Clinical Documentation Integrity Week

Industry Overview Survey 2021

Association of Clinical Documentation Integrity Specialists
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CDI Week

2021 CDI Week Industry Overview Report

About the CDI Week survey advisor

Kelly Sutton, RN, BNS, MHL, CCDS, is the corporate CDI implementation specialist and educator for AdventHealth, headquartered in Altamonte Springs, Florida. She has 28 years of nursing experience and her CDI career started in 2015 as a CDI specialist in a suburban facility in Sebring, Florida. She earned her CCDS certification in 2018 and was promoted to a newly created CDI educator role in January 2019 as the CDI program transitioned from a facility-based to a divisional lead program. The educator role allowed Sutton to participate in the creation of policies and processes.

Ahe is a member of the Florida ACDIS local chapter and the National Association of Healthcare Revenue Integrity Leadership Council. She has been a frequent subject matter expert for ACDIS and presented at the 2020 ACDIS Virtual Education Curtain Call event. Sutton was elected to the ACDIS Advisory Board in 2021, serving through April 2024.

By Carolyn Riel

ACDIS celebrates CDI specialists annually with a full week of recognition for the profession through activities, education, and fun. This year's CDI Week theme is CDI Kitchen: Recipes for a Successful Program, aiming to go back to the basics of what it takes to make a CDI program great.

Each year leading up to CDI Week, ACDIS releases a survey to gain insight into the state of the industry. This year's survey included questions about the basics of CDI, physician engagement, outpatient CDI, productivity, and staffing/professional development. It marks the 11th annual CDI Week Industry Survey, continuing more than a decade of industry evaluation.

"Surveys such as this are important to gain perspective on industry trends, growth, and areas for improvement," says **Kelly Sutton, RN, BNS, MHL, CCDS,** who was the CDI educator of the West Florida division of AdventHealth in Tampa when this article was written. "The data in this type of survey can be leveraged to support the expansion of CDI programs—for example, increasing the number of frontline staff, creating new positions for second-level reviews, incorporating denials management, or expanding the scope of a program to include emergency room or outpatient reviews."

This year, 944 respondents took part in the survey, nearly 100 more than last year's 849 and the highest number of respondents to date. Although this report will not discuss every survey question in detail, readers can examine all the responses in graph format beginning on p. 13.

Survey respondents were asked their title and role to get a picture of different positions within the field. Similar to last year's results, CDI specialists made up the largest group, with 44.39% of respondents fitting into this role. This number, however, is down slightly from last year's 49.32%. The change is likely due to more 2021 respondents who are CDI managers (17.37% versus 14.72% in 2020), directors (11.44% versus 10.6% in 2020), and team leads (4.13% versus 3.3% in 2020). The shift from respondents in CDI specialist roles to those in higher positions likely demonstrates individuals growing within their career. (See Figure 1.)

"As the potential for program growth is realized, the opportunity for promotion to a leadership role allows a pathway for continued professional growth," Sutton says. "I have watched many nurses throughout my career leave positions due to the lack of opportunity for professional advancement. The data in this survey suggests a career in CDI has both longevity and the potential for upward mobility."

Only 48.09% of respondents noted working in an acute care hospital, down drastically from 85.28% of respondents who selected this answer last year. This

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large drop is likely because the 2021 survey added survey answer options aimed at greater specificity. These options included academic medical center/teaching hospital (16.53% of respondents) and healthcare system with multiple sites (26.27% of respondents), which were not available choices on the 2020 CDI Week Industry Survey. (See Figure 2.)

According to survey results, most respondents (33.47%) said that they have been in their current profession for over 20 years. Additionally, 18.54% have been in the profession for six to eight years, and 17.69% selected 11 to 15 years. Most respondents (56.36%) have been in their current role between zero and five years. An additional 21.4% have been in their role for six to eight years, and 1.38% of respondents have been in their current role for more than 20 years. (See Figure 3.)

"I am not surprised to see so many people in the CDI field for so long," says Sutton. "CDI demands use of critical thinking skills, clinical knowledge, and collaboration with other disciplines to ensure success. What other career away from the bedside allows professionals to utilize all these skills and still learn something new every day?"

When respondents were asked how long they intend to stay in CDI, their answers were spread fairly evenly across the board. Most respondents said they intend to stay for more than 20 years (20.44%), and an additional 17.69% said they intend to stay for three to five years, while 15.04% of respondents picked the middle road and answered nine to 10 years. (See Figure 4.)

Most respondents (34.22%) indicated their facility has between 101 and 400 beds, and 25.53% said the total number of beds in their health system is 3,000 or more. (See Figures 5 and 6.) While these numbers are comparable to those on the 2020 CDI Week Industry Survey, it should be noted that those with more than 2,000 beds in their healthcare system increased by over six percentage points (from 30.97% in 2020 to 37.29% in 2021), and those who answered they were not part of a healthcare system decreased by more than seven percentage points (from 22.14% in 2020 to 14.62% in 2021) year-over-year. The increase in overall hospital beds in a system and decrease in respondents who are not part of a larger hospital system could be due to the trend of larger organizations acquiring smaller hospitals. (See Figure 7.)

Folks in the CDI field come from different educational and professional backgrounds, including nursing, coding, and health information management (HIM). Because of this, it is not uncommon for CDI professionals to hold a vast array of credentials. Most respondents (74.58%) noted that they hold an RN credential, and 63.03% of respondents hold ACDIS' Certified Clinical Documentation Specialist (CCDS) credential. All other credential options offered on the survey had lower response rates. For example, 15.36% of respondents noted holding the CCS, 10.49% hold the CDIP, and 6.25% hold an RHIA credential. (See Figure 8.)

"As CDI programs expand into realms other than traditional inpatient CDI, and the programs become more robust, the list of credentials will continue to grow and become more diverse," Sutton says.

For this year's CDI Week Industry Survey, ACDIS increased the amount of answer choices for the question about CDI reporting structure, allowing for a more detailed look at whom CDI departments ultimately report to. Just over 27% of respondents said their CDI department reports to revenue integrity/cycle (a new option on the 2021 survey), and closely behind, 23.31% of respondents report to HIM/coding. Another new answer option, finance, garnered 14.19% of responses, and only 6.89% of respondents indicated they have a stand-alone CDI department, down from 11.43% in 2020. While the decrease in respondents from a

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stand-alone CDI department could have resulted from additional answer options redistributing that number, it is also possible that the past year has seen a shift away from stand-alone CDI departments. (See Figure 9.)

"As more CDI programs expand and diversify, the financial impacts will be realized. It makes sense that more programs are reporting to finance and rev cycle," Sutton says. "As the focus in healthcare is trending toward preventative medicine and managing chronic conditions so patients do not require inpatient hospitalization, revenue cycle and finance are perfectly positioned to forecast, track, and adapt to the changing landscape in healthcare."

CDI pantry staples: Back to basics

CDI as an industry has done an amazing job of capturing accurate descriptions of the patient. Unfortunately, that success makes it more and more difficult to identify opportunities on a day-by-day basis and puts all of us at risk of falling behind as everyone continues to excel. To stay ahead and continue to find opportunities without significant HR investment is a huge challenge. Therefore, the future means plugging all the holes where opportunities are missed and augmenting the capabilities of our CDI staff with AI. Advancement in AI over the last few years truly offers a synergistic relationship between technology and the CDI specialist that can continue to optimize the work and effectiveness of our CDI teams."

Anthony F. Oliva, DO, MMM, FACPE, vice president and chief medical officer, healthcare division, Nuance Communications

This year, ACDIS decided to take a step back to basics and include survey questions about CDI "pantry staples," investigating the fundamentals of CDI that can be overlooked, particularly in the presence of new, more flashy expansion topics.

In the 2021 CDI Week Industry Survey, we asked respondents how their CDI staff are assigned reviews. Just over 25% of respondents said reviews are assigned through software and IT assignment protocols, such as prioritization software. Additionally, 17.78% of respondents answered that reviews are assigned by service line (expertise), 15.59% have reviews assigned by patient census patterns, and 15.05% have reviews assigned randomly. (See Figure 10.)

"In our division, we use a mix of being unit-based and prioritization software to ensure all records are reviewed," Sutton says. "The CDI specialist will first complete unreviewed new-admits [24 hours or longer length of stay]. To select cases for re-review, the specialist will review cases that have been prioritized in the software. If there are more cases that are prioritized than can be completed, the CDI specialist utilizes their critical thinking skills to review cases where the DRG could be improved, a procedure may have been performed, or where the case may have progressed."

Respondents were also asked about the tasks CDI specialists are expected to perform as part of their typical routine. The majority of respondents (92.04%) said sending concurrent queries is part of CDI specialists' duties. Respondents also noted following up on concurrent queries post-discharge (73.5%), sending retrospective queries (69.9%), DRG reconciliation (69.68%), and developing and/or presenting physician education (61.61%) as CDI specialist duties. Though many respondents noted some form of physician education was part of their duties, only 23.56% of respondents noted rounding with physicians as an actual duty of CDI specialists, which could be a result of the increase in remote CDI work in the wake of the COVID-19 pandemic. (See Figure 11.)

"I was surprised that only 52.89% of respondents indicated that asking verbal queries was part of the duties they perform," says Sutton. "In my experience, most providers increase engagement when queries can be discussed verbally. It allows time for both the CDI specialist and provider to learn from each other. Clinical validation clarifications seem to be better received when presented verbally."

Many respondents also noted that concurrent reviews for financial impact (87.35%) and concurrent reviews for quality/nonfinancial impact (83.64%) are CDI specialists' responsibility. The large number of respondents who noted nonfinancial and quality reviews as part of the typical responsibilities mirrors the trend that year-over-year, CDI departments are focusing more on quality impacts instead of simply reimbursement.

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"I believe reviews for quality/nonfinancial opportunities are important to ensure an accurate representation of the patient's visit and utilization of resources. We owe this to the patients we serve," Sutton says. "I feel this move provides credibility to our profession, especially with the providers, as they come to understand we are quality focused and not just querying them so the hospital can make money. As payment models focus on quality of care and consumers have access to hospital outcomes data, it is imperative each chart reflects the true severity of illness and risk of mortality that nonfinancial reviews provide."

In terms of onboarding and training, 63.36% of respondents allot between one and six months for new CDI team members (26.72% allot one to two months, and 36.64% allot three to six months). Several respondents wrote in that the training time depends upon the new CDI professional's needs, and that the time differs for those who have prior experience in the field versus those who are green to the industry. (See Figure 12.)

Sutton herself has onboarded 37 new team members in the last two and a half years, a majority of whom had no prior CDI experience.

"When I first started my career in CDI, our program was a financially based program with onboarding focused mainly on CC and MCC capture; it was much easier to become proficient," she says. "Today, the onboarding process has an emphasis on understanding the 'why' behind quality-based CDI, streamlining the review process, and learning about concepts such as risk adjustment, mortality reviews, HCCs [Hierarchical Condition Categories], HACs [hospital-acquired conditions], and PSIs [Patient Safety Indicators]." In her experience, Sutton says a range of 10 to 12 weeks for onboarding is usually appropriate to understand the basics and to perform reviews in a quality-based CDI program.

"I have had a few team members who have completed the *ACDIS CDI Apprenticeship* prior to applying for a CDI specialist position who needed significantly less time in orientation," she adds.

Respondents were also asked to select their top three queried diagnoses. Unsurprisingly, most respondents (67.28%) named sepsis as one of their top three queried diagnoses, followed by respiratory failure (47.76%); congestive heart failure (CHF) and malnutrition nearly tied with 46.35% and 46.24%, respectively. Along with the provided answer options on the survey, a notable number of respondents wrote in obesity/body mass index or pressure injuries as one of their top three queried diagnoses. (See Figure 13.)

Respondents to *last year's survey* noted comparable conditions as being their top denied diagnoses. In 2020, 74.81% of respondents noted sepsis as their top denied diagnosis, followed by respiratory failure (66.67%) and malnutrition (54.96%). When it came to CHF, only 13.74% of 2020 respondents mentioned it as a top denied diagnosis. This means that while most of the top queried diagnoses are also the top denied diagnoses, CHF breaks the trend and is queried more than it is denied. Encephalopathy, however, follows the opposite trend: Only 28.57% of 2021 respondents noted it as a top queried diagnosis, while 44.27% of 2020 respondents said it was a top denied diagnosis. (See Figure 14.)

Continuing the topic of queries, 90.4% of respondents said that they use query templates, while only 6.98% do not. (See Figure 15.) For those who use templates, the majority (64.61%) developed them internally among

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their CDI team, physicians, and/or coders. Other respondents noted that templates were created by their software vendor (20.05%) or adapted from *the samples available in the ACDIS Resource Library* (1.69%). (See Figure 16.)

To finish the pantry sample basics section, ACDIS asked respondents which quality measures their CDI team reviews on a concurrent basis. Most respondents (82.74%) said their CDI team reviews present on admission indicators (POA) and HACs, while 70.35% review severity of illness/risk of mortality (APR-DRG methodology) concurrent to stay, and close behind 69.36% review PSIs. Only 7.52% of respondents said that they do not review for quality measures at all, again solidifying the idea that CDI is transitioning into a greater focus on quality versus pure financial impact. (See Figure 17.)

Serving your customers: Physician engagement

Any time ACDIS asks about CDI professionals' top pain points, the topic of physician engagement comes up. Year-over-year, though, physician engagement seems to be trending toward less of an issue as more clinicians learn what CDI is and grow more accustomed to related documentation needs. The COVID-19 pandemic, however, threw a wrench into the mix. Not only were physicians even more busy caring for severely ill patients, but most CDI professionals transitioned to working remotely, meaning they had less face-to-face time with providers.

"We noticed a decrease in our physician engagement and response rate. Many providers indicated they were working long hours caring for critically ill patients in what sometimes felt like a war zone," Sutton says. "In our division, CDI was on the front line of the provider-employee vaccination clinics. The respect CDI verbalized for the providers being on the front line throughout the pandemic and the gratitude the providers verbalized for CDI as we assisted with vaccination efforts helped improve relationships and engagement. As we were able to return to our facilities, the physician-CDI relationships and engagement improved."

While it seems survey respondents feel their physicians are generally engaged, as only 5% said their physicians are mostly disengaged and unmotivated, fewer respondents than last year rated their physicians as being highly engaged or motivated. In the *2020 CDI Week Industry Survey*, 20.42% of respondents said their physicians were highly engaged; in 2021, only 14.44% gave the same answer. Still, the 2021 survey numbers for those with medical staff who are highly engaged are higher than *2019*, meaning the growth in high engagement seems to be continuing. This slight drop from 2020 may have been caused by the huge uptake of remote work and increased demands on physicians' time over the last year and a half. (See Figure 18.)

Those struggling with physician engagement may find success in recognizing physicians' good work and publicizing their appreciation, Sutton suggests.

"Physician recognition has improved engagement within our division. Each facility selects a physician of the month based on collaboration with CDI and quality documentation. The division also selects a physician and mid-level of the quarter out of all the providers within our 11 facilities," she says. "We usually post pictures of the provider receiving their award on social media. This seems to spark the competitive nature of many providers and has prompted many discussions about CDI."

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In addition to physician support, respondents were also asked how supportive their organization's administrative team is of their CDI department. Most respondents (52.89%) said that their administrative team is strongly supportive, while an additional 30.22% noted that admin is moderately supportive. Some respondents wrote in that admin is supportive in words, but not in deeds. In CDI, just as in any profession, support is only support if things come to fruition, and administration should ensure they are putting their words into action. (See Figure 19.)

In terms of physician advisors, the majority of respondents (65.56%) said they have an advisor in some capacity (31.89% have a full-time advisor, and 33.67% have a part-time advisor). Only 12.22% of respondents said that they do not have a physician advisor and do not plan to hire one in the future. (See Figure 20.)

"I think [whether a physician advisor is necessary] depends on the size and structure of the program. We do not have CDI physician advisors within our division," Sutton says. "Our escalation process includes team lead and [chief medical officer] involvement. We recently hired a physician educator/liaison. This role not only provides monthly education to the providers, but also is a point person for provider documentation questions across the division."

Of those respondents who reported having a part-time advisor, just under 65.5% said that they share their advisor with another department, down from 73.03% in 2020. (See Figure 21.)

"Throughout the pandemic, many facilities had to find creative ways to save financial resources to stay afloat. Sharing a physician advisor was likely one of those solutions," says Sutton.

While the survey reveals a wide range for the time frame given to physicians to respond to a query, most respondents (34.2%) said they give physicians two days. Additionally, 14.06% of respondents give physicians three days to respond, 10.91% give one day, and 10.69% said they do not specify a time frame for query response. (See Figure 22.)

For response rates, most respondents (58.27%) said they have a response rate of 91% to 100%. Fewer respondents (20.81%) have a response rate of 81% to 90%, and even fewer respondents noted a rate lower than that. (See Figure 23.) The time frame physicians are given to respond to queries does not seem to have an impact on response rate, as across the board most respondents (regardless of response time frame expectations) said they see a high response rate between 81% and 100%. (See Figure 24.)

Most respondents (71.32%) have a high physician agree rate—between 81% and 100%. Only 6.97% of respondents noted an agree rate of 70% or lower. (See Figure 25.) In regard to physicians responding to queries, 81.66% of respondents noted that they have an escalation policy requiring physicians to respond to such queries. (See Figure 26.)

Ordering takeout: Outpatient CDI

Outpatient clinical documentation programs are an essential extension of the patient care documentation process, especially as healthcare organizations transition to risk-adjusted payment models. Expertise is needed to understand the complexities of the patient's condition and treatment across the continuum of care. The role of the clinical documentation specialist, traditionally focused on inpatient care, requires a forward-looking view, engaging with physician practices, outpatient services, and other areas of patient care that might have been seen in the past as more simplistic. Organizations that take a more holistic approach, investing in both inpatient and outpatient clinical documentation programs, are well positioned to address the continued complexities of accurate documentation required to represent the patient care delivered.

Keri Hunsaker, 3M HIS Marketing

Each year, ACDIS has seen increased CDI involvement in the outpatient setting, whether that means CDI professionals reviewing hospital-based outpatient settings or freestanding clinics and offices. The same holds true this year. Just over 24% of 2021 respondents noted their CDI team reviews outpatient charts in some capacity, up from 19.73% of *2020* respondents. (See Figure 27.)

"Our program has plans to expand to the outpatient arena in the next couple of years," says Sutton. "As a shift in services from the inpatient to the outpatient

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setting is being realized, it is important to help capture the acuity and chronic conditions of the patients our organization serves."

According to 2020 survey respondents, nearly 26% did not have an outpatient program but were planning to become involved in this area. This year, 21.85% of respondents said they are planning to expand into outpatient, meaning that number year-over-year decreased by about four percentage points. The number of respondents who are currently involved in outpatient CDI, however, also grew four percentage points in 2021, meaning that those who indicated in 2020 that they planned to expand into outpatient CDI seem to have done so by 2021.

"It is very impressive; starting a new program involves a lot of planning, communication, education, and normally being on-site," says Sutton. "CDI expanded in the outpatient setting despite a majority of the work being accomplished remotely and through video programs such as Teams® and Zoom®."

Respondents to the 2021 survey who are involved in the outpatient setting noted they review for several services and settings. According to the survey results, 28.11% of respondents review physician practice/clinics/Part B services, 26.1% review for risk adjustment of hospital outpatient services, and 17.27% review ambulatory surgery. (See Figure 28.)

Most respondents (44.58%) said the primary focus of their outpatient reviews is HCC capture. Only 6.83% of respondents have a primary focus of evaluation and management (E/M) coding, and very few respondents have primary focuses outside of these two areas. (See Figure 29.) One-third of respondents (33.33%) noted that the outpatient reviews take place prospectively, before the physician sees the patient. Almost another third (30.92%) review retrospectively, after the appointment has happened, and only 15.66% noted reviewing concurrently while the patient is in the office. (See Figure 30.)

The outpatient query process comes with its own set of struggles, such as working around physicians' fast-paced workflows and finding a technology platform that allows for seamless integrated querying. For query practice policies in the outpatient setting, most respondents (39.36%) said they do not know if such a policy exists in their organization. An additional 19.28% of respondents noted that they have a policy based around the ACDIS/AHIMA "*Guidelines for achieving a compliant query practice*" brief, and 12.85% said their policy is based on the ACDIS position paper "*Queries in outpatient CDI: Developing a compliant, effective process*." Only 8.84% of respondents said they do not have an outpatient query policy and have no indication of developing one. (See Figure 31.)

CDI programs often struggle with showing their impact, and this can be especially difficult in the outpatient setting. About one-quarter of respondents (26.91%) track outpatient impact manually using spreadsheets. An additional 15.66% said they do not have a way to track their impact, and 11.65% use outpatient-specific CDI software to track impact. (See Figure 32. To read more about outpatient technology and metric tracking, check out *this article from the July/August 2021 edition of the CDI Journal*.)

If you are not currently involved in outpatient CDI but wish to be, Sutton suggests researching the benefits, networking with people who have an outpatient CDI program, and visiting an existing program to see the benefits in person.

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A full menu: Productivity

Some of the most common questions ACDIS receives center around CDI productivity standards. The last time ACDIS conducted *a full survey on this topic was in 2016* and the CDI industry has changed significantly since then—from new technologies to new review areas and settings. Because of this, the 2021 Industry Survey included an entire section focused on productivity.

"CDI has started expanding its role in the quality realm. As it does, it has become clear that all charts need to be reviewed, not just certain patient populations or payers," Sutton says. "National productivity guidelines help programs determine benchmarks and how their programs compare."

According to the survey, most respondents (57.35%) noted the average CDI specialist in their facility completes between six and 10 new reviews each day, followed by 21.78% who said an average specialist completes 11 to 15 new reviews per day. In terms of re-reviews/subsequent reviews, 36.22% of respondents said an average CDI specialist completes 11 to 15 re-reviews daily, and a close 32.55% said a specialist completes six to 10 re-reviews each day. (See Figure 33.)

When respondents were asked the number of reviews they were expected to complete per day (as opposed to actually completing), it appears most CDI specialists are meeting their expectations. Similar to performed reviews, most respondents (53.94%) noted their expected number of new reviews per day is six to 10, and 20.47% have an expectation of 11 to 15 new reviews. For re-reviews, 38.19% of respondents said they are expected to complete 11 to 15 each day, and 26.77% noted an expectation of completing six to 10 re-reviews per day. (See Figure 34.)

"This is good in the respect that it provides a baseline industry standard when developing program metrics," says Sutton. "Facility and organization leaders will need to consider variables such as the program's focus, CDI specialist duties, acuity of the cases, and level of experience of the CDI specialist when developing their own program standards."

For CDI specialists who are not meeting their expected productivity, respondents noted various consequences. Most respondents (67.98%) said that if a CDI team member is not meeting productivity expectations, the CDI manager or leader will meet with the team member for a one-on-one discussion. About one-third of respondents (31.23%) said that the person not meeting expectations will undergo one-on-one education with the department educator or other leader, and 21.65% said if the poor productivity goes on for an extended period of time, the staff member may be let go. (See Figure 35.)

"In our division, the CDI specialist will work one-on-one with the educator to identify any barriers to meeting productivity expectations," says Sutton. "If the root cause is identified as a process issue, time management issue, or knowledge gap, the educator works with the CDI specialist to make improvements in that area."

Many outside factors can contribute to a CDI specialist's level of productivity, including patient census, the pandemic, and limited staffing. One major factor that can impact productivity is technology solutions. According to the survey, very few respondents find technology negatively impacts their productivity, and certain solutions appear to be helpful. Just shy of half of respondents (49.87%) said that computer-assisted coding solutions have increased productivity, either immediately or after a period of adjustment; 64.57% noted a similar experience with electronic querying; and just under 55% said they've had improvement of

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productivity with adoption of an electronic grouper. (See Figure 36.)

"Technology has become a huge part of CDI and productivity," says Sutton. "Relevant and effective technology decreases the amount of time a CDI specialist spends looking for resources or information that is not easily accessible."

Respondents were also asked about the greatest impact on CDI productivity during dedicated chart review time. Experience of the reviewer (seasoned versus inexperienced) was noted as the most important factor, according to 61.55% of respondents (16.4% listed it as the second most important factor). Also ranked highly were complexity of the account and/or diagnoses under review (with 14.57% putting it in first place and 27.69% of respondents having it in second)

and reviewing for financial metrics only versus quality elements (with 4.46% of respondents having it as most important and 14.83% having it as second). (See Figure 37.)

Less impactful to productivity are DRG or coding reconciliation responsibilities, with 11.81% putting this item in ninth place and 18.5% putting it in tenth (last) place. Having to manage physician education responsibilities also has little productivity impact (with 19.95% putting it in ninth place for impact and 10.63% putting it in last place). Seemingly least impactful to productivity is verbally querying physicians versus electronic queries only, with 13.65% of respondents placing this ninth on their list and 21.78% having it last.

"The advantage to written queries is they can be addressed when the provider has time. A disadvantage is written queries may cause confusion for providers if they do not understand what is being asked," Sutton says. "The advantage to verbal queries is the opportunity for dialogue between the CDI specialist and provider. Inconvenient timing of the CDI specialist call or in-person visit is a disadvantage to verbal queries."

The COVID-19 pandemic prompted many changes with work models, such as remote work and a major shift in hospital workload. It's not surprising that the impacts extended to the CDI world as well. As such, the Industry Survey asked respondents about the impact that COVID-19-prompted remote work had on their productivity over the last year. Most respondents (40.94%) noted that productivity increased over the past year, and 38.98% said the remote work had no impact on their productivity. Only 6.04% said that it caused decreased productivity. While there may have been some obstacles to overcome when first working remotely during the pandemic, once people adjusted, it's apparent that CDI specialists are capable of not only maintaining their productivity while working from home, but also improving it. (See Figure 38.)

Managing your kitchen staff: Staffing, professional development

According to respondents, most people (47.02%) entered the profession primarily because they wanted to grow professionally, and CDI offered them the chance to do so. Another 19.07% started their work in CDI primarily because they were involved with a different department (such as case management, utilization review, or HIM/coding) and were asked to fill a CDI role. (See Figure 39.)

"The CDI specialists in our division have opportunities for advancement with clinical ladders. For example, they can achieve a promotion to CDI specialist level 2 or level 3," says Sutton. "A career in CDI can also take a management track with the CDI specialist advancing from team lead to manager or director. Additionally, there is opportunity for a role as a second-level reviewer for quality, mortality, or denials. CDI analytics is another role that seems to be gaining popularity."

There *isn't a single professional background that excels at CDI work better* better than all others, and the

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2021 survey continues to show a diverse professional background set among respondents. While 96.69% of respondents said their department includes members from a nursing background, 35.63% said their department includes folks from an HIM/coding background, and 32.72% have physician champions/advisors (e.g., MD, DO, etc.) included as well. (See Figure 40.)

The majority of respondents (78.96%) said that their organization has a written policy requiring a clinical credential to be a CDI specialist. Only 22.78% of respondents have a written policy requiring a CDI-specific credential, up from only 17.35% who said the same when ACDIS last asked this question in *2018*. Just over 19% of 2021 respondents require a coding credential, which is up from 15.99% in 2018. Just over one-tenth of 2021 respondents (11.92%) do not require any specific type of credential. (See Figure 41.)

When it comes to staff numbers, most respondents (34.3%) said they have between zero and five full-time CDI specialists in their facility, followed by 23.58% of respondents who noted between six and 10 specialists in their facility. As for systemwide, 19.34% of respondents said they have more than 50 CDI specialists, while 13.51% said the question does not apply to them, suggesting they are not part of a larger hospital system. Behind that, 10.6% of respondents have 16 to 20 CDI specialists in their full system, and 9.27% only have between zero and five specialists systemwide. (See Figure 42.)

Despite the financial strain from the COVID-19 pandemic, 60.13% of respondents said that they have hired additional staff in the past 12 months, and another 12.58% are either actively recruiting or plan to hire in the next 12 months. About one-quarter (24.5%) said they have not hired new staff members and have no plans to do so. Only 2.78% of respondents noted that they have not hired new staff and have laid off employees to decrease their overall department size. (See Figure 43.)

"Our division has hired 13 new CDI specialists since January 2021 with two more expected in the coming months," says Sutton. "While general admissions had decreased and surgeries were canceled during the beginning of the COVID-19 pandemic, the census has rebounded. Here in Florida, the summer is usually our slowest time of the year due to the lack of seasonal residents. Our sites are currently still seeing a high number of admits trending month after month. We have yet to see our expected 'slower season.' "

One of the most important things any employer can offer their staff is opportunities for professional development. This helps with staff retention and shows employees they are valued. Survey respondents noted a variety of professional development opportunities offered by their organization, including budget allocation for CDI-specific credentials and recertification (43.44%); specialized roles within the CDI department, such as CDI educator or preceptor (41.19%); and a budget for continuing education for the department as a whole (37.09%). (See Figure 44. For more professional development ideas, read the September/October 2021 edition of the CDI Journal.)

"Most of the people I know in CDI are high performers and achievers who are inspired and engaged by continued learning and professional growth," says Sutton. "No one wants to be professionally or financially stagnant in a role. Recognizing employees with raises for advanced degrees or CDI-specific credentials as well as providing continuing education opportunities for the department demonstrates the organization's investment in their employee's professional growth."

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2021 CDI Industry Overview Survey

CDI Kitchen: Recipes for a Successful Program

1. Title/role, year-over-year

Answer Options	2020	2021
CDI specialist	49.32%	44.39%
CDI second level reviewer	1.06%	1.06%
CDI lead	3.30%	4.13%
CDI supervisor	3.89%	3.28%
CDI manager	14.72%	17.37%
CDI director	10.60%	11.44%
CDI auditor	1.53%	2.01%
CDI educator	2.71%	3.07%
CDI physician educator	0.24%	0.64%
CDI informaticist/analyst	0.35%	0.53%
CDI-coding liaison	0.12%	0.42%
CDI quality specialist	0.71%	0.85%
CDI denials specialist	0.47%	0.42%
HIM/coding supervisor	0.12%	0.11%
HIM/coding manager	0.12%	0.74%
HIM/coding director	2.00%	1.17%
HIM/coding professional	0.82%	0.64%
Physician advisor/champion	0.47%	0.64%
Hospital executive	0.47%	0.95%
Consultant	1.53%	1.59%
Other (please specify)	4.95%	4.56%

Selected other responses:

- Risk adjustment specialist
- Senior quality assurance professional
- CDI mortality and PSI reviewer
- Medical records technician
- CDI analytics director
- Ambulatory CDI specialist
- Nursing coordinator CDI

2. Organization type

Answer Option	Percentage
Acute care hospital	48.09%
Academic medical center/teaching hospital	16.53%
Healthcare system with multiple sites	26.27%
Outpatient/physician practice	1.59%
Children's hospital/pediatrics	0.64%
Critical access hospital/rural healthcare	0.21%
Rehab (inpatient or outpatient)	0.32%
Home health	0.00%
Long-term acute care	0.53%
Consulting firm	3.07%
Other (please specify)	2.75%

Selected other responses:

- Insurance company
- Accountable care organization
- Multi-level geriatric care physician group
- Acute care and behavioral health
- Revenue cycle company
- Vendor
- Government
- State Medicaid

3. Time in profession and current role

Answer Options	In profession	In current role
0-2 years	4.13%	25.53%
3-5 years	10.70%	30.83%
6-8 years	18.54%	21.40%
9-10 years	8.05%	7.52%
11-15 years	17.69%	10.91%
16-20 years	7.42%	2.44%
More than 20 years	33.47%	1.38%

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4. Length of time expected to remain in CDI

Answer Options	Percentage
0-2 years	7.94%
3-5 years	17.69%
6-8 years	12.71%
9-10 years	15.04%
11-15 years	14.83%
16-20 years	11.33%
More than 20 years	20.44%

5. Number of facility beds

Answer Options	Percentage
100 or less	5.51%
101-200	10.49%
201-300	12.08%
301-400	11.65%
401-500	8.90%
501-600	8.05%
601-700	5.51%
701-800	3.50%
801-900	3.60%
901-1,000	2.97%
More than 1,000	14.62%
N/A	13.14%

6. Number of systemwide beds

Answer Options	Percentage
500 or less	12.61%
501-600	4.03%
601-700	2.54%
701-800	2.54%
801-900	3.28%
901-1000	5.51%
1001-1500	10.70%
1501-2000	6.89%
2001-2500	4.87%
2501-3000	6.89%
3000 or more	25.53%
N/A, I don't work in a healthcare system	14.62%

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7. Beds per health system, year-over-year

Answer options	2019	2020	2021
500 or less	16.75%	10.95%	12.61%
501-600	5.08%	4.24%	4.03%
601-700	3.38%	4.36%	2.54%
701-800	3.89%	3.89%	2.54%
801-900	N/A	2.94%	3.28%
901-1,000	4.74%	N/A	5.51%
1,001-1,500	41.46%* option was 1,001 or more	13.90%	10.70%
1,501-2,000	N/A	6.60%	6.89%
2,001-2,500	N/A	5.77%	4.87%
2,501-3,000	N/A	4.71%	6.89%
3,000 or more	N/A	20.49%	25.53%
N/A, I don't work in a healthcare system	24.70%	22.14%	14.62%

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8. Credentials held

Answer Options	Percentage
RAccredited Case Manager (ACM)	2.33%
Certified Clinical Documentation Specialist (CCDS)	63.03%
CCDS-Outpatient (CCDS-O)	3.81%
Certified Case Manager (CCM)	4.34%
Certified Coding Specialist (CCS)	15.36%
Certified Coding Professional (CPC)	4.34%
Certified Documentation Expert Outpatient (CDEO)	0.64%
Clinical Documentation Improvement Practitioner (CDIP)	10.49%
Certification in Healthcare Revenue Integrity (CHRI)	0.21%
Certified Professional in Healthcare Quality (CPHQ)	1.69%
Certified Risk Adjustment Coder (CRC)	2.86%
Fellow of American College of Healthcare Executives (FACHE)	0.21%
Licensed Practical Nurse (LPN)	0.64%
Bachelor of Medicine, Bachelor of Surgery (MBBS)	1.06%
Doctor of Medicine (MD)	2.44%
Master of Healthcare Administration (MHA)	3.81%
Nurse Practitioner (NP)	0.53%
Physician Assistant (PA)	0.21%
Registered Health Information Administrator (RHIA)	6.25%
Registered Health Information Technician (RHIT)	4.13%
Register Nurse (RN)	74.58%
Registered Respiratory Therapist (RRT)	0.64%
Other (please specify)	26.80%

Selected other responses:

- Accredited Case Management Association Registered Nurse (ACMA-RN)
- Bachelor of Business Administration (BBA)
- Bachelor/Master of Nursing (BSN/MSN)
- Certification in Infection Prevention and Control (CIC)
- Certified Billing and Coding Specialist (CBCS)
- Certified Clinical Research Professional (CCRP)
- Certified Coding Specialist-Physician-based (CCS-P)
- Certified Emergency Nurse (CEN)
- Certified Health Data Analyst (CHDA)
- Certified Healthcare Constructor (CHC)
- Certified Healthcare Technology Specialist (CHTS)
- Certified in Health Care Quality Management (CHCQM)
- Certified Legal Nurse Consultant (CLNC)/Legal Nurse Consultant Certified (LNCC)
- Certified Medical-Surgical Registered Nurse (CMSRN)
- Certified Outpatient Coder (COC)
- Certified Patient Account Representative (CPAR)
- Certified Professional in Healthcare Information and Management Systems (CPHIMS)
- Certified Professional in Healthcare Management (CPHM)
- Certified Professional Medical Auditor (CPMA)
- Certified Revenue Cycle Representative (CRCR)
- Contract and Insurance Credentialing Analyst (CICA)
- Critical Care Registered Nurse (CCRN)
- Doctor of Business Administration (DBA)
- Fellowship in the American Academy of Case Management (FAACM)
- Legal Nurse Consultant (LNC)
- Master of Business Administration (MBA)
- Master of Health Services Administration (MHSA)
- Master of Jurisprudence (MSJ)
- Master of Public Administration (MPA)
- Master of Science (MS)
- Master of Science in Health Informatics (MSHI)
- Nurse Executive-Board Certified (NE-BC)/Nurse Executive Advanced-Board Certified (NEA-BC)
- Public Health Nurse (PHN)/Master of Public Health (MPH)
- Registered Nurse Certified-Neonatal Intensive Care (RNC-NIC)

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9. CDI department reporting structure

Answer Options	Percentage
Stand-alone CDI department	6.89%
HIM/coding	23.31%
Finance	14.19%
Revenue integrity/cycle	27.44%
Quality	11.65%
Nursing/clinical	1.38%
Case management	7.42%
Other (please specify)	7.73%

Selected other responses:

- Population health
- Chief medical officer
- Compliance director
- N/A, consultant
- Practice management
- Business office
- Care coordination

10. Assignment of reviews

Answer Options	Percentage
By service line (expertise)	17.78%
By patient census patterns	15.59%
By DRG prioritization	8.94%
By software/IT assignment protocols (e.g., prioritization software)	25.08%
Randomly	15.05%
N/A; we don't conduct chart reviews	1.20%
Other (please specify)	16.36%

Selected other responses:

- By unit (assigned to unit for 2-month period)
- By hospital
- By admission date
- By assigned work queue
- By floor on rotation
- By payer
- By permanently assigned units

11. CDI specialist responsibilities

Answer Option	Percentage
Concurrent reviews for financial impact	87.35%
Concurrent reviews for quality/ non-financial impact	83.64%
Retrospective, pre-bill reviews for financial impact	41.33%
Retrospective, pre-bill reviews for quality/non-financial impact	42.75%
Rounding with physicians on floors	23.56%
Developing and/or presenting physician education	61.61%
Sending concurrent queries	92.04%
Sending retrospective queries	69.90%
Asking verbal queries	52.89%
Reviewing queries submitted by the HIM/coding team or another department	19.41%
Following up on concurrent queries post-discharge	73.50%
DRG reconciliation	69.68%
Participating in the denials management process	36.53%
Don't know	0.44%
Not applicable	1.53%
Other (please specify)	9.38%

Selected other responses:

- Prospective reviews
- Denials
- Post-bill second level mortality reviews
- Audits for fraud, waste, and abuse
- Education to the CDI group
- Virtual rounds with physicians

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12. Time allotted for onboarding

Answer Options	Percentage
A few weeks to a month	17.99%
One to two months	26.72%
Three to six months	36.64%
Six months to a year	10.69%
Other (please specify)	7.96%

Selected other responses:

- From my experience, a couple of weeks
- Depends on specifics outlined in contracts
- 12 weeks for unexperienced CDI professional, experienced CDI depends on level of experience
- Six weeks for experienced professionals, 12 weeks for inexperienced professionals
- Varies with experience
- Two years

13. Top queried diagnoses (Selected up to three)

Answer Options	Percentage
Congestive heart failure	46.35%
Sepsis	67.28%
Respiratory failure	47.76%
Malnutrition	46.24%
Kidney disease	15.05%
Acute blood loss anemia	10.03%
Pneumonia	8.94%
Altered mental status	10.03%
Encephalopathy	28.57%
Chronic obstructive pulmonary disease	2.29%
Acute myocardial infarction	3.82%
Other (please specify)	13.63%

Selected other responses:

- Obesity
- BMI
- Pressure injury/ulcer
- Clinical validation
- Diabetes
- Complications
- Diagnosis ruled out
- Present on admission
- Electrolytes
- Depression

14. Top denied diagnoses versus top queried diagnoses

Answer Options	2020 top denied diagnoses percentage	2021 top queried diagnoses percentage
Congestive heart failure	13.74%	46.35%
Sepsis	74.81%	67.28%
Respiratory failure	66.67%	47.76%
Malnutrition	54.96%	46.24%
Kidney disease	16.54%	15.05%
Acute blood loss anemia	13.99%	10.03%
Pneumonia	16.28%	8.94%
Altered mental status	3.31%	10.03%
Encephalopathy	44.27%	28.57%
Chronic obstructive pulmonary disease	2.04%	2.29%
Acute myocardial infarction	8.40%	3.82%
Other (please specify)	15.01%	13.63%

15. Query template use

Answer Options	Percentage
Yes, we use templates	90.40%
No, we don't use templates	6.98%
Don't know	0.98%
N/A	1.64%

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16. Query template development

Answer Options	Percentage
Internally by the CDI team, physicians and/or coders	64.61%
By our software vendor	20.05%
Adapted from the Resource Library at ACDIS	1.69%
Other (please specify)	13.65%

Selected other responses:

- Combination of above options
- Query committee
- Consultant group
- CDI analyst

17. Concurrently reviewed quality measures/items

Answer Options	Percentage
CMS Inpatient Quality Measures, i.e., “core measures’ (not specific to Hospital Value-Based Purchasing [HVBP])	37.28%
Present on admission indicators (POA)/hospital acquired conditions (HAC)	82.74%
Hospital readmissions reduction program (HRRP)	19.69%
Patient safety indicators (PSI)	69.36%
HAC reduction program	47.01%
Severity of illness/risk of mortality (APR-DRG methodology) concurrent to stay	70.35%
Severity of illness/risk of mortality (APR-DRG methodology) retrospective mortality reviews	53.76%
Severity of illness/risk of mortality (not specific to APR-DRG methodology)	40.15%
Surgical Care Improvement Project (SCIP) or other quality specialty database	7.74%
U.S. News and World Report	9.85%
Vizient	22.23%
Elixhauser	12.28%
We don’t review quality measures/metrics	7.52%
Other	5.64%

18. Physician engagement, year-over-year

Answer Options	2019	2020	2021
Highly engaged and motivatedIf	12.71%	20.42%	14.44%
Mostly engaged and motivated, with some exceptions	51.03%	50.00%	50.89%
Somewhat engaged and motivated	31.78%	25.49%	26.78%
Mostly disengaged and unmotivated	4.49%	4.08%	5.00%
Don’t know	–	–	0.78%
Not applicable	–	–	2.11%

19. Administrative team support

Answer Options	Percentage
Strongly supportive	52.89%
Moderately supportive	30.22%
Somewhat supportive	13.89%
No apparent support	1.78%
Other (please specify)	1.22%

Selected other responses:

- Local administration is somewhat supportive; corporate administration is strongly supportive
- Verbally supportive, but no substance

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20. Physician advisor/champion involvement

Answer Options	Percentage
Yes, we have a full-time physician advisor/champion	31.89%
Yes, we have a part-time physician advisor/champion	33.67%
No, but we plan on engaging one in the near future	10.22%
No, we have no plans to engage a physician advisor/champion	12.22%
Don't know	3.33%
Other (please specify)	8.67%

Selected other responses:

- We have a physician on an as-needed basis
- We had one in the past but not so much now; he has other duties currently
- The chief medical officer (CMO) acts as the CDI advisor when needed
- Allegedly, but their name has not been shared with the CDI staff
- We did but he retired and a new one has not been identified
- We have one but to date, they do nothing with us due to other responsibilities
- We have one under case management who helps with CDI when asked
- We have one, but he is not supportive

21. Sharing physician advisor/champion with other departments, year-over-year

Answer Options	2020	2021
Yes, we share an advisor with) another department(s)	42.48%	65.44%
No, we don't share an advisor with another department(s)	9.15%	19.53%
Don't know	6.54%	15.04%
N/A	41.83%	N/A

22. Required timeframe for physician query response

Answer Options	Percentage
One day	10.91%
Two days	34.20%
Three days	14.06%
Four days	2.81%
Five days	2.70%
Six days	0.22%
Seven days	5.06%
Eight-14 days	5.74%
Within 30 days	5.74%
We don't have a timeframe for query response	10.69%
Don't know	2.25%
Other (please specify)	5.62%

Selected other responses:

- At time of visit
- They get three notices that coincide with their schedule
- Seven days post discharge
- Chart is finalized if query is not answered by three weeks
- 24 hours if concurrent, five days if discharged
- One day concurrent queries, three days retrospective queries
- Prior to discharge is preferred; we escalate every 24 hours
- Before the patient discharges
- Up to 48 hours after discharge

23. Physician query response rate

Answer Options	Percentage
0%-25%	0.56%
26%-50%	1.12%
51%-60%	1.69%
61%-70%	1.91%
71%-80%	3.71%
81%-90%	20.81%
91%-100%	58.27%
Don't know	8.55%
We don't track this metric	3.37%

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24. Timeframe for query response versus response rate

Response rate	1 day	2 days	3 days	4 days	5 days	6 days	7 days	8-14 days	<30 days
0%-25%	1.03%	0.33%	0.00%	0.00%	4.17%	0.00%	0.00%	0.00%	1.96%
26%-50%	3.09%	0.66%	1.60%	0.00%	0.00%	0.00%	2.22%	0.00%	0.00%
51%-60%	0.00%	2.30%	0.80%	0.00%	0.00%	50.00%	2.22%	0.00%	0.00%
61%-70%	3.09%	2.63%	1.60%	0.00%	0.00%	0.00%	2.22%	1.96%	0.00%
71%-80%	3.09%	3.62%	4.00%	4.00%	4.17%	0.00%	6.67%	5.88%	5.88%
81%-90%	20.62%	25.66%	24.80%	8.00%	16.67%	0.00%	17.78%	5.88%	21.57%
91%-100%	61.86%	55.59%	60%	80.88%	66.67%	50.00%	62.22%	86.27%	62.75%
Don't know	5.15%	7.24%	6.40%	8.00%	4.17%	0.00%	6.67%	0.00%	7.84%
We don't track this metric	2.06%	1.97%	0.80%	0.00%	4.17%	0.00%	0.00%	0.00%	0.00%

25. Physician query response rate

Answer Options	Percentage
0%-25%	1.24%
26%-50%	1.69%
51%-60%	1.12%
61%-70%	2.92%
71%-80%	6.41%
81%-90%	35.10%
91%-100%	36.22%
Don't know	11.14%
We don't track this metric	4.16%

26. Escalation policy requiring physicians to respond to queries

Answer Options	Percentage
Yes, we have an escalation policy	81.66%
No, we don't have an escalation policy	10.57%
Don't know	3.94%
Other (please specify)	3.82%

Selected other responses:

- Yes, but it's not effective
- Escalation policy depends upon each facility
- We have a process involving the physician advisors but no policy/no authority
- Nothing formal; usually myself or the CDI supervisor will try to follow-up with providers
- There is an escalation policy, but response is not required

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27. Outpatient CDI expansion, year-over-year

Answer Options	2020	2021
Yes, we have a standalone outpatient CDI department with dedicated outpatient reviewers	16.58%	20.61%
Yes, our inpatient reviewers also review some outpatient records or provide education	3.15%	3.60%
No, we don't have an outpatient CDI department but are planning to	25.87%	21.85%
No, we don't have an outpatient CDI department and have no plans to add one	46.27%	44.37%
Don't know	4.15%	5.63%
Other (please specify)	3.98%	3.94%

Selected other responses:

- Pilot program in place for outpatient review
- No plans for outpatient CDI at this point, but it has been discussed
- Currently in the assessment phase
- In the process of implementing

28. Outpatient services reviewed

Answer Options	Percentage
Hospital outpatient services: Ambulatory surgery	17.27%
Hospital outpatient services: Emergency department	16.47%
Hospital outpatient services: Medical necessity of admissions	9.64%
Hospital outpatient services: National and local coverage determinations	8.84%
Hospital outpatient services: Quality measures	12.45%
Hospital outpatient services: Risk adjustment	26.10%
Physician practice/clinics/Part B services	28.11%
Rehabilitation (outpatient)	4.82%
We don't review outpatient records	10.44%
Don't know	24.90%
Other (please specify)	9.64%

Selected other responses:

- Observation cases
- Preoperative clinic
- Risk adjustment for Accountable Care Organization
- All primary care sites
- Depends on client needs
- Facility-specific
- Specific ambulatory departments
- Pain clinic procedures

29. Primary outpatient review focus

Answer Option	Percentage
Hierarchical Condition Category (HCC) capture	44.58%
Evaluation and management (E/M) coding	6.83%
Denials prevention	2.41%
Medical necessity/patient status	2.81%
Medical necessity/coverage of drugs/ devices/procedures, etc.	2.01%
Emergency department review/observation	2.41%
Accuracy of current procedural terminology (CPT) codes for expensive surgeries/procedures	1.61%
Don't know	28.11%
Other (please specify)	9.24%

Selected other responses:

- Complete and accurate documentation that supports code assignment (similar focus as inpatient CDI reviews)
- Risk stratification
- Provider education
- Dependent on client needs
- Accurate representation of patient's current health status
- Documentation and diagnosis specificity and completeness

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30. Timing of outpatient reviews

Answer Options	Percentage
Prospective – before the physician sees the patient	33.33%
Concurrent – while the patient is in the office	15.66%
Retrospective – after the appointment has happened	30.92%
We don't perform chart reviews/ focus is on education	5.22%
Don't know	31.73%
Other (please specify)	6.43%

Selected other responses:

- When consulted by coding
- Post-bill
- Only review ED for physician education opportunity
- Currently developing retrospective process

31. Policy for outpatient query compliance

Answer Options	Percentage
Yes, we have a policy based on the ACDIS position paper "Queries in outpatient CDI: Developing a compliant, effective process"	12.85%
Yes, we have a policy based around the ACDIS/AHIMA query practice brief, "Guidelines for Achieving a Compliant Query Practice"	19.28%
Yes, we have a policy that was homegrown within our program	9.64%
No, but we are developing one	5.22%
No, we do not have an outpatient query policy	8.84%
Don't know	39.36%
Other (please specify)	4.82%

Selected other responses:

- Yes, developed from National VHA guideline recommendations
- We do not query ED providers
- Utilize vendor software/process, no queries

32. Tracking outpatient CDI impact

Answer Option	Percentage
We use outpatient-specific CDI software	11.65%
We use a modified version of our inpatient-specific CDI software	7.63%
We track impact manually using a spreadsheet	26.91%
We contract with an external company to monitor our performance	2.81%
Our internal IT department created a tracking tool or us	7.63%
N/A; we don't have a way to track our impact	15.66%
Other (please specify)	34.94%

Selected other responses:

- Don't know
- It's a work in progress
- We utilize several automated tracking software tools—one homegrown and tracking capabilities within our EHR
- Our CDI analytics team has developed a weekly dash-board that tracks and trends HCC capture which is distributed to all system leaders

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33. Number of new and re-reviews completed per day in reality

	0-5	6-10	11-15	16-20	21-25	>25	Don't know	N/A
New reviews	6.82%	57.35%	21.78%	5.25%	1.05%	1.57%	2.89%	3.28%
Re-reviews	7.48%	32.55%	36.22%	11.15%	3.15%	1.57%	3.81%	4.07%

34. Number of new and re-reviews expected per day

	0-5	6-10	11-15	16-20	21-25	>25	Don't know	N/A
New reviews	3.81%	53.94%	20.47%	5.12%	2.49%	2.10%	4.46%	7.61%
Re-reviews	4.33%	26.77%	38.19%	10.24%	3.67%	2.23%	5.38%	9.19%

35. Consequences for staff members failing to meet productivity expectations

Answer Option	Percentage
The CDI manager/leader meets with them for one-on-one discussion	67.98%
They undergo one-on-one education with the department educator or other leaders	31.23%
They lose their remote work privileges until they meet their productivity expectations consistently for a set amount of time	19.95%
If it goes on for an extended period of time, they may be let go	21.65%
N/A; we don't have a productivity expectation for CDI staff members	14.04%
Other (please specify)	16.14%

Selected other responses:

- There is a network and work will be shared if one person's not making quota
- Our team attempts to be as didactic as possible and assist the CDI specialists in performing to the highest efficiency possible
- Annual review percentage
- Every situation and case is different. Our manager would rather have us perform quality reviews than rush through charts
- Usually, there's higher quality from slower productivity
- We get it done either by doing it the next day or working until we complete; there is no back log
- Performance improvement plans may include retraining on CDI software
- Performance metric covered routinely at yearly performance review
- Union negotiations preclude any consequences
- Work improvement plan, closer attention to and accountability for personal productivity; daily activity reports to leader

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36. Technology's effect on productivity

	It increased our productivity immediately upon implementation	It increased improved somewhat	It made no change to our productivity	It negatively impacted our productivity	It's too soon to tell (we implemented recently)	We don't have this technology
Computer-assisted physician documentation	6.69%	17.32%	17.98%	2.62%	3.81%	51.31%
Computer-assisted coding	13.91%	35.96%	16.67%	3.94%	3.28%	26.25%
Natural language processing	8.92%	28.74%	19.03%	3.94%	3.28%	36.09%
Electronic querying tool	23.49%	41.08%	17.45%	1.97%	1.44%	14.57%
Electronic grouper	23.49%	31.50%	21.13%	1.84%	1.44%	20.60%
Chart prioritization	11.02%	24.41%	22.97%	3.54%	5.51%	32.55%
Quality database	5.25%	12.47%	24.93%	2.89%	2.76%	51.71%
Some internally developed EHR modifications	8.27%	24.02%	20.47%	2.49%	2.89%	41.86%

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37. Impact of variables on CDI productivity (1=greatest impact, 2=second greatest impact, etc.)

	1	2	3	4	5	6	7	8	9	10
Experience of the reviewer (seasoned versus inexperienced)	61.55%	16.40%	6.30%	3.81%	3.02%	2.10%	1.57%	0.92%	1.84%	2.49%
Reviewing for financial metrics only (CC/MCC) versus quality elements	4.46%	14.83%	15.35%	11.68%	11.02%	11.02%	9.19%	8.40%	6.96%	7.09%
Technological solutions that flag nonspecific documentation versus no access to such technology	1.71%	7.22%	14.17%	13.91%	9.71%	10.76%	11.42%	10.50%	12.60%	8.01%
Technology solutions that include prioritizations/ evaluating cases with perceived opportunity	4.72%	10.50%	10.89%	13.12%	9.32%	9.84%	10.10%	9.97%	11.15%	10.37%
Composing free-text queries versus using preformatted query templates	1.18%	5.25%	10.76%	12.07%	16.67%	14.57%	13.78%	9.97%	9.45%	6.30%
Verbally querying physicians versus electronic queries only	1.18%	2.76%	4.46%	6.96%	8.79%	13.12%	14.04%	13.25%	13.65%	21.78%
Complexity of the account and/or diagnoses under review	14.57%	27.69%	14.96%	11.02%	6.56%	7.35%	8.40%	4.86%	2.76%	1.84%
Remote working environment versus onsite	7.74%	8.27%	9.97%	10.24%	10.10%	8.79%	7.48%	14.57%	9.84%	12.99%
Physician education responsibilities versus dedicated chart review	0.92%	3.02%	6.17%	7.09%	12.47%	11.15%	12.73%	15.88%	19.95%	10.63%
DRG or coding reconciliation responsibilities	1.97%	4.07%	6.96%	10.10%	12.34%	11.29%	11.29%	11.68%	11.81%	18.50%

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38. Effect of COVID-19-prompted remote work on productivity

Answer Options	Percentage
It increased productivity	40.94%
Productivity remained the same	38.98%
It decreased productivity	6.04%
Don't know	8.27%
N/A, we did not work remotely in the last year	5.77%

39. Primary reason for for the CDI profession

Answer Options	Percentage
I wanted to grow professionally, and CDI offered me a chance to do so	47.02%
I needed a less strenuous job after direct patient care	12.98%
I needed a job with predictable hours due to family/personal reasons	11.79%
I was involved in a different department (e.g., case management, utilization review, HIM/coding) and was asked to fill a CDI role	19.07%
N/A; I'm not in the CDI profession	1.32%
Other (please specify)	7.81%

Selected other responses:

- Entry level job after college graduation
- Different growth opportunity in nursing
- Wanted a change and now I stay because I am paid well
- I felt I could make a contribution in accurately reflecting the patient's story through improved documentation and help my organization
- Severe plantar fasciitis and couldn't be on my feet any longer
- I was working in insurance review and needed a change, CDI was a good fit professionally
- I had an accident and could no longer work on the floor
- Back pain from years of nursing, not for less stress—this is more stress
- Thought the role was important to ensure sustainability of the hospital system
- Developed an allergy to latex which required me to move from the bedside to a non-clinical environment. CDI position was open, and I took a chance. Best decision I ever made. Had never heard of CDI before internal HR referred me.
- I interviewed for a CDI job to hone my interview skills, having no clue what a CDI was/did. By the end of the interview, I really wanted to be a CDI specialist! I was told I'd be offered the position; I was offered the job and the rest is history

40. Professional backgrounds represented in CDI department

Answer Options	Percentage
Nursing (RN, BSN, etc.)	96.69%
HIM/coding (RHIT, RHIA, etc.)	35.63%
Foreign-trained medical graduates/ MBBA, etc	19.07%
Physician champions/advisors (MD, DO, etc.)	32.72%
Other clinicians (PA, LPN, etc.)	11.92%
Other (please specify)	4.24%

Selected other responses:

- Respiratory therapists (RRT)
- Social worker
- Emergency services (EMS)

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41. Policies necessitating certain credentials for CDI work, year-over-year

Answer Options	2018	2021
Yes, we require a clinical credential (i.e., RN, MC, etc.)	77.55%	78.96%
Yes, we require a coding credential (i.e., RHIA, RHIT, etc.)	15.99%	19.21%
Yes, we require a CDI-specific (i.e., CCDS, CDIP, etc.)	17.35%	22.78%
No, we don't require a specific type of credential	14.29%	11.92%
Other (please specify)	8.16%	8.74%

Selected other responses:

- CCDS and CCS must both be received within one year of hire
- Not sure
- CCS or CCDS
- Three tiers: I—CCDS or CDIP; II—Add CCS; III—Add CRC
- CCDS required within 2-3 years of employment
- Allowances made for coders with CDI experience
- We require four-year degree in healthcare (coding, nursing, etc.) with an RN preferred; for higher level roles we require a variety of credentials/certifications depending on the specific role

42. Number of facility and systemwide staff members (1 part-time CDI specialist=0.5 FTE)

Answer Options	Facility	Systemwide
0-5	34.30%	9.27%
6-10	23.58%	6.49%
11-15	12.85%	7.95%
16-20	5.70%	10.60%
21-25	2.91%	8.87%
26-30	1.19%	6.49%
31-35	1.19%	5.70%
36-40	0.26%	5.30%
41-45	0.26%	3.18%
46-50	0.26%	3.31%
More than 50	0.93%	19.34%
N/A	16.56%	13.51%

43. Hiring new CDI staff

Answer Options	Percentages
Yes, we've hired new staff members in the last 12 months	60.13%
No, but we're in the process of recruiting new staff members now	5.56%
No, but we're planning to hire in the next 12 months	7.02%
No, we haven't hired new staff members and we have no plans to do so	24.50%
No, and we've laid off staff to decrease our overall department size	2.78%

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44. Professional development opportunities

Answer Options	Percentages
Budget allocation for CDI-specific credentials and recertification	43.44%
Raises based on obtaining CDI-specific credentials	17.75%
Budget for continuing education for each CDI staff member	25.70%
Budget for continuing education for the department as a whole	37.09%
Raises based on advanced degrees in related fields (e.g., masters and doctorate degrees)	7.81%
Step increases based on seniority and experience	16.42%
Management and leadership training for all staff members	22.91%
Specialized roles within the CDI department (e.g., CDI educator, preceptor, etc.)	41.19%
None	18.28%
Other (please specify)	5.43%

Selected other responses:

- CDI specialist level I and level II for career ladder opportunity
- Can get recertification reimbursement, if requested
- Provides HCPro Modules for CEUs at no cost to employees
- Organization pays for the ACDIS membership if you have your CCDS credentials.
- Stipend for getting a certification that covers the cost of exam prep materials, the exam cost, and extra as a “bonus”
- Annual merit increases. Annual lump sum bonus per certification
- Career ladder
- COVID has cut funding for education and does not pay for recertification for any credentials
- 3% cost of living raise annually if supported by corporate
- We cover professional membership dues. We cover educational materials for CDI credentialing exams as well as the exam as long as it is passed successfully.

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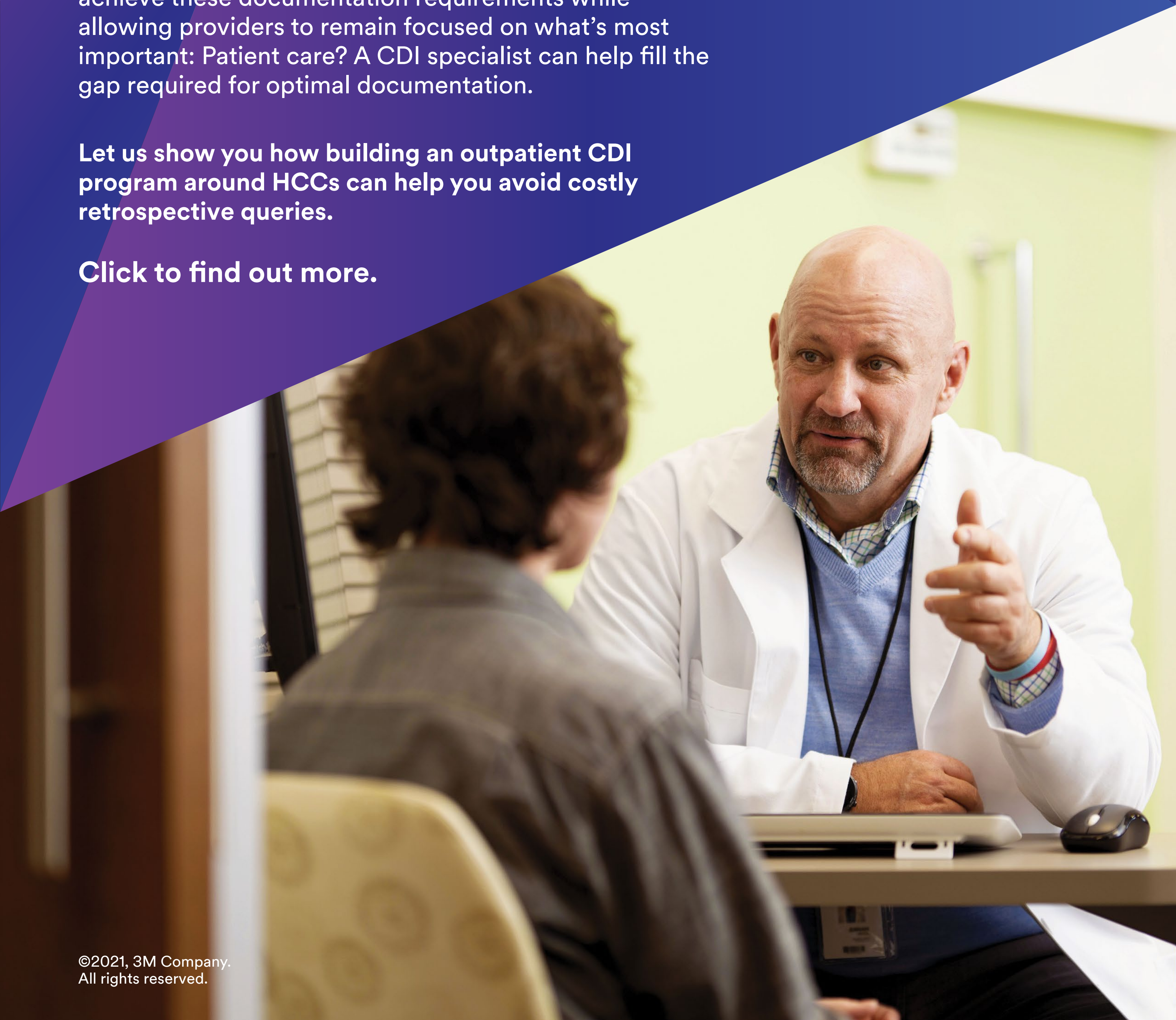

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