The health information workforce of the future

Julie Brophy

This issue of HIM-Interchange (HIM-I) provides an opportunity for us, as a profession, to reflect on where we have come from but, more importantly, to consider where we are going. Since the beginning of our profession in Australia over 60 years ago, the health sector has seen dramatic changes. Major advances in knowledge and technology have changed the way we deliver healthcare and the role of professionals working in the health system, and these changes are likely to continue into the future at an even more rapid pace. With constant evolution and advances in healthcare and changes in the roles and skills of the health workforce, it is an exciting environment to be working in. This is a challenge we must accept and decide how we can contribute positively to shape the future of our profession.

The health workforce

Comprising 1.4 million workers, the health and social welfare sector is now the largest workforce in Australia and its importance has been recognised by the Australian federal and state governments (Robinson & Brooks 2012). It has also been the subject of public interest, with perceptions of widespread and increasing workforce shortages that could impact upon patient care (Segal & Bolton 2009).

Concerns about the capacity of Australia’s health workforce to meet community needs was identified in the first Intergenerational Report released as part of the 2002-03 Budget, which highlighted the future expected increase in government spending. The report focused on the impact of demographic change for economic growth and an assessment of the financial implications of continuing current policies and trends over the following four decades. The report found that Commonwealth spending on health was projected to increase to 4.3% of Gross Domestic Product (GDP) by 2011-12 and to 8.1% of GDP by 2041-42. Projections showed spending on Medicare Benefits Scheme (MBS) subsidies as a proportion of GDP was expected to grow by 60%, with hospital and health services expenditure growing by 40% (Mason 2013). The most recent estimates from the AIHW are that expenditure on health in Australia was $140.2 billion in 2011-12, which was 9.5% of GDP, with an estimated recurrent expenditure on health of $5,881 per person. Governments funded 69.7% of total health expenditure, with the largest components of health spending being public hospital services ($42.0 billion, or 31.8% of recurrent expenditure), followed by medical services ($23.9 billion, or 18.1%) and medications ($18.8 billion, or 14.2%) (Australian Institute of Health & Welfare 2006). Expenditure on workforce services accounts for about two-

In 2010, the ABS Labour Force Survey found that there were 500,600 employed people in direct healthcare occupations. Others (236,800) were employed in non-direct occupations (e.g. hospital caterers, hospital cleaning staff, clerical workers). In addition, 266,200 people employed in health occupations were not working in health services industries but in other industries that support and complement healthcare (e.g. health professionals teaching at university, dieticians in sport and recreational facilities, pharmacists working in pharmaceutical manufacturing) (Australian Institute of Health & Welfare 2012).

In 2005, the Productivity Commission was requested to undertake a research study on health workforce issues, including supply and demand pressures over the next ten years. This study arose from a decision by the COAG in June 2004. The report detailed shortages in the health workforce in general practice, various medical specialty areas, dentistry, nursing and some key allied health areas (Productivity Commission Report 2005).

Government commitment to health workforce issues was recognised in 2009, with the establishment of Health Workforce Australia (HWA). The history of HWA is presented on its website as follows:

HWA was established by the Council of Australian Governments (COAG) as a national health workforce agency through the 2008 National Partnership Agreement on Hospital and Health Workforce Reform (NPA). It commenced operations in January 2010, following the enactment of the Health Workforce Australia Act 2009. HWA is a Commonwealth statutory authority and takes direction from the Standing Council on Health (SCoH), which comprises the nine health ministers of the Commonwealth, state and territory governments. In establishing HWA, COAG recognised that a national coordinated approach was needed to create a health workforce able to meet the current and future healthcare needs of all communities. COAG recognised that without strategic and coordinated reform, the demand could not be met and the challenges could not be overcome. It recognised that reform must be national and large-scale and that it must cut across jurisdictional, sectoral and professional boundaries. (Health Workforce Australia 2014)

HWA delivers a work program that supports its goal of building a sustainable health workforce for Australia. In 2011 HWA received a request from the NEHTA and the AHIEC to undertake a study of the health information workforce. This review was undertaken in 2012 and a report published in October 2013.

The report identifies HIMs as a component of ‘Level 1 health information workforce specialists’, defined as ‘workers who self-identify as part of the health information workforce and work full-time with health information systems’. The report identifies the diverse role HIMs play, and that HIMs are viewed as providing an ‘umbrella service to all parts of the health service, supporting clinical services and business analysis’ and a ‘major role in change management of health information systems’. The report recommends some broad strategic directions for the future workforce, changes required to education and career pathways, and an increasing demand for health informatics roles (Health Workforce Australia 2013).

Richard Lawrence has provided a comprehensive review of this report in this issue of HIM-I, and highlights the potential for HIMs to fill future health information workforce specialist roles; but we need to be seen as part of the solution and seem to have been overlooked in the recommendations (Lawrence 2014).

The urgent need

There are many forces driving a structural change in healthcare delivery. Patient expectations, longer life expectancy, rising incidence of chronic diseases, new knowledge and medical treatments are just a few of the significant factors. A major impetus for change is the rising cost of healthcare as we face an unsustainable healthcare budget. Concerns with health sector ‘productivity’, ‘efficiency’ and ‘cost effectiveness’ is increasingly included in health economic discourse. An analysis of the frequency of these terms in English language books shows a steep increase since the 1980s with the incidence of the term ‘efficiency in health’ trebling (Michel et al. 2011).

One of the tools we have to transform healthcare and address these areas of efficiency, effectiveness and productivity is the effective use of information: getting access to the right information at the right time and place, and using that information to improve healthcare delivery and preventive strategies. HIMs have the capacity to be at the forefront of applying their knowledge and skills to realise that potential.

Some of the major trends where information will be vital include:

- From hospital to home: moving healthcare delivery away from hospitals to home and community settings, including using telemedicine as a form of healthcare delivery.
- From consultation to collaboration: accepting that healthcare is now delivered as a team activity by various health professionals.
- From prognosis to prevention: today healthcare is focussed on diagnoses and treatment, but in the future we will analyse and avoid (Gold 2014).

A fundamental of healthcare delivery is the interaction between patient and clinician. EMRs will significantly change the tasks of gathering and evaluating data, ordering and evaluating diagnostic investigations, confirming a diagnosis, communicating to the team of clinicians treating the patient, and communication with the patient about their care. Collecting, critiquing, and interpreting the vast amounts of new information will be an increasingly important skill for future clinicians and those working in healthcare. As EMRs change the health information management department structure, and as electronic information is used in different ways across health services, the role of HIMs will change. HIMs can play an important new role in facilitating communication between IT, clinical staff and administrative staff to select and implement proper systems and address EMR issues. As the roles of the HIM change so too do the education requirements and skills necessary to do their jobs well.
EDITORIAL

Changes to the health information profession

As Chris Dimick (2012) writes, ‘The health information technology revolution has begun, and as it progresses, the shake-up in health information management departments, processes, and data management will leave the profession profoundly different’. There is some debate as to what roles health information management professionals will have in the next 10-15 years, but all agree that the fundamentals will not change. HIMAA has outlined the competencies standards of an entry-level HIM that define the core skillset and knowledge domain of a HIM (Health Information Management Association of Australia 2012). Health information and record management, language of medicine, healthcare terminologies and classification, research methods, health services organisation and delivery, health information law and ethics, e-health, health information services and management, as well as generic professional skills form the domains of these fundamental skills. In 15 years, HIMs may well be performing many of the current roles, but in vastly different ways. HIMs will need to build on these fundamental skills and adapt our mindset, education and the roles we perform.

At the HIMAA 2013 Conference, Mevat Abdelhak provided some insight into the new roles and titles emerging in the United States (US) and Canada, including:

- Director of Information Management Governance
- Director of Clinical Documentation
- Director of Quality Improvement
- Director of Fraud and Abuse
- Health Information Exchange Specialist
- EHR Implementation Manager
- Director of Data Analytics and Use Care Research
- Director of Compliance
- Director of Revenue Cycle
- Director of Risk Management
- Director of Privacy and Security
- Chief Learning Officer
- Chief Knowledge Officer (Abdelhak 2013).

Dr Abdelhak spoke of the changing role for HIMs to transform enterprise-wide data into actionable information. Interestingly, many of these roles are corporate director roles. US writer, Chris Dimick, also thinks HIMs could be headed for ‘C-suite’, predicting that these emerging roles are expected to grow with health information management professionals managing a set of functions carried out within various hospital departments, rather than managing HIM functions within the traditional health information management department structure (Health Information Management Association of Australia 2013). This is a shift from health information management in its traditional form to what is being referred to as ‘enterprise information management’, where health information management is a set of functions that are carried out throughout the health services, often closer to where the information resides and where the business processes that use that information are.

To cover these roles health information management professionals will need more skills in areas such as project management, statistics, data analysis, ICT, governance and change management. We need to prepare health information management specialists to work in essentially embedded roles through a health service. We must also expect that some roles will become obsolete, especially where technology changes work processes. For example, EMRs are reducing the need for physical handling of a paper medical record and all the processes that go with that. Further advances in computer-assisted coding and voice translation software will change coding and transcription roles, but not necessarily for the detriment of staff working in those areas. Many healthcare organisations in the US are retraining and repurposing staff into new roles, such as roles that support documentation quality initiatives. The critical thinking, problem-solving abilities, computer skills, understanding of health records and medical language provide many staff from medical transcription backgrounds a foundation for moving into documentation specialist roles (Devrick 2014).

The challenge

The US has experienced a lot of partial or poor implementations of EMRs, and some there suggest finding flaws in EMRs could get worse before it gets better (Butler 2014). EMRs and other health systems will continue to evolve, just like iPhones, so the challenge will be with us for some time to come. While the future may excite some, it will also challenge many others. To transition successfully into future health information management roles, we must confront the uncertainty of moving outside our comfort zones. We must not fight change, but let it empower us. This will require changes to the educational pathways for entering the profession and continued professional development for those already in the workforce. We need to continue to maintain the standards set over the years, and continue to evolve and move forwards. We are a small profession, so it will be important to work strategically to maintain our professional status and recognition. Health information management leadership is imperative to the success of this transformation. We need to embrace EMRs and other technology advances and aim to lead the health-care industry into the next generation of health informatics and data analytics. To do this, we need to make sure we have a solid skill set to deliver, or market forces will take over and others will fill the skills gaps we leave open.

References


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Julie Brophy, BAppSci(HIM), GradDip(IT)Hons, GradDip(HlthStats)
Principal Advisor, Patient Costing & Analysis
Department of Health (Victoria)
50 Lonsdale Street
Melbourne VIC 3000
Tel: +61 3 9096 5917
email: Julie.Brophy@health.vic.gov.au