



THE LIGHTHOUSE

**The official publication of the Maine Association
 Medical Staff Services, published by and for the
 MeAMSS membership.**

President's Message

By Frederica Jackson, CPMSM

**May/June 2005
 Volume 5, Issue 3**

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**We're on the Web! Meamss.org
 Check us out!**

Next Newsletter Deadline: June 24

Hi all – greetings from Portland. I hope everyone is enjoying the lovely Spring weather we've waited so long for.

Just a few quick things:

Our next Board meeting will be held on May 13th, and we will be touring Maple Hill Farm in Hallowell (a potential location for our 2006 educational conference). If anyone has hot topics you'd like us to discuss, please forward them to me.

Also, I'd like to urge everyone to consider nominating one of our members for the Golden Star award. There is a lot of amazing work being done in the organization, and it's always so nice to be recognized for a job well done. Thank you to Kim for heading up this process.

I guess that's it for now. Hope to see everyone at the next Association meeting which will be held in conjunction with the Maine Hospital Association Summer Forum in June.

Freddie

The Value of Education

By Kim Pelletier, CPMSM

I am writing today specifically to those who believe they cannot take a day out of the office to attend the MeAMSS' education sessions. I am here to tell you, "YOU CANNOT AFFORD NOT TO ATTEND!"

It all began with Kay Pierson's disaster privilege presentation. She chronicled a member of her family's harrowing experience as a resident of Punta Gorda, Florida during hurricane Charley's recent devastation. On a visit there to comfort her brother and sister-in-law, she also paid a visit to the local medical staff service professional to discuss how she had prepared for the disaster. The findings were essential to our work here and I have a lot to share with my hospital as a result. What I will share, I truly believe, will make the difference between an adequate disaster plan and an outstanding one.

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Credentialing (or Membership)-and-Privileging Is Not One Word What They Mean, and Why It's Important for You to Know

By Cheryl Schilke, RN, CPMSM

Because we tend to say these words with one breath, there is a widespread belief, even among some of our own medical staff leaders, that it is all one process with one purpose. The situation gets even murkier when the talk turns to provisional status. So let's set the record straight.

Membership on the medical staff may be granted with or without clinical privileges. Physicians may desire and hospitals may accommodate request for membership for a number of reasons. Medical staff membership is a prerogative granted by the Board of Trustees to individuals who meet criteria defined by the medical staff. However, meeting membership criteria does not, in and of itself, entitle a physician to appointment to the medical staff. The Board also wants individuals who are interested in promoting and helping the hospital achieve its mission. Medical staff members may contribute to the hospital mission by generating revenue by admissions, referrals, or outpatient procedures; by assisting in meeting patient care responsibilities by providing subspecialty consultations; by assisting the educational responsibilities by serving as faculty or preceptors for a residency program or providing continuing medical education lectures; by conducting research or obtaining research grants; or by helping the medical staff meet its medico-administrative obligations to the board by taking an active role in peer review, by accepting committee assignments, and by attending meetings.

Credentialing is the process of collecting information and verifying

basic membership criteria. Such criteria usually include education, training, and licensure. It may also include geographic limitations, professional liability insurance, character-based criteria such as ability to get along with others and behave in an ethical manner, be free from health-related limitations and board certification. Membership criteria should also include willingness, for initial applicants, and demonstrated support of the hospital at the time of reappointment.

Clinical privileges are the permission granted by the Board of Trustees to treat specific conditions or perform specific procedures within the walls of the hospitals. While information in support of privileges may be collected during the credentialing process, privileging has its own set of criteria and privileges may be granted without membership (e.g., allied health professionals). Privileging criteria demand evidence of clinical competence and professional liability insurance. If a physician does not have sufficient volume at the hospital to adequately assess competence as defined by the privileging criteria and cannot provide such evidence from another acute care facility, the physician may be allowed to retain his medical staff membership, but may not be granted clinical privileges.

The medical staff defines, and recommends to the Board, the criteria necessary for each and every privilege or core privilege group provided by the hospital. When the hospital decides to offer a new service or new technology creates new privileges, the medical staff must define the criteria for the

privilege prior to accepting a request for that privilege.

Every request for new privileges, either on initial appointment (or for new privileges), should be accompanied by a provisional period of heightened scrutiny to ensure the provider is truly competent. This provisional period is necessary as the initial granting of a privilege is usually based on someone else's judgment, a trainer or another medical staff leader. The provisional period can be different for different specialties. For example, hospital based docs (ER, anesthesia, radiology or pathology) may see enough patients in one week to ensure a reviewer that they are competent. Family practice providers may need a whole year, or even two, to have sufficient admissions to make that judgment. The method of scrutiny may also be different (record review, direct observation, over-reads). The medical staff should help define what, in terms of length of time or volume of work, would make the reviewers comfortable asserting a provider is competent. Clinical privileges are then granted with a provisional period defined by specialty. At the end of the provisional period, the chief makes a written recommendation to remove provisional status, continue it for a defined period not to extend beyond 24 months or to initiate a corrective action plan to address performance deficiencies. The recommendation is forwarded to the credentials committee, medical executive committee, and the board for their information, if there are no concerns, or for action if corrective action is required.

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Credentialing/Privileging
Continued from Page 2

Rarely would medical staff membership be provisional. The one common exception to that rule is a board certification requirement. Surgeons must be in active practice for a period of time before completing their board certification exams. As a consequence, hospitals that require board certification for medical staff membership often allow up to five years post residency/fellowship training to obtain board certification. Failure to do so may result in termination of membership. If your medical staff bylaws contain such a provision, it would be correct to say the appointment is provisional until board certified or five years, whichever comes first. Clinical privileges, however, may be provisional at any time during a physician's tenure on the medical staff after every request for new or additional privileges.

So slow down, take a deep breath, and pronounce those words one by one. They are actually two separate decisions with two separate sets of criteria.

Reprinted with permission from the January/February 2005 issue of *SYNERGY* magazine, the official publication of the National Association Medical Staff Services.

About the author: *Cheryl L Schilke, RN, CPMSM, has worked in the healthcare industry for many years as a nurse, in performance improvement, risk management, and as a hospital medical staff coordinator. She has been involved in credentialing since 1992 and is the founder and past president of the Maine Association Medical Staff Services. She is a Certified Professional, Medical Staff Management.*

Network Questions

Network question: Do changes to a privilege form need to be submitted to the Board of Trustees for approval?

Answers:

1. When there are minor changes to our privileges forms, we do not take them to the Board of Trustees for approval. We did receive approval from the Board to switch to core privileges, but we are not bringing the individual forms to them for approval.
2. Yes.
3. Our Medical Executive Committee minutes go to the Board each month and the Board votes to approve those minutes, therefore, anything in the minutes is approved by the Board. We wouldn't go into detail about the changes, but we would make mention of it in the minutes.
4. As long as the Bylaws/Rules & Regs don't require it I don't believe changes have to go to the Board. At least we don't send them. Credentials/Medical Executive Committee is enough.
5. Anytime we revise our privilege forms, we send them to our Board of Trustees for approval. It is conceivable that the Board would not allow certain procedures to be performed at a facility; therefore, they have the final say on what is included on these forms.
6. All credentialing forms need approval by the medical staff, but I've never seen any reg. that requires Board approval. I don't take any forms beyond the Medical Executive Committee.
7. We do not take a change in privilege forms anywhere. They

are approved by the chief. Changes to someone's privileges do go to the Board (after all of the other committee approvals) for their approval.

8. We send our privilege forms to the Board for approval. Our president's theory is that the Board is ultimately responsible for what procedures are done in the hospital, so they should approve the forms.
9. Well, you're going to get a mixed message from me, too. When we make small changes (additions/deletions) we don't send them to the Board (but they are, in effect, approved by the Board through the Board approval of the Medical Executive Committee minutes). When we've done major overhauling of privileges (we recently broke out all the different surgeries into separate forms and made numerous changes on them), we have sent those to the Board.
10. I would say yes.

Submitted by Kim Pelletier, CPMSM

Below is a summary of the midwife survey sent to MEAMSS members as to whether CNMs can admit and practice independently (without any plan of supervision or agreement).

12 hospitals responded:
4 hospitals allow certified nurse midwives to admit, but none of the facilities allow them to totally practice independently. They all have a supervisory arrangement/plan of supervision of some sort.

Submitted by Barbara Allen, CPMSM
Stevens Memorial Hospital

See EMTALA-related article on CNMs on Page 7

UPCOMING EDUCATIONAL MEETING DATES

By MaryCarol Rumsey, CPMSM

ZEAL WITHOUT KNOWLEDGE IS THE SISTER OF FOLLY
Sir John Davies

The Education Sessions for 2005 have been scheduled for the following dates and locations:

March 18, 2005

St. Joseph HealthcarePark
Bangor

June 23, 2005

MHA Summer Forum
The Samoset, Rockland

September 09, 2005

Waldo County Hospital
Belfast

November 4, 2005

Mid Coast Hospital
Brunswick

***Please note that the September Education Session has been changed to September 9th from the 16th**

HELPFUL WEBSITES

- jcaho.org
- namss.org
- docboard.org
- msleader.com
- msspnextus.com
- qualityforum.org
- credentialinfo.com

The Value of Education

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Next, Randal Manning spoke about licensing issues. But first, he let us know how impressed he was with the disaster privilege discussion that took place as a result of Kaye's presentation and our preparedness. The main question he had for us was, "how do you define professional behavior?" You would have had to attend to learn the answer.

Freddie Jackson led discussion during our MeAMSS Business meeting during a wonderful lunch prepared by the St. Joseph Dietary staff and a significant amount of interesting information was shared. You could have found out what your Board members have been doing on your behalf over the past year or so.....had you attended.

Claudia Edwards presented "The Art of Minute Taking". Now we all take minutes, but Claudia's presentation shed some light on the important parts that you may be leaving out, or not even considered, as well as providing samples of various minutes formats. I am going to propose one of those formats to my hospital as it is much more attune to our needs than what we are currently using.

Lastly, Ron Lambert gave a presentation on Core Privileges. This was important in light of the recent bantering between the various regulators. Ron shared his process and sample forms and significant discussion took place regarding privileges spanning specialties, what happens to the laundry list, etc.

So, the next time you think you just cannot leave the office, think about the pertinent, insightful topics above. Think about those nagging questions that you could have gotten answered. Think about the fact that, although each of us would be missed briefly, someone would be chosen rather quickly to fill our shoes and move on were we to leave for whatever

reason. Make yourself a valuable player of the team – make the time to attend the MeAMSS education sessions. Everyone benefits!

My Experience as a New Board Member

By Melissa Tibbetts, Board Secretary

Happy spring to every member and everyone! It is such a wonderful time of year, isn't it? I wanted to express my excitement thus far towards my participation as a new board member. Obviously there are always adjustments that are needed when taking on new tasks or positions however this change has not been as grueling of a task as one would think. I have taken the opportunity to be the Secretary for the MeAMSS Board and I have done this with the guidance of fellow board members. Everyone is so helpful and this is such a wonderful group of people to work and network with. I am so glad I took the opportunity to participate not only as a MeAMSS member but also as a Board member - it has really helped to broaden the horizon! I highly encourage other members to take the opportunity to broaden their horizon by opting to *run* for a position on the board in the near future. And maybe it is not just about *running* for the board but maybe you have a great topic you would like to lead a discussion on at the next educational session. There are so many knowledgeable and talented individuals that are part of the MeAMSS membership – wouldn't you like to be recognized for sharing your knowledge and talent with others???

Motivation is a fire from within. If someone else tries to light that fire under you, chances are it will burn very briefly. - Stephen R. Covey

Credentialing Potpourri

Is the provider's SSN required to obtain a successful NPDB query?

No. Although there are minimum query input requirements, the querier should enter as much identifying data as possible to ensure an accurate match to reports stored in the NPDB-HIPDB database. If the SSN is unknown/not entered, you must enter either the Individual Taxpayer Identification Number (ITIN), or the professional School, Year of Graduation, State of License, and License Number.

(Source: *Data Bank News, April 2005*)

If an application is received with portions completed and then a note that says 'see CV', should you consider this a completed application?

An application left blank or portions not completed should be considered an incomplete application and returned to the applicant. The additional CV is helpful in providing information but could be detached during processing.

Credentialing Clinical Counselors

Are you aware of the minimum continuing education requirements for counselors? A licensee must achieve a minimum of 55 contact clock hours during a 24-month period. A minimum of 4 of those hours shall be specifically designated as continuing education in professional ethics related to their specialty. 15 contact hours shall be supervision received by the licensee and provided by a licensed professional. Supervision may be individual or group. The remaining 36 contact hours shall be in the theory and practice of professional counseling. **Tip: In your cover letter at time of reappointment, you might request the name(s) of the counselor's supervisors as references.**

Letter to the Editor

I just finished reading the March/April edition of the Lighthouse. Excellent job! The articles were well thought out and well written. My congratulations to all those who contributed.

I would like to add a caveat to the "Credentialing Potpourri" item about professional liability insurance certificate holders. Being a certificate holder does not necessarily mean that you will be notified of cancellation. In fact, there is a disclaimer usually printed right on the certificate saying they will try, but will not guarantee notification. The real advantage is that renewal certificates are sent automatically and you need not follow up with the provider annually. So being a certificate holder is a time saver for the medical staff office, but does not need to be a requirement for credentialing or privileging.

**Cheryl Schilke, RN, CPMSM
03/21/05**

Editor's Note

We thank Ms. Schilke for her compliments and clarification from last month's *Credentialing Potpourri*.

Welcome New MeAMSS Members

The Board would like to welcome the following new MeAMSS members:

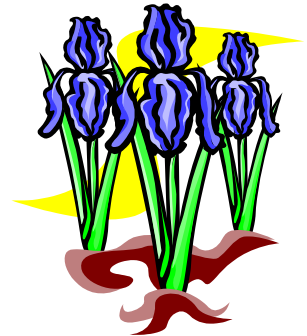
Kandi Brown
St. Joseph Hospital

LuAnn Coleman
Maine Network for Health

Martha Holden, BSHCA
Bridgton Hospital

Susan Pottle
Down East Community Hospital

Melinda Wood
Maine Network for Health



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From NAMSS

Applications for the September 18, 2005 or the November 5 - 19, 2005 Certification Examinations may now be submitted. The deadline is past for the certification exams being offered in June.

The Candidate Handbook is the primary source of preparation information for the interested certification examination applicant.

CPMSM and CPCS certification exams will be offered in paper and pencil ONLY format at the 2005 NAMSS Annual Conference, Phoenix, Arizona, Pre-Con Session, Sunday, September 18, 2005, 8 am-12 noon. **Deadline for Application:** August 1, 2005 **Exam Fee:** Current NAMSS Member \$350, Other Candidates \$475

Candidates interested in sitting for the Certification Examination in June or November 2005 have the opportunity to apply under either the new 2005 eligibility routes or the 2004 eligibility routes.

CPCS

2005 Eligibility Requirements:

1. Be employed in the medical

services profession for THREE years.

2. Be a Certified Professional in Medical Services Management in good standing.

2004 Eligibility Requirements:

1. Be employed in the medical services profession for FOUR years.
2. Be a Certified Professional in Medical Services Management (CPMSM) in good standing.
3. Be employed in the medical services profession for THREE years and have completed NAMSS Independent Study Courses 4 & 5.
4. Be employed in the medical services profession for TWO years and have completed an Associate Degree program or 15 college credits from a college of university accredited by one of the six regional accrediting bodies listed in this Handbook AND NAMSS Independent Study Courses 4 and 5.

CPMSM

2005 Eligibility Requirements:

1. Be employed in the medical services profession for FIVE years.
2. Be a Certified Provider Credentialing Specialist in good standing and be employed in the medical services profession for THREE years.

2004 Eligibility Requirements:

1. Be employed in the medical services profession for SEVEN years.
2. Be employed in the medical services profession for FIVE years and have completed all NAMSS Independent Study Program Courses.
3. Be employed in the medical services profession for THREE years and have completed a minimum of 60 college credit hours from a college or university accredited by one of the six regional accrediting bodies listed in this Handbook.

See Page 8 for Acronyms to Study

From the Board of Licensure in Medicine

The moratorium on PA/NP prescriptive authority has been lifted. Interested parties may access instructions by going to the Board's website address at http://www.docboard.org/me/me_home.htm. Click on Policies and scroll down to Prescriptive Authority for Physician Assistants (this policy also addresses prescriptive authority for advanced practice nurses). Please be advised that the Maine chapter of ACEP (American College of Emergency Physicians) will be providing the Board with recommendations regarding the prescribing of Schedule II medications from the Emergency Department. Those guidelines will be published when finalized.

Also, please note that, in order to maximize staff efficiency and effectiveness, the Board is now limiting phone verification requests from credentialers to 3 per call. The Board encourages credentialers to either use its web site or to buy the monthly list of licensees, which contains addresses also. The Board updates its web site daily. (Note: If your telephone calls involve verifying a license that appears to have expired on the web site or is listed as pending renewal, you can request via fax at 287-6590 a letter confirming receipt of a renewal application, said confirmation allows you to consider the license as active.)

The Importance of Communication

By Claudia J. Edwards, CPMSM

Privilege – according to Webster’s Collegiate Dictionary, privilege is a right or immunity granted as a peculiar advantage or favor, a personal right, especially in derogation of common right.

Hmm, it’s interesting to learn how each of us interprets language.

For example, I was speaking with Jeff of our IS department the other day about the upcoming intranet service that the IS Department was developing. To show you how technologically unsophisticated I am, I asked him to explain. ‘Basically, it’s an in-house web page.’ ‘Oh, I said. Will I be able to display medical staff privileges on it?’ ‘Privileges? No. Not everyone will have privileges to the intranet.’ Jeff explained which computers would have privileges to the intranet. I looked at him puzzled. ‘I envisioned I could create a file in which all staff could view practitioners’ privileges.’ Jeff looked at me and stated that I couldn’t have privileges to all the files. I looked at him puzzled again. ‘Why not?’ ‘Because only a select few have access to most of the data on the intranet.’

Suddenly came the dawn! I said, ‘I’m not talking about accessing the files in the system. I’m talking about being able to somehow show the entire organization which practitioner has what privilege.’ ‘Privilege?’ he said. ‘What are you talking about?’ I had to explain that **members of the medical staff** are granted privileges that define what they can and cannot do in terms of medical/surgical treatment in the hospital. ‘Oh, he said, privileges to me means access.’

This is just something to ponder when speaking with people. I guess there’s truth in the old adage: Know your audience! What may seem

clear to you is a foreign language to your listener.

Certification of False Labor

The EMTALA regulations state, while a qualified medical provider can, under special circumstances, perform a medical screening exam, they do in one place state that a woman experiencing contractions is to be considered to be in active labor unless a *physician* certifies that she is in false labor.

CMS has literally interpreted this regulatory language in a letter to

Regional Administrators on January 16, 2002, and included similar interpretation in the most recent surveyor interpretative guidelines May 13, 2004.

On Page 32 of the interpretive guidelines: "If a QMP other than the physician (Registered Nurse, Physician Assistant, etc.) determines a woman is in false labor; a physician must certify the diagnosis" The letter to regional administrators states "When a QMP diagnoses a woman to be in "false labor," a physician is required to certify that diagnosis before the patient can be discharged."

Health Message

The three questions described below are from the Cincinnati Stroke Scale, a tool used by pre-hospital personnel to determine the presence of a potential stroke. ACLS encourages the use of the scale to enable EMS personnel to recognize a possible stroke and to alert the ER so that a "Stroke Protocol(including timely TPA.) could be implemented. We thought our readers might find this article beneficial.

RECOGNIZING A STROKE - A true story (Author Unknown)

Susie is recouping at an incredible pace for someone with a massive stroke all because Sherry saw Susie stumble --that is the key that isn't mentioned below - and then she asked Susie the 3 questions. So simple - this literally saved Susie's life. Some angel sent it to Susie's friend and they did just what it said to do. Susie failed all three so 911 was called. Even though she had normal blood pressure readings and did not appear to be a stroke as she could converse to some extent with the Paramedics they took her to the hospital right away. Thank God for the sense to remember the 3steps!

Read and Learn!

Sometimes symptoms of a stroke are difficult to identify. Unfortunately, the lack of awareness spells disaster. The stroke victim may suffer brain damage when people nearby fail to recognize the symptoms of a stroke. Now doctors say a bystander can recognize a stroke by asking three simple questions:

***Ask the individual to SMILE.**

***Ask him or her to RAISE BOTH ARMS.**

***Ask the person to SPEAK A SIMPLE SENTENCE.**

If he or she has trouble with any of these tasks, call 9-1-1 immediately and describe the symptoms to the dispatcher.

After discovering that a group of non-medical volunteers could identify facial weakness, arm weakness and speech problems, researchers urged the general public to learn the three questions. They presented their conclusions at the American Stroke Association's annual meeting last February. Widespread use of this test could result in prompt diagnosis and treatment of the stroke and prevent brain damage.

ACRONYMS - A STUDY GUIDE FOR CERTIFICATION

ABMS	American Board of Medical Specialties	Umbrella organization for medical specialty boards that certify physicians training based on established graduate medical educational standards
ACGME	American College of Graduate Medical Education	Responsible for the accreditation of post-MD medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines
ADA	Americans with Disabilities Act	The Americans with Disabilities Act gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications
AHP	Allied Health Practitioner	Non-physician practitioner, defined in one's bylaws
AMA	American Medical Association	Important to obtain the AMA Code of Ethics. State licensing boards and medical staff bylaws expect physicians to abide by the AMA Code of Ethics
CME	Continuing Medical Education	All practitioners must obtain a certain number of education credits in order to qualify for renewal of licensure. Hospitals use the CME log provided at time of appointment/reappointment as a tool in monitoring current competence
CMS	Centers for Medicare & Medicaid Services	Formerly HCFA – Health Care Finance Administration – responsible for administering Medicare and Medicaid programs
COBRA	Consolidated Omnibus Budget Reconciliation Act	COBRA is a U.S federal statute from 1986 known best for its provisions that modified the <u>Employee Retirement Income Security Act</u> (ERISA), a federal law governing employee benefit plans, to require those plans to provide the right to choose to continue group <u>health care</u> benefits provided by their group health plan to workers and their dependents who have lost their health care benefits under certain circumstances. COBRA also provides similar protections for employees and their dependents who participate in "governmental plans", that is, employee benefit plans established by state and local governmental entities for their employees that would not otherwise be covered by ERISA. Employees of the federal government, who are likewise not covered by ERISA, are also entitled to similar protections
CVO	Credentials Verification Organization	Provides credentials verification services for managed care organizations and/or healthcare delivery organizations or providers (e.g. HMOs, PPOs, PHOs, hospital provider groups)
DEA	Drug Enforcement Agency	Registration to have prescriptive authority for controlled substances
DRG	Diagnosis Related Group	Method to code medical records
ECFMG	Educational Commission for Foreign Medical Graduates	The purpose of ECFMG Certification is to assess the readiness of international medical graduates to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME). To be certified by ECFMG, you must pass a series of exams; you must also provide ECFMG with copies of your medical education credentials, which ECFMG will verify directly with your medical school

Reminder from the Editor: Anyone who submits an article or credentialing tidbit that is published in the newsletter will be included in the drawing held at the September meeting for a one-year MeAMSS membership.

Contributors to date: Barbara Allen, CPCS; Joyce Allen, CPMSM; Claudia Edwards, CPMSM; Frederica Jackson, CPMSM; Kim Pelletier, CPMSM; MaryCarol Rumsey, CPMSM; Cheryl Schilke, RN, CPMSM; and Melissa Tibbetts, Board Secretary.

Claudia J. Edwards, CPMSM, Editor