Making HIPAA Second-Nature
Page 18
Trust the specialists.

Helping physicians reach their financial goals since 1993.

Entrust your financial goals to an organization dedicated to physicians. At UMAFS, we understand the unique circumstances of school loans, insurance needs, career changes, family and retirement goals. Take your financial needs to the specialists. Call us for a no-cost financial analysis today.

CALL 801-747-0800 OR VISIT ONLINE AT UMAFS.ORG
FEATURES

2 CEO's Message
By Michelle S. McOmber, MBA, CAE

4 UMA Leadership Development: Houston, We Have a Revolution
By Rodney A. Pollary, MD, FAAP

8 Yes, Now Is A Good Time To Discuss Your Estate Plan
By Gregg D. Stephenson, Ray Quinney & Nebeker

10 2019 Legislative Session Report
By Mark Brinton, JD – UMA General Counsel and Director of Government Affairs and
Michelle S. McOmber, MBA, CAE – UMA CEO

18 Making HIPAA Second-Nature
By Sara Vandermolen, Utah Health Information Network

20 The Small & Medium-Sized Practice's Guide to HIPAA
Originally Published By Docbookmd, A UMA Member Benefit Partner

24 Utah Health Status Update

26 The Value of Expertise
By Ryan M. Bladen MBA, CFP®, Vice President, Financial Advisor, UMA Financial Services

DEPARTMENTS

CME Calendar 27
CME Spotlight 27
Today, physicians and healthcare in general are under constant scrutiny and attack by the legislature and others. I am concerned about what is happening in the legislature and how people view physicians, particularly in the past few years. How people feel about physicians affects what happens in the legislature. It affects where healthcare is going, and the role physicians will play in that healthcare. Physicians are the high-profile providers who are often blamed for all healthcare problems including the cost of healthcare and patient unhappiness with their healthcare experience.

In my many years of legislative sessions, I have never seen such animosity and direct attacks on healthcare or physicians as I have during the session that just ended. The scrutiny and desire to change and control all healthcare started in full force about 2008. Since that time, without fail and ever increasingly, we have discovered and fought to stop or change bill proposals that seek to control and legislate every aspect of healthcare, particularly what physicians can and can’t do via parameters that others seek to put on physicians through legislation. Instead of looking to rein in mid-level and other types of providers (including fringe providers) and keep appropriate parameters around them, I have seen an increasing number of bills which allow expansion for every healthcare provider (whether legitimate or not) while putting more constraints on physicians.

Physicians in the past, and even today, are still near the top of the list of those whom individuals trust most and rank highly for honesty and ethical standards. However, over the past few years, physicians have been bypassed by nurses and, depending on the survey, by other professionals. Gallup's 2019 list of ‘Most Trusted Professionals’ once again ranks nurses as number 1 (84% ranking very high/high), physicians as number 2 (67% ranking very high/high), and pharmacists are number 3 (66% ranking very high/high), just barely lower than physicians. On the flip side for very low rankings, nurses are again number 1 for the fewest low rankings (only 2% ranking low/very low, pharmacists are number 2 (5% ranking low/very low), accountants are number 3 (7% ranking low/very low) and physicians are number 4 (8% ranking low/very low). Other surveys or polls rank physicians even lower for trust and honesty, below firefighters, teachers and others.

Why are physicians losing ground? There are many reasons that are espoused by experts including: 1) patients questioning a doctor’s honesty or ethics of a diagnosis; 2) patients blaming physicians for a diagnosis or not believing a physician because they have diagnosed themselves; 3) third-party interference in the physician/patient relationship – dictating decisions or care such as what procedures or even medications can be given; 4) administrative burdens placed on physicians which require them to spend more time on administrative tasks and less time with patients; 5) media focus on a few bad actors that give all physicians a bad name; 6) physicians not giving patients everything they want; 7) patients blaming a physician when they have a bad experience or outcome during care (long wait times, rude providers – medical assistants, others; 8) curt or abrupt communication between a physician and a patient; 9) blaming physicians for rising healthcare costs; and 10) blaming physicians for public health epidemics – opioid crisis, not doing enough to help those who may be suicidal when they may have seen those individuals
Recently, etc. These are just some of the reasons there has been a decline in public trust in physicians even though most of these reasons have nothing to do with the integrity of or ability of a physician to give good care.

Unfortunately, all these reasons also bring more scrutiny to physicians and healthcare and an attempt to control both. With the rise in healthcare costs and since healthcare takes such a large portion of state and national budgets, legislators increasingly focus on physicians and healthcare and on how they interact. Some of this scrutiny has helped bring about good changes to healthcare, but much of it just brings forth legislation that someone thinks is a good idea without thought of the consequences. Or legislation proposed because someone else has asked for it whether it is good policy or not.

For example, while transparency in healthcare is a good idea, transparency that does nothing but increase costs is not something that should be passed. This year we had four transparency bills, all asking physicians (and hospitals) to provide different information to patients to place “transparency” in the system. We support transparency, but it should be meaningful. Some of the requests were reasonable and made sense and were possible, others were completely unreasonable and impossible and would cost the healthcare system more money without providing any benefit to patients. One bill would have required a physician to tell a patient exactly how much they would have to pay for care before the care and not allow the physician to charge something different even if the care ended up being different from that used to calculate the original estimate. It would have required the physician to see the patient. The bill was completely unreasonable, even impossible in certain cases, and would have increased costs because a physician would have to give the highest possible estimate to make sure they covered any possible contingencies. Without all the insurance information (co-payment, co-insurance, deductible paid for the year and exact amount that would be paid to the physician and what they could collect from the patient for care), even those estimates would be unrealistic and impossible in many cases. Physicians simply do not have that information prior to initiating most care. There was no requirement to require insurers to have this information immediately available to physicians or for patients either so providing the tools that physicians would need to do something like this was not included in the bill.

In addition to transparency, we had bills that would limit how much physicians could be paid for certain care by third-party non-government payers, bills to place additional educational requirements on physicians, bills requiring physicians to participate in one-on-one counseling if their patient was on a controlled substance and happened to die with the possibility that the controlled substance contributed to the death, and bills that told a physician what they must say or do with a patient, and many more. We also had the anticipated scope of practice expansion bills where mid-levels and other types of fringe providers propose to allow, through legislation, what they have not earned through education.

Most physicians strive to do what is right for their patients under new and increasingly difficult practice environments and that should be recognized.

Physicians are being attacked from all sides and the decreasing trust by patients does not help. Some of those patients are legislators, or they approach legislators, and then a bill is opened that will affect the ability of a physician to practice without more restrictions or requirements.

While many of the requirements placed on physicians are the reason for the lack of trust or loss of trust in physicians, I believe we need to work on the public image of physicians in Utah. We need to fight back against this attack on physicians. I believe in physicians, in who they are and what they are, and their importance to healthcare. Most physicians strive to do what is right for their patients under new and increasingly difficult practice environments and that should be recognized. Physicians should not be under attack and blamed for all healthcare woes. We need to make sure that we let legislators, the media, and others know what physicians do and how much they contribute to the good of healthcare.

We will push this next year to really change the discussion about physicians. With that in mind, I urge all physicians to step up and let us know all the good that you are doing – for your patients, for your communities and for healthcare. I thank all physicians who participate with organized medicine. It makes a difference. One voice does not do much, but together we can continue to make a difference, push back on bills that make no sense, that harm physicians and their ability to practice good medicine, and make sure that physicians are recognized as the great professionals that they always have been. It is time to bring back trust in physicians.

References
Healthcare as we know it is changing, and not for the better. We physicians need the leadership skills necessary to come together and find unified solutions on how to put healthcare back where it belongs — in the hands of the patient and the physician.

As a retired pediatrician of 40 years, I recently had what I feel is an outstanding opportunity for every physician and practitioner in the State of Utah. I attended the UMA Physician Leadership Development Course, where 40 physicians from all specialties came together to learn to do our jobs better. We did so by relearning one of our greatest responsibilities as physicians — how to lead. We learned about ourselves. We completed questionnaires on each other and received feedback on our own leadership abilities. We addressed our own personal values and beliefs that make us who we are. We shared our concerns openly with each other. We worked together to create unique solutions to problems and enhance our ability to make a difference. During the meeting it was joked that we should work on solving the problems of healthcare, and the wonderful instructors backed us off and said that was for another day. Perhaps that day is coming soon.

That day needs to come soon. We are in a healthcare crisis.

The Crisis of Healthcare
I know very few physicians who are happy with the way healthcare is going. We have outrageous costs for routine, yet life-saving medications. Loaded, government-backed acronyms control everything from which types of exams we are allowed to do at which visits to which ICD-10 code will cover which prescription. And there’s enough paperwork and regulations to add hours to our workweeks. We are in need of some solutions, and it is only through unity and shared leadership skills that will we ever get there.
I would like to speak of “we” as the wonderful group of physicians who have made the commitment to serve. When I started 40 years ago, the practice of medicine was truly independent. It was much simpler, though not without flaws. Most of us were trained with the idea that if you wanted something, you should get it, and problems were solved in whatever style those in charge were accustomed to. I met a wonderful man by the name of Irwin Rubin, organizational psychologist of Temenos, who wrote a book about this era of leadership, titled “My Pulse Is Not What It Use To Be.” It is a true story of a physician leader named Ray Fernandez who chose to become a part-time leader of his medical group. Within a short period of time he had to give up his entire practice to focus on the leadership position because he struggled so much to get the doctors to agree on anything. The entire clinic soon disbanded and failed. The bottom line was those doctors didn’t know how to be governed by values, common goals, and mission statements. In order to lead, we need to learn how to follow.

I would like to speak of “they” as those who came into healthcare to first assist us in our mission, but whom I believe now control healthcare and are steering it in the wrong direction. What started out as attractive offers about rapid payment plans and easy collection systems has turned into page after page of rules on what we can and cannot do and how we have to do it. Insurance companies now tell us which hospitals and pharmacies we can use, when and how often we can test our patients for certain things, and how much of our charges will be allowed and paid. The government also first entered into healthcare to assist, but this, too, quickly turned into bullying leadership as they implemented overarching safety controls with OSHA, lab controls with CLIA, information controls with HIPAA, and eventually a massive, mandatory computerized medicine system implementation. All of this again allowed for more supervision, and is made worse by the tens of thousands of dollars in penalties for failure to comply. Quality checks and oversight are important, yes. But micromanagement to the point of paralysis is not efficient, and becomes unacceptable when it leads to the sacrifice of patient care.

The third participant in healthcare is us—all of us. Every one of us has been or will be a patient at one time, and most of us know the frustrations that come when we can’t seem to access or afford the healthcare we feel we deserve. I myself had a disheartening experience when I went to pick up a prescription for Eliquis to manage my recently acquired pulmonary embolism, and found out that it would be over $500 a month—about as much as the average car payment.

There was a time when the doctor-patient relationship—rather than the clinic-insurance company relationship—was the guiding force behind everything we did. That has changed significantly. Now we physicians are too focused on problems to be solved at the expense of people who need to be loved, and those people are losing their trust in us. Though we are there for the most important events in our patient’s lives—from birth to death and in between—only 36 percent of Americans say they have a great deal of trust in the medical system. As someone who has spent over half his life taking care of others, this statistic is heartbreaking. We are all on a ship called the USS Healthcare Titanic, and I hate to say it but there are still not enough lifeboats.

A Call For Unity

Without a sense of who we are and what we are about we will continue to struggle. Mid-way through my career I moved to Vernal, Utah and was soon after elected chief of staff. I felt it was a good idea to institute a value-based system in the medical staff. We had several meetings and argued about the smallest details. Doctors are not known for speaking from their hearts, and this group was the same. Wonderful people, but united they were not. At about the same time I went to Philadelphia to visit my new miracle granddaughter who was born with a tennis ball-sized tumor in her lung. The skilled surgeons removed her left upper lung and the tumor and she was home breastfeeding in a week. While I was there I felt the spirit of the place and the men who met in the Assembly Hall and constructed our Declaration of Independence. They, too, were not united and struggled for unity—and succeeded. Thomas Jefferson took it upon

### Consultants Needed for Long-Term Disability Claim Analysis

**PEHP**

**Health & Benefits**

Our Long Term Disability Program is seeking licensed practitioners in the SLC area as outside consultants in Internal Medicine and Family/General Practice. Board Certification is required.

PEHP is a nonprofit trust providing health benefits to Utah’s public employees. We are experts in self-funding and serve only the public sector — the State of Utah, its counties, cities, and other public agencies. To learn more visit [pehp.org](http://pehp.org); information about PEHP LTD can be found under the “Our Products” tab.

- Will review LTD claim files and medical records to determine eligibility.
- Most work performed via internet; you determine when you work.
- Must be able to communicate effectively and work collaboratively.
- Will participate in our appeal process.
- No experience necessary.
- Impairment rating knowledge, testimony and disability claim experience helpful.

**If you are interested in learning more about this LTD consultant position forward your CV and current contact information to angie.benson@pehp.org.**
himself to create the first draft of a unifying document, and the rest is history. I came back to Vernal and picked the wisest and most senior person on our medical staff, Dr. James Allen, and asked him to do the same for us. He took a month and came back with a mission statement and, not surprisingly, it was ratified.

As I reviewed the Utah Medical Association website and bylaws, I could feel the intense organizational commitment to defend us, and that is wonderful, but what do we as Utah’s physicians believe personally and professionally? There are no easy answers to these healthcare problems, but if we are to solve them we need to approach them with a unified mindset as our guidebook.

The Leadership Skills to Make It Happen

All these changes in healthcare are bringing about a host of emotional responses, both on our end as physicians and from our patients who deserve nothing less than dependable, compassionate care. I believe the time for true leadership is now. Not by a select few, but by all of us. This is a healthcare revolution we are in, and the battle lines are being drawn. We are in need of an army of physician leaders paddling in harmony to keep us afloat as we move up stream.

I believe this Physician Leadership Development Course offered through UMA should be required for everyone practicing medicine today. This two-and-a-half-day course accomplished more for me than years of attending physician executive training. We had to work as a team. We worked on our issues. We worked on us. Upon completion I would proudly say that I would take my 40 physician warriors with me to work on any issue.

It reminds me of the efforts made to save the astronauts from Apollo 13. As you may recall, their mission was a wash, their oxygen tank had exploded, and now they were living in the LM that was not designed for 3 people. The carbon dioxide levels were becoming toxic and a group was assigned to come up with a way the astronauts could eliminate the CO2 using whatever they would have on board. Like our founding fathers, they sequestered and struggled and in the nick of time came up with the solution. I truly believe we need teams of well-trained physician leaders to sequester and come up with solutions to this healthcare epidemic. If we don’t, “they” will, and we will be left drifting down the stream the wrong way, exhausted, discouraged, and without a paddle.

To my fellow physicians: please attend this leadership course. It will do wonders for yourself, your family and your practice. It will put you in a place to begin to solve these healthcare problems. I only wish I had done it years earlier.

And to the UMA: please take it upon yourself to organize committees to solve these problems. We need committees to create a list of values for UMA so we know who we are as a whole. We need other committees to take this leadership course together, then sit down and look at these real-life problems with our current healthcare system and come up with real solutions to get things back to how we want them. I wholeheartedly believe that it can be done.

Thank you for reading this, and I wish each of you the very best in your personal life and practice to find that balance you need.

Rodney A. Pollary, MD, FAAP is the founder of Willow Creek Pediatrics, Nighttime Pediatrics, and Dinosaurland Pediatrics. He graduated from the University of Utah Pediatrics Residency Program in 1977 and practiced medicine for over 40 years as a dedicated and compassionate pediatrician. His honorary titles include the Lifepoint Hospitals Physician Leadership Award, Rural Hospitals Doctor of the Year, and being a great-grandfather.

Rubin IM. My Pulse Is Not What It Used To Be. Temenos Incorporated; 2006.


A TRUSTED PARTNER WITH PROVEN EXPERIENCE

COPIC is a better option for medical liability coverage that offers more. Our industry-leading programs support physicians, medical professionals, group practices, hospitals, and medical facilities to deliver improved patient care. And having a proven partner means you can focus on what matters most—better medicine and better lives.

COPIC benefits include:

• **Physician-led company** recognized for its patient safety and risk management programs.

• **A 24/7 risk management hotline staffed by physicians** for guidance in urgent situations.

• **An array of educational activities** that include in-person seminars, on-demand courses, and multi-day conferences.

• **Frequency of claims among COPIC insureds is 30% less than the national average.**

• **20+ years of experience with communication and resolution programs** that address patients’ needs and work toward a resolution after an unexpected outcome.

• **On-site reviews that identify high-risk areas** and best practices to address these.

COPIC is the endorsed carrier of the:

Better Medicine • Better Lives

www.callcopic.com

For more information, please contact Connor Macey at cmacey@copic.com or (800) 421-1834 x6185.

Colorado Hospital Association
Colorado Medical Society
Iowa Medical Society
South Dakota State Medical Association

Minnesota Medical Association
Nebraska Medical Association
North Dakota Medical Association
Yes, Now Is A Good Time To Discuss Your Estate Plan

BY GREGG D. STEPHENSON, RAY QUINNEY & NEBEKER

MY MOTHER LIKED TO remind me from time to time that the failure to plan is still a plan, it’s just not a well thought out plan. Thinking about death is an uncomfortable subject for many, but that does not change the fact that death is coming.

If you were to die today, what would happen to your assets? If your spouse inherits your assets, will he/she manage them properly? If you are in a second marriage, how do you want your assets split between your spouse and your children? What if your spouse remarries, will he/she protect your assets for your children? If your children inherit your assets, will they know how to properly manage them? Do any of your heirs have financial problems? Do any of your heirs have mental health issues, or substance abuse issues, that would make receiving a significant sum of money dangerous or problematic? If you own a business, is there a plan in place to ensure that the business can survive your passing? Have you nominated guardians for your children? Who will administer your estate? These are significant questions, and planning today can save your family from a great deal of difficulty at your death.

Even if you have a plan in place, a periodic review of your documents is essential. Changes in your family situation may have occurred that should be reflected in your estate planning documents, or you may have decided to alter how your estate is to be divided among your beneficiaries. On the other hand, changes in your financial situation may also have occurred that impact your desire for how your estate is to be administered at your death. A periodic review of your assets and your estate plan can ensure that you are still comfortable with the ultimate distribution of your assets.

What Is Estate Planning?

Estate planning is simply the process of reviewing what you own, how you want what you own to be administered upon your death, and who should be in charge of ensuring that what you own is administered according to your desires following your death. While many people have an estate plan in place, surveys typically show that a majority of Americans have not completed an estate plan. There are many reasons why it is important to have a carefully thought out estate plan, including ensuring that your assets will be distributed and managed in the way you want.
Estate Taxes

The estate tax laws have changed significantly over the past decade. In December of 2017, Congress passed the Tax Cuts and Jobs Act, and doubled the estate and gift tax exemptions from $5,000,000 per person to $10,000,000 per person. Adjusted for inflation, the estate and gift tax exemption for 2019 is $11,400,000. The $10,000,000 estate and gift tax exemption will fall back to $5,000,000 on January 1, 2026 unless Congress acts to extend the current level. The tax rate for assets in excess of the estate and gift tax exemption is set at 40 percent.

While the increase in the estate and gift tax exemption to $10,000,000 (adjusted for inflation) may expire in 2026, it is a significant increase that provides individuals with planning opportunities that have not been available with lower exemption levels. For example, a married couple with a net worth under $10,000,000 may no longer need the complex estate tax planning provisions typically found in estate planning documents.

The higher estate tax exemption may also allow individuals to simplify their estate plan. Individuals who previously set up limited liability companies, life insurance trusts, or took other actions in an effort to reduce the value of their estates and the impact of the estate tax, can now review whether such complicated estate tax planning tools are still necessary, potentially easing the administration of their assets during life and the administration of their estates at death. On the other hand, high net worth individuals can take advantage of the higher exemption to complete more sophisticated planning for their children and later descendants, such as the funding of trusts that will protect assets for multiple generations.

Appointment of Fiduciaries

Of primary importance is selecting who you want to manage your affairs at your death or incapacity. Even if you have estate planning documents in place, you should review your documents from time to time to ensure that the individual you appoint to serve as trustees under your trusts, personal representatives under your wills, and agents under your powers of attorney remain appropriate.

Power of Attorney & Advance Health Care Directive

In addition to a will and trust that will govern the administration of your assets at death, it is also important that you have both a Durable Financial Power of Attorney (to name an agent to handle your finances if you cannot) and an Advance Health Care Directive (which combines the appointment of an health care agent to make health care decisions for you in the event of your incapacity with a living will) in place.

Review of Beneficiary Designations

As a final note, any review of your estate plan should include a complete review of the beneficiary designations on your retirement accounts and life insurance policies. Beneficiary designations must be updated to match the overall estate plan, or the plan may fail to accomplish your goals. A well drafted will and trust agreement cannot override a poorly thought out beneficiary designation.

Conclusion

So, to answer the question “When should I review my estate plan?” is simple – if you have not reviewed your estate plan recently, then do so as soon as possible. In many cases, once a well thought out estate plan is in place, there will not be a need for changes for many years, but the plan should be reviewed nevertheless.

Gregg D. Stephenson
Mr. Stephenson is a shareholder at Ray Quinney & Nebeker. His practice focuses on estate planning, business succession planning, and estate and trust administration. He assists clients in structuring estate plans and transactions to achieve their goals in a tax efficient manner. Mr. Stephenson has experience with irrevocable life insurance trusts, charitable trusts, dynasty trusts, defective grantor trusts, family partnerships, and other estate planning techniques. He also represents clients in probate proceedings and the administration of estates and trusts.
The 2018 election brought 19 new Representatives and 6 new senators to the 2019 Legislative session – almost one fourth of the state’s legislators. We were sad to see three physicians leave the legislature: two representatives who had served for several years, Rep. Ed Redd, MD (Logan) and Rep. Mike Kennedy, MD (Alpine); and Sen. Brian Zehnder, MD, (Cottonwood Heights) who had replaced Sen. Brian Shiozawa, MD the previous year. A new physician joined the legislature, Rep. Suzanne Harrison, MD, an anesthesiologist from Draper, who is already distinguishing herself as an effective and capable legislator. Physician spouses are Sen. Keith Grover (Provo) and Rep. Jennifer Dailey-Provost (Salt Lake City); family members include Rep. Marie Poulsen and Sens. Dan Hemmert, and Gregg Buxton. We want to thank Sen. Evan Vickers, a pharmacist, who ran our prior authorization bill. Thanks also to Rep. Brad Daw and Sen. Dan McCay and others who also worked closely with us on particular bills and helped us be successful in fighting for physicians and patients.

As state representatives are elected to two-year terms and state senators are elected to four-year terms, little change is expected in the makeup of the legislature for next year. The patients and physicians of Utah were helped significantly by the steadfast service of these physicians who dedicated full time service during the legislative session, as well as the many days of service, preparation, and follow up that occur before and after the session during interim.

Some Representatives and Senators are willing to run legislation against the interests of physicians and patients and fight against us on significant bills. The number of legislators who are willing to do seem to have increased over the years. These legislators, many times, believe there should be restrictions on physicians but not on other health care providers. There is also a growing trend to allow the buyer to beware and allow all who want to practice in the health care space to practice. This is one reason UMA issues Calls to Action during the session. It is very important for physicians to respond promptly to these calls. This is also why
it is so important for physicians to get to know their legislators. When we send out a Call to Action and physicians respond, it lets legislators know that physicians are concerned and watching what is happening in their districts.

Many pieces of legislation happen very quickly. When we send out our Calls, they often require a very quick response, because the legislature can act with little notice at times. We greatly appreciate those physicians who take the time to respond to our Calls to Action. When you contact your own legislators in response to a Call to Action and identify yourself as a constituent (including your home address), legislators notice and are often influenced by your input. It is so valuable because the legislators are also contacted by those seeking to pass legislation that either expands their scope or requires parameters be put around physicians through legislation. Knowing your legislator outside of the legislative process can really help when you then contact them during the legislative session. It is also valuable if you participate by serving as county or state party delegates, help physicians or physician family members run for office by contributing money, sponsoring fundraising events at your home or talking with delegates and others about supporting these candidates.

The bills that were particularly important to physicians and patients are discussed below.

**Balance Billing**

For another year, UMA tried to negotiate fair compensation rates for physicians who provide out-of-network emergency services. Rep. Jim Dunnigan was intent on passing legislation to “take the patient out of the middle” and prohibit billing for these services. While Utah physicians also don’t want patients to be caught in the middle, the solution needs to also be fair to physicians, not just insurance companies who provide coverage but require physicians who are out of network to cover their patients in emergency situations. Through many hours of consultation with physician specialties, and back and forth with Rep. Dunnigan, UMA insisted on fair treatment for physicians. At the end of the day, UMA and Rep. Dunnigan could not come to an agreement on what would constitute fair reimbursement for out-of-network physicians. After agreeing on a concept for reimbursement, while UMA came back with a number of compromises, Rep. Dunnigan stayed at one rate and would not budge. There were other pieces of the legislation that Rep. Dunnigan was willing to agree to, but without fair reimbursement, no deal could be struck. Rep. Dunnigan could not come to an agreement with the hospitals either. At the end of the session, with pushback from UMA because no agreement was reached, no bill was proposed. To get in front of the issue and try to pre-empt what might happen next year, UMA will continue to work on this issue in the coming months with the affected physician specialties.

**Medicaid Expansion**


This bill made many changes to full Medicaid expansion that was passed by the voters under Proposition 4 during the 2018 election. Because the proposition was drafted over a year earlier and because of certain oversights in the drafting and since the tax that was proposed did not cover the extent of the proposed expansion of coverage according to the budget office, there were several problems with the law. The UMA House of Delegates supported a series of tenets of Medicaid expansion. These included: an increased payment to providers annually based on CPI; no mandate for any provider participation in Medicaid; no restrictions on the categories of care, services, and benefits beyond those in place for Medicaid and CHIP as of 2017; Medicaid coverage for about 150,000 uninsured individuals without taking money from another part of the state budget; and no support if federal funds are withdrawn. With these tenets in mind, when the bill was introduced as a leadership bill and as it moved forward, UMA worked to have our tenets included in the bill. Ultimately the bill met some but not all of UMA’s tenets. **PASSED**

**UMA Sponsored Or Supported Bills**


UMA continued its efforts from the end of last year through the end of this session to successfully pass this bill to reform health insurers’ prior authorization process in Utah. The UMA House of Delegates had adopted a resolution directing UMA to work on improving and standardizing prior authorization for physicians and patients. UMA researched laws passed in other states as well as model legislation drafted by the AMA and developed language with the best ideas for a bill to propose in Utah. UMA brought together a coalition of patient organizations and other groups interested in improving the prior authorization law. By working and negotiating extensively with interested parties, including the main health insurers in the state, we were able to avoid the enormous fiscal note that played a big role in undermining our efforts last year and we developed a bill for this session.

Among other provisions, the bill requires insurers to be transparent about their prior authorization requirements, posting on the Internet which drugs, devices, and procedures require prior authorization and all the information that needs to be submitted to get authorization. It prohibits post-care review for medical necessity. Authorization now will include verification of the patients’ insurance coverage to make it a complete pre-procedure review for payment. The bill requires advance notice for changes to prior authorizations, which physicians and patients...
can ask to have sent to them if they don’t just look at it as it is updated and kept current on the insurer’s website. It sets deadlines for insurers to make a determination on prior authorization requests. It requires a physician (or pharmacist, for a drug) to review medically based appeals made by a physician. It requires insurers to do more to provide continuity of care when the formulary is changed. The deadline for responding to non-urgent care requests is 15 days and for non-emergency follow-up care to emergencies and for urgent care, the deadline is 72 hours. In addition, insurers are required to report to the Insurance Department how quickly they are getting non-urgent care requests processed. This will show us if insurers are acting quickly on these requests. **PASSED**


After years of efforts by UMA and others, this bill finally passed! It raises the minimum age for obtaining, possessing, using and providing tobacco products, including e-cigarettes, in annual steps from 19 to 20, then 20 to 21. UMA supported this bill to reduce tobacco use in vulnerable teen years and promote better public health. **PASSED**

**HB 174 Psychiatry Medical Residents Amendments (Rep. Steve Eliason and Sen. Ralph Okerlund)**

This bill is an attempt to increase the number of psychiatry residents in Utah because of the need to increase access to mental care and because of the impact of the shortage of psychiatrists on suicide prevention. The bill requires the UofU Health Sciences Department to select up to four more psychiatry residents each year than the number selected in 2018, provided money is appropriated (or comes from another source). UMA supported this bill as an important way to train more psychiatrists and have more psychiatrists working in Utah since 88% of psychiatric residents stay here. **PASSED**

**HB 147 Physician Certification Amendments (Rep. Mike McKell and Sen. Curt Bramble)**

This bill is a re-run of the sponsor’s bill last year, which would have prohibited hospital systems, health insurers, and DOPL from requiring board certification for purposes of employment, hospital privileges, reimbursement or licensure. UMA supported the bill this year and last, under the direction of the UMA Board, because it was consistent with a UMA Resolution and decision by the Board which expressed concerns about using MOC in certain areas. UMA did express concerns about the prohibition of MOC for employment, not the other parts in the bill, and asked the sponsor to change that part of the bill – the concern being that if a group, system or others could not require MOC for employment, it would change what even physician groups required of those they hired. The bill was not pushed out of rules by its sponsor. **FAILED**


As promised last year, UMA fought to allow first class mail for notices when trying to collect a debt from a patient. This bill further eases the burden placed on physicians by recent bills that imposed expensive notification requirements on physicians and their collection agencies attempting to collect debts from patients. The notification requirement may now be met by first class mail or email, in addition to certified mail with return receipt requested or text message, which were previously allowed. UMA supported this reduction in the burden placed on physicians. **PASSED**


This bill would extend the law for anesthesia reporting in an outpatient setting. Two years ago, UMA worked on amending the bill that requires healthcare providers that intravenously administer anesthesia in an outpatient setting to report any adverse events to the Department of Health and to provide specific information about the administration of the anesthesia. It had a two-year sunset that would have taken affect this year. Since the rules for this law were not implemented for over a year, the Department of Health has not had a chance to collect much data. UMA supported extending the sunset for another three years. **PASSED**


This bill directs the state auditor to use information from the All Payer Claims Database to create a web-based transparency website available to the public, like the price tool that PEHP already offers its insureds. This was one of four bills introduced in this legislative session on price transparency requirements for health care providers. (The others were **HB 443**, **SB 229**, and **SB 265**, discussed in the next section of this article.) UMA supported this bill as a reasonable proposal to provide more cost information to patients and as the most reasonable of the proposed bills. **HB 178 PASSED**

**Bills UMA Opposed, Then Worked To Change Or Defeat**


While the intent of the bill was worthy, as introduced, the bill would have mandated an in-person visit and education from DOPL for a every prescriber, and their office personnel, of a patient that died of an overdose on any controlled substance, if the provider prescribed controlled substances to the patient. After
extensive work by UMA with the sponsor, the bill was modified to authorize representatives of DOPL to consult with prescribers to help them follow evidence-based guidelines regarding the prescribing of controlled substances if the prescriber so desires. It directs DOPL to offer an educational visit to prescribers identified by the state medical examiner as having prescribed a controlled substance to a person who died from poisoning or overdose involving a prescribed controlled substance. The bill protects from being used in lawsuits and from public disclosure under state law, records created by DOPL as a result of an educational visit. After significant changes requested by UMA, UMA supported. PASSED


Acupuncturists have been injecting fluids under rule even though their statute did not necessarily grant them the privilege. This bill, as originally drafted, would have enabled acupuncturists to acquire and use any sterile substance for injection therapy, including controlled substances and other prescriptive substances. They would not have been limited in where within the body they could make these injections, including injections into the vein, joint, artery, blood vessel, nerve, tendon, deep organ or the spine. Strongly opposed to this significant expansion of practice scope, UMA negotiated extensively with the sponsor and the proponents, with Rep. Ward (MD) working with UMA to restrict what Acupuncture would be able to do under this bill. Although our efforts were rejected at first, UMA persisted and forced them to make changes to scale back what they are able to inject and obtain to a small list of substances. In addition, Acupuncturists were limited to injecting subcutaneously or intramuscularly only and not on pregnant women or children under the age of eight. UMA was finally neutral on the bill when it had a limited list of substances acupuncturists could inject in limited places (with certain sites expressly excluded) after appropriate training. PASSED


As introduced, this bill would have repealed last year’s bill SB 217 Physician Testing Amendments. UMA supported that bill, which prohibited cognitive testing of older physicians unless the test reflected nationally recognized standards adopted by the AMA. This prohibition applied to hospitals for credentialing, health insurers for paneling, and DOPL for licensing. Intermountain Healthcare objected to the law, wanting no restrictions on their ability to test older physicians at a certain age and so ran a bill this year to repeal last year’s bill. After much negotiation, UMA was able to work out a compromise that put into law the testing standards recommended by the AMA Council on Medical Education, with some minor editing. This will continue to protect physicians from testing that is irrelevant to their ability to practice safely and effectively as a physician in their practice setting. PASSED


Just three years after agreeing to a compromise on nurse prescribing, the APRNs again ran a bill to remove any restrictions on their ability to prescribe opioids. The APRNs initially rejected UMA’s offer for further compromise and attempted to push their bill forward without making any changes. After running into significant opposition, they finally agreed to the compromise. The compromise bill will allow new APRNs (with less than 1 year of licensure or 2000 hours practice experience) who work under another provider or for a hospital or health system to prescribe a Schedule II controlled substance without a consultation and referral plan (CRP). New APRNs in independent solo practice will still have to have a CRP but it can be with a physician or an experienced (at least 3 years of practice) APRN. APRNs who own or operate a pain clinic will still need to have CRPs with a physician. PASSED

HB 393 Suicide Prevention Amendments (Rep. Steve Eliason and Sen. Don Ipson)

This bill revisits the issue of suicide prevention education, which has been the subject of several bills over the past few years. As originally proposed, physicians (NPs and PAs) would have had to take two hours of suicide prevention education. After a series of discussions and negotiation with UMA, the sponsor agreed to limit the physician education requirement to only 15 minutes, with 30 minutes of CME. The bill directs DOPL with the Division of Substance Abuse and Mental Health to create a series of web-accessible videos no more than 15 minutes long on suicide prevention and intervention that will be free to all providers. All physicians, PAs, and nurses (LPNs, RNs, APRNs) will be required to view a suicide prevention video at the time of license renewal. This education will basically go over suicide prevention resources and give the provider an opportunity to take more free education on suicide if they desire by linking to one of the educational videos. The bill also creates and provides funding for a Psychiatric Consultation Program implemented by a health facility to provide primary care providers access to a telehealth psychiatric consultation when evaluating a patient for or providing mental health treatment. PASSED

SB 188 Consent for Medical Procedure Amendments (Sen. Dan McCoy and Rep. Kim Coleman)

This bill was brought in response to news reports of women undergoing a pelvic examination while sedated for other purposes. As introduced, the bill would have made unmanageable any pelvic exam in a teaching setting. The patient would have had to have been presented with a full list of everyone who might
be involved in the examination - including medical students and residents for teaching purposes and any other physicians, including specialists who might need to be called in mid-procedure – and given the opportunity to interview them and choose which ones could participate. After discussions with the sponsor and interested parties, the bill was narrowed to exclude emergency care, non-training circumstances, or court-ordered examination for the collection of evidence. The bill does require a separate informed consent form, in teaching situations, that allows the patient to choose whether a student(s) or resident(s) may observe or otherwise be present at the patient examination, either in person or through electronic means. **PASSED**


Before the session started, the PAs approached UMA about running a bill to “harmonize” all laws that mention physicians with the PA scope of practice. In other words, wherever a physician was mentioned the PAs wanted to insert the ability of a PA to do the same thing regardless of what the law said or what the law pertained to in terms of type of care or for what service. Although their practice act provides that PAs can do things as provided with their supervising physician in the delegation of services agreement, the PAs had been limited in some instances as to what they could do if a law did not specifically mention them. The first draft of this bill was compiled by the PAs national organization, which simply proposed to add “physician assistant” everywhere “physician” was mentioned in code. This resulted in a bill that went far beyond the needs of the PAs and would have authorized them to do things they had no training or reason to do. After many hours of work in going through each of these more than 250 laws, UMA was able to work out a reasonable list of provisions in which to include PAs. **PASSED**


This bill requires a prescriber to discuss the following issues with a patient or the patient’s guardian before issuing an initial opiate prescription: the risks of addiction and overdose associated with opiate drugs; the dangers of taking opiates with alcohol, benzodiazepines, and other central nervous system depressants; the reasons why the prescription is necessary; alternative treatments that may be available; and other risks associated with the use of the drugs being prescribed. **PASSED**


This bill authorizes DOPL to substitute competency-based requirements for time-based requirements for individuals applying for any DOPL licensure. UMA persuaded the sponsor to include the requirement that any time-based requirement that must be approved or accredited by a specific entity or board (such as the ACGME-approved residency requirement for physician licensure) may only be substituted by a competency-based requirement approved by the same entity or board. With UMA’s changes the bill **PASSED**.

**HB 471 Controlled Substances Modifications (Rep. Jennifer Dailey-Provost)**

This bill would have reduced a surgeon’s discretion in prescribing opioids after surgery. The current law allows a surgeon to prescribe up to a 30-day supply, which can be partially filled. The bill would have only allowed a 14-day supply and, oddly, would have eliminated the partial fill option. UMA was opposed to these changes. The bill was never assigned to a committee. **FAILED**


As introduced, these bills would have imposed a range of excessive and unreasonable requirements on healthcare providers under the banner of transparency. One of the bills (SB 265) would have required a physician to give a patient, before providing any services, an itemized estimate of the patient’s cost (including any copay, coinsurance, or deductible) for all procedures, supplies, use of healthcare facilities, and other health care associated with the diagnosis or treatment of a condition for a patient until the time treatment ends. Any healthcare not included cannot be provided until a separate detailed cost estimate is provided. And the provider may not bill the patient or insurer more than the amount in the estimate. It would also have required the provider to provide the care after providing an estimate and not turn down a patient for not being able to give an estimated cost. **HB 443** would have required providers to publish annually their median allowed price received from insurers and the median charged price (which could be calculated three different ways) for the 25 procedures they most commonly perform or for all procedures – for all patients in every circumstance regardless of insurance or whether they were self-pay patients. **SB 229** originally would have required the Department of Health to “anonymize” the data in the All Payer Claims Database (APCD) and make it available to the public. After discussion with UMA and others, **SB 229** was amended to exclude patient identifiable health data and is data that is already available through APCD. **SB 229 passed** after changes. **HB 443 and SB 265 FAILED**


This bill prohibits pregnant women from getting an abortion solely because the unborn child has or may have Down syn-
Thanks also to the members of the UMA Legislative Committee and Board of Directors for their dedication in reviewing the bills and developing UMA positions, particularly a special thanks to Jim Antinori, MD, who continues to chair the Legislative Committee, as he has for many years. We encourage all physicians and their spouses to get involved with UMA in the legislative process.

drome based on information given to the women when testing has been done. This bill failed at the end of last year because it ran out of time so was run again this year. Last year UMA had to fight to have important changes made to the bill, which were then included in this year’s bill. However, the bill this year was changed to require a physician to tell the patient the information on the health department’s website that contains support information. UMA worked again to change the language to only require that the patient be informed of the website by a provider. After UMA made changes to the bill, UMA was neutral on the bill. PASSED

SB 38 Mental Health Amendments (Sen. Lincoln Fillmore and Rep. Brad Daw)

As originally drafted, among other provisions, this bill would have made it unprofessional conduct for a mental health professional to fail to ask a patient to waive the patient’s HIPPA privacy rights. UMA worked to change the language to only apply to situations where there is a pattern of failing to offer the patient the opportunity to waive their rights, and to prohibit DOPL from taking licensure action against those professionals. With these changes, the bill PASSED

HB 106 Medical Cannabis Modifications (Rep. Marsha Judkins)

This bill would have added any autoimmune disorder to the list of qualifying conditions for medical marijuana. Because of the compromise reached by UMA and the proponents of marijuana in December, no marijuana bills that did not pertain to technical changes were going to be heard this year. The bill was never heard in committee. FAILED

HB 362 Controlled Substance Database Retention Amendments (Rep. Travis Seegmiller)

This bill would have required DOPL to delete information in the controlled substances database (CSD) after two years, apparently as a matter of patient privacy. UMA talked with the sponsor and opposed limiting the information in the database to such a narrow window. The bill was never heard in committee. UMA has committed to working with the sponsor to find the right amount of time to keep the data in the CSD. FAILED

HB 398 Substance Use and Health Care Amendments (Daw)

The bill modifies provisions requiring a county jail and the Department of Corrections to report certain information to the Commission on Criminal and Juvenile Justice regarding an inmate's death; modifies provisions relating to licensing of a practitioner who dispenses certain opiate agonists; requires the Commission on Criminal and Juvenile Justice to convene a committee to study certain health care and other services provided to inmates in a correctional facility; and makes technical changes. UMA requested an amendment which was added. Originally UMA opposed the bill but after the amendment, supported. PASSED

Other UMA Supported Bills

SB 29 Health Care Malpractice Act Sunset Extension (Sen. Allen Christensen and Rep. Stewart Barlow)

The law authorizing arbitration agreements in the context of professional liability cases involving healthcare providers was scheduled to expire July 1, 2019. This uncontested bill extends the sunset date for 10 more years. UMA supported this. PASSED

HB 77 Health Information Exchange Amendments (Rep. Brad Daw and Sen. Allen Christensen)

This bill protects health care providers from civil liability when they access patient information from the chIE (clinical health information exchange). The law previously provided liability protections only for putting information into the chIE. UMA supported the bill. PASSED
SB 241 Treatment Medication Amendments (Sen. Karen Mayne)

The sponsor of this bill consulted with UMA before introducing it, to seek our support. The bill would have required health insurers to cover prescription drugs approved by the FDA for stage-four advanced metastatic cancer without having to complete a fail-first or other step therapy protocol. It was introduced during the last two weeks of session and had no chance to move forward. FAILED

HB 275 Contraception for Women Prisoners (Rep. Jennifer Dailey-Provost)

This bill would have required jails to provide women prisoners with the option of continuing any medically prescribed method of contraception. This is important not only for contraceptive purposes, but also for the health of many of the women. Recognizing that further work was needed on the bill and with the agreement of the sponsor, the committee referred the bill to the Health and Human Services Interim Committee for further study. Sent to INTERIM

Other Bills UMA Worked On


This bill criminalizes the practice of female genital mutilation, broadly defined to include actions intended to alter the structure or function of the female genitalia. With input from UMA, the bill’s exception for a surgical procedure performed by a licensed physician was extended beyond just when necessary to preserve or protect the physical health of the woman or is requested for sex reassignment surgery, to also include when the procedure is medically advisable. UMA also changed civil actions that have not been criminally prosecuted against a provider to be moved back under the medical malpractice act, whereas civil actions that follow criminal prosecution do not have to go through prelitigation, etc. PASSED


Concerned individuals asked the sponsor to run this bill because the state’s Child Care Center Licensing Committee was having a hard time filling the position on the committee reserved for a pediatrician. UMA explained to the sponsor that it and the state pediatric society had never been approached for help in finding a pediatrician to serve. Working with the sponsor, the bill was modified from allowing APRNs or PAs to fill that position, to allowing mid-level providers to fill in when a pediatrician cannot be found to serve. It also requires the licensing committee to query the UMA and/or the state pediatric society before making that call. With these changes, UMA supported the bill. PASSED

HB 344 Student Asthma Relief Amendments (Rep. Mark Wheatley and Sen. Ronald Winterton)

This bill enables schools to have stock albuterol on hand for trained employees to administer to students with an asthma action plan. UMA worked with the sponsor to clarify that the healthcare providers that can diagnose asthma and provide a school with a statement that a student can self-administer asthma medication are physicians, PAs, and APRNs, not just any healthcare provider. This will provide greater safety for children with asthma to be at school. PASSED

HB 211 Rare Disease Advisory Council (Rep. Lee Perry and Sen. Luz Escamilla)

This bill would have created the Rare Disease Advisory Council to advise the state on identifying best practices for providing services and care to individuals with rare diseases and improving access to care for these individuals. At the request of UMA, the sponsor included physicians on the council. FAILED

HB 469 Controlled Substance Database Notification Amendments (Rep. Kim Coleman)

The sponsor of this bill approached UMA before the session seeking to work out a legislative solution to a problem that arose
when an opioid-addicted patient got off opioids, but then was prescribed them again by a physician/pain clinic. With input from UMA, the bill would have enabled a prescriber to put a flag on a patient’s record in the state’s controlled substances database to indicate vulnerability to addiction to a type of controlled substance. The bill came out so late that it had no time to go through the process of the session. FAILED

This bill makes it a crime to knowingly fail to report the diversion of a significant amount (equal to or more than 500 morphine milligram equivalents) of drugs by a licensee or employee that the person knows about. UMA proposed some changes that were included in the bill. PASSED

E-cigarettes are much more popular for youth than are regular cigarettes and have become a significant public health problem. UMA strongly supported this bill which would put e-cigarettes products under the same tobacco tax as other tobacco products to help deter minors from using e-cigarettes. This bill has been run in previous years and will have to go through the process of the session. FAILED

HB 399 Prohibition of the Practice of Conversion Therapy upon Minors (Hall)
Prohibits certain mental health therapists from providing conversion therapy to a minor; limits the application of the prohibition; and makes a violation of the prohibition unprofessional conduct. Because of language in the bill dealing with reduction therapy, UMA had concerns with the bill and asked the sponsor to amend the bill. The bill was amended drastically in committee and ultimately opposed. FAILED

Conclusion
Thanks to the hard work of UMA leaders, staff, and involved members, UMA accomplished much for Utah’s physicians and patients through its legislative work this year.

We thank all the physicians and spouses who traveled from many parts of the state to attend the UMA Day at the Legislature. They visited the Capitol, learned about the legislative process, and discussed with their legislators important issues for physicians and patients. Your willingness to take the time to participate demonstrates to legislators that their votes and actions matter to you.

In addition to the bills discussed and explained above, UMA also reviewed, and tabled or took no position on additional bills. The UMA legislative committee considered and took a position on more than 150 bills this year. UMA members who login can review a more complete list of bills on the UMA website, under Advocacy.

Thanks also to the members of the UMA Legislative Committee and Board of Directors for their dedication in reviewing the bills and developing UMA positions, particularly a special thanks to Jim Antinori, MD, who continues to chair the Legislative Committee, as he has for many years. We encourage all physicians and their spouses to get involved with UMA in the legislative process. We appreciate your continuing support.

Note: Unless another effective date is stated in the bill or it is vetoed by the Governor, the legislative changes adopted in the 2019 general session go into effect May 14, 2019.
In the world of HIPAA compliance, people frequently talk about the importance of training employees periodically. However, it takes more than a mandatory annual or quarterly training to create meaningful change. Adhering to HIPAA takes consistent actions over the course of days, weeks, and years. So how do we prepare employees for this reality without extensive, time-consuming training sessions?

One answer is to help employees to develop good “HIPAA habits,” or a set of actions that can be repeated often enough that they become second-nature. If the actions that promote compliance can become a matter of habit, employees can follow good practices instinctively rather than consciously, which itself promotes greater consistency in results.

Lay a Supporting Foundation

Even though habits are formed by individuals, they do not form in a vacuum. If individuals are to succeed in building good HIPAA habits, the organization must lay a supporting foundation.

• Ensure your organization has updated policies and procedures regarding HIPAA, privacy, and security. Not only will this set the correct expectations for individual actions, but it also provides a framework if an employee must tell someone “no” to maintain compliance.

• Identify your gatekeepers for information and provide extra HIPAA training for these employees. This likely includes front office staff, anyone handling record requests or similar inquiries, and IT personnel.

• The path of least resistance; evaluate whether your organization encourages decision-making that supports HIPAA compliance, and whether those actions that detract from compliance are easy or inconvenient. Consider if there are ways to make the correct action easier than the incorrect alternatives.

• Give employees the skills and support they need to take the correct actions. This may include ensuring that employees know how to recognize an email phishing attempt or providing training for handling people who aggressively demand information.

Principles of Good HIPAA Habits

When a supporting foundation at the organization already exists, employees are in a good position to begin creating good HIPAA habits. As the possibilities for good HIPAA habits are endless, as a starting point, consider these guidelines:

• Minimum Necessary: The concept of “minimum necessary” is critical in HIPAA; if a permitted
Give employees the skills and support they need to take the correct actions. This may include ensuring that employees know how to recognize an email phishing attempt or providing training for handling people who aggressively demand information.

The Nature of Habits

Habits are often formed by accident, but they can also be formed deliberately. To increase your chance of success, leverage the science behind how and why habits are formed.

• **Repetition** is a must when creating new habits. If you're trying to create a habit, choose actions you can repeat frequently. It is less helpful to try “being more secure,” and more helpful to pinpoint a specific action that is repeated often, such as locking your computer every time you leave your desk.

• **Aim for consistency.** Although one or two slip ups won’t ruin your efforts, it’s important to be as consistent as possible with your new habit. This is especially critical during the initial stages of habit-forming.

• **It takes time** to create a habit. Recent research indicates that it takes an average of 66 days to form a habit, although timelines can vary. Set realistic expectations for how quickly you’ll be able to add habits.

• **Take it one step at a time.** Don’t try to take on too many habits at once… and try to keep each habit simple. Overloading your brain with too many goals at once will reduce your odds of success.

• **Hold yourself accountable.** Whether this means focusing on the importance of the results or asking a colleague to call you out on incorrect behaviors, find a way to keep yourself focused on sticking to your new habit.

• **Be aware of your triggers.** Habits are usually triggered by environmental factors like places, people, smells, and sounds. For example, drinking coffee may trigger an urge to smoke for someone who has had a cigarette with their coffee for years. Deliberately selecting and creating triggers for new habits helps associate the new habit with the appropriate situations.

• **Set reminders as needed.** Whether it’s a sign at a strategic location or an electronic reminder, use the resources around you to reinforce the new habit.

• **Make it a team sport.** When your entire office is involved, everyone can reinforce the correct actions and keep each other accountable.

Set up your organization for success by helping employees develop good HIPAA habits. These actions, once they become second-nature, will provide greater consistency and security than is otherwise possible to achieve.

Sara Vandermolen is the corporate trainer at UHIN where she develops educational outreach and presents on a variety of topics related to compliance training, healthcare data exchange, medical claims billing and other topics important to the healthcare community. She holds a degree in Psychology from Westminster College.

---

2. Train the brain to form good habits through repetition, ScienceDaily; https://www.sciencedaily.com/releases/2019/01/190128105227.htm
3. University College London; https://www.ucl.ac.uk/healthy-habits/science-of-habits
4. https://medium.com/@SparksRemarks/triggers-the-key-to-building-and-breaking-habits-fa8ed153ab0c

---
A general rule, small healthcare providers have a difficult time keeping up with HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance, when compared with larger, more resourced organizations. While practices at the smaller end of the scale may be disadvantaged due to a lack of personnel, time, and budget, The HHS Office for Civil Rights (OCR) - the agency responsible for enforcing the HIPAA Privacy and Security rules – makes no exceptions on practice size when it comes to ensuring patients’ health information remains protected.

To highlight this, in 2016 the OCR announced an initiative to more widely investigate HIPAA breaches that affect fewer than 500 people. While this announcement wasn’t solely directed at small practices - small breaches can happen at large organizations too - it was a stark reminder of the OCR’s commitment to improving privacy and security standards across the healthcare industry, and that no HIPAA-covered entity is exempt from the rules.

Small Breaches, Huge Consequences

According to a 2016 survey of America’s physicians, there are approximately 800,000 practicing physicians in the U.S., approximately 70 percent of whom work independently or in practices consisting of 30 physicians or fewer. Just over half of all physicians - approximately 400,000 based on the figure above - work independently or in practices consisting of 10 physicians or fewer.

Now, consider that around a third of small practices do not have a HIPAA compliance plan in place, and it becomes clear why healthcare was the most targeted industry by cyber hackers in 2016. According to a report by Protenus, the healthcare industry averaged at least one data breach per day in 2016, affecting more than 27 million patient health records in total. What’s more, insiders were to blame for most of these breaches, suggesting that lack of education on HIPAA rules is a large part of the problem.

Failure to comply with HIPAA rules can result in both civil and criminal penalties, and this applies to covered entities and business associates of all sizes. Civil penalties, which are enforced by OCR, are monetary and vary from $100 to $1.5 million, while criminal penalties, enforced by the U.S. Department of Justice can be even more severe. Unfortunately, there are
many examples of small to medium-sized organizations that have learned this the hard way in recent years.

Naturally, smaller breaches do not receive the same national press attention as larger breaches, and often slip under the public’s radar entirely, as OCR is not required to publish breaches affecting fewer than 500 individuals on its Breach Portal, or ‘wall of shame,’ as it is more commonly referred to. However, in the digital age bad news travels fast, meaning it doesn’t take long for news of even a small data breach to reach affected patients via the likes of social media, review sites, and local news pages.

This presents major reputational challenges for practices. For some organizations, fines can be paid without inflicting too much long-term damage, it is more difficult to regain the trust of patients whose PHI has been compromised. With more and more patients taking to the internet to share their personal health experiences, and influencing others in the process, the effects of a HIPAA breach can be much longer lasting than many realize.

**HIPAA Compliance Advice for Small Practices**

HIPAA compliance is a constant burden for all organizations, regardless of size. For large organizations, these challenges typically stem from having to manage high numbers of staff across multiple sites; this means more PHI being exchanged daily, more devices being carried around, and generally more potential entry points for cyber thieves. However, the major advantage large organizations have over smaller organizations are the resources to manage these issues by investing in the right staff, regular training, and market-leading tools.

Conversely, most small businesses simply do not have the resources for managing a full-time HIPAA compliance program in-house, nor the budget to outsource it. With no CIO or compliance specialist to oversee daily operations, responsibility lies solely with medical staff. While in one sense this makes HIPAA compliance easier to contain, individuals face a juggling act between being a medical professional and compliance expert, which can be a risky game.

**5 steps to smarter security and privacy**

1. **Invest in the right tools**

   When sending, receiving, or storing PHI, it must be done within a HIPAA-secure environment. Text messaging, for example, is not a secure form of communication. Instead, practices should invest in a secure mobile messaging solution that encrypts data during its entire lifespan, ensuring only the intended recipient(s) can view it.

2. **Stay educated**

   Whether working in a solo practice or on a team of 20 or more, education is the key to HIPAA compliance. Taking time to stay updated on HIPAA and cybersecurity best practices is critical for identifying and preventing potential breaches before they occur. If the budget is available, it can be beneficial to appoint a third-party expert to carry out staff training, as this will help ensure all key areas are covered.

3. **Don’t assume HIPAA is just an IT issue**

   HIPAA compliance is not just an IT issue. It is equally important to safeguard paper records and discard them properly or shred them when no longer needed. This was highlighted in 2014 when the OCR reported a data breach involving over 1,500 patients, which was caused by health records being scattered down the street after being thrown in an open top dumpster by staff. The Kansas City-based facility was later ordered to pay $400,000 to compensate the patients.

4. **Keep on top of BAAs**

   Any entity that manages the transmission and storage of PHI on behalf of a healthcare organization is known
as a business associate (BA). This may include, for example, messaging platforms, hosting companies, fax and email providers, and EHRs. Under HIPAA, covered entities must ensure business associates enter into a Business Associate Agreement (BAA) to safeguard PHI. Revising business associate agreements is an arduous task for any organization, but it’s crucial for ensuring HIPAA compliance. Earlier this year, a small healthcare practice was hit with $31,000 HIPAA settlement due to a business associate’s agreement not being in place.

5. Secure all mobile devices
The increased adoption of BYOD (bring your own device) in healthcare environments presents many potential benefits, however according to the HHS, a reported 10 percent of major health data breaches involve a mobile device. This considered, it is critical that practices take necessary steps to ensure that mobile devices do not become a vulnerability in the security chain. As a minimum requirement, all devices that carry PHI, even temporarily, should be secured using strong passwords, encryption, and multi-factor authentication. PHI should only ever be sent, received, or stored using HIPAA-secure applications, and a BAA should be in place with all third-party providers.

This is by no means a complete HIPAA compliance checklist, and we would urge all covered entities to review the information on HHS.gov for a detailed explanation of their responsibilities under HIPAA, and advice for preventing data breaches. If past breaches have taught us anything, it is that no organization is exempt from HIPAA and the repercussions of a breach can be crippling for all involved. HIPAA compliance is an issue that needs to be taken seriously, not just for avoiding fines and protecting business integrity, but also for safeguarding the privacy of patients.

---

### Examples of HIPAA breaches affecting small practices

<table>
<thead>
<tr>
<th>Organization</th>
<th>Breach Overview</th>
<th>Fallout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phoenix Cardiac Surgery</td>
<td>Posted surgery and appointment schedules on a publicly accessible online calendar</td>
<td>Fined $100,000 and required to take corrective actions</td>
</tr>
<tr>
<td>Center for Children's Digestive Health</td>
<td>Failure to provide a signed Business Associate Agreement (BAA)</td>
<td>Fined $31,000 and required to take corrective actions</td>
</tr>
<tr>
<td>Adult &amp; Pediatric Dermatology</td>
<td>Loss of USB thumb drive containing unencrypted PHI of more than 2,000 individuals</td>
<td>Fined $150,000 and required to take corrective actions</td>
</tr>
</tbody>
</table>

HIPAA. | continued from page 13

22  www.utahmed.org
Dr. Cass Davis
Joined in 2010

It’s time to lead. To innovate. To practice medicine the way it was meant to be practiced. OptumCare has created a place to make that happen. By emphasizing work/life balance. Providing the tools and technology to shape the future of medicine. Putting emphasis on outcomes. And focusing on patients. For 46 years, we’ve empowered physicians to do their best work. Because with the right commitment, we can do wonders.

Find out more at workatoptum.com

OptumCare® is looking for these qualified professionals:

**Las Vegas**
- Primary Care
- OB/GYN
- Hospitalist
- Gastroenterologist
- On Demand Care
- Pediatric Care
- Rheumatology

**Phoenix**
- Primary Care
- On Demand Care
- Anesthesiologist
- Orthopedic Care
- Oncology

**Tucson**
- Primary Care

It’s time to lead. To innovate. To practice medicine the way it was meant to be practiced. OptumCare has created a place to make that happen. By emphasizing work/life balance. Providing the tools and technology to shape the future of medicine. Putting emphasis on outcomes. And focusing on patients. For 46 years, we’ve empowered physicians to do their best work. Because with the right commitment, we can do wonders.

Find out more at workatoptum.com
The Utah Department of Health identified a small proportion of Medicaid beneficiaries who accounted for a large burden of resources. This pattern mirrored Medicaid nationally. Little was known about these beneficiaries and it was suspected that they were possibly a heterogeneous group with complex needs. High utilization often indicates chronic physical conditions with mental health needs. These complex needs are often worsened by socioeconomic disparity among the beneficiaries. We needed to improve our understanding of this population in order to make recommendations that could help in addressing the problem of resource burden and poor health outcomes. To do this, we conducted an analysis to characterize Medicaid beneficiaries and to examine the relationship between complex needs, healthcare utilization, and socioeconomic status.

For our analysis, we included Medicaid beneficiaries aged 18 years and older enrolled in Medicaid during the state fiscal year 2017 (July 1, 2016 to June 30, 2017). All cost data associated with each beneficiary in the 12 months leading up to his or her last medical claim for the state fiscal year were used. We defined complex needs as beneficiaries with either one chronic condition plus depression, or ≥2 chronic conditions plus ≥1 mental health condition. We geocoded beneficiary addresses, assigned them to census block groups, and identified complex needs through claims data.

**KEY FINDINGS**

- 18.9% of Medicaid beneficiaries in Utah were classified as having complex needs in state fiscal year 2017.
- The proportion of complex needs Medicaid beneficiaries was higher in areas of high deprivation.
- More than half of Utah complex needs Medicaid beneficiaries had depression (69.4%), anxiety disorders (56.8%), and hypertension (56.0%). A significant number had rheumatoid arthritis/osteoarthritis (35.5%), hyperlipidemia (33.7%), drug use disorders (16.2%), or alcohol use disorders (15.4%).
- Geographically, there were no Medicaid covered mental health facilities within the six census blocks with the highest prevalence of complex needs Medicaid beneficiaries.

---

**Complex Needs Medicaid Beneficiaries by ADI**

*Figure 1.* Proportion of Medicaid beneficiaries with complex needs by area deprivation index (ADI) group, Utah, state fiscal year 2017

**Complex Needs Medicaid Beneficiaries by Cost**

*Figure 2.* Proportion of Medicaid beneficiaries with complex needs by cost of claims in a 12-month period, Utah, state fiscal year 2017

Source: Utah Medicaid Claims Database
and designated an area deprivation index (ADI) for measuring socioeconomic status. An ADI calculates a score by census block group using 17 United States census measures that characterize the level of socioeconomic need in a neighborhood. Higher index values represent higher levels of deprivation.

Of the 157,739 Medicaid beneficiaries included in the analysis, 29,742 (18.9%) were classified as having complex needs. The proportion of beneficiaries with complex needs increased with increase in socioeconomic deprivation reaching 20.4% among those living in areas with the highest deprivation index as shown in Figure 1. We used the Kruskal-Wallis test to examine if the ADI groups were significantly different among them for the proportion of the population with complex needs. There were statistically significant (at p<0.05) differences among the ADI groups for the proportion of cases with complex needs. Pairwise Kruskal-Wallis tests showed that comparison of ADI groups 2&3, 2&4, and 3&4 were not statistically significant at p<0.05 level. The rest of the pairwise comparisons of ADI groups for proportion of cases with complex needs were statistically significant at p<0.05 level. The proportion of cases with complex needs reached to 39.7% among beneficiaries whose claims were greater than $5,000 in a 12-month period (Figure 2).

The top mental health conditions among complex needs beneficiaries were depression (69.4%) and anxiety disorders (56.8%). Also, 16.2% had a drug use disorder and 15.4% had an alcohol use disorder. The top chronic physical conditions among beneficiaries with complex needs were hypertension (56.0%), rheumatoid arthritis/osteoarthritis (35.5%), and hyperlipidemia (33.7%). Figure 3 shows the proportion with specific mental health disorders in each of these categories.

Among all census block groups, the median number of beneficiaries with high needs was 12 and the median prevalence was 17%. The highest prevalence quartile had 97 census blocks which totaled 7,250 beneficiaries with high needs. Census block group prevalence of beneficiaries with high needs in this quartile ranged from 21.8–63.0%. The six census blocks with the highest prevalence had no Medicaid covered mental health facilities.

In conclusion, we found that approximately one of five Utah Medicaid beneficiaries had physical and mental health needs. Our analysis found that areas with greater socioeconomic deprivation had a greater proportion of beneficiaries with complex needs; these areas also had a reduced number of mental health facilities. Development of programs to address both physical and mental health by integrating services, focusing on socioeconomically deprived areas may help address this need.


For additional information about this topic, contact Srimoyee Bose, 801-538-6214, sbose@utah.gov; or the Office of Public Health Assessment, Utah Department of Health, (801) 538-9191, chdata@utah.gov.

UDOH ANNOUNCEMENT:

In 2018, the Utah Legislature passed the Utah Statewide Stroke and Cardiac Registry Act (S.B 150, Chapter 8d, section 26-8d-102). This legislation instructed the Utah Department of Health to establish statewide stroke and cardiac registries in order to analyze information on the incidence, severity, causes, outcomes, and rehabilitation of stroke and cardiac diseases; promote optimal care for these patients; alleviate unnecessary death and disability from stroke and cardiac diseases; encourage the efficient and effective continuum of patient care, including prevention, prehospital care, hospital care, and rehabilitative care; and to minimize the overall cost of stroke and cardiac diseases. To learn more, visit https://bemsp.utah.gov/operations-and-response/specialty-care-vulnerable-populations/.
The Value of Expertise

BY RYAN M. BLADEN MBA, CFP®, VICE PRESIDENT, FINANCIAL ADVISOR
UMA FINANCIAL SERVICES

ONE OF THE KEY characteristics of an expert is the ability to process information to make the best decision possible about the situation at hand. For example, someone might describe troubling symptoms to a doctor simply as chest pain, but a trained physician will be able to ask questions and test several hypotheses before arriving at any conclusions.

There are striking parallels between the work of a physician and the work of an experienced financial advisor. While many individuals may have the capacity to achieve a high level of understanding within a given field, reaching this point takes time, dedication, and experience. In the New York Times best-selling book “Outliers”, Malcolm Gladwell explains that reaching the 10,000-hour threshold is a critical component of expertise in any field. The consultative nature of a relationship with a financial advisor who has this level of experience—both when a situation arises and as we progress through life—is one of the key benefits that an expert can provide.

The responsibility of an advisor is to understand the needs, goals and objectives of their client so that they can fully assess their situation, then develop a treatment plan. Starting a relationship with a well-thought-out plan will help ensure that clients will be in the best position possible to meet their long-term financial goals and will also form the basis for future behavioral coaching conversations. Once the plan is underway, the advisor monitors the client’s situation, evaluates if the course of action remains appropriate, and helps the client to maintain the discipline required for the plan to work as intended.

Advisors often experience conversations with clients who are triggered by sensationalized news reports or informed by unqualified sources. Such sources might suggest that if they’re not making changes to their investments, they’re doing something wrong. Advisors understand that market headlines change far more often than do investors’ objectives. There is probably no harm done when a person, recognizing the onset of a common cold, takes cold medicine, drinks plenty of fluids, and rests. However, without the presence of an expert to collaborate with, if an individual self-diagnoses and self-medicates, it may cause serious harm.

Research shows that the most significant pitfalls of investing are the temptation to chase performance and the allure of market timing. Abandoning a planned investment strategy can be costly since there is no reliable way to forecast when positive returns in equity markets will occur. Very few predicted that January would be the best start to the year for the stock market in over 30 years, following the worst December since 1931. One might think that missing just a few days of strong returns would not make much difference over the long term. On the contrary, as illustrated in Exhibit 1, had an investor missed the 25 single best days in the S&P 500, between 1990 and the end of 2017, their annualized return would have dropped from 9.8% to 4.5%. Such an outcome can have a major impact on achieving an investor’s financial goals.

Improving someone’s financial health is a lot like improving their physical health. The challenges associated with pursuing a better financial outcome include diagnosis of the current situation, development of the appropriate course of action, and sticking with the treatment plan. The benefits of working with a financial expert are demonstrated through the ability to both help clients pursue their financial goals and to provide a positive experience along the way. By creating a long-term financial plan and providing the prescription of reassurance and education over time, we believe the proper financial guidance can play an irreplaceable role in investors’ lives.

Improving someone’s financial health is a lot like improving their physical health. The challenges associated with pursuing a better financial outcome include diagnosis of the current situation, development of the appropriate course of action, and sticking with the treatment plan. The benefits of working with a financial expert are demonstrated through the ability to both help clients pursue their financial goals and to provide a positive experience along the way. By creating a long-term financial plan and providing the prescription of reassurance and education over time, we believe the proper financial guidance can play an irreplaceable role in investors’ lives.

Exhibit 1: Reaching Can Hurt Performance
Performance of the S&P 500 Index, 1990-2017

<table>
<thead>
<tr>
<th>Growth of $1,000</th>
<th>$13,779</th>
<th>$12,313</th>
<th>$5,314</th>
<th>$3,366</th>
<th>$3,453</th>
<th>$2,109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Period</td>
<td>9.81%</td>
<td>9.38%</td>
<td>8.27%</td>
<td>6.18%</td>
<td>6.53%</td>
<td>2.77%</td>
</tr>
<tr>
<td>Missed 1 Best Day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missed 5 Best Single Days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missed 15 Best Single Days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missed 25 Best Single Days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Month U.S. Treasury Bills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CME Spotlight

Title: Generations: Behavioral Health & Addiction Interventions for Professionals
When: April 15-16, 2019
CME: 18.5 AMA PRA Category 1 Credits*

This year, Generations will incorporate two stand alone activities for primary care providers in the conference. On Monday, April 15, a one-day program Psychiatry for the Primary Care Provider will be offered to increase primary care providers’ knowledge on diagnosing and treating mental health conditions. The following day, a four-hour workshop Applying the Integrated Care Approach: Practical Skills for the Consulting Psychiatrist and Primary Care Providers will provide PCPs with the practical skills need to work in collaborative care. Both sessions will be lead by Lori Raney, MD, a master trainer and leading authority on the collaborative care model and integration of primary care and behavioral health. For more information on these activities, visit https://medicine.utah.edu/psychiatry/upcoming-events/psychiatry-for-primary-care-2019/

CME Calendar

APRIL 2019

15-16 Generations: Behavioral Health & Addiction Interventions for Professionals, Salt Lake City, ESI (18.5)
15 Psychiatry for the Primary Care Provider, Salt Lake City, ESI (8.75)
16 Applying the Integrated Care Approach (4.0)
26-27 2019 Utah Dermatology Annual Conference, Springdale, UMAF (TBD)

MAY 2019

11 Advanced Trauma Life Support Refresher Course, Murray, ACS (5.0)
14-17 Ogden Surgical Medical Society Conference: Bringing Health Care to the World, Ogden, OSMS (27.0)

17 2nd Utah Amyloidosis Symposium, Salt Lake City, UUCME (TBD)
17-18 Advanced Trauma Life Support Student Course, Salt Lake City, ACS (17.0)

JUNE 2019

3-5 41st Annual Common Problems in Pediatrics, Salt Lake City, IHC (17.0 and 4.0 MOC)
12-14 Addictions update: Science, Policy, and Treatment, Salt Lake City, ESI (TBD)
13-15 2019 Advances in Pediatric Retina Course, Salt Lake City, UUCME (19.0)
14-15 1st Annual HIV Prevention in Primary Care Conference, Salt Lake City, Utah AAFP (22.0)
21-22 25th Annual Utah Otolaryngology Update, Salt Lake City, UUCME (11.0)

ONGOING ONLINE EDUCATION

Counseling on Access to Lethal Means (CALM) Utah (1.0)
https://www.train.org/utah/course/1081014/

Controlled Substances: Education for the Prescriber, UMAF (3.5)
https://cme.utahmed.org/

Suicide Prevention, UMAF (1.0)
https://cme.utahmed.org/products/suicide-prevention

Utah Million Hearts Hypertension Webinar (1.0)
https://healthinsight.org/resources/utah-million-hearts-hypertension-webinar
Many of the hospitals in the state offer ongoing regularly scheduled series. Intermountain Healthcare, Primary Children’s Medical Center, and the University of Utah School of Medicine offer ongoing regularly scheduled series. Lakeview Hospital also has a schedule for grand rounds. Contact the sponsor for specific information. For more information on the above listings, please call the provider at the phone number listed below.

ACOG American College of Obstetrics and Gynecology
UT Chapter, SLC, 801-747-3500

ACP American College of Physicians
UT Chapter, SLC, 801-582-1565 x2441

ACS American College of Surgeons
Please contact UMA 801-747-3500 re ATLS

AMA American Medical Association
Chicago 312-464-4761

AUCH Association for Utah Community Health
SLC, 801-924-2848

CA Collegium Aesculapium
Orem, www.collegiumaesculapium.org

ESI ESI Management Group
SLC, 801-501-9446, www.esimt.org

HI HealthInsight
SLC, 801-892-6645
healthinsight.org/ut-events

IASIS IASIS Healthcare
SLC, 801-984-2384
www.iasishealthcare.com/

IHC Intermountain Healthcare CME
SLC, 800-842-5498
intermountainphysician.org

LVH Lakeview Hospital
Bountiful, 801-299-2546

MM Mountain Medical Physician Specialists
801-866-2977
www.mtnmedical.com/physician/

MVH Mountain View Hospital
Payson, 801-465-7073

OSMS Ogden Surgical-Medical Society
Ogden, 801-564-5585
ogdensurgical.com/

PCH Primary Children's Hospital
SLC, 800-910-7262

TRH Timpianogos Regional Hospital
Orem, 801-714-6330

UAFP Utah Academy of Family Physicians
SLC, 801-587-3285
UtahAFP.org

UHFL Utah Healthy Living Foundation
SLC, 801-993-1800 or 801-712-8831

UDS Utah Dermatology Society
SLC, 801-266-8841

UMAF UMA Foundation
SLC, 801-747-3500

UOS Utah Ophthalmology Society
SLC, 801-747-3500
www.utaheyemds.org

USH Utah State Hospital
Provo, 801-344-4265

UUCME University of Utah Continuing Medical Education
SLC, 801-581-8664
medicine.utah.edu/cme/

VA VA Center for Learning
SLC, 801-584-2586

The following websites offer online continuing medical education (some free, some for a charge):

http://cme.utahmed.org
https://psnet.ahrq.gov/cme
http://www.thedoctorschannel.com/cme/
www.freecme.com
http://pri-med.com/pmo/OnlineCME.aspx
http://medicine.utah.edu/cme/
www.cmelist.com
www.baylorcme.org
http://www.medscape.org/

https://www.vlh.com/
http://www.primarycarenetwork.org/
https://www.emedevents.com/
https://www.ama-assn.org/education-center
https://reachmd.com/programs/
https://www.cms.gov/Outreach-and-Education/Learn/
Earn-Credit/Earn-credit-page.html

The following sites allow you to search databases to locate medical meetings throughout the country:

www.ama-assn.org
www.eMedEvents.com
For nearly 80 years, Ray Quinney & Nebeker has provided sophisticated and comprehensive legal services both nationally and across the Intermountain West. Our collective expertise and collaborative approach assure our capacity to grow with changing legal markets. We solve problems the right way — with expertise, responsiveness, and integrity. In the end, we not only solve our clients’ problems, we build relationships to help prevent problems in the future.
Despite living with osteogenesis imperfecta (brittle bone disease), Dash can boogie down!

When he was born, his family wasn’t sure he’d ever walk. But surgery and regular treatments at Shriners Hospitals for Children — Salt Lake City make him stronger, enabling him to walk, run and even dance. Now his family believes in miracles.

Shriners Hospitals for Children — Salt Lake City has been changing the lives of children like Dash since 1925 through state-of-the-art pediatric orthopaedic care. Services include inpatient and outpatient surgery; physical, occupational and speech therapy; custom wheelchairs; orthotics and prosthetics; outpatient clinics; low radiation imaging and a motion analysis center.

All care is provided regardless of a patient’s ability to pay. Learn more at ShrinersSLC.org.