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Summer greetings! Regarding COVID19, we seem finally to be in the bottom of the ninth inning, hallelujah and yet not quite amen. With nearly half of our eligible Utah population vaccinated, the reprieve from masking and social distancing without an upshot in ICU census has been most welcome. I would like to extend a special thanks to the “first responders” in our midst, those of you who work the ERs, Instacares, and primary care clinics, who were willing to risk your own health to protect public health, and individual patients. I would especially like to thank the “tertiary responders” in our ICUs who helped those most-afflicted through all stages of this pandemic. It goes without saying that as physicians we recognize and are grateful for all the frontline nurses and staff, in hospital and clinic settings, who make what we do possible.

As schools shutter for summer and masks come off, please continue to encourage the wary and skeptical among your patients, staff, family, and friends to be vaccinated. Tell them what you know and be candid about what we really do not know. If you have war stories about patients you have cared for, or your own COVID19 illness, please share. Sharing is therapeutic even if they never pursue vaccination. I am hopeful that FDA approval for the vaccines will come in September, without a fall surge.

The CDC still recommends that masks be worn by everyone in health care settings through September 13, 2021, even if they are fully vaccinated, and especially if they are not vaccinated yet. This is also true in transportation hubs and transportation venues. Please encourage and post “masks are always welcome” for anyone concerned or at risk, especially those who are immunosuppressed by health conditions or prescription medications, and those who have non-COVID respiratory conditions that may be contagious. We are thrilled to see less flu, RSV, and common cold. This preserves days in school for our children and at work for adults.

It has been interesting to see re-entry angst among many of my older patients and colleagues. A little statistics refresher regarding the real current risks of exposure and illness, with vaccine status and local community prevalence in mind, has been helpful in some cases. Believe it or not, even if it’s decades old and in need of dusting off, your math and stats is better than most. Some have internalized “the fear” or are having trouble shaking off the blues, others just got used to the quiet life alone indoors and learned to like it, along with online shopping.

The second defining feature of this UMA year has been the scope of practice discussions. The PAs want to practice independently, as NPs do, and pharmacists, optometrists, podiatrists, physical therapists, and...and.... and the question begs, with an alternative pathway to primary care, why bother going to medical school? Will for-profit and online DO, NP, PA and other programs usurp the role of university medical schools? What does this mean for the character, tone and timbre of medicine and patient care? For patient safety? For MDs and DOs? Will MDs and DOs be able to practice independently anymore, or only as part of an institutional team? (For some this is a multigenerational set of questions as our children consider their choices in medicine, or not.)

Student debt is already a driving factor in choice of specialty and practice mode for MDs training in traditional allopathic programs. Why would we expect this...
to be any different in these alternative (and often for-profit) programs with equally high tuition? These programs have no obligation to ensure residency or employment for the graduate, and the for-profit business model of the program drives them to produce as many “tuition-paid” “graduates” as possible. The argument for expansion of scope is usually “access” in “rural” areas, but provider service distribution doesn’t actually change after an expansion of scope of practice, unless the arrangement is an enforceable contract.

How do patients discern the differences in our alphabet soup?

Who decides how many providers are enough? By type of training, or by specialty?

Is there an infinite supply of student loan money for aspiring medical and health science students?

How do you define and discern quality, or safety?

How super-specialized can a smart multiple-fellowship-trained practitioner be without getting bored to death after ten, or twenty years within that super-specialized “scope” or “turf”?

Thank you to all who participated in the legislative session in any capacity. With your engaged participation, medicine is and can continue to be richly satisfying. The Utah Medical Association is here to serve physicians and advocate to legislative and regulatory decision makers whatever comes, and we are stronger for every well-informed and vocal physician who engages.

Happy Spring! May it be full of sunshine, warm embraces and renewed will to fight the good fight on behalf of our patients and one another. ■

Yours,

Sharon R.M. Richens, MD
UMA President

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ABSTRACT
Medical students, residents, and practicing physicians experience high burnout, depression, and suicide rates, and the COVID-19 pandemic has exacerbated stress for many.1–6 While laudable, current well-being efforts appear insufficient to meet the challenges that so many are facing. This essay explores approaches that individuals and organizations can take to promote mental health and well-being from medical school to practice.

INTRODUCTION
Medical student, resident, and physician mental health has been the focus of growing concern in recent years as it becomes increasingly clear that burnout, depression, and suicide are serious problems.1–4 Mental health challenges from the COVID-19 pandemic have added new stressors—professional, personal, and financial—for many.5–6 Uncertainty—often a primary source of anxiety—has never been greater for so many of us. While significant numbers of medical schools and medical centers have ramped up their mental health services in recent months, these are not likely to meet the mental health needs of trainees and physicians in the face of widespread, unprecedented levels of stress and traumatic exposure in the healthcare setting. Using a treatment model, rather than a preventative model, to meet the mental health needs of physicians was not sufficient pre-COVID as burnout and depression rates remain stubbornly elevated—and it will not be sufficient in the midst, and aftermath, of this pandemic.

A PATH FORWARD
A number of foundational principles can inform approaches to a looming mental health crisis for physicians and trainees. First, we tend to conceive of well-being and mental health as binary—you are depressed or you are not; you are burned out or you are not. This is not accurate, and not particularly functional, because these conditions all exist along a continuum. Second, well-being may not be the best primary goal for our efforts. Instead, a more reasonable goal may be to increase satisfaction with your work, your life, and, for some, yourself. The goal should then be to help people move

As individuals cultivate skills to promote their own satisfaction and well-being, efforts must also be made to improve the clinical and learning environment.
up the continuum no matter where they are, so that if you are fairly satisfied, perhaps you can become very satisfied; and, if you are extremely dissatisfied perhaps you can become moderately dissatisfied. This, for many, will feel more attainable than reaching some magical state of well-being. Our focus cannot only be on those who meet a clinical diagnosis of depression or anxiety, or those who meet criteria for burnout; our approach must target those from across the continuum. Third, it’s important to note that encouraging physicians to work on their resilience comes with risks. Many physicians feel they are very resilient, and rightly so. They tolerate enormous demands and pressures, working heavy hours, and they show up to work, take care of their patients, and complete their charting. While this is true, this is only one kind of resilience, what I term survival resilience. But there is also another form of resilience which is a thriving resilience, and this also exists along a continuum. What is exciting is that there are easily teachable, learnable skills that anyone can use to cultivate this latter form of resilience. Fourth, because many physicians have limited time to learn and practice time-consuming well-being practices, the tools we offer to support physician mental health and well-being may have greater impact as they require little time to use and learn. Still, this is largely an environmental health problem, rather than an individual one. Finally, while this piece focuses largely on individual strategies, it does not remove the obligation to work to improve clinical and learning environments. And while environmental factors are the main drivers of distress, individual mindsets and patterns of thinking commonly found in physicians can contribute substantially to personal distress and mental illness. We need to help physicians and trainees develop skills to recognize and address these damaging mindsets and patterns of thinking.

MINDSETS AND THOUGHT PATTERNS

Common physician mindsets that contribute to distress can be categorized into three main clusters. These mindsets often have been acquired on the long and arduous path to becoming a physician, and people should feel no shame or guilt if they have them. Like well-being, they exist along a continuum that is fluid and subject to change with circumstances and environment. These mindsets are not always dysfunctional in moderation, and they even may have contributed to many physicians’ success along their academic paths. Cognitive psychologists have documented many of these mindsets in terms of automatic thoughts and cognitive distortions.

The first cluster of mindsets is the largest, and it consists of mindsets that are characterized by a self-critical voice.

**Performance as identity:** the tendency to view your performance—whether academic in school, or professional as a physician—as your identity and worthiness. If you make an error, the thought process is often, “I’m a bad doctor and a bad person,” rather than “I made an error.”

**Maladaptive perfectionism:** a condition where you set the bar so unattainably high for yourself that you are repeatedly disappointed in yourself. The key here is disappointment in *yourself*, not just in your performance.

**Impostor phenomenon:** the feeling that you are incompetent, that you are a fraud, and it is only a matter of time before other people discover this.

**Personalization and self-blame:** the tendency to place complete blame on yourself when things don’t go well.

**Feelings of guilt and shame:** Thoughts of imperfection and self-blame can contribute to self-critical thoughts and feelings of guilt and shame, often adding substantially to personal distress.

**Hiding vulnerability and distress:** many physicians and trainees tend to hide their distress which can then create the impression that others are doing fine. This can lead to individuals’ belief that they are the only ones struggling.

The second cluster of mindsets is characterized by negative mood or affect—cynicism, negativity, and pessimism—that are understandable given the professional and emotional challenges in medicine. While understandable, these mindsets can fuel personal dissatisfaction and diminish well-being both in the workplace and at home.

The final cluster consists of two miscellaneous, but critically important, mindsets and thinking patterns. The first is having a fixed mindset rather than a growth mindset. Fixed mindsets have been associated most typically with cognitive ability—namely, holding narratives such as “I’m not good at math”—but the same mindset presents around skills like resilience, and this can inhibit personal growth. If a person has a fixed mindset around their own
personal resilience, they will be less likely to become more resilient. The other problematic pattern of thinking involves automatic thoughts and cognitive distortions that can activate other mindsets.

These mindsets are common in medical students, residents, and physicians and can contribute to both personal distress and mental illness. A study that I led of first-year medical students found that those who screened positive for maladaptive perfectionism or imposter phenomenon were more likely to have feelings of inadequacy, embarrassment, or shame about their academic performance. Those who experienced these latter feelings were significantly more likely to screen positive for depression and anxiety. The good news though is that every one of these mindsets is changeable through the cultivation of simple techniques of metacognition and mindful awareness.

**METACOGNITION**

Metacognition is simply the ability to examine your thoughts and to change to be more accurate and beneficial to your mental health. The most important metacognitive skill is cognitive reframing, the basis for Cognitive Behavioral Therapy (CBT). CBT is the preferred treatment for anxiety disorder and panic attacks, helpful for depression, and useful for addressing maladaptive perfectionism and/or imposter phenomenon. Unfortunately, we usually don’t teach these skills until someone has already developed clinical depression or anxiety and seeks support from a therapist. The key to preventative mental health care is learning these skills before many mindsets, cognitive distortions, or emotions culminate in mental illness.

**COGNITIVE REFRAMING**

We tend to go through life thinking that an adverse event equals an adverse outcome—meaning that if something bad happens, that is the personal outcome as well. This is not true; it is an adverse event plus your cognitive/emotional reaction that equals the outcome. We all suffer from distorted reactions or automatic thoughts that can contribute to distress, but there are concrete steps we can take to gently reframe them. Following are some of the most common automatic thoughts:

- **Magnification:** taking a relatively small event and blowing it up into a much bigger problem.
- **All or none thinking:** either getting the result you wanted or feeling like a failure.
- **Tunnel vision:** focusing on one negative event and ignoring or discounting the many positive ones.
- **Overgeneralization:** seeing a negative event as part of a pattern of bad things that always happen to you.
- **Fortune-telling:** predicting a future outcome with certainty.
- **Mind-reading:** feeling like you know with certainty what another person is thinking. For example, when a colleague passes in the hallway and looks up and frowns, we create narratives that we must have done something to offend the person and they are angry at us.
- **“Should” statements:** second-guessing yourself when the outcome isn’t ideal by thinking “I should have done this; I should have done that.”

Albert Ellis, one of the fathers of cognitive-behavioral therapies, introduced many helpful concepts for challenging these types of thinking. Cognitive reframing, also known as cognitive restructuring, consists of three steps. First is to simply notice your thoughts. This requires having some skill in mindful awareness, which I will outline next. Second is to label the thought—whether a mindset or a cognitive distortion—to recognize that you are, for example, magnifying, or are thinking in perfectionistic terms. The third step is to try to dispute the thought distortions. There are many options for disputing strategies, but the following two are particularly easy to understand and to use. The first is to simply examine the evidence there is to support the thought, and the evidence there is against it. For example, some medical students who perform poorly on an exam can feel “stupid.” The evidence that they are low in intelligence is non-existent; they are in medical school, and there are a whole host of reasons why someone would not perform well on an exam. The second approach, called the double standard, is one that I find particularly illuminating and helpful. Here is an example. Let’s say a colleague comes up to you and says, “I feel terrible, I didn’t do well on my exam.” Would you say to them? “Well, you’re stupid. You’re not cut out to be a doctor.” Of course not (or at least I hope not!). The goal in countering the double standard is to extend the same compassion you have toward other people to yourself.

Metacognition can also help in managing future oriented worries, fears, and anxieties. A common and
understandable worry and fear that clinicians may have in the midst of the pandemic is that they may get ill, or that they may bring COVID-19 home to their spouse, children, and/or other family members and that they could get sick and die. These are completely understandable fears to have, and they may feel terrifying or even debilitating. The question is not how to completely eliminate or suppress these feelings, but rather how to manage these thoughts to decrease distress. One way of framing: yes, that reality that is possible, but how likely are certain outcomes? Even though you may face a relatively high risk of getting the infection, it is very likely that you will recover. Those less than 60 years of age without underlying medical conditions appear to have a mortality rate below 1%, with child mortality rates even lower. Therefore, even if you or they become infected, the great, great likelihood is that you will recover and your family members will too. In addition to managing these understandable fears, you also can move to the strategic. What can you control? Do everything you can to reduce the risk that you and your family members will get infected. Be vigilant about protecting yourself. Change of clothes, a serious hand wash before you leave the hospital, hand wash when you get home, and continued social distancing outside the home are things within your control. Optimizing sleep, nutrition, and exercise can boost your immune system and decrease the likelihood of an adverse outcome from COVID-19 should you become infected. A key principle here is that the goal is not to eliminate thoughts and worries. Rather, it’s to hold them gently—to work with them so they will cause you less suffering and harm.

MINDFUL AWARENESS
The second essential skill to develop is mindful awareness. One needs to be sufficiently present and aware to notice thoughts and feelings in order to be able to work with them. The classical approach to becoming more mindful has been meditation, and numerous courses and apps are available for this. Meditation works, but in my experience relatively few physicians are willing or able to incorporate regular formal meditation practices in their lives. I have given talks to audiences across the country and have asked physicians...
to raise their hands if they have a meditation practice of 15 minutes or more a day. I have never seen more than 3% raise their hands even in places like California where meditation may be more in mainstream consciousness. Meditation works but if many are not likely to practice it due to time and effort, it may not be an optimal public health intervention for physicians unless we change the structural demands on their time. The good news is that you can become significantly more mindful (moving up a mindfulness continuum) through informal practices that take little or no time to employ. There are a number of informal mindful practices, but a simple one is to just focus on one of your senses (auditory, smell, touch, or sight) for just 30 to 45 seconds. As thoughts appear, just notice them and return your attention to the sense you were focusing on. This can be used as you are walking from one place to another, when washing your hands before seeing a patient, or in a myriad of other activities.

**REDUCING LIMBIC SYSTEM ACTIVATION**

During the COVID pandemic, the skill of reducing a sense of alarm and overall limbic system activation is essential. A self-calming technique that has been proven effective in the military is called tactical breathing. Here’s how it works:

Relax yourself by taking four breaths as follows. If you want, try to visualize each number as you count. Breathe in counting 1, 2, 3, 4. Stop and hold your breath counting 1, 2, 3, 4. Exhale counting 1, 2, 3, 4. Repeat the breathing cycle.

You can practice this as many times a day as you would like, for just a minute or so. Then, when you are feeling acute stress, you can do it—even for a few breath cycles—to calm your amygdala. To reduce activation of your limbic system, be mindful of excessive caffeine consumption, as well as excessive consumption of news and social media. A study after the Boston Marathon bombing found that those who had heavy consumption of media in the week following the bombing led to higher acute stress levels than those who witnessed the bombing in person.

**OTHER TOOLS IN A RESILIENCE TOOLBOX**

Metacognition and mindfulness are essential skills in finding greater satisfaction with work, with life, and with the self, but there are other skills that can also be helpful in this quest. I view these as forming a toolbox, and you can choose tools that you feel that you need most. The tools include the following strategies: combating negativity bias and pessimism, cultivating positive emotions, emotional self-regulation, dealing with difficult people, investing in well-being, avoiding learned helplessness, cultivating a sense of generosity and gratitude, and finding meaning and purpose in life.

The key with the toolbox approach is its adaptability; some tools may be helpful for you, while others may not be—and you can tailor your toolbox to fit your own specific needs. I do not use all of the tools listed here, but some have changed my life in recent years in ways I did not think was possible. You can find more about the toolbox in a series of four podcasts produced by the ACGME at https://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being/AWARE-Well-Being-Resources, and on Spotify and other podcast platforms by searching ACGME AWARE.

**CHANGING THE CLINICAL AND LEARNING ENVIRONMENT**

As individuals cultivate skills to promote their own satisfaction and well-being, efforts must also be made to improve the clinical and learning environment. In 2009, Saint Louis University School of Medicine embarked on a series of simple changes designed to reduce pressure on students—reducing class time and curricular content, freeing time for elective opportunities, and changing to pass-fail grading—that led to decreases in depression and anxiety of more than 80% in pre-clerkship students. The clinical environment is more challenging to change, but conceptual frameworks from organizational psychology can guide action. A helpful model for this merges the concepts from work by Christina Maslach and Daniel Pink, and includes eight main drivers of burnout in health care. They include the following:

- **Workload:** not just how much, but the qualities and characteristics of it.
- **Rewards:** not just financial, but whether and to what extent a person feels appreciated and valued.
- **Control:** transparency in decision-making and feeling like your voice matters.
- **Community:** sense of connection to others at work.
- **Fairness:** whether people are treated with fairness and equity.
- **Values:** whether the organization acts consistently with the values it states.
**Mastery:** if effective and regular feedback on performance is given.

**Meaning:** if people in the organization feel a sense of meaning and purpose.

**CONCLUSION**

I have ended virtually all of my talks in the last two years with a quote from Viktor Frankl, and I will end this commentary in the same way. Frankl, the noted psychiatrist, author, and Holocaust survivor wrote, “There is nothing in the world, I venture to say, that would so effectively help one to survive even the worst conditions as the knowledge that there is a meaning in one’s life. There is much wisdom in the words of Nietzsche: ‘He who has a why to live for can bear almost any how.’” Physicians, in the midst of the challenges in medicine, need to find that why, feel that why, and be sustained by that why. But we also have to remember that we can and must work to change the how.

**References**


**DISCLOSURE**

None reported.

*Article originally Published in Missouri Medicine*

Stuart Slavin, MD, MEd, is Senior Scholar for Well-Being, Accreditation Council for Graduate Medical Education, Chicago, Illinois.
The Physicians Foundation has recently launched A Personal Crisis Management Plan\(^1\) to help physicians navigate their mental health needs. As part of the Foundation's Vital Signs initiative\(^2\), the plan was created to help physicians, their colleagues and their loved ones access and have available the coping strategies and resources needed when navigating a moment of crisis.

This resource was inspired by Angela Chen, MD, Loice Swisher, MD, FAAEM, and Mary Jane Brown, MD, who introduced a personal crisis management tool for residents, like safety plans used by psychiatrists in suicidal patients. They found\(^3\) nearly 60% of participating residents agreed that the tool would help them manage a crisis. Nearly a third of the participating residents (31.8%) indicated that they had used their personal plan within the first three months of their internship.

“Whether it’s stress, feelings of burnout or another challenge, physicians, just like anyone else, should feel comfortable seeking help,” said Gary Price, MD, president of The Physicians Foundation. “Our own research found that 58% of physicians reported experiencing feelings of burnout during the pandemic; however, when asked about mental health support, only 13% of physicians reported seeking medical attention.”

The Physicians Foundation’s 2020 Survey of America’s Physicians: COVID-19’s Impact on Physician Wellbeing\(^4\) also found nearly 1 in 4 physicians knew a physician who committed or considered suicide. While physician suicide has been a crisis long before COVID-19, the pandemic has created a sense of urgency to better support physicians’ mental health and wellbeing. This personal crisis management tool offers physicians and their loved ones a personalized, step-by-step plan to set themselves up for success in the event of a mental health crisis.

“We continuously hear from the loved ones of physicians who died by suicide that it could have been avoided,” said Robert Seligson, CEO of The Physicians Foundation. “We hope this tool gets us one step closer in breaking the culture of silence around physician mental health issues—helping physicians not be in fear of being judged or losing their right to practice.”

To explore Vital Signs, visit www.physiciansfoundation.org/vitalsigns. The website is intended for educational purposes only. If you need further guidance or are in a crisis, call the National Suicide Hotline at 1-800-273 TALK (8255) for free 24/7 support.

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Endnotes

2. https://physiciansfoundation.org/physician-wellbeing/vitalsigns/
3. https://escholarship.org/uc/item/iv92z16g
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As a family medicine physician, I have the privilege of getting to know my patients across different moments in their lives. Sometimes these patients are establishing care with a primary care physician for the first time in their adult lives and have multiple concerns. I have found that in many of these cases, the patient has been estranged from the medical system because they have significant trauma histories or even negative experiences directly related to the healthcare system. There is often distrust surrounding doctors and the entire medical system that has been present long before they walked through our clinic doors. Primary care doctors are in the unique position to gain these patient’s trust long enough to start chipping away at their concerns and have a positive impact on their health.

As I am over halfway through my residency training, I have begun to establish a panel of such patients, and I have had the opportunity to deepen my relationships with them in this process. Often this includes listening to their story and validating their concerns for the first few visits. Sometimes I will try to bring up my concern about their high blood pressure or suggest a diabetes or cholesterol screen, and this will be met with varying degrees of receptivity. I remember in my first year of residency, I would often leave these initial visits feeling frustrated that I did not accomplish anything “medical” during the visit as I attempted to (not always very) patiently listen to their concerns. Each time I saw these patients, I would ask myself why they kept coming back to me when it felt like we did not make headway on any of their “real” medical issues.

I have found that if I continue to stick with these patients and see them regularly, this will start to pay off as we slowly develop a relationship. For example, I have a patient that was very hesitant to start a hypertension medication because they were concerned about the side effects of starting any...
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medication and didn’t believe it was necessary. After several visits with this patient where I learned more about their history of deep trauma from sexual abuse and family abandonment, they trusted that I was invested in their wellbeing and were ready to start a medication. After this, we slowly started chipping away at other medical concerns such as getting a colonoscopy, catching up on vaccines, and initiating a statin. It took several months of seeing this patient, but I truly believe that most of the healing that took place in that clinic room started with simply holding space for that patient to share their story and express their doubts and concerns.

Of course, there are times that my patients will not be able to establish a relationship with me, either because they are looking for something else or because of other barriers beyond their control. I have a patient who has been in the hospital multiple times this year for alcohol withdrawal and frequently has not shown up to appointments. On the times that he has shown up, he has shared that he hasn’t made it to his appointments because he was recently evicted from his home and has been unable to get access to a cell phone. In “The Hot Spotter” from the New York Journal which discusses focusing on patients that are high utilizers of healthcare, Dr. Brenner states that “The ones you build a relationship with, you can change behavior. Half we can build a relationship. Half we can’t.” While it can be frustrating to feel like we can’t make progress in some situations, it is important to continue to be present for these patients when they do show up.

As I build my practice in residency and beyond, it is important to keep reminding myself that the best I can do a lot of the time is listen to my patient’s story, validate their experiences and past traumas, and continue to show up and be present. Historically, the medical field has done a poor job of doing this—particularly in BIPOC, LGBTQIA+, and economically disadvantaged individuals. We as healthcare providers are working against centuries of oppression, trauma, and discrimination, but we are also working in a system that continues to be flawed. Unfortunately, we still often fail at building trust with at-risk populations, but it is our job as physicians to be persistent and hold space for the individuals that do grace our clinic rooms.

Dr. Weaver is a University of Utah Family Medicine Resident from Ephrata, PA. Her medical interests include women’s health, obstetrics, pediatrics, mental health, and LGBTQ medicine. During her free time, she enjoys running, camping, weight training, playing violin, reading, and baking bread.
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Most physicians know that health insurers’ prior authorization policies delay access to care, often causing serious harm to patients. A survey of physicians taken in December 2020 by the American Medical Association shows just how often prior auth delays occur.

According to the AMA survey, 94% of physicians reported delays while waiting for health plans to authorize necessary care, and 79% have had patients abandon treatment because of prior auth. In addition, 70% of the 1,000 physicians surveyed said health insurers had reverted to pre-COVID-19 authorization policies or never relaxed these policies. “As the COVID-19 pandemic began in early 2020, some commercial health insurers temporarily relaxed prior authorization requirements to reduce administrative burdens and support rapid patient access to needed drugs, tests and treatments,” AMA President Susan R. Bailey, MD, said in a statement. “By the end of 2020, as the U.S. health system was strained with record numbers of new COVID-19 cases per week, the AMA found that most physicians were facing strict authorization hurdles that delayed patients’ access to needed care.”

According to the AMA survey, only 15% of physicians reported health plans’ prior authorization criteria were often or always based on evidence-based medicine. Other survey findings include:

- 85% said burdens associated with prior authorization were high or extremely high,
- 40% employ staff who exclusively work on tasks associated with prior authorizations, and
- 30% said prior authorizations led to a serious adverse event for a patient in their care.

The Utah Medical Association has continuously worked to ease the burden prior authorizations put on physicians and the harm it can cause to patients. If you have first-hand examples of cases where prior authorization delays caused patient harm, please let UMA know.

Reference
2020 AMA prior authorization (PA) physician survey

Patient impact

Care delays associated with PA
Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Always</td>
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</tr>
<tr>
<td>Often</td>
<td>39%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>40%</td>
</tr>
<tr>
<td>Rarely</td>
<td>4%</td>
</tr>
<tr>
<td>Never</td>
<td>1%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
</tbody>
</table>

94% report that care delays are associated with PA.

Abandoned treatment associated with PA
Q: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?

<table>
<thead>
<tr>
<th>Frequency</th>
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</thead>
<tbody>
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<tr>
<td>Often</td>
<td>55%</td>
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<tr>
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<td>18%</td>
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<tr>
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<td>2%</td>
</tr>
<tr>
<td>Never</td>
<td>1%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2%</td>
</tr>
</tbody>
</table>

79% report that PA criteria are based on evidence-based medicine and/or guidelines from national medical specialty societies.

PA and patient harm
30% of physicians report that PA has led to a serious adverse event for a patient in their care.

Clinical validity of PA programs
Q: How often are health plans’ PA criteria based on evidence-based medicine and/or guidelines from national medical specialty societies?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Always</td>
<td>13%</td>
</tr>
<tr>
<td>Often</td>
<td>42%</td>
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<tr>
<td>Sometimes</td>
<td>29%</td>
</tr>
<tr>
<td>Rarely</td>
<td>11%</td>
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</tbody>
</table>

While 98% of health plans report they use peer-reviewed evidence-based studies when designing their PA programs, 32% of physicians report that PA criteria are rarely or never evidence-based.

Impact of PA on clinical outcomes
Q: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?

<table>
<thead>
<tr>
<th>Impact</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Somewhat or significant negative impact</td>
<td>9%</td>
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<tr>
<td>No impact</td>
<td>90%</td>
</tr>
<tr>
<td>Somewhat or significant positive impact</td>
<td>9%</td>
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</tbody>
</table>

Percentages do not sum to 100% due to rounding.

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REBALANCING—PORTFOLIO FIXED INCOME DECISIONS

BY ERIC HALVORSEN, MBA, CFP®, CIMA®
UMA FINANCIAL SERVICES

There has been much discussion in the news recently about new highs in stock indices like the Dow Jones Industrial Average and the S&P 500. Markets, by nature, do fluctuate on a consistent basis and as such it is always important to be aware of one’s strategic allocation and rebalancing process. Normally rebalancing occurs between stocks and fixed income assets; this rebalancing is especially important when growth assets like stocks are at, or near, peaks. When unmonitored stocks can drift away from the desired target and expose an investor to additional and sometimes unknown risks. Behaviorally, in the moment, it is challenging to trim the “winners” and buy the perceived “losers”. Given this known flaw in human nature it is important to have a pre-determined plan in place so that when the moment arrives, we can confidently act combatting our innate biases. A well-built portfolio should have a disciplined rebalancing process in place; most commonly this consists of allowable
tolerance ranges around an asset's target percentage within a portfolio.

The fixed income portion of one's portfolio may appear basic although it is vitally important when controlling the risk of a strategic allocation. Its role can vary according to an investor's financial needs, concerns, and goals. For example, many investors look to fixed income for safety, income, and more stability in their portfolios. They must weigh these priorities against their concerns over future interest rates, inflation, government debt, and other factors that might affect fixed income returns.

Striking this balance can be a challenge in any market environment, but especially now, as low interest rates have sent many investors on a quest for higher-yield bonds, alternative investments, or pushing their equity allocation higher. Each of these changes can materially alter the overall risk of an investor's portfolio—some of these changes may be challenging to see or understand.²

So, what's an investor to do? How can you make prudent fixed income decisions while also addressing today's low interest rates? Consider these principles:

**REMEMBER HOW MARKETS WORK**

The same core investment principles apply in any market environment. One key principle is that in a well-functioning capital market, securities prices reflect all available information. Today's bond values reflect everything the market knows about current economic conditions, growth expectations, inflation, Fed monetary policy, and the like. So, according to this principle, the possibility of rising interest rates is already factored into fixed income prices.

This is one reason investors should view future interest rate movements as unpredictable. Even the market experts who have access to vast amounts of research have a hard time predicting the direction of interest rates.

Rather than trying to predict macroeconomic forces that are difficult to foresee, investors can look to the market to set prices and focus on the variables within their control.

**START WITH A CLEARLY DEFINED GOAL**

Fixed income choices should follow a broader
investment strategy that defines the role of fixed income in a portfolio. The portfolio can then be customized to meet those specific goals while managing tradeoffs.

An investor who seeks to avoid losing market value might have a different fixed income allocation than someone who needs immediate income or is seeking higher returns. Investors with different objectives typically have different tradeoffs regarding risk, expected return, and costs.

**KNOW WHAT YOU OWN**

Strive for transparency in a portfolio. This means understanding an investment manager’s basic strategy and knowing how the instruments held in the portfolio might respond in different economic, market, and interest rate scenarios.

Unfortunately, investors who chase performance often make their investment decisions based on the past performance and perceived popularity of the strategy. For example, some of the mutual fund categories experiencing the heaviest inflows of cash in the industry are in asset groups that have recently experienced higher than average yields. Higher yields are typically accompanied by higher risks. But do investors know what risks their managers are taking to deliver those attractive yields?

**UNDERSTAND THE TRADEOFFS**

When reaching for higher yield, investors should carefully consider the potential effects of their decisions on expected portfolio performance and risk. In the fixed income arena, investors have two primary ways to increase expected yield and returns on bonds. They can:

- Extend the overall maturity of their bond portfolio (take more term risk).
- Hold bonds of lower credit quality (take more credit risk).

These may be reasonable actions. But pursuing higher income means accepting more risk, as measured by interest rate movements, price volatility, or greater odds of losing value if the issuer defaults. Higher yield can also bring potentially higher volatility.

**PAY ATTENTION TO COSTS**

Investors typically do not realize that investment-related costs determine a large part of a portfolio’s yield and return. In a low interest rate environment costs are important to fixed income securities. In fact, research has shown that a bond mutual fund’s expense helps explain much of its net performance—and funds with the highest expenses tended to have the lowest performance within their peer group.²

**SUMMARY**

No one can perfectly predict the speed and magnitude of interest rate changes. Most investors are best served by building a fixed income strategy to complement their broader portfolio objectives, understanding the sources of risk, and paying attention to fees. Pursuing a defined strategy in a disciplined fashion has proven to be a successful way to approach investing. Rebalancing is a vital risk management tool which will assist you and reaching your goals while helping to control risk. Although selling the “winners” to buy the perceived “losers” does not feel great it is an important part of controlling risk. If you don’t have one, I’d encourage you to determine a rebalancing strategy. If you’re interested in engaging with an investment advisor familiar with the goals and concerns of Physicians one of our trained UMAFS financial advisors would welcome the opportunity to review your portfolio and discuss these topics in further detail. ■

This information is for educational purposes only and should not be considered investment advice or an offer of any security for sale. UMAFS is an investment advisor registered with the Securities and Exchange Commission.

Investing risks include loss of principal and fluctuating value. Fixed income securities are subject to increased loss of principal during periods of rising interest rates. Fixed-income investments are subject to various other risks including changes in credit quality, liquidity, prepayments, and other factors.

**Endnotes**

1. When interest rates rise, the value of an existing bond declines; when rates fall, existing bond values rise. The market adjusts a bond’s price to match the yield available on a new instrument. Investors who hold fixed income securities with longer maturities are exposed to the amplified effects of term risk. A long-term bond is more exposed to rate changes than a short-term instrument, and usually (but not always) offers a higher yield to compensate investors for the extra risk. Also, lower-coupon bonds are more affected by interest rate changes than higher-coupon bonds. For example, if rates move 1%, a bond that pays 5% will experience a greater gain or loss than one paying 5%.

2. The study examined monthly alpha and expense ratios for bond funds in the CRSP survivorship-bias-free mutual fund database from January 1992 to December 2011. Source: Dimensional Fund Advisors.
The national public health emergency related to COVID-19 has been extended to July 20 and likely will be extended throughout 2021, according to the federal Health and Human Services (HHS) Department.

The public health emergency, originally issued in January of last year, has been renewed every 90 days throughout the pandemic. It was last set to expire April 21 before being again extended.

The current extension allows the Centers for Medicare & Medicaid Services (CMS) to maintain several COVID-19-related Medicare waivers and flexibilities, including paying the same rate for telemedicine visits as for in-person visits, and allowing use of audio-only telemedicine services.

The extension also means private health insurers’ copayments related to COVID-19 testing (though not necessarily treatment) and related to any forthcoming vaccinations will be waived. The Utah Insurance Department website at https://insurance.utah.gov/featured-news/coronavirus includes the various Utah insurance carriers’ COVID-19 cost-sharing policies.

Certain HIPAA enforcement actions also will continue to be relaxed. Specifically, physicians who use certain telemedicine platforms in good faith will not be penalized for noncompliance.

Throughout the pandemic, UMA has called on state and federal leaders continuously to allow flexibilities and expand programs to protect practices financially. Watch for updates in the UMA MediByte newsletter.

References
HELP AVAILABLE ON COMPLYING WITH INFO BLOCKING RULES

ADAPTED FROM SEVERAL AMA SOURCES

The American Medical Association (AMA) has launched an array of online educational resources to help physicians understand and ultimately end the current information blocking practices that impede access, exchange or use of patients' electronic health information. As of April 5, 2021, healthcare providers, certified health IT developers, and health information exchanges (HIEs) have needed to comply with the information blocking regulations.2

“The AMA supports the Cures Act’s purposes to increase information sharing between patients and physicians, improve patient care, and ensure electronic health information follows patients,” Jesse M. Ehrenfeld, MD, AMA Immediate Past Chair, said in a statement. “However, the regulation is complex with dozens of exceptions, sub-exceptions, and conditions. Physicians can turn to the AMA resources for reliable help that explains what the new rule means for them and their medical practices.”

The AMA resources include a CME course: Information Blocking Regulations: What to know and how to comply,3 which has three main learning objectives:

- Explain the new information blocking federal regulations
- Identify which exceptions to leverage and when
- Select top methods to comply with regulation and incorporate in practice

Once the physician completes the educational materials, she can take a quiz to assess her comprehension of the information blocking regulations.

AMA also wrote two information blocking resource guides. These intend to educate physicians on specific definitions, patient data access, and patient data exchange.

The first resource guide, What is information blocking?,4 defines information blocking, describes and outlines critical terms, outlines which practices are considered information blocking, and defines exceptions to the definition of information blocking.

The second, How do I comply with info blocking and where do I start?,5 outlines a compliance roadmap about where to start, how to maintain a compliance program, and what to look for next.

To prepare and educate healthcare stakeholders for the information blocking regulations, AMA joined seven other top healthcare organizations, including College of Healthcare Information Management Executives (CHIME), to deploy the Information Blocking Resource Center6 in February 2021. The Center compiled articles, cheat sheets, documents, guides, ONC resources, regulatory overviews, webinars, and other forms in one place.

References

2. https://www.healthit.gov/buzz-blog/information-blocking/a-new-day-for-interoperability-the-information-blocking-regulations-start-now
6. https://infoblockingcenter.org/
UMA MEMBERS IN THE NEWS

On May 20th, the Ogden Standard Examiner profiled UMA member Emily Cook, DO, who is not only a busy family physician, but manages to juggle a career in fine arts and jewelry as well. According to the story in the newspaper, she works on commission pieces and hosts art and jewelry making classes in Studio 5 at The Monarch in Ogden. Originally from Scottsdale, AZ, Dr. Cook studied fine arts on scholarship at Brigham Young University. After graduating, she studied gemology and honed her skills as a jeweler and in metal working. Desiring a profession with more stable income, she attended medical school at Midwestern University in AZ.

Even with a demanding day job, Cook remains committed to her art career and enjoys the balance of the two disciplines. Her approach to medicine is similar to her philosophy as an artist, as she uses both platforms to inspire creativity in others. “Being creative can allow people to feel better about themselves,” she says. “So I like to encourage my patients who are struggling to follow a dream they’ve given up, or to pursue something creative.” Several of her artistic creations can be seen at www.emilycook.art.

On May 1st, Scott C. Woller, MD, FACP, was introduced as Governor of the American College of Physicians Utah Chapter. Dr. Woller succeeds Dr. Mary Parsons under whose leadership the ACP Utah Chapter has flourished. Dr. Woller graduated from Northwestern University Medical School in 2000, completed residency training at the University of Utah, then served then as Chief Medical Resident. Dr. Woller is boarded in general internal medicine with a clinical and research expertise in thrombosis medicine. Dr. Woller serves as Chair of Medicine at Intermountain Medical Center, and is Professor of Clinical Medicine in the University of Utah School of Medicine. Dr. Woller’s scholarly efforts include service as Co-Chair the American College of Chest Physicians (CHEST) Antithrombotic and Thrombolytic Therapy Writing Panel Guideline, and as panelist for the Centers for Disease Control and Prevention Venous Thromboembolism Surveillance Workgroup Committee.

Special interests for Dr. Woller’s work with ACP include establishment of the Diversity, Equity and Inclusion (DEI) Committee, enhancing engagement of ACP members beyond the Wasatch Front, pursuing opportunities for ACP Member voices to inform Healthcare Policy, and engagement of Early Career Physicians.

PHYSICIANS WANTED

The Utah Labor Commission seeks physicians to serve on two-person medical panels which examine injured workers for workers’ compensation benefits. Number of cases varies each month, but would not likely exceed five. Compensation upon request. Please send a resume and cover letter to:

Aurora Holley
P.O. Box 146600
Salt Lake City, UT 84114
auroraholley@utah.gov

Only qualified applicants will be contacted.

Cartoonist: Christian F. Schmutz, MD, UofU Resident
In the summer of 2019, public health across the United States investigated an outbreak of e-cigarette, or vaping, use-associated lung injury (EVALI). By mid-January 2020, more than 2,800 hospitalization cases and 68 deaths were reported nationwide. The Utah Department of Health reported 134 Utah hospitalization cases for EVALI from April 2019 to January 2020 (Figure 1). In addition to these hospitalizations, Utah reported one EVALI-related death and exhibited the highest population-adjusted EVALI rate in the United States (four cases per 100,000 people). Although the number of new cases reported have significantly decreased since a peak in late August 2019, EVALI is an example of the public health threat created by vaping devices and unregulated vape products.

Symptoms of EVALI include:
- respiratory symptoms (cough, shortness of breath, or chest pain)
- gastrointestinal symptoms (nausea, vomiting, stomach pain, or diarrhea)
- nonspecific constitutional symptoms (fever, chills, or weight loss)

Some patients reported symptoms developing slowly over a few days, while other patients reported their symptoms developed over several weeks.

Timeline of Utah EVALI Cases, April 15, 2019–January 14, 2021
Figure 1. The majority of cases in Utah had symptoms beginning in August and September.
other patients reported their symptoms developed over several weeks.

In 2019, age groups with the highest vaping rates in Utah were among 8th, 10th, and 12th-grade students (ages 13–18), young adults (ages 18–24), and people ages 25–34, with current e-cigarette use rates of 12.4%, 18.5%, and 9.6%, respectively.1–3 Similarly, the majority of Utah EVALI patients (65%) were between the ages of 14 and 29 (Figure 2).

Regarding the substance use of Utah’s EVALI cases who self-reported or were interviewed, 94% reported vaping THC cartridges in the three months prior to developing EVALI. Meanwhile, 67% of cases reported vaping nicotine cartridges in the three months prior to developing EVALI, and 51% reported vaping both THC and nicotine during that time (see Figure 3).

The Centers for Disease Control and Prevention (CDC) identified vitamin E acetate (VEA) as a substance of concern regarding the cause of this outbreak.⁶ VEA is not typically found in nicotine liquids or THC cartridges, but it is used as an additive, most notably in black market THC-containing vaping products. VEA typically does not cause harm when ingested as a vitamin supplement, however previous research suggests when VEA is inhaled, it may interfere with normal lung function.

The Utah Department of Health and local health departments collected products from eight interviewed cases, and tested the contents of 19 samples had detectable amounts of VEA. By contrast, none of the 20 liquids containing nicotine had detectable amounts of vitamin E acetate.

### Utah EVALI Cases by Age Distribution, 2020

Figure 2. The majority of cases in Utah were under the age of 30.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>20–29</td>
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<tr>
<td>30–39</td>
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<tr>
<td>19 and under</td>
<td>20.9%</td>
</tr>
<tr>
<td>40 and over</td>
<td>9.0%</td>
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</tbody>
</table>

Utah Division of Disease Control and Prevention, 2020

### Percentage of Vape Product Usage

Figure 3. 94% of interviewed Utah EVALI cases reported vaping THC cartridges.

- THC Cartridges: 94%
- Nicotine Cartridges: 67%
- Both THC and Nicotine: 51%

Utah Division of Disease Control and Prevention, 2020

### References:


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

ama-assn.org  eMedEvents.com

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.

CME CALENDAR

JUNE 2021

6–9  Common Problems in Pediatrics, Online, IHC (13.75)
15–19  Utah Certificate of Palliative Care Education, Online, UUCME (26.25)

JULY 2021

9  MOUD Waiver Training, Online, PRKA (4.0)
16  1st Annual Intermountain Healthcare Concussion Conference, Provo, IHC (6.5)

SEPTEMBER 2021

14–17  Utah Certificate of Palliative Care Education, Online, UUCME (26.25)

OCTOBER 2021

6–8  Ogden Surgical-Medical Society’s Hybrid CME Conference, Ogden, OSMS (29.5)
23  20th Annual Cardiovascular Update, SLC, IHC (6.0)
29  2021 Advances in Primary Care Medicine Conference, SLC, IHC (7.25)

Links to each of these and other events are available on the UMA website at https://www.utahmed.org/wcm/_PhysicianSupport/CME_Calendar.aspx
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

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<tr>
<th>Sponsor</th>
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<td>ALT</td>
<td>Alternative CME, SLC, 801/200-4321</td>
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<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>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>CoMagine, SLC, 801/892-6645</td>
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<tr>
<td>ESI</td>
<td>ESI Management Group, SLC, 801/501-9446</td>
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<td>IHC</td>
<td>Intermountain Healthcare CME, SLC, 800/842-5498</td>
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<tr>
<td>LVH</td>
<td>Lakeview Hospital, Bountiful, 801/299-2546</td>
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<tr>
<td>OSMS</td>
<td>Ogden Surgical-Medical Society, Ogden, 801/564-5585</td>
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<tr>
<td>PCH</td>
<td>Primary Children's Hospital, SLC, 800/910-7262</td>
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<td>PRKA</td>
<td>Program of Addiction Research, Clinical Care, Knowledge, Advocacy, SLC, 801/585-6667</td>
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<tr>
<td>STW</td>
<td>Steward Health Care, South Jordan, 801/984-2384</td>
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<tr>
<td>TRH</td>
<td>Timpanogos Regional Hospital, Orem, 801/714-6505</td>
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<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>
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<td>UMAF</td>
<td>Utah Medical Association Foundation, SLC, 801/747-3500</td>
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<td>UMIA</td>
<td>Utah Medical Insurance Association, SLC, 801/531-0375</td>
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<td>UOS</td>
<td>Utah Ophthalmology Society, SLC, 801/747-3500</td>
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<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>
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The following websites offer online continuing medical education:

cme.utahmed.org  cmelist.com  cmemlist.com  ama-assn.org/education-center  reachmd.com/programs/
psnet.ahrq.gov/cme  baylorscme.org  cms.gov/Outreach-and-Education/Learn/
thedoctorschannl.com/cme/  medscape.org  Earn-Credit/Earn-credit-page.html
freeclme.com  vhl.com  primarycarenetwork.org/
pri-med.com/pmo/OnlineCME.aspx  nejm.org/continuing-medical-education  emedevents.com/
In a competitive healthcare system, marketing of healthcare services becomes important to not only bring new patients in the door, but also to retain existing patients. Before engaging in a marketing campaign, medical providers must be aware of the many laws applicable to the marketing of healthcare services. While not comprehensive, this article provides a summary of some of the more common laws applicable to providers so that you may avoid the traps that could negatively impact your practice and cause you to incur penalties.

ANTI-KICKBACK STATUTE
The federal Medicare and Medicaid Anti-Fraud and Abuse Law, 42 U.S.C. § 1320a-7(b) (the “Anti-Kickback Statute”), imposes both criminal and civil penalties on persons who either pay or receive illegal remuneration in exchange for the referral of federal healthcare program business (including services or supplies covered under Medicare or Medicaid). For purposes of the Anti-Kickback Statute, “remuneration” includes the transfer of anything of value, in cash or in-kind, directly or indirectly, covertly or overtly. Where remuneration is paid purposefully to induce referrals of items or services paid for by a federal health care program, the Anti-Kickback Statute is violated.

CIVIL MONETARY PENALTIES LAW
The Civil Monetary Penalties Law (“CMP Law”) prohibits offering or transferring remuneration to a Medicare or Medicaid beneficiary that the person knows or should know is likely to influence the beneficiary’s prescription of a particular provider, for which payment may be made in whole or in part by Medicare or Medicaid. Violation of the CMP Law may be penalized by a civil fine of $10,000 per item or service. In addition, the OIG may initiate administrative proceedings to exclude the offending party from federal healthcare programs. There are several exceptions to the general rule, including the following:

- Nominal gifts of a value of no more than $10 per item and $50.00 total per year.
- Incentives given to individuals to promote the delivery of preventive care services where delivery is not tied to the provision of others’ services reimbursable by federal health care programs.
- Waiver of coinsurance and deductible amounts by a provider but only if certain enumerated requirements are met.
- Assistance to the needy.
- Remuneration which promotes access to care and poses a low risk of harm to patients and federal healthcare programs.

HIPAA
The Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued pursuant thereto (“HIPAA”), requires a patient’s written authorization before using or disclosing PHI for marketing purposes. For HIPAA purposes, “marketing” means making a communication about a product or service that encourages the recipient of the communication to purchase or use the product or service. HIPAA also prohibits the selling of PHI to business associates or other third parties without the prior written authorization of the patient. There are exceptions to HIPAA’s general rule prohibiting marketing without a written authorization, including:

- Communications with an existing patient about the provider’s own products or services.
- Communications made with an existing patient regarding the patient’s treatment.
- Communications for case management or care coordination.
- Face-to-face communications between provider and patient.
- Communications about free health fair, wellness activity or discussion group.

With respect to patient testimonials, you must comply with the rules that pertain to marketing in general, as well as HIPAA. You must obtain the informed consent of the patient to use the patient’s name, story, and protected health information (“PHI”) in marketing a product or service. The form of the consent must be HIPAA compliant for the release of PHI. Such a document should also limit your responsibility for compensating the patient for such services.

TELEPHONE CONSUMER PROTECTION ACT
The Telephone Consumer Protection Act (“TCPA”) makes it unlawful for any person or entity to use an automatic telephone dialing system or an artificial or prerecorded voice message to call a wireless number. This also applies to text messaging. Violations can result in penalties of $1,500 per call. Violations of the TCPA have become fertile ground for class-action lawsuits.

The TCPA has a healthcare exemption for autodialed calls to wireless numbers for certain restricted calls that have a healthcare treatment purpose. The types of calls that qualify under this exception include: appointment/exam confirmations and reminders, wellness checkups, hospital pre-registration instructions, lab results, post-discharge follow-up, prescription notifications and home healthcare instructions.

FEDERAL TRADE COMMISSION ACT
Misleading, false or deceptive advertising is prohibited by the Federal Trade Commission Act. The FTC has determined that a message is deceptive if it is likely to mislead consumers and affect consumer’s behavior or decisions about a product or service. The law applies to all types of advertising including blogs, websites, and social media. The key to medical advertising is to substantiate the claim you are making with competent evidence. Testimonials and endorsements are generally not considered competent evidence to substantiate advertising claims.

AMA CODE OF MEDICAL ETHICS
The AMA Code of Medical Ethics also makes it unethical for a physician to engage in false or deceptive advertising. The American Medical Association has also considered splitting fees to be an unethical practice. Fee splitting occurs when a provider splits his or her fees for professional services in exchange for referrals. This practice is considered by the American Medical Association to be an unethical practice.

CONCLUSION
In an increasingly competitive market it is important for providers to enter into innovative marketing programs. However, given the number and complexity of the laws applicable to the marketing of healthcare services and products, it is crucial that all business arrangements and marketing programs be established and implemented properly and under the review of competent advisors.

David J. Castleton is a shareholder, director and member of the Executive Committee at Ray Quinney & Nebeker, P.C. He also serves as Chair of the firm’s Healthcare practice group. Mr. Castleton represents medical providers in a wide variety of business and real estate transactions, regulatory compliance, licensing, contracts and employment matters.

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In the fast-changing field of health care, maintaining a healthy medical practice can be challenging. Ray Quinney & Nebeker's legal health care experts have the ability to navigate the industry’s complex legal and regulatory environment with the insight gained from nearly 80 years of experience. Our team understands the multiple aspects of health care law. We take a personal approach. We solve problems. That not only results in successful transactions, it builds long-lasting relationships with our clients and helps keep their business healthy.
TOTAL PRACTICE MANAGEMENT
Streamline and perfect the office workflow and profitability with this all-inclusive package.

Our practice management package includes HR support and benefits, coding and billing, collections, basic data analytics, compliance, yearly training, policies and procedure development, credentialing, contract negotiation, workflow analysis, accounting, and financial management. We also offer access to a comprehensive Electronic Health Record that includes practice management, RCM, and patient engagement.

COMPREHENSIVE DATA ANALYTICS
Drive the success of your practice with accurate and effective data.

VPM’s data analytics team provide a comprehensive review and analysis of your practice data to help you make appropriate and effective decisions regarding the operational and financial health of your practice. Our data will also help providers become compliant with CMS ACO requirements and Medical Home plans.

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Specialty specific services.

Our team of specialized coders and billers will ensure you are billing appropriately for the services you provide. Our collections team monitors your recoveries, denials, and returns to ensure you are paid appropriately and in a timely manner.

ACO AND MEDICAL HOME SUPPORT
We support your goal to qualify as an ACO or Medical Home provider.

We provide the additional data reporting, quality measures, and case management support to qualify for ACO and Medical Home.

CONSULTING SERVICES
We provide consulting services to identify areas of improvement.

- Clinical Care Coordination
- Population Management
- Operational Efficiencies
- Practice Valuation
- New Start Ups

- Physician Integration Alignment
- Compensation Strategies
- Patient Cost Analytics
- Cost Reduction
- Auditing

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