The Bulletin

THE MEDICAL SOCIETY, COUNTIES OF ERIE AND CHAUTAUQUA

FALL 2018

Medical Society of the County of Erie and
Medical Society County of Chautauqua
1317 Harlem Rd.
Buffalo, NY 14206

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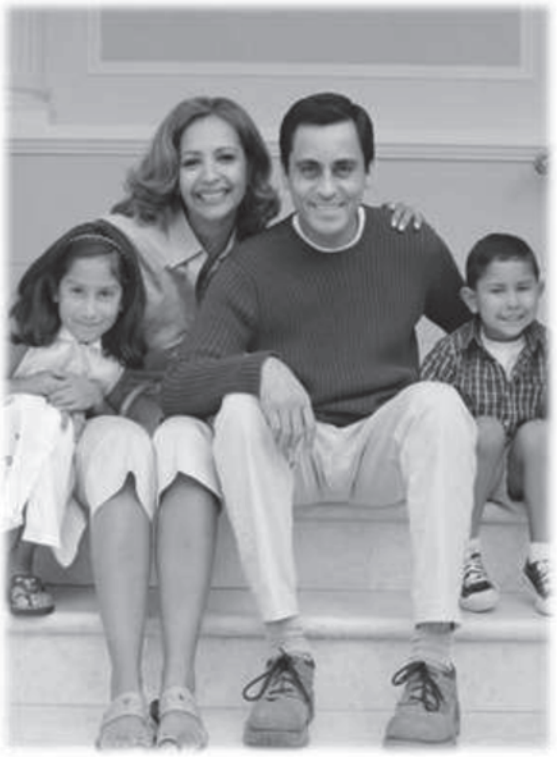

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St. Luke's Mission Toy Drive

This year the Erie County Medical Society will be collecting toys for the St. Luke's Mission of Mercy, for children ages 0-18 at our office location at 1317 Harlem Road. We are asking that our members please drop of a **NEW** toy, hat/gloves, books, stocking stuffers, gift cards etc. to help aid the 2400 children representing almost 800 families who are in need this holiday season.

Donation Drop Off Location:

Erie County Medical Society
1317 Harlem Road
Buffalo, NY 14206

Hours:

8:30AM - 4:30PM
Monday - Friday

DONATIONS WILL BE ACCEPTED BY THE MEDICAL SOCIETY
MONDAY, SEPTEMBER 17th - FRIDAY, NOVEMBER 30th

If you have any questions regarding donations, please contact Emily McMullen at 716-852-1810 x 102 or mcmullene@wnydocs.org

** Please note at this time no toy guns or summer toys will be accepted for donation.*

Table of Contents

The Bulletin

Medical Society, Counties of Erie and Chautauqua

Medical Society, County of Erie
"Better Health Through Advocacy"™
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OFFICIAL PUBLICATION
Medical Society of the County of Erie
Medical Society of the County of Chautauqua

MEDICAL SOCIETY WEBSITE:
www.eriemds.org

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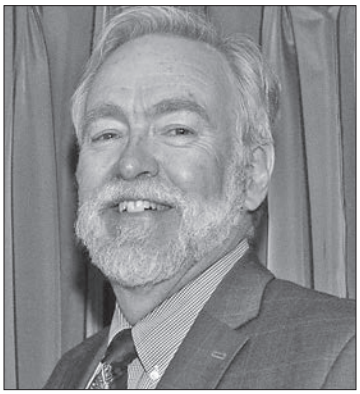
A Message from the President

John A. Gillespie, M.D.



Fellow Providers as we approach fall, I would like to review the Medical Society's major goals for this year.

1. To increase the membership of our organization.
2. To better inform our membership of the goals of the state Political Action Committee (MSSNYPAC) and what the MSSNYPAC accomplishes.
3. To advocate for the physicians on Value Based Payment (VBP) arrangements with the payors especially regarding audits and contracts.
4. To encourage each of you to be politically active this year across both parties to help ensure that everyone has access to quality care.

Addressing the first goal, the Medical Society sponsored lunch for the UB first year students on August 14th. Many thanks to Dr. David Milling for his assistance in arranging this meeting. As a result of the 2018 MSSNY House of Delegates meeting, all medical students are exempt from any dues for the state or county membership. The presentation focused on the following:

1. Membership is free for students.
2. This is a great opportunity to join an organization of your peers and evaluate its strengths.
3. There are many opportunities for students to volunteer to serve on committees such as health law, public health, health policy etc.
4. It opens the door for shadowing physicians in their area of interest.
5. It offers opportunities to learn about the business of medicine, Value Based Payments, contracts, the pros and cons of being self-employed vs employed.
6. We asked them for help in designing our website to make it more user friendly.

Our major point was that we wanted to hear from the students about which areas they would want to pursue. This meeting continued the work that Chris Nadolny and the Executive Board of the Medical Society have been pursuing during the past year.

Obviously our hope is if they become active members of the society as students that they will continue as members into residency and practice.

Equally important is that we need our current membership to continue to recruit new members to our society. Physicians need to protect their profession through organizations that have a broad base. Please help us recruit more members.

Numbers 2 and 4 can be easily combined. We all need to support members of both state and national legislative bodies that will advocate for our profession. Key areas remain such as malpractice rates and laws, fair and equitable reimbursement rates, tort reform, scope of practice, accessibility to care, elimination of pre-existing conditions that prevent insurability and protection of those members that choose to deal with the opioid epidemic.

We need to contribute to the MSSNYPAC and work for candidates that will help our cause. If you are friends with a candidate that supports physicians, help them get elected whether through contributions to their campaigns or working the streets for them.

We will continue to work with the MSSNY to simplify their message on what the MSSNYPAC does and accomplishes.

As for number 3, we will continue to actively support physicians with any audit that they need help with. We will interact and advocate for better VBP contracts for all physicians. The office of the Medical Society will continue to be available and support our members.

I would like to thank you for your continued support of our efforts and committees.

John Gillespie

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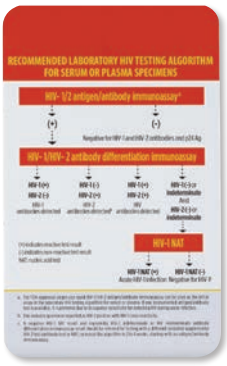

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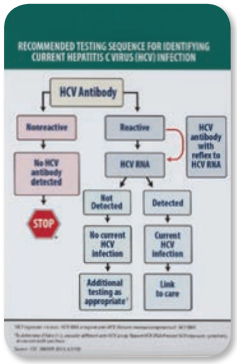

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A Message from the Executive Director: Focus on the Future

Christine Ignaszak Nadolny

One of the most rewarding elements of my position as Executive Director is finding opportunities to speak with individuals and groups about the Medical Society – its mission and vision. During the past few months, more events took place that provided that opportunity.

As Dr. Gillespie has pointed out, we met with 180 first year medical students to encourage them to take advantage of "membership without dues". At the MSSNY House of Delegates meeting this past March, the delegation unanimously passed a resolution to offer all enrolled students' free membership. I'm happy to report that over 50% of the class has already signed up, and a number of them have stated their willingness to become more involved in subsets of our public health and legislative committees.

Recently Doctors Gregory Bennett, Gale Burstein, Ernesto Diaz-Ordaz, Julie Faller, Aravind Herle, John Gillespie, Carlos Martinez and 4th year medical Student Moudi Hubeishy participated in a round table discussion with pre-med students enrolled at Canisius, Niagara and UB. You might ask why waste time with pre-med students? Who knows how many may ultimately be accepted into a med school? I'm happy to report that everyone who was there would agree that it was time well spent. Each of the speakers provided a little of their own personal story – what brought them to the decision to be a physician, what challenges they overcame as well as how they became involved with the Medical Society and how they and their practices have benefited. The students, for the most part, were surprised that an organization existed which would provide support and educational programming as they started their professional journey and would always exist to promote the health and well being of physicians and their patients. Based upon the calls and texts I've received they want to come back to WNY and they want avenues for involvement as they start med school – no matter where that school is located. Oh, and yes they want another meeting in the Spring...

Lastly, I've had the opportunity to meet with a some of the residency program directors to discuss bringing more speakers and topics to their departments. Already one program has been scheduled for January, with more events to come.

In the upcoming months, it's my hope that the medical student members will be actively participating in our 2 contests. Whether it's a new logo, new website or new social media presence – we are focusing on the future so that our mission is visible to both members and non-members of the Society and the patients of WNY.

Chris

"STARS AMONG US" – CALL FOR NOMINATIONS

At the annual strategic planning meeting the members of our Executive Board decided it was time to recognize those member physicians who consistently participate in activities which raise the awareness of the profession and their personal commitment to patient care. A maximum of 6 physician members will be recognized each year. Once selected, the recipient will be notified by phone, to determine the date and time for a photo to be taken. The photo and announcement will:

- be displayed prominently on the MSCE website, on all MSCE social media (Linked In, Twitter, FaceBook),
- be sent via email to all MSCE members and published in the next issue of the BULLETIN,
- be sent to all print and broadcast media in WNY, and
- be sent to the Medical Society of the State of New York.

Each recipient will receive a framed copy of the photo and announcement, as well as an electronic version for personal and professional use.

Nominees must be a member of the Erie County Medical Society and must be either in active practice or currently teaching medical students, residents or fellows or be in an administrative capacity of a health facility or insurer.

- Commitment to quality, compassionate care for all patients,
- Professionalism in all forums or interactions within the WNY community,
- Dedication to the principles of medical ethics,
- Sustained involvement in continuing medical education,
- Technical competence,
- Personal integrity,
- Involvement in local regional state or national professional societies befitting either the medical or surgical specialty,
- Commitment to the MSCE, including advancing and supporting the mission and vision of the Society.

Nominations must be submitted in writing (400-word maximum) via email to the Executive Director, Christine Nadolny at nadolnyc@wnydocs.org. Deadline for submission of nominations are by the following dates:

- January 1, 2019
- March 1, 2019
- May 1, 2019
- July 1, 2019
- September 1, 2019
- November 1, 2019

Health Information Exchange: A Valuable Asset to WNY Health Care

By Anthony J. Billittier IV, MD, FACEP

HEALTHeLINK was formed more than ten years ago as a collaborative effort that included the region's major hospital systems and health plans. The collaboration was formed to create a mechanism for physicians and providers to securely exchange clinical information to improve quality of care, enhance patient safety and mitigate rising health care costs.

After spending the last decade building Western New York's health information exchange (HIE), HEALTHeLINK is building on its current offerings, through supporting care coordination and care transitions, improving the quality of data, and exploring how best to serve the community for population health measures and reporting.

As HEALTHeLINK continues to learn more and better ways to serve the Western New York health care community, it has also become a valuable asset when something unforeseen happens to a hospital or practice impacting the ability to access their patient records. Through HIE, HEALTHeLINK can ensure business continuity and patient safety by providing instant and secure access to data that may have become inaccessible for treating providers through their own electronic medical record.

For instance, when the computer network at Erie County Medical Center was suddenly shut down due to a cyber security attack last year, they turned to HEALTHeLINK. ECMC was already a HEALTHELINK data source prior to the outage and had been uploading its patient care data to HEALTHeLINK for quite some time so other health care organizations could provide even better care of shared patients. This forward thinking on ECMC's part proved to pay dividends as HEALTHeLINK essentially became ECMC's backup while they worked to restore their systems. While this cyberattack prevented ECMC staff from accessing its own electronic patient records directly, ECMC's patient information was still readily available by connecting to HEALTHeLINK.

But what if an organization isn't sharing data with the HIE and something should happen? The sudden closing of CCS Oncology earlier this year may have resulted in significant patient safety issues due to a lack of medical records. The practice, while signed up as a HEALTHeLINK participant

continued on page 22

National Spotlight Shines on Buffalo's Opioid Court

Bonnie O'Brian, Director of Communications, Bar Association of Erie County, NY

NBC, NPR and The New York Times are just a few of the national news outlets who have recently reported on the success of Buffalo's Opiate Crisis Intervention Court (OIC), the first of its kind in the nation. The necessity of such a court underscores the crippling severity of the nation's drug crisis, which killed about 64,000 Americans from February 2016 to February 2017, according to an NPR report by Eric Westervelt on "Morning Edition" (October 5, 2017), citing preliminary data from the CDC. In Buffalo, the number of opioid overdose deaths doubled from 2015 to 2016, to about 300.

The court was established last year after Jeffrey Smith, treatment court liaison for the Eighth Judicial District, voiced his concerns that many of those arrested while high on opiates were not surviving long enough to see their day in court. Buffalo has long been a pioneer of other specialty courts, including the development of drug courts in the 1990s, which work to rehabilitate defendants rather than imprisoning them. The city was also an early adopter of mental health courts and City Court Judge Robert T. Russell, Jr. created the nation's first Veterans Treatment Court in 2008. City Court Judge Amy Martoche presides over the first Human Trafficking Intervention Court, which began here in 2013.

In January 2017, City Court Judge Craig D. Hannah was appointed to preside over the Adolescent Diversion and Opiate Intervention Parts and he also serves as the Supervising Judge over the Lackawanna, Tonawanda and North Tonawanda City Courts. Chief Judge Thomas Amodeo selected Hannah for the role because of his "demeanor and temperament." The OIC is a judicially supervised triage program where participants are linked with medication-assisted treatment and/or behavioral treatment within hours of being arrested. The OIC's widely-reported mission is "keeping our participants alive."

The intervention process begins by diverting participants at arraignment and placing them into treatment with 24 hours. Criminal charges are held in abeyance and not returned to the calendar until treatment is completed. Participants are linked with staff and agencies to help stabilize them. There is an 8:00 p.m. curfew, along with random drug testing and random wellness checks. They also receive mental health treatment, along with job readiness and employment assistance. After a month of residential treatment, participants are required to report to Judge Hannah every weekday morning for 30 days and to attend treatment and counseling programs as instructed.

"I always tell everyone, we play by Vegas rules: What happens here stays here," Judge Hannah says. "You tell me what's happening, we're not going to charge you with new charges. We're going to give you the help that you need, because we know that this is an addiction."

Q & A with Judge Hannah

Q. Can you give us some background on the genesis of this program?

A. Our program was the brain trust of our treatment staff as a result of several of our treatment clients succumbing to drug overdoses prior to their cases being adjudicated. As you know, Drug Court is a "post disposition" court where defendants participate in their recovery as part of their sentence. Because of the potency of these new heroin/fentanyl batches, our clients were not making it to Drug Court; they were overdosing prior to being linked with treatment. Consequently, we started the OIC to link defendants at "first contact" with the court to treatment so we can jump-start their path to recovery.

Q. A recent article by Timothy Williams in the New York Times (January 3, 2018) showcases success stories along with relapses. Of the defendants you see, roughly what percentage of them are able to get and stay clean?

A. All of our participants (we call them participants, not defendants because we want to install hope and pride in our clients) are at the beginning of their recovery process so it will take a while to truly gauge how they are doing. As you may know, recovery is a lifelong healing process and relapse is not a sign of failure but rather a sign that we need to re-evaluate and modify our treatment strategy. I serve in the role of a "recovery coach" and like all good coaches, I strive to get the best out of our participants. I don't want them to be like anyone else; I want them to strive to be their best.

Just because someone stumbles and loses their way doesn't mean that they are lost forever. They will struggle and stumble with this addiction but my job is to assist them with the knowledge and tools to start on their path of recovery. In short, our primary purpose is to help people, or at the very least not hurt them. We want them to walk out of the courtroom better than when they came in. Because we deal with people at their lowest point, it is our duty to look after the last, the lost, the least and the overlooked and to give encouragement and support as they begin to heal.

Since the project started last May, only one of our 204 participants has died from an overdose.

Q. How many participants do you see on a typical day? And what is their overall demographic makeup?

A. We have about 25 to 30 people doing "daily reporting" and another 25 are in residential treatment facilities. Most of our participants are between 21 and 35 years old and are either white or Hispanic. The gender makeup is about 50/50. I try to spend as much time with each person as they need; so it may be five minutes or 15 minutes because I want to see how they are doing and assess their needs. We want to treat the "whole person" so we link our participants with ancillary services (insurance, cash/food assistance, transitional housing) as well.

Q. It seems that you've formed personal relationships with a lot of them. Is it difficult to stop thinking about them when you leave the courthouse?

A. I treat our clients like family. Some of them have lost these familial linkages from the "bridges they've burned" or the hearts that they have broken over the years. I want them to know that we care about them and that we are pulling for them. Sometimes all you need is to know that someone gives a damn about to get you to start giving a damn about yourself. We want to restore hope and that comes from truly caring about our "peeps"!

Do I think about them after they leave the courthouse? All the time; that's my job;

continued on page 10

Pre Med Student Event

On September 6, 2018 Doctors Gregory Bennett, Gale Burstein, Ernesto Diaz Ordaz, Julia Faller, John Gillespie, Aravind Herle, Carlos Martinez, 4th year medical student, Moudi Hubeishy, and Christine Nadolny, MSCE Executive Director met with pre-med students from Canisius, Niagara and UB. The event resulted from meetings between Allyson Backstrom, PhD, program director at Canisius and the MSCE Medical Service committee. As an invited guest to the committee Dr. Backstrom was impressed with the advocacy of the Society in providing educational forums for members and staff, its invitation to medical students and residents to participate on any of the standing committees and its offer to establish liaison activities with the pre-med programs.

Approximately 55 pre-med students and the three program directors attended the evenings event which began at 6:00 PM. During each 20 minute segment the doctor at each table discussed his or her involvement with the Society, when it began and how it has progressed, and why membership in the Society provided a "voice" to the physician community on issues that affect the practice of medicine. Questions from the students included physician shortage in WNY; how the doctor had decided on specialty, practice location and type (solo, group, hospital or university).

Since the event, a number of non-member physicians in Erie County have either submitted a membership application or have scheduled a meeting to find out more about the work of the Society. Phone calls from student participants have asked how soon another event can be scheduled; if assistance is available through the Society for more shadowing experiences; if opportunities for mentorship can be established when the students are accepted into medical schools.

The event was broadcast as part of the evening news on WKBW-TV.














National Spotlight...continued from page 8

we have to care, plan and "game plan" for them. I have to "Bill Belichick" them: get the best out of them by keeping it simple and having them do their job (in simple tasks).

Do I worry about them using? Of course, how do you ask a person not to seek out the greatest euphoric feeling in their life? They say getting high on heroin is like for a Christian to kiss Jesus Christ. It releases all your pleasure receptors all at one time. If the birth of your baby is an 8, and the best sex of your life is a 9.5, the first shot of heroin is a 4,000.

Our program is based upon honesty over abstinence; we don't throw the baby away with the bath water. We work the problem, as we encourage our participants to work the program. We treat it as a triage where we need our clients to be open and honest about everything so we can properly assess their illness - and this IS an illness.

Q. What do you see as the most compelling aspect of the program?

A. The daily personal contact with our participants. Not only are we re-establishing communal and familial interactions and relationships with our clients but we are also encouraging them to establish and meet proximal and distal goals. Also, we like to "put eyes on" our clients; then we can see if they are healthy or using.

Q. Are other jurisdictions around the country working to emulate this model?

A. We have had several inquiries from courts and governmental agencies across the country. It is our hope that we are creating or packaging a treatment program that can "travel" so other jurisdictions can replicate our success. Our mission is keeping our participants alive and we have been extremely successful so far.

Q. What can our members do to help you in the battle against this deadly national epidemic?

A. Of course, we need to educate our friends and family; we need to take away the stigma and shame of addiction. Some people are afraid or too ashamed to seek treatment because of the stigma of being an addict. As I said before, this is an illness and with other ailments (e.g. diabetes, heart disease, etc.), people are not afraid to seek treatment. No one gets upset when a pharmacy moves into their neighborhood but people get in an uproar if a treatment client moves in. Like the old HIV bumper sticker: Silence = Death. We have to encourage our friends and family that if they know anyone who needs help, do not be afraid to take advantage of the resources that are out there.

Clearly, Judge Hannah's efforts have had life-altering consequences for those who appear before him. His philosophy of "tempering justice with mercy," combined with his way of treating participants as "family" and his belief in their ability to change, has shone a beacon of hope on "the last, the lost, the least and the overlooked."

About Judge Hannah

Hon. Craig Hannah

In January 2006, Craig D. Hannah was appointed by Mayor Byron Brown as a Buffalo City Court Judge. In November 2006, he was elected to this seat with close to 80 percent of the vote. In November 2016, Judge Hannah was re-elected to a second 10-year term. Previously, he was an attorney in private practice with close to ten years of experience as a trial lawyer in city, state and federal courts. His practice was concentrated primarily in the areas of personal injury and criminal defense litigation. Judge Hannah is also an adjunct professor at the State University at Buffalo Law School, where he lectures on Trial Advocacy and Procedure. He is a former adjunct professor at Medaille College in Criminal Justice and Criminal Procedure. He also served as co-instructor/lecturer for the City of Buffalo Youth Court.

In January 2008, Judge Hannah was appointed to serve as an Acting Erie County Family Court Judge, where he primarily handled juvenile matters. In December 2015, he was appointed to the prestigious Franklin H. Williams' Judicial Commission on Racial and Ethnic Fairness by Chief Judge Jonathan Lippman.

A graduate of Canisius College and the University at Buffalo Law School, Judge Hannah began his legal career as an assistant district attorney in the Erie County District Attorney's Office. As an ADA, he was assigned to the Buffalo City Court and the Grand Jury Bureaus. Further demonstrating his commitment to public service, Judge Hannah joined the City of Buffalo Law Department in 1999. For five years, he served with distinction as one of the city's chief litigators in the Corporation Counsel's Office and later served as legal counsel to then-New York State Senator Byron Brown.

A former president of the Minority Bar Association of Western New York, Judge Hannah's distinguished legal career has been recognized with numerous awards, among them the Jurist of the Year Award from the Buffalo Special Police Benevolent Association; the Community Service Award from the Afro-American Police Association; the Legal Service/Lifetime Achievement Award from Medaille College; the Distinguished Alumni Award from City Honors School; the Community Service Award from the Westside Business & Taxpayers' Association; the Pay It Forward Award from the Community Foundation for Greater Buffalo; the Legal Service Award from the Minority Bar Association of Western New York; and the Distinguished Alumni Award from the University at Buffalo Law School. In May, he will receive the President's Award from Hilbert College. For his work with the OIC, he will receive the Outstanding Contribution to the Bar and the Community Award from the New York State Bar Association's Criminal Justice Section at their spring meeting, also in May.

His involvement in community organizations and activities is similarly extensive.

Judge Hannah chairs the nominating committee of the City of Buffalo Ethics Commission and serves on the boards of Buffalo Prep, the Buffalo Police Athletic League, and the Bar Association of Erie County's Aid to Indigent Prisoners Society, Inc. He is also co-director of the City Kids at Camp Youth Initiative, which takes several inner-city kids camping every summer to expose them to new ideas and cultures and to teach them leadership and survival skills.

This article was originally published in the Bulletin, the official publication of the Bar Association of Erie County. It is reprinted here with permission.

IN MEMORIAM

David Dean, M.D. – 5/21/2018
Edmond Gicewicz, M.D. – 3/28/2018
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The Bulletin

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Emily McMullen at (716) 852-1810
or mcmullene@wnydocs.org

Welcome New Members!

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Allison Binkley, M.D., Orthopaedic Surgery
Matthew Binkley, M.D., Orthopaedic Surgery
Andrew Campbell, M.D., Diagnostic Radiology
Erica Colligan, M.D., Neurology
Susan Daoust, M.D., Orthopaedic Surgery
Jonathan Fogel, M.D., Emergency Medicine
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Thomas Suchy III, M.D., Pain Management
Kierann Toth, M.D., Family Medicine
Nallasivam Vivekanandan, M.D., Anesthesiology
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Representatives from the Erie County Medical Society and Medical Society State of New York meet with NYS DEA Officials to discuss issues surrounding buprenorphine audits, August 2018

ATTENTION MEDICAL STUDENTS

WEBSITE AND FACEBOOK PAGE DESIGN CONTEST

$500 Prize
Guaranteed Winner

Open to Medical Student Members of the Erie County Medical Society

Requirements:

No technical programming skill is required.
This contest is focused on visual style.

1. Design a Facebook page for the Erie County Medical Society; and
2. Re-design the front page for our website and Medical Student/Resident page, to include:
   - Links believed to be useful to students and residents
   - Design that will appeal to all ages
   - User friendly access for people of all ages

You may:

- Use stock photography (watermarks allowed for submission)
- Take artistic liberties with color and design

Contact Emily McMullen at 716-852-1810 ext. 102
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STARS AMONG US

It is with great pleasure that the MSCE Executive Board has chosen Daniel P. Schaefer, M.D., FACS as our first "Star Among Us".

Daniel P. Schaefer, M.D., F.A.C.S.

Dr. Schaefer is a Clinical Professor in the Department of Ophthalmology, Clinical Assistant Professor in the Department of Otolaryngology and the Director of Oculoplastic, Orbital, Plastic and Reconstructive Surgery at Jacobs School of Medicine – SUNY at Buffalo. He has served as Chairman and Co-Chairman of several professional organization committees and those at St. Joseph's Hospital. Dr. Schaefer is an Active Staff member of Erie County Medical Center, Sisters of Charity Hospital, St. Joseph Intercommunity Hospital and serves as a Consultant for Kaleida and Oshei Children's Hospital. His involvement in the Erie County Medical Society and the Medical Society of the State of New York dates back to 1986 and he continues to be a member of several other professional organizations.

He is Board Certified by the American Board of Ophthalmology and holds medical licenses in New York and Pennsylvania. He is currently President Elect of The American Board of Oculoplastic and Reconstructive Surgery and has been invited to speak locally, nationally and internationally and has published numerous articles and chapters in books, as well as co-authoring both.

He has served patients in Guatemala, India, Nicaragua, Colombia, Africa and Bolivia; providing ophthalmic care to the poor, procuring pharmaceuticals, intraocular implants and medical supplies to service needy peoples. He has lectured, instructed and performed multiple surgical procedures in the field of ophthalmic, plastic and reconstructive surgeries while in these parts of the world. For the past 32 years, Dr. Schaefer has volunteered his services and time teaching the Ophthalmology Residents at the Jacobs School of Medicine – SUNY at Buffalo and the Buffalo VA Medical Center.

As a professional dedicated to the principles of medical ethics, and based on his personal integrity, his compassionate care for all patients, his contributions to the medical profession and the education our future physicians, Doctor Schaefer is deserving of being named the Erie County Medical Society's first, "Star Among Us".

Congratulations, Dr. Schaefer!

Employment Related Liability in the "#MeToo" Era

By Kathleen Sellers, JD, CLU – Vice President, Charles J. Sellers & Co., Inc.

The last year or so has seen near-constant revelations of sexual misconduct by high-profile individuals, such as Harvey Weinstein, Matt Lauer, and Charlie Rose, in the workplace, giving rise to the "#MeToo" movement. This movement has emphasized that all employers and supervisory employees have to work to prevent and address sexual harassment, which has existed for too long in many workplace cultures. While being mindful of these responsibilities, business owners and managers also need to consider the potential financial ramifications for our own businesses and workplaces. Employment lawyers are anticipating that the heightened social awareness around these issues is likely to drive up the requency and costs of employment related litigation for all employers.

Healthcare businesses need to be aware of the potential for employment-related claims. According to the US Liability Insurance Group, a medical practice is more likely to have an employment claim brought against it than a general liability claim, and over 40% of all employment claims are brought against businesses with less than 100 employees. Employment practices claims can include allegations of wrongful termination, breach of an employment contract, failure to promote, violation of anti-discrimination and harassment laws (such as Title VII of the Civil Rights Act, state, or local laws), wrongful demotion, and retaliation for making a claim of an illegal employment practice. And while sexual harassment scenarios are claiming headlines now, employees may bring claims of discrimination or harassment on the basis of race, national origin, religion, pregnancy, age, disability, and sexual orientation, as well. The typical power structure in many medical practices – with mostly male physician owners and mostly female staff – results in a heightened risk of actual or alleged wrongful conduct in medical practices.

Medical practices, like other businesses, need to take action to establish a fair and safe workplace culture, by making sure that anti-harassment and discrimination policies and practices are in place, and that all managers and staff are trained to prevent and address improper workplace conduct. But even the best policies and procedures can't prevent all employment practices claims, which is where Employment Practices Liability Insurance (EPLI) comes into play. This insurance covers the cost of a judgment or settlement in an employment related claim, as well as paying defense costs, which in many employment-related claims, exceed the eventual judgment or settlement (if there is one). Coverage for these types of claims is excluded from Workers Compensation and standard Business Owners Policies (although some Business Owners Policies may include or add on some Employment Practices Liability coverage). Employment Practices Liability coverage can be purchased on a stand-alone basis, or as part of a management liability package that can include Directors & Officers Liability coverage (for claims brought in connection with other wrongful acts or omissions by management) and/or Fiduciary Liability coverage (for claims against fiduciaries of employee benefit plans).

EPLI policies can also include coverage for claims of harassment or discrimination brought by third parties, such as patients or customers and vendors (for example, a pharmaceutical representative who visits a medical practice). US Liability Insurance Group offers a policy that we have put in place for many of our customers that is specifically designed for medical practices, and it includes coverage for defense costs for claims of patient molestation (availability of this coverage varies by medical specialty). As a truly valuable add-on, most EPLI policies also provide access to services to help a business prevent or mitigate loss from an employment practices claim. These include sample employment policies, on-line sexual harassment prevention training, a set amount of free consultation with a lawyer or human resources professional, and other smart hiring resources (for example, discounts on background checks for job applicants).

When purchasing an EPLI policy, a business should consider what limits to purchase (many of our customers purchase a $1,000,000 limit), as well as the deductible and premium offered by the insurance company. In some policies, the costs of defending the claim are subtracted from the overall limit available for a judgment or settlement (this is referred to as defense "within" or "inside" the limit), while with others, defense costs are covered in addition to the limit (referred to as "outside" the limit). EPLI policies are written on a claims-made basis, which means that they cover claims made during the policy period, subject to the retroactive date. Claims based on acts that took place before the retroactive date are not covered. Typically, the retroactive date is the date that coverage with the insurance company writing the policy first went into effect. If coverage is offered on a "Full Prior Acts" basis, there is no retroactive date, which means that more claims may be covered.

EPLI coverage is now more important than ever for the financial protection of medical practices, with the increased attention being brought to harassment in the workplace. Even if these issues aren't a problem in your practice, a disgruntled employee can sue your practice, alleging discrimination or harassment. An EPLI policy can help your practice survive the financial impact of such a claim.

Know What You're Signing: Contract Clauses That Make A Difference

By Lisa Coppola, Esq., The Coppola Firm

We get it. No one wants to read the fine print of a contract. As a lawyer who frequently works with businesses and health care providers involved in contract disputes, I know that most people don't pay much attention to contract terms until it's time to call in the lawyers.

With a busy practice and patients demanding your attention, or a residency that's nearing an end, we understand that the last thing you want to think about is what "indemnification" means and whether you should agree to it. Unfortunately, there are common contract clauses that invariably result in significant, unforeseen consequences if you remain unaware of their meaning or scope.

The good news is that because many of these important contract clauses are common, you'll see them again and again in the contracts you're asked to sign. By taking some time to understand what they mean, you'll take the smart approach the next time you're asked to sign. Knowing what to look for in a contract avoids repeatedly cringing at the fine print.

So, what do you need to know to read a contract like a pro? The following clauses appear in almost all contracts and can make a big difference depending on what they say.

Venue & Choice-of-Laws: These are two boilerplate provisions that address similar concepts, but they're very different.

A venue provision identifies where your dispute will be heard. In other words, a contract that provides for a venue - which simply is another word for location - states that if one party sues another, the lawsuit must be filed in a certain place which might be a State, a county, or even a particular court.

Let's say you're a physician in New York, and your vendor's contract says that any dispute must be venued in the State of Montana. Consequently, if you need to sue the vendor, you've got the chase it in Montana, even if the vendor did all its work for you in New York. You can't file suit in New York, and if you do, it's likely the vendor can have the lawsuit dismissed or moved to its home state, creating considerable expense for you.

Choice-of-laws, on the other hand, identifies which State's laws govern a dispute arising from the contract. Assuming you're a New Yorker, it's likely you (and your lawyer) are far more familiar with New York laws than, say, the laws of Iowa. If, however, your vendor is from Iowa, and its boilerplate contract states that Iowa's laws govern, then Iowa law will apply regardless of where your lawsuit is heard. Even if you can file your claim in New York, the judge must use Iowa's laws to decide the case. Keep in mind that laws can vary significantly from State to State.

Simply put, *venue* determines where a dispute is heard while choice-of-laws determines which State's laws will guide the court in making its decision. Both clauses are important, and both can measurably affect the outcome of a dispute.

Our everyday tip? Look through the teeny-tiny type in a contract to see if there's a venue of choice-of-laws clause (sometimes they're labeled) and use your new knowledge to negotiate the best outcome for you.

Indemnification: What does that mean? Well, sometimes entering into a contract creates risk, and one way to limit risk is to have a well-drafted indemnification clause (also called a hold harmless clause). The words indemnification and hold harmless essentially mean the same thing, so you may see either or both in contracts.

This language shifts responsibility for damages from one contracting party to another. For example, suppose a nursing home contracts with a food service company to provide meals to its residents. In the contract, the nursing home may require the food service company to provide indemnification for any loss or damage arising out of its services. This broad hold harmless net may very well result in the food service company having to step up to the plate if a nursing home patient is injured and then sues the nursing home for an injury that possibly arises out of his dining experience. Essentially, the nursing home uses this language to shift responsibility to the food service business.

As you can see, it's better if the hold harmless language favors you. If you don't have the bargaining power to negotiate a favorable hold harmless provision, at least think about limiting your potential exposure by agreeing to indemnify only for damages that you cause instead of being more broadly responsible for any and all damages relating to the contract or arising out of the work.

Depending on how an indemnification clause is written, it can drastically change who's ultimately held responsible in the event of a claim.

Our everyday tip? Pay close attention to a contract that uses the phrases "hold harmless" or "indemnify." If you see these words and you're not sure how they'll impact you, talk to a contract law attorney. And an effective way to limit your risk is to have your attorney include a hold harmless provision in your favor that creates protection for circumstances that may crop up down the road.

Attorneys' Fees. When a contract dispute arises and you have to bring a lawsuit, you'll want to know: can you get the other side to pay for your lawyers? After all, they're the ones who've required you to pursue them.

Many clients are surprised to find the general rule in New York is that you're responsible for your own attorneys' fees unless there's a law saying otherwise, which isn't terribly common. As a result, even where the other party clearly violates the contract, you'll generally be responsible for the cost of pursuing the wrongdoer and any fees associated with the lawsuit.

This upsets clients because, honestly, who wants to pay the costs of a lawsuit to recover something to which you're already entitled? And what happens when the proceedings drag on and the fees pile up? What can you do?

One way to protect yourself is to include a contract clause that awards reasonable attorneys' fees to the prevailing party. In New York, this sort of language must make it unmistakably clear that the prevailing party is entitled to receive legal fees and expenses. Attorneys familiar with contract litigation can draft this language and put you in the best position to protect yourself in case of a dispute. It's a precautionary measure that can be a great bargaining chip if a dispute arises.

Our everyday tip? Provisions for attorneys' fees are useful when you're the party who's been wronged under a contract. Keep in mind, however, that attorneys' fees provisions typically protect both parties. This means if you violate your obligations under the contract, you can be stuck paying your opponent's legal expenses in addition to your own.

Social Media: Responding to Unflattering Online Reviews

By Frances A. Ciardullo, Esq. – Fager Amsler Keller & Schoppmann, LLP
Counsel to Medical Liability Mutual Insurance Company

The number of patients and healthcare professionals using social media has exploded in recent years. Social media is used for social networking, professional networking, media sharing, blogging, and research and information gathering. New sites are popping up with increasing frequency, allowing users to easily connect with each other. Healthcare practices have also recognized the benefits of social media, establishing websites, Facebook pages and Twitter accounts for public relations and marketing.

Many social networking sites invite participation and engagement by the online community. Practice owned Facebook pages and websites may allow readers to respond to published content by posting their own comments. Some sites, such as Healthgrades, Zocdocs, RateMDs.com, Vitals.com, Google Reviews, Yelp, and Angie's List are specifically designed to solicit patient reviews of their experiences with healthcare providers.

According to a 2015 study of a large accountable care organization in eastern Massachusetts, 53% of physicians and 39% of patients reported visiting a physician rating website at least once. Interestingly, while physicians had a higher level of trust in comments associated with health system surveys compared to independent websites, patients felt just the opposite.[1]

Reviews left by patients can be positive or scathing. They are not based upon any empirical data and reflect the patient's perception of his or her experience. A negative comment about you or your practice will exist in the blogosphere for years to come and could turn up whenever your name is searched online. Thus, when a healthcare provider is faced with a negative review, there is a strong temptation to respond and to defend oneself against the criticism. The fear is that the review is damaging to one's reputation and that it will be relied upon by others. Yet the impulse to immediately respond should be checked for several reasons.

First and foremost, responding to a negative review online runs the very real risk that the provider will divulge details about the patient's care in violation of patient privacy laws.[2] In 2016, The Washington Post reported that Yelp identified 3,500 instances of one-star reviews in which patients mentioned privacy concerns or HIPAA. The report stated that in dozens of instances, responses to complaints about medical care turned into disputes about patient privacy, and it identified at least two instances where dentists were under investigation by the Office of Civil Rights for HIPAA violations.

In 2013, a California hospital was fined $275,000 for disclosing a patient's medical information in response to a patient's complaint to the media.[3] Therefore, a provider cannot generally respond directly to a negative posting without risking a privacy violation. If the patient's complaint is relatively benign, it may be best to ignore the post.

Providers may wonder if they can sue a patient for posting an online review. Aside from the notoriety which accompanies suing one's patients,[4] there is little to gain by diving into litigation. Web site operators are insulated from liability for the content of patient reviews under federal law.[5] Under First Amendment principles, patients have a right to voice their opinions online, no matter how hurtful those opinions may be. An action for defamation will not be successful unless the posting, read as a whole and looking at the overall context, states false facts rather than protected opinions.[6] Finally, if a provider wishes to bring legal action against a patient for a negative review, the provider will have to pay his or her own attorney's fees. Professional liability polices do not cover the initiation of a lawsuit against a patient.

So, what can you do by way of a response to a negative online review? Caution is advised before you make any response. Don't do anything immediate or rash. Take a step back, a deep breath, and think carefully about your response strategy. Remember that one bad review will not destroy an otherwise good reputation and that many readers will just ignore comments which seem malicious or motivated by spite.

Try to determine if the review is from a patient, an unhappy employee or former employee, or a friend or relative of a patient.

If you choose to respond online, keep the comment general. You may speak to your overall policies or procedures without mentioning any patient identifying information. You may reiterate that your office is always available to discuss concerns with patients and that they should feel free to contact you directly. If you are able to identify the patient, you may wish to reach out to that patient with an invitation to personally discuss his or her concerns.

Think carefully before discharging the patient in response to the review because it may be viewed as retaliation and may set off another round of negative comments. However, if the post threatens the safety of you, your staff or your family, you should notify the police.

Finally, if you believe the review raises the possibility of a malpractice action against you or your practice, notify your professional liability carrier to report the event.

Generally speaking, the best course of action in response to a negative online posting is to not spend a great deal of energy refuting it. Instead, encourage all your patients to provide honest feedback regarding their experiences. You will most likely find that most patients are happy with your services and the good reviews will far outnumber the bad ones.

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[1]Holliday, A.M., Kachalia, A., Meyer, G.S. et al., Physician and Patient Views on Public Physician Rating Websites: A Cross-Sectional Study, Journal of General Internal Medicine, June 2017, volume 32, Issue 6, pp. 626-631.

[2]C. Ornstein, Doctors fire back at bad Yelp reviews-and reveal patients' information online, May 27, 2016, accessed at https://www.washingtonpost.com/news/to-your-health/wp/2016/05/27/docs-fire-back-at-bad-yelp-reviews-andreveal-patients-information-online/?utm_term=.c1c4d331433c.

[3]Shasta Regional Medical Center Resolution Agreement, https://www.hhs. gov/sites/default/files/ocr/privacy/hipaa/enforcement/examples/shasta-agreement.pdf.

[4]Caitlin Nolan, Doctor Sues Patient for Writing Negative Review of His Services He Claims Was Defamatory, Inside Edition, November 6, 2015, http://www.insideedition.com/headlines/12838-doctor-sues-patient-for-writing-negativerevieW-of-his-services-he-claims-wasdefamatory;Barbara Ross, Manhattan dentist sues five patients in four years over negative web reviews, New York Daily News July 26, 2013, http://www.nydailynews.com/new-york/manhattan/manhattan-dentist-sues-5-patients-4-years-bad-reviews-article-1.2726895.

[5]The Communications Decency Act, 47 USC § 230

[6]E.g., Crescendo Designed Ltd. V. Reses, 2017 Slip Op. 05198 (2d Dep't June 28, 2017).

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Outpatient Encounter Documentation

Leah S. Ranke, Esq., Law Office of Leah S. Ranke, Esq.

After years of audit defense work, I have seen many instances of quality medical care suffering large audits due to common charting habits that leave the record vulnerable to negative interpretation. They are often obvious requirements that get missed. My Top 10 List of Easy Charting Do's and Don'ts for 2018 are as follows:

1. Do affix appropriate signatures. The provider that saw the patient must be the one to sign the note, and if you have electronic records, must lock it. This seems obvious, but often in the course of the office operations, this can get missed. You must use your own user name and password to do this, and you may not let other staff ever sign in under your name. Notes of mid-levels should be reviewed, and should be signed and agreed to by the supervising physician as proof of supervision is usually required by third party payers. If a provider other than the individual scheduled to see the patient happens to step in, either due to the office being very busy or a complication required an MD where, perhaps, a mid-level had been scheduled, then the physician usually takes over the appointment. In this situation, bill it at the full physician rate (mid-levels can still prepare the note.) Be sure the note documents that you as the physician examined the patient, diagnosed the patient, and developed the treatment plan for the patient. In these cases, the physician should sign the note. In the reverse situation, where a mid-level sees a patient that was originally on the schedule for an MD, then be sure the bill does not go out bearing the physician's full rate ID number.

2. Don't forget to attach to the note the results of blood work, imaging studies, correspondence from other providers, telephone encounters to your office with medical questions, and other data you reviewed since the patient was last seen in your office. These are important data points that count toward the assessment of the complexity of your medical decision making. By omitting the data, it allows the auditor to enter a zero in two sections of the note score; the portion that involves scoring the amount and complexity of the data you had to read, and the portion scoring the invasiveness to the patient of the test.

3. Do keep track of your time with a patient, and how much of it was spent on patient case management and counseling. Billing according to time is not always something you intend to do when the appointment starts, but you may find that at least once daily, your appointment time with a patient lasts longer than expected due to patient questions, concerns, and problems. Being able to bill for that time is an advantage. Your time to counsel and educate patients and their caregivers is compensable. In fact, it is the easiest way to support the code billed. Documenting the time you spent requires that you detail the minutes spent face-to-face with the patient, and that at least half of it was spent on counseling and/or case management, but only if you specifically state what you counseled them about, and what aspects of their case you managed. It is not enough, for example, to say, "smoking cessation." You should not use canned or "cloned" language. Instead tailor this section for each patient, to discuss a few phrases to describe exactly what you spoke with that patient about regarding cessation and their case. Did the patient say she often smokes right after meals? Did you discuss behavioral modification techniques, particularly after meals, or did you offer a suggestion of nicotine patches, exercise, or diet? These are specific details you should mention under case management and counseling.

4. Don't leave sections blank, or empty, such as CC, ROS, and PFSH. Documentation of a Chief Complaint is required for every other coding method other than keeping time (see above) and having a missing or incomplete chief complaint is an easy target for auditors. Many providers have re-named this section "Reason for Appointment," or some other title, but it is still the case that a CC by any name is required for reimbursement. Review of Systems is intended to be the patient's subjective opinions about symptoms or complaints they have. Past medical, family and social history is a section of the note, particularly in electronic health records, that is easy to satisfy in full for every visit. Take it once and update it only as necessary. These sections go a long way toward satisfying the History portion of the note. Add in Allergies and you will always have pertinent findings to help substantiate every encounter. If it is missing, you have only one other option left, which is very good physical exam details, to support the code you bill.

5. Do make sure your exam and the rest of your note agree with each other. If they do not, explain why. For example, if the patient failed to note any abdominal discomfort when they signed in at the front desk, or even when they filled in their ROS in the waiting room, but in the exam room they start describing abdominal pain, point this out in your note. This is very common, by the way, that patients for one reason or another under-report symptoms to the receptionist and/or on their ROS questionnaires. Some providers prefer instead to ask the patient in the exam room (or have their mid-levels do it) all the ROS questionnaire sections before beginning the exam, to try to get the most accurate responses. Sometimes patients have communication or cognitive limitations, and if so, this can add to the difficulty of the appointment. Document this difficulty to get full acknowledgment of the complexity of the visit. In every case, auditors look for inconsistencies in the note between the CC, HPI, ROS and Exam. They are constantly scrolling through these sections looking for canned or cloned language that does not appear to fit the appointment, the patient, or agree with the other entries. If your CC, HPI, ROS and/or Exam disagree, they can even cancel each other out and leave you with no code to bill.

6. Do put information in the correct section. Notes about preventative screenings, for example, entered under HPI by mistake, will not count as HPI elements. History of Present Illness can have up to eight elements describing the nature of the acute problem, its duration, and accompanying symptoms. You should always aim to document all eight for any patient with a sick visit, injury, or other acute onset problem, even if they were there for a scheduled appointment but happened to also present as a sick visit. This happens a lot. Patients know they have an upcoming scheduled appointment for one or two chronic or follow up conditions, and they wait until then to present their acute symptoms to you. "I injured my back four days ago when I was moving a dresser." Document all eight HPI elements. This is

continued on page 22

Outpatient Encounter Documentation ...continued from page 21

a very simple and effective way to get full credit for the HPI. There is no good reason to miss the HPI. Enter the screenings portions of your note elsewhere, after you list your numbered Findings/Assessment, and each should have a corresponding Treatment Plan. Remember that a full HPI gives you some leeway regarding a complete physical exam.

7. Provide a meaningful treatment plan for every current finding. If you make a finding or assessment, and it does not have a corresponding treatment plan, auditors can view this as a failure to address a patient complaint. Make sure any past finding that is not part of today's visit is not listed in today's Findings. If a Finding is for a chronic condition, be careful not to simply say the patient, "needs medication refill," or is in for a general "follow up." While these statements may be true, by themselves they are insufficient to move a diagnosis from chronic to "actively managed" and permit you to count it as a condition that you deserve to be paid to have handled on that date. I have often seen auditors dismiss a note when it states simply, "medication refill," claiming there was no active medical management that took place. If you disagree and believe that there was, then document it. Especially if there was a reassessment of the need or efficacy of a medication, a change in instructions, a drug started, stopped or dose recalculation, make sure this is clearly documented. Active medication management, even for treatment of a chronic condition, does count when it is documented. For this reason, it is extremely helpful to keep the Current Medication list up to date, and separate from past medications.

8. Do explain in the note the medical importance of your findings and the risk to the patient of differential diagnoses. When you order blood work, refer to a specialist, or send the patient for an imaging study, you should be clear about why, and provide in the note at least a brief phrase of explanation of what you are hoping to rule out or learn. A very important and often overlooked portion of an audit happens when a non-physician auditor, sometimes an individual with no current clinical employment, is attempting to stand in your shoes and suppose how much complexity was in the medical decision making you were called upon to perform. The same is true when you select a medication, or choose to stay with a medication rather than switch a patient to an alternative. You have very good medical reasons for choosing as you do, reasons that are doubtlessly perfectly clear to you and to any other physician. But auditors often miss them. In many, many instances the auditor has no idea what you were weighing, supposing, considering, balancing, or otherwise deciding. Dumb it down a bit and in a couple of key words, explain it briefly in the note, for the non-physicians like me who may be reading your note three or five or more years from now.

9. Don't under-value your services and under-code as a means of trying to avoid an audit. Bill accurately and fully for everything. Some providers are under the misperception that if they never bill a 99214, for example, they will never be audited. At one time, this may have been true. But just as audits first only targeted suspected fraudsters, and then only targeted outliers, and then only targeted frequent high coders, they now target everyone, and all code levels are included in the audits when they happen, including 99212s and 99213s. As we move toward capitation and value-based payments for many providers, it is more important than ever to be sure your notes tell a clear story about what the patient presented and what you did for them. Under-valuing your services and playing it safe in the note can cost you more than the difference between codes.

10. Do defend yourself if the code you affixed or the quality of the preventative medicine you performed is called into question. Just like everyone else, auditors sometimes make mistakes. They may not have reviewed all portions of your chart, or they may not have known what risks and complications were present at a particular visit, or how diligently you counseled the patient. It is very important that providers stand by their notes and exercise their procedural rights to challenge audit findings. Extrapolation and interpolation techniques are sometimes used in post-payment audits, and sometimes instead, letters arrive in your billing department saying a desk review was conducted and you did not even know it. Either way, you have the right to know and challenge these downgrades and clawbacks.

In the next article, we will discuss value-based reimbursement in more detail. If you have specific questions on this or another topic, please feel free to contact the Medical Society and submit them, to be answered in upcoming articles.

Health Info ...continued from page 7

and accessing data regularly, was not sharing clinical data via the HIE. Had they been, the new physicians that took on the care of the practice's former patients would have had access to this information. Instead, the new physicians were basically flying blind as patients' past medical history and current treatment information was being pieced together from other sources, including the patients and caregivers themselves.

While these are worst-case scenarios, they demonstrate the efficacy of HEALTH eLINK and provide valuable lessons for the health care community as it pertains to accessing important clinical data in a crisis.

However, if providers are not using HEALTHeLINK to not only access medical information but also, and just as important, contributing medical information from their own electronic records, then HIE will not reach its full potential in Western New York. There is no doubt that HEALTHeLINK is enhancing patient care and safety; it's time and critical for all providers to embrace it.

Anthony J. Billittier IV, MD, FACEP is an emergency physician with UBMD at the Erie County Medical Center and chief medical officer of Millennium Collaborative Care, a Performing Provider System (PPS) under New York State's Delivery System Reform Incentive Payment (DSRIP) program serving Western New York's eight counties. He also serves on HEALTHeLINK's board of directors.

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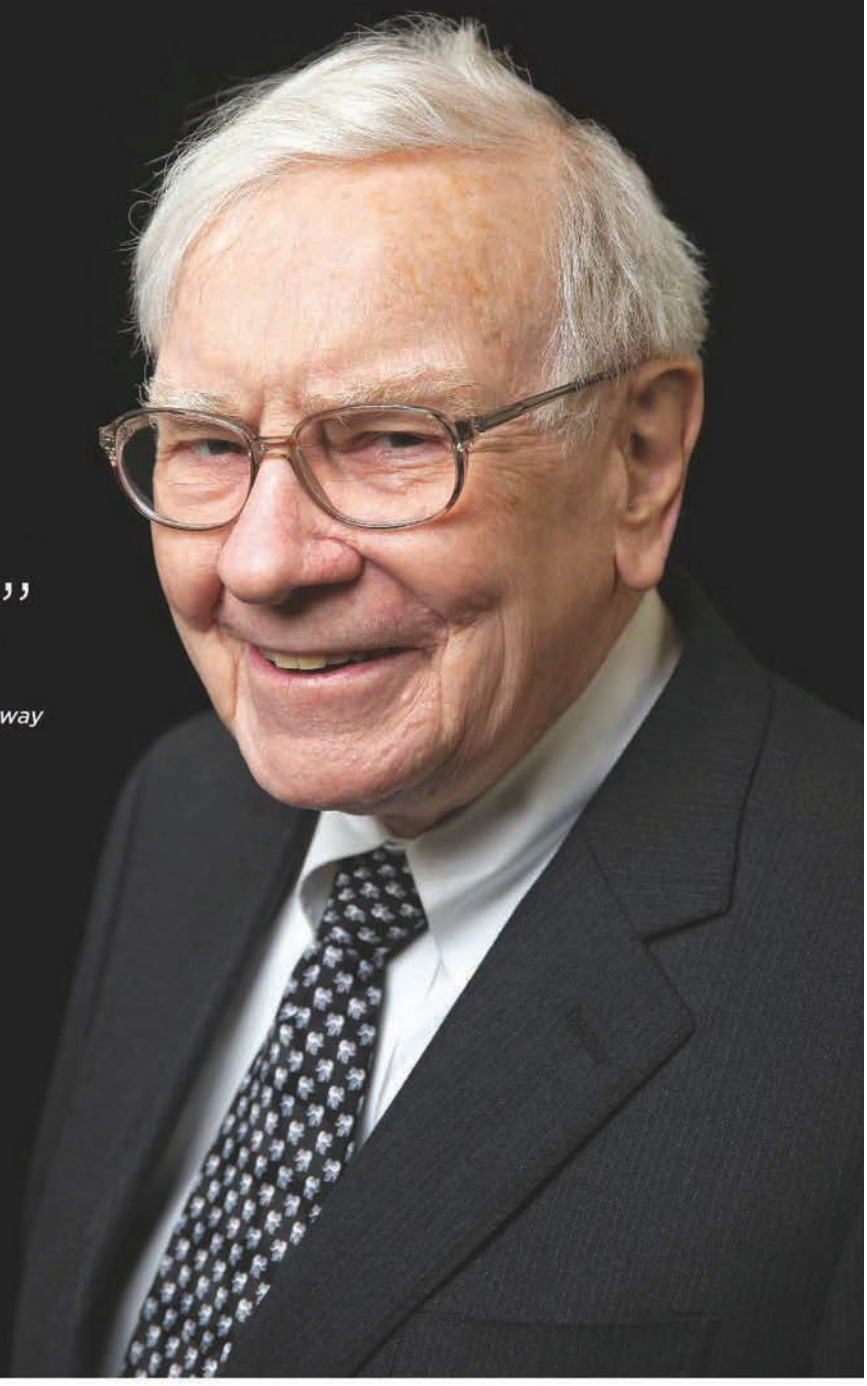

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