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PRESIDENT'S MESSAGE

First, THANK YOU to every Delegate for attending, for making the trip and taking the risk. We are glad you are here; and please spell that “H-E-A-R.” Please take the time to hear one another, as we represent a diverse crowd of physicians. We each have different expertise and skills. We represent different communities. Please also hear your own voice speaking up. I value the civil discourse and meeting of minds that happens here, even around the most difficult of topics to be discussed. What we all have in common is an incredible fund of knowledge, and a commitment to evidence-based medicine, science, and math.

In a year marked by a virulent virus variant vaccine push (say that 3 times fast), I have found both courage, humor, and grace in this crowd. This year has been an interesting one, with a focus on 3 main topics: COVID19 of course, abortion, and scope of practice.

With regard to the COVID19 delta surge, I need to ask each of you to continue to champion evidence-based medicine, science and math-based policy. Gather your courage to speak wherever you can, to kindly and gently encourage good choices with strong, positive energy, to patiently answer questions without making anyone feel inferior. This has been a daunting task regarding vaccines, and masks. Where we are failing to change minds, perhaps we can change hearts. It may not happen until everyone knows someone affected.

EXCERPTS FROM DR. RICHENS’ REPORT TO THE UMA HOUSE OF DELEGATES

One thing that surprised me this year was that the best strategy for getting the word out was, in the end, exactly like a job search, or selling a house -- telling everyone you know what’s up, what you need, and asking them who else they know that might be interested. Recruit your friends and build allies.

At one point I was on the phone with my freshman roommate from college, who was visiting in Park City, from Palo Alto, CA. She was worried about being in Utah with the numbers here, but her husband was so happy to be out of their house. Her husband Larry, who works for Google, had thought to call an old friend who has become the President of Deseret News while here, assuming she’d moved to Utah. Ironically, he discovered she still lives in Palo Alto. Before I knew it, I had an email from Larry introducing me to her, the name of an interested reporter, and an invitation to help them get the stories of physicians and patients out. When Dr. David Grygla posted a story on Facebook, I introduced him to the reporter, and his story was featured on the front page of the Sunday Deseret News. It was a detailed account from an M.D. about what’s really happening in our hospital.

One of the best things we did to help move the COVID vaccine needle this year began from sheer frustration over my own elderly LDS ward, and Bishop. Bishop Osborne is the sweetest man and has been my neighbor for 20 years, but I came a little unglued when he said he couldn’t reiterate church President Russell M. Nelson’s support of vaccines and masks to our elderly & vulnerable crew without clear authorization from the chain of command above him. So,
I called the stake presidency and was told the president would bring it up in a meeting with the area authority in 2 weeks. Impatient, I called Michelle (UMA CEO Michelle McOmber) and asked how we could get a letter to President Nelson, a retired CT surgeon who would see the numbers and understand the urgency.

I figured a Hail Mary to the Mormon President was fair game since the delta curve looked so eerily like Halloween of 2020. Same slope! And rising, especially in Washington County. Our vaccination rate sat at 35%. Nobody in the ward was wearing a mask, including the gentlemen on the stand. President Nelson, MD, had already voiced his support for the vaccine, masks, and distancing, but had not reiterated it in light of the delta surge. I needed help.

Michelle took seriously my impetuous request to reach out to President Nelson at church headquarters, and to every other ecclesiastical organization in the state (Catholic, Episcopalian, Muslim, Jewish). Michelle is an amazing ghost writer, better than me because she can write without the virus vitriol quaver in my voice, Michelle being a hardened politician. While we all know our letter was likely not the only buzz in President Nelson’s ear, the result was spectacular. It did move the needle on vaccines. BTW, his very kind letter in reply said, “I was President of the UMA in 1970.” Two days later the bulletins from the 1st Presidency came out in print, social media, radio, and TV.

The Catholic Bishop of Utah has also come out in the Intermountain Catholic saying clearly, please be vaccinated, please wear a mask, and there will be no religious exemptions from the vaccine because your choice may have serious health consequences for another. The Pope’s position was already clear, regarding vaccines and masks.

Early in the year, Dr. Ray Ward (R-Bountiful state representative) placed a personal after-hours call. He asked me to come up with a consensus in the UMA, for the Utah State Legislature, on abortion. How’s that for a little black humor? There is no consensus on abortion. Of course, it’s not just Dr. Ward; many physicians and our patient constituents are concerned with the shifting tides in our nation’s courts and congress, and the impact on health and choice.

Although there is no consensus on abortion, the Board has put considerable effort into the recommendations in its report. The vote of the Board (5 in favor, 4 opposed, one abstention) reflects the fact that it is more a statement of the middle of the road based on the survey of membership than a consensus. We thank all those who participated in the survey on abortion, and especially Dr. Matt Wilson, Past President and OB/Gyn, for his careful wording and stewardship.

As delegates, we are separate, but equal. We are not alike, and yet we have a common purpose in representing the house of medicine, as a team. We have taken different opportunities, represent diverse specialties and disparate practice modes. Some of us have opted out of clinical practices. We have an opportunity to work together. And when we are done here, please run for office. Not kidding. We need your STEM skills in the state legislature, and we need you here in the UMA.

This year the hot topics are COVID, abortion, and scope of practice. In another year they were the opioid addiction and medical marijuana. Next year, I hope the hot topics will be something new and equally interesting.

However, the scope of practice issues are likely to stay with us. In some of my research into internet influencers regarding medical misconceptions, I came across a fair number of “Doctors” and “Physicians” who are Chiropractors. They have never rounded in an ICU or done a fellowship in infectious disease, but they have an awful lot to say “direct to consumer” about how to manage a complex and life-threatening virus!

Even if you enjoy working in an integrated team of MD/DO and allied health professionals, you will have to stand up and stick up for yourselves. I know what each of you did to be even barely qualified to participate in this House of Delegates. You will have to defend your education, your expertise, the expediency of your care, your value to the patient or contractor, and the terms under which you are willing to work. The scope of practice battles will not be over any time soon. Again, they depend on evidence-based medicine, and knowing your science and math. But mostly they depend on you being willing to distinguish yourself.

If you have run a marathon, you are one in a hundred. If you have finished a course in calculus and medical school, you’re a rare gem. We are honored to hear your voice. You belong here. And what we do here matters.
After last year’s “virtual” House of Delegates meeting, several delegates expressed their delight to return to an in-person meeting this year, even with masks and a vaccination requirement in place. Though there were a couple of delegates who expressed their opinion that the restrictions were unneeded, UMA Board leaders wanted to make sure that our meeting would have no chance of becoming a “super-spreader” event with all the bad publicity which that might have generated. And since the UMA CEO was informed of a positive COVID-19 test result during the meeting despite being fully vaccinated and masked during the meeting (she immediately exited to go into quarantine), it appears the decision to favor preventive measures was a wise one.

The restrictions did not prevent vigorous debate on the issues presented to the House, especially regarding the recommendations of a report from the UMA Board of Directors on the abortion issue (see separate story on page 12). A special “Committee of the Whole” was convened on the first day of the House for delegates to examine the report and offer testimony to the Reference Committee charged with evaluating the recommendations in the report and presenting its suggestions to the House for a final vote. Though the reference committee suggested modifying the Board report’s recommendations, the House opted rather to adopt the Board recommendations without modification.

Though debate on this and other issues was robust and passionate, the House remained remarkably civil and professional throughout, maintaining a decorum and respect for opposing views that would be the envy of any legislative body. A full report of the outcome of this year’s resolutions is included below.

In addition to the debates and policymaking, UMA delegates also took the time to honor a few of their own. Dr. Marc E. Babitz was named the Utah Doctor of the Year (see separate story on page 14). UMA Board Member Patrice Hirning, MD, was honored by the UMA Women Physicians’ Section as this year’s recipient of the Deborah Robinson Memorial Award. One of our meeting’s Platinum Sponsors, COPIC, also presented its second annual humanitarian award to Mark...

Despite vigorous debate, delegates were respectful and professional throughout the meeting.
D. Housley, MD, for his work at the Midtown Community Health Center in Ogden, Utah.

Delegates also elected new officers at the meeting. After installing Noel C. Nye, DO, as its new President (the first osteopathic physician to hold the post), delegates then elected the following slate of new officers:

**President-elect:**
Mark R. Greenwood, MD

**At-Large Director:**
Carissa Monroy, MD (re-elected)

**AMA Delegate:**
Mark N. Bair, MD (re-elected)

**AMA Alt. Delegate:**
Anne GW Lin, MD

Continued on page 8…

Delegates and Vendors mingle masked at 2021 HOD.
Finally, the House adopted a significant change to the Association Bylaws by deleting the membership category of "Affiliate" members. This change limits membership in the association to only physicians (M.D.s or D.O.s) and medical students.

RESOLUTIONS ADOPTED
BOARD REPORT 1 on 2020 Resolution A3 – Early Abortion Access in Utah

RESOLVED 1, that UMA oppose legislation that directly seeks to deny patients the ability to obtain an elective abortion prior to 13-weeks estimated gestational age; and be it further

RESOLVED 2, that UMA oppose legislation that puts any restrictions on physicians’ discussions and treatment options, including but not limited to medical termination for families facing difficult decisions about continuing pregnancies including but not limited to situations dealing with maternal health complications, fetal anomalies, and non-viability, regardless of estimated gestational age; and be it further

RESOLVED 3, that UMA support legislation that seeks to reverse previous limitations or oppose future limitations placed by legislative bodies on elective abortion prior to 13 weeks or medical termination for maternal health complications, fetal anomalies, and non-viability regardless of estimated gestational age; and be it further

With a bang of the gavel, Speaker of the House Paul Clayton, MD, opened the House for another year.

Outdoors, masks were optional. Indoors, mostly required.
RESOLVED 4, that UMA reaffirm 2019 RESOLUTION LATE A7 - Reproductive Health Promotion and Protection, Resolved Clauses 1 and 2:

2019 RESOLUTION LATE A7 - Reproductive Health Promotion and Protection

RESOLVED 1, that UMA oppose legislation that infringes on the content or breadth of information exchanged within the professional patient-physician relationship; and be it further

RESOLVED 2, that physicians be free to have open and honest communication with patients about all aspects of health and safety.

RESOLUTION A1 – Expanding Health Insurance Coverage for Utah Children

RESOLVED 1, that UMA support legislation to increase health insurance coverage to all children living in Utah regardless of legal status; and be it further

RESOLVED 2, that UMA support legislation for a comprehensive outreach program to increase health insurance enrollment for all children living in Utah regardless of legal status.

RESOLUTION A3 - Increasing Dispensing Rights of Utah Office Practices

RESOLVED 1, that the UMA advocate for legislation and regulations allowing physicians to dispense and bill for routine medications in their practice settings.

RESOLUTION B1 – Standardization of Medical Screening Exams of Arrested Persons Brought to the Emergency Department

RESOLVED 1, that UMA support the efforts of local medical organizations, law enforcement personnel, and other stakeholders to find consensus regarding procedures that will support emergency departments in performing appropriate medical examinations and communicating their evaluations in accordance with prevailing standards of
emergency care to the medical providers who will be responsible for justice-involved patients in correctional settings.

RESOLUTION B3 – Health Initiative for Illness in School

RESOLVED 1, that UMA recommend to the state legislature, Utah state and local public health departments, Utah State School Board, and local school districts in Utah through correspondence from the UMA President and Board to implement and actively exercise options for students and teachers to stay home when sick or sick-appearing while maintaining student educational progress; and be it further

RESOLVED 2, that UMA partner with said entities [the state legislature, Utah state and local public health departments, Utah State School Board, and local school districts] to recommend pragmatic options for symptomatic children to participate in education from home, or in school facilities but separate from classrooms, to ensure continuity of education or flexible solutions for a variety of school settings; and be it further

RESOLVED 3, that UMA support employee leave policies and childcare that allow for parents to care for children when ill.

RESOLUTION REFERRED TO THE BOARD FOR ACTION

RESOLUTION B2 – Negative Health Impacts of the Utah Inland Port

RESOLVED 1, That UMA advocate that the state legislature fund the Human Health Risk Assessment of Utah Inland Port operations during the 2022 legislative session; and be it further

RESOLVED 2, That UMA advocate that the state legislature formally and publicly review the Human Health Risk Assessment of Utah Inland Port prior to appropriating more tax money to the Utah Inland Port Authority.

New President Noel Nye, DO, thanks Immediate Past President Sharon Richens, MD, for her service.

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UPDATE
The 2021 UMA House of Delegates (HOD) has approved a Report from the UMA Board of Directors, changing UMA policy on legislation addressing medical termination of pregnancy. Under the new policy, the association will “oppose legislation that directly seeks to deny patients the ability to obtain an elective abortion prior to 13-weeks estimated gestational age.”

The policy directs UMA to “oppose legislation that puts any restrictions on physicians’ discussions and treatment options, including but not limited to medical termination,” such as in situations dealing with maternal health complications, fetal anomalies, and non-viability, regardless of estimated gestational age.

The policy also directs UMA to “support legislation that seeks to reverse previous limitations or oppose future limitations placed by legislative bodies on elective abortion prior to 13 weeks or medical termination for maternal health complications, fetal anomalies, and non-viability regardless of estimated gestational age.”

The House also reaffirmed prior UMA policy from 2019 that UMA “oppose legislation that infringes on the content or breadth of information exchanged within the professional patient-physician relationship” and that “physicians be free to have open and honest communication with patients about all aspects of health and safety.”

**BACKGROUND**

Until now, UMA had opposed abortion bills if they went against widely recognized medical care, unduly restricted a physician’s ability to counsel or treat patients, or otherwise interfered with the physician-patient relationship. UMA has generally been able to work out its concerns with bill sponsors and then take a neutral position on a bill after requested changes were made or after a compromise had been reached.

Previously, UMA had not taken a stand on “elective” abortions, remaining neutral. UMA had supported “medical” terminations, defined by statute as when:

1) The abortion is necessary to avert:
   a) the death of the woman on whom the abortion is performed; or
   b) a serious risk of substantial and irreversible impairment of a major bodily function of the woman on whom the abortion is performed; or

2) Diagnosed in writing by two physicians who practice in maternal fetal medicine, the fetus has:
   a) a defect that is uniformly diagnosable and uniformly lethal; or
   b) a severe brain abnormality that is uniformly diagnosable.

   i) “Severe brain abnormality” means a malformation or defect that causes an individual to live in a mentally vegetative state.

   ii) Severe brain abnormality does not include Down syndrome, spina bifida, or cerebral palsy.

3) The woman is pregnant because of rape or incest.

Last year, the House of Delegates debated the abortion issue and referred the following resolution to the Board for
RESOLUTION A3 – Early Abortion Access in Utah

RESOLVED 1, that UMA oppose on a case-by-case basis legislation that directly or indirectly seeks to deprive people of the right to obtain an abortion prior to fetal viability, with viability considered as the capacity of the fetus for sustained survival outside the uterus, which is a medical determination, may vary with each pregnancy, and is a matter for the judgment of the responsible health care providers; and be it further

RESOLVED 2, that UMA support legislation that seeks to reverse previous limitations placed by legislative bodies on that right.

The Board Report containing the new policy recommendations had been developed, debated, and refined over the past year. The Board of Directors approved the report on a 5-4 vote (with one abstention) shortly before this year’s HOD meeting.

“We understand that this is a controversial topic and that many of our members will have varying opinions on the UMA stance; some saying it goes too far, while others argue it doesn’t go far enough,” said UMA CEO Michelle S. McOmber, MBA CAE. “After vigorous debate and a vote of 85-54 in favor, the UMA Delegates, however, saw the Board Report as a middle ground that they could support, as evidenced by the vote.”

Current Utah law under Roe v. Wade allows for elective abortions up to viability, which is not defined in statute. The state of Utah tried to limit that to 18 weeks, but the courts rejected that proposal, so typically, abortion is allowed to approximately 20-21 weeks. There is no limit for “medical” terminations.
A dedication to public service and compassionate patient care are hallmarks of this year’s Utah Doctor of the Year. His accomplishments would take several pages to detail, so we will hit just some of the highlights.

Dr. Marc Babitz served as a Commissioned Officer in the U.S. Public Health Service, retiring as a Captain after 20 years of service. He then spent 12 years as a Professor and Director of Student Programs in the Department of Family and Preventive Medicine at the University of Utah School of Medicine, before accepting positions as Director of the Division of Family Health and Preparedness and Medical Director of the Health Clinics of Utah for the Utah Department of Health (UDOH).

Along the way, he also served a total of 13 years on Utah’s Physician Licensing Board and directed a guideline development work group on opioid prescribing for the UDOH. He also served a stint as Deputy Director of UDOH and held adjunct faculty appointments as a Professor in the College of Nursing and College of Pharmacy at the University of Utah.

Dr. Babitz has been a fixture at the UMA House of Delegates for longer than most of us can remember and served several years on the UMA Board and as Speaker of the House. In 2017, he added a UMA Distinguished Service award to a 5-page list of other awards in his Curriculum Vitae. We wonder if all those awards are weighing down the walls of some trophy room at the Babitz home, or if they are molding in a storage box as relics for some future medical historian to unearth.

Even more than all the awards and public service, however, it’s Dr. Babitz approach to understanding and caring for individual patients that really qualify him for our praise.

Once while directing family practice residents caring for migrant farm workers in California, Dr. Babitz listened patiently as one of the residents triumphantly detailed the physical findings supporting a presumptive diagnosis of otitis media in an infant patient and their treatment plan of prescribing a course of Augmentin. The resident even took time to educate the mother about how to measure the dose in the dropper. The resident must have felt very confused when Dr. Babitz disagreed entirely with the treatment plan; after all, that resident had likely correctly diagnosed and treated otitis media numerous times previously with that same medication.
What, then, made that treatment plan wrong for this infant? The infant’s family were migrant farm workers and did not have access to a refrigerator in which to store the medication. Dr. Babitz taught that resident (and likely hundreds of other students along the way) that it is not enough to know facts; you must come to understand the patient to fully serve them.

Dr. Babitz has made a difference wherever he has served, as a doctor, a public servant, and as a dedicated husband and father of four children. The Utah Medical Association is delighted to name him the UMA Utah Doctor of the Year for 2021.
HEALTHCARE PROFESSIONALS (HCPs) ARE WIDELY REGARDED AS HEROES. UNFORTUNATELY, THIS VIEW OFTEN LEADS TO THE MISPERCEPTION THAT HCPs ARE NOT SUSCEPTIBLE TO ILLNESS THEMSELVES.

A STUDY FUNDED BY THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA), PART OF THE NATIONAL INSTITUTES OF HEALTH, FOUND THAT BETWEEN 10 AND 15% OF AMERICANS WILL MEET CRITERIA FOR A SUBSTANCE USE DISORDER AT SOME TIME IN THEIR LIVES. NUMEROUS STUDIES HAVE CONFIRMED COMPARABLE PREVALENCE AMONG HCPs.

SUBSTANCE USE BEGINS IN A VARIETY OF WAYS. IT MAY START WITH A PRESCRIPTION FOR AN ILLNESS OR INJURY, SOCIAL DRINKING, OR A WAY TO “WIND DOWN” AFTER A LONG DAY. WE KNOW TOO THAT THERE ARE GENETIC RISK FACTORS THAT INCREASE THE LIKELIHOOD OF PEOPLE DEVELOPING A SUBSTANCE USE DISORDER.

IN ADDITION TO GENETIC VULNERABILITIES, WE KNOW THAT HEALTHCARE PROFESSIONALS HAVE ADDITIONAL RISK FACTORS THAT MAY FURTHER INCREASE THEIR SUSCEPTIBILITY TO SUBSTANCE USE DISORDERS. THESE INCLUDE:

1. HIGH LEVELS OF STRESS
2. EXPOSURE TO ILLNESS TRAUMA AND DEATH
3. ACCESS TO PRESCRIPTION DRUGS

STRESS AND TRAUMA ARE KNOWN RISK FACTORS FOR MISUSING SUBSTANCES AS A MEANS OF “COPING.” ACCESS TO PRESCRIPTION DRUGS AND FAMILIARITY WITH THEIR EFFECTS OFTEN INCREASES THE LIKELIHOOD THAT HEALTHCARE PROVIDERS WILL BEGIN TO MISUSE SUBSTANCES. FOR THOSE WHO ARE VULNERABLE, THE CONSEQUENCES ARE OFTEN DIRE. TIFFANIE BROWNLEE, A REGISTERED NURSE IN UTAH, SHARED HER EXPERIENCE: “I DIVERTED MEDICATIONS. AFTER I HAD GIVEN MY PATIENT THEIR PORTION, I WOULD TAKE THE REST OF IT FOR MYSELF. IT STARTED OUT AS ONCE OR TWICE AND THEN IT JUST BECAME WHERE I HAD TO.”

WHEN HEALTHCARE PROFESSIONALS FIND THEMSELVES STRUGGLING WITH A SUBSTANCE USE DISORDER, THEY OFTEN HAVE NO IDEA WHERE TO TURN FOR HELP. THEY ARE AFRAID TO COME FORWARD BECAUSE OF CONCERNS THAT THEY WILL LOSE THEIR LIVELIHOOD AND THEIR COMMUNITY STANDING. THEY FEEL ISOLATED AND ASHAMED. INEVITABLY, THEIR DISEASE WORSENS. EVENTUALLY, THEY BECOME IMPAIRED AND PATIENT CARE BEGINS TO SUFFER.

RECOGNIZING THE NEED FOR A PROGRAM WHERE HEALTHCARE PROFESSIONALS CAN SEEK HELP CONFIDENTIALLY, THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING (DOPL) CREATED THE UTAH PROFESSIONALS HEALTH PROGRAM (UPHP) TO ASSIST HEALTHCARE PROFESSIONALS WHO HAVE SUBSTANCE USE DISORDERS. PROVIDING A “SAFE HARBOR” WHERE HEALTHCARE PROFESSIONALS CAN CONFIDENTIALLY SELF-REPORT PROVIDES MANY BENEFITS TO BOTH LICENSED HEALTHCARE PROFESSIONALS AND TO THE PUBLIC.

A LANDMARK ARTICLE AUTHORED BY McLellan et al in 2008 FOLLOWED MORE THAN 900 PHYSICIANS WITH SUBSTANCE USE DISORDERS WHO WERE MANAGED BY PHYSICIAN HEALTH PROGRAMS IN THE US. THEY FOUND THAT AT THE END OF A 5-YEAR MONITORING PROGRAM 80% OF THE PARTICIPANTS WERE IN SUSTAINED REMISSION FROM THEIR SUBSTANCE USE DISORDER. THEY REMAINED FULLY LICENSED AND WERE WORKING.

BECAUSE PARTICIPATION IN UPHP IS VOLUNTARY, THE FIRST STEP IS ADMITTING THERE’S A PROBLEM. THIS IS A VERY DIFFICULT STEP FOR ANYONE WITH A SUBSTANCE USE DISORDER, AS THEIR DEFAULT IS DENIAL. DR. ELIZABETH HOWELL, MD, MS, AN ADDICTION PSYCHIATRIST
COPIC’s unique streamlined process helps providers spend less time worrying about an open claim or pending lawsuit.

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

COPIC is proud to be the endorsed carrier of the Utah Medical Association. UMA members are eligible for a 10% premium discount.
& Associate Professor at the University of Utah, said, “The first thing that I think hits most people is that, ‘This can’t be true. I can’t be addicted. I’m too smart. I should know better. I should be able to control this.’ But the truth is, Addiction doesn’t care how smart you are.”

Dr. Jared Hemmert, a Dentist, recounted how he was running out of his prescription and decided to forge one in another person’s name. When it came time to pick up the prescription, Dr. Hemmert said he had an internal struggle, but decided to go through with it. “And all of a sudden, three police cars pull around the building. And they put me in the back of the police car and they took me to jail. I still didn’t think I was a drug addict.”

While admitting you need help or have a problem is difficult, it is an important step in the healing process. The earlier a person can take this step the better. As substance use disorders progress, the person’s health and family life deteriorate, legal consequences ensue, and careers as well as patients become endangered. There is also strong evidence that substance use disorders are linked to “burn out” and even suicide.

The aim of UPHP is to provide support before these tragic consequences occur. Professions currently eligible to participate in the program include:

- Dentists
- Dental Hygienists
- Physicians
- Physician Assistants
- Nurses
- Pharmacists
- Pharmacy Technicians
- Veterinarians
- Podiatrists

If a healthcare professional with a substance use disorder gets in trouble before reaching out to UPHP, it may mean an appearance before their professional licensing board. Records of licensing board proceedings are public documents. Public discipline often results in loss of employment and board certification, inability to get credentialled with insurers and hospitals and the inability to obtain malpractice insurance. Alternatively, participation in UPHP can avoid many of these issues.

UPHP does not offer treatment; rather it identifies relevant resources, makes appropriate referrals for clinical evaluations and/or treatment, and monitors the ongoing recovery and treatment of professionals. Participation in the program is confidential and takes a non-disciplinary and clinical approach. This approach protects public safety and allows the healthcare professional an opportunity to demonstrate in a non-public, non-disciplinary manner that they can become safe and sober and remain so, while retaining their license.

“The Goal is to help those health professionals who have substance use disorders continue to practice while being monitored confidentially by our division. Of the thousands of cases that I have seen come through…. The vast majority have kept their licenses,” said DOPL Director Mark Steinagel.

Those with substance use disorder can feel isolated, lost, and hopeless. UPHP offers resources and a community to turn to. Brownlee, who did not use UPHP services while getting help for substance use disorder, said, “I wish I would have known about it. I wish I would have known that there already was a village of people out there just waiting for someone like me to come forward and say, ‘Please, please, help me.'”

You are not alone. There is hope. To learn more about UPHP, visit UPHP.Utah.gov.

Reference
I am fortunate to live in Park City, where I volunteer as a physician at People’s Health Clinic, a free clinic for the uninsured members of Summit and Wasatch Counties. Park City is supported by a working class, many of whom are undocumented residents. They are essential members of the community who fulfill strenuous jobs in this tourist town, and who pay taxes; yet our patients live in relative or absolute poverty.

There is a lot of medical research to prove how poverty negatively affects health, but we do not need the data to believe that being poor is bad for you. Imagine living in Park City on $12,760 per year, which is considered the U.S. poverty threshold for a single adult. At People’s Health Clinic, 64% of our patients live at or below this poverty level. Due to their undocumented residency status, they are not eligible for government subsides like Medicaid.

My patient, Jose, developed advanced lung disease from inhaling silicon dust while working as a stone mason in Park City. He is oxygen dependent and not eligible for disability or a lung transplant. He lives in a single-wide trailer home with multiple family members including his wife, Tina, who suffers from diabetes. One evening I had our medical assistant bring diabetic supplies to Tina on her way home from work. When I asked her where Tina lives, she said “Little Tijuana.” “We have a Little Tijuana?” I asked. In disbelief, I found the neighborhood with the help of our diabetic educator, Jen. It turns out that just a few miles from Deer Valley, there is a block-wide collection of dilapidated trailer homes. Jen and I sat at the end of an alleyway for several minutes, absorbing what poverty looks like in one of the wealthiest small towns in America.

At People’s Health Clinic, we see patients with heartbreaking stories every day, who struggle to afford food, let alone medications. The stories we hear are filled with terror, courage, and injustice. They are stories of survival, which are not known to many in this town. If only residents understood that the dishwasher at a popular restaurant is Francisco, who crossed the Rio Grande in fear of his life with insulin packed in ice taped to his chest; or that their housecleaner, Maria, was labor trafficked by a coyote; or that Miguel, the condominium maintenance worker, died in May from COVID after being unable to afford quarantine.

Our patients suffer from housing insecurity, food insecurity, illiteracy, unemployment, and discrimination. These social determinants of health incite chronic disease and shorten life expectancy. However, poverty does not have to be a lifelong condition. Imagine if we all carried awareness of the poverty underlying Park City’s postcard tourism. Imagine if we all acted, together, to resolve the inequality in our state.
We all know the feeling of going to the grocery or hardware store and realizing our paycheck isn’t stretching as far as it used to—that is inflation.

Inflation is a persistent rise in the average cost of goods and services over time. Inflation decreases the purchasing power of your dollar. In other words, when prices go up, your money doesn’t go as far. A little bit of inflation is a good thing. That’s because it shows the economy is growing; prices of products and services generally go up because there is rising demand for them. That, in turn, prompts manufacturers and providers to increase supply, leading to more jobs, higher wages, and even more demand.

Inflation is measured by the Consumer Price Index (CPI)—which compares the change over time in the price of a basket of commonly used goods and services. The price of one item going up isn’t inflation, but the basket’s price going up over time is.

For the past few decades, inflation hasn’t been a significant problem in North America. The U.S. Federal Reserve (Fed) aims to keep inflation at around 2% a year. That level is seen as the most consistent for maximum employment and price stability.

But worries about higher inflation in the future are growing. Inflation generally comes from three sources:

- **Demand-pull inflation**—this is generally caused by a strong economy

- **Cost-push inflation**—this may come from rising wages or the cost of energy or materials

- **Easy-money policies**—when central banks try to boost the economy by lowering borrowing costs or increasing the money supply

As the global COVID-19 pandemic is brought under control, many observers worry that all those sources of inflation are now at play.

For most of the past year and a half, our economy was in various stages of lockdown in which certain sectors were shuttered or activities limited. The savings ratio has skyrocketed—In the U.S., the personal savings rate in May 2021 was 12.4% of disposable income compared to 8.3% in February 2020, just before the first wave of lockdowns were imposed.

Now that services are reopening (think haircuts, manicures, and movies!) and other activities are normalizing, some of those savings will be used. Just think about all the things you missed doing during the lockdowns, and you can see how there is a risk of demand-pull inflation.

Anyone who has recently tried to renovate a home, build a new patio deck, buy a used car, or even fill up their car’s gas tank has a sense of the potential for cost-push inflation. But it’s not just input costs that have risen—wages have too, especially...
in the U.S. As well, unemployment rates have been declining in 2021 as the economy revives.

Most importantly, however, have been the easy-money policies as authorities worked to keep the economy afloat during the pandemic. Interest rates have been held at record lows. The money supply has increased through asset purchases by the central banks and substantial fiscal stimulus; the wage supports to individuals, grants to small businesses, tax credits, and other measures introduced throughout the pandemic. As normal activities resume, this stimulus could provoke much higher inflation in the future unless the central banks raise interest rates or other actions are taken.

**WHAT DOES THIS MEAN FOR YOUR INVESTMENTS?**

Inflation has the same impact on your portfolio as it does on your pocketbook. Let’s say your investments returned 9% last year. That’s pretty good, but if inflation was 2%, then your real return falls to 7%. And if there’s a bad year in the markets and your returns are negative, inflation will take a bite out of those returns as well, increasing the magnitude of the loss.

When inflation rises due to an overheating economy, interest rates often do as well. Higher rates have a different impact on different assets.

**Equities**: Rising interest rates can increase borrowing costs for companies, eating into their profit margins. Some equities offer more protection against inflation than others: demand for some goods remains robust even when companies pass on price increases to customers. People will always buy toilet paper, shampoo, and toothpaste, for example. They’ll keep paying their cellphone bill, although they may not upgrade their device.

**Fixed income**: Rising inflation may nip at the returns of fixed-income assets, such as government treasury bills and corporate bonds, which pay fixed interest rates. This is because inflation negatively impacts the real level of income from bonds (yield minus inflation). If inflation rises higher than a bond’s interest rate, the bond’s real return will fall below zero. Inflation also reduces the purchasing power of a bond’s interest payments and principal.

The best solution to the problem of possible—but not certain—inflation is to remain diversified with a broad selection of asset classes across geographies, industries, market capitalization, and styles. That way, you are prepared for a range of outcomes.

**Equities** remain an essential part of any portfolio no matter the economic environment because of the growth potential they provide. As well, earnings and dividends have traditionally been good hedges against inflation over the long term. Diversifying globally may be helpful as different regions experience inflation differently.

**Fixed income** remains necessary to offset the risk from the equities portion. While some fixed-income assets such as government bonds may pay yields below inflation, moving to shorter-duration instruments may be an appropriate strategy. Since bond yields tend to rise with inflation (and prices fall), holding shorter-term bonds allows you to reinvest your cash flows at higher rates over a shorter period.

**Real Assets** unique characteristics mean they can provide investors with an income stream that is generally protected from the impact of rising inflation over time. Most infrastructure assets have an explicit link to inflation through regulation, concession agreements, or contracts. Real estate revenues can be adjusted higher through contract renewals, providing some protection against inflationary pressures. The prices of commodities such as gold and oil typically rise when inflation accelerates.

While inflation risks are rising, we aren’t likely to see a sharp spike as the Fed is committed to its inflation goals and target. Still, the outlook is uncertain, and therefore it is prudent to prepare for a higher inflation rate by diversifying across a broad suite of asset classes.
TIME FOR REFLECTION—AND ACTION—ON MORAL CHALLENGES FACING HEALTH SYSTEM LEADERS

BY MATTHEW WYNIA, MD, MPH, FACP

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It’s become a truism that the pandemic has elevated public awareness of ethical issues in medicine and public health. Triage of scarce resources in disasters, the ethics of quarantine and isolation, the legal and ethical legitimacy of mask and vaccination mandates—these are no longer just public health ethics classroom exercises, they are topics of dinner-table conversations worldwide and the subjects of wrenching real-world decisions by leaders.

Longstanding racial, ethnic and geographic health disparities have also been exacerbated by the pandemic, leading to heightened public awareness of historical and structural injustices in U.S. health care. The racial justice protests of 2020 didn’t focus much on excess deaths among minorities in the US health care system, but they could have. And more people now recognize systemic injustices as intertwined, with health disparities intersecting with structural injustices in policing, education, transportation and other domains of American life.

For many health system leaders, this recognition has prompted a difficult acknowledgement: racial, ethnic, geographic and disability-related health disparities cannot be solved by “cultural competence” initiatives aimed at individual clinicians. Just as frontline clinicians have long struggled to help their patients facing various barriers to good health—over which individual clinicians have little or no control—many leaders are now struggling to figure out their roles in remedying structural problems in payment, geographic distribution of resources, transportation, employment and other barriers to the wellbeing of historically disadvantaged communities, because these factors lie outside the traditional purview of the health care systems they lead.

In the meantime, the fact that professional ethics calls on frontline clinicians to put patients’ interests ahead of our own was probably already widely known, but it was also mostly theoretical for many patients. The pandemic changed that too, as the news filled with stories and images of doctors and nurses, often haggard and broken but labeled as “heroic.” But this dynamic also poses a challenge for health system leaders, with many predicting a mass exodus of clinicians in the coming months and years.

Similar to the complex challenge of addressing health inequities, many leaders are coming to realize that addressing the challenge of rising moral distress and burnout among clinicians cannot be solved using an approach focused on bolstering individual...
resilience. Clinicians being ground down by packed schedules, resource shortages, and EMRs tailored to billing rather than patient care might not find enough solace in free yoga classes at noon on Wednesdays. But do individual health system leaders really have the leverage to change the core functionality of available EMRs, or the rates at which their communities choose to be vaccinated, or payment models that reward volume over value?

With the complex challenges confronting health system leaders, it’s no surprise that they are experiencing moral distress and burnout, too. Moral distress arises when someone knows the right thing to do but is constrained by external forces and can’t do it. It arises most often from power dynamics—and while moral distress can be alleviated by naming it and recognizing its effects, it is solved only by effective advocacy to improve underlying conditions.

As I write this, I can almost hear frontline clinicians muttering that their system leaders are paid quite well for bearing these burdens. But so are many clinicians who burn out nevertheless. In health care, remarkably, there is little relationship between one’s level of remuneration and the experience of burnout.

The bottom line is that health system leaders, like clinicians, need to learn how to recognize, analyze and act on the ethical challenges they face. Today more than ever, they need to create safe spaces for talking about the painful experiences of the last year, to share creative practical interventions, and to practice the skills of ethical leadership.

Matthew Wynia, MD, MPH, FACP, directs the Center for Bioethics and Humanities at the University of Colorado Anschutz Medical Campus.
A person contracts an embarrassing highly contagious and easily treatable disease. He fears that if his friends knew about the disease, let alone how he got it, he will be shunned. He weighs the risks — he could muscle through the recovery on his own and try not to expose others, or get help from a doctor with the possibility that everyone will find out. If he does not live in a society with a strong physician-patient privilege, society will suffer. The sick person will likely not seek the help he needs, and others will be exposed unnecessarily.

In a civilized society, we need pockets of protected communication. It advances the good of the whole when an individual knows she can openly discuss pressing problems without fear of public disclosure. Think about privileged communications amongst spouses, or between the penitent and clergy. In Utah, our policy makers have phrased it this way: “There are particular relations in which it is the policy of the law to encourage confidence and to preserve it inviolate.” (Utah Code Section 78B-1-137). And within a list of recognized privileges, the physician-patient privilege is prominently recognized: “A physician, surgeon, or physician assistant cannot, without the consent of the patient, be examined in a civil action as to any information acquired in attending the patient which was necessary to enable the physician, surgeon, or physician assistant to prescribe or act for the patient.” (Utah Code Section 78B-1-137(4)).

Utah physicians, and their patients, should be confident that a privilege exists when the patient shares information necessary for treatment. The law establishes the expectation that court
actions cannot penetrate those private consultations. Nevertheless, physicians should also know that there are limitations to the privilege. Notably, while Utah state law is clear on the privilege, federal law does not recognize an outright general privilege between patient and doctor. Moreover, a critical reading of the Utah law reveals that privileged communications are narrow in scope.

On another front, physicians and their organizations can also be the beneficiaries of privileged communications. As the oldest recognized privilege, the Supreme Court has underscored the importance of the attorney-client privilege as it relates to healthcare providers, individuals and corporations alike. (See Upjohn v. U.S., 449 U.S. 383 (1981)). The attorney-client privilege has grown in significance amidst the ever-complicated administration of healthcare in the United States.

Indeed, healthcare regulations are complex and confusing. One prominent court bluntly characterized the Medicare and Medicaid regulatory landscape as “among the most completely impenetrable texts within human experience.” (Rehab. Ass’n v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir.1994)). And another court colorfully described the Medicare statute as “a law written by James Joyce and edited by E. E. Cummings.” Catholic Health Initiatives – Iowa, Corp. v. Sebelius, 841 F.Supp.2d 270, 271 (D.D.C. 2012), rev’d, 718 F.3d 914 (D.C. Cir. 2013).

Physicians and health care providers can benefit from the attorney-client privilege “[i]n light of the vast and complicated array of regulatory legislation . . . .” (Upjohn at 392-93). The privilege is founded on the principle that full and frank communication between attorneys and their clients promotes broader public interests because sound legal advice and advocacy serves public ends. (Upjohn at 389).

To ensure that an attorney-client privilege is recognized and enforced, physicians and healthcare providers must treat the privileged communications carefully. Consider the cottage industry of whistle blower actions alleging fraudulent and false claims in billing and care practices. Healthcare organizations strive to improve upon and correct deficiencies in the services they offer, and they often seek legal advice on how best to employ a corrective plan. A disgruntled employee may get their hands on portions and pieces of information and try to profit through a Qui Tam lawsuit. The attorney-client privilege may or may not offer the desired protection from disclosure depending on the way in which privileged information is managed.

Physicians engage in privileged communications on a daily basis. Most often, physicians serve their patients by providing advice and care in a setting that serves not only the individual patient, but greater society, as well. Physicians and their offices can also benefit from privileged communications as they engage with legal counsel. Privileges serve a broader public purpose and help us maintain and advance a civilized society.

Author: John Huber offered 27 years of public service as a prosecutor in state and federal courts. From 2015-2021, Mr. Huber served as the United States Attorney for the District of Utah, having been appointed by both President Obama and President Trump and unanimously confirmed twice by the United States Senate. He is now in private practice with global law firm Greenberg Traurig and is based in Salt Lake City.
More than 4,500 student injuries occur in Utah every school year, which is almost 26 student injuries every school day. The Student Injury Reporting System (SIRS) was first developed in partnership by the Utah Department of Health (UDOH) and the Utah State Board of Education. It is currently maintained by the UDOH Violence and Injury Prevention Program. All 41 Utah school districts contribute to the Student Injury Reporting System, including more than 800 public schools; approximately 90% of schools in Utah participate. The Student Injury Reporting System is a voluntary system with many under-reported injuries. The Student Injury Reporting System includes injuries happening while going to or from school, during school-sponsored activities, and anywhere on school property during normal school hours. The Student Injury Reporting System collects data on injury types, what caused the injury, when the injury occurred, basic demographic data of the student, and any follow-up after the injury occurred. This report includes injuries meeting the UDOH Reportable Injury Criteria, meaning the injury was severe enough to cause the student to miss a half day of school or more, OR required any sort of medical attention or treatment.

Due to in-person school closures and issues with reporting, the number of student injuries in 2019–20 dropped below the previous seven-year rolling average of 5,100 annual student injuries (Figure 1). However, trends in type of injuries appear to have remained stable. The 2020–2021 school years where there were issues with reporting and in-person school closures due to the COVID-19 pandemic.

**Total Number of Student Injuries during School Years 2012–2013 through 2020–2021**

*2020-2021 data are preliminary, less than 5% of cases are under review.*

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-13</td>
<td>5,623</td>
</tr>
<tr>
<td>13-14</td>
<td>4,150</td>
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<tr>
<td>14-15</td>
<td>4,730</td>
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<td>5,465</td>
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<td>17-18</td>
<td>5,167</td>
</tr>
<tr>
<td>18-19</td>
<td>5,230</td>
</tr>
<tr>
<td>19-20</td>
<td>2,194</td>
</tr>
<tr>
<td>20-21*</td>
<td>4,047</td>
</tr>
</tbody>
</table>

Figure 1. Utah reported more than 4,100 injuries most school years except during the 2019-2020 and 2020-2021 school years where there were issues with reporting and in-person school closures due to the COVID-19 pandemic.
Injuries and demographics of students appear to have remained stable. The 2020–2021 student data are still preliminary as fewer than 5% of cases are still under review.

During the 2016–2017 through 2020–2021 school years, more than 20,000 student injuries occurred. More than half of student injuries occurred among male students (61%). Approximately half of all student injuries occurred between 5th–9th grade (48%). Among female students only, the total number of injuries remained fairly consistent with lower numbers during preschool and kindergarten, and again in 11th and 12th grades (Figure 2).

The most common types of student injury are possible fractures or breaks, cuts or lacerations, sprains, strains, or tears, possible concussions, and bumps, bruises, and contusions (Figure 3). No major differences were found between school years, grade, or student sex.

More than one third of student injuries occurred during recess (38%) (Figure 4). Athletic injuries may be underreported due to voluntary reporting.

Prevention Tips Data from the SIRS can be used for prevention. Some prevention tips from the data include:

- Provide trained adult supervisors at recess
- Establish playground safety rules
- Schedule regular inspections of school grounds and equipment

The most reported injury among students was a fracture or break.

Student Injuries by Period in Utah, 2016–2020

Figure 4. Most reported injuries for students occured during recess and P.E. class.

- Recess (including lunch recess) 8433
- P.E. Class 4677
- Class time 3227
- Before and After School 2049
- Lunch 995
- Athletic Practice Session 752
- Class Change 710
- Athletic Event 589
- Field Trip 249
- Other 229
- Assembly 70


References:


* 2020-2021 data are preliminary, less than 5% of cases are under review.
CME SPOTLIGHT

NEWLY UPDATED COURSE

Title:  [2022] Controlled Substances: Education for the Prescriber
When:  On-demand Webinar
Where:  Online at cme.utahmed.org
CME:  3.5 AMA PRA Category 1 Credits™
Provider:  UMA Foundation

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;
- Know Utah requirements and limitations in recommending medical cannabis.
### UTAH CME SPONSORING ORGANIZATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
<th>Contact Information</th>
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</thead>
<tbody>
<tr>
<td>ALT</td>
<td>Alternative CME, SLC, 801/200-4321</td>
<td>PRKA</td>
</tr>
<tr>
<td>ACOG</td>
<td>American College of Obstetrics and Gynecology, UT Chapter, SLC, 801/747-3500</td>
<td>STW</td>
</tr>
<tr>
<td>ACP</td>
<td>American College of Physicians, UT Chapter, SLC, 801/582-1565 x2441</td>
<td>TRH</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>
<td>UAFP</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association, Chicago 312/464-4761</td>
<td>UHLF</td>
</tr>
<tr>
<td>AUCH</td>
<td>Association for Utah Community Health, SLC, 801/924-2848</td>
<td>UDS</td>
</tr>
<tr>
<td>CA</td>
<td>Collegium Aesculapium, Orem, 801/802-0449</td>
<td>UMAF</td>
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<tr>
<td>CM</td>
<td>CoMagine, SLC, 801/892-6645</td>
<td>UMIA</td>
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<tr>
<td>IHC</td>
<td>Intermountain Healthcare CME, SLC, 800/842-5498</td>
<td>UUCME</td>
</tr>
<tr>
<td>LVH</td>
<td>Lakeview Hospital, Bountiful, 801/299-2546</td>
<td>VA</td>
</tr>
<tr>
<td>OSMS</td>
<td>Ogden Surgical-Medical Society, Ogden, 801/564-5585</td>
<td></td>
</tr>
<tr>
<td>PCH</td>
<td>Primary Children’s Hospital, SLC, 800/910-7262</td>
<td></td>
</tr>
</tbody>
</table>

### The following websites offer online continuing medical education:

- cme.utahmed.org
- psnet.ahrq.gov/cme
- thedoctorschannel.com/cme
- freecme.com
- pri-med.com/pmoOnlineCME.aspx
- medicine.utah.educme
- cmelist.com
- ama-assn.org/education-center
- baylorcme.org
- medscape.org
- vhl.com
- nejm.org/continuing-medical-education
- reachmd.com/programs
- cms.gov/Outreach-and-EducationLearnEarn-CreditEarn-credit-page.html
- primarycarenetwork.org
- emedevents.com

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

- ama-assn.org
- eMedEvents.com
Nothing can be more frustrating than to treat a patient, provide a service, or deliver a good, and then not get paid. Unfortunately, this happens too often. So here are some things to know when you start to collect money and payments you are owed.

**WHAT TO INCLUDE IN INITIAL AGREEMENTS WITH PATIENTS**

Your ability to collect starts when you first get a new patient or customer. At the outset of any new relationship, it is important to provide disclosures and have your new patients sign the appropriate agreements. In these agreements, you should include at least the following items related to payments. First, your agreement should state an expectation of payment and the term in which all payments should be made. For example, all co-pays may be required at the time of service and any further amounts which may remain due and owing should be paid within thirty days of the invoice being mailed. Second, the agreement should state what occurs in the event of default. It should state if any late fees are going to be charged and if so, what those late fees will be. If you intend for interest to accrue on unpaid amounts, it should also state when interest will start to be incurred and the applicable rate. For example, for any payment that is not paid within thirty days, a late fee of 10% of the amount owed will apply and interest will accrue on any outstanding amounts at a certain rate.

In addition, it is important that any agreement state that the provider will be entitled to collect any costs of collection, including attorneys’ fees and costs, which may be incurred in collecting amounts which remain due and owing. In Utah, for a party to collect attorney fees, it must be provided for in a statute or in a contract. That is why it is important that your agreement provide such a disclosure. In addition, to ensure your ability to enforce these terms, your agreements should require a signature of the patient agreeing to the subject terms.

**WHAT IF SOMEONE WHO OWES YOU MONEY FILES FOR BANKRUPTCY?**

At times, a customer or patient will file for bankruptcy. What then? First, 11 U.S.C. § 362 provides that once a company or individual files for bankruptcy, all collection efforts are automatically stayed. This means that a collecting party is prohibited from the commencement or continuation of any action or proceeding that could have been commenced or had commenced prior to the bankruptcy filing to collect the amounts that are owed to you. In addition, if you have already obtained a judgment for any amounts owed, you are prohibited from taking any further action to collect on the judgment.

This leads to the obvious question of whether you will be paid. In certain bankruptcy cases, a portion of debt will be paid. In others, the debt may be discharged without payment. In any bankruptcy case, however, when the debtor files for bankruptcy, the debtor is required to list the name and address of all their creditors. This should include you if you are a creditor. Those listed as creditors will then receive a Notice of Bankruptcy Case. In that notice, in certain cases, particularly Chapter 13 bankruptcy cases, you will see a deadline for filing a proof of claim. A proof of claim is a document that is filed with the bankruptcy court to identify what you are owed. To participate in any payout that may come from a bankruptcy case, you must file a proof of claim, so it is important to read these notices carefully. In some bankruptcy cases, a proof of claim may not be required at the beginning of the case, but it may be required later. In such cases, a second notice requesting proofs of claim will be sent. For this reason, proper attention to bankruptcy notices is vital.

**THE FAIR DEBT COLLECTION PRACTICES ACT**

In some situations, the Fair Debt Collection Practices Act (“FDCPA”) applies. Consult with your counsel to determine if the act applies to you. If it does apply, the FDCPA governs certain aspects of collection and is intended to protect creditors. Among other items, the FDCPA prohibits you from making misrepresentations concerning the debt, using threats of violence or harm, using obscene language, or other types of actions that could be considered harassment. It also requires you to provide validation information concerning the debt including how much is owed, the name of the creditor, how to get the name of the original creditor, and what to do if the debtor disputes the debt.

**HOW TO COLLECT**

Finally, if the patient or customer does not pay, a lawsuit may be commenced to collect the debt due and owing. In Utah, a business entity cannot represent itself in court without a lawyer, so you will want to retain counsel or hire a collection agency. Once a lawsuit is commenced, the party to whom money is owed can obtain a judgment. If a judgment is obtained, then processes such as garnishment of wages or of bank accounts or other writs of execution can be used to collect what is due and owing. In addition, at this point, you will seek to collect the late charges, interest, attorneys’ fees, or other amounts which your contract allows. Although cumbersome, if a customer does not pay, through effort, satisfaction of the debt may ultimately be obtained.

**Author:** Mr. Sorenson is a member of the firm’s Bankruptcy and Creditor’s Rights and Litigation sections. His practice is concentrated in creditor’s rights and commercial and bankruptcy litigation. As part of his creditor’s rights practice, Mr. Sorenson represents parties in all aspects of collection matters and evictions. Mr. Sorenson currently serves on the boards of the Utah Center for Legal Inclusion and Asian Utah Chamber of Commerce and is a past president of the Utah Minority Bar Association.
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.
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