Immunity
One Less Worry for COVID-19 Care

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I would like to personally thank all Utah physicians who have rallied and come together during this pandemic. Thank you for your dedicated service to your patients and to health care. Thank you for going the extra mile and providing care in any area you have been needed over these past few months. Thank you for your tireless service to all of us. Thank you for making the world a safer place. Thank you for sharing your vast knowledge and information with all of us and for being on the front lines through this crazy time and always. You risk your health and sanity for all Utahns continuously. Know that you are greatly appreciated and that we want to recognize you and give thanks to all of you. My best wishes and heartfelt gratitude goes out to each and every one of you.

If the Utah Medical Association can help you in any way, please let us know. We will work with you and for you to help you have the resources and information that you need during this stressful time. Your UMA knows that you are all heroes and we want you to know that we are thankful for all of your hard work. WE HONOR YOU!

With deep gratitude and thanks,

Michelle S. McOmber, MBA, CAE
CEO, Utah Medical Association

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I would like to warn the house of medicine and any who will listen of the dangerous OMT Committee. No, this is not a reference to osteopathic manipulative therapy. I’m referring to the generally well-intentioned stakeholders who frequently ask physicians for “ONE MORE THING.” My practice partner cleverly refers to this group—who are unwittingly members of a large consortium—as the OMT Committee.

An estimated 300 to 400 US doctors commit suicide each year, a rate more than double the general population, and doctors have the highest rate of all the professions (https://www.medscape.com/viewarticle/896257). Suicide is a serious topic, and will not be explored fully in this article; if you are struggling, please know that I care and I encourage you to seek help. Doctors have different average personality traits and habits than the general population, but you cannot deny that some of this high rate is due to burnout. Burnout is popularly defined as a state of emotional, physical, and mental exhaustion caused by excessive and prolonged stress. We are losing good doctors at an even higher rate to early retirement, resignation, reduction of clinical hours, and to other actions because of burnout. This means fewer providers available to care for our growing population.

There are many factors that contribute to burnout, but mandatory wellness classes and resilience courses can never do enough to cure this epidemic. If a woman were traversing the Amazonian rain forest with a huge parka on, to cool her down you would not just teach her how to purify water and make a fan out of leaves. You would help her remove the parka. Similarly, we must reduce the excessive and prolonged stress heaped on doctors—not just try to help them cope with the stressors.

Saving and prolonging life is a stressful endeavor. In the Amazon, the woman in my example is never going to be completely removed from heat; similarly, doctors will never be completely removed from stress, but the proverbial parka, earmuffs and scarf can be removed or thinned. This requires buy-in from all leaders and participants in healthcare.

Some Examples
Everyone who works directly in or tangentially to healthcare has been tasked with improving quality and availability, while driving down costs. Often, the ideas that are generated lead to another policy adopted by the OMT Committee. Below are a few examples that affect my practice; I’d love to hear some of your examples.

Insurers, hospital administrators, legislators, and physician leaders have created rules, policies, or laws, demanding that Physicians must:

- Manually input a certain percentage of orders into the EMR
- Personally have the patient sign the surgical consent form
- Sign the Patient Status Order (PSO) prior to admitting the patient
- Check the Controlled Substance Database prior to writing any opioid prescriptions
- Help a patient decide on the final disposition of the remains of her miscarriage
- Sign death certificates within a certain time-frame
- Obtain consent from patients to have residents or students present for surgery
- Assure that patients follow through with their screening exams
- Stay in hospital when a certain type of patient is admitted—without compensation

Not one example above sounds unreasonable. In fact, alone each seems like a good idea. Most of these can be done while multi-tasking or can be completed in just a few minutes. But they add up. And we physicians (and our APC colleagues) feel them adding up and stealing some of the joy of our care-giving. When the creating minds implement their novel idea, they might rightfully claim that the impact to physicians is small, but it is seldom/never accompanied by some increase in compensation, some decrease in another burden, or even an increase in appreciation.

Good Intentions Can Lead to Unexpected Consequences
One reason for the recent expansion of the OMT Committee comes from good intentions. Forward-thinking hospital systems, have created jobs, departments, and committees, assigned to a

Matthew Wilson, MD, FACOG
President, Utah Medical Association
particular topical effort to optimize healthcare for our community. The individuals in each of these departments want to find the most impactful solution. These often result in policies that—in part—add to the work-load of doctors. No matter how innocuous or inflammatory the concept, if it takes time and energy from the healthcare provider without removing some other load, it is contributing to burnout.

Imagine if lawmakers passed laws requiring attorneys to perform tasks X, Y, and Z, and they cannot bill for the time required to perform those tasks. Then imagine the next year lawmakers added tasks A, B, and C—and again did not allow them to bill for these tasks. This is the medical equivalent of the vast majority of the changes created by the OMT Committee. Nevertheless, legislation is only a part of the stress.

A Call to Action
I hereby call upon 1) administrators of hospitals and healthcare systems, 2) national and local lawmakers, 3) insurers, and 4) physician leaders to beware the OMT Committee. This means, when you are trying to improve healthcare with some change or addition to policy or laws, you should follow the proceeding guidelines.

- Determine what impact it will have on doctors, and if the answer is not “none,” or “positive” then go back and consider physician burnout.
- Determine whether your proposal is worth the cost of losing good doctors to resignation, retirement, or worse.
- If the above have not deterred you to implement a policy, then either A) remove an equally-weighted burden from healthcare providers, or B) find a way to compensate them for this new effort.

Protecting doctors from burnout means preventing mental and physical illness, job dissatisfaction, and general unhappiness. Fighting burnout also is fighting for our patients. Every time we lose a doctor to resignation, early retirement, disability, or death, it will inevitably make it harder for patients to get good care. It is often the best doctors that burn out the quickest. If you are a physician leader, my call to action should speak loudest to you. Advocate for yourself and your colleagues by slowing or reversing the ever-increasing load of uncompensated tasks heaped on doctors.

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The COVID-19 pandemic is putting additional strain on healthcare organizations. Relief is available, but there is a lot of information to sort through. Eide Bailly can help you make sense of relief provisions, so you can be better prepared to weather the storm.

What inspires you, inspires us.
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The legislative session started off with the repeal of the tax reform bill that the legislature had passed in a special session in December. UMA had worked to make sure physician services/medical care would not be taxed in the bill. But popular sentiment was so strong against it, the legislature decided to repeal it rather than wait for the referendum to go to the ballot in November. This affected the first several weeks of the session, as well as reducing the amount of general funds in the budget for the coming year. One of the biggest challenges this session was the significant turnover in the Office of Legislative Research and General Counsel. Several key drafting attorneys left shortly before or at the beginning of the session, greatly slowing down the ability of the office to draft bills, substitutes, and amendments. This delayed the introduction of many bills, including key bills that the UMA had been working on for months. Through the hard work of the legislature’s staff, we were able to get through and make changes to the most important bill we were working on, even though fewer bills were numbered and passed this year than last. The legislature was fortunate to finish its work just before restrictions on large gatherings were announced by the Governor due to the COVID-19 pandemic spreading across the state and nation. As a precaution, the legislature passed a law at the end of the session enabling them to convene electronically if necessary. At the end of the session, the legislature also approved special funding of $16M for the COVID-19 crisis. With that said, they also opened the door for more funding if needed.

The members of the 2020 legislature were generally unchanged from the last session. Physician-Representatives Suzanne Harrison, MD, (anesthesiologist, Draper), Stewart Barlow, MD (a UMA past president, ENT, Fruit Heights) and Ray Ward, MD (family practice, Bountiful) continued their service in the legislature. Many other legislators are physician spouses or family members and other friends of medicine. Physician spouses are Sen. Keith Grover (Provo) and Rep. Jennifer Dailey-Provost (Salt Lake City); family members include Rep. Marie Poulsen (who is not running for reelection) and Sens. Dan Hemmert, and Gregg Buxton.

Continued on page 8.
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Special thanks go to Rep. Melissa Garff Ballard and Sen. Allen Christensen who ran our telehealth bill, and Rep. Brady Brammer who introduced our balance billing bill. We particularly note with appreciation the long, valuable service of Sen. Christensen who is retiring after this year. He has been a wise legislator and loyal friend to the physicians and patients of Utah. Thanks also to Rep. Brad Daw, Rep. Suzanne Harrison, Sen. Evan Vickers and several others who ran many important bills for the health and healthcare of Utahns. Senator Vickers, who is a pharmacist from Cedar City, is always willing to work with the Utah Medical Association on health care bills and he often runs our bills. We appreciate all he does to help us with medical issues.

Many times during each legislative session, UMA issues Calls to Action. It is very important for physicians to get to know their legislators and to respond promptly to these calls. When physicians respond to a Call to Action, legislators know that physicians are concerned and watching the actions of their representative. Many legislative actions come up very quickly with very little notice. When we send out a Call, it often requires a very quick response. We greatly appreciate those physicians who take the time to respond and contact their legislators. Legislators are also often contacted by those on the other side of the issue, particularly by mid-level or unlicensed providers when they are seeking to expand scope. That is why we encourage all physicians 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 are influenced by your message.

Getting to know your legislator outside of the legislative process can make your message to them during the legislative session even more powerful. You can develop a good relationship by serving as county or state party delegates. It’s valuable to help good individuals run for office by contributing money, sponsoring fundraising events at your home, or talking with delegates, friends, and neighbors about supporting these candidates. We want to thank all of you who do run for office, contribute money to UMPAC, and participate in the political process.

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

**Telehealth**

**HB 313 Telehealth Parity Amendments (Rep. Melissa Garff Ballard and Sen. Allen Christensen) UMA’s telehealth bill**

Months before the coronavirus pandemic struck and under the mandate of UMA HOD Resolution A4—Utah Coverage Parity for Telemedicine Services (2019), UMA was negotiating with stakeholders and working on a telehealth bill to provide greater access to telehealth services for patients and compensation for physicians providing telehealth services. Rep. Ballard was an excellent sponsor who was strongly motivated to expand telehealth access. Our goal was to require insurers to provide service parity—coverage for any services appropriately provided by telehealth—and payment parity—payment rates for telehealth that are the same as for services provided in-person. Both goals were adamantly opposed by representatives of the insurers. Other stakeholders weighed in with concerns and requested changes. After extensive negotiations, we were able to get agreement on a bill that requires insurers to provide coverage for the telehealth services, the same as are covered by Medicare and reimburse the services at a commercially reasonable rate. Insurers are prohibited from imposing originating site restrictions, geographic restrictions, or distance-based restrictions on providers or patients. The bill also requires the telehealth provider to report the diagnosis and treatment to the patient’s designated health care provider, unless the patient doesn’t want it reported. **PASSED**

**Balance Billing**

**HB 379 Emergency Services Balance Billing Amendments (Rep. Brady Brammer) UMA’s balance billing bill**


**HB 457 Health Insurance Amendments (Rep. Jim Dunnigan)**


Based on UMA Resolution A3 (2019), our bill (HB 379) would have done several important things. It would have required insurers to pay physicians “a commercially reasonable amount” for emergency services provided to out-of-network patients. “Commercially reasonable” was to be based on the usual and customary reimbursement rate, as well as “the circumstances and complexity of the particular case, including time and place of the service, individual patient characteristics, and other relevant clinical and economic factors.” The bill would have established that the usual and customary reimbursement rate for emergency services provided to out-of-network patients would have been “the 80th percentile of all total amounts paid for the particular health care service performed by a physician in the same or similar specialty and provided in the same geographical area of the state as reported in a benchmarking database, excluding Medicare and Medicaid.” The Department of Health’s All Payer Claims Database would have been used for benchmarking. In addition, the bill would have required direct payment to the physician, authorized the physician to continue care after emergency stabilization (paid at network rates) if the physician
and patient agreed, set basic requirements for network adequacy, and provider directory standards.

Since the hospitals were opposed to any balance billing legislation, we left them out of our bill, but discussed the bill with them before session. But after telling us they were OK with our bill as it related to physicians, they later came back and told us they opposed our bill when it came out during session because it would apply to physicians employed by health systems. Even though PEHP slapped our bill with fiscal note of hundreds of thousands of dollars we were confident we could bring the cost of the bill down to under $60,000. However, in the end, after discussing with our specialty physician task force, UMA decided that physicians would be better off without any legislation on balance billing than to pass our bill in its current form.

Rep. Dunnigan’s bills, HB 456 and HB 457, came out at the very end of the session—too late to be considered by the legislature and passed. However, we were strongly opposed to them. The bills were designed to divide the hospitals from the physicians and the emergency physicians from the on-call specialty physicians. HB 456 would have paid health care facilities “the median of the health care facility’s contracted in-network rates with all managed care organizations in the state,” which is not a reasonable reimbursement rate. HB 457 would have paid on-call physicians (not including emergency physicians) the 90th percentile of all total amounts paid for the health care service performed by a licensed provider in the state in the same or similar specialty as reported in DOH’s all payer claims database. The misleading part of this is that it did not exclude Medicare or Medicaid rates in determining the rates. However, the bill would have paid emergency physicians the median of their contracted in-network rates with all managed care organizations in the state, which would reduce overall reimbursement to physicians and give insurers greater leverage in negotiating unreasonable rates for in-network providers. Both bills would automatically decrease rates and incentivize insurers to push physicians out of network or to renegotiate contracts at the lower rate for any contracts they have that are above the median. We have seen this in other states that have passed similar legislation. HB 457 also included some of the network adequacy and provider directory provisions from our bill (and previous bills). But both bills would have been a serious setback for Utah healthcare providers and patients. UMA will regroup with specialties and come up with better language for the balance billing issue.

Before the session, Sen. Mayne approached UMA and insurers about drafting a bill, which became SB 155, that would gather information on the scope of the balance billing problem in Utah. We worked with her and other stakeholders to develop a consensus bill. It directs healthcare providers who, between July 1, 2020, and June 30, 2021, provide emergency services (under EMTALA) and balance bill to provide a report to the Utah Insurance Department. They are to report the percentage of episodes of care for an emergency service provided to a Utah resident who is an enrollee of a health benefit plan offered by an insurer for which the qualified provider was out-of-network for which the qualified provider engaged in balance billing. They are to aggregate the percentage for each insurer they saw patients for who are from Utah. No out of state patients need be included in the aggregate. Providers will also need to include their specialty or subspecialty in the report. The insurers are to report for the same time period the percentage of emergency department claims received from all qualified providers for enrollees of a health benefit plan who are Utah residents that were provided by an out-of-network provider. Insurers are also to report whether they sent payment for out-of-network emergency services directly to the patient, rather than the provider. UMA supported the collection of this information to get a clearer picture about balance billing in Utah. The reporting period will be from July 1, 2020 to June 30, 2021 and must be reported to the Utah Insurance Commissioner by January 1, 2022.

None of the three House bills prohibiting balance billing advanced through the legislature, but the balance billing reporting bill, SB 155, PASSED.

More UMA Sponsored or Supported Bills


Last fall the UMA House of Delegates adopted Resolution A2 - Removing Harmful Health Effects by Discontinuing Daylight Saving Time, directing UMA to work with the state legislature to end the twice annual time change because of the negative health impact. The directive was conditioned on permission by federal law and coordination with surrounding states. SB 59 did exactly that; it will put Utah on year-round daylight savings time when authorized by Congressional action and similarly adopted by at least four western states. UMA testified in support, highlighting the benefits to public health that could be realized by the plan. PASSED

HB 34 Tanning for Minors (Rep. Brad Daw and Sen. Allen Christensen)

Four years ago, UMA had worked to restrict access by minors to tanning salons. At the time, a compromise was adopted that gave parents the authority to allow their children to go to tanning salons and for physicians to give a directive for tanning for a minor patient. Rep. Daw brought this bill to remove that authority by parents for their children and even for a physician’s prescription for tanning. It did retain the ability for a physician to use phototherapy in offices. It was approved unanimously by the Health and Human Services
Interim Committee last fall. During the session, in the House and without our support, some legislators insisted that it be amended to allow minors to go if a doctor provides a written order. This garnered some additional support. UMA lobbied House members to support the bill. It passed the House 41–31 (with three not voting). Unfortunately, it was assigned to the Senate Business and Labor Committee chaired by Sen. Bramble, which we do not so affectionately call “the kill committee.” Senator Bramble got his committee to hold the bill from going to the full Senate, so the bill FAILED.

The sponsor began working with us, pharmacists, dentists, and other stakeholders on this bill before the session started. She wanted to require electronic prescribing—by physicians, mid-levels, as well as dentists and others—of all controlled substances to reduce fraud and diversion of controlled substances, especially opioids, similar to what will be required by Medicare beginning next year. We were concerned about the breadth of the bill, but several exclusions and extensions were included to minimize the impact on responsible practitioners. Prescriptions issued in an emergency or during a temporary technical or electronic failure are excused. Other exceptions can be put into place through the rules process. We will work on it to make sure that all appropriate exceptions are in place. The requirement does not go into effect until January 1, 2022, and an additional two-year extension will be available if needed, among other provisions. We will send out more detailed information on the requirements as we get closer to the due date. PASSED

Abortion Bills

UMA does not take a position on the pro-life, pro-choice policy of abortion. For example, SB 174 Abortion Prohibition Amendments (Sen. Dan McCay and Rep. Karianne Lisonbee) was a straightforward though controversial bill to invite the US Supreme Court to overturn Roe v. Wade. While there are medical aspects regarding access to an abortion, the physicians of Utah reflected in the membership of UMA are divided regarding Roe v. Wade and the policy of abortion. Since this bill only takes effect if Roe v. Wade is repealed and since the bill did not change current requirements under the law, UMA did not spend a lot of time on this bill. PASSED.

As drafted, among many other things, this bill would have required a physician or technician to administer an ultrasound to a pregnant woman seeking an abortion and make the heartbeat audible to the woman. UMA opposes legislation that dictates how to practice medicine and strongly opposes the requirement of a procedure that could be harmful. The sponsor was willing to work with us and modify his bill to condition making the heartbeat audible only if it complies with best medical practices. In addition, the ultrasound requirement was replaced with a requirement to display fetal images, etc. UMA worked with the Utah chapter of ACOG to minimize the requirements in the bill. After working with the sponsor and having changes inserted into the bill, UMA had to withdraw opposition but still did not support the bill. Unlike other abortion bills, this bill was highly offensive to all women in the legislature whether they agreed on abortion or not. With this strong opposition, the bill was held at the end of session even after passing the House, being further amended in the Senate and passing in the Senate. It was never heard for consensus at the end of the session because of this opposition. FAILED

The purpose of this bill was to require any healthcare facility to bury or cremate the remains from an abortion or a miscarriage at any age of gestation. UMA in conjunction with the Utah Chapter of ACOG worked hard to change language from the original bill. After all the changes, the bill still eliminated the option for a mother, possible under current law, to allow the facility to dispose of the remains in another way, as is often done. In the end, even with the changes, UMA opposed the bill on two points. First, pregnancy remains are often sent to a pathology or genetic lab for testing. Fetal tissue that is permanently fixed for study cannot reasonably be returned for burial or cremation. The sponsors agreed to exclude this tissue from the requirements of the bill. The second point of opposition was elimination of the mother’s option to dispose of the tissue without burial or cremation. We supported an amendment to the bill to preserve that option. The House adopted the amendment only for miscarriages, and not abortions. Sen. Bramble, claiming there was a constitutional concern, got the Senate and ultimately the House to reject this change. PASSED

Bills UMA Opposed, Then Worked To Change Or Defeat

HB 341 Associate Physician License Amendments (Rep. Stewart Barlow, MD and Sen. David Buxton)
Three years ago, UMA worked with Rep. Barlow to create a restricted, temporary license for medical school graduates who failed to match for residency—associate physician. This year the sponsor introduced this bill to delete the requirement that the associate physician’s scope of practice be limited to medically underserved areas or populations and to remove the four-year time limit on the license. UMA opposed changing the program to
create a permanent underclass of physicians who did not have to finish training and worked with the sponsor and others to allow the license to continue for a maximum of six years, rather than indefinitely, then took no position. **PASSED**

**HB 354 Associate Physician and Physician Assistant Amendments (Rep. Ray Ward, MD)**

Like Rep. Barlow put in HB 341, Rep. Ward proposed in this bill to eliminate the requirement that associate physicians practice only in or with medically underserved areas or populations and to extend the license to five years. In addition, this bill would have added physician assistants to the mental health licensing act giving them the same authority as a psychiatrist and an APRN Psych nurse without requiring extra training. This was an issue UMA worked on extensively during the last legislative session and over the summer with the PAs and licensed mental health providers. The groups, including the PA Association had agreed that more work needed to be done on this issue before it moves forward. The PA Association said they were not pushing the bill either. It came from one or two PAs acting on their own who asked Rep. Ward to run the bill. After discussion with UMA, the sponsor agreed not to advance his bill. **FAILED**


Utah was among the first group of states to consider a newly drafted Audiology and Speech-language Pathology Interstate Compact. And we were the first state to dig into the language of the compact. Usually, interstate compacts are presented to a state for an up-or-down vote, with no opportunity to propose changes or amendments. When we first saw the bill, we contacted the AMA for their insights. However, AMA staff had not really reviewed it yet, so they referred us to the American Academy of Otolaryngology—Head and Neck Surgery. The Academy was simply opposed to the compact because of some generalized concerns. We knew we had to work on the compact to change it so it was acceptable, as many other professions including physicians, physical therapists, nurses, and others were allowed to have a compact, and our legislators would say “why not audiologists and speech pathologists?” We also knew that we would have to fight it if we could not find language that would leave scope decisions to each state participating in the compact instead of having scope determined by a national “committee.” As we reviewed the bill, we found that we had several concerns about the compact, so we voiced our concerns and opposition to the bill sponsor. To our surprise he was willing to make changes and we worked with the
attorneys for the Council of State Governments—National Center for Interstate Compacts, who had drafted the compact, to change the bill so it was acceptable. They agreed to changes that resolved our concerns—clarifying that audiologists and speech-language pathologists in a remote state work within the scope defined by the state where the patient is, which cannot be changed by the interstate commission; clarifying communication among states when disciplinary action is taken by one; refining the definition of telehealth; and more—and we agreed to withdraw our opposition. The changes we made were then shared with other states to form the basis for their consideration of the compact. PASSED

The sponsor ran this bill with the encouragement of a medical researcher who suggested that pharmacists be allowed to administer Tamiflu to patients who come to their pharmacies without a diagnosis or prescription, but just based on a general standing order through the Department of Health and a self-screening questionnaire. We strongly opposed this proposal as bad healthcare for patients. We negotiated back and forth with the sponsor in the House and got support from the Senate sponsor to push the bill to be discussed during the Interim session. HELD FOR INTERIM

Motivated by reports of deaths of diabetic patients unable to get or afford the insulin they need, this bill sought to increase access to insulin through authorizing emergency refills of prescriptions that have run out and various insurance changes to enable Utahns to get insulin for discounted prices. While we recognized the value of increased access to a life-saving drug, we were opposed to authorizing pharmacists to dispense insulin for up to three years based on an expired prescription, without contacting the prescriber. Working with the sponsor we were able make the bill safer for patients who need to follow up with their physicians while enabling them to get refills (for up to one 90 day extension) if the patient has run out and the prescriber is not immediately available to authorize the refill. The pharmacist will be required to inform the prescriber of what was dispensed, and this can only be done in limited circumstances, on an emergency basis, and not as continuing refills. The bill also authorizes the pharmacist to dispense an “interchangeable biological product” unless the prescriber has written “dispense as written.” The pharmacist will also be able to dispense a therapeutic equivalent when filling a prescription for a glucometer, diabetes test strip, lancets, or syringes. With these changes UMA withdrew opposition to the bill. PASSED

UMA worked extensively with the sponsor on this bill to make many changes to increase access of patients to life saving medications without authorizing pharmacists to prescribe and without increasing danger or risk to patients. The bill enables a pharmacist to dispense a quantity different from the amount prescribed if this amount is not commercially available and to dispense a different dosage form unless it would change the bioavailability or treatment parameters of the medication or if the prescriber wrote “dispense as written.” The bill authorizes 30-day emergency refills for prescriptions for non-controlled substances that have run out if it is an emergency, they cannot get ahold of the prescriber, and it is in the best interest of the patient. The bill lets a pharmacist consider a written record of a patient’s current diagnosis or treatment protocol as a prescription for purposes of dispensing nebulizers, spacers for use with nebulizers or inhalers, and diabetic testing supplies. This is designed to help patients get insurance reimbursement for these items. Pursuant to a standing order by a physician working for the Department of Health or a local health department, the bill enables pharmacists to dispense stock albuterol to trained adults working with public or private schools and dispense epinephrine auto-injectors to a trained adults working with schools, places of employment, food establishments, day care facilities, and a variety of recreation areas. We worked with the sponsor to make sure that none of changes allowed a pharmacist to prescribe but still just to dispense under a physician’s order. With the many changes and refinements, UMA supported the bill. PASSED

HB 252 Health Insurance Athletic Trainer Services Modifications (Rep. Brad Last)
Athletic trainers have been working on slowly expanding their opportunities since getting licensure several years ago. Most recently they added themselves to the definition of “healthcare providers.” This year they would have mandated that health insurance companies pay for their services even if they were working independently of a physician or physical therapist. UMA tried to work out an agreement that would preserve the supervisory relationship that physicians have with athletic trainers, but the bill’s advocates would not agree. So, UMA and the insurers strongly opposed the bill. FAILED

HB 314 Controlled Substance Database Access Amendments (Rep. Craig Hall and Sen. Evan Vickers)
This bill increases access of a managed care organization’s pharmacist to the controlled substances database. UMA opposed the initial draft because it would have given the pharmacist unrestricted access to anyone’s information in the database if the

Continued on page 14.
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Physician Legislator Rep. Suzanne Harrison, MD, (center front) asked for a group shot of Doctors’ Day participants.

insurer believed an enrollee had violated a medication management program contract. UMA worked with the sponsor and SelectHealth to narrow the access to information about the specific enrollee they were targeting and to access only what they needed in relation to the medical management agreement violation. With that change, UMA took no position on the bill; however, the bill was not prioritized enough to pass in the final days of the legislature. FAILED

The original bill called for the Department of Health to identify wasteful spending practices in Utah healthcare and make recommendations on consumer action, employer action, payer action, and medical delivery action to the legislature. Recognizing that could have unintended consequences and result in counterproductive ideas, particularly if they only looked at cost and physicians would have the highest cost, we discussed the intent of the bill with the sponsor, then helped her make important changes, consistent with her purpose, and helping her accomplish them more effectively. The bill was changed to sunset in three years and gather suggestions about duplicative quality initiatives, instances of non-alignment in metrics used to measure health care quality that are required by different health systems, and potential overuse of non-evidence-based healthcare. With those changes UMA was neutral on the bill.

PASSED

Originally, this bill would have authorized registered nurses to sign death certificates. We worked with the sponsor to take that out and to require that a physician working with a patient in hospice establish clear assessment procedures for determining death, so that an RN can determine death in appropriate circumstances and the death certificate would still be signed by the physician. With the changes UMA withdrew its opposition. PASSED

HB 380 Health Care Consumer Protection Amendments (Rep. Norm Thurston)
UMA strongly opposed this bill to penalize a healthcare provider for representing to a patient that the provider is in-network for the patient if that is not the case. UMA explained to the sponsor that it is often difficult for a physician to know when their network status changes, and it is something that is largely out of the control of the physician and that the bill would penalize providers at the word of a patient without proof of what was said to the patient.

PASSED

As introduced, this bill would have made it unprofessional conduct to enter any false or misleading information into a medical record or altering a medical record to conceal any circumstance related to the patient or the care provided. While it was well-intended, we let the sponsor know that the language as drafted was not acceptable and that there are times when it is in the best interest of the patient to omit some information or to redact something that might get called concealment by an aggressive attorney. We were able to work with the sponsor to have the bill prohibit falsely making an entry in or altering a medical record to conceal wrongful or negligent conduct. With this important change, UMA was O.K. with the bill and it PASSED.
The sponsor was unconvinced but did not advance his bill. **FAILED**

**SB 251 Seizure-related Student Accommodations Amendments (Sen. Todd Weiler)**
This bill would have been a big step backward from the current law regarding medications for children with seizure disorders. It would have taken nurses out of the safety plan, would have authorized children to carry anti-seizure medications with them (which would not be safe for them to do and they would not be able to administer themselves while they are seizing), and would have let marijuana be used as an anti-seizure medication. Due to UMA's expressing its concerns and opposition to the sponsor, the bill was sent by the sponsor for interim study.

**HB 307 Pharmacy Amendments (Rep. Sandra Hollins)**
As a licensed clinical social worker, Rep. Hollins proposed a bill that would allow individuals exposed to HIV to quickly get post-exposure prophylaxis. Her bill would have authorized pharmacists to dispense HIV post-exposure prophylaxis pursuant to a standing prescription drug order issued by a physician or under the health department. UMA is opposed to pharmacist prescribing or expanding the use of standing orders in this way. UMA communicated to the sponsor this opposition, concerns for the significant expense for the prophylactic drugs, their strong side-effects, and the need for a physician to be involved in this process. The sponsor agreed not to have the bill be considered by the legislature. **FAILED**

**HB 117 Controlled Substance Database Amendments (Rep. Adam Robertson)**
This bill would have significantly expanded access to the controlled substances database by law enforcement officers. Currently, law enforcement officers may access the database only if they are investigating an individual whom they already suspect of violating the law. This would have given designated officers to general access the database, enabling them to search for patterns, prescribing, or usage they deemed suspicious. UMA communicated to the sponsor its strong opposition to use of the database for “fishing expeditions.” We were reassured that the bill would be significantly modified before it moved forward. The bill was never advanced, so it **FAILED**.

**E-Cigarettes and Tobacco**

This bill went through seven substitute versions before finally passing both houses of the legislature. Compromises were necessary to see the bill through because there is powerful, influential opposition to restrictions on tobacco and e-cigarettes from the tobacco industry lobbyists. In the end the bill does many important things. It restricts sale of flavored e-cigarette products to tobacco specialty shops only. It prohibits tobacco specialty shops from locating within 1000 feet of a school. It raises the minimum age to 21 for buying, possessing, using, or providing tobacco and e-cigarettes, as well as to enter a tobacco specialty shop. It tightens the requirements on specialty shops and other tobacco retailers in many other ways and includes additional enforcement provisions. With these improvements in tobacco and e-cigarette law, UMA supported this bill. **PASSED**

Like the process HB 23 went through, this bill attracted much attention and opposition before the sponsors worked out a compromise that finally passed the House and the Senate.

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bill directs local school boards to develop policies to address possession and use of e-cigarettes at school and requires them to educate students about the risks and dangers of e-cigarettes and address the problem of student use. UMA supported this step forward in tobacco prevention among youth. **PASSED**

In addition to the bills above, this bill made several further changes to restrict youth access to nicotine products, added additional responsibilities to the selling of the products, and imposed an excise tax on e-cigarettes that is just a bit lower than on other tobacco products. UMA supported the bill. **PASSED**

**Other UMA Supported Bills**

This bill prohibits companies offering life insurance, accident and health insurance, and long-term care insurance from discriminating against an individual who is a living organ donor. UMA strongly supported this effort to encourage and protect from insurance discrimination those who volunteer to help someone else by becoming an organ donor while alive. **PASSED**

**HB 97 Newborn Safe Haven Amendments (Rep. Patrice Arent and Sen. Scott Sandall)**
This bill extends the window of time in which a parent may safely relinquish a newborn child at a hospital from 72 hours to 30 days of age. It provides funds for training and education about this program and fine-tunes the program. UMA supported this bill. **PASSED**

**HB 167 Insanity Defense Amendments (Rep. Carol Spackman Moss)**
Current Utah criminal law provides only a very limited defense based on mental illness. Most other states have a broader defense based on a defendant’s inability to appreciate the nature and quality or wrongfulness of the defendant’s actions. This bill would have brought Utah’s law into line with half the other states and the recommendation of psychiatrists. This bill had a very large, $1.6 M fiscal note from agencies, so we knew it would probably go nowhere. This bill, even with that fiscal note was estimated to only help around 10 individuals on an annual basis. UMA did support the bill, but mainly for these reasons, it died on a 4-4 vote in committee. **FAILED**

**HB 210 Insurance Coverage for Children Amendments (Rep. Ray Ward, MD)**
This bill would have made several improvements in the Medicaid and Children’s Health Insurance Programs, allowing automatic payment of premiums, improving communication with accountable care organizations, and studying further improvements in notifications and renewals. UMA supported the bill, though it didn’t get out of Rules Committee. Other bills dealing with some of the same issues passed but this one **FAILED**

**HB 443 Prohibition on Age Based Testing for Physicians (Rep. Keven Stratton)**
This bill would have prohibited age-based testing of physicians by DOPL, hospital systems, or insurers. Although UMA has not yet finished the process called for under UMA HOD Resolution B2 (2019) to study neurocognitive testing and convene a task force to determine the best path forward, UMA supported this step in the right direction. It was introduced too late in the session to get through. The bill **FAILED.**

Recognizing the need for funding flexibility during the coronavirus pandemic, this bill authorizes the state Department of Administrative Services to transfer money to other parts of the state government to help respond to the pandemic. UMA supported it. **PASSED**

**HB 88 School Water Testing Requirements (Rep. Stephen Handy)**
This bill would have required public schools to test drinking water for lead and, if the level is too high, correct the problem or shut off the tap. Because of the significant health implications of lead for children, UMA supported this bill. Despite the $2 million fiscal note, the bill nearly passed the House, 34-33 (8 not voting; 38 required to pass). **FAILED**

**Other Bills UMA Worked On**

**SB 105 Surgical Smoke Evacuation System Requirements (Sen. Kathleen Riebe)**
Representatives of the Association of perioperative Registered Nurses approached UMA before the session to propose legislation to encourage hospitals and surgical centers to adopt surgical smoke policies. However, when the bill was introduced, it required implementation of a policy to prevent human exposure to surgical smoke. With the proponents unwilling to make changes, UMA opposed the bill and it was **SENT TO INTERIM for study.**

The sponsor discussed his bill with us before introducing it, so we were able to discuss our concerns with him early in the process
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and to change the language so it was acceptable. Original language would have required reporting that could have been punitive toward the mother and the physician. Instead the bill, as it broadened fetal alcohol syndrome reporting to include adverse effects of the mother's substance abuse or impairment of the parent or person responsible for the child’s care caused by substance abuse. And the Division of Child and Family Services is directed to help the mother get needed services from the Division of Substance Abuse and Mental Health. The result was a much better bill to truly help mothers in need, which UMA supported. **PASSED**


This resolution, if passed by a two-thirds vote in the House and in the Senate, would have amended the Utah Rules of Civil Procedure to require a party taking the deposition of the other party’s expert witness to pay the expert’s reasonable hourly fees for the deposition. This would conform to current general practice. With the encouragement of medical malpractice defense attorneys, UMA supported this measure. However, after passing the House unanimously, it failed in the Senate because it was suggested that this should be brought to the Supreme Court’s Advisory Committee on the Rules of Civil Procedure first, and brought back to the legislature if it is not addressed there. **FAILED**


UMA and the Utah Hospital Association joined to oppose the original version of this bill, which would have required very detailed and specific sepsis procedures and protocols in acute general hospitals with training for certain staff. The first substitute, supported by UMA, provided greater opportunity for hospitals to adopt protocols appropriate for their circumstances without dictating in law what the details should be. **PASSED**


This bill legalizes many of the services that untrained family members and other unlicensed individuals perform while caring for individuals, often in their homes. Some of these services have been given in technical violation of the Nurse Practice Act. The bill directs the Department of Health to identify the healthcare services that can be performed by a responsible, unlicensed caregiver with and without delegation from a nurse, including things that pose little potential hazard to the patient. After clarifying, at UMA’s request, that these are “nursing” services, rather than “medical” services, UMA was not opposed to the bill. **PASSED**


This bill expanded the Charitable Prescription Drug Recycling Program to allow individuals to transfer eligible prescription drugs to a physician's office for transfer to an eligible pharmacy for dispensing to a medically indigent individual. Current law only allowed individuals to transfer the drugs directly to a pharmacy. UMA supported the bill. **PASSED**

**Conclusion**

Thank you to UMA leaders, staff, and involved members for your hard work and support. With your help UMA accomplished much for Utah’s physicians and patients at the legislature this year.

We appreciate 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 2020 general session go into effect May 12, 2020.
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A Tale of Two Decades
By Ryan Bladen, CFP®, Financial Advisor, UMA Financial Services

As we close out the first two decades of the 21st century, it’s a good time to reflect on financial market returns. When viewed over shorter horizons, the markets have been both overly generous and painfully punitive, depending on the market and period of time being examined.

Looking at a common measure of the US stock market, such as the S&P 500 index, one might recall Charles Dickens; it was the best of times and the worst of times (see Exhibit 1). For US large cap stocks, the worst came first. Bookended by the dot-com bubble bursting and the worst economic crisis since the Great Depression, the “lost decade” from January 2000 through December 2009 resulted in negative returns for those solely investing in the S&P 500. Keep in mind that this is the same index that averaged more than 10% annually during the 1990s.

Exhibit 1: S&P 500 (Total Return)
January 2000–December 2019, monthly levels

Yet it was a good decade for investors who diversified their holdings globally beyond the S&P 500 and included other financial markets such as international stocks, real estate investment trusts and bonds (see Exhibit 2), as all three handily outperformed the US stock market.

Exhibit 2: The 2000s
Annualized returns (%): January 2000–December 2009

The next decade revealed quite a different story. It looked more like best of times for the S&P 500, which more than tripled in the bounce-back from the global financial crisis when viewed by total return. Large US growth stocks were some of the brightest stars during this time. Accordingly, from 2010 through the end of 2019, many parts of the market that performed well during the previous decade did not outperform the S&P 500 (see Exhibit 3). Since many of these financial markets didn’t keep pace with the S&P 500, these returns might cause some to question their allocation to the asset classes that drove positive returns during the 2000s.

Exhibit 3: The 2010s
Annualized returns (%): January 2010–December 2019

It’s been stated many times that investors should take a long-term perspective toward investing, and the performance of stock markets since 2000 supports this point of view. Over the past 20 years (see Exhibit 4), investing outside the US presented investors with myriad opportunities to capture annualized returns that surpassed the S&P 500’s 6% annualized return, despite periods of underperformance. Cumulative performance from 2000 through December 2019 also reflects the benefits of having a diversified portfolio. This also underscores the principle that longer time frames increase the likelihood of having a good investment experience.

Exhibit 4: 2000–2019
International Diversification Still Matters
Foreign Equity Markets Often Outperform the U.S.

As illustrated, the last two decades should reinforce for investors some timeless market lessons; returns can vary sharply from one period to another. While no one knows what the next 10 years will bring, maintaining patience and discipline while holding a broadly diversified portfolio puts investors in position to increase the likelihood of long-term success.
Legally Protecting Yourself During the Pandemic

By Mark Brinton, Esq., UMA General Counsel

The circumstances in which you are practicing medicine during the public health emergency caused by the COVID-19 pandemic are extraordinary. The way you are able to treat patients is being influenced by the high demand for certain services, constrained resources, the need to modify patient encounters to conserve resources and reduce the risk of spreading infection, and other healthcare providers unable to practice because of illness or exposure. And you are being forced to adapt to rapidly changing circumstances.

These circumstances and the care you are providing could affect your personal liability, whether license discipline or professional practice liability, so you should consider ways you can reduce your potential liability. In general, your responsibility and possible liability will be shaped by the circumstances you are working under. You can better protect yourself by thinking about, communicating, and recording the significant aspects of those circumstances.

It is always important to provide your patients information so they can give informed consent to treatment, and it is even more critical now. You may want to take a moment to reflect on and decide what you would want to tell regulators or plaintiffs about the known risks and incorporate this into your informed consent documentation. This can also be a useful road map for more patient-specific note that needs to be made after the visit is complete.

You might want to begin by adding to the record of each patient encounter, “NOTE: This encounter occurred during the COVID-19 pandemic crisis.” Patients need to be told of any relevant constraints or other reasons you were not able to do or perform any aspect of quality of care that you would have preferred to do or that their care was changed in some way. You should document this information and your discussion with the patient in the patient’s medical record. Documentation is everything. The more complete the explanation, the better, especially when it comes to care affected by the pandemic.

When possible, engage the patients in the decision-making and give the patients options, such as choosing a telehealth visit now or an in-person visit sometime in the future, or trying available treatment now or waiting to take a more complete approach later. And make a record of the discussion and decision.

If relevant, document how something on a telemedicine visit could not be done unless an in-person visit is made. Consider documenting specifically why the in-person visit isn’t possible for that patient’s presenting condition(s) and the facility’s circumstances. There should probably also be a statement in the record if you considered an alternative point of care for the condition(s) presented, such as another facility or clinic that does permit, or has capacity, for an in-person visit under the patient’s presenting circumstances.

If some aspects of the constraints being imposed on a patient seem unreasonable or inappropriate, consider advocating for your patient, e.g., for needed surgery that is being denied, and again document your efforts and the results.

Keep in mind that your professional liability carrier, your employer, your attorney, and others may have additional suggestions that you should apply to your situation.

We are providing this legal information to UMA members to help you make better decisions during this extraordinary time. This information is not legal advice and cannot take the place of legal advice. If you want legal advice or legal representation, we will be happy to refer you to attorneys who can help.

References
1 With suggestions and language from the following fellow attorney members of the American Society of Medical Association Counsel:
4 Alex Keoskey, DeCotiis, FitzPatrick, Cole & Giblin, LLP, DecotiisLaw.com
5 Catherine Hanson, catherinehansonjd@gmail.com.
Here are online links to information about various funding packages that are available (at press time) to physicians who may be in need due to disruptions caused by the COVID-19 pandemic.

**CARES Act Provider Relief Fund**

hhs.gov/providerrelief – (866) 569-3522

HHS has begun distributing the remaining amounts of a $50 billion general distribution to Medicare providers proportional to providers’ share of 2018 net patient revenue. Medicare providers for whom HHS did not have adequate cost report data on file will need to submit their revenue information to the General Distribution Portal to be able to receive additional general distribution funds. Providers who received their additional money automatically will still need to submit their revenue information so that it can be verified via the portal. It is found at: https://covid19.linkhealth.com/docusign/#/step/1


The CARES Act Provider Relief Fund Payment Attestation Portal is open. Providers who have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the terms and conditions within 30 days of payment. The Attestation Portal is here: https://covid19.linkhealth.com/#/step/1

**COVID-19 Care for Uninsured Reimbursement**

The COVID-19 Uninsured Program Portal, which allows healthcare providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after February 4, 2020 to request claims reimbursement, is now live. Providers can access the portal to register for the program at COVIDUninsuredClaim.HRSA.gov. For additional info about this program, visit: https://utahmed.org/docs/COVID-COVID-19%20Uninsured%20Program.pdf

**Small Business Administration Paycheck Protection Program**

Though plagued by technical difficulties due to demand, the SBA’s Paycheck Protection Program (PPP) is still available for small businesses impacted by COVID-19. The PPP is designed to provide a direct incentive for small businesses to keep their workers on the payroll. Contact your community banking institution for assistance. More information is available here: https://www.sba.gov/funding-programs/loans/coronavirus-relief-options/paycheck-protection-program

**Telehealth Funding**

The FCC has released funding specifically for Telehealth Programs. This funding is part of the CARES Act and provides $200 million to help health care providers deliver connected care services to patients in their homes or mobile locations in response to the COVID-19 pandemic. The COVID-19 Telehealth Program provides support to fund telecommunications and information services & devices needed to provide critical connected care services.

For more Information on applying for funding, visit: https://docs.fcc.gov/public/attachments/DA-20-394A1.pdf

**Governor’s Office of Economic Development Funding**

The Governor’s Office of Economic Development (GOED) has put together a small business bridge loan. The program will give loans of $5,000-$20,000 at 0% interest for up to 5 years with no payments for 1 year. For details, go to: http://business.utah.gov/utah-leads-together-small-business-bridge-loan-program/
Gender Pay Disparities in Medicine

Compiled by UMA Staff

Equal pay for equal work. It is a simple maxim that seems to have garnered acceptance on a philosophical level, and yet, achieving parity in compensation by gender has been elusive in medicine. Although there are now as many women as men in medical school, and increasing representation in every specialty, studies continue to report that women are paid less than men regardless of location, specialty and stage of career for similar work. The differences persist even when controlling for factors that would seem to explain the gender pay gaps: experience, hours worked, academic rank, productivity, time spent on research, publications, administrative activity, etc.

To address this issue, the 2019 UMA House of Delegates adopted the following Resolutions:

RESOLVED, that UMA advocate for institutional and organizational policies that promote transparency for initial and subsequent physician compensation; and be it further
RESOLVED, that UMA advocate for equal base pay for female and male physicians based on objective criteria; and be it further
RESOLVED, that UMA provide education to members and leadership on gender pay disparities.

With the understanding that changes to longstanding cultural phenomena will likely defy easy solutions, UMA looks forward to facilitating further discussion, education and steps to rectify inequities to ensure that the best and brightest of both genders continue to see medicine as the greatest profession.

The following is a presentation of additional information from several sources that may help inform the discussions to come.

Continued on page 24.

**FACTORS INFLUENCING LOWER COMPENSATION AMONG WOMEN PHYSICIANS**

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<td>Lack of periodical compensation audit</td>
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<td>Greater work interruptions and part-time work among women</td>
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<td>Greater burden of family and household responsibilities</td>
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<td>Interactions with spouse/partner employment</td>
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Some possible interventions for addressing gender wage disparities in medicine:

- Training in gender bias recognition
- Compensation auditing
- Salary transparency
- Structured compensation plans
- Family leave policies
- On-site childcare programs
- Contract negotiation training

A few statistics from a recent review of physician compensation:
Passed:
Emergency Health Care Access & Immunity Amendments
By UMA CEO Michelle S. McOmber, MBA CAE

The Utah Medical Association has been pushing both the Governor and the Legislature to provide special immunity provisions to providers, and of course, specifically to physicians during the COVID-19 pandemic. On Friday, April 17, 2020, the legislature in special session passed S.B. 3002 - Emergency Health Care Access and Immunity Amendments. Thank you to all who contacted your legislators at our request about this bill.

The bill does four things:

1. It makes a physician (and the other providers) immune for civil liability for any harm resulting from: a) an act or omission in the course of providing health care, in Utah, during a declared major public health emergency if the care is provided in good faith to treat the patient for the condition or illness that resulted in the emergency (in this case COVID-19); or, b) the act or omission was the direct result of providing health care to a patient for the declared public health emergency. In both cases, the acts or omissions cannot be grossly negligent or intentional or malicious misconduct.

2. A physician is also protected during this public health emergency if the care provided by that physician is outside of applicable standard of care for that physician as long as that care is within a physician's scope of practice. In the state of Utah, all medical care activities are covered under an MD or DO license but standard of care has been limited to what is allowed by hospital or insurance credentialing, or by DOPL based on training (specialty) and typical standard of care—such as not allowing a family practitioner to do heart surgery. Under this new law, during the public health emergency, activities by a physician in any care setting and in any area as required to treat COVID patients are included if the care is provided in good faith to treat the patient for COVID or there is an urgent shortage of health care providers because of the declared public health emergency (which for this declared emergency is COVID care).

3. A physician is not subject to civil or criminal liability or sanctions against a license if the care is not gross negligence or intentional or malicious misconduct and the physician is providing a "qualified treatment" (an FDA-approved drug or device that is off-label for the illness or condition—in this case COVID-19), if the qualified treatment is within the physician's scope of practice under their license and if the treatment has a written recommendation by a federal government agency regarding the use of the qualified treatment for the illness or condition (again, in this case COVID-19). Other requirements for this section include that the qualified treatment must follow the most current written recommendation by the Federal government, that the physician describes the possible positive and negative outcomes the patient may experience and then documents in the medical record the information provided to the patient or the patient's representative and they consented to the treatment.

4. For an investigational drug or device (such as hydroxychloroquine, choloquine, remdesivir or other for COVID), a patient may obtain an investigational drug through an agreement with the investigational drug's manufacturer and the qualified patient's physician provides for the transfer of the investigational drug from the manufacturer to the physician and the physician administers the investigational drug to the qualified patient. The agreement must include an informed consent document, that based on the physician's knowledge of the investigational drug, that describes: a) possible positive and negative outcomes if treated with the drug; b) states that insurer is not required to cover the cost of providing the investigational drug; c) states that an insurer may deny coverage for the qualified patient; and, d) states that the patient may be liable for all expenses caused by the physician treating the patient with the investigational drug unless the agreement provides otherwise. The physician must also notify the patient's insurer of a) the investigational drug the physician treated the patient with; b) the date this was done; and c) that the drug was used under an agreement described above. The bill also states that it is not a breach of the applicable standard of care to treat a qualified patient under this section. It does not create a private right of action by a patient for a physician to reuse to treat with an investigational drug.

These immunity provisions apply even if a physician has expectation of payment for services. Unfortunately, what did not get into the bill was immunity for omission of care, elective procedures and surgeries. As a physician you must make a decision on what care a patient must receive, based on your medical judgement. Remember to also document very carefully in your patient's medical records, the reason for care or omission of care.
Telemedicine: Are You Ready for Prime Time?

By Ellen Terry, TMA
First published, Texas Medical Association, 2020. Reprinted with permission

Like a stage actor who comes across awkward on a television or movie screen, you might find it challenging to connect with your patients during video telehealth visits.

When using telemedicine, the physician is stepping into the patient’s environment. This can change the dynamics of the patient-physician relationship.

Here are two key tactics to make for five-star video visit:

1. Maintain eye contact with your patient by looking into your computer’s camera as much as possible, not at the patient’s image on your screen. Certainly part of diagnosing a patient is listening to the description of symptoms and looking at the patient for physical clues. But remember that when you are looking at the patient’s image, it might appear as though you are looking away. Ideally you’ve arranged your setup so you can see the patient while you’re facing the camera and easily glance from one to the other as needed. If you need to look away, to take notes for example, tell the patient what you are doing.

2. Make a point to be animated. Studies of telemedicine in psychiatry suggest increasing your “energy levels and expressiveness slightly” to counteract the sense of remoteness, Telemedicine Magazine says. Smile more, nod to show you are listening, and show enthusiasm when you speak. Make sure the lighting around you illuminates your face so your smile shows. Avoid backlighting, which darkens your face on screen and obscures facial expressions.

In addition, don’t do all the talking; give patients a chance to ask questions.

One study found that during in-person visits, physicians interrupt patients on average after just 11 seconds. From the patient’s perspective, such interruptions can seem especially off-putting when coming from a face on a screen.

Physicians “need to recognize that telemedicine is a two-way street, not a forum for the provider to talk while the patient passively listens,” Telemedicine Magazine says.

On the other hand, before ending the session, be sure to clearly explain next steps for follow-up, treatment, or prescriptions, as you cannot rely on handouts, nor can the patient ask a staff member for clarification after leaving the “exam room.”

If you have a patient portal, mention to the patient that follow-up information will be accessible there.
Cartoonist Soon to be Doctor

Ed Note: University of Utah 4th Year Medical Student Christian Schmutz has a side gig: drawing cartoons. Some of his work has appeared on the Doximity website and he has begun submitting cartoons for the Utah Physician. Watch for more of his work in future editions.
Well-written employment contracts are essential to a good, long-term working relationship. They can help the parties avoid many problems during the employment relationship and resolve ones that do arise.

It is important to plan and anticipate, as much as possible, key questions that may come up, and decide ahead of time how to answer them. On the other hand, excessive detail could make the contract feel too restrictive and hinder the ability to adjust to future changes, although it should be possible to modify the contract in writing signed by both parties. The key is to achieve a balance that covers the issues that matter to both parties and consider the basis for future discussions and planning. Understandings that are not included in the contract, or worse, contradict what the contract says are a recipe for headaches and disaster. Do not depend on anything spoken that is not also clearly stated in the contract.

The language should be clear and unambiguous. Legal terms can be obscure and difficult to understand at times; they may require some study, discussion, or explanation. Feel free to ask questions. Points of discussion and agreement should not contradict a plain reading of the document. You should be able to read, recognize, and understand what you and they are agreeing to.

Compensation and benefits of course are some of those key issues that must be covered detail. A set salary may not take a lot of explanation, but there are always details, terms, and future adjustments that need to be spelled out. While new physicians more commonly get fixed compensation, more experienced doctors often have variable compensation arrangements. Compensation formulas can be quite complex and should be reviewed not only by an attorney but also an accountant who can analyze the contract from different angles. It can help you understand how it works if you look at the “buckets” of revenue, expenses, and profit for the organization. A pro forma—an attachment that gives an example of how the formula would work under certain circumstances—is helpful to attach to a contract.

Details of the working relationship and responsibilities need to be spelled out. These include call coverage arrangements, support staff arrangements, billing expectations and decisions, and a process for dispute resolution.

If part of the arrangement is that you will join the organization (partnership, PLLC, etc.), you need to understand how it is structured, who owns it, who is in charge, and how decisions are made. The partnership agreement should contain buy-in, buy-out, and liquidation provisions, partners’ liability for lawsuits against the practice, ownership and valuation of assets, including accounts receivable.

One of the most important benefits to cover in the contract is professional liability insurance. Malpractice insurance is typically included. The coverage needs to be adequate; how will that be determined? And what happens when the employment relationship ends? Who pays for tail coverage can and should be spelled out at the beginning of the relationship.

Health insurance as well as vacation, holidays, and sick leave (sometimes combined as personal time off or PTO) are usually discussed in the contract. Other benefits to consider in the contract are CME allowance, licensure fees, student loan repayment, laptops, cell phones, marketing expenses, dues, and subscriptions.

Although it may be uncomfortable to bring up before you have even started, the contract must state what happens as and after your work relationship is terminated by you or your employer. Employers often want to include covenants not to compete. If they are a part of your contract, you need to think through what it will mean for you when, not if, the relationship ends. Although employment relationships can last for many years, most physicians beginning work now will probably work more than one place during their career. Other aspects of the termination process should also be considered.
What will happen with the patients you have been seeing and their medical records? Frustrated physicians changing employment have often contacted UMA when they have found that their soon-to-be-former employer is retaining the physician’s patients and their records. Discuss now and include in the contract what will happen when you leave. That discussion should include what information will be in the patient notifications that will need to be sent when you leave, such as whether it will include your new location and contact information and who will send those out.

Even if you feel comfortable reading, reviewing, and negotiating your contract, you should still enlist the services of an attorney and an accountant to advise you and look out for your best interests. Your employer cannot and will not play that role for you and money you spend on expert advice is well worth it.

Author Note: We are happy to provide legal information as a service to Utah Medical Association members. This article is not legal advice, and I cannot act as your lawyer. For legal advice or representation, you will need to hire a lawyer; we can provide referrals.

FROM THE PHYSICIAN’S LEGAL GUIDE

CME Spotlight

Title: Controlled Substances: Education for the Prescriber
When: On-demand Webinar
Where: Online at cme.utahmed.org
Provider: UMA Foundation
CME: 3.5 AMA PRA Category 1 Credits™

This education is specifically designed to comply with the Utah State Law, Utah Code Section 58—37-6.5, which requires health care providers licensed to prescribe controlled substances to complete DOPL-approved continuing education on Schedule II and III controlled substances that are applicable to opioid narcotics, hypnotic depressants, or psychostimulants.

Following this activity, learners should be able to:

• Know existing laws and rules pertaining to prescribing controlled substances;
• Provide patients the care they need to restore and maintain their health;
• Mitigate the burdens of illness, injury and aging, including appropriate prescriptions for controlled substances when indicated;
• Minimize adverse effects of controlled substance use and reduce risks to the public health.

The following websites offer online continuing medical education:

cme.utahmed.org  |  cmelist.com  |  reachmd.com/programs
psnet.ahrq.gov/cme  |  ama-assn.org/education-center  |  cms.gov/Outreach-and-Education/Learn/
thedoctormsatchannel.com/cme  |  baylorcme.org  |  Earn-Credit/Earn-credit-page.html
freecme.com  |  medscape.org  |  primarycarenetwork.org
pri-med.com/pmo/OnlineCME.aspx  |  vhl.com  |  emedevents.com
medicine.utah.edu/cme  |  nejm.org/continuing-medical-education

ama-assn.org  |  eMedEvents.com

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

ama-assn.org  |  eMedEvents.com
THE CCPA AND STATE PRIVACY LAWS GOING FORWARD

You have probably heard about the California Consumer Privacy Act (CCPA) by now. The CCPA is California’s new privacy law and, as its name suggests, the CCPA prescribes broad data privacy protections for California residents. While the CCPA has received the lion’s share of national attention, other states have quietly started to introduce their own privacy legislation requiring enhanced protections for consumer data.

Still, you may be thinking how important are data practices and the evolving privacy law really? The answer is, in a word, VERY. To understand why, we need to briefly delve into the role that our information now plays in commerce.

Information has been commoditized and is now an asset that consumers, whether wittingly or unwittingly, trade with companies in exchange for services. As the information economy continues to grow, how companies hold, protect, and process consumer information will remain under public scrutiny. Information, its exchange between interested parties, and its protection by third parties mining its value, already touches on all aspects of commerce. This is why regardless of whether you are practicing medicine as a licensed physician, starting a new business venture, or are simply consuming services from a business, data privacy law affects you.

In order to get an idea of what consumers and businesses can expect from comprehensive state privacy laws going forward, it is helpful to first discuss some of the major provisions introduced by the CCPA. Specifically, it is important to understand how the CCPA defines personal information and what new privacy rights the CCPA grants to consumers.

**CCPA’s Definition of Personal Information**

Prior to the CCPA and the recent wave of privacy legislation, the primary law relating to personal data in many states was, and still is, the respective state’s data breach notification law. These laws generally define “personal information” in relation to the negligence or bad act of a third party with respect to the information. The CCPA, by contrast, defines personal information with the understanding that consumer information has become an essential component of the ecommerce marketplace. As such, the CCPA broadly defines personal information to include any information that “identifies, relates to, describes, is reasonably capable of being associated with, or could reasonably be linked, directly or indirectly, with a particular consumer or household.” Cal. Civ. Code § 1798.140(o)(1). The CCPA’s definition is comprehensive and includes any information “regarding a consumer’s interaction with an internet website, application, or advertisement.” Cal. Civ. Code § 1798.140(o)(1)(F).

**Consumer Rights Granted By CCPA**

As summarized by the California Attorney General’s Fact Sheet, the CCPA grants to consumers the following rights:

1. **The Right to Know.** The CCPA grants to consumers the right to know what personal information (including categories and specific pieces of personal information) is collected, used, shared or sold.

2. **The Right to Delete.** Subject to certain exceptions, the CCPA grants consumers the right to delete personal information held by businesses or a business’ service provider.

3. **The Right to Opt-Out.** The CCPA grants consumers the right, at any time, to opt-out of the sale of the consumer’s information by a business. Moreover, for children under the age of 16, businesses must receive opt-in consent prior to selling any information of the child. For children under 13, businesses must receive parental consent prior to selling the child’s information.

4. **The Right to Non-Discrimination.** The CCPA prohibits businesses from discriminating against a consumer due to the consumer exercising any right granted under the CCPA. Specifically, the CCPA disallows businesses from taking any of the following actions with respect to a consumer who has exercised her or his privacy rights:
   
   (a) Denying the consumer goods or services;
   
   (b) Charging the consumer different prices, rates, or discounts for goods or services, or otherwise imposing penalties; or
   
   (c) Providing the consumer with a different level or quality of goods or services.

**Implications of the CCPA**

The takeaways from the CCPA’s broad definition of personal information and the privacy rights that it grants consumers are two-fold. First, consumer “personal information” is not just information that we typically consider sensitive or valuable (i.e., social security numbers, financial information, etc.). Instead, the CCPA redefines personal information to include any information that can be linked to an individual consumer or a consumer’s household. Effectively, the result is that any consumer information collected, processed, or sold by a company can bring that company under the purview of the CCPA.

Second, the CCPA’s grant of privacy rights may indicate a new paradigm, one in which the discrepancy in bargaining power between companies and consumers is reduced. The implication here is simple—businesses will have to tailor their data practices (and potentially certain service delivery models) to account for consumers exercising their newly granted privacy rights.

Currently, there are active bills introducing comprehensive privacy legislation in multiple states, and, in many of these states, the proposed privacy laws broadly redefine personal information and/or grant privacy rights to consumers. Eventually, most, if not all, states will adopt comprehensive privacy legislation (unless, of course, a federal privacy law that preempts state law is enacted). Therefore, although the CCPA’s sweeping provisions are limited to California for now, eventually many, if not most, U.S. consumers and businesses will be subject to some form of the protections and obligations introduced by the CCPA. So, whether you are a consumer or a business, the CCPA (or some version of the CCPA) will likely soon apply to you, if it doesn’t already.

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