Clinical Documentation Improvement

Here, There .....and Everywhere!!

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TODAY’S AGENDA

 CDI in the Outpatient and Physician Environment

 What is CDI?

 CDI Earnings

 CDI and Physicians

 The CDI Process

 The Art of the Query

 Future of CDI

CDI IN THE OUTPATIENT/PHYSICIAN ENVIRONMENT

It’s Not Just For Inpatient Anymore!!
IT STARTED WITH INPATIENT.....

- Primarily Inpatient At Its Inception
- Developed initially to improve documentation needed for DRG assignment
- Utilized primarily to maximize documentation for appropriate DRG assignment
- Improved physician documentation for the facility side
- Sometimes affected the physician documentation for CPT and Medicare Risk Adjustment as well
- Why not utilize to improve OP and physician documentation for appropriate CPT and Medicare Risk as well
- >20% respondents of recent survey indicate implementing OP or Physician CDI in the practice/facility

OR DID IT??

- Coders in the physician arena have been working with physicians on improving their clinical documentation for many years, long before “CDI” became a separate entity within the HIM field
- Now a new opportunity for focus within the outpatient/physician areas

OUTPATIENT AND PHYSICIAN IMPORTANCE OF CDI

- Recent growth of Medicare Part C
- Impact of quality of care measures
- Outpatient Services growth 34% from 2004-2012
- Inpatient Services decline 8%
- Comprehensive approach to reviewing documentation in all settings helps providers improve accuracy of risk scores for MA
- Providers more consistent and comprehensive health record that supports better quality of care and patient outcomes
OUTPATIENT AND PHYSICIAN CDI AREAS

EMERGENCY DEPARTMENT (Outpatient Facility and Physician)
- Documentation Review must occur quickly due to patient turnaround
- Documentation services as basis for inpatient admission - patients usually most severe during ED, CDI preserves and captures patient’s initial presentation
- Documentation utilized for capturing physician services

Advantages:
- Capture documentation for ED facility/physician ED levels
- Improved documentation infusions/injections
- Improved accuracy of Present on Admission (POA) indicators
- Proactive capture of quality of care measures

OUTPATIENT AND PHYSICIAN CDI AREAS (continued)

OUTPATIENT FACILITIES
- Primary Care Clinics
- Infusion Clinics
- Diagnostic Clinics
- Ambulatory Surgery Centers
- Wound Care Centers
- Observation Care

All settings capture documentation for physician as well as outpatient facility coding/charging

HCC Documentation

Which Can Be Captured by CDI:
- Diagnosis must be face-to-face and have documentation of MEAT (Monitored, Evaluated, Assessed, Treated)
- Diagnoses must be stated as a current problem on the specific DOS
- Diagnoses must be documented each year
- Documentation must meet coding guidelines
- Records must be signed and have appropriate credentials

IN ADDITION:
- Improve accuracy of risk scores and reporting diagnosis while mitigating risks associated with inaccurate coding
- CMS utilizes HCC risk adjustment methodology as part of several value-based programs that impact inpatient payments and quality outcomes - reward providers with incentive payments for providing better care and improving healthcare outcomes
Clinical Documentation Improvement (CDI)

So….it’s not just for inpatient anymore!

What IS CDI?
Clinical Documentation Improvement

DEFINITION - What is CDI?
- CDI (Clinical Documentation Improvement) refers to a niche within the HIM field focused on improving the quality of documentation in the medical record from a clinical point of view.
- The purpose of a CDI program is to initiate concurrent and, as appropriate, retrospective reviews of health records for conflicting, incomplete, or nonspecific provider documentation.
- The diagnoses and procedures documented in the record need to be clearly supported by clinical indication so that the ICD-10-CM/PCS codes assigned are accurate and correctly assigned.
- The method of clarification used by the CDI professional is often written queries in the health record.
- In 2015, the AHA (American Hospital Association) conducted a survey of more than 1,000 CDI, coding, HIM, and other hospital professionals.
  - The "Clinical Documentation Improvement Trends Survey" showed that most hospitals now have some form of CDI program and have extended or are extending into the outpatient/physician areas.

These programs generally feature:
- Dedicated CDI resources
- Reviews on mostly Medicare cases
- Some focus on quality measures and metrics
CDI GOALS/BENEFITS

The goal of CDI, summarized, is documentation that accurately and precisely paints the patient’s clinical picture so that coders in the HIM department can paint the exact same clinical picture in codes.

- Obtain clinical documentation that captures the patient’s SOI and ROM
- Identify and clarify missing, conflicting, or nonspecific provider documentation related to diagnoses and procedures
- Support accurate diagnostic and procedural coding & MS-DRG assignment leading to appropriate reimbursement
- Promote health record completion during the patient’s course of care, which promotes patient safety
- Improve communication between physicians and other members of the healthcare team
- Provide awareness and education
- Improve documentation to reflect quality and outcome scores
- Improve coding professionals’ clinical knowledge

These efforts result in improved accuracy and completeness in:
- Documentation
- Coding
- Code assignment
- Reimbursement
- Severity of illness (SOI) score
- Risk of mortality (ROM) score
- Proper severity-adjusted Case Mix Index (CMI)
- Proper charge capture for inpatient and outpatient procedures that are diagnosis-driven.
- Decreased interventions by the insurance companies that are looking for justification of that additional day on the intensive care unit or that addl procedure
- Appropriate evaluation and management services professional billing by the medical staff

CDI STAKEHOLDERS

CDI Stakeholders include:
- HIM coding departments and physician coders
- Case management and utilization review
- Medical staff and provider leadership
- Executive leadership
- Patient financial services and billing
- Finance and revenue cycle
- Quality and risk management
- Nursing
- Compliance and ethics
The Evolution of CDI

- Often CDI programs begin with focused concurrent review of a specific payer type (such as Medicare) or payment type (such as DRG).
- However, this is not a requirement and the focus will depend on the individual organization.
- Although CDI programs are traditionally found in the acute inpatient setting, they also exist in other healthcare settings such as:
  - Provider offices
  - Ambulatory care
  - Acute rehabilitation hospitals
  - Skilled nursing facilities

The CDI Specialist

Regardless of which background the CDI Specialist comes from, they must also possess knowledge and skills in the following areas:

- Clinical knowledge
- Payment systems and methodologies
- ICD-10-CM/PCS coding concepts and guidelines
- Healthcare regulatory compliance
- Experience in setting performing CDI
- Strong verbal and written communication skills

CDI Certifications

Certifications have been developed to give recognition to CDI professionals who have demonstrated a mastery of the various skillsets involved in CDI.

- **Certified Clinical Documentation Specialist (CCDS)**
  - Certification from the Association for Clinical Documentation Specialists (ACDIS).
  - **Certified Clinical Documentation Specialist (CCDS) prerequisites (must meet one of the following):**
    - An RN, BHS, BHT, MD, or DO and two (2) years of experience as a concurrent or retrospective documentation specialist in an inpatient acute care facility using the United States IPPS system.
    - An associate's degree or equivalent in an allied health field (other than what is listed above) and four (4) years of experience as a concurrent or retrospective documentation specialist in an inpatient acute care facility using the United States IPPS system.
  - The education component must include completed college-level course work in medical terminology and human anatomy and physiology.
  - Formal education (accredited college-level course work) in human anatomy and physiology, medical terminology, and human anatomy and physiology.
- **Certified Professional Coder (CPC) from the American Health Information Management Association (AHIMA).**
- **Certified Coding Specialist (CCS) from the American Health Information Management Association (AHIMA).**
CDI Certifications (continued)

Certified Documentation Improvement Practitioner (CDIP)
- Certification from the American Health Information Management Association (AHIMA).
- CDIP Certification requires meeting one of the following prerequisites:
  - An RHIA, RHIT, CCS-P, MD or DO and two (2) years of experience in clinical documentation improvement.
  - An Associate's degree or higher and three (3) years of experience in clinical documentation improvement; candidates must also have completed coursework in Medical Terminology and Anatomy and Physiology.

CDI EARNINGS

ACDIS conducted a CDI Salary Survey in 2013, which included 700 respondents nationwide and showed the following:
- Most earned a salary in the $60,000-$69,999 range.
- 70% reported receiving a raise in the last year.
- CDI Managers reported earning salaries in the $80,000-$89,999 range.
- The report also noted that 10.6% of CDI Specialists and 11.3% of HIM directors earned that amount.
- There were about as many HIM directors earning less than this amount as there were earning more than this amount.
The ACDIS 2013 CDI Salary Survey also noted that:

- 158 respondents had a CCDS (Certified Clinical Documentation Specialist, credentials issued by ACDIS)
- 35 held a CCS (Certified Coding Specialist, credentials issued by AHIMA)
- 31 had an RHIT (Registered Health Information Technician, issued by AHIMA)
- 11 held an RHIA (Registered Health Information Administrator, issued by AHIMA)

The CCDS credential proved to be the highest paying, overall, with 41.2% earning greater than $80,000 – compared to just 6.4% of those with an RHIT and 28.6% of those with a CCS.

According to Payscale.com, salaries for CDI Specialists ranged from $40,730 - $89,584 nationally – as of Jan, 2016.

The median salary is $62,230.

For comparison:

- The range for an RN is $40,403 - $81,171; median is $58,371.
- The range for an RN is $40,089 - $71,833; median is $48,750.
- The range for an HIM Director is $38,119 - $106,681; median is $71,396.
An effective CDI program depends on physician interaction and engagement.

This requires convincing physicians of the high value of clinical documentation.

Physicians are not trained on clinical documentation, so this is often a difficult task.

Many physicians seem to see CDI as a revenue-related initiative rather than a patient care or quality-related initiative.

Key to effectively engaging physicians in CDI is dispelling this myth.

CDI is not about increasing revenue, though revenue is affected by documentation standards.

Inappropriately increased revenue creates a whole series of problems and headaches all its own, with which no facility/practice wants to be plagued.

Effective CDI programs promote appropriate revenue collection, thereby reducing the problems caused by inappropriate revenue collection.

Effective CDI programs also have the potential to improve quality of care.

- (Quality of care is something physicians care about much more than hospital revenue.)
- CDI programs have moved into the outpatient setting in Risk Adjusted Reimbursement models (and physicians do care about their own revenue)

Research conducted by AHIMA shows a positive link between clinical documentation accuracy and higher quality of care.

A 2008 Archives of Internal Medicine article indicated that:

"Medical records for patients with H1N1 (a type of myocardial infection) often lack key elements of the history and physical examination."

"Patients treated at hospitals with better medical records quality have significantly lower mortality . . . (and) the relationship between better medical charting and better medical care could lead to new ways to monitor and improve the quality of medical care."
The Statistics: Physician Errors

Closed claims
59% serious 30% deaths

In-office 181 closed claims
(Average 3 or more errors)

- Failure of judgment 79%
- Failure of vigilance or memory 59%
- Too little knowledge 48%
- Failed to properly hand-off case 20% to another doctor

*Annals of Internal Medicine Oct 3, 2006

CDI AND PHYSICIANS

- CMS now incentivizes/penalizes hospitals by using quality-based programs and measures such as:
  - Value-based purchasing rewards hospitals for quality care
  - Readmissions reduction program
  - Hospital-acquired conditions (HACs)

- CMS bases many of these factors on quality scores from DRG data recorded two years ago.

- Therefore, data generated by today’s documentation will reflect in these measures two years from now.

- These same quality scores are also used to assist with risk adjustment for acuity…some are more ill than others.

- As CMS moves toward value-based reimbursement, the way physicians document needs to change.

- In the 2015 Clinical Documentation Improvement Trends Survey, two-thirds of participants stated that physician lack of understanding of the importance of accurate clinical documentation prevents physicians from being effectively engaged in CDI.

- CDI can work to keep physicians engaged by ensuring they understand the link between quality of care and the quality of their own clinical documentation.

The Physician Champion

- An effective means of addressing these issues that is gaining popularity in the CDI world is employing a physician-to-physician model.

- In this model, a physician advisor known as the “Physician Champion” (or “advisor”, “liaison”) is involved in all formal training provided to physicians, as well as serving in a support role to the CDI Specialists.

- The physician champion confers with certain treating physicians about key clinical indicators and risk factors in the case while the patient is still in the hospital.

- Physician champions help promote an effective peer-to-peer communication environment.

- The physician champion’s role includes:
  - Conducting reviews
  - Communicating with other physicians or providers about documentation issues
  - Promoting open lines of communication — particularly when there is a lack of response to queries.

- The CDI specialists should work collaboratively with the physician champion to develop resources that can be provided to the medical staff.
THE CDI PROCESS

- The CDI Specialist uses software designed for CDI programs to identify charts that should be reviewed by CDI.
- The CDI Specialist will then “pull” those records.
  - This could mean going to the unit where the patient is located in the hospital and physically reviewing the record (old way).
  - This could mean accessing the record using the facility’s EHR system, from wherever the CDI Specialist’s office is located, and reviewing the record electronically (new way).
- Any appropriate queries are then attached to the record, either physically or electronically.
- CDI then follows up for query response.

DOCUMENTATION REVIEW

- ATTENDING PROVIDER
  - Supersedes documentation of all other treatment providers (including consultants) when there is a conflict.
  - Documentation To Review:
    - Admitting Diagnosis
    - History and Physical
    - Past Medical/Social/Family History
    - Medications
    - Physical Assessment
    - Plan of Care
    - Progress Note
    - Operative/Procedure Reports
    - Discharge Summary
OTHER DOCUMENTATION FOR REVIEW

- EMT Report
- ED Report
- Specialty Consultations
- Anesthesia Assessments
- Physician orders
- Medication administration records (MARs)
- Imaging Reports

Coders cannot assign diagnosis codes from these reports, may be sued information as clinical indicators for queries.

Coding Clinic does however, allow utilizing radiology reports for specific anatomical site as long as treatment MD documents do.

OTHER DOCUMENTATION FOR REVIEW

- Lab results
  Cannot assume from abnormal lab values. If meets definition of reportable diagnosis, can utilize clinical indicators to query.
- Nursing Documentation
  Clues to incomplete, vague or missing diagnoses
  Can be used to capture BMI and pressure ulcer staging
- Therapies
  Source of clinical indicators

HIM CODERS AND CDI

- The specific role of coders will vary from program to program, facility to facility, practice to practice.
- However, one thing that is essential for an effective and efficient CDI program is for the CDI professionals and the HIM coders to work seamlessly together.
- Communication between HIM and CDI is imperative.
  - Typically, coders have a strong documentation background and less of a clinical background while CDI specialists have a strong clinical background and less of a documentation background.
  - Because of this, they won’t always see eye-to-eye.
  - If CDI and HIM work together, unnecessary queries can be reduced or eliminated, and queries that are necessary can be more effective.
HIM CODERS AND CDI (continued)

- Just as CDI Specialists can help coders understand the clinical aspects of the documentation in a medical record, the coders can also help the CDI Specialists better understand the documentation aspects in light of coding guidelines and Coding Clinic advice.
  - This is if the CDI team and the HIM team are committed to working together for mutual success - a key to meeting the goals of both CDI and HIM.

- If either the HIM coders or the CDI specialists allow the process to become a battle of who's right and who's wrong, or let ego get in the way, then the entire process can become cumbersome and ineffective.
  - This will reduce both teams’ ability to meet their goals.

THE ART OF THE QUERY

What Are Queries

- Routine communication and education tool that encourages complete and compliant documentation
  - One method of requesting additional documentation or clarification to ensure all clinical conditions are documented that were managed during the encounter
  - A properly constructed query is a valuable tool for facilities and providers which is used to help ensure both the accuracy and defensibility of the codes and DRG assigned

- Presented to the provider, usually in written format
  - Expectation to consult providers for clarification and possible additional documentation prior to code assignment when conflicting, ambiguous or missing information in the health record

- Utilize to assist and educate provider in areas such as:
  - Additional specificity
  - Resequencing, or additional diagnoses or procedures when needed to reflect the severity of the encounter

- Coder should not change codes or include diagnosis(es), procedures based on payment of insurance coverage

- Should not misrepresent clinical scenario through incorrect coding unsubstantiated by included documentation

- New Challenge/Concept for most physician/outpatient coders
The Query Process

**PRE-QUERY:**
- Make certain to make available provider education before starting the querying process to include areas such as:
  - Reimbursement methodology
  - Purpose of the query process
  - Examples of query forms

Make certain providers understand that the query process is not intended to question their clinical judgement, but to make certain that the documentation supports services billed.

**WHEN QUERIES ARE APPROPRIATE:**
- Clarification of Present of Admission (POA) Status
- Documentation is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Documentation includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Clinical evidence of diagnosis but no documentation of condition
- Evidence that a higher level of severity is present
- Cause and effect relationship between conditions needs clarification
- Notice the majority of reasons for query have to do with clinical validation.
  - CDI is often primarily responsible for identifying when such queries are necessary, generating the queries, and any necessary follow-up.

**BASIC ELEMENTS:**
- **Specific Issue**
  - List diagnosis that requires clarification
  - State where documented within record
  - Provide list of clinical indicators
  - Specific to patient and specific episode of care
  - Query should be unique to patient

- **Specific Problem**
  - Can diagnosis be further clarified/specified
  - What is the relationship to other diagnosis/procedures

- **Resolution**
  - How to respond
  - When/where to respond
The Query Process

Acceptable Query Verbiage:

- General Requirements:
  - Is NOT Leading
  - Does not introduce new information not contained in the record
  - Provides clarification
  - Consistent with other documentation in the medical record
  - Clear and concise
  - Presents only the facts and why clarification is necessary
  - Should always allow a way for the provider to respond without agreeing by adding additional documentation

Proper Query Should NOT:

- Indicate impact on reimbursement (or DRG, relative weight, etc.)
- Exclude reasonable responses (when multiple choice), including "unknown", "other", and "unable to be determined".
- Include clinical findings unrelated to the query.
- Lead the provider to a desired answer.
  - Leading query is not supported by clinical elements in the record or directs provider to specific diagnosis
- Ask a question not supported by clinical findings already documented in the record.
- It is also advisable that queries not include choices that are contradictory to documentation already in the record.

Sample Queries

Example 1: Query Not Appropriate

Queries should not be used when the documentation is already clear.

Example: A patient is admitted from the ED with signs & symptoms of infection, including fever & elevated WBC. The admitting diagnosis is UTI with suspected sepsis. Possible sepsis is noted on the H&P and the infectious disease consult. Progress notes initially include “sepsis.” The blood culture comes back negative however and following this the diagnosis of sepsis continues to be documented on the progress notes as these are copied-and-pasted from day to day. The Discharge Summary documents “UTI - sepsis was ruled out”.

- Even though sepsis is documented on just about every page of physician documentation in the record, it is clear that this was ruled out at the time of discharge.
- It would be inappropriate to query the physician for clarification as to whether or not he/she actually meant the diagnosis documented on the discharge summary.
- The purpose of a query is not to question a physician’s documentation or final diagnosis.
VERBAL QUERIES

VERBAL QUERY REQUIREMENTS:
- Must have an audit trail
- Sometime preferable when addressing complex issues where interaction of conversation may be required
- Contains same clinical indicators and format as written queries
- Audit trail should contain the actual questions posed to the provider

Types of Queries

Open-Ended
- Preferred query format by AHIMA
- More difficult to construct for desired response

Multiple Choice
- Easier to construct
- Should include “Other” and “Unable to Determine” or “Unknown”
- Should include clinically significant options
- There may be only one reasonable option

Yes/No
- Cannot be utilized to add new diagnosis
- Limited to POA status prior to Query Practice Brief February, 2013
- Resolving conflicting documentation from multiple providers
- Determining cause and effect relationship between documented conditions
- Include “other” and “clinically undetermined” allows provider to add additional free text

OPEN ENDED QUERY

OPEN ENDED QUERY EXAMPLES:

EXAMPLE:
ED record indicates respiratory rate 32/minute, HR of 90, febrile at 102.7.
Blood cultures positive for E. coli. UTI identified as admitting diagnosis.
Treatment includes antibiotics, and fluids

Open-Ended Query:
Please clarify condition being monitored and treated.
MULTIPLE CHOICE QUERY

MULTIPLE CHOICE QUERY EXAMPLE

Ed record indicates respiratory rate 32/minute, HR of 90, febrile at 102.7. Blood cultures positive for E coli, UTI identified as admitting diagnosis. Treatment includes antibiotics, and fluids.

Open-Ended Query:
Please clarify condition being monitored and treated
a. Septicemia due to UTI
b. UTI only
c. Other: (Please specify) __________
d. Unknown

Query includes all possible diagnostic statements as well as the option of “other” and “unknown” in the event neither of the diagnostic statements are appropriate.

YES/NO QUERY

YES/NO QUERY EXAMPLE:

EXAMPLE:
Ed record indicates respiratory rate 32/minute, HR of 90, febrile at 102.7. Blood cultures positive for E coli, UTI identified as admitting diagnosis. Treatment includes antibiotics, and fluids. ED physician states “E Coli UTI”.

Yes/No Query:
Do you agree with E coli UTI:

a. Yes
b. No
c. Other: __________
d. Unable to determine

The ED physician identified E Coli UTI, however attending did not mention in any of his documentation.

Query Scenario 1

Appropriate Query?

CLINICAL DOCUMENTATION:

Proposed Query:
Is the patient’s pneumonia due to aspiration?

Is this query appropriate, and, if not, WHY?
Query Scenario 1

Query is NOT appropriate as written due to:
- Leading question
- Diagnosis is included within the scope of question
- Provider did not document findings

How can the verbiage be changed to construct an appropriate query?
Yes/No would not be appropriate as diagnosis was not mentioned in record

Alternative Queries

PROPOSED QUERY: OPEN-ENDED

Query 1:
Can the etiology of the patient’s pneumonia be further specified?

Query 2:
Based on the information provided, can the etiology of the pneumonia be further specified? If so, please document the type/etiology of the pneumonia.

Query Scenario 2

Appropriate Query?

CLINICAL DOCUMENTATION:
Diagnosis of hypokalemia is documented in the progress note; labs indicate a potassium of 3.8

Proposed Query:
Please clarify the status of this diagnosis by documenting your response below

- Hypokalemia was ruled out
- Hypokalemia is valid diagnosis for this encounter
- Hypokalemia was clinically insignificant finding
- Unable to determine
- Other (Please specify): ________________

Is this query appropriate, and, if not, WHY?

Query Scenario 2

Query IS appropriate

RATIONALE:
Potassium level of 3.7 does not demonstrate a clinical significance for hypokalemia, therefore, allowing the choices of ruled out, clinically insignificant, valid, unable to determine and other would be appropriate.

No clinical indicators have been included that were not in the record, and appropriate choices have been provided.
The HIM field, including CDI, is projected to have a 22% growth rate between 2012 & 2022, according to the U.S. Bureau of Labor Statistics.

As U.S. healthcare continues its transition from fee-for-service based reimbursement to value-based reimbursement, the role of CDI is an essential component of maximizing reimbursement potentials for healthcare providers and facilities.

- Fee-for-service model is based on volume.
- Value model is based on quality of care, on which clinical documentation has a direct impact.

CDI programs are an essential component of a successful transition from the outgoing fee-for-service model to the incoming value based model.

The more that reimbursement is tied to quality of care, the more essential CDI programs become.

Because of this, the future of CDI is bright as it is a vital component of the future of healthcare itself.

This also means that CDI programs are continually evolving, and that there is a growing demand for both implementing new CDI programs as well as expanding existing CDI programs.

- Both of which mean increased need for CDI staffing.

All indicators point to CDI’s role in healthcare as becoming more solidified and increasingly more important as time goes on.
FUTURE OF CDI (continued)

- There is currently an increased interest in CDI expansion into other areas of healthcare, including:
  - Emergency department
  - Ambulatory care
  - Physician offices
  - LTACs (Long Term Acute Care)
  - And more

- The ACDIS’s 2013 CDI Salary Survey showed that 89.9% of respondents worked in the short-term acute care setting.
- 1.2% worked in critical access facilities.
- Only 7.5% worked in “other” settings.

FUTURE OF CDI (continued)

- Many opportunities await those who enter the world of CDI.
- Are you the type of person who would be a good fit for such opportunities?
- CDI Specialists should have excellent communication skills, should be outgoing (able to engage and confront physicians), and able to work well with others from a wide scope of practices - case management, nursing, physicians, HIM, utilization review, etc.
- If you think you have what it takes and would like to learn more, please visit: www.ACDIS.org, where you can learn about the steps to take next to become a CDI specialist, obtain certification, and gain employment in this important, exciting, and developing field within the healthcare industry.

QUESTIONS/COMMENTS

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