Survey Report: Female Physicians Receive Less Respect and More Harassment Than Their Male Counterparts

Harassment Witnessed or Experienced

<table>
<thead>
<tr>
<th>Type of Harassment</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discrimination</td>
<td>25%</td>
<td>45%</td>
</tr>
<tr>
<td>Insubordination</td>
<td>20%</td>
<td>26%</td>
</tr>
<tr>
<td>Sexual Harassment</td>
<td>13%</td>
<td>24%</td>
</tr>
<tr>
<td>Retaliation</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>Physical violence/bullying</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Cyberbullying</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Property damage</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td>I have not experienced or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>witnessed any harassment</td>
<td>37%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Women recently overtook men in the number of potential physicians entering medical school. If that trend holds, there may be a future where there are more female physicians than male. However, today women are still greatly outnumbered in the medical field (65% of physicians are men) and they are often dealing with more workplace issues than their male counterparts. CompHealth surveyed more than 700 female and male physicians to find out their thoughts on the work environment, lead-

Gov. Cuomo Announces Success of Landmark Out-Of-Network Law Re Surprise Medical Bills

Department of Financial Services Report Finds Growing Number of Decisions for Independent Dispute Resolution, Growing from 149 in 2015 to 1,148 in 2018

On September 18, Governor Andrew M. Cuomo announced the Department of Financial Services has issued a new report detailing the successes of New York’s first-in-the-nation out-of-network law, which protects consumers from emergency and surprise bills. The law, which takes consumers out of the dispute process, has saved New Yorkers more than $400 million with respect to emergency services alone.

“New York has made extraordinary progress when it comes to enforcing fairness in healthcare costs,” Governor Cuomo said. “These findings show how the out-of-network law has been effective in protecting patients and making it clear to everyone that getting the care New Yorkers need is a right, not a luxury.” NY DFS Superintendent Linda Lacewell, “New York’s law has been a true success in bringing stakeholders together to solve the problem of excessive charges for emergency services and surprise bills.”

Under the OON Law, signed by Governor Cuomo in March 2014, consumers are taken out of disputes over out-of-network emergency and surprise bills, and health plans and providers can use the IDR process to resolve such billing disputes. Consumers are held harmless under the OON Law, which includes other consumer protections including protection from surprise bills, improved disclosure, extended network adequacy requirements, minimum OON coverage to be made available to con-

(Continued on page 2)
sumers, expanded external appeal rights, and easier claims submission. Since the law was implemented in 2015, the Department of Financial Services (DFS) has seen a steady increase in the number of Independent Dispute Resolution (IDR) requests filed through its website, as well as decisions on those requests.

The OON Law builds upon the work started by then-Attorney General Andrew Cuomo to address transparency in out-of-network reimbursements. Today, health plans typically base out-of-network reimbursements on one of three sources:

- the FAIR Health Database, an independent nonprofit established by then-Attorney General Andrew M. Cuomo to create transparency in health rates;
- the Medicare fee schedule;
- or a set fee established by the health plan.

However, there are instances when the health plan reimbursement amount is less than what the provider charges. Providers, health plans, and certain consumers may submit a dispute to an IDR entity (IDRE) through a portal on the DFS website. In the IDR process, a paper review is conducted, and timely decisions are rendered, on disputes involving bills for emergency physician services or surprise bills. IDR requests are submitted to DFS and assigned to IDR entities certified by DFS for review. The IDR entity makes a determination as to whether the provider's fee or the health plan's payment is more reasonable, based upon the last best offer of each party.

The DFS report issued found that between 2015 and 2018, a total of 2,595 decisions were rendered, and the number has been steadily increasing, from 149 in 2015 to 1,148 in 2018. The law has saved consumers over $400 million from its March 2015 implementation through the end of 2018, in part through a reduction in costs associated with emergency services and an increased incentive for network participation.

Consumers in need of emergency services are typically unable to choose the physician that provides the services. In addition, even when the consumer receives emergency services at an in-network hospital, the physician may not necessarily be in-network. Prior to the OON Law, there were no protections from excessive emergency charges. Consumers or health plans would just pay the amount billed. By establishing an independent dispute resolution process for out-of-network emergency services, the OON Law reduced out-of-network billing by 34% and lowered in-network emergency physician payments by 9%.

Among the results, the DFS report found the following with respect to emergency services:

- Of the 2,250 disputes involving bills for emergency services submitted to DFS for IDR during 2015 to 2018, 263 cases were settled, amounting to 12%.
- 43% of decisions were in favor of the health plan, 24% were in favor of the provider, and 33% were split between the health plan and provider, meaning that more than one CPT code was submitted for the date of service, and the IDRE found in favor of the health plan for some codes and the provider for others.

The most common specialty for disputes involving emergency services in 2015 to 2018 was plastic surgery, followed by emergency medicine and orthopedic surgery. Less common provider specialties included cardiology, neurology, radiology, dental surgery, anesthesiology, assistant surgery, psychiatry, gastroenterology, OB/GYN, urology and pediatrics, which each accounted for less than 1% of all disputes reviewed through December 31, 2018.

In 2015 to 2018, 1,486 disputes involving surprise bills were submitted to IDR. Of those, 815 IDR decisions were rendered. Health plans prevailed in 13% of the cases, while

(Continued from page 1)
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Your participation through the MSSNYPAC and the MSSNY Physicians Advocacy Liaison (PAL) program are essential to ensuring physicians have a meaningful seat at the table.

**BEING HEARD IS KEY**

As the ultimate experts in patient care delivery, your participation is absolutely vital to guiding New York toward a better practice environment. Hearings and roundtables are often attended by those pushing viewpoints counter to those espoused by medical professionals and as such it is imperative that our side of the conversation be represented.

For instance, this spring MSSNY President Dr. Art Fougner was able to provide to a legislative panel MSSNY’s balanced perspective on single payer proposals at a hearing overflowing with single payer advocates.

This summer and fall, elected officials are holding legislative town halls and meetings about the biggest issues affecting our state. On (Continued on page 12)
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Physicians certified by the American Board of Internal Medicine (ABIM) will soon have a new option that takes some of the pain out of maintaining their certification.

In a letter sent to its diplomates, the ABIM board of directors announced that it plans to add a longitudinal assessment option for Maintenance of Certification (MOC) that will allow physicians to take shorter, more frequent tests online.

“As a result, the ABIM board in August committed to providing a longitudinal assessment option that will allow physicians to take tests online to maintain their board certification.

“We recognize that some physicians may prefer a more continuous process that easily integrates into their lives and allows them to engage seamlessly at their preferred pace while being able to access the resources they use in practice,” Marianne Green, M.D., chair of the board of directors, and Richard Baron, M.D., president and CEO said.

The American Board of Medical Specialties (ABMS), made up of 24 medical specialty boards including ABIM, has faced a backlash in recent years from physicians over tougher requirements and costs of MOC. That prompted changes in the process by those certifying boards, including the ability to take the exam online as well as allowing doctors to use clinical references to answer questions as they do in practice.

The ABIM said it is developing the new option, and, in the meantime, its current MOC program with the choice of its two-year “knowledge check-in” and traditional long-form exam physicians take every 10 years will remain in effect. The board, which certifies internal medicine doctors to practice in the specialty, said more details about the new option will be revealed in the months ahead as it looks for physicians to play an active role in providing feedback.

The ABMS said other boards have developed a longitudinal assessment option including the American Board of Colon and Rectal Surgery, the American Board of Dermatology, the American Board of Medical Genetics and Genomics, the American Board of Nuclear Medicine, the American Board of Otolaryngology-Head and Neck Surgery, the American Board of Pathology and the American Board of Physical Medicine and Rehabilitation.

The longitudinal assessment option will offer “a self-paced pathway for physicians to acquire and demonstrate ongoing knowledge,” said Green and Baron. However, the traditional long-form assessment will remain an option as some physicians prefer a point-in-time exam taken less frequently.

With the new option, physicians will be able to answer a question and receive immediate feedback as to whether it was correct, along with rationale and links to educational material. “By engaging in such a pathway, physicians can assure their medical knowledge is up to date and utilize—in real time—learning activities to address gaps,” they said.

The ABIM said it developed the new option based on feedback from internal medicine physicians including focus groups and interviews as well as information from other ABMS boards.

The ABMS said its member boards are exploring and piloting longitudinal assessment as part of their continuing certification programs. Longitudinal assessment draws on the principles of adult learning combined with modern technology to promote learning, retention and transfer of information, the group said.

(FierceHealthcare, Aug.21)

**Responging to Physician Pushback, ABIM Announces New Option for MOC**

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**MSSNY’s Vice-Speaker Maria Basile, MD Appointed Chief Medical Officer at US Family Health Plan – St Vincents**

Unformed Services Family Health Plan–St. Vincents has named Dr. Maria Basile as their new Chief Medical Officer for its TRICARE Prime plan providing military beneficiaries care in New York, New Jersey, Eastern Pennsylvania and Western Connecticut.

“We took great care in selecting a new Medical Director to assure our members that we have the right person in place to support our medical management and quality improvement activities,” said US Family Health Plan Executive Director Jeffrey Bloom. “Dr. Basile’s track record proves she is focused on improving the health of the communities she has served, which aligns with our core belief that providing quality care to the families of the service members who protect and serve our country is our mission and primary purpose.”

As Chief Medical Officer, Dr. Basile will oversee all Clinical Operations including Quality Management and Improvement Initiatives; Patient Safety; Clinical and Peer Review Activities; and Patient Care Management. She will ensure compliance with all standards of quality and safety required by accreditation and regulatory agencies.

“I am delighted to join the amazing leadership team at US Family Health Plan – St Vincents. Looking forward to all of the good work we will do, assuring that our active duty families, our retired active duty service and their family members get the highest quality health care,” Dr. Basile stated.

Dr. Basile comes to US Family Health Plan – St Vincents from Mather Hospital - Northwell Health in Port Jefferson, NY, where she served as Assistant Vice President, Medical Affairs where her responsibilities included professional credentialing, physician engagement, medical staff quality improvement and leadership development. Prior to and during her tenure at Mather, Dr. Basile served as an Attending Colon and Rectal Surgeon at four Long Island, NY Hospitals.

She received her medical degree from Georgetown University School of Medicine in Washington, DC; conducted her surgical residency at Mercy Catholic Medical Center, Philadelphia, PA. and her fellowship in colon and rectal surgery at St. Vincent Medical Center, Erie, PA.

Dr. Basile is a prominent figure in organized medicine. She is the current Vice-Speaker of the Medical Society of the State of New York (MSSNY), a Past President and Councilor of the Suffolk County Medical Society, and Co-Chairs the MSSNY Committee on Women. She recently served as an Alternate Delegate from New York to the American Medical Association.
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NY Society of Addiction Medicine Poster Contest

NYSAM (NY Society of Addiction Medicine) is once again proud to sponsor a competition for residents interested in addiction to submit a presentation addressing how addiction affects patients in their specialties. This is now our third year with this successful program. We have had excellent presentations the past two years, and would like to again encourage residents to submit a presentation. Submissions do not require original research, but should demonstrate thoughtful reflection, keen observation and creativity about addiction and how you can address it through your specialty.

Please click here for competition details/rules. The deadline for submission is December 2, 2019.

The prize is a chance to present at the 2020 NYSAM Annual Conference at the Crowne Plaza Hotel Times Square on February 7-8, 2020. Two winning entries from across New York State will receive free transportation to the conference, a hotel room at the Crowne Plaza for one night, a $250 honorarium, and a plaque.

FDA Recommends Approval of Oral Treatment for Peanut Allergy

An FDA advisory panel recommended approval for Aimmune Therapeutics’ Palforzia (peanut powder) as a “treatment for children with peanut allergies.” If approved, Palforzia “could become the first federally approved option for preventing life-threatening reactions.” According to the AP, “The treatment is daily capsules of peanut powder that gradually help children build up a tolerance.” (AP 9/13)

These 10 Physician Specialties Generate the Most Revenue for Hospitals

The amount of revenue physicians generate for hospitals is typically considerably more than their annual salaries, according to a recent survey by physician staffing firm Merritt Hawkins.

The survey was emailed to roughly 3,000 hospital CFOs and other financial managers across the nation between October 2018 and December 2018, and the survey results include data on 93 hospitals. Despite the relatively small data set, Merritt Hawkins believes the survey results are generally reliable and accurate because the overall number for average annual revenue generated by all physician specialties for their affiliated hospitals has remained relatively constant over the 16 years the survey has been conducted.

Below are the 10 physician specialties that generate the highest average annual net revenue for hospitals and the average salaries for those specialties, according to the Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey.

1. Cardiovascular surgery
   Average revenue: $3.7 million
   Average salary: $425,000

2. Cardiology (invasive)
   Average revenue: $3.48 million
   Average salary: $590,000

3. Neurosurgery
   Average revenue: $3.44 million
   Average salary: $687,000

4. Orthopedic surgery
   Average revenue: $3.29 million
   Average salary: $533,000

5. Gastroenterology
   Average revenue: $2.97 million
   Average salary: $487,000

6. Hematology/Oncology
   Average revenue: $2.86 million
   Average salary: $425,000

7. General surgery
   Average revenue: $2.71 million
   Average salary: $350,000

8. Internal medicine
   Average revenue: $2.68 million
   Average salary: $261,000

9. Pulmonology
   Average revenue: $2.36 million
   Average salary: $418,000

10. Cardiology (noninvasive)
    Average revenue: $2.31 million
    Average salary: $427,000

(Becker’s Hospital CFO Report, May 2019)
FAIR Health Study Analyzes Telehealth

In July, FAIR Health released a white paper that analyzed telehealth—the remote delivery of clinical care through telecommunications technology—at a new level of detail. Drawing on data from FAIR Health’s repository of more than 29 billion private healthcare claim records, the study revealed, for example, that private insurance claim lines for non-hospital-based provider-to-patient telehealth increased nearly 1,400 percent from 2014 to 2018.

Entitled A Multilayered Analysis of Telehealth: How This Emerging Venue of Care Is Affecting the Healthcare Landscape, the white paper examined different types of telehealth, comparing them nationally and by rural versus urban area, as well as by age and gender. It analyzed the most common telehealth diagnostic categories and, using longitudinal data, studied the diagnoses associated with patients who have an in-person follow-up visit within 15 days of a telehealth visit. The four types of telehealth studied in the white paper were:

- **Provider-to-patient–non-hospital-based telehealth.** The provider and the patient communicate via telehealth without relation to a hospital.
- **Provider-to-patient–discharge telehealth.** The telehealth visit is a follow-up after the patient is discharged from an inpatient stay in the hospital.
- **Physician-to-patient–emergency department (ED)/inpatient telehealth.** The patient is in the hospital, whether in the ED or as an inpatient, communicating via telehealth with a physician.
- **Provider-to-provider telehealth.** The telehealth exchange involves consultation between healthcare professionals.

The telehealth white paper expanded on a previous FAIR Health white paper that reported on telehealth and other alternative venues of care, such as urgent care centers and retail clinics. These are some of the new white paper’s key findings:

**RAPID GROWTH**

From 2014 to 2018, claim lines for non-hospital-based provider-to-patient telehealth grew 1,393 percent. This was a greater increase than for all other types of telehealth studied and for telehealth overall. Claim lines related to telehealth overall grew 624 percent from 2014 to 2018.

For non-hospital-based provider-to-patient telehealth, the increase in that period was greater in urban than rural areas. Claim lines for that type of telehealth increased 1,227 percent in urban areas, 897 percent in rural areas.

The share of the telehealth distribution held by non-hospital-based provider-to-patient telehealth grew in that period. In 2018, that type of telehealth accounted for 84 percent of all telehealth claim lines, compared with 52 percent in 2014.

**AGE AND GENDER**

In the period 2014-2018, the age group most associated with telehealth overall was that of individuals age 31-40, who accounted for 21 percent of the distribution of all telehealth claim lines. But most of the claim lines (82 percent) for discharge-related provider-to-patient telehealth were associated with individuals 51 and older.

Sixty-five percent of all telehealth claim lines in the period 2014-2018 were associated with females. But for telehealth visits associated with a hospital discharge, 53 percent of claim lines were submitted for females.

**DIAGNOSES**

The top three reasons why individuals sought treatment from a provider via non-hospital-based telehealth, from most to least common, were acute upper respiratory infections, mood (affective) disorders, and anxiety and other nonpsychotic mental disorders.

In 2018, the telehealth diagnosis with the highest rate of patients who had an in-person visit within 15 days of a non-hospital-based provider-to-patient telehealth visit for the same or a very similar diagnosis was heart failure.

FAIR Health President Robin Gelburd commented: “As telehealth continues its rapid growth, we are pleased to use our unparalleled data repository to uncover layers that have been difficult to study. We offer the information in this report for the benefit of all healthcare stakeholders with an interest in the emergence and contours of telehealth.”

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**At-Home Rape Kits Now Off the Market**

Two companies who were advertising at-home sexual assault evidence collection kits appear to have halted selling and marketing the products after widespread objections and two state attorneys general threatened the companies with legal action.

On September 11, New York Attorney General Letitia James sent letters to both MeToo Kits and the Preservekit Group telling them to “cease and desist” either selling or marketing their kits to New York consumers. The PRESERVEkit, which was previously being sold on Amazon, is now listed as “currently unavailable.”

On September 13, the website for the PRESERVEkit stated that “we will not be selling this product while we review the legal concerns.” Jane Mason, the co-founder of the PRESERVEkit, posted a statement on September 15 on the product’s website saying the kits were created to “help the 77% of sexual assault survivors who don’t come forward and report the crime.”

MeToo Kits, another company that had advertised an at-home sexual assault evidence collection kit, apparently suspended its website as of September 13. The company was not yet selling its kits but did have them available for preorder on its website. Other attorneys general have spoken out against the kits, warning consumers to avoid the product and saying it’s unlikely the kits would be admissible as evidence in court.

Advocates for sexual assault victims have also opposed the use of at-home kits. They say survivors of sexual assault would miss out on other crucial aspects of a sexual assault exam, including treatment for physical injuries, a mental health evaluation, referral to other resources and medication to prevent pregnancy and sexually transmitted infections. (KHN, Sep.18)
AMA Releases 2020 CPT Code Set

Updates to medicine’s common language reflect tech-enabled patient services

The American Medical Association (AMA) recently announced the release of the 2020 Current Procedural Terminology (CPT®) code set containing identifiers and descriptors assigned to each medical, surgical, and diagnostic services available to patients. Trusted since 1966 as the health system’s common language, the CPT code set enables accurate reporting, measurement, analysis, and benchmarking of medical services and procedures across the nation’s entire health care system.

“An annual editorial process draws insight from the entire health care community to produce practical code enhancements to CPT that support advancements in technology and medical knowledge available for the care of patients,” said AMA President Patrice A Harris, M.D., M.A. “This capacity ensures reliable codes are available for burgeoning tech-enabled services and affirms CPT as the trusted code set for efficiently sharing accurate information about medical services and procedures. That’s why we believe CPT serves both as the language of medicine today and the code to its future.”

There are 394 code changes in the 2020 CPT code set, including 248 new codes, 71 deletions, and 75 revisions. In making these updates, the CPT Editorial Panel considered broad input from physicians, medical specialty societies and the greater health care community.

Among this year’s important additions to CPT are new medical services sparked by novel digital communication tools, such as patient portals, that allow health care professionals to more efficiently connect with patients at home and exchange information. CPT has responded by adding six new codes to report online digital evaluation services, or e-visits. These codes describe patient-initiated digital communications provided by physician or other qualified health care professional (99421, 99422, 99423), or a non-physician health care professional (98970, 98971, 98972).

Other coding additions to CPT were prompted to better support home blood pressure monitoring that aligns with current clinical practice. CPT added codes (99473, 99474) to report self-measured blood pressure monitoring. The goal of these codes is to expand reporting pathways for physicians across the country who take care of a diverse set of patients that have varying degrees of access to care.

“With the advance of new technologies for e-visits and health monitoring, many patients are realizing the best access point for physician care is once again their home,” said Dr. Harris. “The new CPT codes will promote the integration of these home-based services that can be a significant part of a digital solution for expanding access to health care, preventing and managing chronic disease, and overcoming geographic and socioeconomic barriers to care.”

Additional CPT changes for 2020 include the new codes for health and behavior assessment and intervention services (96156, 96158, 96164, 96167, 96170 and add-on codes 96159, 96165, 96168, 96171). These codes replace six older codes to more accurately reflect current clinical practice that increasingly emphasizes interdisciplinary care coordination and teamwork with physicians in primary care and specialty settings.

One of this year’s largest application expansions to the CPT code set was the result of significant enhancement in the codes for reporting long term electroencephalographic (EEG)
monitoring services (95700-95726). These important services monitor the electrical activity of the brain and are critical to the diagnosis of patients with epilepsy. Four older codes were deleted to make way for 23 new codes that provide better clarity around the services reported by a technologist, a physician, or another qualified health care provider.

New CPT category I codes are effective for reporting as of Jan 1, 2020. To assist the health care system in an orderly annual transition to a new CPT code set, the AMA releases each new edition four months ahead of the Jan 1 operational date and develops an insider’s view with detailed information on the new code changes.

The AMA invites the health care community to learn more about the significant changes to CPT codes and descriptors by attending the CPT and RBRVS 2020 Annual Symposium in Chicago from Nov. 19-22, 2019. For additional information and registration, please visit the AMA website.

The 2020 CPT codes and descriptors can be imported straight into existing claims and billing software using the downloadable CPT 2020 Data File. The file contains the updated code set’s complete descriptor package, including official descriptors for consumers and physicians, and the complete official CPT coding guidelines.
**MSSNY IN THE NEWS**

**New York Amsterdam News** – 08/15/19 Neck pain can be a real you-know-what (MSSNY mentioned)

**Cardiology Magazine** (American College of Cardiology) – 08/23/10 Heart of Health Policy | Tobacco 21 Count Continues (MSSNY mentioned)

**Buffalo News** – 08/25/19 Another Voice: Protect against surprise medical bills, but preserve access, too (Op-Ed by MSSNY President Dr. Arthur Fougner)

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**Crain’s Health Pulse** / **NY Business** – 08/26/19 Fougner interviewed by Dr. Dan Choi (MSSNY YPS Chair Dr. Dan Choi interviewed)

**Daily Heralds**

**Centre Daily Times**

**NewsLive.com**

**Kaiser Health News**

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**PRESIDENT’S COLUMN**

(Continued from page 4)

and devalues the education and degree conferred upon every physician. Why are physicians forced to suffer repeated use of this derogatory professional insult? And why have physicians as one professional body not risen up in anger at this injustice?

While I would not equate those who call physicians “the P word” with the Third Reich, folks should realize that Provider is insulting and demeans our noble profession.

Dr. McClean concludes:

And by the way, this terminology issue was raised through the ACP Board of Governors way back in 2008. Hence, it has been ACP policy since 2009 to eliminate use of the term “provider” and “prescriber” in lieu of “physician” in all publications and communications.

Pass it on.

I leave you now with the inimitable Aretha Franklin.

Art Fougner, MD

**Physicians More Likely to Prescribe Opioids at End of the Day**

A study published in JAMA Network Open on August 30 reveals that physicians were more likely to prescribe opioids later in the day and when appointments were running behind schedule.

The study utilized claims and electronic health data in 2017 for 678,319 patients with new pain who saw 5,603 physicians at health care clinics. The patients’ complaints ranged from back pain and headaches to muscle and joint aches. The researchers looked at the order of appointments and whether an appointment started at its scheduled time. Opioid prescriptions were compared to prescriptions of non-steroidal anti-inflammatory drugs and physical therapy.

Overall, physicians were 33% more likely to prescribe opioids later in the day and 17% more likely to do so if the appointment was running later than its scheduled time. NSAIDs and physical therapy prescribing did not change throughout the day.

When working with patients in pain who want opioids, offering them alternative therapies such as NSAIDs or physical therapy can require time-consuming discussions, Neprash said. “Prescribing opioids may be the quick fix when they do not have enough time to discuss non-opioid options.”

In 2017 there were six times the number of opioid related deaths compared to 1999. While much of the opioid epidemic is due to illicit drug use, prescription opioids still play a large role. The authors note that if prescribing practices remained constant throughout the day, 4,459 opioid prescriptions would not have been written in 2017.

Dr. Mark Linzer, director of the Office of Professional Worklife at Hennepin Healthcare in Minneapolis, “I suspect this is the tip of the iceberg: that time pressure has numerous adverse consequences.” The conversation that avoids narcotics just takes time,” he said.

**Re Surprise Medical Bills**

<table>
<thead>
<tr>
<th>Provider Specialty for Surprise Bills</th>
<th>2015-2018 Percentage of IDR Disputes Submitted for Surprise Bills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>31%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>25%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>15%</td>
</tr>
<tr>
<td>Neurology</td>
<td>12%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>2%</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>2%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>2%</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>1%</td>
</tr>
</tbody>
</table>

(Continued from page 2)

providers prevailed in 48% of the cases. There were split decisions in 39% of the cases.

The dollar amounts of IDR decisions are most frequently in the $1,000 to $5,000 range, regardless of whether the health plan or the provider prevails.

As awareness continues to increase around this issue, DFS expects the number of IDRs to continue to increase. New York’s OON Law has been a true success in bringing stakeholders together to solve the problem of excessive charges for emergency services and surprise bills.

A copy of the full report can be found here.
The Annual MSSNY CME Provider Conference was held on Friday, September 20, 2019, at the Courtyard by Marriott Westbury. Attendees included CME professionals from the 33 CME providers that MSSNY accredits and members of the MSSNY CME Committee. The meeting provides attendees with the opportunity to network with other CME providers from around the state as well learn best practices and novel ways of planning and developing high quality CME that is eligible for MOC and MIPS credit.

MSSNY President Art Fougner, MD, made opening remarks and welcomed participants to the conference.

Keynote speaker for the conference was Steve Singer, PhD, Vice President, Education and Outreach; Accreditation Council for Continuing Medical Education (ACCME). Dr. Singer presented on the topic “Advancing the Trajectory of Accredited CME.” He followed this with “Doing Improvement CME for MOC, MIPS, and More,” a session that modeled “gamification” in CME by having participants play a game on planning improvement CME.

From University of Utah Health, MSSNY welcomed Marci Fjelstad, MPH, MBA, CHCP, Associate Director, Continuing Medical Education and Trisha Veenema, Program Manager/Course Coordinator. Their session, “Stop Handing Planners an Application,” presented and modeled a simplified, collaborative method for planning and approval of CME activities.

Sandhya Malhotra, MD, Chair of the MSSNY Subcommittee on Surveys, conducted two fun collaborative workshops: “Achieving Commendation: SCRUM Session” and “Building CME Activities for MOC, MIPS: An Interactive Workshop.” In the first, participants worked together to develop strategies for planning activities that comply with ACCME’s new commendation criteria. In the second, they teamed up to respond to case scenarios in which MOC/Improvement CME activities were devised to solve a defined problem.

CME for MOC credit is a great opportunity for synergy for physicians. The following ABMS-member boards currently have collaboration agreements with ACCME to allow CME providers to plan and implement CME activities that count for Maintenance of Certification (MOC)/Continuous Board Certification (CBC) points: American Board of Anesthesiology (ABA), American Board of Internal Medicine (ABIM), American Board of Ophthalmology (ABO), American Board of Otolaryngology–Head and Neck Surgery (ABOHNS), American Board of Pathology (ABPath), and American Board of Pediatrics (ABP). The American Board of Surgery (ABS) will begin their collaboration with ACCME in 2020. Information about these opportunities can be found here. The Centers for Medicare & Medicaid Services (CMS) include accredited CME as an Improvement Activity in the Merit-Based Incentive Payment System (MIPS) of the Quality Payment Program (QPP). Information on CME for MIPS can be found here. We hope to see you next year. The conference will be held September 25, 2020.
Support for victims of harassment

<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>My organization listens to victims of harassment</td>
<td>60%</td>
<td>76%</td>
</tr>
<tr>
<td>My organization supports victims of harassment</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>Victims of harassment at my organization feel comfortable reporting the</td>
<td>62%</td>
<td>46%</td>
</tr>
<tr>
<td>infraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative to other industries, medicine has less harassment</td>
<td>28%</td>
<td>14%</td>
</tr>
</tbody>
</table>

(Continued from page 1)

WOMEN PHYSICIANS FACE MORE HARASSMENT AT WORK THAN MEN

While women and men face different types of harassment in the workplace — women receive the brunt of it. Only 12% of women reported having never dealt with some form of sexual harassment versus 38% of men. Women are also more likely to experience discrimination, insubordination, retaliation, physical violence, and sexual harassment than men. Eighteen percent of women had reported leaving a job because of harassment compared to 10% of men.

Collectively, both women (83%) and men (73%) felt the medical industry has an issue with harassment, but the majority have never even considered leaving the field over it. Twenty percent of men and 7% of women stated the medical industry does not have an issue with harassment.

Women also witnessed far more harassment of other women than they did of men. Men witnessed more harassment of women than they did of men but still saw much fewer numbers, usually less than half of the number of women reporting. There are also great differences in how women and men view their organizations efforts to fight harassment. Men were more likely to think their organizations had harassment policies, training, and clear reporting processes in place.

WOMEN PHYSICIANS RECEIVE LESS RESPECT

The perception of life as a physician varies greatly depending on your gender. While 69% of men felt that women and men were respected equally in their organizations only 34% of women agreed. And 63% of women felt that men were more respected than women.

Female physicians were also significantly more likely to state that they are treated differently by administration, other physicians and patients than their male peers. Eighty-seven percent of women feel patients treat them differently than men while only 58% of men feel they are treated differently. Similar numbers were found when looking at treatment by nurses, administration, other physicians and other staff.

WOMEN PHYSICIANS HAVE LESS OPPORTUNITIES FOR LEADERSHIP

Both women (63%) and men (69%) are confident in their ability to fulfill their career aspirations and the majority feel they have advanced in their careers. However, women are less comfortable in being assertive and are less likely to think promotions are based on fair criteria or that the best opportunities go to the most deserving employees.

When it comes to actual advancement opportunities there is a big disparity in what women and men think. Seventy percent of men feel opportunities for

(Continued on page 15)
Survey Report: Female physicians receive less respect and more harassment

(Continued from page 14)

their gender are the same as for women, while just 49% of women feel the same. Comparatively, women were far more likely to think opportunities were worse (49% of women compared to 13% of men).

Organization has clear reporting process

<table>
<thead>
<tr>
<th>Perception of gender equality in organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both genders are respected equally at my organization</td>
</tr>
<tr>
<td>Gender equality is better than average at my organization</td>
</tr>
<tr>
<td>Gender equality is poor at my organization</td>
</tr>
<tr>
<td>Gender equality is improving at my organization</td>
</tr>
<tr>
<td>Gender equality is not an issue at my organization</td>
</tr>
<tr>
<td>Gender equality is important to my organization</td>
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</tbody>
</table>

Attitudes towards advancement opportunities

<table>
<thead>
<tr>
<th>Attitudes towards advancement opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel confident in my ability to fulfill career aspirations</td>
</tr>
<tr>
<td>I have advanced in my career</td>
</tr>
<tr>
<td>I feel comfortable being assertive and challenging my colleagues</td>
</tr>
<tr>
<td>There are opportunities for advancement at my organization</td>
</tr>
<tr>
<td>Promotions are based on fair and objective criteria</td>
</tr>
<tr>
<td>Best opportunities go to the most deserving employees</td>
</tr>
</tbody>
</table>

Reported income

<table>
<thead>
<tr>
<th>Reported income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $199,999</td>
</tr>
<tr>
<td>$200,000 - $399,999</td>
</tr>
<tr>
<td>$400,000 - $599,999</td>
</tr>
<tr>
<td>$600,000 - $799,999</td>
</tr>
<tr>
<td>$800,000 - $1,000,000</td>
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</tbody>
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Sacrifices for family/child care

<table>
<thead>
<tr>
<th>Sacrifices for family/child care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced work hours</td>
</tr>
<tr>
<td>Taken significant time off</td>
</tr>
<tr>
<td>Worked part-time</td>
</tr>
<tr>
<td>Worked locum tenens</td>
</tr>
<tr>
<td>Turned down a promotion</td>
</tr>
<tr>
<td>Quit job</td>
</tr>
</tbody>
</table>

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September 23 Assembly Health Committee Chair Dick Gottfried held a town hall meeting on his plan for a single payer system, titled the New York Health Act. He and Senate Health Chair Gustavo Rivera had announced that a series of meetings such as this would occur across the state, but no schedule has yet been announced. While physicians are split on their support for a single payer system, your input is helpful; providing context and a balanced, rounded argument so that all sides are heard is the only way to ensure a fair outcome.

**OPIOID EPIDEMIC ROUNDTABLES**

In the beginning of September, Senator Pete Harckham (Chair of the Senate Committee on Alcoholism and Substance Abuse) held the second of seven roundtables scheduled across the state focusing on “gathering information on the state’s approach to drug use and treatment, as well as innovative best practices and new interventions that will help save lives and halt the opioid addiction epidemic.”

Physicians could be deeply impacted by any policy changes that come out of these meetings as evidenced by the proposals Senator Harckham pushed last session that would have implemented troublesome mandates on physicians who prescribe opioids. While MSSNY agrees with and has supported successful efforts to reduce the harms of opioid addiction, many of the proposals being advanced – while well-intended – would likely prove harmful to patients and further scare physicians off from prescribing opioids.

**ON THE DEFENSE**

Moreover, throughout the summer and the fall, several MSSNY leader physicians (including your PAC chairs) took the time locally and in Washington DC to meet with Congressional leaders regarding the issue of surprise medical bills. Unfortunately, the insurers, unions and many patient groups are advancing proposals that will destroy the private practice of medicine, drive up health care costs and exacerbate existing ED shortages. Leaders of MSSNY and MSSNYPAC have been leading the fight to assure Congress passing fair legislation that is consistent with New York’s balanced approach to this issue.

If you’re interested in participating in these local events, we encourage you to sign up to be a MSSNYPAL by going to [http://tiny.cc/JoinPAL](http://tiny.cc/JoinPAL).

**POLITICS ARE LOCAL**

At the same time, it is imperative that physicians take the opportunity to participate in local political events through MSSNYPAC. It is a great opportunity to develop or enhance working relationships with your elected representatives so that they will be more likely to seek your input on health care policy issues they may face.

Your impact on your community can be felt far outside of the medical office or operating room. You as a physician are the greatest advocate for your profession and your patients and we hope that you will consider getting involved in the policymaking process.

Join the MSSNYPAL. Join the MSSNYPAC.

**PUBLIC HEALTH IMPACT OF LEGALIZING CANNABIS**

You are invited to join the New York State Public Health Association and the New York State Association of County Health Officials for the “Public Health Impact of Legalizing Cannabis.” Program content will address implications for public health, cannabis policy and health equity resulting from a legalized program. As New York State considers the passage of policy to establish an adult-use cannabis program, it is imperative that public health stakeholders unite to prepare for potential implications and learn about policy, regulatory and governance aspects related to legalization.

When: October 17, 2019

TIME: 8:30 AM - 4:00 PM

WHERE: Hilton Westchester

Hear from nationally-recognized, sought after presenters and subject matter experts in partnership with your colleagues in the public health sector. Throughout this meeting, there will be plenty of opportunities for networking with professionals representing: local health departments; academia; clinical care settings; community-based organizations and others who value the health and safety of communities in New York. For more information and to register, please [click here](https://nypha.org/public-health-impact-legalizing-cannabis-workshop/).

[Click here to download a copy of the workshop flyer to print, post and share within your networks.](https://nypha.org/public-health-impact-legalizing-cannabis-workshop/)

**OBITUARIES**

**BRAVERMAN, Jeffrey Joseph;**
Woodbury NY. Died April 29, 2019, age 59. Nassau County Medical Society

**FIORE, John L.;**
Warwick NY. Died May 30, 2019, age 67. Medical Society County of Orange

**HELLER, Arthur D.;**
New York NY. Died May 21, 2019, age 65. New York County Medical Society

**IMARKELLO, Anthony Philip;**
Buffalo NY. Died July 18, 2019, age 85. Erie County Medical Society

**KLEIN, Donald F.;**
New York NY. Died August 08, 2019, age 90. New York County Medical Society

**IPPOLITO, Elio Joseph;**
Ossining NY. Died May 14, 2019, age 86. Medical Society County of Westchester

**MELE, Dominic;**
Scotia NY. Died July 26, 2019, age 104. Medical Society County of Schenectady

**MENNO, Albert Dominic;**
Buffalo NY. Died July 13, 2019, age 87. Erie County Medical Society

**PARK, Keun Soo;**
Hernando FL. Died September 17, 2019, age 92. New York County Medical Society

**PINEDA, Irene Basilio;**
Englewood Cliffs NJ. Died September 06, 2019, age 80. New York County Medical Society

**POOL, Naomi De Sola;**
New York NY. Died September 12, 2019, age 99. New York County Medical Society

**POST, Paul;**
New York NY. Died September 11, 2019, age 89. New York County Medical Society

**REISS, Harry;**
New York NY. Died June 24, 2019, age 94. New York County Medical Society

**RUSSELL, Edwin P. Jr.;**
Rome NY. Died September 18, 2019, age 93. Medical Society County of Oneida

**SEROG, Pirkko Liisa;**
Jamesville NY. Died January 03, 2019, age 89. Onondaga County Medical Society

**TORRETTI, Jorge A.;**
Jamesville NY. Died July 31, 2019, age 85. Onondaga County Medical Society

**TRETTER, Wolfgang;**
Purchase NY. Died August 07, 2019, age 91. New York County Medical Society

**WEINBERGER, Gerald S.;**
Ardley NY. Died July 10, 2019, age 93. New York County Medical Society

**ZIZZI, Joseph A. Jr.;**
Orchard Park NY. Died February 05, 2019, age 60. Erie County Medical Society
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Human Resource Department e-mail: chunt@mssny.org
Fax: (1-516) 833-4760
Equal Opppty Employer M/F

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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)
St. Lawrence: Riverview Correctional Facility (hiking, boating and museums)
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 or DOCCS Personnel Office at (518) 457-8132 for more information and to apply.

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