storage and secure transmission of health information is crucial not only to quality patient care but, more importantly patient safety. The prevention of adverse patient outcomes caused by poor medication information on allergies and other contraindications is possible only through the effective, ethical and responsible management of patient information. The management of negative trends in the health of the community is possible through the availability of accurately classified health information, at local, regional and population health planning levels, is also a preserve of the HIM profession. In these days of Activity-Based Funding, health facility finance management also depends on timely and accurately coded health information data to inform funding activity.

In the current climate of eHealth reform, there are longer-term benefits that a whole of system digitised Health Information Service can bring to the population in terms of improved quality of care and reduced economic health cost burden. The reduction of duplication in diagnostic tests and procedures in tertiary health facilities alone will save millions of dollars, and save lives. The need for a patient to repeat their health story at every stage of their journey through a health system is relieved, as frontline staff have the relevant patient history at their fingertips. Having the right information for the right patient to the right health care practitioner in the right place at the right time will have an overwhelmingly positive service impact throughout the healthcare system.

Moreover, international evidence^{1,2,3,4,5,6,7,8,9} shows that in terms of general health outcomes, Primary Care is far more effective than Secondary and Tertiary Care, which can at times be ineffective. Digitised health information provides the mechanism of information transfer whereby the integration of Primary Care and Tertiary Care is possible. It is this integration of care that will provide the greatest benefits to the health consumer, both in terms of quality of care and the national relief of health care cost burden. But for the integration of care across the Tertiary~Primary divide to be possible, interoperability between information management systems in both sectors needs to be seamless. This interoperability is not just between health IT and its various softwares, but also between the internationally-based clinical classification systems on which hospitals and general practices depend.

The Australian Modification of the International Classification of Disease version10 (ICD-10-AM), including the Australian Classification of Health Interventions, used throughout the hospital system is the most sophisticated in the world in terms of breadth, depth and complexity of health care delivery it can capture. In contrast, the International Classification

¹ Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *The Millbank Quarterly*, vol 83, no 3, 2005, pages 457-502.

² Greenfield S, Nelson EC, Zubkoff M, Manning W, Rogers W, Kravits RL, et al. Variations in resource utilization among medical specialties and systems of care. Results from the medical outcomes study. *JAMA* 1992;267:1624-30.

³ Forrest CB, Starfield B. The effect of first-contact care with primary care clinicians on ambulatory health care expenditures. *J Fam Pract* 1996;43:40-8.

⁴ Lindman AB, Grumbach K, Osmond D, Komaromy M, Vranizan K, Luri N, et al. Preventable hospitalizations and access to health care. *JAMA* 1995;274:305-11.

⁵ Wasson JH, Sauvigne AE, Mogielnicki RP, Frey WG, Sox CH, Gaudette C, et al. Continuity of outpatient medical care in elderly men. A randomized trial. *JAMA* 1984;252:2413-7.

⁶ Changing remuneration systems: effects on activity in general practice. Krasnik A, Groenewegen PP, Pedersen PA, von Scholten P, Mooney G, Gottschau A, Flierman HA, Damsgaard MT. Institute of Social Medicine, University of Copenhagen, Panum Institute, Denmark

⁷ Ferrante JM, Gonzales EC, Pal N, Roetzheim RG. Effects of physician supply on early detection of breast cancer. *J Am Board Fam Pract* 2000;13:408-14.

⁸ Campbell RJ, Ramirez AM, Perez K, Roetzheim RG. Cervical cancer rates and the supply of primary care physicians in Florida. *Fam Med* 2003;35:60-4.

⁹ Roetzheim RG, Gonzalez EC, Ramirez A, Campbell R, van Durme DJ. Primary care physician supply and colorectal cancer. *J Fam Pract* 2001;50:1027-31

of Primary Care, in its Australian Plus 2 modification (ICPC Plus2), is not used by a single general practice in the country. The only GP research organisation using ICPC Plus 2, the University of Sydney's Family Medicine Research Centre, had its funding pulled by the federal government last year and 17 years of clinically classified research data on general practice activity went with it.

In Australia, GPs are depending on another, terminology-based electronic data collection system, SNOMED-CT, to populate their national My Health Record. But SNOMED-CT is not a classification system. It behaves like a generative grammar, generating meaning. ICD-10-AM, by contrast, is used in the capture of health care information. They serve different functions, but for the transmission of health care information between SNOMED-CT and ICD-10-AM to be managed, HIM professionals are essential.

On so many levels, then, HIM professions are the key to eHealth Reform success. And yet they are not recognised by or included in the NRAS. Instead, the profession is established, on professional entry, by the profession-led accreditation of their HIM degrees by their professional association, HIMAA, and the provision of VET in Clinical Coding to industry standards.

The inclusion of non-frontline professions such as HIM in the delivery of Australian healthcare in the NRAS will greatly assist in achieving the Review's first point of reference, "a consistent and common approach to the regulation of health practitioners and to the accreditation functions".

Education, Training, and Professional Competency Standards

"A second point of reference is that of ensuring the quality and relevance of the education. Two of the six legislated objectives for NRAS refer to facilitating the provision of high quality education and training of health practitioners and to enabling innovation in the education of health practitioners."(p.1)

As the HIM profession's association, HIMAA has been accrediting university degrees in HIM against entry-level professional competency standards since 1992. HIMAA chooses competency standards against which to accredit HIM degrees specifically to avoid prescribing curriculum to its HIM higher education providers. HIMAA understands that universities are better placed and supported in adapting to changes in industry demand and adopting or developing innovations in education delivery: that is the provider's expertise, and their qualification is the result.

HIMAA's competency standards are developed by members of the profession, many of whom are of course the frontline employers of HIM graduates and Clinical Coders. Many HIM graduates choose to specialise in Clinical Coding. This level of the profession, then, firmly represents industry in determining the range of competencies required of an HIM graduate or Clinical Coder entering the profession. This is how HIMAA sees its role in relation to the HIM profession: complementing the role of the education provider and the qualification they offer, by finessing transition to professional entry.

HIMAA's approach to professional accreditation is thus based on quality improvement principles: it is a facilitatory rather than a barrier process.

In relation to the Clinical Coder as a separate occupation emerging in the HIM profession from VET level of tertiary education, HIMAA surrendered its competency standards to what became known as the Skills Councils approach to national regulation of the VET sector in 2007. The aim was to enable the development of Units of Competency based on HIMAA's Clinical Coding Competency Standards, which HIMAA could then deliver in VET as a Registered Training Organisation.

HIMAA has been intensely disappointed by the loss of standards in VET Clinical Coding as a result. Other providers have been able to interpret and deliver the resulting Skills Councils Units of Competency at course duration and coverage far short of the HIMAA product. As a result, HIMAA has found itself aligned with such providers by some in industry as failing to produce work-ready graduates, even though there is no substantive evidence of this.

As a result, HIMAA has itself funded, from its own cash reserves, two initiatives to restore HIMAA standards. It has become the first national provider of a full Certificate IV qualification in Clinical Classification developed by HIMs working in the Victorian Department of Health, and owned by the Victorian Education Department. In its first year of operation the 22274VIC Certificate IV in Clinical Classification has not only exceeded HIMAA return-on-investment targets but has attracted an unprecedented commitment from industry, with employers recognising the value of a full qualification to staff and, as a result, funding their enrolment as HIMAA students supported by their work place.

Employer support is not the only feature of the new certificate course that will improve work-readiness of HIMAA Clinical Coder graduates. An aptitude test has also been developed, again at HIMAA's expense, to enable feedback to enrolling students on their suitability for the occupation, assisting them to make informed decisions about their financial investment in a two year course.

To complement its renewed investment in HIMAA Clinical Coder graduates' work readiness, HIMAA is also resurrecting its Clinical Coding Competency Standards, which HIM employers in industry can then use to guide position descriptions and award setting.

HIMAA believes that its practice as a not-for-profit organisation in professional accreditation, and the provision of VET to industry standards, without any assistance from government or private enterprise, demonstrates not only the importance but also the viability of Review's second point of reference.

Health Workforce

HIMAA agrees with the discussion paper that "the relevance of the health education system is critical in delivering a health workforce that is responsive to the emerging needs of the community" and that this "requires a flexible and adaptive accreditation system which proactively recognises emerging health and social care issues and priorities, and which provides direction to education providers so that curricula appropriately reflects best practice and is evidence based." (p.2)

HIMAA also agrees that "A greater focus on broader workforce priorities and the outcomes of health education programs, both in professional competency frameworks and accreditation standards, has the potential to streamline accreditation processes and encourage innovation in health workforce reform." (p.2)

Such a focus on health workforce reform is not significantly advanced by such micro-innovations as "cultivating an interprofessional learning and practice culture" and "alternate modalities of education and training such as the use of simulated clinical practice". In HIM, a broader and more cogent focus on "opportunities for high-quality training in future-focused healthcare environments" is far more immanent and material (p.2).

In 2010 the Australian Institute of Health and Welfare (AIHW) published a definitive study of health information management workforce in Australia¹⁰ which achieved an 86% response rate in the public hospital system. The report identified the increasing proportion of Clinical Coders in the health workforce who did not have HIM degrees. It also identified a need for a minimum increase of 1,757 FTE Clinical Coders in the ensuing 5-year period to meet industry demand.

¹⁰ Australian Institute of Health and Welfare 2010. The coding workforce shortfall. Cat. no. HWL 46. Canberra: AIHW.

HIMAA was far the largest supplier of VET level clinical coding graduates in Australia during those 5 years, but they succeeded in graduating just 726 coders – not even half the minimum forecast. And this is during a period in which the introduction of ABF has increased demand for coders.

The problem in forecasting the health information workforce (HIW) needs of a rapidly expanding and transformational eHealth sector is the availability of accurate data. Even estimates of health informatician need¹¹ was based on extrapolations of the AIHW research in health information management. Other HIW occupations postulated by the Health Workforce Australia *Health Information Workforce Report of 2013*¹², Data Analysts and Costing Specialists, are difficult to find workforce definitions, let alone workforce data.

Recourse to Australian Bureau of Statistics (ABS) data to analyse HIM workforce demonstrates how fraught HIW data supply is:

ABS Census Data	2001	2006	2011	Census 2001, 2006, 2011	2009 FTE AIHW
Clinical Coders	1805	2183	1069	↓41%	1186
Health Information Managers	865	1255	1473	↑70%	630
Total Profession	2670	3438	2542	↓5%	1816

When the HIM estimate based on population self-report in 2006 and 2011 is compared to the more substantive AIHW estimate in 2009, the dissonance is doubled in both cases.

Concerned by anecdotal reports in its 2013 membership census of increasing workforce shortage, HIMAA held its own survey of members in 2014. The indicative results (R=21%) found that:

- A third of respondents reported coder vacancies, the mean number of vacancies being 2.3, and one fifth of respondents report HIM vacancies at a mean FTE of 1.7.
- Demand for clinical coders was ranked as growing by 61.65% of respondents, compared with poor supply amongst 53.38%.
- In the coming 1-3 years respondents ranked the need for Clinical Coders at 3.2FTE with an additional attrition of 3.35 FTE, and HIMs at 2.25 FTE with additional attrition of 1.12 FTE

As a result, HIMAA combined with fellow Health Information Workforce (HIW) peak bodies the Australasian College of Health Informatics (ACHI) and Health Informatics Society (HISA) to mount a national HIW Summit in October 2015 to address HIW shortfall and future configuration.¹³

The following year the Australian Library and Information Association's Health Librarians Australia group (ALIA HLA) and Australasian College of Health Service Management (ACHSM) joined with HIMAA, HISA and ACHI to mount a follow-up HIW Summit to assess employer interest in committing to the 30 out of 82 actions recommended by the 2015 Summit relevant to employment.

Two key recommendations from two successive national HIW Summits in 2015 and 2016 have been:

- The need for a census of the health information workforce and regular collection of data; to inform

¹¹ Legg M et al, 2009. A Review of the Australian Health Informatics Workforce, Melbourne: Health Informatics Society of Australia.

¹²Health Workforce Australia [2013] Health Information Workforce Report, p.15

¹³ The full HIW Summit 2015 Report can be found at <http://hima2.org.au/index.php?q=node/2898>.

- Development of a national capability framework for HIW configuration

A response to the first of these recommendations has been forthcoming from a collaboration between the University of Tasmania and University of Melbourne, led by Dr Kerryn Butler-Henderson and Associate Professor Kathleen Gray respectively. Development of an HIW data-set is already underway in preparation for a national census of HIW that can be replicated periodically to inform HIW configuration. This initiative has the active support from amongst others, the three peak bodies presenting the 2015 national HIW Summit, HIMAA, HISA and the Australasian College of Health Informatics (ACHI).

It has been suggested at both HIW Summits that a platform already exists for the development of a national HIW capability framework: the international Skills Framework for an Information Age (SFIA). For a capability framework with the agility to meet the rapidly emerging HIW, however, active engagement between education providers, industry (employers), governments and the peak HIW bodies responsible for the professional competencies that underpin the HIW professions is essential. The IT-driven, organisational change focus of SFIA is too narrow and localised to achieve what is required by eHealth in Australia right now.

Without a concerted focus on HIW and its future configuration, the role of accreditation in maintaining professional standards in a rapidly emerging and transforming eHealth sector will be lost.

The Role of Government

It is perhaps in this salient workforce context that the Review should be addressing its third point of reference: “asking the broader question of why do we need an accreditation system, why does government need to be involved, and what is the most constructive role accreditation can play in creating the future health workforce that best serves the needs of the community.” (p.1)

One would imagine government would see a strong and supportive role for the professions, and their various professional associations and colleges, in maintaining professional standards of quality and safety in health care through measures such as professional accreditation and workforce configuration.

Yet the two successive HIW Summits (2015 & 2016) referred to above have been mounted without government funding and only moderate interest (from NSW Health and COAG’s Health Workforce Principal Committee).

The University of Tasmania and University of Melbourne work on the minimum HIW dataset noted above has been undertaken with neither government interest or support.

Yet it is the community that will benefit from these two initiatives in HIW shortage and configuration in terms of improvement to the quality of care capable through the digitisation of health information and its management, as well as the benefit to the nation cost burden of health care services.

Professions Australia and Universities Australia signed an historic Principles of Professional Accreditation in February 2016, and TEQSA is now in negotiation with these two organisations to ensure the role of professional accreditation in higher education governance. Government itself, however, is yet to commit to the value of professional accreditation in complement to the qualifications offered by higher education providers.

HIMAA’s National Conference partner, the National Centre for Classification in Health (NCCCH) is the national authority on international classification, maintaining a close engagement with the World Health Organisation’s Family of International Classifications (WHOFIC) as well as providing biennial edition changes to update ICD-10-AM in Australia. The AIHW is WHO’s research arm here. NGOs like these, and HIMAA as a not-for-profit

(NFP), provide the mainstay to professional standards in health care, rather than government itself.

Admittedly government assists clinical classification through funding to the NCCH, but this is now decreasing with an increasing capability of government's own QANGO, IHPA. HIMAA enjoys a positive relationship with IHPA, with senior HIMAA members contributing to its operations. But the culture of government seems to replicate its own modus operandi, bureaucracy, at the expense of the actual drivers of safe, quality healthcare, the health professions.

Federal government has, for instance, consistently fobbed HIMAA's approaches for workforce support off on COAG as being not of federal concern; even though HIW is essential to the successful integration of digital health information flow and storage between Primary Health Care (very much a federal government concern) and Tertiary Health Care.

State Governments still work to provide their own HIW solutions in HIM without consultation or involvement with the professional association. A NSW Health project with HIMAA between 2012 and 2015 showed how useful HIMAA Clinical Coding coursework was in terms of effective Clinical Coder traineeships and professional development for existing staff, but NSW engaged in no further discussions with HIMAA about role of professional standards in recruitment and retention and prefers still to use its own, in-house RTO to deliver clinical coding VET in competition with HIMAA. Governments seem to have no aversion to anti-competitive practice of benefit to itself at the expense of an NFP even though the health of the population would benefit from greater cooperation.

In fact, HIMAA's experience government's role in supporting the HIM profession is weak to the point of open counterproductivity.

Here is a concrete example of this propensity. The Review says (p.1) that is "takes as one of its points of reference the legislative requirement that the purpose of the accreditation system is to ensure that graduates of approved programs and overseas trained practitioners are suitably qualified and competent to practice in Australia. Accreditation in this context is antecedent to, and inextricably bound together with, practitioner registration."

However, in relation to the HIM Profession, the federal government's Education and Immigration Ministries response to chronic workforce shortage in the HIM occupations of HIMs and CCs is to undermine Australian professional accreditation standards by actively supporting the admission of skilled migrants without HIMAA-accredited qualifications, or qualifications accredited by any member of the IFHIMA, or indeed any qualifications or experience relevant to these occupations in the Australian healthcare system.¹⁴

It is professional standards themselves that contribute to the standing and quality of the services delivered by the profession, yet in this example government is actively undermining the standing of graduates of profession accredited HIM degrees in Australia in the interests of role substitution of key HIM occupations in industry at the expense of standards of quality and safety.

It would be helpful if government could find its way to provide worthwhile assistance in the professional accreditation endeavour, in the case of a HIW so central to the success of eHealth agenda in terms of crucial improvements to quality of care, the integration of primary care and hospital care, and the benefits these will bring to consumers in cost containment of the economic burden of health care. But until it does, health care services continue in their dependence on the professions for standards of quality in care, and professional accreditation is the cornerstone of the admission of the professional to the profession.

HIMAA believes that professional accreditation of qualifications and maintenance of practice standards by professional associations or colleges should remain the mainstay of healthcare

¹⁴ For HIMAA's National Policy on Skilled Migration, go to:
http://himaa2.org.au/sites/default/files/HIMAA_Skilled_Migration_Policy_April2016_dv001.pdf

accreditation. It is the professions that can foster the maintenance and responsiveness of professional standards. Government should support the professions' lead.

Recommendations

HIMAA recommends:

1. The inclusion of non-frontline non-clinical health care professions, such as HIM professionals who have undertaken HIMAA-accredited or –approved qualifications, in its National Regulation and Accreditation Scheme inasmuch as these are as critical to patient safety and accuracy of patient care: the frontline practitioner is only as safe and accurate, for instance, as the health information available to them
2. Full support by government of professional accreditation by NFP professional associations and colleges of qualifications as a cornerstone of the viability of professional standards in the quality delivery of safe health care
3. Taxpayer-funded support for such professional accreditation by NFP professional associations and colleges to reduce the cost burden on education providers; professional standards should not be held ransom to an ideological predilection for private enterprise where patient safety and health is at stake.
4. Support for the development of four-way profession-led national capability frameworks for natural workforce groupings of health care professions, such as the Health Information Workforce, between professional associations or colleges, industry, education and training providers, and government.¹⁵
5. The restructuring of government practice so that government becomes more agile and flexible in supporting those in the health professions capable of delivering timely and needed adaptation to changes in health workforce configuration, rather than engaging in counterintuitive practices such as buck-passing between the state/territories and federal jurisdictions or, indeed, the active debilitation of health workforce as evidenced by the federal government practice of addressing chronic HIM workforce shortages by facilitating skilled migration in the occupations of HIM and CC by migrants without accredited qualifications relevant to the practice of these occupations in Australia, or relevant experience.

¹⁵ Consumers can and should be involved in this capability framework, but research in medicine has shown that consumers' perception of professional expertise is limited in its understanding of the educational detail of professional knowledge skill and practice. Yet this is what is required to develop organisational and national capability.