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McKenzie, Kirsten and Walker, Sue and Klisanin, Andrew and Spallek, Melanie (2003) *The Australian Coder Workforce Survey 2002-Coders' responses*. Coding matters, 10(1). pp. 14-17.

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# The Australian coder workforce survey 2002

## Coders' responses

This report provides the findings of the 2002 Australian clinical coder survey and follows information published in *Coding Matters* 9(4):1–6, March 2003, which focused on responses from coding service managers. This report provides information from the coders' component of the survey and highlights the major findings from this part of the survey.

### Characteristics of respondents

Over a thousand survey responses were received from coders (n=1031). The majority (90.4%) came from coders in hospitals. More responses were received from coders in public (64.8%) than private facilities. Nearly 70% of the coders who responded worked in metropolitan facilities, about 29% were from rural areas, and the remainder from remote locations. Most (n=728) reported that they coded in a single facility, while many (n=291) work at multiple sites.

Respondents' position titles were categorised into 8 types, including an 'other' category for uncommon titles. Figure 1 illustrates that 'clinical coder' is the job title of 55% of respondents.

### Coder workforce

Coders were asked whether they were employed on a full time, part time (with fixed working hours) or casual basis, and whether they had other tasks to do besides coding. Of the 1,021 responses to this question, 33.7% work full time, 28.9% had other tasks besides coding, 28.7% were employed part time (with fixed working hours), and 8.7% indicated that they worked on a casual basis (variable working hours).

Coders were also asked to state the number of hours they worked per week if they were not employed full

time at the facility. Of the 576 responses to this question, 22.7% indicated they worked less than 8 hours per week, 25.2% said they worked between 8–16 hours per week, and 19.4% replied that they worked between 17–24 hours per week.

### Coder industrial conditions and salaries

Coders were asked to indicate whether they were employed under an industrial award, and if so, whether it was a state or a federal award. The majority (76.4%) indicated that they were employed under a state award, 7.4% stated that they were employed under a federal award, while 16.2% were not employed under an award.

Coders were asked to indicate their annual salary within designated ranges. Part time and casual coders were asked to calculate a gross full time equivalent salary. The average salary of coders overall was in the range \$35,000–\$39,999. The minimum salary was less than \$20,000pa and the maximum salary in excess of \$65,000pa. Of the 990 coders who answered this question, 26.9% are paid between \$35,000–\$39,999 followed by 15.9% who reported salaries in the range \$30,000–\$34,999 and 15.1% who stated that they were paid \$40,000–\$45,999. The average salary range was consistent Australia-wide, except for Victoria. Here the average gross annual salary of coders in public metropolitan facilities was between \$45,000–\$49,999, approximately \$10,000 more than the average salary of coders in other states in Australia.

### Coder work environment

Coders were asked to provide the title of the department to which they report. Of the 9 department title categories, health information service/clinical coding department ranked highest (75.7%).

The survey asked coders about their satisfaction with their current work location. Of the 1,000 respondents who answered this question, the most satisfied coders (97.5%) were those who worked in a coding office located on a ward. However, only 3.9% reported that they worked in this environment. The next most satisfied group (88.64%) were coders who have their own offices of a total of 4.3% who reported that they had their own office. The most common work environment (38%) was open-plan space in the health information service/medical record department (HIS/MRD). This location ranked fifth for satisfaction. A third of coders indicated that they were not satisfied working in open-plan spaces because it was too noisy and distracting, too cramped and lighting was inadequate. Figure 2 shows coders' satisfaction about work environment.

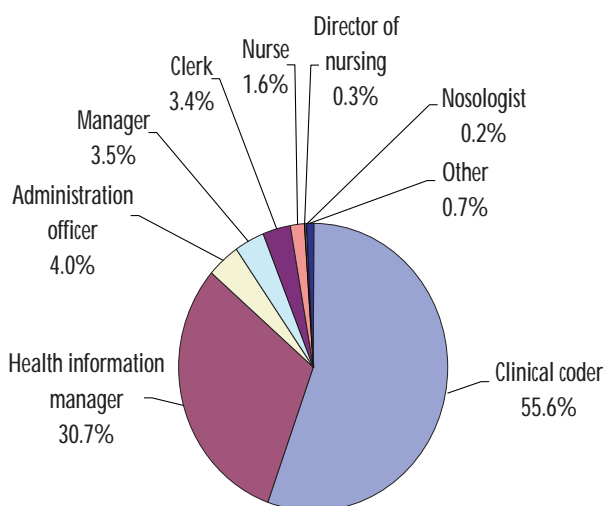


Figure 1: Position titles of coders

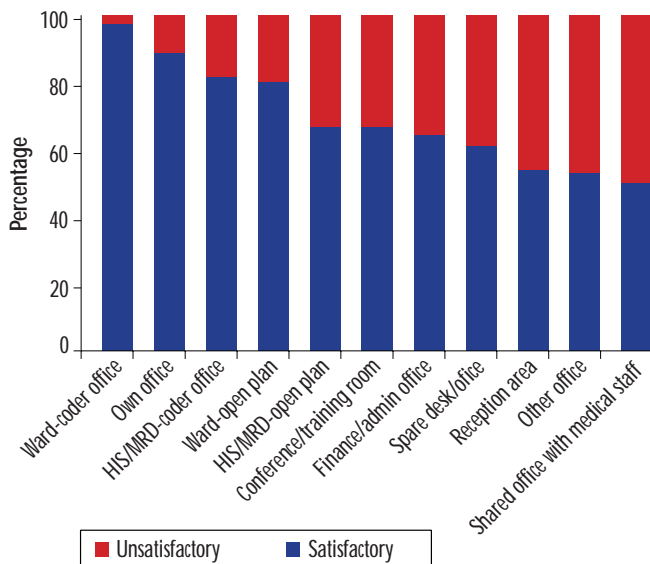


Figure 2: Coders' work environment satisfaction

Coders' work-related resources were also investigated in this survey. Nearly all (94.28%) respondents have access to a full set of the current edition (ICD-10-AM Third Edition) coding books. *Coding Matters* was available to most (88.65%). Over three quarters of respondents reported access to previous editions of coding books. Just over half had Internet access, but only 39% had access to the Code-L list server.

Most coders (74.8%) had access to clinical staff to discuss coding issues at their work sites. Coders were asked to indicate where and how they contact clinical staff. A quarter (24.4%) of coders reported *ad-hoc* meetings with clinical staff. Less than 3% of coders attended ward rounds to access clinical staff.

### Coder duties

It is common practice for coders in the workforce to undertake other tasks in addition to abstracting information from records and assigning codes to episodes. The survey provided 14 categories for coders to indicate the other tasks that they perform. Respondents were asked to tick all that applied to their roles. All respondents answered this question. Two thirds of coders indicated that the most common additional activity undertaken was related to quality initiatives. This was followed closely by data entry and general medical record functions. A break down of the tasks performed in addition to coding is shown in Figure 3.

Coders also provided details about other tasks performed that were not listed in the 14 categories listed in the survey (and illustrated in Figure 3). Of the 352 coders who responded, 24.4% indicated mandatory reporting is the most common uncategoryed additional activity, followed closely by another 21.9% who said that managerial/supervisory duties were also a significant part of their work.

### Coding quantity and quality

Coders were asked whether they were required to meet a coding throughput, and if so, the number of records they were required to code. Only 44% of coders indicated that they were required to meet a coding throughput. Of these, 333 reported the actual throughput targets. The average daily throughput requirement was indicated at 28 records per standard working day (3–4 records per hour). However, the coding throughput mode (most frequently reported) was slightly higher at 30–39 records per day (4–5 records per hour). The coding throughput requirements for free-standing day-care facilities and hospitals were as follows:

Free-standing day-care facilities:

- average 28 records per day
- minimum 3 records per day
- maximum 100 records per day (this was an outlier, and the second highest coding throughput was 42 records per day)

Hospitals:

- average 36 records per day
- minimum 6 records per day
- maximum 80 records per day (11 hospitals stated that their coding throughput requirements were greater than 60 records per day).

Coders were asked to report issues that they believed had an impact on the accuracy, completeness and timeliness of coding at their own facilities. They were asked to rank each factor on a scale from no impact to an enormous impact. For ease of interpretation, the categories of *no impact* and *slight impact* were combined into the *no impact* category. The categories of *moderate impact* and *enormous impact*

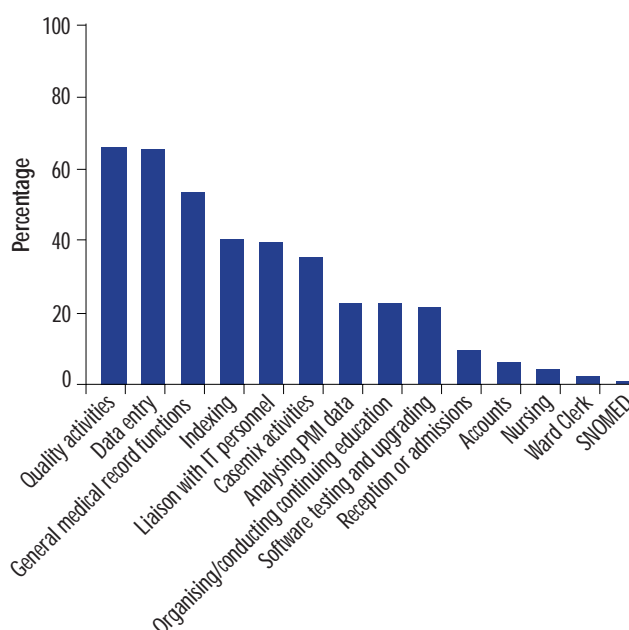


Figure 3: Tasks coders perform in addition to coding



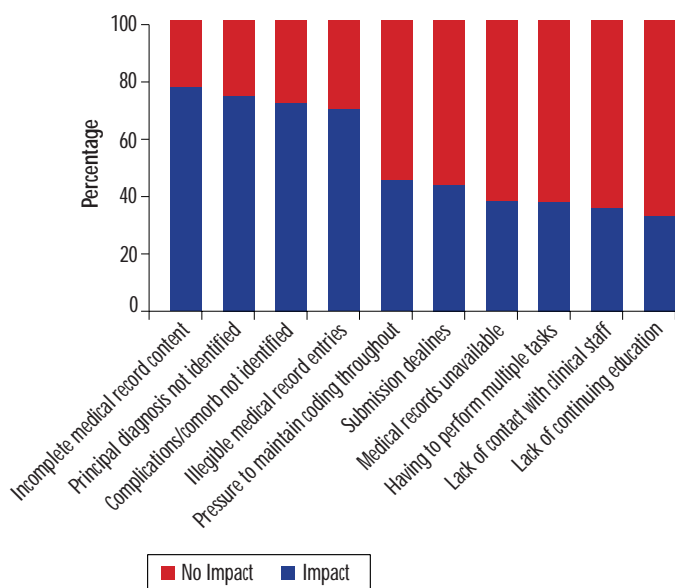


Figure 4: Coders' views of factors affecting coding quality

were combined into an *impact* category. Overall, the availability of complete and accurate documentation was reported as the major problem that inhibited quality coding. The survey found that three quarters of coders (77%) indicated that an incomplete medical record had an impact on coding quality. This was closely followed by the principal diagnosis not being uniquely identified (73.7%) and complications/ comorbidities not being identified (71.1%). A quarter of respondents identified that a lack of coders in their facility had an adverse impact on coding quality. The impact of the top ten reported factors is displayed in Figure 4.

Coders were asked if they performed regular quality assurance (QA) activities in their own facilities. Responses indicate that two thirds of coders are involved in QA activities. New South Wales has the smallest percentage (57.4%) of coders involved in QA activities. Nearly all of the Tasmanian coders who responded (91.7%) performed QA activities. Approximately a third of coders said that audits were performed to assess coding quality. In-house analysis using *Performance Indicators for Coding Quality* (PICQ) was performed by 14% of coders and 9% said that external analysis using PICQ was made to assess coding quality. In-house analysis using *Australian Coding Benchmark Audit* (ACBA) software was performed by 7.6% of coders. Another 6.6% indicated that external analysis using ACBA was made to assess coding quality.

A third of respondents stated that they did not undertake QA activities. Of these, 181 coders specified these reasons for not performing QA activities:

- QA is performed by the manager or health department (23.8%)
- no time is available (21%)
- there is only one coder at the facility or the coder is a contract coder (15.5%)

- there are plans to begin QA in the future (14.4%)
- the coder is a new employee (9.9%)
- *ad hoc* QA is performed (8.3%)
- QA is not required at the facility (7.2%)

### Coder education and training

Coders were asked to indicate where they learned to code. They were asked to tick all applicable categories from a list including undergraduate degree, postgraduate degree, distance education and on-the-job training. Just over a third (36%) of coders held undergraduate health information management/ medical record administrator (HIM/MRA) degrees that contributed to them learning to code. Of these, 78% learned solely through their degree education. An additional 5.5% learned to code both during undergraduate education and from on-the-job training. A third said they learned to code on-the-job. A significant number of coders (10%) said they had no formal coding education beyond on-the-job coding. The Health Information Management Association of Australia Ltd (HIMAA) distance education course was the third most common way that respondents learned to code (28.7%) with half of these coders learning exclusively through the HIMAA distance education course. Coding education responses are illustrated in Figure 5.

Coders were asked if they felt that the education they received adequately prepared them to code when they commenced work. About two thirds (60%) believed that their coding education prepared them adequately. Obtaining HIM postgraduate education was deemed to provide adequate preparation to code in the work environment by three quarters of respondents who had acquired this level of education (n=22). Completion of an undergraduate HIM degree was thought to be the least adequate education mode for coders. Half of all coders who had completed undergraduate degrees said they felt inadequately prepared to code in a work environment (n=176).

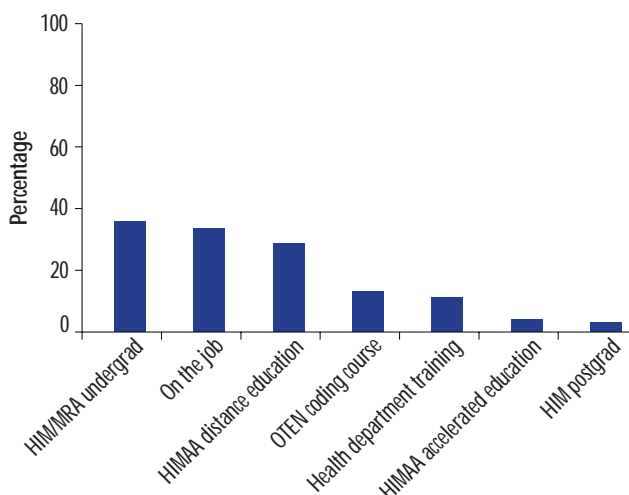


Figure 5: How coders learn to code

The survey evaluated support for coders to participate in continuing education activities. Coders were asked if their facilities supported participation in continuing education. Most (90%) coders stated that their facilities support continuing education. Over half (58%) had employer support to provide time away from work for continuing education without a requirement to make up that time. An additional 4% of coders were allowed to have time off work but were required to make up the time later. Over half (55%) of coders indicated that their organisation supported them by way of payment of registration/enrolment fees. A quarter of employer facilities did not provide any support for continuing education.

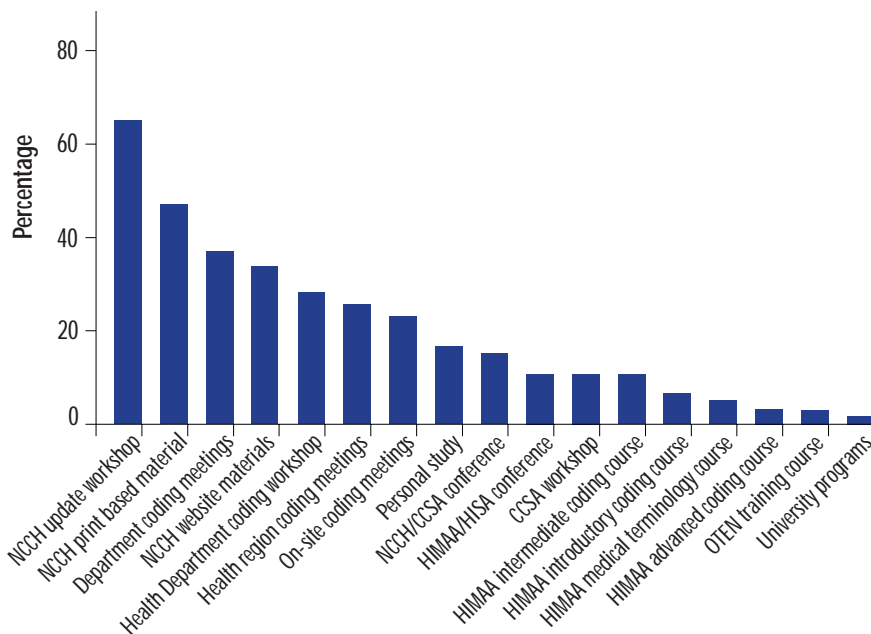


Figure 6: Coders' continuing education events

Coders were asked to nominate types of continuing education activities they had been involved in over the last three years. Nearly two thirds (65%) of coders indicated that they had accessed an NCCH update workshop, about half (47%) said that they had accessed NCCH print-based materials and over a third (37%) had attended department coding meetings. Figure 6 shows the breakdown of coders' continuing education activities.

A comprehensive report of all survey findings will be published in September 2003 as part of the NCCH monograph series.

### About the authors

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## CLOSE IN SPELLING... DIFFERENT MEANING

**Castration** means 'to deprive of the testicles, emasculate...' (Macquarie, 1991)

**Castrametation** means 'the art of designing a camp' (Noble, 2002)

**Fornicate** means 'to commit fornication.

**Fornication:** voluntary sexual intercourse between unmarried persons, adultery' (Macquarie, 1991)

**Formicate** means to engage in ant-like behaviour (Noble, 2002)

Noble G (2002) *More word of the day*. Penguin Books, Australia.

*The Macquarie Dictionary, Second ed* (1991).

The Macquarie Library Pty Ltd, Macquarie University, Australia.