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

6 2021 Legislative Session Report
By Mark Brinton, JD – UMA General Counsel and Director of Government Affairs and
Michelle S. McOmber, MBA, CAE – UMA CEO

18 Physician Assistant Bills - in a Nutshell
By UMA CEO Michelle S. McOmber, MBA CAE

20 When it Comes to Investing, is Bigger, Better?
By Ryan Bladen, CFP® Vice President, UMAFS

24 Healthcare Provider Wellness in the Time of COVID and Beyond
By Lawrence M. Lewis, MD, Christopher R. Carpenter, MD,
Randall Jotte, MD & Evan Schwarz, MD

Departments

4 President’s Message
By Sharon RM Richens, MD

28 CME Calendar
Thank you for all you’ve done to support the house of medicine and one another throughout this tough legislative session. We owe a great debt of gratitude to Michelle McOmber and our staff, who have represented us well. Medicine is under attack from many angles, including scope of practice battles, malpractice, regulatory burdens and reimbursement. Your participation in the lobbying and legislative process helps keep medicine healthy and vibrant in Utah. Please keep in touch with your elected leaders at both the state and federal level, as healthcare and our communities continue to evolve. If you are interested in a greater level of participation, the legislative committee and leadership positions are wonderful opportunities. Your individual communications with your own local elected officials and committee leaders helps us collectively too. For federal issues, remember that your elected officials have local offices easily accessible to you, their staffers in those offices are knowledgeable in many of the healthcare issues, and they are usually willing to meet with you in their office. You need not travel to Washington D.C. to “make a difference” and it really does make a difference when you show up. This grass roots lobbying will become increasingly important as the new Biden administration seeks to mold health care policy throughout 2021. (It’s true, the work is never done... and the world is run by those who show up.)

Please keep up with your membership. Encourage your friends and colleagues to do the same. We have a considerable flux in membership and rely upon membership and resultant dues to maintain a presence in government, and to provide services to members. The UMA has a valuable gestalt that can’t be matched by subspecialty associations, and yet interfaces with all of our subspecialty associations. It makes financial sense to invest in UMA and AMA, in addition to your subspecialty societies. Your dues are an investment in your reputation as a physician, your revenue stream, and representation in legislative and budgetary matters. We need you, and you need UMA.

The COVID-19 pandemic has shown improvement in case numbers and outcomes, and we are grateful for your support of the community and patients. UMA is concerned to see that these positive trends continue. As the mask mandate ends (on April 10) courtesy of our conservative state legislature, we are also concerned with vaccine hesitancy. Governor Cox has done a terrific job in supporting the effort to vaccinate the state. Please pitch in by encouraging patients to be vaccinated and offering to answer any questions if they haven’t had a chance to get their vaccination(s) yet. In our office, we have a patient handout with the phone numbers and websites for local appointments with both the hospital and health department, as well as eligibility criteria, which is now all Utahns over 16 years of age.

There is a silver lining in a pandemic year. Patients are reading more about health care and asking very good questions. Your patience with patients, and your encouragement of their curiosity with referral to reputable sources of evidence-based medicine, are wonderful ways to practice medicine and improve public health. Physicians and nurses have regained a bit of their patina with the realization that we go where needed, when needed, regardless of risk. Regardless of your specialty or practice...
setting, please teach by example, and encourage the autodidacts among our patients. When they look unsure, tell them what you would do if they were family, and what you yourself are doing.

Besides your patients, please look to, and open up to, your family and friends. The last member of our family will be vaccinated Thursday, but he will have to drive from his Provo college campus to St. George to make that happen. Healthy college students are finally eligible to be vaccinated (hooray! and thank you Gov. Cox!) This will make it safer for them to visit with grandparents and get back to graduation parties and weddings.

Again, thank you, each and every one of you, for reaching out to UMA, to your elected officials, and to the press with editorials, throughout the legislative process, and through the winter COVID-19 surge and current groundswell toward vaccination and herd immunity. We’re in the 9th inning—may we finish safe and strong(er).

Sharon R.M. Richens, MD
UMA President

Our healthcare professionals can help you navigate the increasingly competitive healthcare market with solutions such as payor & value-based contracting, quality & value-based care strategies, practice analytics, revenue cycle enhancement, partnerships/mergers, outsourced business services, tax reduction strategies and more. Get real insight from a firm that cares as much as you do.
The past legislative year—and the 2021 legislative session in particular—was significantly shaped by the Covid-19 pandemic, which in turn, was the focus of much of the past legislative year. Six special sessions were held in the legislative cycle. And an extensive series of legislative interim meetings convened over the prior nine months, with most legislators and essentially all witnesses, lobbyists, and members of the public participating via electronic meeting connections. UMA CEO Michelle McOmber, MBA, CAE, and UMA VP of Communications Mark Fotheringham already reported on the myriad issues the UMA worked on before and in preparation for the session in prior issues of the Utah Physician.

In the end, the Legislature passed 503 bills, fewer than prior recent sessions, but it included many bills just as significant to medicine and public health as previous years, if not more so.

The 2021 legislature welcomed five new senators and 15 new representatives elected last November or appointed since the election. UMA physicians and 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. Michael Kennedy, MD, JD, (family practice, Alpine/Lindon) rejoined the legislature as a senator after having served as a representative 2013-2018 (appointed to take Dan Hemmert’s seat after Gov. Cox selected Dan to lead the Governor’s Office of Economic Development). Rosemary Lesser, MD (retired Ob-Gyn, Ogden) was appointed to replace Rep. LaWanna Shurtliff who passed away unexpectedly in December.

A couple of new physician spouses were elected to the legislature: Rep. Gay Lynn Bennion is married to James Bennion, MD (occupational medicine, SLC VAMC) and Rep. Doug Owens is married to Cynthia Owens, MD (peds, SLC). Physician spouses continuing in service are Sen. Keith Grover (Provo) and Rep. Jennifer Dailey-Provost (Salt Lake City). Many other legislators are family members and other friends of medicine.

Aside from COVID and lobbying differently this session, the session was slightly unusual in the number of bills UMA fought against and called on you to oppose. UMA issued Calls to Action to enlist your help with these very difficult and very hard-fought bills. Legislators receive thousands of emails from many constituencies asking them to vote for or against certain bills. Many of these emails are on issues of importance to physicians and patients but are from the other side of the issue. This is especially true when mid-level or unlicensed providers want to expand their scope of practice. The Utah Legislature is very much for de-regulation and “competency,” although that is not defined, so this includes wanting to do away with licensing or expanding what everyone can do regardless of training and education. Your UMA legislative team strives to inform and influence the legislators, but your voice to your legislators (identify yourself as a constituent and include your home address) is often critical to balance the input they receive on these issues.

Legislative actions often come up with very little notice. A vote may be scheduled for the next day, so physicians need 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 own representative or senator. You as a constituent can be very powerful in your influence.

Your message can be even more powerful if you get to know your legislators and support them in their elections. You can develop a good relationship by serving as county or state party delegates. It’s important 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 greatly appreciate those physicians who take the time to respond and contact their legislators.

We sincerely thank all of you who do run for office, contribute money to UMPAC, and participate in the political process. The political process takes money and contributing to UMPAC helps us help those candidates who are friendly to the House of Medicine.
The bills that were particularly important to physicians and patients are discussed below.

**MIDLEVEL PRACTITIONER SCOPE OF PRACTICE BILLS**

**SB 27 Physician Assistant Act Amendments (Sen. Curtis Bramble and Rep. James Dunnigan); and**


UMA has worked cooperatively with the physician assistant leaders since their license category was created by UMA over 50 years ago. In fact, the physician assistant program in Utah is the oldest continuously accredited program in the western U.S. The Physician Assistant Practice Act has been amended and updated in five of the past seven years by the physician assistants working with UMA. This year the physician assistants decided to bring forward two bills, SB 27, and SB 28, that were initially drafted with little regard for the input of UMA and would have radically changed the nature of their practice and have not been adopted by any other state. UMA fought against the original drafts of the bills and managed to stop them until the PASA agreed to negotiate. UMA negotiated with the physician assistants and the bill sponsor very long and very hard to bring these bills to a place that could be acceptable to the physicians of the state and provide appropriate, safe care for the patients of Utah. Please see the separate article in this issue of the Utah Physician (page 18) for the essential highlights of the bills. **PASSED**


Despite (or because of?) our negotiations with the nurse practitioners the year before last, they ran this bill to remove the practice restrictions they had agreed to earlier. They pointed to the states surrounding Utah and most of the states in the West, which allow “full practice” where Utah only allowed “reduced practice,” according to their national organization. Their bill as introduced, however, would have gone far beyond the practice parameters of some “full practice” states, such as Colorado and Nebraska. After extensive negotiations with the nurse practitioners and changes made to the bill, UMA agreed to drop its opposition to the revised bill. The statute before passage of this bill required an NP to have a consultation and referral plan with an experienced NP or a physician for one year if they went into solo practice right out of school or if they owned and operated a pain clinic. The final bill that passed this year removes the restriction on pain clinics and requires, before they can prescribe Schedule II controlled substances, that nurse practitioners who are in their first year of practice will have to 1) receive board certification from a nationally recognized organization, 2) complete at least 30 hours of instruction in advanced pharmacology, 3) demonstrate at least seven hours of continuing education on prescribing opioids, and 4) participate in and document a prescribing mentorship with a physician or experienced nurse practitioner for 1000 hours of clinical experience. **PASSED**

**COVID-19 BILLS**


Although the Department of Health’s public health emergency may remain in effect to receive federal money and distribute vaccines, with a few exceptions this bill terminates the COVID-19 emergency powers and any COVID-19 public health order under the public health emergencies declared by the Department of Health and local health departments once 1) the state’s COVID case rate is under 191 per 100,000 people; 2) the statewide 7-day average COVID-19 ICU utilization is under 15%; and 3) at least 1,633,000 prime doses of a COVID-19 vaccine have been allocated to the state. One exception allows public health safety measures in K-12 schools to continue until July 1, 2021. Also, the statewide mask mandate is terminated April 10, 2021, though local health departments (with approval of the county commissions) may continue local mask mandates and a state mask mandate for gatherings of over 50 people (where 6-foot distancing is not possible) may continue until the public health orders are terminated. With a special effective date, the bill went into effect on March 26. UMA opposed the bill, but the Department of Health and counties worked with the sponsor to put in precautions they wanted so while UMA remained concerned about significant public health decisions being based on policy rather than science or medical considerations, the whole legislature approved of the process. **PASSED**


This bill limits the powers of the Department of Health and local health departments to issue public health emergency declarations and orders in several ways and restricts the governor and others in their ability to impose public health restrictions for an extended period. The length of time that an order can remain in place is restricted, orders cannot be extended by being reissued, and the legislature or a county governing body can terminate public health orders under a declared public health emergency. The bill also provides a process for the Legislature to limit executive emergency powers during a long-term state emergency. It prohibits a government restriction on the practice of religion unless the burden is the least restrictive means available to accomplish a compelling government interest, among many other provisions. UMA opposed the original
bill. Many changes were made to the bill because of the individual and public health implications of such a law. The bill was never referred to a committee; though it was considered for inclusion in other pandemic related bills, parts of it in concept were added to SB195. It was never moved forward. FAILED

HB 233 Education Immunization Modifications (Rep. Mark Strong and Sen. Michael Kennedy, MD)
As introduced, this bill prohibited state colleges and universities from requiring a vaccination as a condition of enrollment or attendance unless the institution also allows medical and personal exemptions. This is what is already required in K-12 educational institutions. The bill also prohibited public and charter schools offering remote and in-person learning from not allowing a student to attend in person based on vaccine status. After the bill was held in committee because of strong concerns voiced by UMA and others, the sponsor amended the bill to allow state and local health departments to override the bill’s prohibitions to contain the spread of an infectious disease and to exempt institutions of higher education from these restrictions for students “studying in a medical setting.” The sponsor reported the Utah System of Higher Education supported his bill after the changes. UMA continued to be concerned about politics trumping health and science. PASSED

HB 184 Protection of Personal and Religious Liberty (Rep. Cory Maloy and Sen. Michael Kennedy, MD)
This bill would have prohibited a health care facility, even during a public health emergency, from preventing a patient from receiving a visit from at least one family member (even extended family) or clergy member at a time and would have prohibited any government entity from taking an action that has the effect of not allowing a religious organization to hold a service in a church. UMA was opposed to the bill because of the individual and public health implications of such a law. The bill was never referred to a committee; though it was considered for inclusion in other pandemic related bills, parts of it in concept were added to SB195. It was never moved forward. FAILED

SB 107 In-person Instruction Prioritization (Sen. Todd Weiler and Rep. Paul Ray)
This controversial bill finally passed after a joint second conference committee report of the House and Senate recommended the 7th Substitute with an amendment. The bill requires public and charter schools, beginning March 22, 2021, to offer in-person instruction and, if 2% (schools over 1500 students) or 30 students (schools under 1500) test positive for COVID-19, to initiate a test to stay program with supplies and resources from the Department of Health. The test to stay program is to identify cases of COVID-19 and allow students that test negative to continue in-person. In-person instruction can be suspended only if the governor, the president of the Senate, the speaker of the House of Representatives, and the state superintendent of public instruction jointly agree with the school that the risks of in-person instruction temporarily outweigh its value. Schools cannot test a student without the consent of the parent. Beginning with the fall 2021 semester, the bill also requires the state’s colleges and universities to offer at least 75% of the number of in-person courses that they offered in 2019-2020 unless enrollment in a school has gone down. UMA strongly supports scientifically based public health decisions and opposes decisions based on political considerations, so it opposed the bill but because of the compromises between the schools and the legislature the bill PASSED.

This bill prohibits a governmental entity from requiring that an individual receive a vaccine for COVID-19 as a condition of employment or participation in an activity of a governmental entity, including outside or extracurricular activities or attendance at events the entity sponsors. The bill does not allow the governor to waive this prohibition through the Emergency Management Act. The bill will be repealed July 2024 because the sponsor believes that the COVID vaccines will have standard FDA authorization by then, rather than the emergency use authorization they have now. UMA explained its strong concerns to the bill sponsor, who subsequently added these exceptions to the vaccine requirement ban: the vaccine may be required for helping with the COVID-19 vaccine or for an employee acting in a public health or medical setting and who is required to receive vaccinations to perform their job. UMA testified against and remained opposed to the bill. PASSED

UMA SUPPORTED BILLS

In UMA’s continuing effort to prevent the passage of bad balance billing legislation, a bill was passed last year (supported by UMA) requiring providers to report certain elements of their balance billing to the Utah Insurance Department. Congress’s enactment on balance billing at the end of last year changed the rules and made it not meaningful or necessary to collect the information. So, UMA worked with the sponsor to pass this bill to repeal the reporting requirement. PASSED

This bill requires jails to provide inmates with the option of continuing these medically prescribed methods of contraception: an oral contraceptive, an injectable contraceptive, or an intrauterine device (if the other methods cause the inmate adverse effects). The cost is paid by the Department of Health. UMA supported this bill to provide access to important medications and devices to individuals. Unfortunately, to get the bill through the legislature, the sponsor had to agree to make it a one-year program. UMA supports extension of the program on an on-going basis. PASSED

As introduced, this bill would have required vaccine providers to register with the Utah Statewide Immunization Information System (USIIS) and report the vaccines they administer. It would also have allowed schools to provide immunization records to USIIS. Despite the public and individual health benefits of this bill, there was so much opposition to mandating records of immunizations that a whole series of changes were made to water down the bill and it still was voted down in the Senate committee hearing. FAILED

SB 41 Mental Health Access Amendments (Sen. Todd Weiler and Rep. Steve Eliason)
In addition to the provisions of SB 41 that require health plans to provide coverage parity for mental health services provided by telehealth, this bill requires health plans to reimburse these telehealth services at a commercially reasonable rate that is negotiated. Supported by UMA, this bill started off providing payment parity for these services, but this was adamantly opposed by the health insurers. So, UMA worked to have the reimbursement rates be commercially reasonable and negotiated. The bill also prohibits DOPL from denying a healthcare provider’s license application or renewal solely for participating in mental health or substance abuse treatment. The bill requires payment of certain mental health and substance use treatment if the plan provides behavioral health services. And finally, the bill changes the assumptions in the legislative budget process to increase beginning point for funding for Medicaid mental health services on an on-going basis. PASSED

SB 134 Tobacco Regulation Amendments (Sen. Curtis Bramble and Rep. Francis Gibson)
This bill would have made several changes to the regulation of the sale of e-cigarette products. The Department of Health (DOH) proposed a rule in January to prohibit the sale of manufacturer sealed e-cigarettes and liquids with over 36 mg/mL of nicotine after January 1, 2022. UMA helped push for these rules to limit the nicotine these products. Because of that rule, tobacco/e-cigarette manufacturers pushed for a bill to allow 75mg/mL of nicotine in manufacturer sealed e-cigarettes. The sponsor of this bill did include increasing fines for violation and raising the tax on e-cigarettes, but it was not enough. UMA opposed the bill and was negotiating with the bill sponsor to lower the nicotine limit allowed in his bill. The DOH agreed to change the rule proposal to 59 mg/mL to stop the bill. Because of that agreement, the sponsor of the bill stopped the bill and it died on the Board. UMA has been working with many others for years to restrict the sale of e-cigarettes and liquid with high-nicotine content because it is powerfully addictive. In a Notice of Change in Proposed Rule published March 15, DOH proposed to allow a nicotine concentration up to 59 mg/mL. UMA has sent comments against the new proposed rule and will testify against it. For reference, the European Union only allows 20 mg/mL of nicotine in their e-cigarette products. FAILED

SB 192 Medical Cannabis Act Amendments (Sen. Evan Vickers and Rep. Francis Gibson)
Among many other changes this bill makes in the state’s medical cannabis law, mainly for the convenience of the processing and for the Department of Agriculture, the bill does several things of interest to physicians. It requires the electronic verification system, which is the state’s system for tracking medical cannabis recommendations and dispensing, to communicate medical cannabis dispensing information to the controlled substance database. This way, any prescriber treating a patient and checking the CSD will be aware of all controlled substances the patient may be taking, including medical cannabis. Revocation of a medical cannabis card will also show up in the CSD. The bill allows a qualified medical provider to advertise that they are a QMP. The bill also clarifies the information that a QMP must provide if they intend that the pharmacy determine directions of use and dosing guidelines to a patient instead of doing it themselves. UMA participated in drafting the language of this bill and pushed for the information from the
medical cannabis electronic system to be included in the CSD. UMA supported the bill. **PASSED**


Current law requires a physician to take 4 hours of training to become a qualified medical provider (QMP) to be able to recommend medical cannabis to a patient. Among many other changes this bill makes to the state’s medical cannabis program, it allows physicians who have not taken the qualified medical provider training to recommend medical cannabis to a few of their patients. They may recommend to no more than 15 of their patients at any time. If they exceed 15 patients at a time, they must become a qualified medical provider. These providers are called “limited medical providers.” The bill also requires QMPs to report to Department of Health the fees they charge a patient for a medical cannabis recommendation. It requires the 3.5 hours of continuing education on controlled substances that is required of all controlled substance prescribers to include some training regarding medical cannabis. UMA negotiated extensively with the sponsor and other stakeholders regarding the provisions of this bill to keep the program focused on responsible, true medical care for patients, and ultimately was supportive of the bill as whole. **PASSED**

**HB 231 Fetus Transport Restrictions (Rep. Cheryl Acton)**

As introduced, this bill would have made it a crime to transport or arrange for transport outside the state miscarried or aborted fetal remains for any purpose other than burial. UMA strongly opposed this proposal and contacted the sponsor to explain the important medical purposes for which fetal remains may need to be sent to another state, such as, for medical testing, analysis, evaluation, or research, and that current health systems, labs, and insurance companies frequently work across state lines for these purposes. The sponsor began to respond to our concerns, and we tried to work out a solution for both the sponsor’s concerns and UMA concerns, but ultimately the sponsor decided not to push the bill forward during this session because of UMA concerns. **FAILED**

**HB 15 Controlled Substance Amendments (Rep. Ray Ward, MD and Sen. Michael Kennedy, MD)**

This bill makes two changes to controlled substance prescribing. First, it eliminates the surgery exception to the 7-day limit on prescriptions for Schedule II and Schedule III opiates issued for acute conditions. Prescribers have been allowed to issue prescriptions for up to 30 days for surgery if the patient needed it. In making this change, the sponsor pointed out that second and subsequent 7-day prescriptions can be issued if the initial 7-day supply was not enough. Also, the 7-day limit continues to apply only to acute conditions and not to complex or chronic conditions documented in the medical record.

The second change made by this bill applies to a “high risk prescription” which is defined a prescription for an opiate or benzodiazepine that is written for longer than 30 days. The bill requires a prescriber who issues a high-risk prescription first to check the controlled substance database to see if the patient has any currently active high-risk prescriptions from other prescribers. If the patient already has a high-risk prescription in the database, the prescriber must contact all other prescribers who have issued the patient current high-risk prescriptions and then document in the medical record that contact and the reason “the patient needs multiple high-risk prescriptions from different practitioners.” The contacting and documenting must be done in a timely manner but may be after issuing the prescription. As originally proposed, the bill would have made violation of its rules unprofessional conduct. UMA was successful in having that part removed. **PASSED**


This bill is the successor to a bill last year that UMA opposed for going too far and imposing an unreasonable burden on physicians; the bill did not move forward last year. The version this year applies to any individually licensed health care provider or any facility licensed to provide health care. It is narrower than the bill proposed last year and more realistic. This year it includes the language of knowingly and intentionally. It prohibits a health care provider from knowingly or intentionally representing to someone who has health insurance that the provider is contracted with the person’s insurer if the provider is not. A violation of this law can be enforced by the Division of Consumer Protection in court. There would be an investigation to protect from a patient-said, provider-said type of incident. The burden of proof would require more than supposed conversation. UMA did not take a position on the bill this year. **PASSED**

Continued on page 12...
Why Do Physicians Who Choose MICA for Their Medical Malpractice Coverage Stay with MICA?

Since 1976, MICA has specialized in medical professional liability insurance. Dedicated to protecting and defending the practice of medicine, MICA offers our members:

- Financial Strength and Longevity
- Assertive Claims Defense
- High-Touch Customer Service
- Proactive Risk Mitigation

Contact MICA today to learn more or request a quote. Visit mica-insurance.com/quote or call 602.956.5276.

This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete detail of coverage, contact MICA or your insurance agent.
HB 253 Abortion Amendments (Rep. Steve Christiansen and Sen. Michael Kennedy, MD)
This bill would have made several changes to tighten the state’s abortion law. It would have imposed a $50,000 fine per occurrence on a physician who violated a provision of the section of the law requiring informed consent, information module viewing, 72-hour mandatory wait, etc. It would have changed the content of the information module that women must watch before getting an abortion to include a detailed, step-by-step description of each step of each type of abortion procedure used in current medical practice, with medically accurate visual images of what is happening to the unborn child at each step of each type of abortion procedure, and a high-resolution, 3-dimensional video of an unborn child at 6, 8, 10, 12, 16 and 20 weeks gestation with audio of the heartbeat. It would have required a woman seeking an abortion to sign an oath under penalty of perjury that she has viewed the entire information module.
It would have required any facility that treats an abortion complication regardless of the reason for the abortion or medical termination, to report to the Department of Health the number of complications treated, by complication type. UMA opposed the bill. It was not referred to a committee. FAILED

This bill makes it a crime to give false information to the examiner when the medical examiner is responsible to certify the cause of death. Since false information might inadvertently or unintentionally be provided in those circumstances, UMA persuaded the sponsor to change the bill to read that an individual may not “knowingly” give false information. PASSED

This bill would have prohibited physicians from performing “a sex characteristic-altering procedure or medically unnecessary puberty inhibition procedure” on a patient younger than 18. These procedures were defined to include any sex-change surgery as well as administering or supplying drugs that would block puberty or contribute to a potential sex change. This was a highly controversial bill that attracted strong opinions on both sides. Under current standards of care, no surgery below the waist is performed before a patient reaches 18 and the only surgery performed on an individual between 16 and 18, is breast reduction surgery. The bill would have imposed significant non-medical constraints on the ability to practice medicine in the best interest of patients and would have been deemed a violation unprofessional conduct by physicians, so UMA was opposed to the bill. It was voted down in House committee. FAILED

This bill was introduced to greatly expand the ability of pharmacists to dispense without physician prescribing by directly allowing pharmacists to “prescribe” within very wide parameters. The sponsor had worked from a recently passed laws that would have imposed significant non-medical constraints on the ability to practice medicine in the best interest of patients. and a high-resolution, 3-dimensional video of an unborn child at 6, 8, 10, 12, 16 and 20 weeks gestation with audio of the heartbeat. It would have required a woman seeking an abortion to sign an oath under penalty of perjury that she has viewed the entire information module.
It would have required any facility that treats an abortion complication regardless of the reason for the abortion or medical termination, to report to the Department of Health the number of complications treated, by complication type. UMA opposed the bill. It was not referred to a committee. FAILED

This bill would have enacted an interstate compact (not yet adopted by any other state) that would have offered prize money for curing diseases, to be financed from the money saved by states in the compact from the disease cure. While recognized the initial attraction of the plan, UMA opposed the bill as an unworkable and unrealistic way to encourage research to cure diseases that could do more harm than good. It passed the House but was voted down in the Senate. FAILED

HB 210 Qualifying Conditions for Medical Cannabis (Rep. Gay Lynn Bennion)
This bill would have added opioid use disorder as a qualifying condition for medical cannabis for a patient in acute pain or in a pain clinic. UMA opposed this bill because pain that cannot adequately be managed by other treatment is already a qualifying condition and medical cannabis has not been shown to be an

Continued on page 14...
Wilkins & Associates Insurance
Specializes in insurance needs for Utah professionals and businesses.

With more than 40 years of experience, Utah physicians depend upon our expertise, knowledge and support.

Insurance Coverages Available:
- Medical Professional Liability
- Commercial General Liability
- Business Property
- Workers’ Compensation
- Employee Benefits
- Personal Home & Auto

175 East 6100 South
Murray, Utah 84107

801.268.6834
wilkinsassoc.com
appropriate or effective treatment for substance use disorder and studies indicate that those who suffer from opioid use disorder should not be recommended medical cannabis. FAILED.

**SB 76 Controlled Substance Database Access (Sen. Todd Weiler and Rep. Paul Ray)**
This bill provides the Utah Medicaid Fraud Control Unit with access to the controlled substance database. As introduced, it would have provided the Unit with wide-open access to “fish” for information on prescribing. UMA opposed this and convinced the sponsor to narrow the Unit’s access only to investigating active cases since they get this information in a roundabout way now anyway because of the nature of their investigation. This means they cannot go on fishing expeditions but can only gain access for active investigations. With this change UMA was neutral on the bill. PASSED

This bill began as an effort to let attorneys representing patients get the patients’ medical records at the discounted patient price and was fueled by stories of bills for medical record copies costing in the thousands of dollars. Through the work of the UMA and other stakeholders, that effort was blocked. The bill as finally negotiated makes various changes to the amounts that can be charged for a patient’s medical records. The maximum fee for a request that the records be delivered in an electronic medium is $150, regardless of the number of pages. The fee for certifying the record as a duplicate of the original is set at $20; for locating a patient’s record has been increased from $21.16 to $30 per request. For an electronic record request, the healthcare provider shall deliver the records in the electronic medium customarily used by the provider or in a universally readable image, such as a portable document format. Providers may not charge a fee for the first copy of the record that is needed to support a claim for workers compensation or social security disability in a calendar year. Providers are required to waive fees for the first request in a year from an indigent individual (who is at or below the federal poverty level). Providers may require the individual to provide proof of their status by executing an affidavit. Subsequent copies may be charged full price. UMA ultimately took no position on the final version of this bill. PASSED

As introduced, the bill said a public or charter school would not be required to enforce a COVID-19 public health order requiring mask wearing on school grounds. UMA contacted the sponsor and found that he mainly just wanted the public health authorities to consult with the schools before implementing mask orders. So, UMA developed language to accomplish that rather than the approach initially taken by the bill. Although many other stakeholders got involved and the bill went through three more substitutes, the final bill maintained the ability of the governor, Department of Health, county executive, and local health department to issue a public health order, such as a mask requirement, after consulting with the schools that would be affected by it. Consultation would not be required if the time required for it would substantially increase the likelihood of loss of life due to an imminent threat. PASSED

Among several other changes to pharmacy laws, this bill re-worded the statute that already allowed pharmacists to administer certain long-acting injectables intramuscularly under the direction of a physician and to continue to administer naloxone. The law already required pharmacist to receive special training and only administer these drugs under the direction of a physician. UMA worked to ensure that pharmacists’ scope of practice was not expanded by this bill and that the Physician Licensing Board would be consulted when appropriate in developing the rules to implement this bill. UMA supported the amended bill. FAILED

**FIREARMS BILLS**

**HB 60 Conceal Carry Firearms Amendments (Rep. Walt Brooks and Sen. David Hinkins)**
This bill allows individuals 21 and older to carry a concealed firearm in public without a permit—called “constitutional carry.” It was introduced to strong support by a large majority of the legislature. UMA against the bill, pointed out that it would remove the current training required for the concealed carry permit, which includes a module on suicide prevention, and that states with relaxed gun laws have higher rates of pediatric firearm mortality. In response to the concerns raised by UMA and others, the bill was modified to provide funding to the Division of Substance Abuse and Mental Health for suicide prevention efforts, though UMA did not remove its opposition. There were many organizations against this bill, but it was veto proof and the Governor had stated he would sign the bill. PASSED

**HB 216 Firearms Amendments (Rep. Karianne Lisonbee and Sen. David Hinkins)**
Under current law, a person can apply for a concealed carry permit when they turn 21, but they may have to wait up to 60 days to get the permit. This bill enables a person to apply for a concealed carry permit before turning 21, which then becomes valid when they turn 21, so they don’t have to wait until to get the permit. UMA did not take a position on this bill. PASSED
OTHER UMA SUPPORTED BILLS

HB 81 Mental Health Days for Students (Rep. Mike Winder and Sen. Lincoln Fillmore)
This bill adds “mental or behavioral health” of a child to the list of valid excuses for which a child may be absent from school without being considered truant. (Other valid excuses include mental or physical illness, a family death, an approved school activity, a health care appointment, and a scheduled family event.) UMA supported this bill for recognizing the importance of mental and behavioral health for children. PASSED

HB 116 Student Attendance Amendments (Rep. Adam Robertson and Sen. Lincoln Fillmore)
If a student is absent from school for a mental or physical illness, this bill prohibits the public or charter school from requiring parents to provide documentation from a medical professional to substantiate the illness. UMA supported this bill because a physician does not always need to see (and provide written documentation to the parent of) a child who has an illness that might prevent the child from attending school. PASSED

This bill directs the Department of Health to create a child blood lead epidemiology and surveillance program to encourage screening and testing during the first and second year well child clinical visits and to promote greater public awareness of the effects of lead exposure in children and the availability of free screening and testing. These services are paid for by insurance. Utah has many children who are exposed to lead and thus have health problems associated with that exposure. UMA supported this bill. PASSED

A law was passed last year requiring prescribers to transmit prescriptions electronically to pharmacies beginning January 1, 2022 (to coincide with the Medicare federal law requiring the same thing for controlled substances). Pharmacy software programs, however, generally do not have the capability to transfer an unfilled prescription to another pharmacy, which they need to be able to do if the first pharmacy cannot fill the prescription. This is so patients, if they cannot get a prescription filled at the first pharmacy they go to, do not have to go back to the physician for another prescription to get it filled but it can automatically be transferred by the patient or the physician to get the prescription transferred to another pharmacy. This bill requires the programs to be able to make the transfer by July 1, 2024. UMA supported this bill. PASSED

This bill adds treatment for autism spectrum disorder to the benefits of the Children’s Health Insurance Program. UMA supported this bill. PASSED

HB 326 Suicide Prevention Amendments (Rep. Steve Eliason and Sen. Michael Kennedy, MD)
This bill has several different provisions that address suicide. One of the key provisions directs the Division of Substance Abuse and Mental Health to create a program to help rural healthcare providers and smaller health systems implement a Zero Suicide program that involves targeted screening and referral to resources. This is similar to programs already running at Intermountain and University Health, which are very helpful. Another key provision makes it easier for individuals cleaning up a suicide site and needing counseling to get grant money from the Division to help pay for these things. The bill also changes the coupon program for purchasing gun safes (which help prevent suicides) to a rebate program. UMA supported this bill. PASSED

Mental health therapists, psychologists, behavior analysts, and behavior specialists are prohibited from disclosing confidential communication with a patient without the express authorization of the patient, parent or legal guardian of the patient, or an authorized agent of the patient. This bill replaces the authorized agent with a person authorized by the patient in a written document signed by the patient. UMA supported this bill. PASSED

This bill reorganizes the Department of Health and the Department of Human Services into a new Department of Health and Human Services. The transition begins on the effective date of the bill and ends on July 1, 2022. The transitioning departments are to develop a written transition plan for merging the functions of the departments by December 1, 2021, with input from interested stakeholders. The Department of Workforce Services will take over non-clinical eligibility for Medicaid and the Children’s Health Insurance Program. This is part of the Governor’s plan to look at state agencies and find efficiencies. The DOH and the DHS used to be combined and many states combine the two. UMA had no position on the bill. PASSED

This bill makes several changes to the Medical Examiner Act. Of greatest significance to physicians is the change to the definition of unattended death. The
medical examiner is generally responsible for determining and certifying the cause, date, and place of an unattended death, which under current law means the death of a person who has not been seen by a physician or physician assistant within the prior 30 days. The bill changes the definition to mean the death that occurs more than 365 days from when a health care professional last examined or treated the deceased individual for any purpose, including writing a prescription. This will leave the responsibility for preparing the death certificate more often to the decedent’s healthcare provider, rather than the medical examiner. The Medical Examiner’s office asked UMA about parts of the bill and UMA gave input and approved the 365 days. UMA supported the bill. PASSED

SB 83 POLST Order Amendments (Sen. Jani Iwamoto and Rep. Ray Ward, MD)
This bill makes a few changes to the POLST law. It changes the name of the life with dignity order back to POLST; this is an order that gives direction to health care providers, health care facilities, and EMS providers regarding specific health care decisions for a patient. The bill also authorizes the form to be signed electronically and authorizes the parent, guardian, or surrogates of the patient to give verbal agreement (within certain parameters that allow for authentication of the authorizer) to the form if it would be too hard for them to do it in person or electronically. UMA supported the bill. PASSED

This bill makes several improvements to tobacco retailing laws. It significantly increases the penalties for selling a tobacco product, including an e-cigarette, to someone younger than 21. The current law has a sunset on tobacco specialty businesses that are within 1000 feet of a public or private school (K-12) but were grandfathered. The businesses had filed a notice of intent to sue the state over the sunset. The bill addresses the issue by waiving the residential distance requirement if the businesses relocate away from the school and move to a strip mall. The bill also prohibits any employee, contractor, or patron from coming into the store if they’re younger than 21. UMA supported portions of the bill. PASSED

Last July, the Federal Communications Commission designated 988 as a nationwide 3-digit number to connect with suicide prevention and mental health crisis counselors, to be operational by July 2022. Later last year Congress passed and the President signed a bipartisan bill to create the 3-digit number and authorize states to collect a fee to help support the 988 function and services. This bill appropriates $4 million to help implement and support the 988 system and delivery of 988 services in Utah. UMA supported the bill. PASSED

Until 988 is working in July 2022, people in crisis should continue to call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

OTHER BILLS UMA FOLLOWED OR WORKED ON

HB 344 Program Eligibility Amendments (Rep. Steve Christiansen)
This bill would have enacted several costly and significant changes to eligibility for Medicaid and food stamps and would have directed the program to request several program waivers of the federal government, which Dr. Brian Shiozawa testified are likely to be turned down. It would have directed Medicaid to use private third-party vendors to assist with verifying Medicaid eligibility; required frequent publication of benefit fraud information; required removal of ineligible individuals when the federal restrictions end; required annual renewal applications to be entered without pre-populating last year’s information for the applicant; prohibited a hospital from making presumptive eligibility determinations for anyone other than pregnant women and children; barred a hospital from making any presumptive eligibility determinations for five years if it makes three mistakes within one year; and several similar provisions relating to SNAP and TANF. UMA opposed the bill. The committee hearing this bill voted unanimously to hold it. FAILED

This bill makes several changes to the regulation of industrial hemp products, which by definition must have less than 0.3% total THC. The bill includes delta-9-tetrahydrocannabinol in the definition of total THC; requires industrial hemp labs to test for THC analogs and prohibits more than 0.3% of any THC analog; makes it unlawful to sell, distribute, or transport outside the state under the
industrial hemp laws any product that with too much THC; prohibits selling or using a cannabinoid product that is added to an alcoholic beverage or food, enticing to children, or in smokable flower; among other things. UMA worked with the sponsor to ensure that it did not relax the forms in which the product could be sold or otherwise make psychoactive cannabis (which is under medical cannabis, not HEMP) available under this law. **PASSED**

This bill creates a new license for behavioral emergency services technicians and advanced behavioral emergency services technicians under the Department of Health, as a specialized EMS professional skilled in responding to behavioral health issues confronted by EMS staff. **PASSED**

**CONCLUSION**
Thank you to UMA leaders, staff, and involved members for all you do to support UMA's legislative efforts. With your help UMA continued to accomplish much for Utah's physicians and patients this year.

We were disappointed to be unable to hold our traditional Doctor's Day at the legislature this year. Many physicians and spouses have traveled to attend the event year after year. As mentioned above, we greatly appreciate those who took the time to be involved despite the restrictions and obstacles of the pandemic. We look forward to when we can meet and work together again in person with our legislature.

In addition to the bills discussed and explained above, UMA also reviewed and tabled or took no position on many other bills. The UMA legislative committee considered and took a position on nearly 150 bills this year. UMA members can login to the UMA website and review a more complete list of bills, 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. We particularly give 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 continued 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 5, 2021.

---

Elevating the industry

Mutual is more than part of our name, it’s part of everything we do. We stay on top by focusing on our policyholders, developing bold innovations and smarter solutions to help you understand your risk, predict your outcomes and improve your odds better than any other insurer. We keep raising the standard in healthcare liability insurance – because when you always put policyholders first, there’s no limit to how high you can go.

magmutual.com/innovation | 800-282-4882
1. SB 27 removes the delegation of services agreement that a physician assistant must have with a physician and changes it to a collaboration for 4,000 hours with one or more physicians in one specialty and for a further 6,000 hours of collaboration with a physician or a physician assistant in the same specialty—total of 10,000 hours (5 years) before a physician assistant can be independent. That independence is limited to practicing what they have been previously trained and privileged, credentialing, or authorized to do (“scope of practice”).

2. Collaboration is defined as the interaction and relationship that a physician assistant has with one or more physicians in which:
   a. The physician and the physician assistant are cognizant of the physician assistant’s qualifications and limitations in caring for patients, and
   b. The physician assistant, while responsible for the care that the physician assistant provides, consults with the physician or physicians regarding patient care, and
   c. The physician or physicians give direction and guidance to the physician assistant.

3. For a physician assistant who has fewer than 10,000 hours practice experience, regardless of where they work, this collaboration will be established at the practice level (physician practice, clinic, health system, etc.) in written policies and procedures that describe how this collaboration will occur and the methods for evaluating the physician assistant’s competency, knowledge, and skills. (This document determines their “scope of practice.”) If they later go out on their own, this establishes what they can and cannot do.

4. An individual physician assistant’s scope of practice is what the physician assistant has been trained and credentialing, privileged, or authorized to do under the collaboration parameters above (with specific restrictions listed below). The scope shall not be more than they have had the training and credentialing, privileging, or authorization to do—under the written collaboration document described above.

5. If a physician assistant has more than 10,000 hours practice experience and works for a healthcare system, physician practice, clinic or other employer, THAT ENTITY determines the consultation, collaboration, and referral that the physician assistant needs to do. The restrictions and collaboration and consultation will be whatever a practice or system decides it should be.

6. If a physician assistant wants to change specialties, they must gain a further 4,000 hours of collaboration (as defined above) with a physician in that specialty.

7. Restrictions on independent practice include the following:
   a. A physician assistant can only be independent after 10,000 hours (as delineated above) in the same specialty they have been practicing and within their individual scope of practice.
   b. A physician assistant practicing independently may only provide a health care service if it is appropriate to do outside of a health care facility and if they have been trained and credentialing or authorized to provide it.

---

**Senate Bills 27 and 28 introduce several changes to how you might work collaboratively with physician assistants and require a rigorous path to their independent practice.**
8. With three narrow exceptions, physician assistants may not administer general anesthetics:
   a. They can do a certain minimal sedation procedure if the procedure is within the physician assistant's scope of practice.
   b. They can do rapid sequence induction for intubation of a patient if it is within their scope of practice, they are ACS/ACLS, or equivalent certified, and are either directed by a physician or a physician is not there to do it.
   c. They can also administer anesthetics in an intensive care unit for the purpose of enabling a patient to tolerate ventilator support or intubation under the supervision of an intensive care physician and if they are trained to do so.

9. SB 28 establishes the standards and process for a physician assistant to specialize in mental health care. These are the requirements:
   a. Obtain and maintain a Certification of Added Qualification in psychiatry;
   b. Complete either an accredited doctorate level academic program, a post-graduate certificate in psychiatric and mental health, or a post-graduate residency in psychiatry with additional clinical practice or coursework, plus any addition work required by the board; and
   c. Complete 10,000 hours of clinical practice in mental health.
      i. At least the first 4,000 hours will be under the supervision of a psychiatrist;
      ii. At least 2,000 hours will be in psychotherapy under an experienced psychiatrist or mental health therapist; and
      iii. The rest of the hours (4,000 hours) will be completed in collaboration with a psychiatrist. Collaboration as defined in SB27 above.

10. A physician assistant who meets these requirements will be considered a mental health therapist under Utah law and be able to practice consistent with the physician assistant’s education, experience, and competence.
   a. A physician assistant specializing in mental health and working in a healthcare system, clinic, or other employer is subject to the consultation, collaboration, and referral responsibilities determined by the employer and also by the requirements under statute as delineated above.
   b. A physician assistant specializing in mental health and who has more than 10,000 hours of practice experience may practice independently, providing services for which the physician assistant has been trained and credentialed, privileged, or authorized to perform (same as SB27 information above).

11. A physician assistant specializing in mental health care:
   a. may administer a behavioral health screening instrument, but not perform a psychological or neuropsychological assessment; and
   b. may not administer neurostimulation or neuromodulation, unless done in a health care facility under the supervision of a physician who does that work, but may not be done outside of those parameters.

12. With the additional responsibilities of the physician assistant licensing board for those who want to specialize in mental health care, including deciding which academic programs, certificates, and residencies meet the requirements, at least one of the physician board members will be a psychiatrist who has experience working with physician assistants.

Medical Professionals Needed

The Utah State Hospital (USH) is seeking medical professionals willing to provide their services to the patients in their facility when that service is not available in the USH on-campus clinics. Any willing provider should contact Dr. Paul Whitehead, Clinical Director at 801-344-4200.
Just like professional sports teams, the stock market has its stars. Over the last several years, some of those stars have been known by the acronym FAANG (Facebook, Amazon, Apple, Netflix, and Google). Whether due to technological innovation, competitive advantages, or the result of a pandemic during which the economic impact has been unevenly distributed, these companies have exhibited tremendous performance and have amassed a larger percent of the overall market, accounting for over 20% of its value.

While investors may think the current “top-heavy” positioning is unusual, giant firms atop the stock market is nothing new. In 1967, IBM represented about the same portion of the market as today’s largest company, Apple (6% vs. 7%, respectively). And as you can see in the following chart from Dimensional Fund Advisors (DFA), the market has often been concentrated in a handful of stocks. (Exhibit 1) In fact, from 1927 through the mid-1960s, the top 10 stocks made up more than 25% of its value.

A breakdown of the largest US stocks by decade in Exhibit 2 (see page 22) shows some companies have even maintained their top positions for a significant amount of time. AT&T was among the largest two companies for six-straight decades beginning in 1930. General Motors and General Electric ranked in the top 10 at the start of multiple decades. IBM and Exxon were also mainstays in the second half of the 20th...
Why COPIC

COPIC’s unique streamlined process helps providers spend less time worrying about an open claim or pending lawsuit.

Claims resolved 27% faster than the national average. That’s why.

COPIC is proud to be the endorsed carrier of the Utah Medical Association. UMA members are eligible for a 10% premium discount.
The types of businesses most prominent in the market have varied through time but they have often been on the cutting edge of technology. AT&T offered the first mobile telephone service in 1946. General Motors pioneered such innovations as the electric car starter, airbags, and the automatic transmission. General Electric built upon the original Edison light bulb invention, contributing to further breakthroughs in lighting technology, such as the fluorescent bulb, halogen bulb, and the LED. We know, then, that technological innovation dominating the stock market is not a new normal; it is an old normal, too.

Over the 5- and 10-year periods before becoming one of the 10 largest companies, they outperformed by 19.3% per annum and 10.0% per annum, respectively.

Over the 5- and 10-year periods after becoming one of the 10 largest companies, they underperformed by 1.1% per annum and 1.5% per annum, respectively.

Of course, this does not mean that the largest stocks didn’t perform well over the subsequent five and ten-year periods, just not as well as the overall market. These results are consistent with modern portfolio theory, as investors would likely view them as great companies and, as such, safe investments – and safer investments often exhibit lower expected returns.

While it remains impossible to predict which companies will outperform the market and which will underperform, Intel is a recent example of this relative underperformance after becoming one of the 10 largest companies. The technology giant posted average annualized excess returns of 29% the decade prior to ascending to the Top 10 but, in the next decade, underperformed the broad market by nearly 6% per year.

The fact that a small subset of companies can account for an outsized portion of the stock market is not new. And as companies grow to become some of the largest firms not just in the US but around the world, the returns that push them there can be enticing. But stars come and go, and as illustrated, not long...
after joining the top 10, have often lagged the overall market over the next 5- and 10-year periods. While past performance is no guarantee of future results, it does serve as a reminder of the importance of having a broadly diversified portfolio that provides exposure to a vast array of companies and sectors. If you would like a second opinion on your portfolio to help ensure proper diversification and allocation based on your time horizon and risk tolerance, please contact UMAFS at 801-747-0800.

Exhibit 3

We want to be your Hospice Agency
Fax Referrals to: (801) 261-5856
Serving You and your Patients since 2004
Physician well-being and the larger topic of healthcare provider well-being has taken on an increased sense of urgency during the current COVID-19 pandemic. To be sure there has been a unique set of challenges resulting from caring for patients with COVID-19 (Table 1). Early in the pandemic, based on multiple interviews, Shanafelt, et al. identified eight frequently cited sources of healthcare provider anxiety related to COVID-19. The COVID-19 pandemic has mostly illuminated the problems that have been lurking within our healthcare system for quite some time. It would be misleading to focus solely on this pandemic crisis as a novel cause of physician and healthcare provider burnout and dis-satisfaction. The recognition of physician burnout and the quest to improve physician well-being predates COVID and will outlast it.

It is impossible to divorce wellness in the workplace from the overall wellness experienced within a society. Over the past two decades much has been published regarding how to best define and measure societal well-being and quality of life, along with multiple efforts to develop validated tools to measure it. These tools advanced beyond the previous simplistic model which equated wellness solely with national wealth and gross domestic product, to one that was complex and multidimensional. This model includes material living standards (income, wealth), health, education, personal activities (including work), political governance, social connections, environment, and insecurity (both economic and societal).

**PHYSICIAN BURNOUT**

Within this larger framework, work or occupation can be a dominant positive factor in achieving and maintaining well-being in that it affects many of the other components, including wealth, health, education, social connections, and insecurity. The benefits of work in these other areas of well-being likely varies based on one’s exact role in the healthcare system (technician, nurse, advanced practice provider, or physician). Physicians might be expected to benefit in many, if not most, of the wellness measures based on their occupation; so why do physicians apparently score lower on well-being measurements than other professionals and even non-professional workers? Interestingly, it does not start out that way. At least one large study found that persons about to begin medical school suffer less from burnout and have higher quality of life scores across all tested domains when compared to age and education matched controls in the general population. This suggests that it is not an underlying lack of personal resiliency or psychological well-being which leads to excessive burnout among physicians, but rather the circumstances of their training and practice.

Physician burnout has been a hot topic in the international medical literature for at least a decade. It turns out that the United States is not alone when it comes to physician burn-out, and the same causes seem to be universally responsible, although the magnitude differs by country (and likely on a more granular scale by work location). The factors which are most often cited by physicians as the major contributors to job dis-satisfaction and burn-out are: administrative burden, excessive bureaucratic tasks, insufficient time to complete tasks, spending too many hours at work, and lack of respect. Although the electronic health record is a significant contributor to burnout, its relative importance is
age-dependent, with only post-World War II “baby boomers” rating it in the top three causes. An overarching theme summarized by a paper from the Agency for Healthcare Research & Quality (AHRQ) is that chaotic environments, low control over work pace, and an unfavorable organizational culture were strongly associated with burnout and intent to leave practice (AHRQ).

Hospitals and medical centers (whether academic, public, or private) have become increasingly aware of the problem of physician burnout. The answer many organizations initially embraced to this growing threat was to offer mindfulness and resiliency training. West et al. found that mean physician resiliency scores were significantly higher than those of the general population, and although higher resiliency scores were associated with less burnout, there were still high burnout rates even among those with high resiliency scores. We do not minimize the benefit of mindfulness and resiliency programs, as they can help to promote well-being. However, such individually initiated measures must be part of a larger effort to 1) improve work conditions, 2) allow more autonomy, 3) promote a culture of respect and cooperation, and 4) make employee satisfaction a measured quality indicator (AHRQ). Relying solely on resiliency training as a solution to burnout brings H.L. Mencken’s quote to mind: “For every complex problem there is an answer that is clear, simple, and wrong.”

**HOW COVID HAS CONTRIBUTED TO BURNOUT**

Our struggle with identifying and fixing the underlying causes of burnout and dissatisfaction in the clinical practice of medicine may be at least partially informed by the ongoing COVID-19 pandemic. However, there is a unique factor which has emerged with COVID-19. That factor is fear; fear of contracting the disease and fear of spreading it to loved ones. Those of us in healthcare have seen unique changes in practice during this pandemic, from decreasing availability of consultations to segregating admissions by COVID-19 testing. We have also seen alterations in off-work behavior, with many healthcare workers isolating in basements, garages, or trailers rather than going home and exposing their family to possible infection. Although physicians in general recognize that they can contract disease from their patients, this pandemic has been vastly different. The response of healthcare administrators and managers regarding the very real fear factor during this pandemic is one of the universal lessons regarding clinician burnout we can learn from COVID-19. We have seen how expressions of appreciation from patients, the public, and health administrators can inoculate to some extent against the overwhelming fatigue of caring for a continuous wave of sick patients, often with insufficient personal protection, and constantly having to fill shifts for those that have been taken from our ranks by disease or quarantine. A recent Canadian survey of emergency physicians showed that physician burnout remained stable during the first 10 weeks of the pandemic and acknowledged that expressions of patient gratitude and renewed purpose were important factors for maintaining physician wellness. But we have also seen that expressions of appreciation are hard to sustain. We have seen how lack of commitment, if not resistance, by many to undertake the steps required to control the pandemic and the reluctance of healthcare administrators to maintain their workforce in the face of financial losses have demoralized our frontline caregivers. Initially there was a concerted St. Louis metropolitan-wide effort to streamline processes and to provide space and resources to care for COVID-19 patients. This was given the highest priority. There was also an unprecedented cooperation among various departments and services to meet this once-in-a-lifetime challenge, but as overall patient volumes and revenues decreased, and it appeared that the wave of illness was waning, these efforts and attitudes were not sustained. When the third (and by far most devastating) wave hit, it felt as though there was little appetite to redouble the efforts that had been put in place to suppress the first wave. As a tsunami of patients inundated our emergency departments and hospitals, a familiar feeling of chaos, time pressure, and lack of control over our workplace descended. These of course, are well known to be associated with dissatisfaction and burnout, but many have begun postulating that the real underlying cause of physician burnout, particularly in the time of COVID-19, is something more egregious: “moral injury.” This relatively recent idea has been elevated to the fore by the ongoing pandemic. The term “moral injury” was first used in 1981 by Friedman to describe a psychological condition found in post-Vietnam war veterans. It was further explored in a wider array of war veterans by Litz, et al. in 2009. Litz described moral injury in the veterans he was seeing as “a wound that can occur when troops participate in, witness or fall victim to actions that transgress their most deeply held moral beliefs.” Diane Silver, in a 2015 article describing the epidemic of post-traumatic stress disorder that Litz and others were treating among Afghanistan and Iraqi veterans, wrote that moral injury is “a deep soul wound that pierces a person’s identity, sense of morality, and relationship to society.” The first reference I could find regarding moral injury in healthcare workers was in an opinion piece by Talbot and Dean in 2018. In this piece they attempt to explain the difference between the source of moral injury in war veterans and those in healthcare workers. They suggest that...
The root cause of moral injury among physicians (and I dare say among other healthcare providers as well) is “being unable to provide high-quality care and healing in the context of health care.” They go on to say that the failure “to consistently meet patients’ needs has a profound impact on physician well-being — this is the crux of consequent moral injury.”

The National Academy of Medicine has recently put out a statement entitled “Strategies to Support the Health and Well-Being of Clinicians During the COVID-19 Outbreak” recognizing the role that “moral dilemmas” are playing in exacerbating physician burnout during this pandemic. They provide several recommendations for managers and healthcare leaders which almost all of us would agree would be helpful, but which are woefully underutilized currently. The statement begins with a simple directive: “Provide clear messages that clinicians are valued.” The need for this is further emphasized in the opinion piece by Shanafelt et al. Based on interviews with 69 healthcare workers, they conclude that “simple and genuine expressions of gratitude for the commitment of health care professionals and their willingness to put themselves in harm's way for patients and colleagues cannot be overstated.” But statements without tangible signs of support and care “ring hollow.” The most important way to send a clear message that front-line healthcare workers are valued is by supporting them in real actions and in real time. Asking “everyday heroes” to care for COVID-19 patients without adequate PPE is not a show of support or respect. If the procurement of adequate PPE is impossible, then all energy must be focused on developing and implementing the best evidence-based alternatives with honesty and transparency. It is not just managers and healthcare leaders that must step up. The need for real actions to lower physician burnout during this critical time is required by the general population as well. A recent survey of more than 2,300 physicians found that 80% identified lack of population compliance with masking and social distancing protocols as the single greatest cause of frustration to them.

We have entered what we hope is the final phase of this pandemic, with the approval of highly effective vaccines for general use. However, even with this promising news, the implementation of vaccination policies has appeared haphazard and problematic. The best strategy regarding vaccination priority can be debated, but the debate should include representatives from the most impacted groups and should be transparent. If vaccination access across the healthcare workforce will take a month or more, and our frontline workers are seeing a peak in COVID-19 patients right now, then putting younger frontline workers (whether they be nurses, technicians, therapists, environmental services, security, transportation, trainees, or physicians) at the back of the queue, allowing older providers earlier access, even if they have an extremely low exposure risk does not seem equitable. A more equitable approach may be to vaccinate frontline healthcare workers who are exposed daily to known or suspected COVID-19 patients, and within this group to stratify by risk factors for severe disease, such as age. There are clearly reasons for vaccinating our older population as quickly as possible, but it makes little sense to delay frontline workers, not because they are at high risk of dying, although there are estimates that there have been nearly 3,000 deaths among healthcare workers as of November of 2020. But rather because, when they get sick or need to quarantine, the loss can decimate the workforce we are relying on for our care.

The National Academy of Medicine and the Agency for Healthcare Research and Quality also have some wellness recommendations for clinicians, which are likely to be helpful if they can be implemented. Self-care, taking breaks, staying connected, and performing self-check-ins are among these, but it may be the final recommendation that is most important to heed: Take the time to “Honor your service: remind yourself and others of the important and noble work you are doing. Recognize colleagues for their service whenever possible.” This has been even more challenging in the time of COVID-19. As an example, our Medical Staff Association has had to cancel several traditional annual events in which they honor their extraordinary clinicians and scientists for their service.

CONCLUSION
Ours is a noble profession, but we must be allowed the time and resources to fulfill our obligation to our patients or we take home the guilt of a job poorly done. That job has always been to help those we can and to comfort those we cannot. In the time of COVID-19, there is often insufficient time to do either. This is not an insolvable problem, but it will take determination and grit and the reimagining of a healthcare delivery system that is truly driven by patient-centric outcomes rather than production parameters. As Dean & Talbot conclude: “Physicians must be treated with respect, autonomy, and [given] the authority to make rational, safe, evidence-based, and financially responsible decisions.”

-First published in Missouri Medicine (Jan/Feb 2021)
References

18. RVs 4 MDs: Healthcare Workers Given Trailers During Pandemic | NBCLA. https://www.youtube.com/watch?v=QR0hZth0UYQ. Accessed 12.20.20
CME SPOTLIGHT

Title: Suicide Prevention  
When: On-demand Webinar  
Where: Online at cme.utahmed.org  
Provider: UMA Foundation  
CME: 1 AMA PRA Category 1 Credits™

Approximately 45 percent of all individuals who die by suicide visited a primary care physician in the month preceding their death. Yet according to the Utah Behavioral Health Workforce Suicide Prevention Survey, only 57 percent of physicians said they were confident in their skills to help/assist a suicidal individual. This training will provide physicians with training and resources in suicide screening and risk assessment/triage, brief evidence-based interventions to reduce suicide risk, skills in communicating with patients at risk of suicide, and an increased understanding of available resources.

Following this activity, participants should be able to:

1. Describe the epidemiology of suicide.  
2. Identify the warning signs and risk factors for suicide.  
3. Assess a patient’s suicide risk.  
4. Develop a safety plan with the patient.  
5. Access available resources.

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

ama-assn.org  
eMedEvents.com

Utah Seeks Physician For Deputy State Epidemiologist

The Utah Department of Health (UDOH) is seeking a licensed Medical Doctor with knowledge of surveillance epidemiology and infection prevention and control to fill a critical role as the Deputy State Epidemiologist providing medical and clinical expertise to the Healthcare Associated Infections/Antibiotic Resistance (HAI/AR) Program, the Disease Response, Evaluation, Analytics and Monitoring (DREAM) program, and the Utah Public Health Laboratory (UPHL). This role includes serving as medical director of infectious disease outbreak responses, engaging in strategic planning as it relates to infectious diseases, offering guidance on surveillance of reportable conditions, and engaging with the healthcare provider community on infectious disease topics.

For more information, visit www.governmentjobs.com/careers/utah/jobs/3017066/deputy-state-epidemiologist-infectious-diseases
Recurring Activities
Recurring activities are scheduled at St. Mark’s Hospital, IHC Hospitals, Primary Children’s Medical Center, and the University of Utah School of Medicine. Contact the sponsor for specific information. For more information on the above listings, please call the provider at the phone number listed below.

List of Sponsors

<table>
<thead>
<tr>
<th>Sponsor</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOG</td>
<td>American College of Obstetrics and Gynecology, UT Chapter, SLC, 801/747-3500</td>
</tr>
<tr>
<td>ACP</td>
<td>American College of Physicians, UT Chapter, SLC, 801/582-1565 x2441</td>
</tr>
<tr>
<td>ACS</td>
<td>American College of Surgeons – Email <a href="mailto:UtahATLS@gmail.com">UtahATLS@gmail.com</a> for info about ATLS</td>
</tr>
<tr>
<td>ALT</td>
<td>Alternative CME, SLC, 801/200-4321</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association, Chicago 312/464-4761</td>
</tr>
<tr>
<td>AUCH</td>
<td>Association for Utah Community Health, SLC, 801/924-2848</td>
</tr>
<tr>
<td>CA</td>
<td>Collegium Aesculapium, Orem, 801/802-0449</td>
</tr>
<tr>
<td>CM</td>
<td>Cine-Med, Woodbury CT, 800-253-7657</td>
</tr>
<tr>
<td>ESI</td>
<td>ESI Management Group, SLC, 801/501-9446</td>
</tr>
<tr>
<td>IHC</td>
<td>Intermountain Healthcare CME, SLC, 800/842-5498</td>
</tr>
<tr>
<td>LVH</td>
<td>Lakeview Hospital, Bountiful, 801/299-2546</td>
</tr>
<tr>
<td>OSMS</td>
<td>Ogden Surgical-Medical Society, Ogden, 801/564-5585</td>
</tr>
<tr>
<td>PCH</td>
<td>Primary Children’s Hospital, SLC, 800/910-7262</td>
</tr>
<tr>
<td>PRKA</td>
<td>Program of Addiction Research, Clinical Care, Knowledge, Advocacy, SLC, 801/585-6667</td>
</tr>
<tr>
<td>SHC</td>
<td>Steward Health Care, South Jordan, 801/984-2384</td>
</tr>
<tr>
<td>TRH</td>
<td>Timpanogos Regional Hospital, Orem, 801/714-6505</td>
</tr>
<tr>
<td>UAFP</td>
<td>Utah Academy of Family Physicians, SLC, 801/587-3285</td>
</tr>
<tr>
<td>UHLF</td>
<td>Utah Healthy Living Foundation, SLC, 801/993-1800 or 801/712-8831</td>
</tr>
<tr>
<td>UDS</td>
<td>Utah Dermatology Society, SLC, 801-266-8841</td>
</tr>
<tr>
<td>UMAF</td>
<td>Utah Medical Association Foundation, SLC, 801/747-3500</td>
</tr>
<tr>
<td>UMIA</td>
<td>Utah Medical Insurance Association, SLC, 801/531-0375</td>
</tr>
<tr>
<td>UOS</td>
<td>Utah Ophthalmology Society, SLC, 801/747-3500</td>
</tr>
<tr>
<td>USH</td>
<td>Utah State Hospital, Provo, 801/344-4265</td>
</tr>
<tr>
<td>UUCME</td>
<td>University of Utah Continuing Medical Education, SLC, 801/581-8664</td>
</tr>
<tr>
<td>VA</td>
<td>VA Center for Learning, SLC, 801/584-2586</td>
</tr>
</tbody>
</table>

The following websites offer online continuing medical education:

- cme.utahmed.org
- psnet.ahrq.gov/cme
- thedoctorschannel.com/cme/
- freecme.com
- pri-med.com/pmo/OnlineCME.aspx
- medicine.utah.edu/cme
- cmelist.com
- ama-assn.org/education-center
- baylorcme.org
- medscape.org
- vhl.com
- nejm.org/continuing-medical-education
- reachmd.com/programs/
- cms.gov/Outreach-and-Education/Learn/Earn-Credit/Earn-credit-page.html
- primarycarenetwork.org/
- emedevents.com/
For at least the last decade, health care providers (e.g., physician practices, imaging centers, ambulatory surgical centers, assisted living facilities) have been the targets of robust merger and acquisition (M&A) activity, including by health systems and, in some cases, acquisitions by insurers seeking vertical integration. More recently, a new player has entered the fray—private equity-sponsored firms. This article provides an overview of the goals and objectives of private equity investments in health care providers and some of the key issues involved in a private equity acquisition transaction.

Private Equity—General
For purposes of this article, “private equity” refers to a broad range of pooled investment vehicles (funds) that raise equity capital from multiple investors to finance their investment and trading activity in private companies. A typical private equity fund (a “Fund”) will seek to “exit” its portfolio companies (e.g. sell to other private equity buyers, strategic acquirers or take public) in 5-7 years. Depending on its strategy, a Fund may seek a “platform” acquisition (initial acquisition made as the starting point for other acquisitions in the same industry/service line, where the target has strong management expertise and infrastructure that can be leveraged), followed by “tuck in” acquisitions of smaller practices which can then realize operational efficiencies.

PE’s Laser Focus: All-Important EBITDA and Quality of Earnings
The primary benchmark for a private equity investor is “EBITDA” (earnings before interest, taxes, depreciation and amortization) since it provides a useful measure of cash flows (historical and anticipated “pro forma” future cash flows). For valuation purposes, EBITDA is multiplied by a negotiated multiple in order to establish an enterprise valuation (which, after deducting liabilities, results in the equity value). Given its critical importance, EBITDA is closely scrutinized and adjusted to eliminate non-recurring items.

“Scrape” and its Impact on Valuation and Taxes
At this point, consider just how many physician practices have no EBITDA—because they “zero out” the corporation (or other entity) by paying out all or substantially all profit as compensation to physicians. However, EBITDA can be created through financial engineering—the target practice will reduce physician compensation by 20-30% of earnings before physician compensation (this reduction is sometimes called “scrape” since the acquirer “scrapes” compensation off the top from physicians in order to provide a return on investment). So, from the physician owner standpoint, there is an important trade-off: (a) cash at closing (taxed at favorable capital gains rates, subject to certain exceptions, plus the 3.8% net investment income tax) vs. (b) compensation paid in the future (taxed at less favorable ordinary income tax rates and subject to FICA, FUTA, etc.).

Certain Regulatory Issues
From a health care fraud and abuse perspective (generally meaning the “wide and deep” regulatory footprint arising from the Ethics In Patient Referrals Act (42 U.S.C. § 1395nn) and related legislation (the “Stark Law”), the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7(b), CMS conditions of participation and coverage and reimbursement rules, anti-markup rules, etc.), careful structuring is required to assure that the transaction and resulting venture, where its physician owners are sources of referrals, is compliant (e.g., no unexpected Stark Law financial relationships with a designated health services provider).

Rollover Equity—The Good, the Bad and the Ugly
A Fund will seek to invest in companies with strong management teams and will often require some of the target company’s equity owners, particularly those members of the management team who are critical to the future success of the business, to “rollover” a portion of their equity such that they will own a minority equity position in either the target company or a higher-tier holding company (which holds the target company and other similar acquisition targets). Rollover equity raises a number of negotiation issues, such as:

- Whether the rollover equity will be on par (pari passu) with the equity interests held by the Fund or sit lower (subordinate) in the capital structure of the target or holding company?
- Whether, given the continued service requirement, the rollover equity will be taxable as compensation (ordinary income under IRC §83), the timing of recognition of that income, or whether the rollover equity can be structured on a tax-deferred basis as a contribution to a partnership?
- The events triggering forfeiture (what if a physician is forced out?) and the purchase or redemption price upon those events.

Generally speaking, careful structuring can result in tax-deferral on the rollover equity component of the transaction.

Corporate Practice of Medicine—Profits vs. Patients
Utah’s corporate practice of medicine prohibition is not particularly strong, but does prevent a corporation (including evil MBAs acting as holding company management) from interfering in a physician’s clinical judgment (doing so would constitute the unlawful practice of medicine). While this provides a legal barrier against interference in clinical matters, from a practical perspective it often falls short and is an unsatisfactory barrier when physicians are forced to object to “financial” decisions. Well-advised physicians will negotiate for sole control or veto power (supermajority voting) over clinical decision making (e.g., hiring and firing nurses, medical directors, etc., clinical protocols and quality improvement initiatives). This effort seeks to strike a balance between (a) profit motives of the Fund (or the subsequent owner once the Fund exits its investment) and (b) physician control over quality of care and the best interests of patients.

Conclusion
We can be certain that the trend of private equity investments in health care providers will continue, whether as “platform” or “tuck in” acquisitions, and that the resulting networks of affiliated providers (owned and managed by the same Fund or its portfolio holding company) will gain market strength through collaboration, back office efficiencies with respect to human resources, coding and billing, etc. Those physicians in a later career stage will generally have far more interest in pursuing a private equity “exit” transaction, whereas the trade-off for earlier career physicians is not as simple and often causes consternation. In any event, the good news is that, at least in the current market environment, deal competition between hospitals and health systems (as strategic acquirers) and private equity funds (as financial acquirers) should benefit physicians through higher multiples and resulting valuations.

MARK A. COTTER. Mr. Cotter is a shareholder in Corporate, Securities and Health Care practice groups of the law firm Ray Quinney & Nebeker P.C. Mr. Cotter has significant transactional experience with respect to the development, financing, syndication, operation and acquisition of ambulatory surgery centers, including hospital system-physician joint ventured surgery centers. More generally, Mr. Cotter devotes a substantial portion of his practice to health law regulatory and transactional matters in the context of physician group practices, ancillary service providers, ambulatory surgery centers, home health, assisted living facilities, pharmacy and other providers, as well as physician-hospital and other provider M&A and joint venture transactions.

*Advertorial from Ray, Quinney & Nebeker
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 them in the future.
WHY YOU SHOULD TRUST THE COVID-19 VACCINE

- Vaccines do not give you COVID-19. None of the vaccines currently available or in development contain a live virus. The mRNA vaccine contains a “blueprint” for a small (non-living) piece of the virus, which your body will use to build up antibodies against should you ever become exposed to the actual virus.

- There is no evidence vaccines affect fertility or harm an ongoing pregnancy. Clinical data available shows no effect on the health of a pregnant individual or fetus. However, if you get the COVID-19 virus, complications associated with it can pose a serious risk to pregnancy and the mother’s health. Those who are pregnant and thinking of getting the vaccine should discuss their concerns with a physician.

- COVID-19 vaccines do not alter your DNA. The mRNA contained in the vaccine does not interact with our DNA in any way. The mRNA is used to act as a blueprint for a small, non-living part of the virus that will be used to help our bodies build up an immune response. That way should the virus ever enter our body, our immune system can act quickly.

- The science behind mRNA vaccines has been around for several years and has been clinically proven to be safe and effective. Neither science nor safety shortcuts were taken in the development of the vaccine. Increased priority, collaboration, and funding contributed to its expedited development.

- COVID-19 vaccines do not contain any microchips, implants, tracking devices, or other questionable substances. COVID-19 vaccines currently available and in development do not contain any ingredients that have not been already used in manufacturing vaccines. The vaccine does not contain any solid implants or fetal tissue.

- COVID-19 vaccines have been deemed safe by the Centers for Disease Control and Prevention (CDC). Serious or dangerous side effects are extremely rare. The most common side effects are sore arm, feeling tired, headache, body aches, or a mild fever. These side effects usually last no more than two days. The symptoms are the result of the vaccine working to strengthen the immune system.

- The vaccines will let us get back to spending time with family and friends. The more people who get vaccinated, the more difficult it would be for the virus to infect others and spread the disease, even to people who are unable to get the vaccine. This is called herd immunity.

- Until we can understand if those who received the vaccine can spread the virus, you should still wear a face mask when around others, practice social distancing, and frequently wash your hands.

- The vaccines can offer longer term protection, even if you have already had COVID-19. People who have had COVID-19 can benefit from the long-term protections from severe complications that can come with the virus, as it is possible to get reinfected.

- Even if you are not at increased risk for severe complications from COVID-19, getting the vaccine may protect others from getting sick. It will also help you return to work or school sooner.

To help stop the pandemic, we will need to use all the tools and information available. This includes wearing face masks, practicing social distancing, staying home when you feel sick, and getting the vaccine if you can.

To learn more about COVID-19 vaccines, visit cdc.gov/coronavirus/2019-nCoV/.