LEGISLATIVE SESSION WRAP UP
Brings Several Positive Outcomes for Physicians

The State Legislature wrapped up its 2019 Legislative Session, one of the most memorable in recent years given the breadth of issues the Legislature decided to address following the power-shifting election that occurred last November. Despite the many threats we faced, the Session produced several “wins” for physicians and their patients, though some adverse bills were also passed that will require MSSNY and others to request vetoes from the Governor.

Your DGA staff thanks the many physicians and county society staff who took the time to make phone calls, write letters, send tweets and personally meet with their local legislators on the myriad of issues which we prioritized our advocacy. Moreover, we thank the numerous specialty societies we regularly partnered with to help achieve these outcomes.

Among the highlights of the last few weeks of Session:
- Enactment of legislation supported by MSSNY that ensures that medical contraindications are the only acceptable exception to vaccine requirements;
- Passage of legislation supported by MSSNY that significantly curtails health insurers making mid-year changes to their prescription formularies; or increasing patient cost sharing;
- Passage of legislation supported by MSSNY that will provide extensive new regulation of Pharmaceutical Benefit Managers (PBM);
- Passage of legislation supported by MSSNY that permits a prescriber to arrange with a pharmacist to “partially fill” a patient prescription for opioid medication;
- Passage of legislation supported by MSSNY to reduce insurer prior authorization (PA) requirements when a PA for a related procedure has already been received;
- Defeat of legislation opposed by MSSNY that would have legalized adult use marijuana, as well as proposals that would have significantly expanded the medical marijuana program. Instead legislation was enacted supported by MSSNY that provides further “decriminalization” of small amounts of marijuana;
- Defeat of every major scope of practice expansion bill opposed by MSSNY, including pushing back against aggressive efforts by podiatrists and optometrists;
- Defeat of numerous trial lawyer backed bills opposed by MSSNY that could have greatly expanded lawsuits or damage awards against physicians, or made it much more difficult to defend a lawsuit. It should be noted that the Legislature did pass a couple of smaller measures opposed by MSSNY and many other groups that will affect certain cases involving multiple defendants and where an adverse judgment has been reached;
- Defeat of several bills opposed by MSSNY that would have overridden physician clinical judgment and added even more regulation of Medicaid reimbursement.

The Session produced several “wins” for physicians and their patients (Continued on page 2)

Childhood Vaccinations
THE ROAD TO VICTORY

First and foremost: MSSNY had two legislative champions on the removal of the religious exemption. Assembly Jeffrey Dinowitz had introduced the bill after the measles outbreak in 2014. He had always made this a priority to pass it, but both the Assembly and Senate over the last several years, saw no need for action.

The 2018-19 measles outbreak changed that. Also, in 2019, Senator Brad Hoylman took up the legislation. The Democrats now control the Senate chamber, and Sen. Hoylman is one of the leaders in the Democratic majority in the senate. Both the Speaker and the Majority Leader in both houses believed and supported the legislation.

MSSNY’s leadership also “championed” the bill—Our president, Arthur Fougner, MD, and Joseph Sellers, MD, came to Albany several times to meet with legislators and to help support the bill; as did the ACP and the AAP.

Second: New York State is at the center of the worst measles outbreak since it was declared eliminated in 2000 in the United States.

Third: We understood our numbers regarding the religious exemption vs. medical exemptions. NYS requires all school districts, including public, parochial and private schools to report the numbers of religious and medical exemptions. That information goes into a publicly viewed database.

There were over 400 schools in New York State that had less than a 95% immunization rate; 250 schools that were less than 80% immunization rate. MSSNY created a map of NYS showing where these schools were. The number of religious exemptions was over 26,000 students and 4,500 who had a medical exemption. We also knew that the outbreak could be directly tied with schools in Rockland County that had less than 30% immunized. (Rockland County was the site of the initial outbreak).

Four: In April, as the outbreak numbers continued to climb, MSSNY convened a meeting with various medical special groups and several children and parent advocacy groups, along with public health organizations. The group decided the time was right for repeal and that our efforts would be more effective if we joined together to advocate for medical exemptions only. There was a strategic decision to use medical exemptions as being the only exemption that should exist under the law. Every (Continued on page 2)
LEGISLATIVE WRAP UP

(Continued from page 1)

requirements on physicians prior to prescribing opioid medications to patients.

Click here for a more detailed summary of these issues.

- Rejection of the proposed approximate $80/patient Medicaid cut for deductibles for patients covered by Medicare and Medicaid that had been strongly opposed by MSSNY. This action prevents the imposition of potentially tens of thousands of dollars in cuts to physicians who treat many such “duel eligible” patients as part of their practice.
- Rejection of a proposed measure opposed by MSSNY that would have placed new prior authorization on physicians prescribing medications to their patients covered by Medicaid.
- Funding for the Excess Medical Malpractice Insurance Program was continued at its historical level, as well as continuation of the authority of the DFS Superintendent to set medical liability premium rates.
- Comprehensive reforms to better ensure insurance coverage parity for mental health conditions (MHC) substance use disorders (SUD) and Autism Spectrum Disorder (ASD):
  - Provides coverage for ALL MHCs, SUDs, and ASDs as each is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of another generally recognized independent standard of current medical practice such as the International Classification of Diseases (ICD).
  - Prohibits preauthorization and concurrent utilization review of SUD services during the initial 28 days of treatment;
  - Medical necessity criteria with respect to benefits for MHCs/SUDs and ASDs shall be made available to patients and their physicians (and other health care providers) upon request.

Perhaps one of the most significant provisions of this section is an expanded “Anti-retaliatory” measure that prohibits a health insurer from taking “any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such insurer...”

- Health Insurance policies for groups with 100 or more full-time employees will be required to cover at least three cycles of in vitro fertilization,
- A new 20% tax on the sale of “vapor products” to be used in e-cigarettes, e-cigarettes and vaping pens, and requiring sellers of such products to register with the NYS Tax Department.
- A new $150,000 grant for MSSNY’s Veterans Mental Health Training Initiative physician educational programming.
- Continued funding of $990,000 for MSSNY’s Committee for Physician’s Health
- A re-appropriation of $100,000 to MSSNY to continue its educational programming for physician’s regarding women’s health issues.
- While not specifically in the State Budget, the Legislature passed legislation supported by MSSNY that would raise the tobacco and e-cigarette purchase age from 18 to 21.

Childhood Vaccinations

(Continued from page 1)

article, every discussion we wrote or had with legislators we said that we supported medical exceptions only for NY State.

In May, MSSNY kicked off our campaign with a press conference, with physicians, public health groups, and parents. The campaign consisted of 37 organizations that supported this measure. Throughout May and June there were two other press conferences—one with physicians and other members of the campaign and one with the March of Dimes. At this conference, a mom spoke about the loss of her son from a vaccine preventable disease. MSSNY then took the video and sent it to every member of the legislature. Both Assemblyman Dinowitz and Senator Hoylman also held press conferences, including one with children and adults who can’t be immunized for medical reasons.

MSSNY organized continuous joint meetings with members of the Assembly Health Committee–From May to the end of Assembly vote on the bill. The main objection to the legislation was about First Amendment Rights. The campaign countered with the 14th Amendment – essentially saying that all children were entitled to be protected under the 14th amendment and that was part of the 1965 US Supreme Court Decision. This court decision said that the greater public health needs overrode an individual right. The measure did not mandate that a child be vaccinated. However, if a parent decided not to vaccinate that was his/her choice, but their child could not attend school if he/she were not vaccinated.

MSSNY activated a grass roots action letter, phones, contact with legislators as did other members of the campaign. MSSNY also provided members of the campaign a weekly update on where we were with our efforts. MSSNY also sent a message every day that the legislature was in session that articulated the rising measles cases statewide and nationally, along with articles from the press, organizations, etc. The county health officials also provided us with an analysis of the cost impact on local governments for investigating the measles outbreak.

As the outbreak grew, the governor came out in support of the bill as did the Senate Majority Leader. We knew early on that our “fight” was in the Assembly Health Committee that this measure would pass on the Assembly floor.

The press was on the side of repeal—editorial after editorial supported the repeal of the religious exemption. As the outbreak continued, those editorials pretty much urged that the bill be brought to the floor for a vote.

As the bill neared a vote in the Assembly Health committee, we met with the Commissioner of Health and the Governor’s counsel about next steps – certainly education is an important component that our campaign will be supporting. At this meeting, MSSNY indicated that it was important that the Governor sign the bill immediately as there was a public health crisis. The Governor signed the bill immediately after passage in both houses. MSSNY stands ready to assist the governor’s office and DOH in educational efforts and with any possible court challenges.

Five: The Anti-Vaccine Movement was organized, relentless, aggressive and well-funded. Legislators heard every day from them – even those that were not in their district. They came to Albany several times, rallied on the steps of the Capital, aided by Robert Kennedy Jr; and showed up at committee meetings, in the capitol, with children and signs. They were aggressive – which in part, may have worked against them.

Six: As a campaign, we DID NOT engage with the anti-vaccine movement. The campaign countered everything with scientific fact and we kept this issue in the forefront of the public. The most important thing that happened for us was a public opinion poll – the poll was taken in April and about 75% of the public supported the removal of the exemption – another poll was taken at the end of May and the public opinion was now at 84%! Keeping this in the news with the number of measles cases increasing certainly helped win the day for us.

This collective effort has effectively changed vaccine policy in New York State – and is viewed as a significant win for public health. Certainly, the efforts with all the organizations had a significant impact on moving this bill over the finish line. Both legislators credit MSSNY and the campaign in having a consistent and visible message.

Note: See our many partners on this issue on page 21.
“MLMIC is a gem of a company.”

- Warren Buffett, CEO, Berkshire Hathaway

MLMIC is now part of Berkshire Hathaway.

For more than 40 years, MLMIC has been a leader in medical malpractice insurance. In fact, we’re the #1 medical liability insurer in New York State. Now, as part of the Berkshire Hathaway family, we’re securing the future for New York’s medical professionals.

When it comes to medical malpractice insurance in New York, nothing compares to MLMIC.

Learn more at MLMIC.com or call (888) 996-1183.
PRESIDENT’S COLUMN

Lives, Fortunes and Sacred Honors

Matthew was born in Ireland and came to America with his parents at the age of three. As a young man, he saw the need to ease people’s suffering and so began to study medicine at Leicester, eventually establishing a thriving practice in New Hampshire and later becoming a military surgeon.

Josiah was born in Massachusetts and from early on had an aptitude for medicine. He studied hard, apprenticing himself when only 16 to a noted expert physician and later moved to New Hampshire where he set up practice at age 21.

Oliver was the youngest of 14 children. Educated at Yale, he studied medicine for a time but never really established a practice. Instead, he devoted himself to a life of public service.

Lyman was born in Connecticut and pursued a career in the clergy. Later, he shifted gears to study medicine which he actively practiced, eventually moving to Georgia and becoming politically active.

Benjamin was born into a devout Presbyterian family. Originally intending to study law, young Benjamin shifted gears and traveled to Edinburgh where he studied medicine and earned his degree. Eventually returning to America, Benjamin opened his medical practice in Philadelphia where his knowledge of chemistry earned him a professorship at the College of Philadelphia.

Matthew Thornton, Josiah Bartlett, Oliver Wolcott, Lyman Hall and Benjamin Rush were all respected physicians but today we know them for one more thing. They all pledged their lives, their fortunes and sacred honor and signed the Declaration of Independence. As Paul Harvey would have said, now you know the rest of the story.

This year marks the 243rd anniversary of the Declaration of Independence. While we enjoy our long weekend, backyard barbecues, and fireworks, remember Drs. Thornton, Bartlett, Wolcott, Hall and Rush who risked everything so that we could enjoy the blessings of their bold declaration.

Could we do the same?

SURVEY: What are Your Challenges with EHR?

MSSNY, in conjunction with other physician associations, has been working with the New York e-Health Collaborative (NYeC) on ways to reduce the hassles associated with the implementation and use of electric health record (EHR) systems.

To that end, they have developed a survey for physicians to complete gauging the challenges of EHR use, including connecting to and using medical information from your local Regional Health Information Organization (RHIO) to enhance patient care delivery.

Please take just a few minutes to complete the survey here.

Zocdoc Update

Recently, MSSNY expressed concerns with Zocdoc based on physicians expressing discontent with the verbiage of “Dr. XXX has no appointments on Zocdoc right now.” The site then lists other specialists nearby. Many physicians viewed this as Zocdoc steering patients away from their practice to practices that have an agreement with Zocdoc. MSSNY asked Zocdoc to reconsider their language.

In an effort of cooperation and in an attempt to address our stated concerns, Zocdoc advised that they are going to adjust the language on these pages as a show of good faith to MSSNY and its members.

Zocdoc asked their Product team to update the language to read as follows: “Dr. [NAME] does not participate in Zocdoc to offer online booking at this time.” This should resolve our specific concern. MSSNY is appreciative of Zocdoc’s consideration.
Injuries from Cosmetics
Send a Child to ED Every Two Hours

Research indicates “encounters with everyday cosmetic products from shampoo to deodorant land a child in the emergency department (ED) every two hours in the U.S.” The study found that “between 2002 and 2016, an estimated 64,686 children below the age of five visited emergency rooms across the country for injuries caused by cosmetic products.” The findings were published in Clinical Pediatrics.

Investigators “found 75% of injuries from cosmetic products occurred when a child swallowed a product, while 19% occurred when a product made contact with a child’s eyes.” The study indicated that “the three most common types of products that caused injuries in young children were nail care (28%), hair products (27%) and skin care (25%).” Meanwhile, “nail polish remover was the individual product that caused the single most injuries.”

DOJ Pursues Slew of EHR Cases: 5 Things to Know

The Department of Justice is taking legal action against hospitals, health systems and technology companies for submitting false claims to Medicare and Medicaid pursuant to the Electronic Health Records Incentive Program, according to the National Law Review.

FIVE THINGS TO KNOW:
1. The Electronic Health Records Incentive Program was established to encourage healthcare providers to adopt and demonstrate their “meaningful use” of EHR technology. To receive incentive payments, providers must attest that they satisfy certain requirements, including measures for analyzing and addressing security risks to EHRs.
2. In recent years, the Justice Department has settled several false claims cases related to the incentive program, according to the National Law Review.
3. Burlington, Kan.-based Coffey Health System, which operates a 25-bed critical access hospital, entered into a settlement agreement with the Justice Department earlier this month. The health system allegedly falsely attested that it conducted or reviewed security risk analyses, as required to receive the EHR incentive payments.
4. In February, Tampa, Fla.-based EHR company Greenway Health agreed to pay $57.25 million to resolve allegations that it misrepresented the capabilities of its software, causing clients to submit false claims to the government in violation of the False Claims Act. The government alleged the company misrepresented its software’s capabilities to HHS and caused clients to falsely attest that they were eligible for EHR incentive payments.
5. In June 2017, eClinicalWorks, an EHR vendor, and some of its executives and employees agreed to pay $155 million to resolve allegations it violated the False Claims Act. The government alleged eClinicalWorks falsely obtained certification for its EHR software by withholding information from its certifying entity. Due to eClinicalWorks’ alleged misrepresentations, healthcare organizations using the company’s software submitted false claims for federal incentive payments. (Becker’s Hospital Review, Jun12)

MSSNY-PAC

No Time To Rest on Recent Victories

With the 2019 session in the rearview mirror, we can now process the breadth of the Legislature’s policy changes enacted this year. However, our work is not complete - the off-session period is the perfect time to talk with legislators in their district offices to discuss physician priorities for improving our health care system.

The new dynamic in Albany ushered in substantial change that New York hasn’t seen in quite some time. While the majority of the headline-grabbing legislative achievements were focused on “social justice” issues, the Legislature did embrace a variety of public health initiatives that will positively impact physicians and their patients.

Equally important, they wisely refrained from taking action in other areas despite immense public pressure.

For example, many believed at the start of the year that legalization recreational marijuana was a fait accompli. However, due to the efforts of MSSNY, led by Immediate-Past President Dr. Tom Madejski, together with county health officials, the PTAs and others, we were able to stave off passage and force a real, public conversation about the harmful effects of legalization. The legislature instead passed a

Our State Fair Is a Great State Fair…Don’t Miss It August 21 to September 5!

Once again, the Onondaga County Medical Society will staff the Medical Society of the State of New York/New York State Society of Anesthesiologists booth at the state fair. Medical Society physician members are encouraged to volunteer to work the booth during a time slot. This is a great opportunity to perform public health outreach, and to promote your practice or organization at the NYS Fair, free of charge. Those who work at the booth will receive free admission tickets and free parking (on a limited basis). Feel free to bring handouts about your practice or other timely medical information to share with fair goers.

Please let us know if you have any ideas for exhibits, testing, etc., that you feel will be informative and help advance a positive image of the medical profession.

Contact us for available time slots remaining for the 13-day fair, which runs from Wednesday, August 21 - Monday, September 2, 2019 (Labor Day). You can choose to work as little as two hours or the entire day. We need only one physician-member group per time slot. Time availability is on a first-come, first-served basis. The schedule is being updated daily. Contact Patty Corasaniti at (315) 424-8118 or corasaniti@oncms.org for more information.
MSSNY Selects Altfest Personal Wealth Management as the Sole Preferred Wealth Management Provider for Members

Altfest Personal Wealth Management is pleased to announce the Medical Society of the State of New York (MSSNY) has selected the firm as the exclusive preferred wealth management provider for its close to 30,000 members. Altfest provides personalized financial guidance for physicians and their families that goes beyond just investments, offering expertise in key services for medical professionals, including creditor and asset protection, tax planning and student debt management.

In speaking about the partnership, Phil Schuh, MSSNY’s Executive Vice President, said, “We are pleased to work with Altfest Personal Wealth Management. Many of our members, whether starting their careers or preparing for retirement, face complex financial planning and investment challenges. Teaming with Altfest will provide members the type of access, education and service they deserve, further underscoring MSSNY’s commitment to its members.”

“We are honored to partner with MSSNY and look forward to making an impact on the financial wellness of its members,” said Andrew Altfest, CFP®, President of Altfest Personal Wealth Management. “For over 35 years, physicians have trusted Altfest to grow and protect their wealth. We see the burnout epidemic facing healthcare professionals today, and how it can impact multiple facets of their lives. Altfest’s service is tailor-made to promote financial wellness, stress relief and peace of mind.”

ABOUT ALTFEST PERSONAL WEALTH MANAGEMENT

Altfest Personal Wealth Management provides tailored wealth management services, including financial planning and investment management, to individuals and their families. As a fiduciary since its founding, Altfest is committed to serving solely in the best interests of each client. As such, the firm sells no products and receives no commissions. As evidence of Altfest’s unwavering dedication to clients, the firm has been frequently recognized since its founding as a leader in the fee-only financial advisory business.

To learn more, visit www.altfest.com/physicians

VA Expands Veterans’ Access to Private Physicians

The Department of Veterans Affairs will start “allowing a broad swath of its nine million enrollees to seek medical care outside of traditional VA hospitals, the biggest shift in the American health care system since the passage of the ACA. Although “department officials say they are ready, veterans groups and lawmakers on Capitol Hill have expressed concerns about the VA, which has been dogged by problems with its computer systems for years.” The groups are concerned “the department is not fully prepared to begin its new policy, which Congress adopted last year to streamline and expand the way veterans get care.”

The article says “veterans facing a wait of 30 days or more for an appointment at their closest VA health care center could seek private care,” but “under the new policy, that waiting time would be reduced to 20 days, with the goal of 14 days by 2020.”

With respect to “specialty care, they can see private doctors at VA expense if they have to wait longer than 28 days or drive more than an hour to see a VA provider.” Prior to this update, “veterans who had to drive more than 40 miles or wait longer than 30 days could choose to see a private doctor paid for by the VA.”

Attention All Physicians: Do You Know about Having to Research Exclusionary Databases of Your Managing Employees?

MSSNY has heard from several physicians and specialty societies regarding the significant burdens associated with a requirement that managed care companies are imposing on its participating physicians to check numerous databases on a monthly basis. The Office of the Medicaid Inspector General (OMIG) checked with their Office of Counsel (OOC) and it’s their interpretation of the contract that MCOs must require their participating providers to check exclusion lists for their managing employees, not all their employees.

Network physicians are being instructed by managed care organizations to conduct routine checks of Federal and State databases. These include the Social Security Administration’s Death Master file, the National Plan and Provider Enumeration System (NPPES), the Excluded Parties List System (EPLS), either the List of Excluded Individuals and Entities (LEIE) or the Medicare Excluded Database (MED), the NYS OMIG Exclusion List and any such other databases as the Secretary may prescribe. In addition, network physicians must check the LEIE (or MED), the EPLS and NYS OMIG Exclusions List no less frequently than monthly.

The NYS DOH has stated that this is a requirement for providers seeing Medicaid patients (and receiving public dollars), whether they are in FFS or managed care. Plans are enforcing the requirement.

Are you aware of this? Please provide your feedback to MSSNY at csouthard@mssny.org or rmcnally@mssny.org

MSSNY Council Notes—May 30, 2019

- MLMIC has filed for a no rate increase and a “claims free” discount with DFS. The decision is expected at the end of June.
- MLMIC has contributed $50,000 to MSSNY’s Physician Wellness Committee, which is chaired by Dr. Charles Rothberg.
- On behalf of MSSNYPAC, Dr. Thomas Lee reported very successful fundraising events in Erie County and Staten Island, and encouraged each county in New York to develop a local fundraising effort to bring new members into MSSNYPAC. Contact Jennifer Wilks at twilks@mssnypac.org or 518.465.8085 to get started.
- Hayden S. Wool, a partner with Garfunkel Wild, presented “Key Considerations in Informing Ancillary Services through a Group.” He provided an overview of the key regulatory compliance issues related to patient referrals and the performance of ancillary services by Group Practice. The presentation focused on an overview of physician consolidation/service expansion; structural changes; and regulatory compliance issues.
- Onondaga County Medical Society hired Erika Barry as their new executive director.
5 Reasons to Call, Now:
1. Founded in Freeport, 1958.
2. First practice on Long Island to adopt routine collaborative care for complex spinal conditions.
3. Only our experienced neurosurgeons will perform your surgery.
4. Leaders in “Bloodless” brain and spine surgery, including laser spine surgery, radiosurgery, and other advanced minimally invasive techniques.
5. Make the Right Call for:
   - Brain Tumor
   - Herniated Disc
   - Trigeminal Neuralgia
   - Spinal Stenosis
   - Brain Aneurysm
   - Back Pain
If your practice is using an EHR to capture patient data and coordinate care, you may be eligible for free support and assistance achieving Promoting Interoperability (formerly Meaningful Use) Program objectives through the Medicaid Eligible Professional Program, a New York State Department of Health initiative.

The New York eHealth Collaborative Healthcare Advisory Professional Services (HAPS) team is ready to assist providers in achieving the various stages of Promoting Interoperability.

Find out more at nyehealth.org/support

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**NYS Buprenorphine Waiver Eligibility Summer 2019 Trainings for Clinical Providers**

The NYSDOH AIDS Institute, in partnership with various local health departments, are sponsoring free Buprenorphine Waiver Eligibility Trainings for Clinical Providers. In response to opioid overdose deaths in New York State, increased access to buprenorphine treatment for Opioid Use Disorder (OUD) is urgently needed. Physicians, Nurse Practitioners, Physician Assistants and Medical Residents are highly encouraged to attend.

Under current regulations, authorized practitioners (MDs, DOs, NPs & PAs) are required to obtain a ‘waiver’ to prescribe buprenorphine. To acquire this waiver, physicians are required to complete a standardized 8-hour buprenorphine waiver training. Nurse Practitioners (NPs) and Physician Assistants (PAs) are required to complete the 8-hour buprenorphine waiver training as well as an additional 16 hours of online training as established by the Comprehensive Addiction and Recovery Act (CARA). Residents may also take the course and apply for their waiver once they receive their DEA license.

The 8-hour buprenorphine waiver training is offered in a ‘half and-half’ format [4.5 hours of in-person training followed by 3.5 hours of online training]. Upon completion of the required training, providers will meet the requirement of the DATA 2000 to apply for a waiver to prescribe buprenorphine for opioid-dependent patients. Visit PCSS for more info including how to complete all required training online, [click here](#).

- June 22nd: Ulster County (Kingston), 8AM-1PM, [Register here](#).
- June 26th: Suffolk County (Great River), 1PM-6PM, Registration: email jennifer.culp@suffolkcounty.ny.gov
- June 29th: Onondaga County (Syracuse), 8AM-1PM, [Register here](#).
- July 12th: Nassau County (Bethpage), 8AM-1PM, [Register here](#).
- August 14th: Broome County (Johnson City), 4PM-9PM, [Register here](#).

For more information about waiver trainings held outside of NYC, email buprenorphine@health.ny.gov

For more information about waiver trainings held in NYC, email buprenorphine@health.nyc.gov

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**Close to Half of Last-Year Residents Would Prefer Hospital Employment, Survey Finds**

Forty-three percent of final-year medical residents said they would prefer being employed by a hospital over any other practice option, according to a survey from healthcare consulting firm Merritt Hawkins.

The 2019 Survey of Final-Year Medical Residents consisted of an emailed questionnaire that gauged the demand of final-year medical students. About 400 final-year residents responded to the survey.

**Five additional findings from the report:**

1. When considering an employment opportunity, geographic location was cited as a top priority for final-year residents. A good financial package and availability of personal time were second and third, respectively.
2. Just 2 percent of last-year residents said they would consider opening their own practice.
3. More than half of residents said they didn’t receive any formal instruction on business issues like contracts, compensation arrangements and reimbursement methods during their training.
4. About two-thirds of last-year residents received at least 51 recruitment offers during their training. Sixty-three percent said they received too much contact from recruiters.
5. If offered a do-over, nearly 20 percent of residents said they wouldn’t choose medicine as a career. ([Becker’s Hospital Review, May 20](#))
How Often Do Physicians and Medical Students Die of Suicide?

Two in five physicians screen positive for depression and mental health issues and burnout and other stressors are prominent across the continuum of physician education and practice. Medical students, meanwhile, are three times likelier to die of suicide than their counterparts in the general population, according to data cited in an AMA Council on Medical Education report presented at the 2019 AMA Annual Meeting.

The AMA House of Delegates (HOD) adopted the council report’s call for the Association to work to better understand the routine occurrence of burnout, depression and suicide among physicians, residents and medical students.

“It is vitally important that we take action now to fully understand the actual impact of suicide on our physician workforce. Our goal is to have access to data that will help us identify the systemic patterns and risk factors that lead to suicide, and ultimately help us prevent it,” said AMA Board Member S. Bobby Mukkamala, MD. “We will continue working to reduce burnout and increase access to mental health services for physicians and physicians-in-training—improving their well-being and leading to better health outcomes for their patients.”

The AMA will:

• Explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents and medical students listed as deceased in the AMA Physician Masterfile for long-term studies.
• Monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education to collect data on medical student and resident or fellow suicides to identify patterns that could predict such events.
• Support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression, and support access to free, confidential, and immediately available stigma-free mental health and substance use disorder services.
• Collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents and medical students. (AMA Newsletter, June)
NY’s Getting a Bit Grayer

WHERE THE OLDEST ARE

The top five list reflects two characteristics of New York counties with older age profiles: most, such as Delaware and Essex, are both sparsely populated and poor; but some, such as Columbia and Warren, have also become retirement havens for relatively affluent senior citizens.

The concentration of elderly residents in each county is depicted in the map below.

YOUNGER GENERATIONS

New York State’s largest concentration of 25 to 34 year-olds was in New York City—topped by Manhattan, where this core millennial category made up 22.3 percent of all residents, followed by Brooklyn at 18.4 percent, and Queens and the Bronx, where millennials were 16.1 percent (although in Queens, this actually reflected a slight decrease).

The only upstate area with a 25-34 population above the national average was Jefferson County, home to the Fort Drum military base, where the millennial share was 17.1 percent. Elsewhere in upstate, Erie County had the largest 25-34 share, at 14.3 percent. This was below the national and statewide averages, but reflected an exceptionally strong gain of 2.5 percentage points since 2010.

Among upstate’s other larger counties, Monroe and Rensselaer, each had millennial population shares of 14.2 percent, but Albany County’s share was only 13.3 percent and had barely grown since 2010. At the other extreme, the share of 25 to 34 year-olds in Broome County’s population decreased slightly to 11.3 percent.

The concentration of millennial population shares by county is illustrated by the map below.

As for the count of children, the under-5 share of New York City’s population equaled the national average at 6.4 percent. Otherwise, the only New York counties above the U.S. average in this category were Rockland (at 8.1 percent) and Orange (6.6 percent), in part reflecting large families in large ultra-orthodox Jewish communities, and Jefferson County (7.8 percent), home to many younger military families at Fort Drum.

New York Torch, June 20

By E.J. McMahon, Research Director, Empire Center for Public Policy, Inc.

The elderly share of America’s population has been growing—but New York is graying a bit more slowly than the rest of the country.

That’s among the trends to be gleaned from the latest U.S. Census estimates of population distributions by age groups at the state and county levels.

As of mid-2018, according to the new data, the proportion of New York residents aged 65 and older stood at 16.6 percent—slightly below the national average of 17.0 percent. New York’s 65-and-over population was up three percentage points over the 2010 level, while the U.S. average rose by 3.9 percentage points.

New York ranked 35th out of 50 states in its elderly population share. Retiree haven Florida topped this category with 23.1 percent of its population aged 65 and over, while Alaska was at the bottom of the list, with 12.2 percent.

MIDDLE TO MILLENNIAL

The median age for all New Yorkers as of 2018 was 39, not far above the national median of 38.2. Both the New York and U.S. age medians increased a single year between 2010 and 2018.

The share of New York’s population in the core millennial age bracket of 25 to 34 years was 14.8 percent, same as the national average. However, New York’s share has grown more slowly since the last census, by 1.1 percentage points compared to 1.5 percentage points nationally.

The Empire State’s population of children under 5 remained lower than the national average—and among the bottom 11 states—at 5.9 percent. With the U.S. birth rate falling, both New York and the nation saw their under-5 shares of population decrease by slightly less than a percentage point. Only nine states had even slight gains in this category, led by North Dakota, Florida and Texas.

REGIONAL DIVIDE

As usual, there are some pronounced differences in the age profiles of upstate and downstate areas. Some takeaways concerning older residents:

New York City’s 65-and-up population was well below the state and national averages, coming to just 14.8 percent of the total, an increase of 2.6 percentage points over 2010.

In downstate suburban counties, the 65+ population was roughly equal to the national average, at 17.0 percent. Within that grouping, the elderly percentage ranked from a low of 15.7 percent in Rockland County to 17.8 percent in Nassau County.

Upstate—the 50 counties north of the mid-Hudson Valley region—the 65-and-over population was 18.2 percent of all residents. Only 10 states had more elderly residents as a share of population. The list of counties with large elderly populations was topped by Hamilton County, where elderly residents made up 31.3 percent of the population, followed by Delaware, Columbia, Essex and Warren, all of which had elderly populations of more than 22 percent.

The concentration of older residents as a share of population was 14.8 percent of New York residents aged 65 and older in the mid-Hudson Valley region—the 65-and-over population was 18.2 percent of all residents. Only 10 states had more elderly residents as a share of population. The list of counties with large elderly populations was topped by Hamilton County, where elderly residents made up 31.3 percent of the population, followed by Delaware, Columbia, Essex and Warren, all of which had elderly populations of more than 22 percent.

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“Do I Really Need An Employee Handbook?” “Absolutely!”

By Madelin Zwerling

Creating an employee handbook can seem like a daunting task for an employer. Some employers have few, if any, written policies in place when they begin the process. Others may have adopted individual written policies in the past with little, if any, consideration given to how the policies can or should fit together in a handbook. Questions abound over what policies must or should be included, or over how often the handbook should be updated.

Despite such issues, there is no question that every employer should have a handbook in place. A properly drafted employee handbook can be a critical risk management tool, communication tool and cost containment tool. Specifically, a handbook informs employees and supervisors of the rules and policies of the workplace in a uniform way, and provides for clarity concerning expectations and standards that must be followed and adhered to by employees. A handbook is a primary tool for placing employees on notice of an employer’s policies, expectations and benefits.

Moreover, employers can refer to provisions of an employee manual for purposes of establishing legitimate and lawful reasons for taking an adverse employment action against an employee. Furthermore, a handbook informs the employees of their rights and benefits in a clear consistent manner and of grievance procedures to ensure that complaints are handled appropriately and effectively. The prospect of supervisors enforcing rules consistently is enhanced by the existence of a handbook.

Finally, a properly drafted handbook can reduce the risks of litigation or provide a defense should a lawsuit arise. This is because its existence can show an employer’s intended consistent treatment of employees, the plaintiff-employee’s violation of the workplace rules, and that a plaintiff-employee’s claim for benefits is baseless given the express language of the handbook.

Madelin T. Zwerling is an attorney at Garfunkel Wild, P.C., which she joined in 2011, and a member of the Employment Law Practice Group, which provides legal advice on a full range of employment matters. She may be reached at mzwerling@garfunkelwild.com or (516) 393-2510.

Mail-Order Medicine: Prescribe With Caution

The ads on the New York City subway last summer were hard to miss. The suggestive billboards for the company “hims” are selling prescription drugs for erectile dysfunction. Hims also sells prescription hair loss medication, while its recent spinoff “hers” offers emergency contraceptives and female libido drugs. Both brands — styled all lowercase — also offer prescriptions for skin products that promise to combat acne and aging.

A growing number of clinicians are working with online direct-to-consumer (DTC) health companies like hims and hers. Physicians can supplement income and create a more flexible schedule working with DTC telemedicine platforms, but the Federation of State Medical Boards (FSMB) and others urge caution about sites that may not lend themselves to long-term doctor-patient relationships. At least one doctor lost his license after prescribing drugs with only the patient information from an online questionnaire. “The physician is ultimately accountable,” said Lisa Robin, MLA, chief advocacy officer of the FSMB.

As telemedicine increases in popularity, doctors don’t necessarily need to meet with patients in person to form a good medical relationship. But it’s important that doctors and patients verify each other’s identity and clearly establish a relationship before a doctor diagnoses or treats a patient, according to the FSMB telemedicine guidelines. “Whatever that interaction is — if it’s in a virtual environment, it should be held to the same standards as an in-person evaluation,” Robin said. “I think there are platforms that do that and do that quite well.”

Some DTC companies provide a platform for doctors to meet with patients via videoconference and messaging systems. Others, like the tandem hims and hers, sell only “lifestyle” medications — sometimes advertising off-label uses — for specific concerns, such as erectile dysfunction, birth control and hair loss. With hims, patients select their drug of choice and provide credit card information, then fill out a medical history form. If they’re buying hair loss or acne prescriptions, they’re asked to submit a photo. Within 48 hours, a doctor sends a message introducing himself, said Adrian Rawlinson, MD, vice president of medical affairs for hims and hers.

Rawlinson said the vast majority of consults will include at least one or two questions and answers between doctor and patient. But sometimes the prescription is approved right away, and the doctor simply directs the patient to online resources with more information. The patient then confirms the prescription, and the order is processed.

Doctor-patient relationships based solely on an online questionnaire don’t constitute an acceptable standard of care, according to the FSMB. Neglecting to build a consistent relationship can endanger patients, Robin says, and puts physicians’ licenses at risk.

Earlier this year, the California State Medical Board took action against a physician, who subsequently surrendered his medical license, after he prescribed emergency contraceptives and erectile dysfunction medication through an online platform without gathering sufficient health information from patients. (Medscape, June 23)
The Medical Society of the State of New York is accepting nominations for the 2018 ALBION O. BERNSTEIN, MD AWARD

This prestigious award is given to:

“…the physician, surgeon or scientist who shall have made the most widely beneficial discovery or developed the most useful method in medicine, surgery or in the prevention of disease in the twelve months prior to December, 2018.”

This award was endowed by the late Morris J. Bernstein in memory of his son, a physician who died in an accident while answering a hospital call in November, 1940.

The $2,000 award will be presented to the recipient during a MSSNY Council Meeting.

Nominations must be submitted on an official application form and must include the nominator’s narrative description of the significance of the candidate’s achievements as well as the candidate’s curriculum vitae, including a list of publications or other contributions.

To request an application, please contact:
Committee on Continuing Medical Education
Miriam Hardin, PhD, Manager,
Continuing Medical Education
Medical Society of the State of New York
99 Washington Avenue, Suite 408
Albany, NY 12210
518-465-8085
mhardin@mssny.org

DEADLINE FOR NOMINATIONS: September 9, 2019
Willie Underwood, III, M.D., M.Sc., M.P.H., Elected to AMA Board of Trustees

The AMA announced on June 8 the election of Willie Underwood, III, M.D., M.Sc., M.P.H., a urologist based in Buffalo, to its Board of Trustees.

“The goals on which the AMA was founded more than 170 years ago – professionalism, advocacy and ethics – are as noble and worthy today as they were then, and I am privileged to be a part of such a proud heritage,” said Dr. Underwood. “I am excited about this opportunity and honored to have been elected by my peers. I look forward to playing a role in the AMA’s push to unlock the promise of a healthier nation.”

Dr. Underwood has been an active leader in MSSNY for many years. He chairs both the Quality Improvement and Patient Safety Committee and the Independent Practice and IPA Committee and is a member of the Collective Negotiation and Integration AD HOC Work Group, the Committee to Eliminate Health Disparities and the Employed Physicians Committee. Additionally, he has chaired the AMA Council on Legislation and the AMA Resident and Fellow Section, served as president of the Erie County New York Medical Society and he is an AMA Delegate from the American Urological Association (AUA).

A board-certified urologic surgeon specializing in prostate cancer, Dr. Underwood oversees research focusing on methods to improve early detection and treatment of prostate cancer. In all his advocacy work he is proudest of getting prostate cancer early detection legislation successfully passed in Michigan and Maryland.

Dr. Underwood earned his M.D. and M.Sc. from SUNY Upstate Medical University and his M.P.H. from the University of Michigan.

Mimi Buchness, MD Elected President of the New York County Medical Society

Dr. Mimi Buchness became the 181st president of the New York County Medical Society on June 11 at the Society’s Annual Meeting. A graduate of the Columbia University College of Physicians and Surgeons, Dr. Buchness is board certified in Dermatology and is an Attending Physician in Dermatology at the New York Presbyterian Hospital, Columbia University Medical Center. In addition, she is an Assistant Clinical Professor of Dermatology at the College of Physicians and Surgeons, Columbia University.

Dr. Buchness’ long history of leadership in organized medicine includes service as president of the Women’s Medical Association of New York City, the Manhattan Metropolitan Dermatologic Society, and the New York State Society of Dermatology and Dermatologic Surgery. She is a fellow of the American Academy of Dermatology and a member of the New York Academy of Medicine and a long–time Society Board member and MSSNY Delegate.

Dr. Buchness was awarded a Presidential Citation from the American Academy of Dermatology and Certificate of Recognition from New York State Governor Andrew Cuomo. She writes and edits in the field of dermatology and is an active community volunteer.

At the same meeting, the Society thanked Naheed Van de Walle, MD for her service as president, and welcomed President-Elect Arthur Cooper, MD.

NY County Medical Society Presents Romayne Award to Stuart Orsher, MD, JD

At its Annual Meeting on June 11, New York County Medical Society President Naheed Van de Walle, MD presented Stuart Orsher, MD, JD with the Nicholas Romayne, MD Lifetime Achievement Award, named for the Society’s first president, and recognizing exceptional contribution to the Society.

Past president of both the Medical Society of the State of New York (MSSNY) and the New York County Medical Society, Dr. Orsher is a graduate of Hahnemann Medical College in Philadelphia. After he completed his medical training, he earned his JD degree from the Fordham University School of Law.

Board certified in Internal Medicine, Dr. Orsher is in private practice and is an attending physician in the Department of Medicine at Lenox Hill Hospital. He is a Fellow of the American College of Legal Medicine and a Board member of the Island Peer Review Organization (IPRO), as well as an honorary police surgeon.

Dr. Nicholas Romayne was the Society’s first president and was also a founder of the New York College of Physicians and Surgeons. It was said of Dr. Romayne, “He was unwearied in toil and of mighty energy, dexterous in legislative bodies, and at one period of his career was vested with almost all the honors the medical profession can bestow.”

In recognition of the caliber of physician this award recognizes, the New York County Medical Society was honored to make Stuart Orsher, MD, JD, the 2019 Romayne Award recipient.
NYS Workers’ Compensation Board to Highlight Successes, Provide Training at Regional Conferences

The public is invited to half-day events in Rochester and New York City to learn about important advances in the NYS workers’ compensation system.

The New York State Workers’ Compensation Board (Board) has announced a series of three regional conferences to take place this summer in Albany, Rochester, and New York City. The half-day, afternoon sessions are open to anyone with an interest in the New York State workers’ compensation system, and will highlight important advances in workers’ comp, as well as provide Continuing Legal Education (CLE) and Continuing Medical Education (CME) courses.

The conferences come on the heels of several significant Board initiatives, including New York’s first drug formulary and revised medical fee schedules that provide higher reimbursements to health care providers who treat injured workers. Additionally, the Board is gearing up to implement a new law that takes effect on January 1, 2020, that enables more types of health care providers to be authorized to treat workers’ compensation patients. The law is expected to bring thousands of new providers into the system, dramatically improving access to health care for injured workers.

In addition to a general overview highlighting recent accomplishments, attendees can also choose other sessions to attend for a deeper dive into key topics, such as:

- Legal update: significant case law, developments in adjudication and legislation (CLE)
- Ethical considerations in appearing before the Board (CLE)
- Medical marijuana in NYS workers’ compensation (CLE/CME)
- Impairment guidelines for determining schedule loss of use (CME)
- Understanding variances and the drug formulary (CME)
- Combatting fraud
- Best practices in workers’ compensation
- Intro to workers’ compensation for new providers

**REGIONAL SCHEDULE:**

**ROCHESTER:**

**NEW YORK CITY**

Wednesday July 31

Monday, August 5

Hyatt Regency Rochester

New York Marriott Downtown

125 East Main Street

85 West St. at Albany St.

Rochester, NY 14604

New York, NY 10006

For complete details and to register, visit bit.ly/WCBconference19. More information is also available at the Board’s website at wcb.ny.gov or by emailing outreach@wcb.ny.gov.

(Continued on page 15)
Five First Place High School Student Winners Selected at NSPC Health Science Competition

The Nation’s Only STEM/Health Science Competition Featured 300 Students and 50 Prize Winners

Five Long Island high school students recently received first place awards, one in each of five health science categories, at the NSPC Health Science Competition. The competition, sponsored by Neurological Surgery, P.C. (NSPC), is the first of its kind in the nation to focus on health science. Held at the Tilles Center at Long Island University, C.W. Post, 300 students representing the best and brightest from 38 high schools from Nassau and Suffolk counties competed for $80,000 in awards. Students presented their health-focused, self-designed and researched projects to judges with expertise in health science and medical research.

The five first place winners are: Christopher Lu of John L. Miller Great Neck North High School in the “Bioengineering and Computational Biology” category; Feyi Rufai of Roslyn High School in the “Behavioral Sciences,” category; Michael Lawes of Elmont Memorial High School in the “Biology - Microbiology/Genetics” category; Jason Sitt of Lynbrook Senior High School in the “Health Related Biochemistry & Physics” category; and Alessi Demir of Manhasset High School in the “Biology - Medicine/Health” category. Each winner received a $5,500 prize.

“The young people who were part of this competition were brilliant and inspiring. The students’ understanding of medicine and health related subjects was impressive. These students are exactly what we need to address the high demand to fill STEM, health science and healthcare related jobs here on Long Island and across the nation,” said Dr. Michael Brisman of Neurological Surgery, P.C. “The NSPC Health Science Competition exceeded our goals in terms of number of schools and students participating, and will further motivate both those who participated and others who observed these innovative young people to pursue their interest and careers in healthcare and related sciences.”

Created to promote student interest in Science, Technology, Engineering and Math (STEM) as well as healthcare and health science careers, this competition was managed by Long Island-based not-for-profit The Center for Science, Teaching & Learning (CSTL), whose mission is to encourage science-based learning and literacy through hands-on programs, and sponsored by Neurological Surgery, P.C. (NSPC), one of the New York Metropolitan region’s premier neurosurgical groups. The competition’s supporting sponsor was NYU Winthrop Hospital.
MLMIC Case Study: Improper Delegation Involved in Loss of Eye

By Kristen Guarente

This case involves a then 67-year-old male who was referred to a MLMIC-insured professional corporation (PC) in October 2014 for a central vein hemorrhage in his left macula. The MLMIC-insured ophthalmologist who examined the patient diagnosed macular branch retinal vein occlusion of the left eye, and also noted some early macular edema. The plan was to observe the patient. By March 2015, the patient demonstrated more macular edema, and Eylea injections were commenced. Over the ensuing months, the patient continued to have injections without complications.

ROUTINE EYLEA INJECTION

On 8/31/15, the patient presented to our insured ophthalmologist for a routine Eylea injection. At that time, the patient was on a six- to eight-week regimen of injections. The patient’s best corrected vision in both eyes was 20/20. Intraocular pressure (IOP) in the right eye was 24 and 14 in the left. The ophthalmologist noted the patient had some fluid on the optical coherence tomography (OCT), but had improved. The plan was to proceed with the injection, and the ophthalmologist discussed the potential for infections or sterile endophthalmitis.

The ophthalmologist began the procedure by anesthetizing the eye using topical Proparacaine followed by topical Betadine. A lid speculum was inserted. 10% Betadine was then applied to the area to be injected. Our insured then proceeded to inject Eylea (2.0 mg and 0.05cc volume) through the pars plana injection. After the needle was withdrawn, a Betadine-soaked Q-tip was applied to the area of the injection for 10 seconds. Following the injection, the central artery was patent. The patient’s visual acuity was confirmed as being light perception or better. The patient tolerated the procedure well and was scheduled to return to the office in six to eight weeks for reinjection. The patient was provided with instructions to call the office immediately should he note any decrease in vision or an increase in floaters after 24 hours.

The patient returned to the office on 10/19/15 for another injection. Visual acuity in the right eye was 20/20 and 20/50+2 in the left. Pinhole vision was 20/25 in the left eye. IOP in the right eye was 5 and in the left eye 6. The patient stated his visual acuity had improved. Our insured noted there was fluid evident on the OCT, which was basically unchanged. An injection was carried out without complication, and the patient was instructed to return in 6 to 8 weeks for reinjection.

The patient returned to the office on 1/11/16 for reinjection. Visual acuity was 20/20 in the right eye and 20/25 in the left eye. Pinhole vision in the left eye was 20/20. The ophthalmologist noted that the patient’s retinal swelling had improved, and the Eylea injection was given without complication.

PATIENT COMPLAINT

On 1/12/16, the patient called the office and spoke with a receptionist, reporting that he had an injection the day before. He complained of soreness, blurry vision, and tearing in the left eye. The call was triaged by an LPN. The patient noted that with prior injections the symptoms usually went away in a couple of hours. He denied pain or swelling. The LPN instructed the patient to apply a cold compress to his eye, take Advil to relieve symptoms, and to call should he have new or worsening symptoms.

The patient telephoned the office on 1/13/16 with complaints that he had lost vision in his left eye. The eye was also painful and swollen shut. The call was triaged, and an appointment was made with another insured ophthalmologist in the group that same day.

The patient presented for the scheduled appointment on 1/13/16 and advised the ophthalmologist that his left eye had been swollen shut with decreased vision and excruciating pain that he considered to be 9/10. The pain had gotten worse that morning, and the patient noted a lot of mucus discharge from the eye. The ophthalmologist noted that the visual acuity in the right eye was 20/20 with correction and light perception in the left eye. IOP was 18 in the right eye and 36 in the left. A slit lamp examination of the left eye revealed 2+ injection. There was evidence of diffuse corneal edema with some microcystic edema as well. There was limited opacification 360 degrees and a 8.5mm micro-hyphema. 3+ cells were seen in the anterior chamber with 3+ fibrinous strands. There was a 2-3+ nuclear sclerotic cataract. Biomicroscopy revealed no view of the posterior pole. A B-scan revealed evidence of vitreous debris, but no retinal detachment.

The ophthalmologist’s impression was acute endophthalmitis versus TASS syndrome. The plan was to treat the patient as acute endophthalmitis. The ophthalmologist performed a vitreous tap and anterior chamber tap for culture and sensitivities. The left eye was injected with vancomycin, ceftazidime and dexamethasone. The patient was advised to use gentamicin drops and Pred Forte drops in the left eye four times a day. The patient was also advised to follow up with another ophthalmologist colleague the following morning. In addition, the patient was advised to remain NPO in case his condition worsened, which would necessitate a pars plana vitrectomy. Tylenol #3 was recommended for pain every 4 to 6 hours.

ANOTHER OPHTHALMOLOGIST

On 1/14/16, the patient followed up with another insured ophthalmologist as planned. He reported the pain in the left eye was much better but complained of some nausea and increasing pain that started that morning. Visual acuity in the left eye was no light perception. The patient refused having his IOP taken. A slit lamp exam of the left eye revealed 360-degree hypopyon. There was only a cloudy view of the anterior chamber. There was no view on ophthalmoscopy. The ophthalmologist’s impression was endophthalmitis of the left eye with gram-positive cocci and a decrease in vision. The cultures later grew 2+ alpha hemolytic strep on fluid culture and isolate 2+ streptococcus viridians. The ophthalmologist recommended urgent vitrectomy and contacted the MLMIC-insured ophthalmologist who had seen the patient on 1/11/16.

Our insured ophthalmologist met with the patient prior to surgery and examined the external portion of the eye. His assessment was endophthalmitis, left eye. The risks and benefits were explained to the patient, who signed a consent form. The ophthalmologist performed a left eye pars plana vitrectomy, anterior chamber washout and antibiotic injection of vancomycin and ceftazidime.

POST OP PAIN

Postoperatively, the patient reported the pain in his left eye had improved, although he had a “foreign body sensation” in this eye. On 2/1/16, visual acuity in the left eye was no light perception. Intraocular pressure was 11 and 14. Slit-lamp examination revealed 1+ injection of the conjunctiva and engorgement of the sub-episcleral vessels. The cornea was opacified and scarred and offered no view of the anterior chamber. The patient had a bandage contact lens placed on 2/25/16 by our insured ophthalmologist. Subsequently, the patient continued to complain of intermittent, recurring pain in the left eye. By 3/3/16, the pain had worsened.

The patient obtained a second opinion for possible enucleation and was evaluated on 3/7/16. Evisceration of the left eye was recommended as there was no chance for visual recovery for the patient. The left eye was eviscerated on 3/21/16, and he was fitted with a prosthetic eye thereafter.

As of 2017, the patient’s limitations included not being comfortable driving long distances. He drives short distances in good weather. He has changed all of the lighting in his residence to LED lighting to (Continued on page 17)
Improper Delegation Involved in Loss of Eye

(Continued from page 16)

be able to see better in the house. In general, the limitations to his eye have had more of an emotional and psychological effect than physical. He has been a volunteer firefighter for 35 years and will still answer calls during the day if it is good weather.

LIABILITY ISSUES

By Marilyn Schatz, Esq.

A legal & Risk Management Analysis

The initial reviews of this case by defense counsel and the outside expert were supportive of the care and treatment provided by the defendant physician and the LPN. The ultimate loss of the patient’s vision and eye was more likely the result of a known and acceptable risk of the procedure and an aggressive complication, rather than a failure to timely diagnosis and treat the infection. Even if the patient had been treated on the day he called and spoke to the LPN, the outcome would probably have been the same, but the lawsuit may have been more defensible.

Given the patient’s familiarity with the symptoms he experienced after previous injections, he was in the best position to know that his latest complaints differed significantly in intensity, severity and duration. Instead of communicating with the defendant physician about the nature of the patient’s concerns, the LPN triaged him and gave an appointment for the following day. She also provided medical advice. Of note, the LPN was following pre-established protocols implemented by her employer and she was working within those parameters.

DANGEROUS CASE

This was a dangerous case to present to a jury and allow the sympathetic aspects of the patient’s injuries to be factored into a verdict. However, engaging in settlement negotiations was unlikely with a demand of $1.5 million. Defense counsel was prepared to go to trial. The patient’s attorney managed to gain the upper hand based solely on the actions of the LPN since she acted within the scope of her license. The physician was vulnerable to claims of inappropriate delegation of duties to an LPN based on the legal principle of vicarious liability. Inappropriate use of staff in a medical practice potentially exposes healthcare providers to litigation; the delegating provider to a charge of inappropriate assignment of professional responsibilities; and licensed staff to a charge of acting outside the scope of their practice.

SCOPE OF PRACTICE ISSUES

The services provided by LPNs and others, such as RNs, nurse practitioners, CRNAs and medical assistants, are invaluable to enhance efficient operations of a medical practice. These individuals provide expertise based on their education, training and experience. They assist physicians to more efficiently meet the ever-increasing demands of effectively managing a busy practice. It is the responsibility of all healthcare professionals to practice within their scope and licensure. Failure to do so is considered professional misconduct. In the office practice setting as well as in hospitals, it is essential that policies and procedures are clearly delineated for all health care staff functions. This case emphasizes the importance of this process. Physicians have professional, legal, and ethical obligations to appropriately delegate duties. Strict adherence to assigned responsibilities will benefit all parties on a healthcare team.

WHAT SERVICES CAN A LICENSED PRACTICAL NURSE PROVIDE?

According to New York State Education Law § 6902, licensed practi-
New Research Shows Hospitals Continuing to Acquire Physician Practices

This ongoing trend towards consolidation has implications for the health care system

New data compiled by Avalere Health and the Physicians Advocacy Institute (PAI) show hospital acquisition trends continued nationwide between July 2016 and January 2018. Over that eighteen-month period, hospitals acquired 8,000 medical practices, and an additional 14,000 physicians left private practice and entered into employment arrangements with hospitals.

This latest analysis updates earlier Avalere-PAI research, tracking the dramatic, sustained trend of physician practice acquisitions and physician employment by hospitals and health systems between 2012-2016, adding an additional eighteen months of data through January 2018.

Over the full 5½-year study period, the number of hospital-acquired physician practices increased from 35,700 in 2012 to more than 80,000 in 2018. Forty-four percent of U.S. physicians were employed by hospitals or health systems by January of 2018, compared to just one in four in July of 2012.

The cumulative findings by Avalere researchers for the period from July 2012 through January 2018 highlight striking changes and an increasingly consolidated healthcare marketplace in every region of the country: Hospitals aggressively pursued acquisitions of physician practices over this period, growing from 35,700 hospital-owned practices in July 2012 to 80,000 in January 2018. This 128 percent growth represents more than double the number of hospital-owned practices.

This report updates and builds upon prior studies with an additional year of data. Specifically, a previous analysis examined national and regional changes in physician employment trends from July 2012 through July 2016, finding a consistent trend towards hospital acquisitions of physician practices and a dramatic increase in physician employment. This analysis incorporates data from July 2016–January 2018 that shows a continued trend of hospital acquisitions of physician practices and growth in physician employment.

Physician employment increased overall by more than 70 percent, growing from 94,700 employed physicians in mid-2012 to 168,800 employed physicians in January 2018, with increases in every six-month time period measured over five-and-a-half years.

All regions of the United States saw an increase in hospital-owned practices at every measured time period, with a range of total increase from 91 percent to 303 percent by region.

(Continued on page 19)

Detailed Summary: 18 Month Period through January 2018

National Trends

<table>
<thead>
<tr>
<th>Measure</th>
<th>July 2016</th>
<th>January 2018</th>
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<td>168.8</td>
<td>9.0%</td>
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<tr>
<td>% of Hospital-Employed Physicians</td>
<td>41.7%</td>
<td>44.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Number of Hospital-Owned Practices (thousands)</td>
<td>72.1</td>
<td>80</td>
<td>11.1%</td>
</tr>
<tr>
<td>% of Hospital-Owned Practices</td>
<td>29.7%</td>
<td>31.2%</td>
<td>5.0%</td>
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Regional Trends

<table>
<thead>
<tr>
<th>Measure</th>
<th>Region</th>
<th>July 2016</th>
<th>January 2018</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Hospital-Employed Physicians</td>
<td>Northeast</td>
<td>44.3%</td>
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<td>3.3%</td>
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<tr>
<td></td>
<td>South</td>
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<td></td>
<td>Midwest</td>
<td>52.8%</td>
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<td>4.3%</td>
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<tr>
<td></td>
<td>West</td>
<td>38.7%</td>
<td>41.2%</td>
<td>6.6%</td>
</tr>
<tr>
<td></td>
<td>AK &amp; HI</td>
<td>34.4%</td>
<td>34.1%</td>
<td>-0.9%</td>
</tr>
</tbody>
</table>

| % of Hospital-Owned Practices       | Northeast | 30.6%     | 31.6%        | 3.3%       |
|                                    | South     | 26.9%     | 28.5%        | 6.0%       |
|                                    | Midwest   | 37.0%     | 38.4%        | 3.8%       |
|                                    | West      | 25.9%     | 28.0%        | 8.1%       |
|                                    | AK & HI   | 29.0%     | 29.4%        | 1.4%       |
Detailed Summary: Five-Year Period Through January 2018

National Trends

<table>
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<th>Measure</th>
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<th>% Increase</th>
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<td>168.8</td>
<td>78.2%</td>
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Regional Trends

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<th>January 2018</th>
<th>% Increase</th>
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<td>60.7%</td>
</tr>
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<td>West</td>
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<tr>
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<td>AK &amp; HI</td>
<td>18.3%</td>
<td>34.1%</td>
<td>86.1%</td>
</tr>
<tr>
<td>% of Hospital-Owned Practices</td>
<td>Northeast</td>
<td>13.2%</td>
<td>31.6%</td>
<td>139.4%</td>
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<tr>
<td></td>
<td>South</td>
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<td>20.1%</td>
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<td>91.0%</td>
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<td>West</td>
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<td>AK &amp; HI</td>
<td>7.3%</td>
<td>29.4%</td>
<td>302.7%</td>
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</table>

An Additional 8,000 Physician Practices Were Acquired Between July 2016 and January 2018

OWNERSHIP OF PHYSICIAN PRACTICES
NUMBER OF HOSPITAL-OWNED PHYSICIAN PRACTICES (THOUSANDS)

- Between July 2012 and January 2018, the number of physician practices employed by hospitals grew by 44,400 practices; a 124% increase over 5 ½ years.

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files
New Research Shows Hospitals Continuing to Acquire Physician Practices

(Continued from page 19)

By January 2018, Hospitals Owned More Than 31% of Physician Practices

OWNERSHIP OF PHYSICIAN PRACTICES
PERCENT OF HOSPITAL-OWNED PHYSICIAN PRACTICES

- The steady stream of hospital acquisitions resulted in a 129% increase, more than doubling the ownership percentage over 5 ½ years.

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files

IMPOERT OF INCREASE IN PHYSICIAN EMPLOYMENT

The shift towards employment has significant implications for physicians, patients, and the health care system as a whole.

- For physicians, the trend brings challenges – including a loss of clinical autonomy in treating patients - but can alleviate certain burdens of independent practice. Government and private payer payment policies increasingly favor integrated health systems and make it challenging for physician practices to remain independent.
- When physicians are employed by hospitals or health systems, they perform more services in a HOPD setting than independent physicians.
- The higher proportion of services performed in a HOPD setting increases both costs to the Medicare program and financial responsibility for patients.

HOPD= Hospital Outpatient Department

ABOUT THE PHYSICIANS ADVOCACY INSTITUTE

The Physicians Advocacy Institute (PAI) is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients.

As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and also educate policymakers about these challenges. PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine.

Information about PAI research, advocacy and education activities can be found at www.physiciansadvocacyinstitute.org.
Suicide Rates Increasing Among US Teens, Study Indicates

Since 2007, “suicide rates have been climbing among U.S. teens, with an especially pronounced increase in boys recently,” researchers concluded after examining data from “the Centers for Disease Control and Prevention’s Underlying Cause of Death database.” The study’s lead author “hopes the study will alert parents and other relatives to the increasing suicide rates so they will notice changes in teens and young adults that might suggest a risk for suicide.” The findings were published June 18 in a research letter in JAMA.

Overall in 2017, there were 6,241 suicides among young people aged 15 to 24, of whom 5,016 were young men and 1,225 were young women, the researchers found. The study, however, “had some limitations, including that the causes of death in the data were based on death certificates, which can be subject to error; or it could suggest that the observed increase in suicide deaths may reflect more accurate reporting in certificates.” In addition, investigators “did not examine factors behind the increase in suicide rates.”

UK Nurses Create Board Game About Managing Diarrhea Patients

A team of nurses in the United Kingdom have created a board game to help staff learn and refresh best practices for managing diarrhea patients, according to The Guardian. Nurses from the Newcastle Upon Tyne Hospitals NHS Foundation Trust created the board game, Poopology, in 2015. It aims to deliver short training sessions and an active learning experience for busy staff members.

The staff at their organization loved the game, which has a board designed like a toilet paper roll. Players have to navigate the board by answering questions about infection control best practices for diarrhea patient management. The game can be played by up to eight people.

The nurse team took the game to the trust’s innovations team, who brought in Focus Games, a board game maker that helped the nurses develop it for sale. The game has been sold in the U.S. and Australia. (Becker’s Hospital 5/1/19)

MSSNY-PAC

(Continued from page 5)

physicians, or made it much more difficult to defend a lawsuit. Two smaller measures were passed opposed by MSSNY and these groups that will affect certain cases involving multiple defendants, so we will be urging the Governor to veto these bills.

We know that, next year, the lawyers will be making an all-out blitz to achieve enactment of the wrongful death expansion measure, so physicians must take the opportunity to remind their legislators about our terrible liability environment.

Meanwhile, the most publicized and contentious battle of the session – to limited exemptions to New York’s vaccine law to medical contraindications – was correctly decided by the Legislature. While anti-vaccine advocates mounted a noisy campaign to oppose the bill, MSSNY worked together with over 35 physician and public health organizations and teamed up with the bill’s sponsors (Senator Brad Hoylman and Assemblyman Jeff Dinowitz) to successfully highlight the importance of this legislation to protecting the public’s health. These efforts, including press conferences, continued meetings with members of the legislature and extensive physician grassroots advocacy, passage of this bill by the Legislature and an immediate signature into law by Governor Cuomo.

Other significant victories from this session included legislation to:

• Create a maternal mortality board to examine the causes of New York’s high rate of maternal mortality and to implement policies to improve maternal care;
• Prevent insurance companies from adversely modifying their formularies mid-year;
• Provide Extensive regulation of PBMs;
• Assure greater insurance coverage for care to treat mental health conditions and substance use disorders;
• Strong new anti-retaliatory protections;
• Raising the age for tobacco sales to 21 and implementing a 20% tax on vapor products;
• Allowing “partial fills” of opioid prescriptions to reduce medicine cabinet “leftovers”;
• Reducing insurer prior authorization (PA) requirements when a PA for a related procedure has already been received;
• Defeating hefty proposed cuts to dual Medicare/Medicaid payments;

Your advocacy within the district is vital during off-session times. Keeping our priorities in the minds of legislators is key to hitting the ground running next January. Please set up meetings with your legislators in the district and speak with them about the issues important to you and physicians across New York.

You can look up your local elected officials here: http://tiny.cc/LegislatorLookup. You can also join the Physician Advocacy Liaison (PAL) network by going to mssnypac.org/pal.

And of course, please join our efforts through MSSNYPAC to help elect physician-friendly candidates and further develop relationships with key legislators. You can join here: www.mssnypac.org/contribute.

Working together as a team, we can build on these efforts to make New York a better place to practice medicine and provide quality care for your patients.
A Legal & Risk Management Analysis

(Continued from page 17)
tical nurses (LPNs) perform tasks and responsibilities within the framework of case finding, health teaching and health counseling, and provide supportive and restorative care under the direction of a registered professional nurse (RN), clinical nurse specialist, physician, nurse practitioner, licensed midwife, physician assistant, specialist assistant, dentist or podiatrist. An LPN typically provides the following types of services under the direction of an RN or other qualified practitioner (assuming that the LPN is personally competent to do so):

- Administers most types of medications and immunizations and blood (with additional training).
- Provides bedside nursing care in hospitals and residential health-care facilities.
- Observes, measures, records, and reports data relating to a patient’s health status.
- Performs clinical procedures, such as urinary catheterizations, oral or tracheal suctioning, sterile dressing changes, and starting a peripheral IV (with additional training).
- Supervises unlicensed care staff, such as certified nurse aides (CNAs) in nursing homes.
- Identifies patient goals for consideration by the RN for possible inclusion in a patient’s care plan.

New York law does not allow LPNs to determine nursing diagnoses, develop or change nursing care plans, perform triage, or perform any service that the LPN is not personally competent to perform. There are many additional services not listed here that LPNs may or may not be allowed to perform, and there are many New York laws and regulations that impact the practice of LPNs.

ENDNOTES:

1. Regents Rules 29.1(b)(9), (10).
2. NYSED.gov (Office of the Professions) http://www.op.nysed.gov/prof/nurse/nursepracticefaq.htm

Marilyn Schatz, Esq., is an attorney with Fager Amsler Keller & Schopmann, LLP and Counsel to MLMIC Insurance Company.

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Human Resource Department, e-mail: chunt@mssny.org, Fax: (1-516) 833-4760

Equal Opply Employer M/F

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Great Career Opportunities for Clinical Physicians

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- Dutchess: Fishkill and Green Haven Correctional Facilities (Hudson River Valley Beauty)
- Franklin*: Franklin and Upstate Correctional Facility (North Country, 1 hour to Montreal)
- Greene*: Greene Correctional Facility (rural charm yet only 2 hours to New York City)
- Oneida: Mohawk Correctional Facility (Cooperstown, breweries)
- Sullivan: Woodbourne Correctional Facility (mountains, outlets, casinos and entertainment)
- Seneca*: Five Points Correctional Facility (heart of wine country)
- Washington: Great Meadow Correctional Facility (Between Vermont & the Green Mountains)
- Westchester: Bedford Hills Correctional Facility (Less than 1 Hour to NYC)

Contact: www.doccs.ny.gov

For help, information or to place your AD, call Christina Southard 516-488-6100 X355

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Contact geoff_jenkins@hotmail.com / (917) 825-4542

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