AuthenticTesting.com
18401 Tea Rose Place
Gaithersburg, MD 20879
(240) 477-6691

AHIMA

Clinical Documentation Information Specialist Job Task Analysis

Final Report

by Authentic Testing:
Wallace Judd and Bienvenida Thorne
Authentic Testing Corporation

Contents

Development Overview

Task Force Meeting

On May 12th and 13th, a 19-member Task Force met at AHIMA headquarters in Chicago to create a Job Task Analysis survey. The basic outline of their agenda is as follows:

Introductions
Scope Statement
Knowledge Topics
Task Topics
Futures Topics
Survey Scales
Blueprint Topic Weightings
Final Evaluation

A list of Knowledge and Task topics had been prepared by AHIMA staff in conjunction with a small team of four experienced Document Improvement Specialists. The charter of this group was to add to the list of topics, refine their expression, and delete any that didn't seem either likely or appropriate.

The group met from 8:30 a.m. to 5:00 on Thursday, and from 8:30 to 3:00 on Friday. They met all their objectives, and the survey results on the following pages are a direct result of the Task Force's efforts, in combination with the support of the AHIMA staff present.

The primary outcomes of the meeting were:

- ⊙ Statement of the Knowledge Topics to be included in the JTA Survey
- ⊙ Statement of the Task Topics to be included in the JTA Survey
- ⊙ Statement of the Futures Topics to be included in the JTA Survey
- ⊙ Statement of the Survey Scales to be included in the JTA Survey
- ⊙ Preliminary estimate of the Blueprint Topic Weightings
- ⊙ Draft of a Scope Statement for the CDIS Certification

JTA Survey

The topics included in the JTA survey are documented below in the sections: Knowledge Topics, Future Knowledge, Task Topics, and Future Task Topics.

A brief pilot administration of the survey was sent to 17 possible respondents on Tuesday, June 13th, with instructions to complete the survey by Thursday, June 16th. The purpose of the pilot administration was to make sure that the system functioned as expected and to get a reasonable estimate of the time for administration.

Twelve respondents completed the survey by Thursday, June 16th, and their results were analyzed in the report: *CDIS JTA Pilot Study Report 2011-06-20.doc*. The mean time to completion of the survey was 36 minutes, 6 seconds, with a standard deviation of 14 minutes 12 seconds. Consequently, recommending that respondents allow 45 minutes to an hour to take the survey seemed realistic.

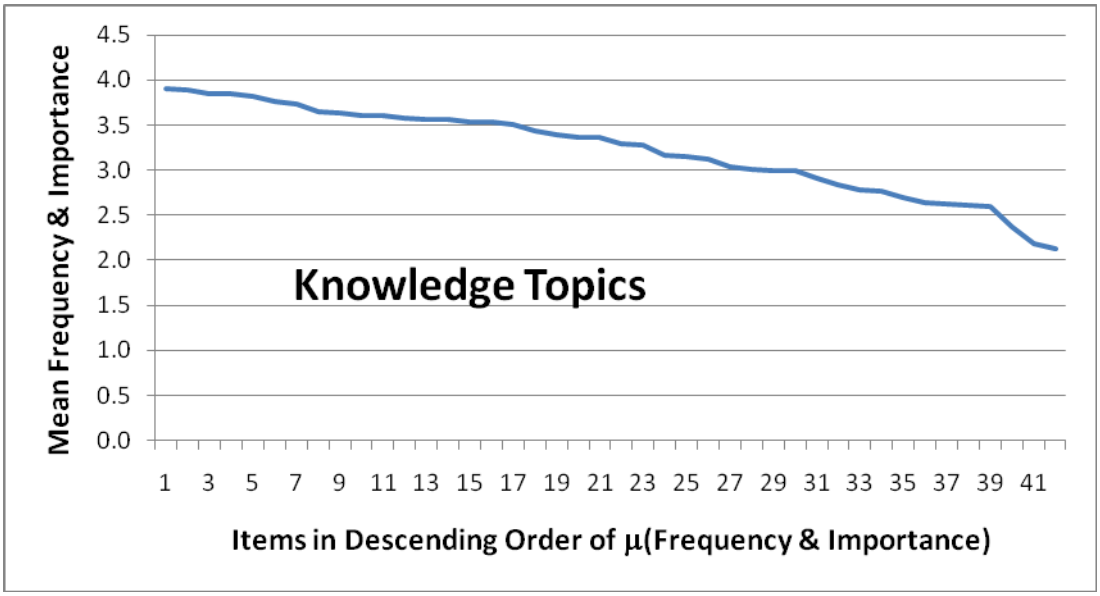
The survey was not modified as a result of the pilot administration, and invitations were sent out to 5,000 respondents on Friday, June 24th at 10 a.m. Eastern Daylight time. The sampling of the 5,000 respondents is documented below in *Appendix B. JTA Sampling Strategy*. The survey was closed on Tuesday, July 12th at midnight, and 733 respondents completed the survey and demographic questions for a completion percentage of 14.7%.

JTA Survey Main Topic Weightings

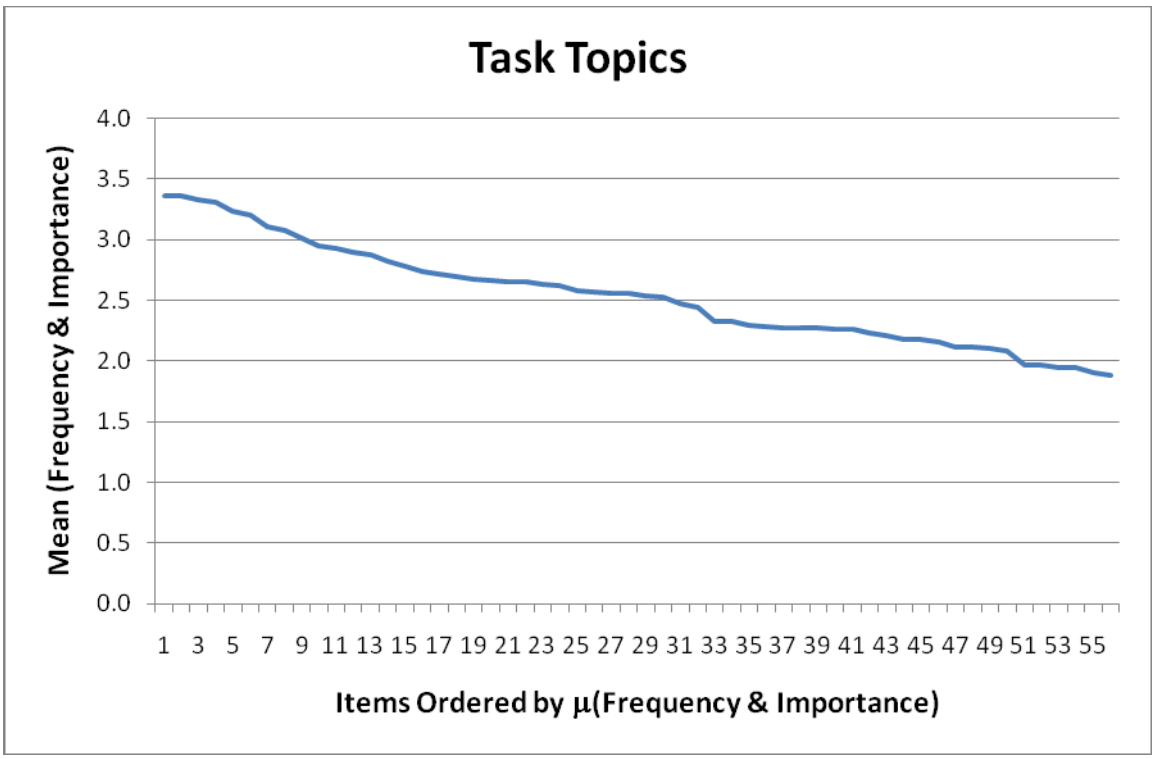
There are two primary ways that topic weightings can be derived from the survey results. Both depend on the weighted average of Frequency and Importance ratings for each topic.

If there is a significant decline in the weightings for topics from the most to the least weighted, then topics above the decline should be incorporated in the final blueprint. However, if the decline in topic weightings is gradual and constant, then the recommended way to weight inclusion of the topics is to calculate the total percentage of weighting in each main topic.

Below is a graph of the Frequency and Importance weightings for Knowledge topics.



Below is the graph of the Frequency and Importance weightings for the Task topics.



Note that for each of the graphs, the decline in mean topic Frequency and Importance weighting is essentially constant. Consequently, the total percentage of weighting for each main topic was used as the way to determine Main Topic weightings.

Reconciliation Task Force

With the results of the JTA Survey in hand, a Reconciliation Task Force of nine Subject Matter Experts met on July 26th in a conference call to determine the final Main Topic weightings in the Blueprint. The results of that meeting are summarized in the section *CDIS Blueprint* below. Their deliberations are summarized in *Appendix F. Blueprint Working Papers* and in *Appendix G. Blueprint Reconciliation Vote*.

CDIS Examination Scope

As a preliminary to determining the topics for the CDIS Job Task Analysis, the 19-member Task Force was asked to formulate a scope statement for the CDIS.

After considerable discussion and debate, a day's respite to think it over, and a renewed effort to articulate the CDIS job both at the present and in the immediate future, the Panel arrived at the following statement.

Clinical Documentation Improvement Specialist

Scope of CDI Certification:

The Clinical Documentation Improvement Specialist (CDIS) is a professional with a health care related background who is competent and proficient in medical record review; coding principles; reimbursement methodologies; regulatory compliance; management of CDI program metrics; and record management.

The CDIS possesses effective communication and critical thinking skills, and the leadership required to continuously improve the overall quality, specificity, usability and completeness of clinical documentation now and into the future.

Adopted May 13, 2011 by the CDIS JTA Task Force

Chicago, IL

CDIS Blueprint

On Tuesday, July 26th, 2011, a group of nine Subject Matter Experts reviewed the results of the JTA survey and finalized the weightings of topics for both the Knowledge and Task domains. They considered the initial blueprint weightings determined by the SME task force, and reconciled them with the weightings calculated as a result of the JTA survey completed by 733 respondents. The blueprint is as follows:

Clinical Documentation Improvement Specialist Exam Blueprint			
Task Domain		**Target Percent**	
#	**Domain**	**Max**	**Min**
1	Clinical & Coding Practice	**26%**	**22%**
2	Leadership	**17%**	**13%**
3	Record Review & Document Clarification	**28%**	**24%**
4	CDI Metrics & Statistics	**18%**	**14%**
5	Research & Education	**15%**	**11%**
6	Compliance	**8%**	**4%**
	Total	**112%**	**88%**
Knowledge Domain		**Target Percent**	
#	**Title**	**Max**	**Min**
1	Clinical & Coding Practice	**30%**	**26%**
2	Leadership	**18%**	**14%**
3	Record Review & Document Clarification	**23%**	**19%**
4	CDI Metrics & Statistics	**14%**	**10%**
5	Research & Education	**16%**	**12%**
6	Compliance	**12%**	**8%**
	Total	**112%**	**88%**

The blueprint vote is provided in *Appendix F. Blueprint Working Papers*.

Pilot JTA

The initial SME Panel selected 59 knowledge topics and 72 tasks for inclusion in the survey. The topics were grouped into domains, listed below.

JTA Survey Domains	
Topics	**Knowledge Domain**
13	Clinical & Coding Practice
7	Leadership
6	Record Review & Documentation Clarification
5	CDI Metrics & Statistics
7	Research & Education
4	Compliance
17	Futures Knowledge
59	**Total Knowledge Domains**
	Task Domains
11	Clinical & Coding Practice
8	Leadership
14	Record Review & Documentation Clarification
13	CDI Metrics & Statistics
7	Research & Education
3	Compliance
16	Futures Tasks
72	**Total Task Domains**

Knowledge Topics

As shown above, there were 59 Knowledge topics included in the survey. Each knowledge topic was asked within the frame below:

Knowledge

Frequency

How frequently do you use knowledge of _____ in your job?

⊙ Never ⊙ Quarterly ⊙ Monthly ⊙ Weekly ⊙ Daily

Importance

How important is knowledge of _____ in performing your job?

⊙ Not important ⊙ Somewhat ⊙ Very Important

The Knowledge topics included in the survey are listed below, in order of the average corrected mean Frequency and Importance rating for each topic. The corrected Frequency & Importance average is listed in the column headed "μ(F + *k*I)".

Because the ratings for Frequency are on a scale of one to five, and the Importance ratings are on a scale of one to three, without correction the average Frequency would dominate the ratings. So a scaling factor of $k = 1.667$ was used to multiply the Importance scaling so that it would have the same weight as the Frequency weightings. When the rescaling was done, only items in only 3 pairs of topics swapped ratings, out of 42 topics. So the same rescaling was not done for the Task topics.

These corrected mean Frequency and Importance ratings are used in the table below to prioritize topics within each Main Topic. They are also used to calculate the weight for each Main Topic in the Survey results for the Blueprint.

Topic ID	Survey Seq	Content Section	Knowledge Item	μ(F + *k*I)
Clinical & Coding Practice				
1	1	1	Medical terminology and anatomy and physiology	4.89
4	7	1	Diagnostic, laboratory and surgical procedures	4.79
3	5	1	Pathophysiology and disease processes and treatment	4.67
12	23	1	Definitions of principal and secondary diagnoses	4.57
2	3	1	Pharmacology	4.51
7	13	1	Complex clinical documentation	4.49
6	11	1	Encoder software, DRG grouper, and coding manuals	4.48

Topic ID	Survey Seq	Content Section	Knowledge Item	μ(F + *k*I)
8	15	1	Assigning ICD-9 CM coding	4.45
13	25	1	Procedural techniques	4.45
11	21	1	Coding references	4.41
5	9	1	Definition of CCs, MCCs	4.23
10	19	1	DRG reimbursement methodologies	3.79
9	17	1	Assigning CPT coding	3.53
Leadership				
14	1	2	Effective communication skills	4.87
19	11	2	AHIMA Practice Briefs	3.97
20	13	2	Professional organizations available for resource	3.87
16	5	2	Conflict resolution	3.86
15	3	2	Presentation skills	3.73
18	9	2	Performance audits	3.68
17	7	2	Interpretation of statistical reports	3.48
Record Review				
22	3	3	Medical record structure	4.55
25	9	3	Best practices for clinical documentation	4.35
26	11	3	Best practices for data integrity	4.18
21	1	3	AHIMA and compliance standards related to query process	4.02
24	7	3	Core measures	3.53
23	5	3	National patient safety indicators	3.33
CDI Metrics & Statistics				
29	5	4	Effective reporting and communication techniques.	4.15
31	9	4	Presentation and spreadsheet software knowledge	3.41
28	3	4	Statistical reports	3.38
27	1	4	Development of statistical graphs & reports	3.10
30	7	4	CDI benchmark metrics	2.87
Research & Education				
34	5	5	Communication skills	4.82
35	7	5	Writing skills	4.53
37	11	5	Web navigational skills	4.46
33	3	5	Coding Clinics and other reference resources	4.30
36	9	5	Variety of uses of clinical data within an	3.99

Topic ID	Survey Seq	Content Section	Knowledge Item	μ(F + *k*I)
			organization	
38	13	5	CDI trends and best practices	3.38
32	1	5	Effective presentation techniques for behavior modification	2.80
Compliance				
39	1	6	Privacy concepts.	4.82
40	3	6	Security concepts.	4.72
42	7	6	Fraud and abuse regulations	4.26
41	5	6	Key components of data records exchange	3.81

Future Knowledge Topics

One of the issues which the Subject Matter Expert panel wished to address was the knowledge our respondents could anticipate would be needed in the future. There were seventeen of these topics included in the survey.

The frame for these topics was the following:

When will you most likely need to obtain knowledge in _____ to continue your professional development in clinical documentation improvement?

- ⊙ Within the next 6 months to one (1) year
- ⊙ Within the next 1-2 years
- ⊙ Within the next 2-4 years
- ⊙ Within the next 4+ years
- ⊙ Never
- ⊙ Unable to respond at this time

The responses to these future knowledge topics are included in the table on the next page. The table is sorted from the most proximate likelihood that the knowledge will be required at the top, to the least likely that the knowledge will be required at the bottom of the table. The sort is descending on 6 mos. to 1 year, and ascending on Never.

Item	Future Knowledge Topic	6 mos. to 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
43	Navigation of electronic health records (EHRs)	482	81	26	4	29	109
44	EHR reporting metrics, standards and criteria	427	75	20	3	44	162
45	EHR design for patient safety	424	96	20	4	38	149
46	Principles of usability of EHRs	422	93	23	6	40	147
47	the Legal Health Record	401	102	27	8	45	148
48	Meaningful use criteria	385	114	28	7	36	161
49	Quality measures	360	114	25	4	33	195
50	Automated data sources for quality measures	357	109	21	4	47	193
51	Computer Assisted Coding application software	340	114	16	6	42	213
52	Resources to assist in data dictionary creation	335	103	20	5	80	188
53	Clinical data content design and construction	333	108	21	6	57	206
54	Best practices for data integrity automation	326	122	29	8	75	171
55	Best practices for clinical documentation automation	305	116	19	4	58	229
56	Sources of data for clinical quality measures	284	111	27	6	67	236
57	Continuity of Care documents	282	114	24	10	71	230
58	Process flow mapping and workflow analytics	273	108	22	5	77	246
59	Principles of change management	270	105	25	5	86	240

Task Topics

Seventy-two Task Topics were included on the survey. The frame within which the topics were couched is shown below:

Tasks

Frequency

How frequently do you _____ in your job?

⊙ Never ⊙ Quarterly ⊙ Monthly ⊙ Weekly ⊙ Daily

Importance

How important is it for you to _____ in performing your job?

⊙ Not important ⊙ Somewhat important ⊙ Very Important

The Task topics included in the survey are listed below, in order of the average Frequency and Importance rating for each topic. The Frequency & Importance average is listed in the column headed "μ(F + I)".

These ratings were used to determine the Survey Weightings for the SME panel. The right column is the sum of the mean Frequency and Importance scores for each topic. To determine the Survey weightings, the average mean Frequency and Importance score was calculated for each main topic.

Topic ID	Survey Seq	Section	Task Items	μ(F + I)
Clinical & Coding Practice				
66	13	1	Use reference resources for code assignment	3.367
70	21	1	Identify the principal and secondary diagnoses in order to accurately reflect the patient's hospital course	3.361
64	9	1	Use coding software	3.326
61	3	1	Assign and sequence ICD9-CM codes	3.313
60	1	1	Use coding conventions	3.230
65	11	1	Display knowledge of Payer requirements for appropriate code assignment. (e.g. CMS, APR,APG)	3.016
62	5	1	Assign appropriate DRG codes	2.824
68	17	1	Communicate with the coding/ HIM staff to resolve discrepancies between the working and final DRGs	2.740

Topic ID	Survey Seq	Section	Task Items	μ(F + I)
67	15	1	Participate in educational sessions with staff to discuss infrequently encountered cases	2.655
63	7	1	Assign CPT and / or HCPCS codes	2.630
69	19	1	Communicate with coding/ HIM staff to resolve discrepancies in documentation for CPT assignment	2.563
Leadership				
71	1	2	Maintain affiliation with professional organizations devoted to the accuracy of diagnosis coding and reporting.	2.876
72	3	2	Promote CDI efforts throughout the organization.	2.692
74	7	2	Foster working relationship with CDI team members for reconciliation of queries.	2.677
75	9	2	Establish a chain of command for resolving unanswered queries.	2.662
73	5	2	Develop documentation improvement projects.	2.480
77	13	2	Collaborate with physician champions to promote CDI initiatives.	2.331
76	11	2	Establish consequences for non-compliance to queries or lack of responses to queries in collaboration with providers.	2.297
78	15	2	Develop CDI policies & procedures in accordance with AHIMA practice briefs.	2.085
Record Review				
80	3	3	Identify opportunities for documentation improvement by ensuring that diagnoses and procedures are documented to the highest level of specificity	3.200
81	5	3	Query providers in an ethical manner to avoid potential fraud and/or compliance issues	3.072
84	11	3	Formulate queries to providers to clarify conflicting diagnoses	2.945
92	27	3	Ensure provider query response is documented in the medical record.	2.929
83	9	3	Formulate queries to providers to clarify the clinical significance of abnormal findings identified in the record.	2.896

Topic ID	Survey Seq	Section	Task Items	μ(F + I)
89	21	3	Track responses to queries and interact with providers to obtain query responses.	2.785
85	13	3	Interact with providers to clarify POA.	2.567
82	7	3	Identify post-discharge query opportunities that will affect SOI, ROM and ultimately, case weight	2.561
79	1	3	Collaborate with the case management and utilization review staff to effect change in documentation	2.525
87	17	3	Interact with providers to clarify HAC	2.327
88	19	3	Interact with providers to clarify the documentation of core measures.	2.287
86	15	3	Interact with providers to clarify PSI	2.260
91	25	3	Determine facility requirements for documentation of query responses in the record to establish official policy and procedures related to CDI query activities.	2.154
90	23	3	Develop policies regarding various stages of the query process and time frames to avoid compliance risk.	2.113
CDI Metrics & Statistics				
93	1	4	Track denials and documentation practices to avoid future denials.	2.276
101	17	4	Trend and track physician query response.	2.270
102	19	4	Track working DRG (CDS) and coder final code.	2.265
94	3	4	Perform quality audits of CDI content to ensure compliance with institutional policies & procedures or national guidelines.	2.232
99	13	4	Trend and track physician query content.	2.214
103	21	4	Trend and track physician and query provider.	2.181
100	15	4	Trend and track physician query volume.	2.115
96	7	4	Measure the success of the CDI program through dashboard metrics	1.969
104	23	4	Track data for physician benchmarking and trending.	1.964
95	5	4	Compare institution with external institutional benchmarks.	1.948
98	11	4	Track data for CDI benchmarking and trending	1.945

Topic ID	Survey Seq	Section	Task Items	μ(F + I)
105	25	4	Track data for specialty benchmarking and trending.	1.901
97	9	4	Use CDI data to adjust departmental workflow.	1.880
Research & Education				
110	9	5	Articulate the implications of accurate coding.	3.106
111	11	5	Educate providers and other members of the health care team about the importance of the documentation improvement program and the need to assign diagnoses and procedures when indicated, to their highest level of specificity.	2.625
106	1	5	Articulate the implications of accurate coding with respect to research, public health reporting, case management and reimbursement.	2.582
107	3	5	Monitor changes in the external regulatory environment in order to maintain compliance with all applicable agencies.	2.535
109	7	5	Educate the appropriate staff on the clinical documentation improvement program including accurate & ethical documentation practices.	2.441
112	13	5	Develop educational materials to facilitate documentation that supports severity of illness, risk of mortality and utilization of resources.	2.174
108	5	5	Research and adapts successful best practices within the CDI specialty that could be utilized at ones own organization.	2.102
Compliance				
115	5	6	Apply AHIMA best practices related to CDI activities	2.720
114	3	6	Apply regulations pertaining to CDI activities	2.651
113	1	6	Consult with compliance and HIM department regarding legal issues surrounding CDI efforts.	2.278

Future Task Topics

The SME Task Force wanted to try to evaluate tasks that respondents may not yet be engaged in, but will likely be asked to perform in the near future. Questions about these tasks were asked within the question framework below.

Other Unclassified Tasks

Which domain does this task belong in?

- ⊙ Clinical & Coding Practice
- ⊙ Leadership
- ⊙ Record Review & Document Clarification
- ⊙ CDI Metrics & Statistics
- ⊙ Research & Education

Are you currently performing this task?

⊙ **Yes**

Frequency

⊙ Quarterly ⊙ Monthly ⊙ Weekly ⊙ Daily

Importance

⊙ Not important ⊙ Somewhat important ⊙ Very Important

⊙ **No**

When do you expect you and/or your organization will do this?

- ⊙ Within the next 6 months to one (1) year
- ⊙ Within the next 1-2 years
- ⊙ Within the next 2-4 years
- ⊙ Within the next 4+ years
- ⊙ Never
- ⊙ Unable to determine at this time

In the frame above, if the respondent answers "Yes" to the question about whether they're performing the task, they are then asked to rate the Frequency and Importance with which they do the task.

However, if the respondent answers "No" they aren't performing the task, they are immediately asked when they expect either themselves or their organization to do the task.

The ratings for these answers are somewhat difficult to interpret, and there is no simple way of ranking the items. The table below includes all the raw data regarding these items as they were asked on the survey.

The table has abbreviated the information so it would fit on a page.

The future task item ID and text appear at the top of each item record. The domains respondents classified the question into appear on the next lines. The next lines indicate how many respondents said they do the task now. If they do the task, the following four lines clarify the frequency and importance they attach to the task. If respondents do not do the task, they indicated when, if ever, they believe their position in the organization would be responsible for performing the task. This is coded on the last two lines of the item record.

1	Do you create data definitions for your organization?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		202	174	182	107	67	0
		Yes	No				
Do it?	30%	168	564				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		83	59	11	15	0	
		Not important	Somewhat	Very important			
Imp.		13	48	107			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		143	66	10	2	9	334
2	Are you involved in EHR content design?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		158	251	231	20	73	0
		Yes	No				
Do it?	30%	167	566				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		46	50	42	29	0	
		Not important	Somewhat	Very important			
Imp.		5	31	131			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		235	68	17	3	28	214
3	Are you involved in EHR and documentation improvement workflow and GAP analysis?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance

Domain		140	228	215	94	55	0
		Yes	No				
Do it?	24%	140	592				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		25	57	37	21	0	
		Not important	Somewhat	Very important			
Imp.		2	32	106			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		204	74	13	5	16	280
4	Do you help define what data is included or excluded from the EHR?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		143	247	252	36	55	0
		Yes	No				
Do it?	26%	153	580				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		37	53	33	30	0	
		Not important	Somewhat	Very important			
Imp.		3	28	122			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		219	74	11	4	15	257
5	Do you evaluate usability of data in the EHR?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		163	235	228	49	58	0
		Yes	No				
Do it?	28%	162	571				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		33	47	30	52	0	
		Not important	Somewhat	Very important			
Imp.		3	29	130			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never

When?		210	78	14	2	10	257
6	Do you design EHR alerts reminders clinical decision support to support documentation improvement?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		156	231	231	47	68	0
		Yes	No				
Do it?	21%	126	607				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		43	42	19	22	0	
		Not important	Somewhat	Very important			
Imp.		7	30	89			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		231	82	13	0	17	264
7	Do you educate others in the proficient use of the EHR?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		140	264	137	15	177	0
		Yes	No				
Do it?	28%	162	571				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		33	45	39	45	0	
		Not important	Somewhat	Very important			
Imp.		3	30	129			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		259	72	10	4	14	212
8	Do you provide feedback on EHR systems usability to physicians and other clinicians?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		123	294	138	27	151	0
		Yes	No				
Do it?	30%	168	565				
Yes		Never	Quarterly	Monthly	Weekly	Daily	

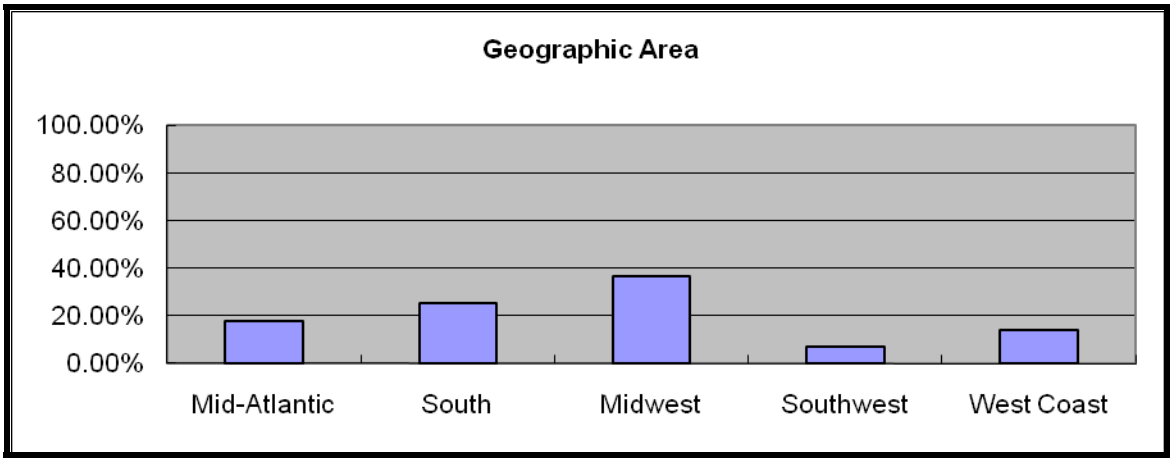
Freq		47	47	39	35	0	
		Not important	Somewhat	Very important			
Imp.		7	39	122			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		201	87	12	2	13	249
9	Are you involved in implementing care protocols?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		176	307	102	36	111	0
		Yes	No				
Do it?	17%	106	626				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		66	21	6	13	0	
		Not important	Somewhat	Very important			
Imp.		15	24	67			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		223	65	12	4	15	307
10	Do you create continuum of care documents?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		168	259	185	28	93	0
		Yes	No				
Do it?	11%	75	658				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		28	26	5	16	0	
		Not important	Somewhat	Very important			
Imp.		3	18	54			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		219	77	16	3	17	326
11	Do you compile disparate data into understandable summary form?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		111	223	166	148	85	0
		Yes	No				
Do it?	13%	82	651				

Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		31	23	12	16	0	
		Not important	Somewhat	Very important			
Imp.		2	24	56			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		168	85	16	4	17	361
12	Are you involved in implementing critical paths or evidence-based medicine?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		158	245	111	66	153	0
		Yes	No				
Do it?	10%	66	667				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		26	20	10	10	0	
		Not important	Somewhat	Very important			
Imp.		7	17	42			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		202	76	21	3	26	339
13	Are you involved in the integration of data from external sources into the medical record?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		135	214	250	43	91	0
		Yes	No				
Do it?	17%	105	628				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		17	27	24	37	0	
		Not important	Somewhat	Very important			
Imp.		0	28	77			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		197	84	16	3	14	314
14	Do you help define sources of clinical data for quality measures and reporting?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance

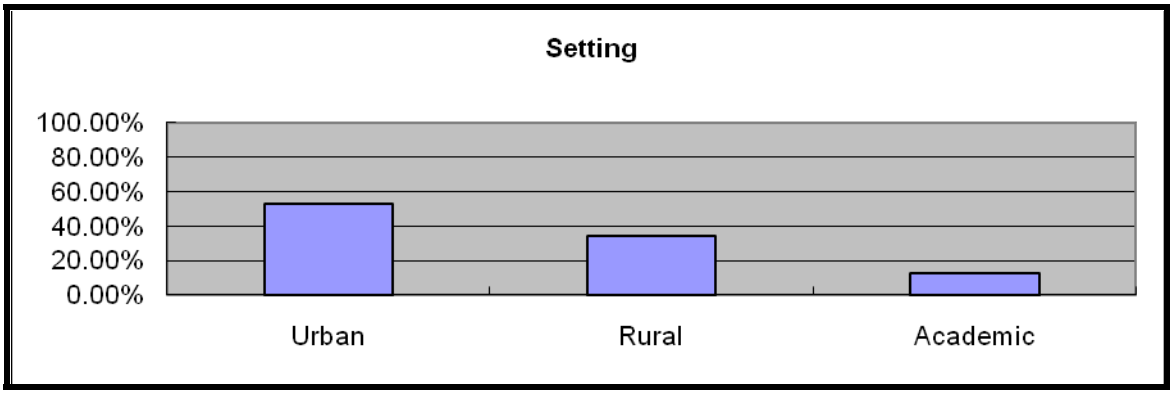
Domain		139	211	162	151	70	0
		Yes	No				
Yes	22%	130	603				
		Never	Quarterly	Monthly	Weekly	Daily	
Freq		37	52	11	30	0	
		Not important	Somewhat	Very important			
Imp.		4	39	87			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		213	68	17	1	12	292
15	Do you review & recommend revisions to Computer Assisted Coding?						
		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
Domain		377	170	92	43	51	0
		Yes	No				
Do it?	18%	110	623				
Yes		Never	Quarterly	Monthly	Weekly	Daily	
Freq		49	23	9	29	0	
		Not important	Somewhat	Very important			
Imp.		8	25	77			
		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
When?		159	92	33	6	37	296
16	Do you communicate HIM principles and expertise in regards to clinical data content and integrity to clinicians?						
Domain		Coding	Leadership	Rec. Review	Metrics	Education	Compliance
		362	171	123	20	57	0
Do it?		Yes	No				
Yes	40%	211	522				
Freq		Never	Quarterly	Monthly	Weekly	Daily	
		35	61	41	73	0	
Imp.		Not important	Somewhat	Very important			
		2	25	183			
When?		< 1 year	1-2 years	3-4 years	3-4 years	4+ years	Never
		174	62	7	1	13	265

Demographics

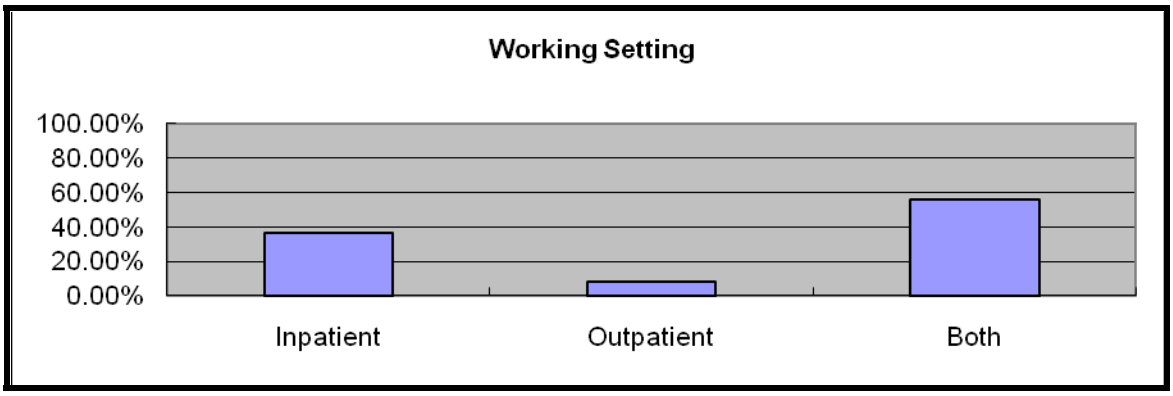
To ascertain the representativeness of the sample, a number of demographic measures were evaluated at the end of the survey. The geographic distribution of respondents is shown in the table below.



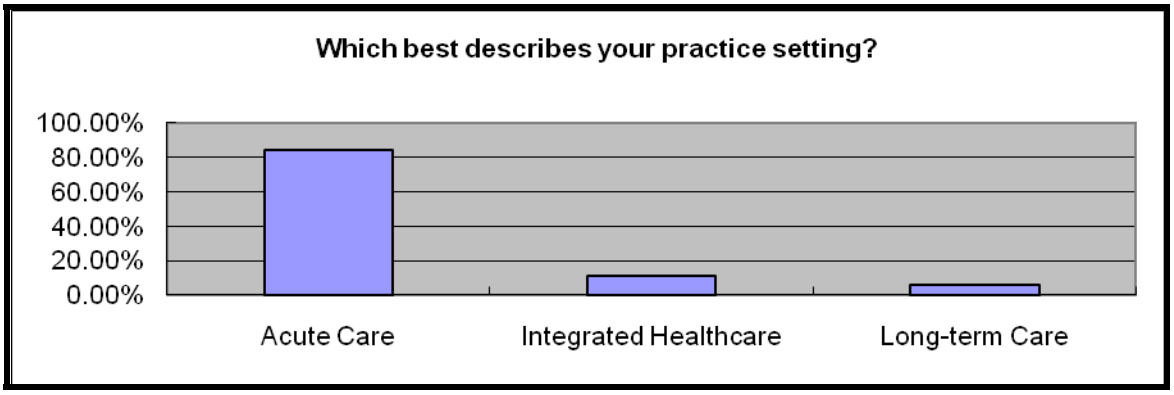
The urban setting in which respondents practice is shown in the graph below.



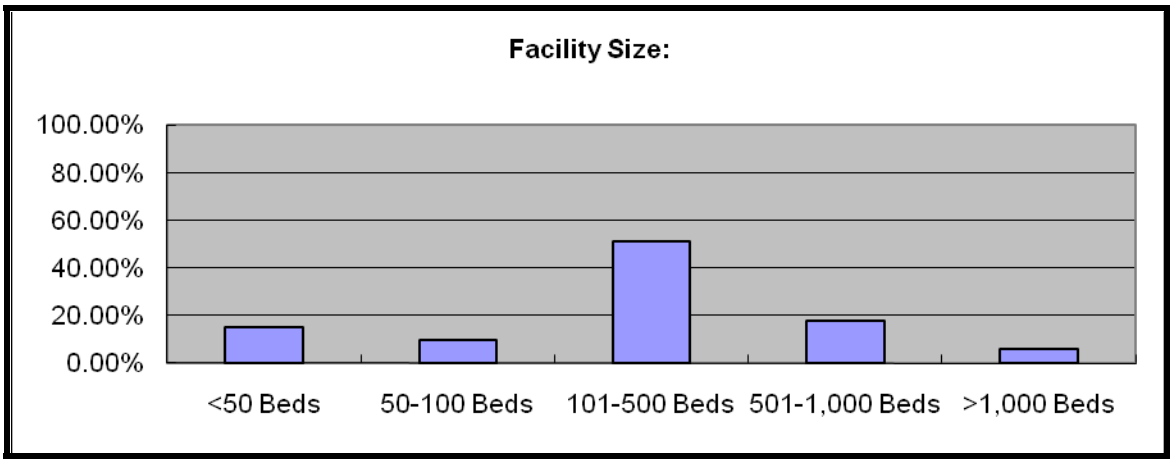
Respondents' work setting is shown in the graph below.



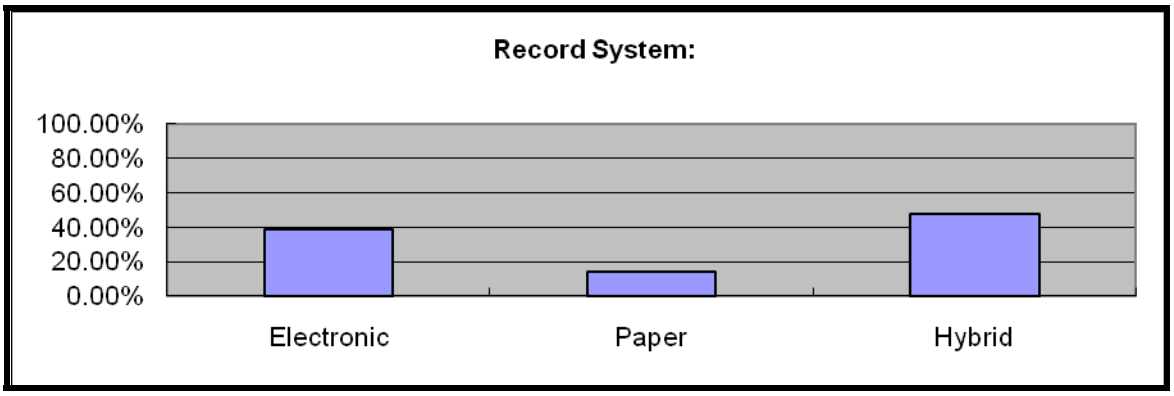
The practice setting is shown below for all respondents.



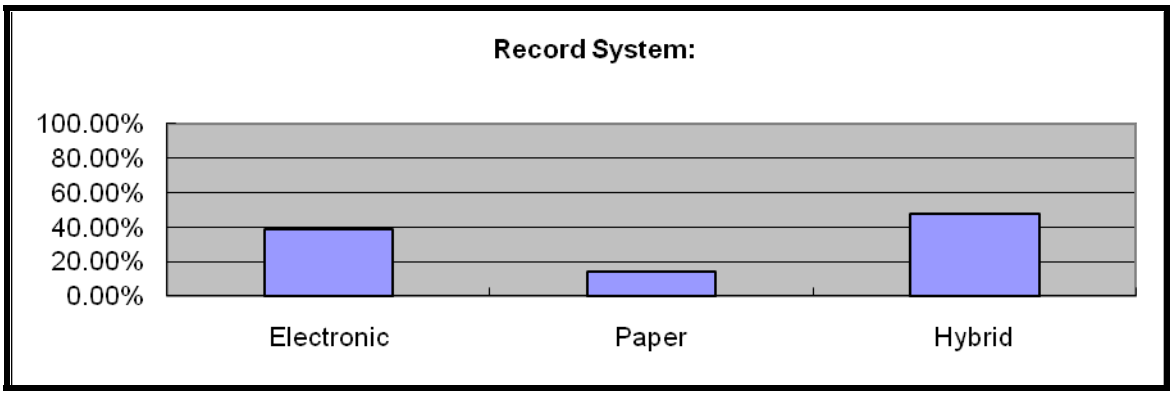
The facility size in which respondents practice is shown below.



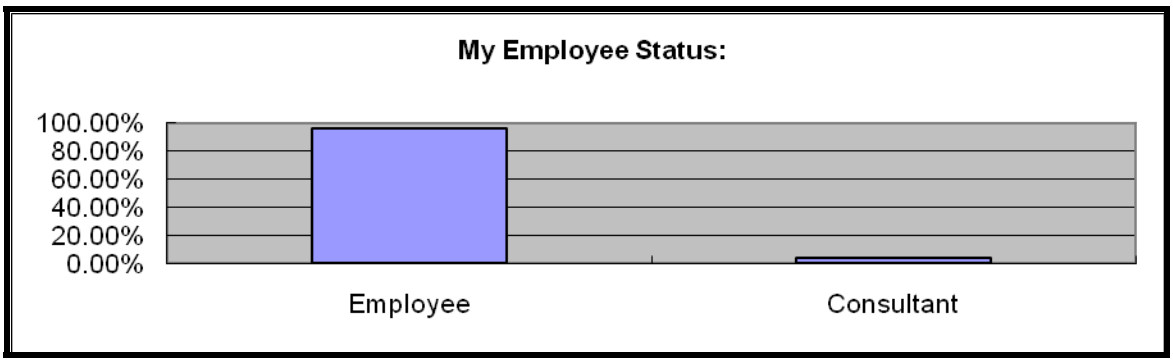
The record system currently in use at the respondents' work setting is shown below.



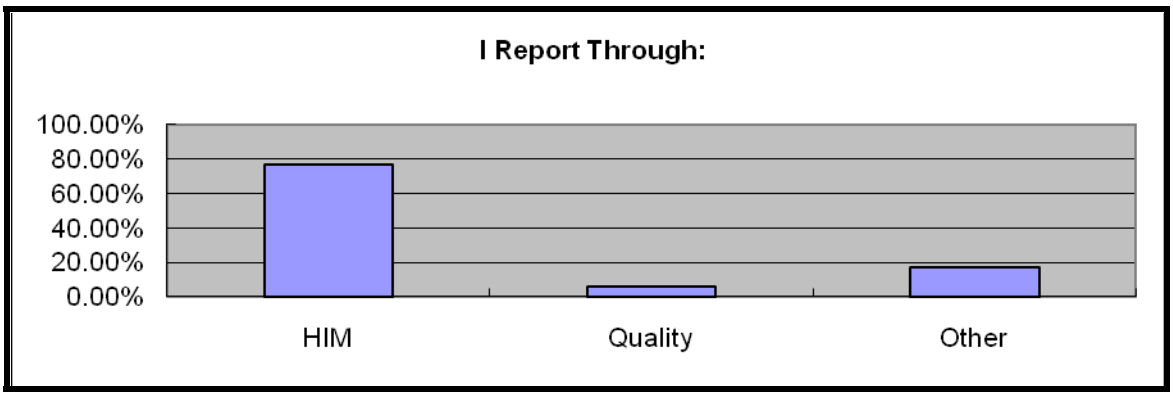
The employment status of each respondent is summarized in the graph below.



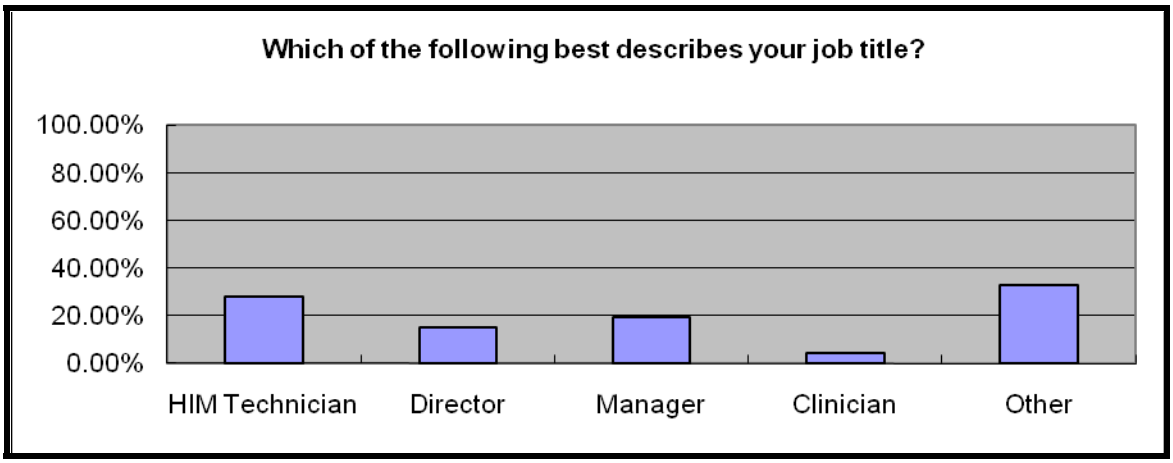
The respondent's employee relationship with the institution is shown below.



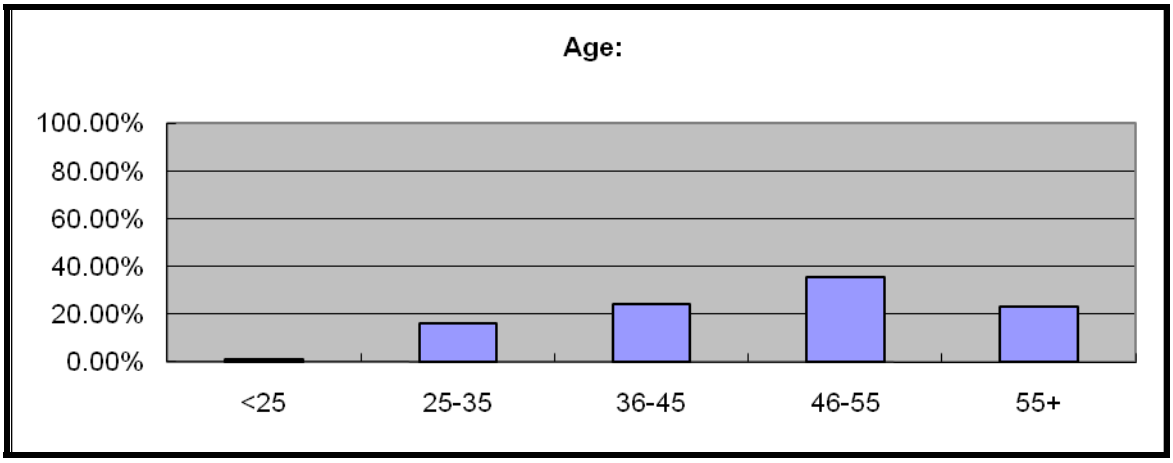
The administrative chain of command through which the respondent reports is shown in the table below.



The respondent's job title is reflected in the next graph.



Finally, the respondent's age is depicted graphically below.



Appendix A. Preliminary Blueprint

As a result of the SME Task Force meetings held on May 7th and 8th at AHIMA headquarters in Chicago, Illinois, the 19-member panel arrived at the following preliminary Blueprint for the Knowledge and Task domains of the CDIS examination.

Clinical Documentation Improvement Specialist		
	Preliminary Blueprint	
Task Domain		
#	**Domain**	**Weighting**
1	Clinical & Coding Practice	**26%**
2	Leadership	**15%**
3	Record Review & Document Clarification	**26%**
4	CDI Metrics & Statistics	**15%**
5	Research & Education	**9%**
6	Compliance	**9%**
	Total	**99%**
Knowledge Domain		
#	**Domain**	**Weighting**
1	Clinical & Coding Practice	**21%**
2	Leadership	**13%**
3	Record Review & Document Clarification	**22%**
4	CDI Metrics & Statistics	**12%**
5	Research & Education	**20%**
6	Compliance	**13%**
	Total	**101%**

This blueprint and its weightings were later reassessed and possibly revised when the Task Force saw the results of the Job Task Analysis and incorporated those results into their assessments of the weightings of the topics.

Appendix B. JTA Sampling Strategy

It was determined that sampling all approximately 40,000 AHIMA members would be too difficult and wouldn't provide the focused information necessary to inform the Certification Committee about the frequency and importance of CDIS tasks and knowledge requirements. Consequently, AHIMA staff in conjunction with the IT department filtered the full membership on qualification criteria. Initially, 12,914 AHIMA members met the criteria for inclusion in the survey.

They met the requirement that they were in one of four roles, that they practiced in one of three clinical settings, and that they had at least one of the credentials shown below. The coded values for role, setting and credential are shown in the tables below.

Role	
Code	**Value**
1	HIM Technician
2	Director
3	Manager
4	Clinician

To be selected for the survey, participants had to practice in one of the settings shown below.

Setting	
Code	**Value**
1	Acute Care
2	Integrated Healthcare
3	Long-term Care

To be eligible for participation in the survey, participants had to have at least one of the credentials listed in the table below.

Credentials		
	Has credential	**Does not have**
RN	1	0
RHIA	1	0
RHIT	1	0
CCS	1	0

The AHIMA member candidates who met the distribution requirements are shown in the table below.

	Original Distribution					
Value	**Setting**	**Level**	**RHIA**	**RHIT**	**CCS**	**RN**
0	4	3	9,367	6,128	8,305	12,701
1	11,449	7,179	3,547	6,786	4,609	213
2	914	2,540	-	-	-	-
3	547	3,016	-	-	-	-
4	-	176	-	-	-	-
	12,914	12,914	12,914	12,914	12,914	12,914

From the initial set of 12,914, a random sample was selected. For each candidate, the random number generator generated a number from 1 to 12,914. If the candidate's number was 5,000 or below, he was included in the survey. The random number generator generated 4,923 numbers below 5,000.

The sample selected is shown below.

Sample Selected						
Value	**Setting**	**Level**	**RHIA**	**RHIT**	**CCS**	**RN**
0	2	---	3,589	2,319	3,195	4,834
1	4,391	2,760	1,334	2,604	1,728	89
2	336	954	-			
3	194	1,149				
4	-	61				
	4,923	4,924	4,923	4,923	4,923	4,923

For each cell in the table, the difference between the proportion in the entire sample and the proportion in the random sample was calculated. The results are shown below.

	Original Distribution					
Value	**Setting**	**Level**	**RHIA**	**RHIT**	**CCS**	**RN**
0	---	---	-0.010	-0.023	-0.006	-0.017
1	-0.009	-0.007	-0.029	-0.009	-0.032	0.077
2	-0.053	-0.030	-			
3	-0.091	-0.016				
4	---	-0.113				
Mean Δ	**-1.6%**	**-1.5%**	**-1.5%**	**-1.5%**	**-1.5%**	**-1.5%**

As can be seen in the table above, the discrepancy between the target numbers in the sample and the actual number selected was never greater than 1.5%. For a sample of 5,000 respondents, this number will not skew the distribution of results significantly.

Appendix C. Coding Tables

The following table shows the codes and choices respondents were given for the frequency with which they either used knowledge or conducted specific tasks.

Frequency	
1	Never
2	Quarterly
3	Monthly
4	Weekly
5	Daily

The following table shows the codes and choices respondents were given for the Importance they attribute to either the knowledge or tasks involved in performing their job.

Importance	
1	Not important
2	Somewhat important
3	Very important

The following table shows the codes and choices respondents were given for the time in the future they estimated that their organization would implement specific tasks or require specific knowledge.

Futures	
1	Within the next 6 mos. to 1 year
2	Within the next 1-2 years
3	Within the next 3-4 years
5	Within the next 4+ years
6	Never
7	Unable to determine at this time

The following table was used to code the Future times when there wasn't enough space for the entire topic used in the survey.

Short Futures	
1	< 1 year
2	1-2 years
3	3-4 years
5	4+ years
6	Never
7	Unable

The following are the domains respondents were asked to classify both knowledge and task future topics into.

Domains	
1	Clinical & Coding Practice
2	Leadership
3	Record Review & Doc. Clarification
4	CDI Metrics & Statistics
5	Research & Education
6	Compliance

Appendix D. Comments

The comments are included unedited below. No corrections, spell checking, or grammatical editing has been done on the comments. There did not seem to be any specific suggestions that would be appropriate to include in the Recommendations.

Knowledge Topics	
Clinical & Coding Practice	
	I work as a Trauma Registrar --coding injuries and comorbids are quite different from typical medical billing coding
	As a coder and part of the CDI team these are all required elements.
	Being a small facility we do not do surgery or OB.
	Being the Director, the coding is handled by the Coding Supervisor. I most use it for meetings on clinical documentation
	cancer registrar not an ICD9 coder
	CDI is not only about reimbursement, but a desire to get the best documentation, that acurately docments the clinical picture for that patient, without CDI we can be left with a capture of the patients, condition, care, and treatment to be vague and incomplete.
	CDI specialists should be certified like coders have to be. Their job affects a coder's job and impacts coding; therefore certification should be required for CDI specialists. Many are nurses with no coding backgrounds and don't understand what queries need to be asked or not needed to be asked.
	Clinical indicators is very important also
	Coding guidelines and ahima ethics in coding are essential in successful cdis programs
	I am a cancer regisrar, but knowledge of ICD-9 coding is very helpful in my job. I do use pharmacology refrences to determine if drugs are for cancer treatment or not. Anatomy/physiology are used every day in my job.
	I am a CCS
	I am a coder in England and use ICD-10

	I am a registered nurse and also an RHIT, and CCS. I would like to see either an online program or 'study at home' program through AHIMA. I would also like AHIMA to have a credential for CDI so I can also take this examine and receive this credential. Thank you.
	I am a trauma registrar and also work in clinical research as well as teach AIS coding of anatomical injury
	I am a trauma registrar I use the AIS 2005 coding for injuries
	I am an HIM Director over medical transcription and medical records clerical, not coding.
	I am an outpatient ED coder. ICD-9 and CPT are very difficult to learn in school. I have my RHIT and I feel they need more focus in the classroom.
	I am at a Critical Access Hospital and rarely access DRG information
	I am having to work with UR (Case Management) nurses daily to assist them since they are not knowledgeable in all of these areas.
	I am HIGHLY insulted that AHIMA is looking to develop a credentialing for CDI. ACDIS has worked diligently to develop and implement a very thorough Clinical Documentation Improvement Specialist certification program. My affiliation with ACDIS includes an admiration for their collaboration with AHIMA. I believe AHIMA is disrespectful instead of supporting ACDIS in their endeavor to become the premiere resource for Clinical Documentation Improvement Specialist as AHIMA is for HIM specialists.
	I believe that computer skills and communication skills are also very important to the CDI. As we often report our data and provide teaching sessions to other health care professionals.
	I do Inpatient Coding and therefore have little use of CPTcodes but the knowlege is important. Coding is VERY difficult and requires much knowledge also because one must maintain the accuracy with productivity
	I do not code, nor are the coders under me.
	I do not like the categories of daily weekly, etc. I would feel more confident in my answers if it was 'daily, sometimes, infrequently, almost never'
	I do not work with CC and MCC yet.
	I do performance reviews for core measures.

	I have coded for 30 years and this has been invaluable to be able to transition into this new position in our health system. Coding knowledge and medical record knowledge is important. Communication with physicians is my weakness at this point since our hosp has offsite coding and I have had limited exposure over the 30 years. Mine is better than most though.
	I only code for the physician side - that thats an important fact in my survey answers
	I put weekly only because I am part time
	I think knowing codes as well as the coders do is NOT ESSENTIAL to this job since there is a huge variety of software programs used to code. It just seems like unnecessary knowledge and we need to be more focused on DRG/accurate documentation. :) just my 2 cents
	I use this information in a cancer registry settng.
	I was trained many years ago in the USN as a hospital corpsman. This is equal to an LPN or more and I use that knowledge in my coding and it helps me to be accurate as to what is going on in the patient record. This means my original clinical training and experience helps me a great deal in being accurate.
	I work for critical access hospital DRGs are not required for payment purposes, but are still used for statistical purposes.
	I work in long term/rehab so we don't use the DRG system; however, I am also adjunct faculty at a local community college and I teach Medical Billing and Coding and I have knowledge of the DRG system so that I may instruct.
	I'm not a coder. For coding jobs this knowledge is very important
	In my particular job with DOC I don't code, so it is not important. It would be in an acute care setting, as well as knowledge of DRG's and ect..
	It is important to work with Case Mgmt. for LOS issues.
	Knowledge about these things are highly essential to deliver our duties.
	knowledge of transfer DRG. Interqual criteria is helpful
	My daily job doesn't relate to/require coding or clinical performances.
	My job primarily focuses on adding ICD 9 CM diagnosis and procedure in the inpatient setting. Don't use CPT codes that often.
	My position is Privacy Compliance Auditor and I do not delve into very much

	coding anymore.
	My working experience is primarily Long Term Acute Care; therefore, we don't code a lot of procedures.
	n/a
	The Code - history of Migraines
	The manager that oversees the Coding Unit reports to me and on a quarterly basis we participate in audits with other departments.
	We are a CAH so we do not do procedures at our facility nor bill by DRG
	We do not actually have a CDI program, but are working towards that end.
	You do not have to have a nursing degree or an RN to be a CDI Specialist. I do believe having a CCS is very important to have since very similar base knowledge for job descriptions.
Leadership	
	AHIMA is a great resourse for coders, but many CDI's believe that the ACDIS provides them with better resources and I would like to see that change.
	Although do not use professional resources on a regular basis important that when I do need them they are there and I know where to find them. AHIMA is go to first
	Could you have put a column for as needed or on occasion.
	Currently I am performing in a supervisory position in Clinical Documentation therefore my communication skills, conflict resolution skills come in to play daily with physician communication and with the CDS staff members. I must also monitor daily performance of the other CDS to ensure we are meeting the standards set by the corporation.
	do you mean AHIMA practice BRIEFS? I never heard of practice BELIEFS
	Great questions! Its vital to be able to communicate with your team, physicians, and to have valuable resources available.
	I am always wanting to know about available resourcess and organizations. Find it hare to find and know which ones are reliable.

	I believe these questions will be answered differently depending on the job set skills of the CDI. I truly feel nurses are not using the coding resources available because they not members of AHIMA and unaware of many coding issues, guidelines etc.
	I have not heard of AHIMA practice beliefs. I have been accredited for many years and have done compliance for more than 10
	i work in the medical utilization review department
	I would like to know more resources. I find AHIMA hard to use when I need coding advice. Maybe I am looking in the wrong place?
	I would use the practice briefs more often if they were updated to reflect today's environment
	Is it AHIMA practice beliefs or BRIEF's? I access the Practice briefs often.
	It would be nice to have a summarized 'knowledge base' book or something specific to CDI for a CDO to reference. As of now we have to trudge through vast amounts of coding guidelines and rules that may or may not effect us and it slows the process down. Maybe there could be new reference tools that are geared specifically toward CDI in a user friendly format
	Knowledge of resources available such as 3 M knowledge base is useful
	n/a
	Not certain what 'performance audit' refers to.
	This is a management problem of too much micromanagement to not provide resources to the point of holding back important information to the coders in a control atmosphere.
	we have limited resourses
	We utilize all new and previous articles. We like to keep up to date on information since this is an evolving field.
	would like to see an AHIMA sponsored group for Trauma Registry
Record Review	
	Agree with all questions!!!
	I do core measure audits

	I have not been involved with national patient safety indicator or core measures but realize their importance for HIM.
	I use TJC compliance standard as a reference and publication from Greeley our consultant. We use Medical Record Briefing by HCPRO. I can't quickly determine if this is an AHIMA product, it is very good.
	I'm not around patients. I work at home.
	It is very important for the CDI specialist to work with Case Management and Quality and the Coders for a sucessful program.
	n/a
	Our managers are not well liked by the hospital as a whole. They are outsourced and go out of their way to cause problems in the dept. We have not been allowed to work with the core measure auditors and my managers actually had the RN who was, fired. (CareTech Solutions Managers)
	Please note that some of the answers I marked,'never' may be done at my facility and it is very important. However, I personally do not perform those tasks.
	please refer to comments, first box
	These are very broad questions
	We currently are on the Chairman's category list for the last 5 quarters.
	We have an EMR.
	Yes, we do this everyday.
CDI Metrics & Statistics	
	For statistical data reporting I get help instead of reinventing the wheel.
	Quality Analyst uses spreadsheet software
	Previous HIM has not collected or reported statiscal data or conducted benchmarking or chart audit. Therefore, no presentations. However, we are current looking to improve these areas.
	CareTech Solutions Managers actually took our reports away from us. Didn't want us to see them.

	We are gearing up to do more presentations to various departments, even non-provider.
	n/a
	Some of these questions, while important in real time events, are not used in remote coding. CDI benchmarks are extremely interesting but coding remotely leaves little time to review benchmarks regularly, as much as I could like to.
	VA does not utilize external comparisons to the extent that we could, or probably should.
	IT can usually help crate spreadsheets to provide to management that are facility specific.
	I don't know what CDI benchmark Metrics means??
	Visuals are required for physicians. They like graphs, etc.
Research & Education	
	A trauma registrar is very dependent on good detailed documentation of the entire patient encounter to a much greater degree than is necessary for coding for payment
	Again choice of on occassion would have been helpful
	Again, I work for the Dept. of Corrections. Acute care settings would be different.
	Because I code inpatient charts remotely and write queries, the art of effectively communicating is paramount.
	Being able to access resources are important. Also, medical staff support is vital, although, unfortunately, not always there.
	Best practices may be used daily; CDI trends may be used quarterly. There are 2 issues in 1 question which require different answers
	CareTech Solutions Managers watch our use of the internet and do NOT want us on the internet. They do not want Us talking with other CDI coders. They say TEAM but do not let it happen.
	Currently work for a large corporation that has set it own standards and performance metrics therefore national measures are not used as much. I would like to see more educational material made available to the CDS staff.

	n/a
	Some of these are marked daily, but they are really 'as needed', which can be anywhere from daily to at least weekly.
	To my knowledge, I have not been exposed to CDI.
	We are finding that we are using all resources to try to do our best at creating this position and making it effective.
	When asking questions please don't use abbreviations
Compliance	
	As the HIM Director, HIPAA Privacy Officer, and a small facility so I work closely with our Compliance Officer.
	If you relate fraud and abuse to RAC audits this is my reference.
	In my corporation, CDI has been moved from under HIM to its own department, therefore components of privacy, security, etc. are handled by HIM and IT. As record becomes more computerized, CDI is becoming more of a user.
	n/a
	-not sure about the key components of data records exchange; only that HIPAA regulations are consistently met and that data is exchanged in a secure manner
	Sometimes CDI specialists will query for malnutrition when the indicators are for another disease process. Also interpret labs values for acute renal failure when the person really has chronic renal failure for a cc.
	Suggest Not Applicable (N/A) as a choice for answers when one does not utilize a concept in their position.
	We are on the units handling the records, and in HIM, and Coding areas, so we are part of this process of security, etc..
Futures Knowledge	
	All my work of coding and analysis is done on computer
	all q's answered with 'Unable to determine at this time' because I already work in a facility that is 100% EHR.
	alot of this we already do

	already using a hydrid EHR. Have implemented some of the above knowledge and it is continuously evolving.
	As a coder, our facility implemented the EHR over three years ago.
	At my facility we already have an EMR, so I answered the question with what I thought was the best answers.
	At our facility (federal government) we already have the electronic medical record.
	currently unemployed
	-EHRs are already in use; although a hybrid system is in place. no additional training is necessary other than system updates or enhancements -staff are already exposed to navigation between different elecatronic systems and applications -stats on safe
	Every thing marked as within next 6 months, I already know, use and work with on at least a weekly basis.
	Have been working EHR for past 6 years
	I already have access to EMR, and do NO management in my capacity as a clinical coder
	I am involved with the implementation of EHR (Meditech) at our facility.
	I am not in a management position and most of the tasks mentioned above are handled by management.
	I based my answers on my experience with the implementation of the medical record as well as my involvement with training for ICD-10.
	I graduated as a RHIT in 1994. I have been coding since that time, and a lot has changed in the HIM field. I feel somewhat ignorant in most areas because of all of the changes. My organization no longer supports nor finances the need for continuing ed, which only complicates matters.
	I have been using ehr for years

	I have been working in EMRs at two different Level 1 trauma centers and have already sought and acquired familiarity and some skills in most of the above mentioned questions. I already have had to deal with many issues and have sought to further my education in clinical analytics but find the AHIMA courses limited to those with Bachelor degrees which I find unnecessarily limiting. I have worked at the state level writing data dictionary, trauma registry guide and trauma manual. I have faced many issues in trauma registry, clinical research etc
	I really need all this info for certification and use all knowledge every day
	It really depends on the job you are expected to do. we all have CE throughout the year and many of the subjects above are updated from our basic skills learned while earning our degree.
	I've been using ERH for the past 7 years no training is needed
	Just went electronic a couple of months ago. Still learning everything.
	Most of the ones that is marked within the next 6 month to one year, I am already doing for my job.
	My facility is already active/involved in many of these.
	my facility is total EHR so currently working in that environment
	n/a
	Ones marked unable to determine are already in place; never is not within the scope of my position
	Organization has been using Electronic Health Record for a number of years and have experience in using EHR. I am not completely involved in clinical documentation improvement at this time.
	Our corporation is moving quickly toward an electronic medical record and hopes to have a system up and running by September 2011, therefore CDI will need a magnitude of updated information very soon. As stated before, our CDI department has been moved from HIM and placed in a separate department with only a regional manager. Therefore any changes to records management procedures will have to be handed down to the CDS through and indirect and convoluted process.
	Our facility already has an EHR and we are in the process of meeting the meaningful use standards
	Our facility already utilizes an electronic health record

	Our facility goes live on October 1 with EPIC EHR.
	Some of these may or may not be in the budget for our hospital, though.
	The answers marked 6mo to 1year indicate that i am already using this knowledge on a regular basis.
	The LTC organization that I work for is in negotiations to get rid of our current EHR provider and contract a new vendor.
	we already have a electronic medical record in place in 10 of the 17 facilities we manage
	We are moving to EPIC May, 2012
	we have an ehr currently although some mds continue to use paper we hope to completely convert in a year the above questions therefore donot apply
	We will be coding from home by January.
	Were I work we have the EHR and it is amazing.
	where is the option for we already have / do this?
	While some of the knowledge/skills are extremely useful, they are not necessary to CDI professional development.
	Will enroll in HIM to HIT consulting training at a community college; program designed to educate HIM professionals in IT..software integration, management, etc
	Would like a choice of 'within NOW to 6 months.' We are engaged and moving quickly with our EMR, document exchange and Meaningful Use.
	You need to take into account that there are facilities that are already using an EHR and have developed data dictionaries etc..... In other words have a choice for already implemented. How are you going to capture correct data??
Task Topics	
Clinical & Coding Practice	
	Again, DOC. They use RHIT's for ROI and ect. Others code from a list.

	CDI was having weekly meetings with our coders to discuss discrepancies and to further educate ourselves on coding procedures and discuss disease processes. In August 2011, all coders will be sent home to work remotely. No information has been given to CDS on how this relationship will be maintained - whether or not it will continue in any way or how discrepancies and education will be handled.
	Critical to have traumatic injury diagnosis as primary reason for admission
	-educational sessions are a part of monthly staff meetings -staff members are always notified when new info is obtained, new discoveries are found, or discrepancies are encountered
	I am a coder not a CDS
	I am a coder on the CDI team
	I am an Outpatient coder so I do not assign DRG's
	I am in the LTC field, so some of these questions do not pertain to this industry. I also found taht some of the questions were repetitive.
	I am the only coder in the facility so everything is done by me.
	I am the only person at our facility responsible for DRG assignment, but I do collaborate with other IP coders in other facilities.
	I do very little coding in my job.
	I provide copies to insurance companies for clincal quality and DRG audits. If there is an issue, the coding manager addresses it. The coding mgr and supervisor address ALL coding issue, I'm just the middle person
	i work in the medical utilization review department we dont coding
	I'm presently working as a Mgr. in CDI and I review all cases reviewed by CDI and validate if i agree with the DRG assigned by coding and if I do not agree the chart is reviewed and rebilled if appropriate. I do not work in the INPT setting with CPT codes. We also treat all payers the same (just like Medicare).
	Management does not allow to talk things over with the TEAM.
	n/a
	Not a full time CPT coder.
	Our coders work with the UR/Case manager to ensure we are capturing all data

	for SOI/ROM.
	Please note my job doesn't relate to coding.
	The coding manager supervises both the coders and CDI. There is a very close working relationship.
	We are a critical access hospital and work with DRG's is limited to RAC audits, Core measure audits and data authority submission
	We do not do CDI for OP yet
	What about non hospital settings?
	Work in HMO - do not code hospital records at this time.
Leadership	
	All CDI policies/procedures are developed on a division level. Currently we do not have a physician champion. There are no current consequences for a physician who does not answer queries.
	As a contract coder and when on site vs. coding remotely, I interact often with the HIM staff and physicians regarding clinical documentation. Remote coding removes those opportunities for collaboration and process improvement.
	As the new HIM Manager at LHC, I will be begin developing a CDI program in the next few weeks.
	CDI specialists call coders when they are on the floor with questions on how to query. We have report we run when they write inappropriate queries to further education CDI specialists. No physician champion and a few doctors who always seem to answer they are unable to determine.
	Currently working as Compliance Officer interacting with HIMS but no longer Director of HIMS
	Discussed at quarterly meeting.
	Do not currently have physician champion. We work with CMO and Dept. chiefs
	employer doe not have a CDI program at this time

	I am a coder on the CDI team; my involvement is directly related to educating the CDI team in identifying documentation lacking for the purpose of capturing not only the MS-DRG but severity and mortality as well
	I have no trouble with physician queries as I only have five on staff physicians and can contact them daily if needed.
	I personally have no say so as whether queries are answered or not..Administration does that and maintain dialog with the Chief of Staff. We keep a monthly totals of money loss to potential queries not answered and this is forwarded to Chief of Staff.
	I work in cancer registry, so I don't do ICD9 coding.
	If we did any of this, it would be very important...
	I'm fortunate enough to be the CDI for our facility, and our physicians have been very open and timely in completing the queries. The physician champion has been very supportive from the start, but I haven't had the need for him to get involved. I do keep him updated.
	I'm not a Supervisor.
	Managemt wants total control.
	Member of AHIMA, CHIA, and ACDIS Our region is in the process of revamping our CDI P&P's.
	-membership in prof orgs eg AHIMA & ACDIS , are paid by the org for management personnel; info is then shared with the staff -CDI policies & procedures in accordance with AHIMA practice briefs are ALREADY in place and therefore, are not developed regular
	Most of these questions doesn't relate to my daily job performance.
	Most tasks handled by management
	n/a
	No physician advisor at our hospital. The CDI program unfortunately is not under the HIM department but under Quality Management.
	Our documentation and compliance team is responsible for some of the procedures listed above.

	P &Ps are developed by corporate.
	policies are developed on as needed basis...same with collaborations.....
	somebody else in the company does these things and while they are important I don't have any direct input
	There are many of these questions inadequately answered by the limited selections. Present situation and goal can be very different
	We began our program in March 2011 so we are still evolving. Any information in these questions would be invaluable.
	We do not currently have a Physician Champion
	We do not have a CDI program
	We don't have a CDI program at this time so it is difficult to answer the questions.
	You us a lot of abbreviations in this survey.
Record Review	
	Again I have no issues in the query process with only five physicians.
	Again, I am not a coder.
	Again, the CDI nurse will at my direction obtain necessary information needed for data collection. CDI nurse is a trainee
	As a contract coder on site, I would keep a log of queries. However, as a remote contract coder, the facilities follow up on queries. I often do not know the outcome.
	At our facility all queries are part of the legal record. We (CDI) does not have a working relationship with Case Mgmt. at this time but we will be reporting to the same director next week and the plan is that we will be one department. This relationship in my experience is the key for a successful CDI program.
	-at present, there is no regular collaboration bet CDI and UM staff, even though these 2 depts are under 1 director
	Because we are not meeting our benchmark of Acute Mortality @ 1.0 (we are currently at 1.4) all these issues are hot issues actively being done.
	CareTech Solutions Managers insist on the verbage of the queries in a genetic type form.

	Coders do all queries
	Core measure compliance is overseen by Quality Systems, a different department.
	do not code
	Dont understand a lot of abbreviations like hac, psi, etc...
	Ensuring the query becomes part of the legal medical record fall under HIM Operations.
	I am not expected to do this aspect of the job. I am expected to contact the person who's job it is to work this part.
	I work at a large teaching hospital. We have coded and we have a CDMP program. Our current CDMP program is with JATA nursed do most of the querying. Coders query if documentation is still unclear, many of these are case that the CDMP nurses have not looked at. CDMP is focusing on patients with medicare. I do very little with this group but it is very important to our hospital, that is why I answered the questions the way I did.
	I work in a nursing home and just do not deal with much of this information
	In previous positions had excellent query process in place. In current position facility does not query because of previous overuse and physician refusal. Working to build trust with MDs again and reinstate a more efficient process. Very frustrating.
	Most of this is not in my job description and I do not do this.
	n/a
	Never response indicates uncertainty as to definition of PSI
	not sure what PSI is
	On the 2 never responses; what do you mean by PSI?
	Other staff provide some of these duties therefore they are important, just not important in my position.
	Our physicians have been very good about POA's.
	Post discharge queries are done by coders. A Core measures team is used to monitor core measure documentation.
	Some duties listed above are handled by other HIM professionals.

	Some items done by someone else or another area.
	these timelines are not reasonable, daily policy development???? only if you have MAJOR problems at your facility and you dont know how to write a policy...
	We are just in the process of starting provider query. Why am I doing this survey?
	We do not have a formal CDI program in place but are formulating one so it is difficult to quantify on some questions. The coding staff for the most part are very experienced although could use the query process more effectively.
	We have 2 nurses and 2 coders working the floors so we have a good combination of types of cases and issues.
	We work with Case Management periodically for accurate discharge disposition code assignment
	work in the long-term care field and a lot of this doesn't neccessarily pertain to my job.
CDI Metrics & Statistics	
	Again I am the only coder responsible for all inpatient and outpatient coding and only have five physicians to deal with.
	All the tracking is done by management. We only get AR ups and downs. Not really info we need.
	As an Inpatient Coder I am at the first level of my job and therefore do not trend or track other jobs
	Currently we are a work in progress for CDI
	-denials management is tracked by a diffrent group; CDI does not follow denials of DI-reviewed cases -MD query responses are checked daily bec escalation might be needed for non responders to DI queries; however, trends are not done daily (not done at al
	Done by a Manager, Auditor or someone else. Facility does not have a CDA program at this time.
	I am Just a coder with no authority.
	I do not perform most of questions on this page

	Many of these items do not fall within the realm of my job...
	Most of the 'never' answers above are due to the fact that we have an internal auditor that maintains stats for us monthly.
	Most tasks handled by management
	My position is regulatory compliance and Forms Committee. I run, report and take minutes to the HIM Committee where much of the data pertaining to your questions is presented.
	n/a
	Note where never was marked doesn't necessarily mean that it isn't done at my facility, it's just not done by me.
	Receive monthly reports from vendor of CDIS software. Constant interaction with coders as needed.
	Some of the above is being done in another department, but not HIM here in the long-term care setting.
	someone else in the company or facility does this work. i just fill out the abstract so they have accurate data
	Sorry to skew the results - we're just not there yet!
	Statistical data are generated by our department director and then shared with us.
	The CDI program is still in the beginning stages. We are still awaiting for the software so the reports can be run.
	These are not under the scope of my job
	These things are tracked by the Peer Review Committee
	tracking of denials is the responsibility of Case Management
	We address prevention of denials as they are identified by PI.
	We are a fairly new program and we are currently establishing policies and workflow
	we are small hospital and just starting to get everyone involved with CDI. Everyone is not understanding ICD-10 will affect more thin just HIM.
	We do not have a CDI program and will not implent one, however, we

	review/audit many records for documentation, QI, POA, external data etc.
	We don't have CDI program and we don't coders on teh units.
	We have an active query log. Denials are not always communicated to our facility by our billing partners.
	We track daily and run reports to trend.
	We will probably increase the frequency of the above once we gather enough data since this is a new department.
Research & Education	
	Again these are mostly handled by auditor or administration.
	again, someone else is responsible for tracking and educating. I just utilize the forms they creat to use as query forms to the providers
	Attend all medical staff meetings providing education.
	Because the organization that I work for has multiple facilities for LTC, many of the areas that I have signified as 'Never' is done by another team member.
	Continuous education of CDI staff, coders & providers is a very high priority in our program.
	currently in my org a coders only concern is productivity. all other info is on a need to know basis, and we get very little in feedback or education, etc
	Education materials have been recommended by our outside auditor, but haven't received the ok from administration.
	-Educational material are ALREADY available and are used daily by CDI staff as part of the CDI responsibilities and CDI initiative (no need to develop materials except when there are industry changes, new codes or coding clinics) -our aim is to be the BE
	In the past, developed monthly physician article that addressed current areas of concern. It was very successful.
	Many of these questions are pertinent to the type of work I am doing. I have performed these tasks on a regular basis when I worked for a facility as DRG coordinator. As a contract coder, many of these tasks are not part of our scope although I do communicate with the HIM Departments.

	Mgr's develop educational material for staff. I educate physicians and nurses on documentation compliance.I worked in UR for years and they have a close relationship with our department, but are separate, most of their staff are RN's./
	Most tasks handled by management
	Much of the education for providers and staff is done informally, on a one to one basis.
	My specific daily job duties doesn't relate to coding.
	n/a
	No CDI program at this time. I do not know who does the education and research at my facility.
	Not under the scope of my job.
	on a lot of these questions, this is done by corporate and we do not have anything to do with it. We get the results, but are part of the process
	Our CDI program is still very new. Trending and change process is really just becoming focused.
	Same as previous comments
	Some of the research questions were not clear....
	This stuff was not important or not a focus for my job as a clinical Applications Coordinator for the EHR because the coding was not done using my EHR and I was more involved with the IT people than the coders. However I have a new job as a Medical Record Chief and much of what I am saying is not important for my job acctually is. I am trying to answer the questions as if I was still the EHR program coordinator.
	We are creating articles for newsletters, our own newsletter, presentations on powerpoint, and other means to get the word out on specific areas in documentation.
	We have to be sneaky and give info to fellow Team coders without the management knowing. They are do not like us inforing eachother.
	We never have to develop educational materials because we are part of a major corporation, that has a department dedicated solely to CDI.
	We use every chance we get to implement and track these processes.

	We use our Medical Staff Newsletter as an avenue to communicate w/medical staff.
Compliance	
	Again our CDI's our all RN's here and very unaware of many of AHIMA standards
	-all query forms have been approved by the compliance dept -CDI efforts are always ethical, and not focused on reimbursement
	I believe these issues are important but are not a part of my job.
	I do not use many AHIMA resources to the best of my knowledge.
	I have to get my own info about this. The managent does not share.
	In these questions are very important responsibilities, but they are under the umbrella of another part of the organization, not mine.
	Marked weekly, but as needed.
	n/a
	No application or opportunity at this time but trying to make a case for just that
	Our program is fairly new some of the reponses are what we have planned so far.
	Same as previous comments
	We do not have a clinical documentation improvement program in our facility but will be initiating one within a few months
	We look to AHIMA and ACDIS for assistance in best practices. And any seminars from 3M and others.
Final	There was no way to answer questions that addressed things that were already part of our program.
	-should one issue per question; ther can be different answers to different issues -there were no comments/ suggestion boxes in the last part of the survey -no choice for 'not applicable'

	The credential for CDI through AHIMA would be redundant because there already is a credential through ACDIS. The last thing I am interested in is paying for and sitting for another exam for a credential that I already have. Why can't there be some cooperation between AHIMA and ACDIS considering that ACDIS established their credential first?
	Please include Managed Care Organizations when questions are developed. We have regulatory requirements that coding and clinical documentation are applicable. It is a different environment but still part of the HIM porfessional practices. Thanks
	Tech management is necessary in the EHR world
	The questions on the last 25% of this survey were difficult for me to answer. We have a hybred MR. We have nursing doc and CPOE electronic. We are wanting electronic clinician documentation, but we haven't gotten there. I have been deeply involved with implementing the electronic MR in several areas of the hospital because of Forms Committee, HIM regulatory compliance and my HIM dept affiliation. My 30 years of experience has helped, too.
	A littlwe too long and some questions needed to be explained better. Also at teh end, if the questions, didnt apply to you, you still had to answer them.
	You need to tell a person if they are answering these question for self only or for an organization, this was very confusing.
	Current position is: Inpatient Coder/Core Measures Abstractor
	Please note our facility has been utilizing an electronic health record for 4 years. Suggest adding to the survey answers related to EHR already utilizing.
	Is it possible to get a copy of this survey? It would be a great tool to use in setting up a CDI program.
	Some of the questions I have not been involved in. See previous comment in Health System

	CDS's at our facility are RN's, who are not bound by AHIMA Practice Briefs or HIM Policies and Procedures, especially in regards to the Query Practice Brief and CDS recommendations by AHIMA. RN's are Licensed by and bound by state boards of Nurses regulations, recommendations and ethical standards. You do not need a college degree to be a Coder, not even a certificate; you can receive on the job training. You require a license to be a RN, be we are Clinicians. RN CDS's follow state nursing board guidance, not AHIMA's; until such time that AHIMA recognizes there is a difference in quality code sets designed for Coders and those designed for RN's, working as Clinical Documentation Specialist. Our RN CDS's are trained in Coding.
	None
	Management Got rid of us RHIA credentialed coders to hire RHIT and CCAs
	As mentioned earlier...I am HIGHLY insulted that AHIMA is looking to develop a credentialing for CDI. ACDIS has worked diligently to develop and implement a very thorough Clinical Documentation Improvement Specialist certification program. My affiliation with ACDIS includes an admiration for their collaboration with AHIMA. I believe AHIMA is disrespectful instead of supporting ACDIS in their endeavor to become the premiere resource for Clinical Documentation Improvement Specialist as AHIMA is for HIM specialists. I refuse to answer age and race questions in general - my answer to age on this survey is incorrect but I answered 'as required'
	Would seek AHIIMA credential if offered
	I didn't feel some of the questions were geared best towards the CDI program. Many questions about the start of EHR... but not if already in place.
	Coding ethics and Case Mix Index knowlege are essential for compliant documentation practices
	future looks bright
	The trauma registry field requires many of the same areas of expertise and more to function efficiently and accurately. Implementing CDI tehcniques to improve documentation of traumatic injury is my goal....I would like to pursue the credential but do not have a Bachelor's degree

	Most organizations want RN for clinical documentation, but I believe that RHIT should be equal to RN, we learn clinical information in the form of A&P, Medical Terminology, and Pathophysiology we also unlike an RN have the coding backround. I think education and marketing of the skills and knowledge of a RHIT, RHIA should be expanded upon. We generally have all the knowledge that an RN has minus the practicum.
	Our CDI are RN's. AHIMA needs to advocate that highly experienced RHITS, CCS CAN DO THE JOB. Our impatient coders have done a of training of the RN but cannot have their jobs but could do it better in many instances. It is not an RN only job and AHIMA needs to promote that by educating more in clinical and pathophysiology
	Coder
	Since we already have electronic medical records I didn't really know how to answer a lot of questions because our system is already implemented and there was not a response for that.
	Need areas for N/A and shortening survey
	This survey needs to be ALOT less boring and easier to understand if you want people to continue participating.
	Coding has prepared me well for most of the CDI job I began this year. Having Nurses with us is very important in that they fulfill other parts that CDI requires, ie., communication skills, ease of those skills with Providers and others on the team. Our manager is a Nurse who worked extensively in Quality reporting and will be invaluable as a leader in providing the statistics the health system needs to show how we impact, will impact our organization in so many ways!!
	I would like AHIMA to have an online program to become a CDI or have courses through 'home study.' I would also like AHIMA to have a test that can be taken to become a credentialed CDI.
	Many questions the answer was 'already in place' but was not one of your choices.
	n/a

	This is such a complex field. I am the only CDI currently at our facility. We are in the process of hopefully establishing a team approach and getting more Case management involvement for medical necessity along with a physician champion to work together in obtaining the needed documentation to establish severity of illness, medical necessity and intensity of care. I believe that it takes a combination of all of those entities, coming together as a group, to get the job done. Not only nurses or only coders but a hybrid of both.
	Would suggest including an answer choice of important.
	Thank you for the opportunity to take part in this survey.
	Made me realize I really need to study up on these areas.
	We have had a CDI program for approximately 8 years. We have combined the UR nurses with the Inpt. coders and perform the CDI function and the inpatient coding function concurrently. The coders assign a working DRG as soon as the patient is admitted so the UR nurses have both a working DRG and an approximate LOS for the patient.
	I had to choose one location on the previous page, although I am not currently living in the USA
	We already have computer assisted coding, clinical documentation improvement software, an electronic record (post discharge totally electronic), etc.
	Lengthy survey. Could have been broken down to modules.
	I'm a coder
	too long for only 1 CE
	provide more educational info for those who work with physicians and their peer review
	Some questions difficult to answer since our program is driven by patient safety and quality. All CDS are RN's but report to RHIA who is very involed in process. Working on better relationship with HIM, not that a new leader is in position--difficult in the previous management. For many of the questions, I would have like to have a category of not applicable as some of the tasks I answered on behalf of my staff. Also, we have much support for the CDI staff so many reports are handled by Quality Analysts and the

	Director, Clinical Decision Support. Program runs differently in a large academic center than in a community hospital (I have done both).
	need a comment box for the last part of the survey. Our EHR is through the clinic setting, which is connected to the hospital setting, and some of my IP records are there. We are in the process of implementing everything into the EHR.
	OBJECTIVE OF THIS SURVEY WAS QUITE INFORMATIVE AND EDUCATIVE.
	THIS SURVEY SHOULD HAVE HAD ONLY QUESTONS THAT PERTAINED TO YOUR OCCUPATION. IT SHOULD HAVE A SELECTION OF CHOICES AT THE BEGINNING OF SURVEY. ALOT OF THE QUESTIONS I DID NOT KNOW WHAT IT WAS REFERRING TO.
	NA
	CURRENTLY WORKING IN QUALITY MANAGEMENT DOING CORE MEASURES BUT WAS A SYSTEM ANALYST DURING EMR IMPLEMENTATION.
	None at this time
	My geographic location is Northeast. That option wasn't listed to choose from.
	I can't imagine that you will get useful results. This has been the longest and most painful survey ever. How do I respond to questions regarding EHR? The VA has had it implemented for many years. It is behind us - not ahead of us.
	Very wordie survey
	Some of the Questions needed a different choice just because i am not performing the task doest mean that my employer doesnt have someone else doing the job; that should have been included as a choice
	Im just an analysis of the patient health record, so this survey really did not apply to the job that I do.

	Thank you!
	AHIMA needs to embrace CDI much like AAPC has done.
	promote more remote coding
	Should add a not applicable to your questions; Should add to your EHR question whether or not an EHR system has already begun at facility.
	I use my coding but do a different type of coding so questions hard to relate to
	Most of this survey did not apply to my position as a Privacy Compliance Consultant and Auditor. You may want to remove my answers.
	I have been coding for 24 years and have experience in all aspects of Clinical Doc review. My main function is managing Inpatient Coding and I work with the Clinical Documentation Team daily
	This is a very useful survey
	Good Survey, but several of the questions didn't really pertain to anything we are doing currently at the Centers, they may be doing some of it at the National Campus.
	LAST SET OF ORGANIZATIONAL QUESTIONS SHOULD HAVE BEEN DIRECTED TO MANAGERS AND DIRECTORS OF DEPARTMENTS.
	anytime and accronym is used in an article, report or survey, the accronym should be defined the first time it is used
	Explanations for some acronyms would have been helpful.
	We are currently on paper but will go to the EHR on October 1, 2011.
	I report to CIO and Coding and CDI is not one of my responsibilities.
	YOU NEED A NOT APPLICABLE CHOICE FOR SOME OF THESE QUESTIONS.

Appendix E. Pilot Recommendations

I have no recommendations for corrections to the survey.

The mean time to complete the survey is 36 minutes, with a standard deviation of 14.2 minutes. That means that 2/3 of the respondents should finish the survey in 50 minutes. In the invitation, I would suggest you tell respondents that they should budget an hour to complete the survey, but many will complete it in less time.

I'd also recommend that you create a strong incentive for people to finish the survey.

The survey as constituted does not ascertain the following information:

Code	Value
1	HIM Technician
2	Director
3	Manager
4	Clinician

Setting	
Code	Value
1	Acute Care
2	Integrated Healthcare
3	Long-term Care

Since this was important in determining the sampling, we may want to include the data in the actual survey.

Appendix F. Blueprint Working Papers

At the meeting on July 26th, 2011, the SME panel had two pieces of information: the Original weightings from the previous meeting, and the weightings resulting from the JTA survey. In this 'Reconciliation' meeting, the panel voted for the target weights for each main topic area within the Knowledge and Task domains. The results are shown in the table below. For each of the target weights, a range of plus or minus 2% was calculated to create the Maximum and Minimum percents for each main topic.

Clinical Documentation Improvement Specialist Exam Blueprint						
	Task	Original	Survey	Target %		
#	**Domain**	Weighting	Weighting	Weighting	Max	Min
1	Clinical & Coding Practice	26%	23.2%	24%	26%	22%
2	Leadership	15%	14.1%	15%	17%	13%
3	Record Review & Document Clarification	26%	25.8%	26%	28%	24%
4	CDI Metrics & Statistics	15%	19.1%	16%	18%	14%
5	Research & Education	9%	12.4%	13%	15%	11%
6	Compliance	9%	5.4%	6%	8%	4%
		99%	100.0%	100%	112%	88%
	Knowledge	Original	Survey	Target %		
#	**Domain**	Weighting	Weighting	Weighting	Max	Min
1	Clinical & Coding Practice	21%	33.4%	28%	30%	26%
2	Leadership	13%	16.0%	16%	18%	14%

3	Record Review & Doc. Clarification	22%	14.0%	21%	23%	19%
4	CDI Metrics & Statistics	12%	9.9%	12%	14%	10%
5	Research & Education	20%	16.5%	14%	16%	12%
6	Compliance	13%	10.3%	10%	12%	8%
		101%	100.0%	100%	112%	88%

The Maximum and Minimum percentage weightings became the weightings for the final blueprint.

Appendix G. Blueprint Reconciliation Vote

Blueprint votes are recorded below

	Task Domain											
#	**Title**	Mean	Std. Dev.	Nancy	Clint	Bambi	Darlene	Dave	Michele	Lynn	Amy	Sherry
1	Clinical & Coding Practice	**24.4%**	1.7%	25%	25%	25%	25%	25%	25%	25%	20%	25%
2	Leadership	**14.7%**	1.0%	15%	15%	12%	15%	15%	15%	15%	15%	15%
3	Rec. Review & Doc. Clarification	**25.6%**	1.7%	25%	25%	25%	25%	25%	25%	25%	30%	25%
4	CDI Metrics & Statistics	**16.4%**	3.4%	15%	20%	18%	20%	15%	20%	15%	10%	15%
5	Research & Education	**12.6%**	2.4%	12%	10%	11%	10%	15%	10%	15%	15%	15%
6	Compliance	**6.3%**	2.1%	8%	5%	9%	5%	5%	5%	5%	10%	5%
	Knowledge Domain											
#	**Title**	Mean		Nancy	Clint	Bambi	Darlene	Dave	Michele	Lynn	Amy	Sherry
1	Clinical & Coding Practice	**28.0%**	2.9%	30%	30%	25%	30%	32%	25%	25%	25%	30%
2	Leadership	**15.6%**	1.7%	15%	15%	15%	15%	15%	20%	15%	15%	15%
3	Rec. Review & Doc. Clarification	**20.9%**	1.8%	20%	20%	20%	20%	23%	20%	20%	25%	20%
4	CDI Metrics & Statistics	**11.7%**	2.5%	10%	10%	15%	10%	10%	15%	15%	10%	10%
5	Research & Education	**14.2%**	1.7%	15%	15%	15%	15%	13%	10%	15%	15%	15%

6	Compliance	**9.7%**	1.0%	10%	10%	10%	10%	7%	10%	10%	10%	10%
				100%	100%	100%	100%	100%	100%	100%	100%	100%
	Votes taken July 26, 2011 at 2:00 - 2:45 Central Daylight Time											
	Webinar conducted by Lisa Chernikoff, Wallace Judd											