



Maryland Association for Healthcare Quality

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PRESIDENT'S MESSAGE

Dear MAHQ Members,

I write this letter as my term as President comes to a close. I would like to take this opportunity to thank all of the 2009 Board Members for their service to the Organization:

- President-Elect: Robin Craycraft
- Past President and Webmaster: Josephine Howard
- Secretary: Mary Gruver-Byers
- Treasurer: Hilary Sporney
- Members-at-Large: Barbara Dailey, Terri Kapetanovic, Linda Kelsen, Maureen McGinty, Mary Whittaker, and Terrie Young
- Committee Chairs: Maureen McGinty and Digna Wheatley (Education), Camille Dobson (Legislative), Sally Morris (Membership), Laura Schwartze (Newsletter)
- Committee Members: Bijoy Mahanti and Nancy Stojinski (Membership), Denice Arthur and Peter Libby (Education).



I'd like to wish a warm welcome to the members new MAHQ in 2009:

- Marcia Bowens
- Anastasia Brown
- Bethany Browning
- Karen Caffi-Lalle
- Patricia Carey
- Laurie Edwards
- Ranella Flowers
- Susan Franklin
- Mark Gaking
- Kristen Geissler
- Ella Giles
- Gayle Hurt
- Diane Lepley
- Barbara Mosser
- Barbar Oot-Giromini
- Sharon Powell
- Tracey Smith
- Joanne Timmel
- Julie Tyler
- Amy Walker
- Carol Ware

2009 Year in Review

MAHQ had a very successful year in 2009:

- Introduced the MAHQ Google Group
- Continued to update the MAHQ web site
- Staffed an information table at the Maryland Patient Safety Conference in April
- Partnered with Consumers Advancing Patient Safety (CAPS)
- Hosted a dinner for MAHQ members and Maryland attendees at the NAHQ Conference in September
- Sponsored two educational conferences with a poster session at the Fall conference

Coming in 2010

MAHQ has a number of activities on the horizon for 2010.

- 1 ½ day CPHQ Review Course instructed by Nancy Claflin, February 18-19, 2010 to be held at the Maryland Hospital Association (MHA) in Elkridge
- Partnership with the QI Project to provide quarterly educational webinars
- Co-sponsoring the keynote address by Susan Sheridan (Co-founder and President of Consumers Advancing Patient Safety) with the Maryland Patient Safety Center at the Maryland Patient Safety Conference in March 2010

It has been my pleasure to serve you as President. I leave the organization in the excellent hands of Robin Craycraft.

Sincerely,
Cheri Wilson

Improving Patient Safety and Healthcare Quality through the Provision of Culturally and Linguistically Appropriate Services for Limited English Proficient Patients

By Cheri C. Wilson, MA, MHS candidate, CPHQ

This presentation:

- Described the need for culturally and linguistically appropriate services (CLAS) for limited English proficient (LEP) patients
- Identified how the lack of CLAS for LEP patients can adversely impact patient safety and healthcare quality
- Discussed experiences, lessons learned, and success stories from The Johns Hopkins Hospital and other organizations.

Scope of the Problem: U.S. Demographics

As the U.S. becomes increasingly diverse, healthcare organizations struggle to provide CLAS for LEP patients. Almost 35 million U.S. residents are foreign born.

Almost 19.7% of the U.S. population speaks a language other than English at home. More than 8.7% of the U.S. population speak English less than "very well" and are considered LEP. Between 1990 and 2000, 15 states experienced more than 100% growth in their LEP populations. In 9 states, more than 10% of the overall population is already LEP. By 2050, it is projected that minorities will constitute 50% percent of the U.S. population.

Federal Mandates and Regulations

- **Title VI** of the Civil Rights Act of 1964 considers the denial or delay of medical care due to language barriers to be discrimination. Any medical facility receiving Medicaid or Medicare must provide language assistance to LEP patients.
- **CLAS Standards** issued by the U.S. Department of HHS, Office of Minority Health and organized by themes into 14 standards for healthcare organizations.
- **The Joint Commission** has developed proposed standards to advance effective communication, cultural competence, and patient-centered care for hospitals, which if approved, would be implemented in January 2011. The Joint Commission standards are also cross-walked to the CLAS standards.
- The **National Committee for Quality Assurance (NCQA)** is developing standards for CLAS and disparities reduction, which are scheduled for release in mid-2009. In addition, the NCQA and URAC accreditation standards are cross-walked to the CLAS standards.
- In February 2009, the **National Quality Forum (NQF)** published "National Voluntary Consensus Standards for a Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency."

Patient Safety and Healthcare Quality Concerns

Of the six Institute of Medicine (IOM) Aims for Improvement, equitable care has received the least attention. Research studies have documented that the safety and healthcare quality of LEP patients can be diminished due to language barriers. One study found that in 46% of emergency department cases, no interpreter was used for LEP patients. In addition, only 23% of teaching hospitals train physicians how to work with an interpreter. A study analyzed 1,083 adverse incident reports from 6 Joint Commission-accredited hospitals for LEP vs. English-speaking patients for 7 months in 2005. This study found that a greater percentage of LEP patients experienced physical harm versus English-speaking patients, 49.1% and 29.5% respectively. The LEP patients also experienced higher levels of physical harm ranging from moderate temporary harm to death, 46.8% and 24.4% respectively.

In an effort to provide language services, healthcare providers have sometimes resorted to drastic measures. In many instances, a family member (or sometimes even a child) serves as an interpreter, which raises privacy and other concerns. Untrained interpreters are more likely to commit errors in interpretation that can lead to adverse clinical consequences. Even at healthcare organizations with ample CLAS resources, providers chose to "get by" without an interpreter. Occasionally, a bilingual healthcare provider may be present. However, this is not without its problems as well. Care can be compromised or delayed in the absence of any language service (trained or untrained). In other instances, the consequences can be catastrophic. For example, a patient was treated for a drug overdose for thirty-six hours instead of a brain aneurysm, when the healthcare team misunderstood the term *intoxicado* to mean "intoxicated" rather than "nauseated." The eighteen year old patient ended up a

quadriplegic and his family was awarded \$71 million in a malpractice settlement.

Best Practices

- The Johns Hopkins Medicine (JHM) International Call Center serves as the language resource center for the entire Johns Hopkins Health System.
- Adventist Health Care in Rockville, Maryland offers a Qualified Bilingual Staff program through its Center on Health Disparities.
- Hablamos Juntos suggests the use of “Universal Symbols in Health Care.”

Brief List of Resources

- Adventist HealthCare, Qualified Bilingual Staff Program
<http://www.adventisthealthcare.com/health-disparities/education.aspx>
- A Cultural Competency Standards Crosswalk: A tool to examine the relationship between the OMH CLAS Standards and Joint Commission/URAC/NCQA Accreditation Standards
http://www.urac.org/savedfiles/CLAS_Standards_Crosswalk_V2.pdf
- Flores, G. et al. (2003) “Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters” *Pediatrics* 111: 6-14.
- Flores, G. (2005) “The Impact of Medical Interpretation Services on the Quality of Health Care: A Systematic Review.” *Medical Care Research and Review* 62: 255-299.
- Flores, G. et al. (2000) “The Importance of Language and Culture in Pediatric Care: Case Studies from the Latino Community.” *Journal of Pediatrics* 137:842-848.
- Hablamos Juntos: Language Policy and Practice in Health Care
<http://www.hablamosjuntos.org/>
 - Universal Symbols in Health Care
<http://www.hablamosjuntos.org/signage/symbols/default.symbols.asp>
- Harsham, P. (1984) “A Misinterpreted Word Worth \$71 Million.” *Medical Economics* 61: 289-292.
- The Joint Commission. *Crosswalk of the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) and The Joint Commission's 2009 Standards for the Hospital Accreditation Program.*
<http://www.jointcommission.org/NR/ronlyres/02E99D6E-E4EA-4F6A-A31F-4A10CAE691DC/0/2009OMHJCCLASXwalkHAP.pdf>
- The Joint Commission. *Hospitals, Language, and Culture: A Snapshot of the Nation Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*, 2007.
http://www.jointcommission.org/NR/ronlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf
- The Joint Commission. “Proposed Requirements to Advance Effective Communication, Cultural Competence, and Patient-Centered Care for the Hospital Accreditation Program”
<http://www.jointcommission.org/NR/ronlyres/D44C4DE4-F5CD-4116-84AF-D5B3E8D4E94F/0/PDF1HAPProposedRequirements.pdf>
- National Quality Forum’s proposed “Framework and Preferred Practices for

Measuring and Reporting Cultural Competency”
<http://www.qualityforum.org/projects/ongoing/cultural-comp/>

- National Quality Forum. *Cultural Competency*
Member:
http://www.qualityforum.org/members/pdf/publications/Cultural_Competency_Rep.pdf
Non-member:
http://www.qualityforum.org/pdf/reports/Cultural_Competency_Nonmember.pdf
- National Standards on Culturally and Linguistically Appropriate Services (CLAS)
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>
<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidance/document.html>
- U.S. Department of Health and Human Services, Office for Civil Rights. *Guidance Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons. 69 Fed Reg. At 47311-47323.*

For a more complete list of resources, please contact Cheri Wilson at cwilso42@jhmi.edu.

Cause-and-Effect Diagrams

By Laura Schwartze, BSN, MS, CPHQ

A cause-and-effect diagram, also called a fish bone or Ishikawa diagram helps identify and illustrate the relationships between outcomes and the factors contributing to those outcomes. The ultimate goal being of a cause-and-effect diagram is to uncover the root cause(es) of a problem.

To create a cause-and-effect diagram, follow these steps:

1. Identify the outcome or problem statement. Place the outcome on the right side of the page, halfway down; draw a horizontal line across the middle of the page with an arrow pointing to the outcome.
2. Determine and define the major categories of variation that describe the system or process under review, e.g.,

5Ps

- People
- Provisions (supplies)
- Policies
- Procedures
- Place (environment)

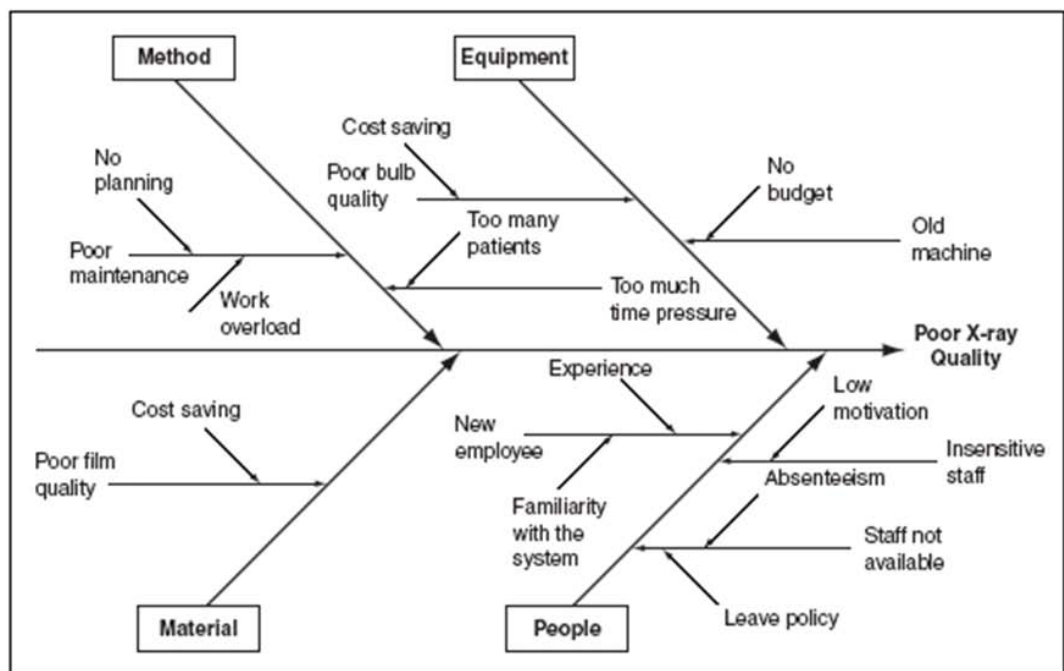
5Ms

- Manpower
- Materials
- Machines
- Methods
- Management

3. List the possible causes under each category by writing the cause on lines or bones branching off the category line.
4. Continue to dig for the causes for each branch of your chart until you reach what you believe to be the root cause of each bone. A good rule of thumb is to ask why five times to weed out the root causes.

5. Evaluate the draft diagram as a team to determine the accuracy of the placement of issues and lines.
6. Once the diagram seems appropriate to the team, further evaluate for:
 - Obvious improvement options
 - Causes already resolved or eliminated
 - Causes easily resolved or eliminated
 - Causes that are not amenable to change (or those you have no control)
 - Issues raised which require more in-depth investigation and assessment
7. Once you have narrowed down to a manageable number, collect data to draw accurate conclusions, and pursue appropriate solutions.

Poor X-ray Quality Cause-and-Effect Diagram



From NAHQ e-news

Major Health Reform Bills Include Quality Provisions

As health reform measures make their way through Congress, with the House of Representatives narrowly passing a health reform bill earlier this week, the issues of universal coverage, cost, and private versus public delivery have been at the forefront of the discussion. The major bills currently in play have included critical provisions addressing a host of areas, including improving quality and healthcare system performance.



Current Healthcare Reform Measures

There are currently three Congressional vehicles for healthcare reform:

1. The House Leadership Bill—The Affordable Health Care for America Act (H.R. 3962)
2. The Senate Health, Education, Labor, and Pensions (HELP) Committee Bill—Affordable Health Choices Act
3. The Senate Finance Committee Bill—America’s Healthy Future Act of 2009 (S. 1796)

With the House narrowly voting to approve the Affordable Health Care for America Act, the measure now moves to the Senate, where support is less certain. The Senate must now pass its own version of the healthcare bill, and Senate Majority Leader Harry Reid of Nevada recently signaled uncertainty over whether that will happen this year.

Quality Provisions in Healthcare Reform Measures

Below are a few highlights of the quality provisions in these three key healthcare reform bills. A complete side-by-side analysis of the three proposals is available on the [Kaiser Family Foundation’s Web site](#).

H.R. 3962: The House Leadership Bill

- Establishes a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of healthcare services and procedures
- Establishes the Center for Quality Improvement to identify, develop, evaluate, and implement best practices in the delivery of healthcare services
- Develops national priorities for performance improvement and quality measures for the delivery of healthcare services
- Requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies

S. 1679: Senate HELP Committee Bill

- Develops a national quality improvement strategy that includes priorities to improve the delivery of healthcare services, patient health outcomes, and population health
- Publishes an annual national healthcare quality report card
- Develops quality measures that allow assessments of health outcomes; continuity and coordination of care; safety, effectiveness, and timeliness of care; health disparities; and appropriate use of healthcare resources
- Creates a Center for Health Outcomes Research and Evaluation within the Agency for Healthcare Research and Quality to conduct and support research on the effectiveness of healthcare services and procedures to provide providers and patients with information on the most effective therapies for preventing and treating health conditions
- Requires hospitals to report preventable readmission rates
- Creates a Patient Safety Research Center charged with identifying, evaluating, and disseminating information on best practices for improving healthcare quality

S. 1796: Senate Finance Committee Bill

- Establishes a nonprofit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research comparing the clinical effectiveness of medical treatments
- Encourages states to develop and test alternatives to the current civil litigation system as a way to improve patient safety and reduce medical errors
- Develops a national quality improvement strategy that includes priorities to improve the delivery of healthcare services, patient health outcomes, and population health

Behavioral Health Treatment for the Suicidal Patient

Scott Beardsley, PhD

Identifying and appropriately managing the suicidal patient is crucial to all behavioral health professionals, regardless of employment setting. In the Joint Commission's National Patient Safety Goals (NPSG), goal #15 requires accredited facilities to identify individuals at risk for suicide. Elements of performance further require a full risk assessment of the individual, including an assessment of his or her environment; addressing the safety needs of the individual and the most appropriate treatment setting; and providing suicide prevention information to the patient and family upon discharge.



The National Committee for Quality Assurance (NCQA) requires Managed Behavioral Healthcare Organizations (MBHO) to collect and review information from identified adverse events when making recertification decisions. Several states, as well as the Centers for Medicare & Medicaid Services (CMS), are creating rules requiring third-party payers to withhold payment for any care provided to a patient as a result of a preventable serious reportable event. As a result, not adequately identifying and managing the suicidal patient can result in loss of accreditation, credentialing, and payment.

Examining Suicide Risk

Sentinel Event committees at MBHOs review medical records after a serious suicide attempt in a facility to identify opportunities for improvement in patient safety. Most often, completed suicides occur during the transition from an inpatient to outpatient setting. Opportunities exist to improve patient safety and decrease risk to facilities by following some basic care guidelines.

These guidelines provide for a thorough assessment of the patient at discharge, including an evaluation of where the member will live after discharge. Is it a stable environment? Does the member have supportive friends or family who will encourage continued treatment? Although not current, the [guidelines](#) published by the American Psychiatric Association in November 2003 provide good suggestions on how to assess suicide risk.

Creating a Discharge Plan

In addition, a discharge plan should be in place before the patient leaves the hospital. The plan should be set up with the full participation and cooperation of the patient and family, if appropriate. Facilities should identify any barriers to the patient keeping the

follow-up appointment and help eliminate these barriers. Coordination with the outpatient provider will also reduce risk and assist the patient in following through with discharge plans.

MBHOs have a vested interest in helping facilitate the transition to other treatment settings and can be an added resource to help with discharge planning. Many MBHOs have intensive care-management services for high-risk members and can provide additional services and outreach. Hospital staff should be encouraged to ask the MBHO about these resources. Patients should have a full understanding of their discharge medications, including dosing, timing of expected improvement, and potential side effects. This information will help them communicate effectively with other healthcare providers and will help maintain adherence.

Finally, all treatment providers should be aware of the discharge plan and patient's suicide risk, and this risk should be clearly communicated to those who will be responsible for each aspect of care. Medically complicated and substance-abusing patients can have an especially high risk of adverse outcomes and need to be managed in a coordinated manner. The healthcare quality professional is in a unique position to lead quality improvement activities to ensure that all aspects of identifying and managing suicidal patients are functioning adequately.

Scott Beardsley, PhD, senior director, Quality Improvement, United Behavioral Health, Philadelphia, PA. Beardsley is team leader of the Behavioral Health SIG.

Joint Commission Q&A

Question: What is The Joint Commission's position on healthcare reform?

Joint Commission: The Joint Commission believes it is essential that any healthcare reform package include a dedicated infrastructure for quality reform. Our position is outlined on the [Joint Commission Web site](#). "As President Barack Obama and Congress wrangle over how to reform the healthcare system, let's not lose sight of one of the most urgently needed reforms - quality improvement," explains Joint Commission President Mark Chassin, MD. He notes that if healthcare were as safe as commercial air travel, there would be sufficient funds to extend health insurance to all Americans. Add in the consequences of inappropriate use of health services—for example, antibiotics for colds—and the possible savings are enormous.

Chassin points out that other industries, such as nuclear power, manage risks every bit as hazardous as those in healthcare but with much higher levels of safety. Yet, the healthcare system has been slow to adopt proven approaches to successful results.

Quality improvement reform would

- address the capacity of organizations to deliver robust process improvement
- harness expertise to create scalable and specified solutions so all organizations could combat the most serious and thorny patient safety issues
- give healthcare providers tools essential to delivering cost-effective care, eliminating preventable complications, and achieving significant reductions in healthcare-acquired infections, rehospitalizations, and unnecessary tests.

Many others in healthcare also hold these views. The Joint Commission is a supporter of [Stand for Quality](#), a diverse coalition of more than 165 organizations that has put together a framework outlining ways the public and private sectors can work together as a coordinated quality enterprise.

Transforming the entire healthcare system will require a new focus by many stakeholders on how quality improvement dollars are spent. The Joint Commission is committed to doing its part to move healthcare along this new pathway to safety.



HHS Awards \$17 Million to Fight Healthcare-Associated Infections

U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius recently announced the award of \$17 million to fund projects to fight costly and dangerous healthcare-associated infections (HAIs). HAIs are one of the most common complications of hospital care. Nearly 2 million patients develop HAIs, which contribute to 99,000 deaths each year and \$28–\$33 billion in healthcare costs. Of the \$17 million in new awards, \$8 million will fund a national expansion of the Keystone Project, which, in the span of 18 months, successfully reduced the rate of central-line blood-stream infections in more than 100 Michigan intensive care units, saving 1,500 lives and \$200 million.



The project was originally started by the Johns Hopkins University in Baltimore and the Michigan Health & Hospital Association to implement a comprehensive unit-based safety program. The program involves using a checklist of evidence-based safety practices; staff training and other tools for preventing infections that can be implemented in hospital units; standard and consistent measurement of infection rates; and tools to improve teamwork among doctors, nurses, and hospital leaders. Earlier this year, the Agency for Healthcare Research and Quality (AHRQ) funded an expansion of this project to 10 states.

With additional funding from AHRQ and a private foundation, the Keystone Project is now operating in all 50 states, Puerto Rico, and the District of Columbia. The new funding will expand the program to more hospitals, extend it to other settings in addition to intensive care units, and broaden the focus to address other types of infections. In addition, AHRQ, in collaboration with the Centers for Disease Control and Prevention, also identified several high-priority areas to apply the remaining \$9 million toward reducing methicillin-resistant staphylococcus aureus (MRSA) and other types of HAIs. To read more about AHRQ's 2009 funded projects to prevent healthcare-associated infections, visit www.ahrq.gov/qual/haify09.htm.

Time to Recertify Your CPHQ Credential



Nearly 40 members sat for the CPHQ exam at the NAHQ National Educational Conference last month. Have you checked that certificate on your wall to see whether your CPHQ certification is up for renewal this year? Remember, certification renewals are due every 2 years, and you have until December 31 to record your hours and recertify. Don't be caught unaware! Half of those who lose their certifying credential do so

because they were not aware of when their recertification cycle ended.

Although the Healthcare Quality Certification Board (HQCB) sends out periodic reminders, it's up to you to get your recertification materials into HQCB on time. If you lose your credential, you must sit for the exam again to regain certification. Simply [click here](#) to recertify online or download an application to mail or fax to the HQCB. You can record your continuing education hours on the Web site. To ensure you receive your recertification reminders, be sure to contact HQCB at 800/346-4722. For frequently asked questions, visit www.cphq.org/2FAQs.html.

DID YOU KNOW.....

.....We encourage you to submit an article, which may be about an interesting session or seminar that you have attended, your recent experience with JCAHO, project results, study or research results, or anything that would be of interest to quality professionals. If you submit an article that is published in the newsletter, you will receive a complimentary conference registration to be used during the upcoming year (excluding the CPHQ review course). Please email your submission to the Newsletter Committee Chair Laura Schwartze at laura.schwartze@hughes.net

BOARD MEETINGS OPEN TO MEMBERS

Board of Director's meetings is held monthly, ten months of the year. Meetings are usually held on the fourth Thursday evening of the month in rotating locations, for the convenience of the Board members. Some meetings are now conducted via teleconference. We welcome the attendance and input of the general membership, at all meetings. Contact any Board Member by email for information and directions. Verify the location and time on the morning of the meeting.

MARYLAND ASSOCIATION FOR HEALTHCARE QUALITY BOARD OF DIRECTORS 2009

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