Productivity

As part of the fifteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Darlene Anderson, RN, CCDS, CRCR, a CDI specialist at Ensemble Health Partners in Tennessee, answered these questions. Anderson is a member of the ACDIS Furthering Education Committee. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

Q: According to the 2025 CDI Week Industry Survey results, most respondents report that an average inpatient CDI specialist completes 6–10 patient new reviews per day (59.78%), followed by an average of 11–15 reviews (18.95%). In comparison, 53.36% are expected to complete 6–10 new reviews by their department, while 23% are expected to complete 11–15 reviews. How does your CDI program handle chart review expectations with its staff? Do you think a specific goal can be helpful, and/or are there other metrics helpful to track? Why or why not?

A: We do a combination of new and re-reviews concurrently for an expected daily average of 20 reviews per day based on productive hours per month. Each month, leaders share productivity and quality audit results with associates during one-on-one meetings. These sessions also serve as an opportunity to collaborate on action plans when performance expectations aren't met.

Working remotely can come with its own set of challenges in meeting productivity expectations, including connectivity issues, computer malfunctions, and internet or power outages. To help navigate these situations, we have a dedicated CDI downtime procedure policy that addresses how to manage unplanned downtime effectively.

Setting specific chart review goals is a valuable strategy for any CDI program. It provides the team with a clear direction, supports effective workload planning, and enables meaningful performance tracking. It also makes it easier to identify trends, gaps, or areas where additional support might be needed.

While volume-based goals offer structure and accountability, it's important to strike a balance. Focusing too heavily on chart review volume can lead to rushed reviews, potentially missing key documentation opportunities. To truly reflect the effectiveness and impact of CDI efforts, volume metrics should be balanced by quality measures that emphasize clinical accuracy and completeness.

To understand how successful your CDI efforts are, it's important to look beyond just how many charts you're reviewing. Incorporating additional metrics can offer a more complete picture of your impact. Tracking query response and agreement rates provides insight into provider engagement and the clinical relevance of your queries. CDI audits further enhance individual and program performance by ensuring documentation consistency and identifying opportunities for improvement.

Highlighting financial and quality outcomes—such as optimized DRG assignment, improved MCC/CC capture, and measurable gains in severity of illness

(SOI) or risk of mortality (ROM)—effectively demonstrates the value and effectiveness of your work. And don't overlook the role you play in education; whether through formal training or everyday feedback, helping providers improve documentation is a big contribution. Even simple recognition from peers or leadership can be a meaningful measure of success. So yes, chart review goals are important and useful, but they're most effective when paired with quality-focused metrics that reflect the real impact of CDI work.

Tracking your personal average query rate can be quite beneficial. First, it helps build self-awareness. When you know your query rate, you can better understand your own performance and even benchmark it against peers or national standards—like the Industry Survey results showing the most common personal average query rate of 31%–40%. It also helps you spot trends over time. If your rate is rising or falling, it might signal changes in documentation quality, provider engagement, or even in your own review approach.

Another benefit is that it can guide targeted improvement. For example, if your rate is consistently low, it might prompt you to reassess your query thresholds or how you're reviewing documentation. And from a broader perspective, it's a great way to demonstrate the value of CDI to leadership—especially when you can tie query activity to financial or quality outcomes.

So, in short, tracking your query rate is useful, but it works best when paired with context, quality measures, and a thoughtful approach.

Q: Survey results showed 31%–40% was the most common personal average query rate (i.e., the percentage of charts that have at least one query opportunity found during CDI review) reported by respondents, followed by 21%–30%, though results otherwise were spread evenly across the board. Can tracking your personal average query rate be beneficial? Why or why not? What other ways can CDI professionals personally measure success?

A: There are several meaningful ways CDI professionals can measure their success beyond just the number of charts reviewed or queries written. For starters, think about query impact. Are your queries helping improve financial outcomes, like better CC or MCC capture? Or maybe they're driving improvements in quality metrics—like SOI, ROM, or even helping prevent Patient Safety Indicators (PSI) and hospital-acquired conditions (HAC). That kind of impact really speaks volumes about the value of your work. Then there's your query response and agreement rates. If providers are responding consistently and agree with your queries, that's a strong sign that your queries are clinically relevant and well-constructed.

You can also look at audit outcomes, whether internal or external. If your chart reviews consistently hold up under audit—meaning the documentation supports the diagnoses, the coding is accurate, and the queries are appropriate—that is a strong sign you are doing things right. It shows that your work aligns with clinical guidelines, coding standards, and organizational policies. So, while audits might feel a bit nerve-wracking, they're actually a great tool for validating the quality and impact of your work.

And don't overlook the value of peer recognition and leadership feedback. A simple "great job" from a colleague or manager can affirm the consistency and quality of your work. These moments of acknowledgment often reflect deeper professional respect and trust.

Finally, success also comes from investing in yourself. Whether it's pursuing certifications, attending conferences, or just staying curious and committed to learning, your growth matters. It keeps you sharp and helps you bring even more value to your role. So really, CDI success is multi-dimensional. It's about quality, impact, relationships, and continuous growth—not just numbers.

Q: According to survey results, 21%–30% was the most common query rate goal of CDI departments, though many free responses stated that their department doesn't have a set expectation. Does your CDI program have a specific goal and if so, how was that number decided on? What other strategies can a CDI program use to encourage personal accountability and best query practices?

A: Yes, we have a specific query rate goal, which is a key performance indicator set by our company's standard operating model. Having a query rate goal like

21%–30% is helpful for setting expectations, but it's just one part of the picture. To really support accountability and strong query practices, it's important for CDI programs to go beyond just the numbers.

One great strategy is to make regular query audits. When queries are reviewed by others, it helps ensure consistency and gives CDI specialists a chance to learn from feedback. It's also helpful to provide individual coaching, especially when someone's trying to improve their clinical relevance or compliance. Education and training play a big role too. Whether it's formal sessions or informal case discussions, keeping up with clinical guidelines and documentation standards helps everyone stay sharp.

Another strategy is tracking query impact—not just how many queries are written, but what they actually achieve. Are they leading to better DRG assignment, MCC/CC capture, improvements in SOI/ROM, or reduction in PSIs and HACs? That kind of data shows the real value of CDI work. Combining volume goals with quality-focused metrics gives a more complete view of performance and helps CDI specialists grow in a meaningful way.

Q: The majority of respondents (62.75%) reported a 91%–100% physician query response rate, which was also the most common goal response rate for CDI departments. What do you think these departments are doing to achieve or reach above their goals? Do you have any advice on query wording, policies, collaboration, etc., to help CDI professionals construct effective queries?

A: First, queries should be clear, concise, and clinically supported, avoiding any leading language. Second, having standardized query templates aligned with the ACDIS/AHIMA *Guidelines for Achieving a Compliant Query Practice—2022 Update* helps maintain consistency and reduce errors. It also makes it easier for providers to recognize and respond to queries quickly.

Collaboration with providers also plays a big role. Building strong relationships, offering education on documentation best practices, and being respectful of their time can really improve engagement. When providers understand the "why" behind a query, they're more likely to respond—and respond accurately. And finally, having clear internal policies around query submission, follow-up, and escalation ensures everyone's on the same page and helps maintain high response rates.

If a majority of CDI departments are consistently hitting that 91%–100% physician query response rate, they're likely doing a few key things really well. First, they're probably focusing on clear, concise, and clinically relevant queries. When queries are easy to understand and backed by strong clinical indicators, providers are much more likely to respond. They're also likely building strong collaborative relationships with providers. That means offering education, being respectful of provider time, and explaining the "why" behind the query. When providers see CDI as a partner rather than just a process, engagement tends to go up.

Standardized query templates and consistent policies also help. Having a clear structure for how queries are written and submitted reduces confusion and keeps things compliant. And finally, they're probably tracking response rates closely and following up when needed. That kind of accountability—paired with a supportive approach—can really help maintain high response rates.

Q: Of respondents whose organization tracks physician query agree rate, 56.3% reported a 91%-100% agree rate, 33.82% reported an 81%-90% agree rate, and 6.51% reported a 71%-80% agree rate. What efforts has your CDI program made, if any, to have a higher physician query agree rate? Do you have any advice on query wording, organization, policies, etc., to help CDI professionals construct effective queries?

A: We share provider scorecards with providers and executive leadership and offer education on how lower agreement rates can impact outcomes such as financial impact and denials. Writing effective queries is a key part of successful CDI work, and a few best practices can really make a difference. When you're writing a query, the first thing to consider is its intent. Are you asking for clarification or increased specificity of a documented diagnosis? Are you trying to determine the clinical significance of certain findings? Or are you seeking clinical validation for a diagnosis that may not be fully supported by the documentation? Being clear about your purpose from the start helps guide how you structure the query and ensures it aligns with compliant practices. It also makes it

easier for the provider to understand what you're asking and why.

The second thing to keep in mind is clarity. You want the provider to understand exactly what you're asking without having to guess. That means referencing specific clinical indicators—like lab results, imaging, documented symptoms, or treatment—that support your question.

Next, be careful with your wording. Queries should never lead the provider to a specific diagnosis. Instead, use neutral language that gives them room to make a clinical judgment. For example, instead of saying, "Can you confirm sepsis?" you might say, "Based on the documented fever, elevated WBC, and tachycardia, can you clarify the clinical significance of these findings?" If you're using a multiple-choice format, make sure all the options are clinically applicable. And, when appropriate, include choices like "Other" or "Unable to determine."

Using query templates helps bring clarity and consistency to the CDI query process. It ensures that every query follows a standardized format, making it easier for physicians to quickly understand what is being asked. They streamline the query writing process, allowing CDI specialists to focus on clinical content rather than formatting. Templates also help maintain compliance with regulatory and organizational standards—like those outlined by ACDIS/AHIMA—reducing the risk of leading or noncompliant queries that could impact coding accuracy and reimbursement. For new CDI team members, templates serve as a helpful guide, speeding up onboarding and reinforcing best practices in documentation.

Q: When asked if their organization has an escalation policy or other policy requiring physicians to respond to queries/CDI clarifications, 89.2% of respondents said they do. Also, those with an escalation policy reported a higher physician response rate than those who did not (64.74% vs. 51.22%). Does your CDI program have a query escalation policy, and if so, what have been your struggles and successes while using it? What advice would you give a CDI program wanting to improve or create such a policy?

A: Our CDI program does have a query escalation policy. Some challenges include rotating provider schedules, provider vacations, and locum providers who may not log in to complete outstanding queries after their last shift and may not return for extended periods.

Q: This year, the most-used CDI software solution by respondents was electronic grouper software (78.25%), surpassing chart prioritization (77.47%) and electronic querying (77.31%), with computer-assisted coding (CAC) close behind (76.83%). What kind of software solutions would you say have become common practice to use by CDI departments, and which, if any, have you noticed growing in popularity over the last few years? What types have you found helpful for your own team, and how have they impacted your productivity?

A: CDI departments have definitely embraced a range of tools to streamline their work. As reflected in the survey, chart prioritization, electronic querying, and CAC seem to have become pretty standard in most programs now.

What seems to really be growing in popularity lately are tools that use artificial intelligence and natural language processing to identify documentation gaps or suggest query opportunities. These technologies aim to help CDI specialists focus their time on the most impactful cases. Also, real-time dashboards and analytics tools are becoming more common for tracking performance and outcomes.

For our team, chart prioritization and CAC have been helpful. Chart prioritization helps us focus on the most impactful cases first, which improves efficiency. While a full chart review is still important, CAC helps speed things up by flagging possible documentation gaps and coding opportunities early in the process. Together, these tools have helped us improve not just the speed of our reviews, but the quality and focus of our work—allowing us to be more strategic and efficient in how we manage our time and cases.

Q: As the CDI profession grows, the way that departments measure productivity is changing with it. How have expectations evolved since you started in CDI and/or your program began? Now

that CDI is better known at most organizations, how do you think productivity and measurements for success will evolve in the future?

A: When I first entered the CDI field nine years ago, the focus was beginning to shift from capturing a single CC/MCC or key procedure that impacted the DRG, to a more comprehensive approach that emphasized capturing all relevant CCs, MCCs, and procedures. At that time, productivity was primarily measured by volume, such as the number of initial and concurrent chart reviews completed and the number of queries issued.

Today, while volume still matters, there's a clear shift toward measuring quality and impact. Metrics like query response and agreement rates, DRG optimization, SOI/ROM improvements, Hierarchical Condition Category and Elixhauser capture, and provider engagement are becoming more central to how success is defined in CDI.

I think we'll see more use of data-driven tools and dashboards that track not just activity, but outcomes. And as CDI specialists take on more roles in education, collaboration, and quality improvement, success will be measured more by clinical insight and strategic contribution than just numbers. CDI productivity metrics appear to be moving from "how much" to "how meaningful," and that's a great direction for the profession. ■