

POSITION DESCRIPTION	
<b>Position Title:</b>	Remote Health Information Manager/ Clinical Coder Part Time – 0.6 EFT
<b>Classification:</b>	Health Information Manager, Grade 2
<b>Department/Unit:</b>	Health Information Unit
<b>Division:</b>	Information and Regional Services
<b>Reports To:</b>	Manager, Health Information Unit

## 1. Primary Purpose of Job

The position is to undertake remote accurate, comprehensive and timely clinical coding across Latrobe Regional Hospital and assist in maintaining an effective and efficient Health Information Unit thereby contributing to the quality of patient care.

## 2. Organisation Context

### 2.1 Shared Vision

We will be a leading regional health care provider delivering timely, high quality, accessible, integrated and responsive services to the Gippsland community.

### 2.2 Core Values

- Person-centred care
- Integrity
- Excellence
- Working Together

### 2.3 National Safety and Quality Health Service Standards (NSQHS)

National Safety and Quality Health Service Standards (NSQHS) is the framework the Australian Commission on Safety and Quality in HealthCare (ACSQH) use to review hospitals for Accreditation. To ensure Latrobe Regional Hospital is an accredited facility, we are continuously reviewing and improving our service through numerous quality improvement initiatives and programs.

### 2.4 LRH Strategic Pillars

- Service Delivery
- Our People
- Regional Leadership
- Education, Training & Research

### 2.5 Diversity & Inclusivity Statement and Child Safe Standards

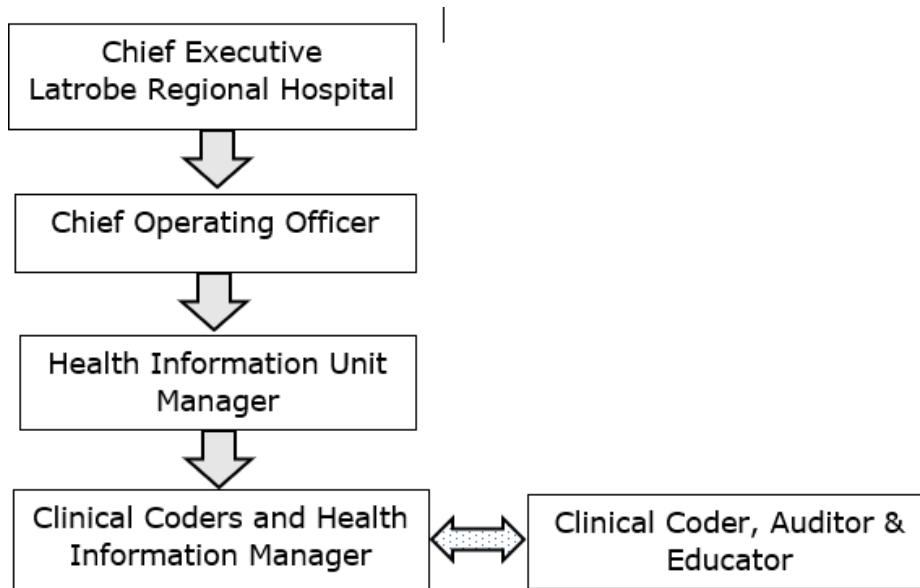
Latrobe Regional Hospital values our community's diversity. We are committed to providing an inclusive, welcoming and safe service and workplace for everyone who engages with our organisation regardless of race, culture, religion, sexuality, gender identity, age or ability.

LRH is a child friendly and child safe hospital with zero tolerance for child abuse or harm of any kind. This includes Aboriginal or Torres Strait Islander children, culturally and linguistically diverse children and children with disabilities.

LRH has policies and protocols in place in line with the Victorian Child Safe Standards to ensure the safety and wellbeing of both paediatric patients and paediatric visitors.

**2.6 Structure**

The HIM / Clinical Coder reports to the Manager, Health Information Unit.



**2.7 Liaison**

Liaise within the frameworks of established protocols with both internal and external agencies

*External:* Local Medical Officers, Visiting Medical Officers and other various external bodies

*Internal:* Executive Management, Medical Services, Information Communication Technology, Finance Department. Patient Services Unit, Ward Clerks and other various staff as needed.

**3 Resource Management**

**3.1 Total Staff Management (FTE)**

- Not applicable

**3.2 Annual Operating Expenditure**

- Not Applicable

**3.3 Personal Responsibilities**

- Compliance with Occupational Health & Safety Regulations
- Compliance with Working from Home Agreement Protocol
- Compliance with Remote Coding Protocol
- Compliance with legislative requirements
- To complete mandatory training annually
- To participate in annual performance appraisal
- Support the delivery of high quality and safe patient care
- Awareness and engagement in continuous improvement initiatives

## **4 Qualifications/Experience**

### **4.1 Mandatory**

- Successful completion of a recognised Clinical Coding Course (HIMAA or equivalent)
- Current knowledge, experience ICD-10-AM coding
- Comprehensive knowledge of clinical coding systems
- Skills in interpretation and analysis of clinical data
- Demonstrated sound time management and organisation skills with the ability to meet tight deadlines within defined resources ensuring targets are met
- Demonstrate capacity to work independently and collaboratively as a part of a high performing team with the ability to motivate and coordinate staff.
- Highly competent computer skills utilising varied and appropriate software programs (e.g. word processing, data management systems and spreadsheets)
- Demonstrated experience, competency and extensive recent clinical coding experience using ICD-10-AM & ACHI with a thorough understanding of the Australian Coding Standards and a understanding of casemix, DRGs and Activity Based Management models and their application the health system.
- Experience and demonstrated competency in Clinical Coding using ICD-10-AM Classification system across a broad casemix for a period of at least 3 years is essential and experience in a hospital or health care setting is desirable

### **4.2 Desirable**

- Recent attendance at coding workshops, education updates and conferences
- Experience working with in-house software program Health smart iPM and AllScripts Sunrise Electronic Medical Record

## **5 Key Selection Criteria**

### **5.1 Key Competencies**

- Respect for confidentiality
- Well-developed organisational skills
- Excellent computer skills
- Attention to detail and production of accurate work
- Ability to work well in an environment of conflicting demands
- Ability to work in a remote setting (home-based clinical coding)
- Demonstrates ability to organise and prioritise daily tasks and meet deadlines
- Demonstrated ability with ICD 10 AM coding standards and Department of Health guidelines
- Strong commitment to customer service

## 5.2 Personal Attributes

- Excellent communication and interpersonal skills (written and verbal)
- High standard of personal presentation, including a professional disposition and diplomatic approach
- Ability to work well under pressure
- Flexible and adaptable.
- Ability to work and participate well within a team
- Willingness to learn new techniques and practices
- Motivated to continual improvement

## **6 Other Attributes Required**

- Not Applicable

## **7 Duties/Responsibilities**

7.1 Maintain patient/client and staff confidentiality

7.2 Contribute and assist with the Clinical Coding of records to meet National Centre in Classification of Health (NCCH) and NSQHS (standard 1)

7.3 Follow Latrobe Regional Hospital Remote Coding Guidelines

*Activities include:*

- Read, analyse and extract relevant information from patient episodes in accordance with ICD 10 AM Australian modification coding guidelines to ensure quality coding
- Ensure the accurate and comprehensive entry of coded information into the hospital's Patient Management System
- Adhere to clinical coding time deadlines set by the Department of Health and Human Services
- Complete coding in accordance with internal Key performance indicators (KPIs).
- Interact with Health Information Managers, Unit Managers and Clinicians to implement appropriate strategies to improve coding
- Participate in quality review activities and coding audits
- Participate in ongoing development and training programs
- Contribute to the editing and verification processes in the preparation of coded data for submission to the DoH and DHS
- Complete registrations and notifications of cancer to the Victorian Cancer Registry
- Keep abreast of current updates to clinical coding standards through self-education and attendance at professional development workshops and/or conferences.

*Measures include:*

- The designated LRH clinical coding process is adhered to
- DHS and internal time deadlines are fully met 100% of occasions
- Coding practices are implemented and evaluated as per NCCH standards via DHS audits
- Audits indicate compliance with DHS coding guidelines using DHS benchmarks
- Internal audits to ensure high level of coding quality
- Standardisation of coding practice achieved by regular meetings
- Cancer registrations are completed as required

7.3 Ensure accurate allocation of Diagnostic Related Groups (DRGs)

*Activities include:*

- Demonstrates an awareness of how the coding affects the allocation of the DRG and its impact on WIES funding

*Measures include:*

- Accurate allocation of DRGs through a grouper interface to the hospitals patient management system

7.4 Ensure coding values and objectives are communicated to Clinicians

*Activities include:*

- Liaise with Clinical Documentation Specialist regarding ambiguous documentation in the medical record and seek clarification
- Notify Health Information Unit of any episodes with an incomplete discharge summary to arrange for completion

*Measures include:*

- Clinical staff are contacted to clarify coding queries

7.5 Other duties as required.

*Activities include:*

- Assist team members as and when required
- Perform other duties assigned by Manager

<b>Initiated By:</b>	Manager, Health Information Unit
<b>Date:</b>	April 2022
<b>Date to be Reviewed:</b>	April 2023

I have read and understand the contents of the position description:

**Employee's Signature:**

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**Date:**     /     /