2014 Program Structure and Productivity Survey
CDI programs still seem to “run the gamut” in terms of structure, productivity expectations, focus, and function, says Donna Fisher, CCS, CCDS, CDI coordinator at UFHealth Shands Hospital in Gainesville, Fla., in response to the results of a recent ACDIS survey on CDI program structure and productivity.

According to 49.8% of 592 survey respondents, the majority of CDI programs continue to be housed in the HIM department. (See Figure 1 for an illustration of additional reporting structures.)

“This seems to be the most current trend as program success depends on coder/CDI communication and reconciliation,” says ACDIS Advisory Board member Wendy Clesi, RN, CCDS, director of CDI services at Huff DRG Review, Inc., in Eads, Tenn.

CDI programs reporting to other departments may run into relationship challenges, communication concerns, and competing priorities, which can affect program assessment and its relative success, Clesi says. (Read more about the CDI specialist’s role and responsibilities in the new ACDIS Advisory Board position paper, which is included in this issue of CDI Journal.)

However, some CDI programs do successfully report to departments besides HIM. When Wendy Tsaninos, RN, BA, CMSRN, CCDS, internal CDI specialist for Maxim in Beachwood, Ohio, first joined the CDI ranks, the team reported to case management. When the program was restructured, they began reporting to quality. Now, at her current facility, the team reports to HIM. “Where you are housed determines the focus of the program,” Tsaninos says.

Although she declines to weigh in definitively on which reporting structure she prefers—each has its pros and cons, she says—differences in program structure
and priorities make productivity assessments difficult to quantify.

Reporting to HIM may make coder/CDI interaction easier, as illustrated in Figure 2, where only 2.7% of respondents indicated they do not meet with their coder counterparts and the majority (34.5%) indicated they meet monthly. Another 32.3% indicated that although they do not have formal meetings, the CDI and coding staff are encouraged to work together and discuss any problematic cases as they arise.

“Regular communication is key to program success,” says Clesi. “Monthly meetings … allow the entire team to benefit from education and support program growth.”

Survey respondents expect interaction to increase with the onset of ICD-10-CM/PCS implementation, too, with 72.9% anticipating more frequent interactions due to the code set change. (See Figure 3.)

**Productivity concerns**

The majority of CDI professionals (76.9%) expect their program productivity to decrease as ICD-10-CM/PCS implementation begins, and as staff begin to query and educate physicians about additional documentation needs. (See Figure 4.)

“I am glad that the majority of our members are aware of the significant impact of ICD-10-CM/PCS around our productivity,” says ACDIS Advisory Board member Deanna Banet, RN, BSN, CCDS, CDI director at Norton Healthcare in Louisville, Ky. Yet Banet was disappointed on the remainder of the respondents who answered otherwise. “Because so many of the people taking this survey were CDI specialists, this may illustrate a lack of awareness on the part of the staff, or it may demonstrate a greater shift in the separation of responsibilities between CDI managers and CDI specialists,” she says. “At this point [so many months into implementation year], I am a little surprised that nearly a quarter of respondents are not at [a higher] level of awareness.”

The CDI program at the 800-plus-bed UF Health Shands Hospital started nine years ago. At the time,
CDI specialists reviewed an average of 25 to 30 records per day, Fisher says. Today the program has expanded to include reviews for all APR-DRG payers, retrospective reviews for outstanding cases, pediatrics, hospital-acquired conditions, patient safety indicators, and more, with expectations for additional queries related to ICD-10-PCS and other items.

“I don’t see any of these responsibilities going away,” says Fisher. “If anything, we’re going to be getting more responsibilities.”

As a result, that former figure of 25–30 charts per day is no longer realistic; now it can be a struggle to thoroughly review eight to 10 charts in a day, she says.

According to a recent ACDIS poll, productivity truly runs the gamut:
- 32% review 1–10 records per day
- 25% review 11–15 records per day
- 18% review 16–20 records per day
- 13% review 21–25 records per day
- 6% review 26–30 records per day
- 6% review more than 30 records per day

For those reviewing APR-DRG payers, productivity is significantly less, with 42% of respondents to a different ACDIS poll indicating they review six to eight records per day (see the poll at http://tinyurl.com/mf6epx).

“The productivity requirements of 20 charts per day is difficult to meet especially since we implemented a new software program and other measures,” wrote one respondent. “The administrators want us to eventually review 30 charts per day, but whipping through the charts does not necessarily mean that there will be a greater impact. It takes time to carefully review the charts in order for the reviews to be of any value.”

“Our set productivity level is to review 24 concurrent charts per day,” wrote another respondent. “We also follow up on any coders’ post-discharge queries that have not been closed within seven days, as well as creating and delivering physician education.”

“We’ve been given productivity metrics that we’re expected to meet,” wrote another. “Right now only six
of the 24 staff members are meeting that target.”
“But productivity depends on how well everyone’s been trained up,” Tsaninos says. “It will depend on whether the program has reviewed its top 10 diagnoses and done the legwork to identify additional documentation needs in ICD-10. The CDI program manager needs to get that data together and assess how these items will affect the overall workload.”

Clesi agrees—productivity depends on a variety of factors. When she worked as a program director and chaired her facility ICD-10-CM/PCS steering committee, she expected productivity to decrease too. “Like many professionals, my reaction was triggered by my fear of the unknown,” she says.

Considering the sheer volume of new codes and the number of physicians needing education, Clesi wondered how her team would possibly manage existing duties while adapting to the new challenges they faced. “Today, I realize that the role and responsibilities of the CDI specialist will not differ from those they currently have,” she says. “Unless your current CDI program is broken, there is no need to change it.”

In fact, most respondents (56%) said they do not expect their principal duties will change significantly with the advent of ICD-10 (see Figure 5).

“Just remember that if you are not getting it right in ICD-9, you won’t get it right in ICD-10. Take the time now to evaluate your process and outcomes and embrace the query process as a mode of communication and education,” says Clesi.

That doesn’t mean CDI programs should expect productivity to maintain its status quo during the implementation phase, however. Some of the factors that could determine a program’s success or failure with the transition include:

» The facility’s ICD-10-CM/PCS implementation plan
» Organization size
» Number of physicians on staff
» Current program model and maturity
» Current staffing level
» Existing analysis of program practices

CDI programs generally employ two to three staff members (33.6%) with another 34% employing more...
Figure 9: If you plan to hire new CDI staff, when do you plan to hire them?

- By January: 25%
- By February: 20%
- By April: 10%
- By May: 5%
- By June: 0%
- Between June and October: 15%
- After the ICD-10-CM/PCS implementation date: 20%

Figure 10: What is the ratio of CDI staff to number of patients discharged annually?

- 1 staff to less than 500 patient discharges: 2014 - 10%, 2009 - 15%
- 1 staff to 500–1,000 patient discharges: 2014 - 20%, 2009 - 25%
- 1 staff to 1,001–1,500 patient discharges: 2014 - 30%, 2009 - 35%
- 1 staff to 1,501–2,000 patient discharges: 2014 - 40%, 2009 - 45%
- 1 staff to more than 2,001 patient discharges: 2014 - 50%, 2009 - 55%
- Don't know: 2014 - 0%, 2009 - 0%
than six specialists in their programs (see Figure 6). But most (50.3%) do not expect to hire additional staff to handle ICD-10-related productivity and training concerns, although 28.7% do expect to add staff in general (see Figure 7). Of those, most (76.9%) expect to hire just one or two new team members (see Figure 8), and 62.4% expect to have hired them within the first quarter of 2014 (see Figure 9).

“It looks like those programs that are planning to ramp up for ICD-10 plan to do so early to get the new staff on board with plenty of time for orientation and training prior to the go-live date, which is good news,” says Banet.

**Information disconnect**

However, most respondents (70% of whom identified themselves as CDI specialists, with only 26% identifying as managers/directors) did not seem to be aware of current staffing ratios (visit [http://tinyurl.com/jvn4ele](http://tinyurl.com/jvn4ele) for the raw results of this survey). Most (57.5%) work at hospitals in the 100- to 400-bed range, but
when asked about the CDI staffing ratio compared to the number of patients discharged, 48% of respondents said they didn't know, compared with just 17.5% in a 2009 survey who said the same (see Figure 10).

In the early years of CDI program implementation, one CDI specialist may have been responsible for everything CDI related—from querying physicians to program monitoring and reporting. As programs grow and add staff, they are able to better define roles and create career ladders to differentiate responsibilities, Tsaninos suggests.

Nevertheless, managers bear a responsibility to keep their staff members informed, says Banet. “I think what this data shows is that a good opportunity is here for management to share facility staffing metrics as well as industry standards to reassure the team that workloads are appropriate.”

**CDI programs mature**

CDI programs appear to be aging. The plurality of CDI programs (25.3%) have been in place for about five or six years, with roughly 60% of respondents working in programs that have been in existence for greater than five years. Compare that to data from 2011, which showed only 17% of respondents working in programs that old (see Figure 11).

With only 6.4% of respondents stating they work in “new” CDI programs (i.e., programs implemented less than a year ago), it might seem that overall program implementation in the country is beginning to slow. “Not so,” says Banet; she sees the glass half full and notes that 40% of programs are under five years old.

“I think we will continue to see new program growth as we move toward ICD-10 and facilities realize the vital assistance CDI specialists provide in ensuring the integrity of the medical record,” she says. “I think it is exciting to see so many new programs popping up.”

**Expanding review focus**

Healthcare facilities expect CDI specialists to include more and more in their reviews, Tsaninos says, and that no doubt affects productivity—as does

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**Figure 13: What are the principal duties of your CDI staff?**

- Physician education (60%)
- Concurrent medical record review (40%)
- Retrospective medical record review (20%)
- Denials prevention (10%)
- Audit response (10%)
- Quality (core measure) abstraction (5%)
- ICD-10 education (5%)

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ICD-10-CM/PCS implementation. Yet the plurality of respondents indicated CC/MCC capture remains the focus of their CDI efforts (see Figure 12). Most programs similarly remain focused on concurrent medical record reviews (98.1%) and physician education (70.7%) as the principal duties of the CDI staff (see Figure 13).

“It is interesting to see so many programs out there with a main focus on CC/MCC capture and case-mix index improvement,” Banet says.

Although 35% indicated their programs have expanded to review all payers, and another 28.3% review all DRG payers, about 35.6% still only review Medicare patients (see Figure 14).

Over the past few years, there has been a push to move record reviews past their financial focus and toward a more holistic approach—to incorporate healthcare reimbursement changes and quality improvement concerns. But survey results illustrate that only a quarter of respondents anticipate a shift toward these areas in the coming year (see Figure 15).

“Mature, advanced CDI programs [need to] focus on complete and accurate documentation in the medical record to minimize the risk and penalties associated with Recovery Auditors, Hospital Value-Based Purchasing measures, readmission, and so on,” says Clesi.

According to the survey results, though, only a handful of CDI professionals think that their jobs may change, says Tsaninos. Such a mind-set may be due to the aforementioned disconnect between CDI specialists and CDI management, she says, but that gap needs to close to ensure overall program growth and success.

“Other priorities are going to be integral to the CDI process,” Tsaninos says. “You have to be comfortable speaking about how documentation affects accurate coding and reimbursement and how it affects quality and other matters. Physicians will be looking to CDI for help in addressing these concerns. CDI specialists have to broaden their perspective. Believe it or not, the outside world is coming in. We all have to be ready for it.”

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**Figure 14: Which of the following payers does your CDI program focus on?**

- All payers: 35.1%
- All DRG payers: 28.3%
- Medicare only: 23.6%
- Medicare and Medicaid only: 12%
- Certain private payers: 0.5%
- Don’t know: 0.5%

**Figure 15: Do you anticipate your CDI staff members’ principal duties changing significantly?**

- No: 56%
- Yes: 26.6%
- Don’t know: 17.4%