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This month I had to renew my state medical license. The process did not take too long, but required several steps, including printing out the electronic file, signing it, and scanning it so it could be used to renew my privileges and credentials. Each of us has a similar biannual process. But this year, as I held it in my hand, my mind flew back to the stressful time of applying to medical school. The idea of being entrusted with the power to practice medicine seemed both distant and covetous. I am sure all doctors can relate. But through the years, we come to feel the administrative burden around our practices to be arduous, thus this yearly rite of passage is added to the numerous organizations, persons, and processes demanding our attention (12 email messages came to my inbox while writing this paragraph).

Think about what it means to hold that license, and what trust it engenders. Yet certain factors of late have challenged the public’s trust in the house of medicine. In fact, a Nobel Prize winning economist recently said to the Washington Post, “Physicians are a giant rent-seeking conspiracy that’s taking money away from the rest of us, and yet everybody loves physicians you can’t touch them.”

It’s not hard to find this type of opinion shared throughout news and social media. There is a lot of confusion and dissatisfaction regarding the costs of healthcare. Physician salaries represent a slice of the healthcare-expenses-pie-chart so small, that if a restaurant served you a slice of pumpkin pie that small, your Yelp review would be scathing. Nevertheless, many call to decrease our pay as a solution to healthcare problems. In the legal arena, physicians often face encroachments of non-physicians into their practice. When we point out the differences in qualifications and training of advanced practice clinicians (APCs), some accuse us of trying to protect our “turf” and income, rather than looking out for the best interest of patients.

These types of opinions are a symptom of a growing lack of trust in physicians across the nation. This mistrust is often in the abstract, as the same individuals publishing such criticisms are often very grateful for their personal physician’s efforts to save their lives and improve their health. Mistrust often comes from ignorance. But I cannot really fault them for not knowing what we physicians know. Until you have gone through the crucible of medical school, residency, and building a practice, you cannot truly see the high value our training gives us; and for the most part we are steadfastly trying to share this with the public.

We can do more to help our patients and the public have more trust in doctors—individually and collectively. At the recent AMA Interim Meeting, President Patrice Harris said there are three dimensions of trust: competency, honesty, and compassion. No one truly trusts another unless these three characteristics are perceived. Your whole life you have been developing your medical competency. And ostensibly, that is what patients state they are looking for in a physician. But that is not enough. I believe the vast majority of Utah physicians are honest and compassionate. We just need to let that shine through.

Our 21st century society has put a lot of emphasis on transparency, and that extends to healthcare. Giving patient’s access to their diagnoses, results, and your recommendations has been a great advancement. Of course, it comes at the expense of phone calls to discuss a patient’s “low BUN” value, the return outweighs the investment. And transparency can go further. In your interactions with patients, be upfront about your expectations and limitations. Feel free to share personal stories. When I am late to the office, I don’t mind telling my patients where I was and why it was necessary for me to run behind. Transparency demonstrates honesty.

The biggest obstacle to trust I see today is the mentality of “that’s not my problem.” The following details are shared with permission. I assumed care of a pregnant patient who was acutely ill with a non-obstetric condition. As her condition spiraled out of control, her obstetrician would proclaim, “I can’t help, what does the gastroenterologist say?” And then her GI would evaluate and add, “I think this should be treated by a general surgeon.” And then
her general surgeon would tell her, “We can try these options, but you’re pregnant, so conservative treatment is better—you really need to go talk to your obstetrician and GI about this.”

She continued in this viscous cycle for weeks, with increasing rapidity, until landed in the hospital where the same game of hot potato was being played. When I got involved, she was sick enough that she would not have survived childbirth. Fortunately, it was not too late, and I stopped making the patient be the go-between, and we three specialists got on the same page and cured her. I’m happy to report that she survived, then thrived, and enjoys her adorable 2-year-old today. Taking ownership of a patient’s health is not paternalistic if you involve the patient, and it demonstrates your compassion. Furthermore, it is better to take ownership of a situation than to worry about “stepping on toes.”

Be aware of every aspect of your practice: from reception to imaging, from billing to patient relations. While you do not need to micromanage all details, if you don’t know who is in charge of a particular aspect of your patients’ healthcare experience, then you may not be aware that you’re being misrepresented. All these interactions influence the patient’s perception of the three dimensions of trust. Continue to grow your competency. Be honest with yourself, your patients, your colleagues, and your staff. Let everyone see your compassion. And be the kind of doctor your mom thinks you are.
Weeding Out Dubious Marijuana Science

By Alex Berenson

Some researchers find ways to minimize increases in crime and traffic deaths that followed cannabis legalization.

Academics depict the peer-review process as the gold standard for intellectual honesty, ensuring published scholarly work is unbiased and accurate. But ideological conformity makes peer review a far thinner defense than advertised.

In January 2019, I published a book about the mental-health and violence risks of cannabis. Several dozen scholars signed a petition expressing in unison their objection to my work. Thus, I’ve recently spent an inordinate amount of time reading papers seeking to prove that marijuana is a cure-all whose deleterious consequences are a figment of our collective imagination. The shoddiness of much of the work has shocked me.

Example: Driving deaths have risen more than 30% in Colorado and Washington, the first states to legalize marijuana for recreational use, since dispensaries opened there in 2014. That rise is more than double the national change. The Insurance Institute for Highway Safety reported in October that the number of vehicle accidents overall were up faster in legalized states than the rest of the nation.

Nonetheless, researchers have claimed legalization doesn’t increase driving deaths. Last year, Benjamin Hansen of the University of Oregon and two other researchers wrote a paper looking at the rise in vehicle deaths in which drivers had THC in their blood. They found such deaths rose in Colorado and Washington at rates “similar” to those in other states.

In fact, the data showed that legalization explains about half the increase in Colorado and Washington. But because the data were limited, the results had wide confidence intervals, which means it’s possible but not probable that the post legalization gap was the result of chance. A more honest way to report the results would have been to say that the paper had found a worrisome trend in cannabis-linked deaths, which more data might confirm.

Violent crime has also soared in the legalized states since 2013. Yet last year two criminologists claimed in a Seattle Times op-ed that they had found “no increase in violent crime that can be directly attributed to marijuana legalization.” That formulation makes the statement a trivial truth. Without examining every murder, no one can say legalization has directly driven the increase.

The authors explain in the op-ed that they based their statement on a paper they co-wrote. They don’t name it, but the only published paper listing them as co-authors is a 2018 study called “Marijuana Legalization and Crime Clearance Rates.” It didn’t even examine whether crime has risen or fallen. It looked only at whether police were likelier to solve, or clear, crimes after legalization. But so what? If murders double from 100 to 200, and the police solve 50 the first year and 110 the second, the clearance rate has risen, but so has the crime rate.

Photo: Image licensed by Ingram Image
Some of the research is comical. A paper published in March reported that cannabis use seemed to increase “satisfactory orgasms” in women. The paper divided subjects into three categories: nonusers, users who answered yes when asked if they used the drug “before sex,” and users who answered no. But it presented results on sexual satisfaction only from the last two categories— not from women who don’t use marijuana at all. The paper provides no data at all comparing users with nonusers.

I could offer a half-dozen other examples of dubious scientific practices—using nonstandard data sets, relying unnecessarily on “synthesized comparators” that are inherently vulnerable to manipulation, and “p-hacking” by looking at endless secondary outcomes until one pops up that reaches the threshold for statistical significance.

The tricks can be hard to find—and journalists, who are almost never trained in science or statistical analysis, often parrot the results un-skeptically, especially when the findings confirm their own biases toward ideology or sensationalism. When car accidents and violent crime are involved, the results can be deadly.

Alex Berenson is a former New York Times reporter and author of 12 novels. Contact: alexberensonauthor@gmail.com
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Addiction. No one wants to talk about it; still taboo, still conjuring undesirable images and stigma. Even as the U.S. witnesses an epidemic-level prevalence of addiction—including opioid use, other substances of abuse, and process addictions—we may be reluctant to see it in our patients. Are we also reluctant to see it in ourselves?

Physicians are statistically equal to or at slightly higher risk for some form of addiction compared to the general population: research suggests 10–12% of physicians will struggle with an addiction across their career. Across the broader population of all health care providers, the rate increases slightly, to 10–15%. Female and male physicians are equally affected, although the type of addiction (with the exception of alcohol) and comorbidities differ somewhat. Verghese postulated that associations between medical specialty and types of drugs “pointed to temperament, not access; cocaine use is more common among emergency room physicians, and psychiatrists are more likely to abuse mood-altering drugs.” In a five-year cohort study of 904 physicians, McClellan, Skipper, Campbell and DuPont found 87% of enrollees were male, and alcohol and opiate addiction ranked highest in use—50% and 36%—with stimulants trailing at 8% and a combination of other substances at 6%. Approximately 50% of physicians combined substances and 14% engaged in IV drug use, either past or present. The window into physician addiction is a prism, multi-faceted and complex; cloaked in secrecy and shame; burnished by long-held social traditions of invincibility and superiority. Physicians in Utah are not immune to the disease nor the deleterious outcomes associated with its progression.

Substance abuse and depression are highly ranked risk factors for suicide; but, while underplayed for and by the profession, 300–400 U.S. physicians take their lives each year, representing the loss of more than one physician each day, the highest suicide rate of any profession, and more than double that of the general population. Although female physicians attempt suicide less often than their male colleagues and women in other professions, their suicide completion rate equals that of male physicians (2.5–4 times); thus, they too exceed the suicide rate of the general population. Yet physician well-being has been identified as a critical factor in patient safety. A recent meta-analysis found a bidirectional association between physician depression and self-reported medical errors. While physicians seemingly apply their professional expertise and connections (early diagnosis and access) to lower their mortality risk from cancer and heart disease relative to the general population, they give short shrift to the addiction and mood disorders—diagnosable, treatable, even manageable—which show up as the most common diagnoses in physicians who take their own lives.

In research for his book, “When Physicians Kill Themselves...,” Dr. Michael Myers reported his research narratives' common theme:

Physician Heal Thyself

By Susan Wiet, MD
physicians “fell through the cracks” of systems and people that would have otherwise helped them. Long years of medical training produce physicians who can push through the physical and mental effects of exhaustion, honing the capacity to become unmindful of burnout, depression and substance abuse. Compound this by the profession's deeply internalized stigma surrounding help-seeking behavior. Help, if obtained, was likely to be sub-optimized by shame that would prevent formation of an effective therapeutic alliance. (ibid) The anguish of separating from self-knowing was described by the Reverend Douglas E. Dandurand, Ph.D., as the space, “when role identity replaces soul identity, an incredibly painful and hollow feeling becomes pervasive.” This “avoidance of self”—my definition of addiction—links to suicidal risk.

As a psychiatrist boarded in Addiction Medicine, I am well-aware of the long-term health, psychiatric, and social risks associated with addiction. I have yet to meet a person struggling with addiction who set forth to develop this disease. Rather, it is a disease born out of other risks, risks incurred during an earlier, developmental phase of life. Epidemiological studies demonstrate that addiction is an adolescent disorder, and life-long challenges with addiction are associated with onset of use prior to 18 years of age.

To understand the long-term course of this disease and how people with addiction can recover and sustain recovery, we must look to the neurobiology of stress. As a developmental psychiatrist and traumatologist, I have studied and observed firsthand the profound effects caused by prolonged and unmitigated stress, including alterations in two important and intertwined neuroendocrine pathways: the reward pathway and the regulation pathway. The latter term, I evolved through my practice, describing for my patients the hypothalamic-pituitary-adrenal axis (HPA) plus the extended limbic system, which serves as the translator of emotions throughout the body. Both pathways share a common goal: survival.

The reward pathway is known for making us “feel good.” It embeds a powerful reinforcement mechanism to ensure that we will repeat the “feel good” behavior (e.g., eating, procreating, accomplishing, etc.). It promotes survival. The regulation pathway is known for maintaining health or metabolic homeostasis via modulation of major systems (e.g. cardiovascular, endocrine, immune, etc.). It maintains survival. The limbic system and HPA interface through the hypothalamus, thereby forming the regulation pathway. I view the hypothalamus as the mind-body nucleus, through which the experience of

Continued on page 10...
emotions—suppressed or expressed—and automatic thoughts and memories—conscious, subconscious or unconscious—directly influence health via the confluence of neuro-immune-endocrine modulation. When generally content, we tolerate intermittent stress well and return to metabolic homeostasis. We also engage in behaviors that reinforce contentment or the feeling of well-being.

In contrast, prolonged or excessive activation of the stress response system is experienced as distress, and ultimately, toxic stress. Without buffering mechanisms, chronic overstimulation of the HPA leads to metabolic imbalances and gives rise to physical and psychiatric pathologies that are also dependent on underlying genetics—the epigenetic effect of chronic stress. Consequent metabolic-emotional-mental changes eventually give rise to the dysregulation pathway and a chronic aversive state or dissonance. The reward pathway subsequently shifts from the mission of potent, positive reinforcement (promote “feel good” and contentment) to a powerful negative reinforcement (remove “feel bad” and aversive states). The predictable emotional-behavioral-mental changes eventually give rise to the addiction pathway.

Despite the broadly recognized conditions of prolonged stress during medical education and training, career building, and the strain on personal and healthy relationships (which may otherwise serve as stress deactivating mechanisms), physicians are rarely educated about the risks of addiction and depression. Under conditions of prolonged stress from career and other demands, the adult must bolster protective factors, akin to the role of caring and supportive parental relationships in the lives of children who thrive despite adversity. Nor are physicians educated about contentment, and its essential role in wellness, though we can achieve contentment through simple grounding activities that increase communication with self. Some examples include exercise, rest, and fun with friends. My favorites are yoga, meditation, prayer, writing poetry and cooking with family and friends. All these examples promote wellness and return to homeostasis.

Impairing health and homeostasis, physicians have historically adopted defensive mechanisms, resulting in disconnection from self: “when role identity replaces sole identity.” By definition, the role of a defense mechanism is to create a barrier between emotional experience and awareness. Neurobiologically, however, such barriers further contribute to the allostatic load of distress.

Moreover, physicians are typically trained to push through demands by ignoring their own needs. Observed tendencies such as emotional numbing and aloofness, are often resulting from the near constant onslaught of demands related to patient responsibility and reinforced by monetary and professional rewards. Despite widespread, anecdotal recognition that demands are excessive and/or prolonged, reflected jokes such as “I’m dead inside, too” are not uncommon. Escape from “feeling nothing” can be quickly remedied with a bolus of “feel good, wanton” dopamine. However, as soon as the highly reinforcing hit of dopamine wears off, the numb, detached, unnatural state returns and the individual is left with an ever-widening chasm between self and the environment.

**Physician, Heal Thyself**

Through my research and practice, I have come to call addiction “an avoidance of self,” a term that resonates with my patients. While sobriety may be achieved in isolation, recovery is achieved through (re)connection with self and others; it is through connectedness that the complex neurochemistry can be nurtured back toward the homeostatic norm of truthfulness with self: the essential goal for sustained recovery. Such truthfulness is an integration of examined behaviors, thoughts and emotions, including cravings. Sometimes, getting to truthfulness requires medication-assisted treatment in order to mitigate the physical symptoms of withdrawal, combined with therapeutic and psychiatric treatment to achieve stabilization and treat co-morbid mental health conditions. As addiction and depression manifest from a multi-layered process, recovery requires a multi-faceted approach.

Understanding the complex neurobehavioral, epigenetic, and sociologic underpinnings of addiction, and treating adults suffering from their consequences, has become my life’s work: the sine qua non of my practice. Help is available here in Utah for professionals with addiction problems, built on a full complement of science-based, outpatient services to help achieve and sustain recovery. Medical and clinical teams can help adults restore and maintain their integrity, and sustain healthy and loving relationships, including with their re-integrated self, through scientifically informed and wellness-based practice, which promotes innovating their lives, long-term recovery, and keeping clinical care sober.

*Every journey of a thousand miles begins with one step.* —Chinese Proverb
Susan Wiet, M.D. is the founder/owner and medical director of Sovegna, the Center for Addiction Treatment and Recovery in Salt Lake City, Utah, where she has a fulltime psychiatry and addiction medicine treatment practice. Dr. Wiet is board certified in child and developmental and adult psychiatry and addiction medicine. She can be reached at swiet@sovegna.com. Visit www.sovegna.com for information about addiction, treatment, and recovery programs for professionals.

References
Utah controlled substance prescribers will want to be aware of new information available when logging in to the Utah Controlled Substance Database (CSD). A Prescriber Dashboard within the CSD is helping physicians view their own controlled substance prescribing behavior and understand how their controlled substance prescribing patterns compare to their peers. In fall 2019, reports began to appear within the CSD to prescribing physicians that allow them to view their own controlled substance prescribing behavior and benchmark their prescribing to Utah peers with the same licensure and throughout Utah; and in 2020, data benchmarking a prescriber to Utah peers in their specific specialty will become available. Additionally, controlled substance prescribers can see their CSD utilization and compare it by profession, state, and later, specialty. All these efforts are designed to give physicians as much information as they can to understand their patients and their own prescribing.

Controlled substance prescribers will see a “Prescription Report” that informs them about the numbers of patients in their CSD data that use higher doses of opioid pain medications (over 90 Morphine Milligram Equivalents), concomitant benzodiazepines and opioid fills, and patients that use more than three opioid prescribers, or use more than three pharmacies to fill their controlled substance prescriptions. These metrics originated with extensive analysis of CDC data and are intended to alert prescribers to higher risk situations for unintended opioid overdose.

Controlled substance prescribers will also see a “Usage Report” that lets them know if they are logging in to the CSD at a similar rate to peers. CSD usage is required by law and reviewing a patient’s history is a best practice to avoid overprescribing and to reduce unintentional overdose from opioids. If your practice sees patients that need acute prescriptions for pain or mostly one-time opioid therapies, you or your CSD-authorized proxy should log on to the CSD every time a controlled substance prescription is made. Utah law states, “A prescriber shall check the database for information about a patient before the first time the prescriber gives a prescription to a patient for a Schedule II opioid or a Schedule III opioid.” Utah Code 58-37f-304(2).

If you have a practice that refills opioid prescriptions for chronic pain treatment, Utah law specifies, “A prescriber is also required to periodically check the database or similar records if the prescriber...”
is repeatedly prescribing Schedule II or III opioids to a patient. Utah Code 58-37f-304(2). If you need assistance to designate CSD-authorized proxy staff to help you review the CSD as directed by Utah law, see Proxy permission forms on the DOPL CSD page (https://dopl.utah.gov/csd/index.html).

Finally, prescribers can view PDFs of patients’ court reports and hospital overdose reports within the “External Records” area of the CSD.

So, what do you do now?
1. Make sure to log on to the CSD as authorized and check your reports.
2. Follow guidance in the Utah Clinical Guidelines on Prescribing Opioids for the Treatment of Pain and only use opioid pain therapies where they are indicated and appropriate.
3. Consider naloxone overdose rescue kit co-prescription for patients on regular, higher doses of opioids or on combined opioids and benzodiazepines.
4. Make sure your CSD-authorized proxies have their individual permissions aligned with your DEA number so you get credit for searches by your designated proxy staff. If you have questions about this, call the CSD at 801-530-6220.
5. Learn to read your reports and the CSD Dashboard prompts.

A free, on-line, 1-hour CME-accredited training on these features will be held on March 4, 2020, noon–1 p.m. for UMA members, and will be at the Ogden Surgical Medical Society meeting May 12, 2020 from 5:30 to 6:30 p.m. in Room 100 at the Ogden Eccles Conference Center. To register for either event, contact abutterwick@comagine.org

Sarah Woolsey, MD MPH FAAFP, is board-certified in Family Medicine. She has worked on quality improvement in outpatient settings for over 15 years and has many years of experience with underserved populations in Salt Lake City.
The biology professor and author Robert Sapolsky wrote of the “building blocks of psychological stressors” that adeptly describe the biggest drivers to burnout and mental illness. The biggest stressors tend to lack an outlet for frustration, such as exercise or a calming hobby; entail weak social support, or not having people one can trust and relate with who will sustain one amid struggles; lack predictability, or the inability to know in a general sense what to anticipate in life (as much as is possible); absence of control, or having little-to-no charge over circumstances; and a perception of things worsening. What does this describe other than modern-day medicine?

Many of us are growing a bit weary of hearing about burnout in our profession, but there is a reason that the conversation is so ubiquitous. There has been a dramatic increase in clerical paperwork required of physicians in recent years, the result of increasing administrative and regulatory burden. This loss of control, along with a lack of predictability of where our profession is heading, and oftentimes a lack of time or structure for an outlet for our frustrations, are huge contributors. The not uncommon abuse we receive from disgruntled patients only magnifies the above difficulties. What does this describe other than modern-day medicine?

We know many of the concerns that prevent us from seeking care. The medical culture of self-denial, perfectionism, and delayed gratification doesn’t allow for a physician to struggle. We don’t often have the time to get into a therapist or physician. If we are ashamed of what we’re experiencing, then we may not want to see an existing or potential colleague. We as doctors are more likely to self-medicate with drugs and alcohol than seek professional help. But one of the biggest reasons physicians delay or do not seek care for mental illness or suicidal thoughts is because of the concern about damage to our career. Many are thus leaving medicine entirely to avoid such consequences of our harmful environment, but most can’t because of the financial constraints of paying off student debt. All these factors also contribute to less stable personal relationships, creating the perfect storm of Sapolsky’s building blocks to stress which can lead to depression, anxiety, and a distorted worldview.

In Caroline Elton’s book Also Human, she points out that this isn’t only an American problem, but also seen elsewhere in the Western world, particularly in Great Britain. Nearly identical issues, nearly identical stigmas, nearly identical hang-ups in addressing physician mental illness persist and worsen, as in the US. They also have limited work hours for trainees, which are even more strict than in America, but with little improvement in the rates of physician illness. The stigma against physician weakness is just as strong, if not stronger, than what I have experienced as a physician with depression and anxiety. Even though every healthcare system is a little different, it really is all the same.
It’s tough to get exact numbers on physician suicide, but roughly one doctor dies by suicide every day in this country. This represents a rate two to three times higher than in the general population. State-wide numbers are very difficult to obtain, but the national numbers are likely an under-representation given that many loved ones may hide the cause of death given the above-mentioned stigma. Death by suicide among female physicians is higher than among male physicians, a reverse of what is seen in other populations, underscoring the unique nature of mental illness in physicians. Suicide isn’t always borne of mental illness but is almost always affiliated with despair and hopelessness.

Why do we continue to breed burnout, depression, anxiety, and suicide among our ranks? The pressures of practicing medicine are immense even before accounting for the growing external stressors of insurance companies and regulators. I was once the classic medical school interviewee, saying that I was entering medicine in order to help people. Like many of us, medical training beat that out of me and I’ve spent my relatively short career re-forming that desire. We have to take better care of each other. We all know the pains and privileges of being a physician, so we can’t ruin it for others through cruel pimping, working endless hours, and being critical of each other. We need to have compassion for one another. We need to support each other with time for treatment of mental illness, burnout, and for maintenance of wellness. We can change policies and regulations if we stick with it. It takes time but can provide the end that we need it to. We need to be open with one another of the struggles we have, to recognize that we are not alone in having problems. I’ve written a book about my experiences with mental illness because it’s a sentiment that needs sharing. And we need to continue to fight the broken system that is creating broken healers.

After all, how can we heal others if we can’t heal ourselves?

Kyle Bradford Jones, MD is a Family Physician in Salt Lake City. He is author of the forthcoming book Fallible: a memoir of a young physician’s struggle with mental illness which can be ordered through kylebradfordjones.com.
Social Determinants of Health (SDoH), health-related social needs, social and behavioral risk factors are terms that are gaining traction in population health circles, even though there is some discrepancy in the ‘appropriate use’ of the terminology. Regardless of the term(s) used, emerging research demonstrates the importance of health-related social needs—such as food insecurity, housing instability, lack of transportation—on health outcomes.

According to the National Academy of Medicine¹, social factors can be responsible for up to 80% of modifiable contributors to health outcomes. Studies² have found an association between conditions of social deprivation and undesired health outcomes, like increased hospital readmissions. One study found patients with food insecurity reportedly cost nearly twice as much³ as their well-nourished peers, in part due to increased hospitalizations and higher readmission rates.

In December 2019, the American Journal of Preventive Medicine⁴ devoted an entire journal supplement to research on health sector interventions on social risk, including payment structures aligned with these efforts. A recent report from Leavitt Partners⁵, based on a survey of employer and physician efforts to address social needs, finds that a significant driver of programs to address patients’ social needs is physician participation in value-based payment arrangements, such as Accountable Care Organizations (ACOs) or other risk- or shared savings-based programs. As these payment models proliferate, the importance of having a plan to address patients’ social needs becomes even more poignant. Research⁶ indicates patients are receptive to this kind of screening in health care settings. So how do you get started? Whether you practice in primary or specialty care, Comagine Health has produced several resources to help you initiate social needs screening and referral with your patients.

First, we have produced a clinic workflow toolkit⁷ that can help you identify where to start, using data from our community partner, Utah 211⁸. This toolkit will help identify the top social needs in the ZIP codes where your patients reside—to get started, you can pick one of the social needs to start screening and referring for services (Screening is the first step in the ideal social needs framework below).

Next, select a screening tool that will enable you to ask about these social needs in your patient population. The Social Interventions Research & Evaluation Network (SIREN) has a good crosswalk⁹ of screening tools. These screening tools are typically designed to accommodate a variety of reading levels and can be effectively administered and scored by trained practice staff, such as medical assistants, case managers, Community Health Workers or social workers.

Once you’ve identified needs, it’s time to enlist the support of community-based organizations like Utah 211 to help you link your patients to needed services where they live. Utah 211 maintains an up-to-date database containing information on over 2,700 providers of almost 10,000 different services across Utah, including shelter, clothing, food, transportation, access to appropriate health care and personal safety. The services are available 24/7 in over 200 different languages and via phone, app, website, text, and email. For more information on engaging with and an overview of the services available from Utah 211, please review a webinar¹⁰ from August 2019.

Once an effective process is in place, you can scale up from there. As you gain confidence in screening, referring, and linking patients to community resources, you can also utilize more sophisticated features of the Utah 211 website, such as creating an account to maintain your customized and up to date lists of frequently used resources. Independently developing and maintaining your own list of resources can be unmanageable, so rely on the experts at
Utah 211 to deliver the most current information to you and your patients. More information about these tools can be found by reviewing another webinar\(^1\) from November 2019.

Looking forward, stakeholders in Utah's health-related acute, ambulatory, and IT systems are partnering with Utah 211 and its statewide network of community-based organizations to build a 'closed-loop' approach to social needs information and referral, a community information exchange or CIE. Much like a health information exchange or HIE, a CIE makes use of all relevant information about a patient's life circumstances and history of interactions with health and social service providers, to enable efficient, targeted interventions. Although we're still in the early stages, other communities\(^2\) have demonstrated the value proposition of bringing this information together and using it to improve health outcomes for residents.

Comagine Health is available to help you navigate the social needs screening and referral process as part of a comprehensive population health strategy for your practice. We are currently accepting practices to join our CMS-funded practice transformation partnership that may enable you to receive subsidized consulting technical assistance at no charge. Please visit the Comagine Health website at www.comagine.org/partnership for more information or to reserve a place for your practice in this partnership.

Dave Cook is the Director of Practice Transformation for Comagine Health (formerly HealthInsight). He is experienced in managing complex quality improvement (QI) projects with demonstrated impact. He has rich experience facilitating health information technology adoption, meaningful use, work process redesign, and the use of QI tools to improve patient care.

Kimberly Mueller is the Director of Analytic Operations for Comagine Health. Her experience includes data collection, validation, analysis, and feedback to support data-driven healthcare quality improvement projects. She is also a Licensed Clinical Social Worker with over 10 years of clinical practice in both inpatient and outpatient healthcare settings.

References


6 “Patient Acceptability of Social Risk Screening,” accessed on December 2, 2019 at: https://sirenetwork.ucsf.edu/sites/sirenetwork.ucsf.edu/files/PatientAcceptibilityWebinar.pdf

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8 https://211utah.org/

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10 How Utah 211 Can Help Address Social Determinants of Health,” accessed on December 2, 2019 at: https://www.youtube.com/watch?v=us8TXQ0pFRdws&feature=youtu.be

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12 “Community Information Exchange, San Diego,” accessed on December 2, 2019 at: https://chesandiego.org/; also “Dallas Connected Communities of Care,” accessed on December 5, 2019 at: https://sirenetwork.ucsf.edu/sites/sirenetwork.ucsf.edu/files/PatientAcceptibilityWebinar.pdf

americanacademyofaddictionpsychiatry.org is the Data 2000 Sponsor for this training (https://pcssnow.org/)

Funding for this initiative was made possible (in part) by grant no. 1H79TI081968 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Does the law impose a mandatory retirement age for physicians? If not, may employers take it upon themselves to require physician-employees to retire at a particular age? And if mandatory retirement is not an option, what other options exist to remove underperforming, older physicians? An older physician whose skills, abilities, or competence may have worn away with time (or where there is simply the fear that has occurred) brings two central concerns into conflict: on the one hand, the paramount concern of public safety and professional competence, and on the other hand, fairly judging an employee’s ability to work not by age, but by merit and demonstrated skill. This conflict plays out in every work setting, but it can be particularly heightened in the field of medicine.

In some professional work settings, the conflict is resolved on the side of public safety and competence, with mandatory retirement ages set by law. In the profession of law, many jurisdictions in the United States impose mandatory retirement ages for judges. For example, Missouri’s Constitution requires state judges to retire at the age of 70; in Colorado, judges must retire at 72. In the aviation industry, pilots cannot fly commercial airlines domestically once they turn age 65.

Commercial pilots flying internationally must also abide by standards imposed by the International Civil Aviation Authority: a pilot who is 60 years or older may only serve as pilot-in-command if there is another pilot in the crew who is not older than 60.

In at least one major way, these mandatory retirement ages are suspect: in analogous, or almost identical, settings, either no mandatory retirement age exists, or it is set much higher. If state court judges must retire at age 70, then surely United States Supreme Court Justices, who sit on the highest court in the land and decide legal issues of utmost national significance, must retire at age 70, too, correct? But the U.S. Constitution imposes no such requirement. Justice Oliver Wendell Homes, Jr. was 90 when he retired. Similarly, although commercial pilots may not be able to fly past a certain age, a federal appellate court has held that similar mandatory retirement ages may not pass muster for an airline manufacturer’s jet transport pilots.

Continued on page 20...
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Physician-Employees are Protected from Age Discrimination

Lawmakers and professional regulators, perhaps implicitly recognizing the arbitrariness and unfairness in mandatory age retirements, have imposed no such requirements for physicians who are employees. To the contrary, physician-employees may enjoy significant federal and state protections from age discrimination, and health care employers who may be tempted to require physician-employees to retire based on age would be strongly advised against doing so.

Under the Age Discrimination in Employment Act (“ADEA”), it is unlawful for a qualifying employer to classify employees “in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual’s age.” Almost every state has an ADEA analog. These anti-discrimination laws recognize that chronological age is not an indicator of competency and should not be used to drive out older workers. As the U.S. Supreme Court has observed, “throughout the legislative history of the ADEA, one empirical fact is repeatedly emphasized: the process of psychological and physiological degeneration caused by aging varies with each individual.” As a result, “many older American workers perform at levels equal or superior to their younger colleagues.” Thus, the ADEA’s baseline assumption is that age itself should not drive employment decisions.

Although the ADEA contemplates certain exceptions to its general rule, allowing employers to establish a legitimate age-based criterion referred to as a bona fide occupational qualification (“BFOQ”), employers would be very hard pressed to justify an age-based BFOQ for physicians. A physician’s skill and competence cannot be reasonably measured by age, which is one legal requirement. One article has reported that, while older surgeons were more likely to have poor outcomes in pancreatectomy, carotid endarterectomy or coronary artery bypass graft surgeries, there was no age effect for five other surgical procedures. Further, there are numerous ways to test a physician’s skills and competence on an individual basis, making it even more difficult to justify a BFOQ under the law. Regardless, it does not appear that any court has upheld an age-based BFOQ for physicians.

To the extent an employer were to try to argue that public safety requires older physicians to retire, under regulations promulgated by the Equal Employment Opportunity Commission (EEOC), the employer will bear the burden to “prove that the challenged practice does indeed effectuate that goal and that there is no acceptable alternative which would better advance it or equally advance it with less discriminatory impact.” This is a very high burden.

In sum, age-based mandatory retirement plans for physician-employees are unlikely to be upheld in courts. The EEOC has
Contrasting Physician-Employees with Physician Owners or Independent Contractors

The picture may be decidedly more complex for physicians who are not classified as employees, but who are partners, members, or owners of physician practices, or who are classified as independent contractors. Just because a physician is a member, partner, or owner of a practice does not mean that anti-discrimination laws do not apply to that physician. Rather, courts generally examine six factors, such as the extent the practice supervises the physician and whether the physician can influence the practice, to determine whether the physician is actually an employer who does not enjoy the age discrimination protections described below, or whether the physician is an employee. In at least one case, a court concluded that a physician-shareholder was not an employee because, in part, she had an equal right to vote on matters, shared equally in the firm’s profits and liabilities, and participated in decisions to hire and fire employees. But courts will analyze the “substance of the relationship rather than the label affixed thereto,” and if a physician is more an employee than a bona fide partner, member, or owner, a physician may enjoy the same age-discrimination protections that apply to employees.

Similarly, as a general rule, physicians who are classified as independent contractors are not protected by age discrimination statutes. But even if physicians agree to call themselves independent contractors, courts in Missouri, for example, will assess whether they actually fit the definition of an independent contractor, which is “one who contracts to perform work according to his own methods without being subject to the control of his employer except as to the result of his work,” and who “are typically hired to complete a specific task, use their own tools in completing their work, are paid a fixed sum on a by-the-job basis, and are not provided with benefits.” A physician who does not fit this bill may be an employee who cannot be discriminated against on the basis of age.

Thus, although physician partners, members, owners, or independent contractors may not possess age discrimination protections, physician practices must fully explore and assess their liability before requiring such physicians to retire based on their age, especially since laws vary from state to state, contracts impose different obligations, and circumstances must be evaluated individually. Even if a physician practice is dealing with a bona fide owner or independent contractor who is forced to retire, that physician may still try to challenge the practice’s actions in court based on age discrimination and other laws. As a result, physician practices considering imposing mandatory age retirements for owner or independent-contractor physicians must proceed cautiously and thoughtfully.

This is so not just for legal reasons, but for pragmatic and fairness reasons, too. Apart from any legal obstacles, there is a pressing need for older physicians to continue to practice medicine. The AMA and the American College of Surgeons have acknowledged that approximately 26% of physicians are over the age of 65, and “one-third of all practicing surgeons are older than age 55.” If physicians were subject to the same age requirements as commercial airline pilots, a quarter of the physician workforce would vanish. Additionally, by 2025, the U.S. will have a shortfall of physicians from between 61,700 to 94,700. Employers may not only face legal liability for imposing mandatory retirement, but they may be shooting themselves in the foot: by requiring skilled physicians to retire, employers may be depriving themselves of the individuals they need to perform work. And skilled physicians do not come cheap and are not quickly trained; jettisoning older, skilled physicians is a terrible waste, especially when society needs them and especially when they want to continue to work. In sum, a mandatory retirement age may not be fair to physicians and may not serve the best interests of physician practices.

Employers Should Work One-On-One with Physician-Employees to Improve Performance

If employers cannot mandate retirement for physician-employees, and if physician practices may not want (or may not be able to) require retirement for physician owners or independent contractors, what options exist to ensure that older physicians remain competent? How can employers strike the right balance between not discriminating against a physician on the basis of age while still ensuring patient safety?

Instead of imposing mandatory retirement, some employers may be tempted to impose mandatory skills testing or medical testing for employees of a certain age. This too would be ill-advised. In one federal case from New York, the plaintiff-employee was denied a promotion after he refused to submit to an EKG, which the employer required for candidates over the age of 40 seeking supervisory positions. The court held that the EKG requirement violated the ADEA, observing that although “medical testing” for “all those above a certain age is,
Perhaps, a practice less noxious under the ADEA than firing outright," because a "facial age classification is still involved," that classification has to be "justified as being reasonably necessary to the operations of the [employer’s] business in order to withstand scrutiny."25 Similarly, in another case, a court concluded that a law requiring all state employees over the age of 70—regardless of position—to take and pass an annual physical examination violated the ADEA.26 Although testing based on age is not permitted, if all employees in a particular position must be tested, then such testing may pass muster.

Since mandatory skills or competence testing based on age is not a viable solution for health care employers, to ensure patient safety and adherence to care standards, employers should scrupulously follow a quality assurance and improvement program. Further, employers should have procedures in place to conduct individualized medical inquiries of impaired physicians or physicians who are failing to meet the standard of care. For example, the Joint Commission’s Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation processes, which strive to provide objective and accurate assessments, allow employers to identify physicians who may not be meeting the standard of care.27

But even here, employers must be careful: disability anti-discrimination laws prohibit employers from making disability-related inquiries or requiring a “medical examination”28 from employees after employment has begun unless the inquiry or examination is job related and consistent with a business necessity.29 The term “job-related and consistent with a business necessity” requires a reasonable belief based on objective evidence that an employee’s ability to perform the essential job functions will either (1) be impaired by a medical condition or (2) pose a direct threat due to a medical condition.30 A direct threat determination must be based on an individualized assessment of the employee’s present ability to safely perform the essential functions of the job.31

All of this teaches a vital lesson for employers working with older physicians whose skills or abilities may have declined over time: employers must focus on performance—not age. Employers and physicians, who have an ethical duty to provide competent care,32 should concentrate not on age, which is an unreliable indicator of performance, but instead on the quality of care a physician provides to patients. In those circumstances where an older physician’s skills and competence are not meeting standards, employers should work with those physicians to determine what steps, if any, can be taken to ensure those standards are satisfied. In doing so, age should never be used as a proxy for performance or talked about as such. Generally, this is also a best practice for physician practices dealing with physician owners or independent contractors, even if such practices may not be bound by the same legal anti-discrimination requirements.

For the same reasons that lawmakers and regulators have declined to impose a mandatory retirement age for physicians, employers should work with older physicians one-on-one to identify and correct performance deficiencies that may jeopardize patient safety. If those deficiencies cannot be timely and satisfactorily corrected, then employers may need to modify, or even terminate, physicians’ employment. By focusing only on performance and communicating standards clearly and professionally, however, employers greatly improve their chances that their physician-employees will recognize that the time has come to make certain changes to their practice, or even to cease practicing. That momentous decision, however, is not one that employers can make for physician-employees based on their age. And even though that is a decision that physician practices may (subject to all the limitations described above) be able to make for physician partners, members, owners or independent contractors, the possible disruption, difficulty, and unfairness caused by mandatory retirement counsels against doing so.

Authors: Barbara Grandjean, JD, a partner, and Chad Grell, JD, an associate attorney, both in Husch Blackwell’s Denver office, wrote this article, with contributions from Tracey O’Brien. Barbara and Chad specialize in defending employers, especially hospitals and other healthcare providers, against allegations of age and other types of discrimination. The information contained in this article should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only, and readers are encouraged to consult their own attorney concerning their specific situation and specific legal questions. Contact: Barbara.Grandjean@huschblackwell.com or Chad.Grell@huschblackwell.com. Reprinted with permission of Missouri Medicine: The Journal of the Missouri State Medical Association
1. Mo. CONST. art. 5, § 26(1) (“All judges other than municipal judges shall retire at the age of seventy years, except as provided in the schedule to this article, under a retirement plan provided by law.”); C.R.S. Const. Art. 6, § 23(1). According to the National Center for State Courts, thirty-two states and the District of Columbia impose mandatory retirement at an average age of 72. [https://www.ncsc.org/newsroom/backgrounder/2012/mandatory-retirement.aspx]

2. 49 U.S.C.A. § 44729(g), (c)(1).

3. [https://www.supremecourt.gov/about/faq_justices.aspx]

4. See EEOC v. Boeing Co., 843 F.2d 1213 (9th Cir. 1988).

5. The question of whether a physician-shareholder is also an “employee” for purposes of the ADEA is a fact intensive one that is based on a review of the totality of the circumstances.

6. 29 U.S.C. § 630(b) (defining an employer as a “person engaged in an industry affecting commerce who has twenty or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year”).


10. Id.

11. 45 C.F.R. §911.13 (HHS regulations); 45 C.F.R. § 90.14 (ADEA regulations)


13. 45 C.F.R. §911.13 (HHS regulations); 45 C.F.R. § 90.14 (ADEA)


16. EEOC, Press Release, $27.5 Million Consent Decree Resolves Age Bias Suit Against Sidley Austin, (October 5, 2007), available at: [https://www.eeoc.gov/eeoc/newsroom/release/10-5-07.cfm]

17. In the 2003 case of Clackamas Gastroenterology Associates, P.C. v. Wells, 538 U.S. 440, the United States Supreme Court identified a list of six, non-exhaustive, factors that were relevant to making this determination: (1) whether the organization can hire or fire the individual or control the individual’s work; (2) the extent to which the organization supervises the individual’s work; (3) whether the individual reports to someone higher up in the organization; (4) the extent, if any, to which the individual can influence the organization; (5) the parties’ intent for someone to be an employee; and (6) whether the individual shares in the organization’s profits, losses and liabilities.


26. EEOC v. Commonwealth of Massachusetts, 987 F.2d 64 (1st Cir. 1993).


28. A “medical examination” has a specific meaning in the context of the federal discrimination statutes. The EEOC considers it to be a procedure or test usually given by a health care professional or in a medical setting that seeks information about an individual’s physical or mental impairments or health. Medical examinations include vision tests; blood, urine, and breath analyses; blood pressure screening and cholesterol testing; and diagnostic procedures, such as x-rays, CAT scans, and MRIs. “Medical examination” is distinguished by the EEOC from other types of tests such as physical agility tests or drug tests. Questions and Answers, EEOC Enforcement Guidance on Disability Inquiries and Medical Examinations of Employees under the ADA, 915.002 (July 27, 2000), available at: [https://www.eeoc.gov/policy/docs/qanda-inquiries.html]


31. Id.

32. AMA Code of Medical Ethics (“A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”)
Throughout 2019, many physicians were hearing one word over and over again: Recession. There was a reason for that word being so prominent in the minds of investors—many of the traditional indicators were signaling an economic slowdown ahead.

Rather than a stock market meltdown or slowing job growth, investors and those saving for retirement through their 401k’s (and more) have instead seen the major benchmarks reach record levels in recent weeks. Job growth has smashed expectations and unemployment is at a 50-year low.

Those positives have quieted much of that recession talk. Economists put the odds of a recession starting by the end of 2020 at 43 percent as of December, down from 60 percent in June, according to results of surveys conducted by the National Association for Business Economics.

“All the bears have gone into hibernation,” Matthew Miskin, a co-chief investment strategist at John Hancock Investment Management, told members of the media during the company’s recent 2020 outlook event held in New York. “We’re sitting here near all-time highs.”

Without question, there were a few rough patches in the market over the course of the year. But moves from the Federal Reserve, including three interest rate cuts that made money cheaper to borrow, have helped keep the economy humming and the market climbing higher. These cuts have certainly not occurred without controversy but for now, they seem to have worked for the near term intended effect. As with all economic policy decisions, the long-term consequences have yet to be determined.

Despite the geopolitical events taking place as I write this article, there is this idea of everything being awesome right now as we savor these all-time highs and low volatilities of 2019. I counsel the physicians I meet with to enter 2020 with some caution.

Wall Street stock forecasters currently project that the S&P 500 will finish 2020 at about 3,272, which is less than 5 percent above its current level. While that’s a smaller percentage of growth than recent years, it’s still more than inflation.

For example, of the 53 professional forecasters who make up the panel of the National Association of Business Economics survey, no one predicts a 2020 recession, and a model from Goldman Sachs estimates that there is a less than a 25 percent chance of a recession in the next 12 months.

Still, you can prepare for any kind of economy this year by taking steps to reduce your debts and remaining consistent with your long-term investment strategy. I would also encourage you to reach out to your UMAFS advisor and schedule a meeting soon. If you are not a client with UMAFS, consider receiving a second opinion.

In 2020, I start my 21st year with UMA Financial Services. UMAFS is solely owned and operated under the Utah Medical Association and remains one of the truly objective financial advisory firms in the state of Utah and the entire United States of America. We were created to help the physicians of Utah. Our mission remains pure and focused thanks to the wonderful physician members of the Utah Medical Association. It’s has been an honor and privilege to help and serve each of you over the past twenty-one years. I hope you have a wonderful 2020.

Patrick J. Brady CRPS®, AIF® is a Vice President and Financial Advisor for UMAFS. He joined UMAFS in 2000, bringing his valuable experience with high net-worth clients. His strong economic and financial background strengthens his commitment to providing objective, unbiased advice to help physicians achieve their financial goals.
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In December 2019, the Utah Department of Health (UDOH) received approval from the Centers for Medicare and Medicaid Services (CMS) to implement full Medicaid expansion in the state. The expansion will extend Medicaid eligibility to Utah adults whose annual income is up to 138% of the federal poverty level ($17,236 for an individual or $35,535 for a family of four). The federal government will cover 90% of the costs of these services, with the state covering the remaining 10%.

Enrollment and coverage for the newly eligible individuals will begin on January 1. It is estimated that up to 120,000 Utah adults are eligible for the expansion program.

Some newly eligible adults will be required to participate in a community engagement requirement in order to receive benefits. Exemptions from the self-sufficiency requirement will be provided for anyone who meets one of 13 exemption criteria, including those who are age 60 or older, pregnant, caring for young children, already working at least 30 hours a week, or students. Those who are subject to the community engagement requirement will need to complete an online job assessment, online training programs, and 48 job searches within the first three months of eligibility. Failure to complete this process will result in termination of benefits.

In addition, the state will require newly eligible adults to enroll in their employer-sponsored health plan if one is available. Medicaid will then cover the individual’s monthly premium and other out-of-pocket expenses like co-pays and deductibles.

The waiver request for this expansion included other program components including premiums and surcharges for those more than 100% of the federal poverty level, housing supports, and penalties for intentional program violations. The CMS is still reviewing these program components and they may be added to the expansion program if the CMS approves them at a later date.
To be eligible for the Adult Expansion Medicaid program, participants must:

- Be a Utah resident
- Be age 19 through 64
- Be a U.S. citizen or legal resident
- Meet income requirements, which vary by household size:

<table>
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<th>Monthly</th>
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Since the program opened enrollment in April, enrollment has steadily grown with more than 40,000 adults currently enrolled as of November 2019 (Fig. 1).

Of all Adult Expansion enrollees, 55 percent are between the ages of 26–44. Seventy-three percent of enrollees reside along the Wasatch Front (Salt Lake, Utah, Weber, and Davis local authorities). Additionally, membership gender is split nearly equally with 51 percent female and 49 percent male.

**Expansion Enrollment**

*The Targeted Adult Medicaid (TAM) program was the first expansion effort in Utah, implemented in November 2017. The program is intended specifically for low-income individuals who are chronically homeless, need substance abuse treatment, or are involved in the justice system.*
CME Calendar

FEBRUARY 2020
8 New Cardiovascular Horizons
SLC, CM, (6.5)
9–12 61st Annual OB-GYN Update
Park City, UUCME (18.0)
9–13 65th Annual Update in Anesthesiology
Canyons Resort, UUCME (29.0)
9–13 33rd Annual PC Anatomic Pathology Workshop
Deer Valley, UUCME (21.0)
10 Medical Cannabis Conference
Murray, IHC (4.0)
14 MOCA - Anesthesiology Simulation 2019
SLC, UUCME (7.5)
20 Trans & Gender Non-Binary Clients: Clinical Issues & Treatment Strategies
SLC, PESI (6.0)
20–22 4th Annual Sports Medicine Symposium
Park City, UUCME (11.75)
24 Autism Translational Research Workshop
BYU Provo, TRH (7.0)
28 UOS 41st Annual Conference
SLC, UOS (7.25)
28–29 13th Annual Western Atrial Fibrillation Symposium
Park City, ESI (20.75)

MARCH 2020
6–8 Therapeutic Endoscopy Course 2020
Park City, UUCME, (20.5)
13–15 Rocky Mountain IBD Course
Park City, UUCME (9.0)
23–25 19th Annual Generations
Salt Lake City, ESI (21.75)
27 Medical Cannabis Conference
St. George, IHC (4.0)
27 Practical Dermatology for Primary Care
SLC, UUCME (8.0)
27–29 Emergency Medicine for Primary Care
Park City, MER (12.0)
28 Intermountain West Hepatology Update
SLC, UUCME (9.0)

APRIL 2020
10 Half and Half MAT Waiver Training
SLC, UUCME (4.0)
27–28 2020 Geriatric Conference
SLC, PESI (14.5)

MAY 2020
12–15 Ogden Surgical Medical Conference
Ogden, OSMS (28.5)

CME Spotlight

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

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

Following this activity, learners should be able to:

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

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

ama-assn.org eMedEvents.com

FEBRUARY | MARCH 2020
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>Website</th>
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</thead>
</table>
| ACOG    | American College of Obstetrics and Gynecology  
         | UT Chapter, SLC, 801-747-3500 |
| ACP     | American College of Physicians  
         | UT Chapter, SLC, 801-582-1565 x2441 |
| ACS     | American College of Surgeons  
         | Email UtahATLS@gmail.com for info about ATLS |
| AMA     | American Medical Association  
         | Chicago 312-464-4761 |
| AUCH    | Association for Utah Community Health  
         | SLC, 801-924-2848 |
| CA      | Collegium Aesculapium  
         | Orem, 801-802-0449 |
| CM      | Cine-Med  
         | Woodbury CT, 800-253-7657 |
| ESI     | ESI Management Group  
         | SLC, 801-501-9446 |
| HI      | HealthInsight  
         | SLC, 801-892-6645 |
| IASIS   | IASIS Healthcare  
         | SLC, 801-984-2384 |
| IHC     | Intermountain Healthcare CME  
         | SLC, 801-842-5498 |
| LVH     | Lakeview Hospital  
         | Bountiful, 801-299-2546 |
| MER     | Medical Education Resources  
         | Englewood CO, 800-421-3756 |
| MM      | Mountain Medical Physician Specialists  
         | 801-866-2977 |
| MVH     | Mountain View Hospital  
         | Payson, 801-465-7073 |

The following websites offer online continuing medical education:

cme.utahmed.org  
psnet.ahrq.gov/cme  
thedoctorsschannel.com/cme  
freecme.com  
pri-med.com/pmo/OnlineCME.aspx  
medicine.utah.edu/cme

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vlh.com  
nejm.org/continuing-medical-education

reachmd.com/programs  
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Earn-Credit/Earn-credit-page.html  
primarycarenetwork.org  
emedeevents.com
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