# GOVERNOR'S TRANSFORMATION ADVISORY BOARD
## State Capitol, Room 104
## March 19, 2009
## Minutes

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Members Present:

Carolyn Archer
Martha Burger
Don Carter
Mike Fogarty
Karina Forrest
Justin Jones
Rocky McElvany
Kermit McMurry
Dennis Shockley
Lisa Smith
Jack Turner
Terri White

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Others Present:
David Asetoyer- ODMHSAS
Lorrie Byrum-ODMHSAS
Richard Bowden-ODMHSAS
Jeff Dismukes-ODMHSAS
Elizabeth Heard-ODMHSAS
Cortney Yarholar-Innovation Center
David Harris-Innovation Center
Sean Couch-Innovation Center
Jean Wood-Innovation Center
Amanda Reeves-Innovation Center
Karen Frensley-Innovation Center
Marva Crawford Williamson-Innovation Center
Susan Lawrence-FOF
Gina Marston-DBSA
Sandy Pruitt-DBSA
Jennifer Glover-RWJF
Annette Fulton-DRS
Ginger Smith-Red Rock
Nancy Wagner-Hope
Carol McFarland-OHCA
Beatrice Johnston-YWCA
David Wright-ODMHSAS
Lissa James-GLMHC/SOC
Leah Taylor-OHCA
Donna Woods Bauer-OCARTA
Debra Andersen-OSDH
Henry Ireys, Ph. D. Senior Fellow, Mathematica Policy Research (MPR)

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## I. DETERMINATION OF QUORUM, CALL TO ORDER

Mr. Justin Jones, Co-Chair, determined that a quorum was not present and called the meeting to order.

## II. REVIEW OF MINUTES FROM PREVIOUS MEETING

Mr. Jones opened the floor to discussion and comments concerning the minutes for the previous Board meeting held on January 15, 2009. No quorum present, therefore, approval of minutes tabled until next meeting.

## III. Budget Report

Mr. Richard Bowden presented the TSIG budget report for YTD Expenditures for the federal fiscal year ending 09/29/09. Expenditures recorded through 02/28/09. The year four budget spreadsheet included the following:

- Direct Costs
- Carryover approval of $6.6 million
- Actual expenditures and contractual costs
- Projected expenditures and encumbrances
- Totals of expenditures and obligations
- Available budget

*No comments or discussion. Approval of budget report tabled until next meeting.*

## IV. NAMI - Grading the States

Ms. Forrest, NAMI Oklahoma Executive Director, reported that the National Alliance on Mental Illness just released the 2009 Grading the States report on America's Healthcare System for individuals affected by serious mental illness. Ms. Forrest stated NAMI's first Grading the States report was released in 2006. The national average for states was a D and the state of Oklahoma received a D as well in 2006. The 2006 report identified that the dynamic leadership indicated great potential for progress and positive change in the years to come.

In the past three years, progress has indeed taken place, and while the national average is still an inadequate D, the state of Oklahoma has improved to a B, the greatest improvement of any state. Ms. Forrest stated it is important to note some of the many areas identified as improvements in our state's system which are critical to the grading process. There were 65 criteria considered this year for the grading score. Some of the areas that were spotlighted were:

- The state comprehensive plan that was monitored and guided by the GTAB Board is one of the most progressive and inclusive plans in the nation of its kind,
- Tele-Health and Tele-Medicine programs,
- Cultural Competency Trainer of Trainers,
- Peer Recovery Support Specialists program, and
- ODMHSAS Data Division, nationally known for their innovative use of data.

Ms. Forrest mentioned that Commissioner White at the last board meeting stated that the bottom line of the Grading the States report is in the last two paragraphs, which reads as follows:

"If Oklahoma can successfully implement its state plan, it could be a national leader in comprehensive, recovery-oriented mental health care. But, the state has one of the lowest per capita rates of mental health funding in the nation.
ODMHSAS' dynamic leadership and considerable goodwill in the mental health community can help build the political support necessary for sustained investment in the plan's vision. However, broader leadership is needed. In particular, the legislature needs to give high priority to mental health care reform. To succeed, this state must transform potential into promise."

***Discussion included:***
Mr. Turner asked if this had been presented to legislative leaders.

Ms. Forrest stated she was not able to make a presentation to them, but she did provide them with the current report, as well as a comparison grade from 2006, and the explanation for the improvement. Ms. Forrest has spoken to several of the legislative members, who were impressed. Ms. Forrest stated the members know and admit that funding is an issue.

The Board recognized the ODMHSAS staff for their efforts to improve the grade from a D to a B.

Commissioner White stated she appreciated the recognition but also wanted to state that this is a collaborative achievement and could not have been done by ODMHSAS alone. Staff from all of the GTAB agencies should also be commended for their efforts in improving the systems of care in Oklahoma.

Mr. Turner asked the board to prepare a resolution to acknowledge this achievement.

No additional comments or questions.

**V. Project Director Report**
Ms. Frensley recognized Commissioner White on her appointment as Secretary of Health. Commissioner White is the first woman to hold that position since its creation in the 1980s.

Ms. Frensley stated that Dr. Terry Cline will be filling the Department of Health Commissioner position in July 2009. Dr. Cline will be rejoining the GTAB as well and we are all looking forward to his participation.

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Ms. Frensley stated the carryover request was submitted to SAMHSA in December, and it was approved. The application for year five was also submitted, and Ms. Frensley is awaiting approval.

**Targeted Anti-Stigma Campaign**

- Ms. Frensley stated the Anti-Stigma Campaign, called "Community Champions for Mental Health and Addiction Disorders", and is growing. There are currently 16 agencies participating. Preliminary data from the agencies that were surveyed show positive results. Some examples are as follows:
  - 22% increase for those who agree or strongly agree that a person with mental illness can eventually recover,
  - 36% increase for those who disagree or strongly disagree that a person with mental illness is unpredictable,
  - 26% increase for those who disagree or strongly disagree that a person with mental illness is a danger to others.

**Statewide Anti-Stigma Campaign**

- Ms. Frensley reported on the Statewide Anti Stigma Campaign. A decision was made to conduct a market research survey, to find out what people really think about addictive and mental health issues in our state. Ms. Frensley stated the results from the survey will help determine what the target message should be to the Oklahoma public for the statewide campaign.

**Suicide Prevention**

- Ms. Frensley stated legislation was passed to expand the Youth Suicide Prevention Initiative to cover the lifespan and to develop a Suicide Prevention Coalition. From this legislation, the Suicide Prevention Coalition was established to represent all ages. This The Suicide Prevention Coalition meets on the fourth Thursday of every month.

**Mental Health First Aide**

Ms. Frensley stated that a draft contract has been sent to Missouri Transformation to train trainers in Oklahoma to present Mental Health First Aide. Twenty-two individuals from the state of Oklahoma will be trained. The dates for the training are July 27-31, 2009 at the ODMHSAS Shepherd Mall Training Center. Outreach has already begun for the trainers. Trainers will be asked to sustain by providing a predetermined number of trainings within their communities/agencies. We are targeting trainees from higher education, faith-based communities, and HR departments.

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**Consumer, Family, Youth Leadership**

- Ms. Frensley stated the Consumer, Family and Youth Leadership Initiative have three contractors providing training to consumers, family members and youth. The initial "Training for Trainers" meeting was held in February 2009 and core curriculum adopted by the trainers. These contractors are initiating the training within 15 counties throughout the State of Oklahoma.

**Peer Recovery Support Training**

- Ms. Frensley stated that NAMI is providing the Peer Recovery Support Statewide Training that was formally done by ODMHSAS. They will begin training in March 2009. Since January 2008, there are approximately 250 Peer Recovery Support Specialists certified within our state.

**Peer Run Wellness Center**

- Ms. Frensley explained that the Peer Run Wellness Center request for proposal that was announced through the Department of Central Services in late 2008 for contractors to develop Peer Run Drop-In Centers for adults 18 and over did not have bidders. A Wellness Center or Drop-In Center is a center run exclusively by individuals with lived experience. Ms. Frensley stated that after consultation with advocacy agencies, the request has been revised and a new RFP will be submitted to Department of Central Services (DCS) by the end of March 2009.

**Residential Transitional Housing**

- Ms. Frensley indicated that there was a request sent to the Center for Mental Health Services (CMHS) for technical assistance on the Residential Transitional Housing project. The Center of Mental Health Services has approved Oklahoma moving forward with this initiative.

**Consumer Involvement Standards**

- Ms. Frensley stated the Consumer Involvement Study Group and Decision Support Services have been working on a measurement tool. Now that the measurement tool is final, they are working with providers to highlight the standards within the provider agencies.

**Access to Care – Bienvienedo's Project**

Ms. Frensley noted the Latino Project is a Collaborative Community Project taking place in southwest Oklahoma City with individuals from Hope Community Mental Health Center and the Latino Development Agency. The agency needs assessment was completed and they decided as an agency where they wanted to start. The decision was to begin training their front office staff in conversational Spanish and translating introductory materials such as brochures and client handbooks to Spanish.

**Access to Housing**

- Ms. Frensley stated the Access to Housing Project is hiring FTEs to be part of the mental health recovery division that will be working to develop community coalitions and- to secure funding for additional housing units for individuals with mental health or substance abuse issues.

**Cultural Competency Training**

- Ms. Frensley reported the Cultural Competency training had their first level one training in December 2008 and second level one training is scheduled for-- April 6-9, 2009. The National Multi-Cultural Institute will be coming to Oklahoma. A learning collaborative has been established and- is meeting monthly. The learning collaborative will develop a strategic plan for cultural competency development within the state. David Asetoyer, Cultural Competency Coordinator at ODMHSAS, will offer technical assistance to any of the GTAB agencies interested in developing an agency strategic plan. (Interest sheet circulated to Board members).

**Screening – Infant and Early Child**

- Ms. Frensley noted that the Screening Initiative for Infant and Early Childhood project is working on training physicians within the community to administer specific screening tools to identify early social emotional and developmental issues. Last month there was training held with Department of Health's child guidance staff that will serve as consultants and trainers in their local areas. There are 67 staff members trained to provide this consultation to primary care physicians. The screening tools are ready to be distributed, the 1-800 number is in place for questions related to screening, and work has begun on a website that physicians can use to learn more about screening and the tools. Amy Chlouber with the State Department of Health is the contact person that physicians can communicate with about this initiative.

**Screening – Post Partum**

- Ms. Frensley stated that the Post Partum Screening Initiative has a contract in place with the OU Department of Pediatrics. This initiative will screen mothers that have children in the neonatal intensive care unit at Children's Hospital.

**Science to Service**

- Ms. Frensley stated the Science to Service contracts were awarded to OU and OSU to test behavioral health screening tools in primary care locations. Projects should be completed by the spring of 2010.

**Statewide Care Coordination**

- Ms. Frensley indicated the Care Coordination Project has individual Care Coordinators working with families whose children have been in inpatient care or have a high chance of accessing higher levels of care. There are 50 families enrolled at this time.

- **Behavioral Health Workforce Training**
  Ms. Frensley stated that conversations are underway with the Beck Institute for Training and Research to train Oklahoma behavioral health staff in cognitive behavioral therapy and techniques. An initial proposal from Beck has been received and further negotiation is underway to work out the final details.

**DOC Workforce**

- Ms. Frensley stated Dr. Powitzky and the Innovation Center are working on finalizing the DOC Workforce development plan and will be submitting in the near future.

**Tele-Health Network**

- Ms. Frensley indicated that the Tele-Health Network staff are working on developing outcome measures, to substantiate return on investment. Ms. Frensley stated there was an application submitted to Human Resource and Services Administration Office of Rural Health Policy and the Western Interstate Commerce for Higher Education nominating the Oklahoma tele-health network as a rural promising practice. The Innovation Center will be informed by the end of April whether or not we made the first cut. If we make the first cut, then additional information about the system will be submitted, and an article published in their Promising Practice Journal.

No comments or questions.

**VI. DOC – ODMHSAS Collaborative Initiatives**

Mr. Bob Mann, Department of Corrections (DOC) introduced himself and Mr. Randy May ODMHSAS, to the Board.

Mr. Mann stated DOC and ODMHSAS have worked together on many different issues and projects. The following is their presentation on the Oklahoma Mental Health and Criminal Justice Collaboration and the Mental Health Reentry Program.

- Oklahoma Criminal Justice and Mental Health Collaboration Timeline:
  - 2000 SAMHSA/DOJ Mental Health/Criminal Justice Conference in Boston
  - 2002 The Oklahoma Partnership in Creating Change (TOPICC)
  - 2003 Oklahoma Conference on Mental Illness and the Criminal Justice System
  - 2004 SAMHSA funded Mathematica Policy Research Project
  - 2005 DOC Board Resolution
  - Drug Court/Mental Health Courts
  - SVORI Grant
  - COSIG Grant
  - T-SIG – Governor's Transformation Advisory Board
  - 2007 Access to Recovery Grant

- Partners in Collaboration:
    - Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)
    - Oklahoma Department of Corrections (DOC)
    - Oklahoma Department of Human Services (DHS)
    - Oklahoma Health Care Authority (OHCA)
    - Social Security Administration
    - Oklahoma Department of Rehabilitative Services – Disability Determination Division
    - Oklahoma Pardon and Parole Board
- Partners in Collaboration:
    - Mathematica Policy Research
    - Oklahoma Governor's Interagency Council on Homelessness
    - Veteran's Administration
    - NAMI Oklahoma
    - Oklahoma Mental Health Consumer Council
    - Oklahoma Depression & Bi-Polar Support Alliance
    - Mental Health Association of Tulsa
    - Multiple faith-based and Native American Reentry groups
- Crucial Elements of a Correctional Mental Health Reentry System:
    - Executive level buy-in
    - Potential partners examine overlap in missions
    - Recovery orientation and public safety awareness
    - Coalition of empowered boundary spanners
    - Focused on solutions-tear down silos
    - Co-occurring capable-underserved population
    - Common vocabulary-framework for identification of target population
    - Shared conceptual framework-Sequential Intercept Model
- Individualized Re-entry Plan:
    - Each person transitioning into the community is actively involved in and has a significant role in the individual planning process. Each person also plays a major role in determining the direction of their individual plan. Planning is consumer-directed and person-centered to find one's:
        - Strengths
        - Needs
        - Abilities
        - Preferences
        - Challenges
- Targeting Interventions To Offenders with the Highest Level of Need:
    - MH-C1 requires psychotropic medications, major diagnosis of psychotic disorder, bi-polar, or major depression
        - Requires special intermediate housing unit with intensive treatment track(s) to be able to adjust to incarceration

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        - History of cycling, sporadic or consistent noncompliance with prescribed treatment with resultant behavioral and/or mental deterioration
        - Requires specialized intensive treatment track(s) and release planning to be able to function upon release to community
- Key Staff for Implementing Mental Health Reentry-Integrated Services Discharge Managers:
    - Discharge managers are boundary spanners:
        - Central office employees of ODMHSAS, based in correctional facilities
        - Have undergone full training required by DOC for an employee to work in a correctional facility and have undergone the ODMHSAS required training
        - SOAR(+) (SSI/SSDI Outreach and Recovery) training
        - Have credibility with DOC and community mental health staff
        - Flex funds available to assist with offender needs
    - Participates as a member of the facility interdisciplinary team
    - Coordinates discharge planning and referrals for persons transitioning from designated correctional facilities into the community
    - Interviews clients to explore strengths, needs and resources which are essential for a successful transition into the community
    - Collaborates with community agencies to arrange for admission or referral to appropriate residential, inpatient or outpatient services
- Key Staff for Implementing Mental Health Reentry-Co-occurring Treatment Specialists:
    - Ability to tailor substance abuse treatment for clients with severe mental disorders
    - Identify and discuss alternatives/coping strategies with the patient/significant others as they relate to the complexity of both mental illness and addiction illness occurring concurrently
    - Develops a plan of care that provides for continuity of care and involves those community programs that can support both mental health and addiction
    - Provides individual therapy and group therapy consistent with accepted theories of recovery from addictions and mental illness
- Key Staff for Implementing Mental Health Reentry-Reentry Intensive Care Coordination Team (RICCT):
    - Four CMHC based teams:
        - Two in Tulsa, two in Oklahoma City
    - Each team consists of a case manager and a credentialed peer recovery support specialist:
        - Experienced or training related to co-occurring disorders
        - Ability to provide face-to-face services as needed during after-hours, weekends, and holidays

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        - Works with the consumer in the community until integrated in traditional services
        - Flex funds available to help with needs
- Intensive Reentry Planning for those Individuals with the Highest Level of Need:
    - During fiscal year 2007, DOC discharged approximately 8,000 offenders to probation/parole supervision or directly to the street without supervision. Approximately 1,000 of those 8,000 discharged had current symptoms of and were in need of treatment for a serious mental illness.
    - Target population for intensive reentry planning (02/07 to 03/09):
        - Discharge managers 232 (serving/served)
            - RICCT – 102
            - PACT – 13
            - CMHC – 34
            - Other – 41
        - RICCT – 159
        - Co-occurring treatment specialists – 300
- Collaboration Fosters Collaboration:
    - Medicaid Reimbursement Program
    - Information Sharing Agreement (qualified service organization agreement)
    - Vocational Rehabilitation
    - T-SIG funded Regional Housing Specialists
    - Recovery Support Specialist training for offenders
    - NAMI peer support groups
- Information Sharing Agreement:
    - 2007 qualified service organization agreement
    - Individual consent not required
    - HIPAA, 42 CFR Part 2 compliant
    - Web based – DOC clinicians credentialed
    - Currently used on an individual basis, will convert to batch file loading when DOC EHR implemented
- Future Goals:
    - Smart on Crime Initiative
        - Additional discharge managers
        - State-wide RICCT coverage
        - Additional Co-occurring treatment Specialists
        - Forensic PACT teams
    - Implement/create recovery focused correctional reentry preparedness curriculum correctional reentry preparedness curriculum
    - CIT-type training for DOC staff
    - Criminal justice training for CMHC staff
    - Increase number of offenders granted parole

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No comments or questions.

## VII. Discharge Planning Program for Inmates with Mental Illness

Henry Ireys, Ph.D., from Mathematica Policy Research was introduced and recognized Commissioner White on her appointment to Secretary of Health.

Dr. Ireys stated that the study, which began in 2004 was a collaborative project and active partners on the project were ODMHSAS, DOC, OHCA, OKDHS, Social Security Administration, Department of Rehab Services, and Division of Disability Determination. SAMHSA made a major contribution to understanding the importance of this issue in providing the funds to develop this model program.

The project goals were to minimize gaps between discharge from correctional facilities and Medicaid enrollment, improve access to treatment, and prevent re-entry to correctional facilities or other residential settings. Many individuals who are in correctional facilities who have a mental illness often are discharged unprepared to deal with the consequences of their mental illness in the community. The study was designed to determine to what extent we can make sure that individuals who have mental illness and are coming out of correctional facilities have access to the care they really need and to make sure that their symptoms do not reoccur and they do not go back. This evaluation is a snapshot of the program at one time. The final report is finished and with SAMHSA, and MPR is hoping that it will be in publication within the next month or two.

Dr. Ireys stated part of the intervention evaluation program was facilitating applications for Medicaid and disability prior to discharge. MPR looked at the intervention group working with the discharge managers and compared the outcomes with three other groups. From a national evaluation point of view this is a relatively rigorous design, and it will convince skeptics about whether or not the impact was real. Dr. Ireys stated there were approximately 77 inmates that were eligible to work with the discharge managers. Of the 77 inmates, 53 of them received intervention services. There were 27 of the inmates that started the Social Security Income (SSI) and Disability Income (DI) applications, 26 started the Medicaid applications and 17 were enrolled in Medicaid by the day of discharge. The inmates that were in the intervention program were enrolled in Medicaid far more frequently than a similar group of inmates who were being discharged from the same institutions prior to the program. Twenty-six percent of the inmates who were involved with discharge managers had Medicaid on the day of discharge and only 8% of the same type of inmates, prior to the implementation of the program, received Medicaid on the day of discharge. The use of Medicaid services was different between the two groups. Within three months after discharge, 23% of the inmates that had worked with the discharge managers had received some type of service through Medicaid, compared to 7% from the comparison group. Numbers rarely alone are sufficient to drive public policy

developments, but when there is a consensus about the need for a new policy or to enhance access to care, quantitative evaluation results can add a lot to arguments. These numbers showed there is an organized program that does make a difference. Dr. Ireys stated not only does it show it was successful but why it was successful. It was clear to MPR it was the extensive interagency collaboration at the state and local levels that really made this program work.

***Discussion included:***
Mr. Turner asked if the state could come up with some reliable numbers of the reduced recidivism rates.

Dr. Ireys thought that data might be able to substantiate reduced recidivism in the future as the individuals are discharged for longer periods of time. ODMHSAS Decision Support staff who are monitoring outcomes post study are working on a number of different comparisons. The outcomes in recidivism for the treatment group will be compared to a similar group of inmates who came out of the same institutions in the years prior to the study and possibly compare it to other inmates who came out of other Oklahoma correctional facilities during the same time that the discharge managers were working.

No additional comments or questions.

**VIII. Evaluation Update**
Mr. David Wright indicated that the Evaluation Workgroup has work underway in the following study areas:

- **Consumer Involvement**
  - The Consumer Involvement Standards developed in Oklahoma are being used as a model in the development of National Standards.
  - The Consumer Involvement Study Team is working with the Evaluation Workgroup on a measurement tool.
    - Measurements have been developed for:
      - Individual Level Standards
      - State Level Standards
  - The Group needs to develop measurements for the Community Standards, as well as determine the process of data collection for the tool.
- **Recovery and Resiliency**
  - The Recovery Study is focusing on the impact of Illness Management Recovery (IMR).
    - Interviews with clients involved in the impacted and non-impacted groups have begun at Hope Community Services and Central Oklahoma Community Mental Health Center; over 20 clients have been interviewed for the baseline measurement.
    - Two additional providers will begin IMR groups in April.

  - The Resiliency Study, focusing on the impact of Care Coordination on youth and their families, in progress with 25 participants interviewed from the treatment group and 24 interviewed from the comparison group.
- **Evaluation of Anti-Stigma Campaign**
  - Four agencies have completed the anti-stigma campaign potentially impacting over 4,500 employees.
  - All participating state agencies on the GTAB have agreed to take part in the campaign.
- **Workforce Study**
  - Currently behavioral health care providers being surveyed include:
    - Community Mental Health Centers
    - Hospitals with Psychiatric Units
    - Office of Juvenile Affairs – Provider Agencies
    - Oklahoma Department of Human Services – Provider Agencies
  - Other agencies will follow
  - A report is being developed based on data collected from the Workforce survey and from other sources, including OPM, Department of Commerce, and Regents for Higher Education.
    Preliminary analysis indicates that workforce shortages that exist now in the behavior health care field will be even greater in ten years.
- **Policy Change Interviews**
  - Policy change interviews will begin in June and will cover FY2007 through FY2009. The Evaluation Team conducted a focus group with consumers and advocacy representatives to get consumer input into the policy change interview process.
  - Agencies should provide Annual Reports, Legislative Updates, administrative rule changes, and other supporting documents to Dr. Wright, so that as much of the report as possible can be developed prior to the interviews.
- **Microsoft Project Tracking and Documenting Progress on the Comprehensive Plan (all GTAB-approved projects and activities)**
  - All projects have been entered into the Microsoft Manager
  - Projects are now tracked through monthly reporting
  - This tracking was implemented in February and covers information from the beginning of this federal fiscal year
  - Last month there was 100% response rate from all parties responsible for project oversight.

Mr. Jones opened the floor for additional comments and questions. There were no additional comments or questions.

## IX. Adjournment

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Mr. Jones opened the floor for additional comments and questions. There were no additional comments or questions.

He opened the floor for motion to adjourn the meeting. Motion was made and seconded by the Board.

Mr. Jones *adjourned the meeting.*

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Justin Jones (Co-Chair)

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