AHIMA Standards Task Force

HIM Practice Standards Project

Specification of Use Cases for

Information Management Practices in Healthcare:

Copy/Paste

Chicago, Illinois, USA

2017

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# Copy/Paste in Clinical Documentation – Need for Standardization

“Copy/paste or copy/forward is a way to pull all the information together in one succinct document – it is optimizing the use of technology to improve workflow and to assure that providers do not miss vital pieces of information. Appropriate use of copy/paste decreases the administrative burden of healthcare (no longer requiring clerks to gather paper records) while minimizing misses with information in clinical hand-offs. It allows providers to read the very last progress note to understand what is going on with the patient rather than having to maneuver through other areas of the record or like in the paper chart to read the tabs or ask for old records.”[[1]](#footnote-1)

Various healthcare organizations that implemented health information technology (HIT) including electronic health record (EHR) systems and their clinical teams have weighed the risks versus benefits of copy and paste (copy/paste, C/P) functionality. The conclusion of this analysis is that ***the vast majority of clinical EHR users will benefit from this efficient tool, and will use it responsibly to document their critical thinking and tell the patient’s story***.[[2]](#footnote-2)

The examples of appropriate use of copy/paste functionality include:

* Exercising accountability to analyze and update copied forward content to assure that it is consistent with the patient’s current status
* Authenticating, signing dating, and timing the updated clinical content or
* If the copied forward material is brought forward verbatim as a file note, the clinician will document the original source, author, date, and time of the content. For example: “As stated in Dr. \_\_\_\_\_’s note of date/time”. Or utilize a “hyperlink” back to the cited documentation.

However, there risks of inappropriate use of copy/paste functionality including:

* Over-utilization resulting in profound redundancy or “note-bloat”. This can lead to continuity of care concerns, including the inability of other providers to efficiently access critically needed clinical information
* Creating coding and billing confusion, including uncertainty of who provided the care, when, and the patient’s current clinical status and/or
* Violation of federal, state, and/or other legal requirements including denial of reimbursement, fraud and abuse, etc. Only reasonable and necessary services provided at the time of the patient encounter will be considered by payers in determining the level of service. [[3]](#footnote-3)

The inappropriate use of copy/paste is caused by the lack of consistency in implementation of organizational copy/paste policies as well as “deficiencies of HIT products that does not allow to properly point to the original source of data when accessing the record creating redundant entries of the same information.”[[4]](#footnote-4)

To standardize the use of copy/paste capabilities in HIT products across healthcare organizations, the AHIMA Standards Task Force developed the AHIMA Copy/Paste Use Case.

# Normative References

The AHIMA Copy/Paste Use Case is based on the following documents:

1. 2011 AHIMA Copy Functionality Toolkit – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems[[5]](#footnote-5)
2. 2015 ECRI Institute’s Copy/Paste: Prevalence, Problems, and Best Practices Report. [[6]](#footnote-6)
3. 2016 ECRI Institute’s Toolkit for the Safe Use of Copy/Paste that were developed with the AHIMA participation with recommendations such as:

Recommendation A: Provide a mechanism to make copy/paste material easily identifiable

Recommendation B: Ensure that the provenance of copy/paste material is readily available

Recommendation C: Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste

Recommendation D: Ensure that copy/paste practices are regularly monitored, measured, and assessed.[[7]](#footnote-7)

1. 2017 Informational Report: Examining the Copy and Paste Function in the Use of Electronic Health Records published by the National Institute of Standards and Technology (NIST), NISTIR 8166.[[8]](#footnote-8)

# Definitions

**Copy** – act of copying text in the electronic record or document with the intent to move this text from one part of the record to another or into another record or document while the original text is not removed from the record[[9]](#footnote-9)

**Paste** – creating a duplicate entry or reuse of information[[10]](#footnote-10) by transferring text, data, files or objects from an original source to a specific destination while the original text is not removed from the record

**Copy and Paste** – action performed either by keyboard command (e.g., Ctrl + C to copy and Ctrl +V to paste) or with a mouse; selecting data from an original or previous source to reproduce in another location.[[11]](#footnote-11) Action that

* allows users to easily duplicate information such as text, images, and other data within or between documents.[[12]](#footnote-12) Copying and pasting can be from one patient’s record to another and not limited to one patient
* represents any intent to move documentation from one part of the record to another[[13]](#footnote-13)
* represents method of selective data moving from one part of the record to another[[14]](#footnote-14)
* represents process of copying existing text in the electronic health record, and posting it to a new destination[[15]](#footnote-15)

Synonyms: cloning, copy forward, carry forward, cut and paste,[[16]](#footnote-16) pull forward,[[17]](#footnote-17) re-use[[18]](#footnote-18)

**Cloning** – copying and pasting previously recorded information from a prior note into a new note[[19]](#footnote-19)

**Copy forward** – allows authors to begin a new progress note by populating the text with the contents of a prior note[[20]](#footnote-20)

**Carry/copy forward** – bringing forward a portion of a note or an entire old note[[21]](#footnote-21)

**Copy and Paste Functionality** – reproducing text or other data from a source to a destination.[[22]](#footnote-22) Copying and pasting can be from one patient’s record to another and not limited to one patient

**Chain of Custody** – The order in which information should be handled by persons or information systems involved in information creation, management and use; the unbroken trail of accountability that ensures the security, authorship and ownership of data and records in a healthcare encounter

**Provenance** – information about the place, time, person and information system behind the creation, modification and use of data in a record

**Data Provenance** – the evidence and attributes describing the origin of health information as it is captured, <modified and used[[23]](#footnote-23)> in a health system[[24]](#footnote-24)

Synonym: metadata describing data origin, authenticity, ownership and process performed on the data

**Disable**: to make ineffective or inoperative[[25]](#footnote-25)

**Enable:** to provide with the means or opportunity[[26]](#footnote-26)

**Note Bloat** – a way of representation of information in the HIT systems when key findings and actions are obscured by superfluous negative findings, irrelevant documentation, and different diagnosis, all of which make the record difficult and time-consuming to read.[[27]](#footnote-27) Expansion of a note’s length and complexity due to a marked increase in copied content[[28]](#footnote-28)

**Truncation of Information** – not capturing everything that was meant to copied[[29]](#footnote-29)

**Review** – a formal assessment of something with the intention of instituting change if necessary[[30]](#footnote-30)

**Validate** – officially prove that something is true or correct[[31]](#footnote-31)

**Verify** – demonstrate that (something) is true, accurate, or justified[[32]](#footnote-32)

**Update** – provide or include the latest information[[33]](#footnote-33)

# Purpose

The purpose of the AHIMA Copy/Paste Use Case is to eliminate inappropriate use of copy/paste in clinical documentation in HIT products by standardizing

1. copy/paste policies and practices in healthcare organizations and
2. requirements for copy/paste capabilities in HIT products to allow
3. to access, select, and pull (assemble) all the information together in a succinct document
4. properly identify copied/pasted information and
5. properly identify the original source of data when accessing/pulling/generating/managing information in clinical records.

# Target Audience

The target audience for the use case includes:

1. **Healthcare organizations (HCOs)** that implemented or in the process of implementing HIT
2. **HIT vendors including EHR vendors** responsible for delivery of appropriate copy/paste capabilities in their products
3. **Standards development organizations (SDOs)** involved in the development of HIT standards for data integrity and legal health record

# Scope

In 2017, this use case is limited to information captured by the following technical actors (information systems): Admission, Discharge and Transfer (ADT) systems, Health Information System (HIS) including EHR systems and Electronic Document Management Systems (EDMS). Patient’s Personal Health Record (PHS) systems are out of scope. In the future we will expand the use case to include ancillary information systems (laboratory, public health, pharmacy and others) and PHR systems.

In addition, the 2017 scope is limited by the requirements for the type of information related to the same patient as listed in the Content section below. Information on multiple patients is out of scope.

# Actors

Table 1 presents the roles of business actors (humans) and technical actors (information systems) involved in the Copy/Paste Use Case. Business actors are grouped according to their roles under the following scenarios:

1. Policy Setting, Data Verification and Risk Mitigation
2. Data Capture and
3. Education/Training.

Table 1. Roles of Business and Technical Actors: Copy/Paste Use Case

|  |  |
| --- | --- |
| **Actors** | **Role Description: Copy/Paste Use Case** |
| **Business Actors – To be reviewed on 5/15** | |
| **Policy Setting (Compliance), Data Verification and Risk Mitigation (Audit) Actors** | |
| Compliance Staff, HIT Staff | Staff responsible for setting and monitoring organizational policies on copy & paste. |
| HIM Staff: Coders, Clinical Documentation Improvement (CDI) Specialists | Staff responsible for data verification, completion of the medical records, report maintenance including review of reports for copy/paste use and provision of feedback to copy/paste users; education and awareness on the copy/paste use (see educator role below) |
| Risk Managers, Business Process Managers, Operation Excellence Officers, Auditors, HIT Staff | Staff participating in addressing any risks associated with copy & paste |
| **Data Capture Actors** | |
| Patient Registration Staff | Staff responsible for registering patients when using copy/paste[[34]](#footnote-34) |
| Healthcare Providers (physician, nurse, pharmacist, care coordinator, diagnostic service technician, dietician, other) | Those who involved in the provision of care and capturing patient information in the EHR and other health information systems |
| Scribes | Staff who is acting on behalf of the clinician to document patient information in the EHR and other health information systems |
| **Education/Training Actors** | |
| Educators | Staff, including HIM professionals, responsible for workforce training on the use of copy/paste. Education may be provided by consultants including professional associations that deliver training to healthcare organization’s personnel regarding the copy/paste |
| **Technical Actors** | |
| Registration–Admission, Discharge, and Transfer (R-ADT) System | An administrative information system that stores demographic information and performs functions related to registration, admission, discharge, and transfer of patients within the organization[[35]](#footnote-35) |
| Health Information Systems (HIS) including Electronic Health Record (EHR) System | An information system that ensures the longitudinal collection of electronic health information for and about persons; enables immediate electronic access to person- and population-level information by authorized users; provides knowledge and decision support that enhances the quality, safety, and efficiency of patient care; and supports efficient processes for healthcare deliver.[[36]](#footnote-36) These include EMR, EPR, CPR systems (see Glossary section for the definitions). |
| Electronic Document Management System (EDMS) | Software consisting of many component technologies that enable healthcare businesses to use documents to achieve significant improvements in work processes[[37]](#footnote-37) |

# Problems and Solutions

Table 2 presents problems (risks) to documentation integrity when inappropriately using copy/paste and solutions to mitigate these problems with the roles of stakeholders involved. These problems are grouped using ECRI’s four area (1-4 below[[38]](#footnote-38)) and an additional 5th area when poor use of copy/paste poses challenges to clinical care by decreasing the quality of documentation via:

1. Introducing new inaccuracies
2. Accelerating the propagation of inaccurate information
3. Promoting creation of internally inconsistent documentation
4. Generating lengthy notes that may obscure important clinical information
5. Limited capabilities of the information systems.

To specified solutions to the five problem areas stated above, we used those identified in the AHIMA 2012 Toolkit and ECRI recommendations as follows:

AHIMA Recommendations for Healthcare Organizations (HCOs): [[39]](#footnote-39)

* Define and implement organization’s acceptable uses of copy and paste

Define and implement documentation guidelines for the medical staff bylaws/rules and regulations developed by the organization, regulatory and accrediting agencies

* Define and implement operational processes, checklists and expected outcomes including
  + Copy/paste responsibilities by business and technical actors
  + Lists of do’s and don’ts for copy/paste
* Auditing and reporting policies specifying reporting entities, reports templates, scoring metrics and periodicity
* Regular monitoring, review and update of copy/paste practices
* Mitigation efforts and sanctions.

ECRI Recommendations

ECRI A: Provide a mechanism to make copy/paste material easily identifiable – see below AHIMA Checklists on Data Capture and Data Verification

ECRI B: Ensure that the provenance of copy/paste material is readily available – see below AHIMA Checklist on Audit

ECRI C: Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste – see below AHIMA Checklist on Education

ECRI D: Ensure that copy/paste practices are regularly monitored, measured, and assessed – see below AHIMA Checklist on Compliance.

Table 2: Copy/Paste Problems, Solutions and Responsible Staff

|  |  |
| --- | --- |
| **Problem** | **Solution by Stakeholders** |
| **1) Introducing new inaccuracies** | |
| 1. Inaccurate or outdated information on the patient may be carried forward and adversely impact patient care | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A-Provide a mechanism to make copy/paste material easily identifiable*  *ECRI B-Ensure that the provenance of copy/paste material is readily available*  *ECRI C-Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste*  *ECRI D-Ensure that copy/paste practices are regularly monitored, measured, and assessed* |
| 1. Information on the wrong patient may be copied/pasted that may adversely impact patient care | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *“Enabling the user to easily transition from the current chart with unrestricted access to input information to another chart by a deliberate action (i.e., identification / activation of the patient chart), would help prevent errors of documentation in wrong patient chart.” [[40]](#footnote-40)*  *ECRI A, ECRI B, ECRI C, ECRI D* |
| 1. Inability to accurately support or defend evaluation and management (E/M) coding for professional or technical billing notes, e.g.:  * Creating coding and billing confusion, including uncertainty of who provided the care, when, and the patient’s current clinical status and/or, * Violation of federal, state, and/or other legal requirements including denial of reimbursement, fraud and abuse, etc. Only reasonable and necessary services provided at the time of the patient encounter will be considered by payers in determining the level of service[[41]](#footnote-41) | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A, ECRI B, ECRI C, ECRI D* |
| 1. Sloppy and paste practices due to deficiencies in c/p policies | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A, ECRI B, ECRI C, ECRI D* |
| **2) accelerating the propagation of inaccurate information** | |
| 1. Redundant information, which causes the inability to determine current information, i.e. note bloat[[42]](#footnote-42) | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A* |
| 1. Truncation of information when information is cut off at the certain point | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *“EHR systems must be designed to enhance the visibility of the information being selected for copy and paste to prevent users from inadvertently copying only part of the information that was intended to be pasted which could minimize the possibility of incomplete reuse of information that could lead to morbid/mortal errors.”[[43]](#footnote-43)*  *ECRI A* |
| 1. Propagation of false information | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A, ECRI C, ECRI D* |
| 1. Pulling information out of context | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A, ECRI B, ECRI C, ECRI D* |
| **3) promoting creation of internally inconsistent documentation** | |
| 1. Inability to identify the author or intent of documentation | **HCOs:**  c/p policies on data provenance; data/record verification; c/p audit  **HIT Vendors:** improved user interface to display information chain of custody on demand  **SDOs:** develop data provenance standards  *“User interface shall display the ‘chain of custody’ of the information associated with the use of copy and paste. However, this information should not be displayed by default, and only be shown on user demand to avoid the possibility of overwhelming clinical users and contribute to errors of commission (taking an incorrect action).”[[44]](#footnote-44)*  *ECRI B* |
| 1. Inability to identify when the documentation was first created | **HCOs:**  c/p policies on data provenance; data/record verification; c/p audit  **HIT Vendors:** improved user interface to display information chain of custody on demand  **SDOs:** develop data provenance standards  *ECRI A, ECRI B* |
| **4) generating lengthy notes that may obscure important clinical information (note bloat)** | |
| 1. Internally inconsistent progress notes | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A* |
| 1. Redundant information which can restrict efficient access to critically needed clinical information and data (field of noise)[[45]](#footnote-45) or note bloat | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A, ECRI C, ECRI D* |
| 1. Inconsistent formatting of information[[46]](#footnote-46) in order to present it in a way that is needed for clinical care | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface for information presentation to providers, e.g., using templates  **SDOs:** develop c/p practice standards and CDI templates standards  *ECRI A, ECRI B, ECRI C, ECRI D* |
| 1. Unnecessarily lengthy progress notes (note bloat) | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface for information presentation to providers, e.g. to show duplicate information  **SDOs:** develop c/p practice standards  *ECRI A* |
| “Skipping’ reading content or skimming over and fail to notice changes, because of lack of provenance (identification) of what has changed and what hasn’t.”[[47]](#footnote-47) This may slow down the work of clinical staff to treat patients and HIM and compliance staff in documentation review | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  *ECRI A, ECRI B, ECRI C, ECRI D* |
| 5) limited capabilities of the information systems | |
| 1. Sloppy and paste and “note bloat”[[48]](#footnote-48) practices due to deficiencies in EHR design to support the process of building a record that is complete, concurrent, concise, chronological, and clear to the end user creating a medical record that accurately tells the story of the patient[[49]](#footnote-49) | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show identifiable c/p information  **SDOs:** develop c/p practice standards  “*HIT Vendors - When challenges with concerns of patient safety, sloppy documentation, and regulatory concerns there was zero understanding by those presenting/showcasing the EHR. How do we influence accountability/collaboration of the vendors for multi-million dollar systems that is actual and produces real change?*”[[50]](#footnote-50)  *ECRI A, ECRI B, ECRI C, ECRI D* |
| 1. Limited capacity of the field in where information have to be pasted/truncated | **HIT Vendors:** improved user interface by generating error message when system/field capacity is not available  **SDOs:** develop c/p practice standards  *“EHR systems must be designed to enhance the visibility of the information being selected for copy and paste to prevent users from inadvertently copying only part of the information that was intended to be pasted which could minimize the possibility of incomplete reuse of information that could lead to morbid/mortal errors.”[[51]](#footnote-51)*  *ECRI A* |
| 1. Error message needs to be presented to the users, e.g., when space for pasting is not available | **HCOs:** c/p policies; data/record verification; c/p audit  **HIT Vendors:** improved user interface to show error message  **SDOs:** develop c/p practice standards  Data/record verification; improved user interface to show error information  *ECRI A, ECRI D* |

# Content

Patient Information. Healthcare information content requirements for copy/paste are presented in Tables 3 and 4. They are organized by content that “can be” and “cannot be” copied/pasted within various records of the same patient within the visit (Table 3) and across the visits (Table 4).

Content examples from the AHIMA 2012 Toolkit are shown by the asterisk\*, from the NISTIR 8166 – by double asterisk \*\*.

Table 3. Patient Information: Content Requirements for Copy/Paste Within the Same Visit

|  |  |
| --- | --- |
| Content | HIM Actions |
| **Information that CAN BE copied/pasted** – The following are examples of content that may be copied if the information has been verified and validated and has remained the same over a specified time period | |
| Demographics\* | Reviewed, updated[[52]](#footnote-52) & verified[[53]](#footnote-53) at every visit |
| Medications\* | Reviewed, updated & verified at every visit |
| Allergies\* | Reviewed, updated & verified at every visit |
| Problems\* | Reviewed, updated & verified at every visit |
| Elements of a History\* (past medical, social and family history) | Reviewed, updated & verified at every visit |
| Test Results (laboratory, imaging, etc.)\* | Encounter-specific; Reviewed, updated & verified at every visit |
| Physiology Studies | Encounter-specific; Reviewed, updated & verified at every visit |
| Review of Systems | Encounter-specific; Reviewed, updated & verified at every visit |
| Discharge Summary\*\* | Specific elements may be copied, e.g., reason for admission, medications |
| Elements of Care Plan (Quick Notes, Consults, Specialty Notes such as Neurology, Cardiology, etc.) | Encounter-specific; Reviewed, updated & verified at every visit |
| **Information that SHALL NOT BE copied/pasted** – The following content should never be copied and pasted | |
| Vital signs\* |  |
| Assessment\* |  |
| New test result\*\* | New test result that is expected in a few days should never be populated with the old one from the earlier record |
| Authorizations\*\* |  |
| Consent forms\*\* |  |
| Anesthesia records\*\* |  |
| Do not resuscitate (DNR) wishes of the patient |  |
| Living Will (LW) |  |
| Any documentation not specific to the admission, e.g., | Discuss with SME |

The *review and update* of copied/pasted information should be documented by**:**

Describing any new information or

Noting there has been no change in the information and

Noting the source, date and author of the earlier information.[[54]](#footnote-54)

*Verification* should be done via electronic signatures or a personal identification number of physician who conducted the review and update of information.[[55]](#footnote-55)

Table 4. Patient Information: Content Requirements for Copy/Paste for the Same Patient Across Visits

Audit/Provenance Information. Table 5 presents information content requirements for copy/paste provenance, copy/paste use monitoring, and audit trail. This content is included in a copy/paste audit report and is available on demand for HIM staff for monitoring compliance, data quality (e.g., accuracy) and information integrity assessments, information protection and reporting.

Table 5. Data Provenance: Copy/Paste Report Requirements

|  |  |
| --- | --- |
| **Context** | **Source Content: Metadata for Information to be Copied** |
| WHERE | Name and ID of facility which maintains source EHR (content manager) |
| WHERE | Source document ID and record ID from which information to be copied |
| WHO | Name and ID of provider who signed (locked) information in source EHR (content author/creator) |
| WHEN | Time stamp when documented (captured) in source EHR[[56]](#footnote-56) first time |
| WHEN | Time stamp when it is signed (locked) in source EHR |
| HOW | How often this content was copied |
| ~~WHOM~~ | ~~To whom this content was supplied by copy/paste function ( i.e., copied) (Names and IDs of facility and provider – content consumers)~~ |
|  | **Target Content: Metadata for Information to be Pasted** |
| WHERE | Name and ID of facility which maintains target EHR (content consumer) |
| WHERE | Target document ID and record ID to which information was pasted |
| WHO | Name and ID of provider who copied/pasted information (content consumer ) |
| ~~WHEN~~ | ~~Time stamp when information was copied~~ |
| WHEN | Time stamp when information was pasted |
| WHEN | Time stamp when information was pasted (captured, documented) in target EHR document/record |
| WHEN | Time stamp when it is signed (locked) in target EHR document/record |
| WHO | Name and ID of provider who signed (locked) pasted information in target EHR (new content author/creator) |

Open Issue: Audit report – is this 1 report or 2 reports (at the source system and target system)

TO STOP HERE at the 5/15 Call

# Use Case Scenarios

The following are the scenarios for the Copy/Paste Use Case:

1. Compliance
2. Education/Training
3. Data Capture
4. Data Verification
5. Audit

TO BE DEVELOPED

1. Lusk K. Personal Communication, February 15, 2017 [↑](#footnote-ref-1)
2. Marcia Matthias. Personal Communication, February 14, 2015; Southern Illinois Healthcare. Copy and Paste Policy. 2015 [↑](#footnote-ref-2)
3. Ibid [↑](#footnote-ref-3)
4. Grzybowski D. Personal Communication, February 15, 2017 [↑](#footnote-ref-4)
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