2025 Mastermind Hot Topic Guide, Part 2: Productivity, staffing, AI, and DRG downgrades

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As the CDI world has expanded, leaders in the industry have been tasked with increasingly varied responsibilities, often without a network of colleagues to help troubleshoot issues encountered along the way. Thus, they frequently must look beyond their organization to collaborate with peers and trade advice. The ACDIS CDI Leadership Council connects leaders nationwide for conversations about hot topics and industry trends, but a smaller subset of the Council, the Mastermind group, gives participants the opportunity for focused brainstorming and problem solving.

This multitopic report, produced in partnership with Solventum, formerly 3M Health Care, shares takeaways from the second half of the 2025/2026 CDI Leadership Council Mastermind term. These conversations cover a range of leadership topics, including productivity, staffing, artificial intelligence (AI) use, and DRG downgrades.

PRODUCTIVITY

Productivity expectations cannot be one-size-fits-all given the wide variety of programmatic priorities at play from organization to organization. Leaders, however, still need tools to measure whether their teams are meeting expectations and reviewing the desired percentage of records each day, month, year, etc. Productivity is one such tool.

When developing expectations, it's important to recognize all the other responsibilities CDI teams are tasked with and be realistic about the time those priorities take away from "traditional" record review productivity, says **Anne Robertucci, MS, RHIA,** vice president of clinical revenue cycle at Prisma Health in Greenville, South Carolina.

"The CDI review process has also changed dramatically over the past few years with the additional focus on quality of care components," she says. "We have been pulled into reviewing additional/non-traditional CDI information, alongside nursing and our quality team members."

"I think that there's been a shift in the industry in general, specifically related to CDI work, from being a production worker to an outcome worker—really looking at the outcomes and what they bring to the organization," adds **Chana Feinberg, RHIA,** CDI product adoption manager at Solventum, formerly 3M Health Care. "You have to look at what your team as a whole and individually is bringing to your organization."

In addition to competing priorities that may take away from traditional productivity rates, it's crucial to consider the patient populations the CDI team is reviewing. In a healthcare system, for example, one organization may be a trauma center that sees high-complexity patients, and another organization may be a small community hospital where patient complexity is much lower.

"We expect a 25% query rate, but I do have two reviewers who review at community hospitals, and they don't provide the same services as our larger hospitals," says **Katie Parsley, MSN, RN, CCDS, CPHQ,** CDI manager at Providence Health and Services in Oregon. "Their patients and surgeries are not as complex by nature and we typically find that there is a lower query opportunity."

At the end of the day, though your productivity rates help to paint the picture of your department's impact, relying on them too stringently may hurt the quality of your reviews. As Feinberg notes, focusing on the *outcomes* of your CDI efforts in conjunction with your productivity numbers will provide a more complete picture. Plus, shifting the focus may have a positive impact on your department's performance, according to **Fakhar Khan, MD,** medical director of revenue cycle at Hartford Healthcare in Connecticut.

"Taking that focus away from numbers and productivity makes the CDI staff do better-quality work, in my opinion, because now that pressure is off," he says. "You'll find that it may be a breath of fresh air to say, 'I'm moving away from these metrics. We're going to do our audit process, and we expect you to do good work no matter what role you're in.' "

With recent legislation, healthcare organizations are projecting financial shortfalls in the coming year, which means that already short-staffed CDI programs may be asked to do without the reinforcements they desperately need.

According to Parsley, when you're short staffed with no plans to hire in sight, you may need to get creative with the resources you already have at your disposal. In her case, her department has an administrative assistant who takes care of things like the PTO calendar, ordering equipment, etc. While this individual wouldn't be qualified to do CDI reviews, she *could* take on some of the other administrative tasks currently being handled by CDI staff, freeing them up for issues that demand their expertise.

"All of our executive reporting, CDI productivity reports, additional data our CMOs or leadership requests, provider response reports—all of this is being compiled by a CDI specialist. So, we're taking them away from reviews to do all of that," Parsley says.

In addition to freeing up CDI staff time, such a move could be a professional development opportunity for the staff member taking on the reporting function, Feinberg adds. The position may not require the same skill set or be a pathway to a CDI specialist role, but it can still be a benefit to the department, organization, and individual.

"They probably would start to understand and learn the data. It's something that can grow with that position. The person starts to run those reports, gets a little bit of background about them, and then starts to understand how to leverage them even more," says Feinberg.

With that greater depth of reporting, CDI leaders may be able to turn around and leverage the data to justify more staffing by clearly demonstrating the return on investment to organizational leadership. To make the case as compelling as possible, Khan suggests focusing on the metrics that the chief medical officers (CMO) are concerned with.

For example, he says, "[the CMOs are] pressured with GMLOS. Say, 'Listen, I'm only getting to 45% of the cases. You want your GMLOS to go up, let me get to more cases. I can only do that if I get more staff or at least let me keep my staff.' Go after the metrics that they're judged by. That's where your buy-in is, right?"

AI USE

No matter the industry, you can't go very far before the topic of AI comes up—whether it's heralded as the best thing since sliced bread or the downfall of civilization as we know it. The CDI industry, of course, is also tied up in the AI conversation.

"AI is a topic that's transforming healthcare and the world. It's showing up in so many areas of healthcare, from predictive analytics to clinical decision support," Feinberg says. "We as CDI professionals sit at the crossroads of expertise and data."

The advent of so many advanced AI technologies can leave CDI professionals feeling uneasy about the security of their roles and even their departments as a whole. From a leader's perspective, however, that fear is largely unfounded. Instead, the technology will augment and extend CDI's reach.

"I do not see AI replacing the CDI team, that's for sure," says **Olusegun John Ajsefinni, MD, DHA, MSIT, RN, RHIA, CCS, CCDS,** director of CDI services at Cedars-Sinai in Los Angeles, California. "What I do see AI doing is acting as a decision support system because even when you get vendors to bring in a lot of technology, you still have to teach it toward what you want to see—and most of the time, when you teach it, the technology still doesn't capture *everything*."

Part of the reason the technology will never fully capture everything is that the rules upon which CDI bases its work are ever-changing. While this constant change can be challenging for CDI professionals, it does provide a sense of job security as they are positioned as up-to-date regulatory and coding experts.

"I don't see the human element being taken away. We live in the landscape of payer rules that are ever-changing. We live in the world of coding rules that are ever-changing. We live in the world of doctors and providers who continue to come into the healthcare system without any education as to what documentation impact even is," says Khan. "Even if the AI [learns] and continues to adapt, you're still going to need that human element."

The thing that AI likely *will* help to streamline, in Robertucci's opinion, are the low-complexity cases that don't need the expert critical thinking skills of a CDI specialist or a coding professional. Training the AI to handle those simpler cases will free up time for thornier issues.

"Everything that a CDI specialist needs to review is very complex. There's no such thing as an easy review anymore," says Robertucci. "I do see AI helping and assisting for the next several years. I do not believe it will ever replace the human aspect of CDI review, nor do I think it will replace a coder on an inpatient setting. Could it possibly help in low-complexity situations? Absolutely."

According to the most recent CDI Week Industry Survey, more than 64% of CDI departments are involved in reviewing DRG downgrade denials. Managing those denials, however, could be a full-time job. Some CDI departments keep it all in-house, but many don't have the bandwidth to do so and instead seek the help of vendors. While there are pros and cons to both methods, if you choose to keep the DRG downgrade mitigation process in-house, developing a solid data collection process will be paramount.

"We do everything in-house. I will say our struggle is not having a strong tracking system," says Robertucci. "When you bring it in-house, you have to become more savvy with the data so that you can get more granular with what's being downgraded."

Part of the reason keeping track of the data can be such a challenge is because the payers count on organizations either not challenging denials at all or giving up after the first level of appeal. Staying on top of each denial's position in the often-lengthy appeals process, and doggedly following up as appropriate, needs to be a priority to make headway.

"I sent a lot of cases for peer-to-peer [review] to one of the third-party auditors for one of the big insurance companies. That was a request two months ago," says Khan. "They have not scheduled that peer-to-peer. It's very much a game that they play of pushing off the peer-to-peer as much as they can."

In addition to keeping track of the appeals process and following up with the payers, your data needs to show you trends about your denials so that you can catch potential problems on the front end and *prevent* the denials in the first place. Knowing the trends will also help you show a return on investment for CDI efforts, Feinberg points out.

"One of the pieces from a technology perspective is closing that loop," says Feinberg. "Who did the review? Was there a second-level review? Was there a DRG mismatch? Were there queries on this case? Was this case even reviewed? I can tell you my CDI program brought in this amount of money, but have you been able to tie it back to what's been denied?"