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EDITORIAL

Encode to manage☆,☆☆

Codificar para gestionar

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The article published in this issue of the journal by our colleagues from the Endocrinology, Nutrition and Diabetes Society of Castilla - La Mancha (*Sociedad Castellano Manchega de Endocrinología, Nutrición y Diabetes*)[1] highlights an unquestionable reality: What goes on in our outpatient clinics is totally opaque to the different healthcare services, beyond the classical and inefficient indicator represented by the relationship between first visits and follow-up visits - which is not applicable to our specialty - or the measurement of delay in referrals from primary care (PC). At present, the greater or lesser complexity we have in our clinics cannot be measured even by ourselves, and at managerial level we typically mix general consultations, usually referring to the first line of care for patients referred from PC, with monographic consultations of maximum complexity, some of which are even recognized by the Spanish Ministry of Health through the Centers, Services and Reference Units (CSUR) program.

It is hardly a consolation that this situation is far from exclusive to our specialty, but affects all care provided in our country in outpatient clinics. However, unlike other specialties, the percentage of our activity dedicated to such consultations is far higher. Perhaps because of this, and in line with the innovation capacity characteristic of endocrinologists, we should, as suggested by our colleagues, address this issue from other levels of the specialty at national level and propose some practical solutions.

But let us first examine the global framework in which we move. The encoding of outpatient processes is generally complex. The Royal Decree regulating the Registry of Specialized Healthcare Activity in Spain limits its scope to day hospitals, physicians and outpatient procedures of special complexity, initially excluding outpatient clinics.[2] Technical reports of the Ministry indicate that the encoding of external consultations is the last objective contemplated in this Registry.[3] Other authors who have described the trajectory from the traditional Minimum Basic Data Set (MBDS) to the current situation have also emphasized the importance of having an encoding system for the activities carried out in external consultations, but in turn draw attention to its complexity.[4] In addition, implementation of the ICD-10 as an encoding system, with its 70,000 diagnostic codes, has implied a greater amount of information (e.g., regarding the different types of diabetes), but has also added complexity to the encoding process.[5] In spite of some familiarity with automation or semi-automation strategies for encoding purposes,[6–8] diabetes is specifically one of the scenarios in which the greatest percentage of errors or miscoding problems occur, especially in reference to the outpatient setting.[6] The use of Natural Language Processing (NLP)

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☆☆ Note: The authors have had responsibilities in the Andalusian Health Service, as Director of the Participation and Joint Responsibility Strategy (AMSM), and as Head of the Participation and Joint Responsibility Service (RVP).
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tools has allowed some hospital emergency departments (with encoding difficulties similar to those in outpatient clinics) to obtain good results, with a precision of 0.976 (95%CI: 0.957–0.990), a recall (sensitivity) of 0.878 (95%CI: 0.844–0.910) and an F-score of 0.925 (95%CI: 0.903–0.943).[9]

The relevance of the above-mentioned article is therefore clear. The problem regarding measuring activity in outpatient clinics is real and is widespread. As an alternative, the authors developed a Delphi method with the participation of some fifty colleagues from their Autonomous Community, reaching a fairly plausible consensus when seen from the perspective of a specialist in Endocrinology and Nutrition. However, there are a number of deficiencies that the authors themselves comment on in the article. The number of participating specialists was small, and their dedication greatly conditioned the scores awarded. Moreover, it is questionable whether an index of greater complexity would reflect three times the care time (a variable that would determine schedule times) or three times the difficulty and, therefore, training and study (a variable that would determine the need for the selection of staff specially trained for the most complex consultations), or a combination of them. We agree that by securing a broader and more representative expert consensus within the Departments of Endocrinology and Nutrition throughout the country, such classification could be useful for establishing comparisons among centers. Without this, it would only be useful for allocating resources within the Department, with all the other nuances that arise at micromanagement level. The authors propose that the Spanish Society of Endocrinology and Nutrition perform an analysis with this same or a similar method, which could reach a consensus such as that which we suggest. We think that it would be the appropriate setting for this work, since the leadership and indications afforded by the scientific bodies would be that of our own peers, this being essential for carrying out a project requiring the maximum implication of all members of the specialty, free from personal interests and working for the benefit of all.

If we can achieve this, if we as specialists in Endocrinology and Nutrition can agree and assess, compare and evaluate ourselves, will this allow us to move beyond a mere comparison and rearrangement of activities? Is this objective enough, or do we need to be more ambitious? What would be our role as coordinators of the majority of multidisciplinary teams focusing on patients with diseases in Endocrinology and Nutrition? The role of endocrinologists in complex units such as the CSUR regarding complex hypothalamic-pituitary disease or innate errors of metabolism, in cases of short bowel, thyroid cancer, and so many other conditions, is essential. The characteristics of our specialty refer to many diseases, and our work goes beyond mere patient care in the consulting room. We will try to answer this issue from the convictions of the authors of this editorial in relation to clinical management. Modern medicine is built around multidisciplinary teams, professionals who each contribute their specific expertise to the treatment of disease, obviating the conventional hierarchical structure and working in an intermingling matrix network within the healthcare center. The only way to secure quality care is through the involvement of these professionals, getting them to do their work as they understand they should, without obstacles or instructions that correspond more to old hierarchical structures and to small victories that do not win wars. To achieve such involvement, professionals need to feel important, to participate and to share the responsibility of their results, feeling part of the final outcome. To this end, it is essential for management in each center to grant terrain to professionals who want to take on roles and also responsibilities. Central to this model is the role of the middle managers[10,11] as spokesmen for their colleagues, as the ''interpreters'' between central management and the unit, as the individuals their colleagues place their trust in for negotiating, and which the management team trusts to delegate responsibilities. The heads of service need tools to be able to negotiate with management, and in this regard having the work load of the clinic well analyzed may be one of them. They also need to take on their role and propose efficient alternatives in the care of our patients, assuming responsibility in many cases.

We would like to close this editorial by encouraging the Spanish Society of Endocrinology and Nutrition to accept the challenge proposed by the *Sociedad Castellano Manchega de Endocrinología, Nutrición y Diabetes*. Let us expand, improve and develop a tool which, as mentioned earlier, does not exist yet and is complex. Finally, once we have this tool, we should use it wisely and for the good of the specialty as a whole, ensuring reasonable work times that improve working conditions, as this will undoubtedly benefit quality care for our patients, as the ultimate purpose of our profession.

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