Provider Bulletin

December 2011 Volume 17, Issue 4

Medi-Cal Cuts and the Road to 2014

On October 27th, the State received federal approval to implement 10% cuts to certain Medi-Cal provider payments, and then made those cuts to the Alliance's revenue, effective back to July 2011. The State had modified their original plan for Medi-Cal payment cuts, now exempting physician services to children, as well as hospice, and home health. The State also excluded hospital payments from the cuts. However, the remaining State cuts focused on physician and clinic services to adults, and also allied health services such as lab, DME, and therapies.

On December 7th, the Alliance's board met to consider their response to the State's Medi-Cal provider cuts. Their decision was to not implement any of the State's cuts to provider payments at this time, and to revisit the situation in mid-2012. Therefore, the Alliance will subsidize the State's 10% cuts to affected Alliance provider payments during the State's FY 11/12. The Alliance's board made that decision because the plan is financially strong and able to make the subsidy, and because the board greatly values local providers' services to Alliance members. This situation will evolve in the coming year, but for the time being, the Alliance will not cut its Medi-Cal provider payments.

As we enter the home stretch on 2011, we have witnessed a year of stark contrasts. With a struggling economy, our State and nation is facing record unemployment and deficits. At the same time, 6 million more Californians can expect new peace of mind from health care coverage starting in 2014. To make this coverage affordable, it is imperative that we work together to bend the health care cost curve. Not through cuts, if avoidable, but by changing the profile of health cost through better access, prevention, treatment and self-care.

To move that agenda forward, the Alliance has implemented Care Based Incentives (CBI) for our primary care providers. CBI rewards providers for best practices in access, prevention and chronic disease management, and provides Practice Profiles with performance scores and rankings. CBI provides feedback and incentive payments to providers that are important tools in reshaping health care costs. The Alliance's CMO, Dr. Richard Helmer, provides an update on CBI in this Bulletin.

The Alliance also encourages personal responsibility for the daily health behavior that shapes future medical needs. The Alliance's member incentive programs engage our enrollees to improve their access behavior, compliance and self-care. The medical cost curve doesn't originate in the exam room, it begins at home.

Certainly, we must do a better job of managing complex care. Among Alliance members, only 8% of our 200,000 members account for an astonishing 75% of cost. The Alliance is launching new Care Management Programs focused on complex medical needs, ED frequent users, readmission risks, and chronic disease management. With an Alliance budget of over $500M, even modest improvements in the care of our "hot spotter" members can yield big results.

In an era of State budget cuts, the Alliance's goal is to maintain the integrity of our local system of care, so that coverage expansion in 2014 can provide true peace of mind for an estimated 50,000 new Alliance members in our tri-county service area. Better care, higher quality, less cost. These are the milestones on the road to 2014.

Alan McKay
Executive Director

CBI 2011 – What we learned and what we will change for 2012

The Alliance introduced the Care Based Incentive (CBI) program in 2011 as a mechanism to promote physician satisfaction and to drive the care our members receive toward the medical home model. This model appears to be successful at both improving care and reducing costs. During initiation of the CBI program in 2011, it accounted for 10% of the budgeted incentive payment program. At the same time, the Alliance modified member incentive programs to better target many of the same issues that arise for providers.

The Alliance plans to make CBI its sole incentive program for our primary care providers as of January 1, 2012. Therefore, when the program was first implemented as part of the overall incentive package, we wanted to make certain that we got the methodology "right" and that we were using reliable data to evaluate important issues in a consistent way. We did not expect CBI to be perfect (hence using only 10% of the budgeted incentive payments for CBI in 2011), and as expected we received a number of comments, suggestions and criticisms. In response to that feedback, we made some changes to the 2012 program that we expect will address at least the major issues that were raised this year.

While most of the CBI measures will remain unchanged for 2012, there will be some alterations:

Ambulatory Care Sensitive Conditions
CBI 2011 referred to "Preventable Inpatient Admissions," a term that did not sit well with some of our providers. The list of diagnoses that would qualify as "preventable" was actually developed by the federal Agency for Healthcare Research and Quality as Ambulatory Care Sensitive Conditions, and they have been demonstrated to reflect the quality and robustness of the primary care delivery system around the hospital. The better that primary care is provided in the immediate community, the fewer patients with these conditions will require hospitalization. Thus while we will continue the same methodology for this parameter, we will now be referring to it as "Rate of Ambulatory Care Sensitive Admissions."

Quality of Care Measures
The major change affecting this section of the incentive plan relates to scoring. Previously some physicians were penalized for not having enough qualifying members for a particular measure to count. For 2012, a provider will always be eligible for the full amount of available points. The points will then be allocated across those measures for which a provider meets the basic qualifications.

A second update for 2012 changes the total points available for the Quality of Care measures, increasing them from 25 to 30. The additional five points come from the inclusion of the measure known previously as "Rate of Controller Medications for Asthma Care," now to be called the "Asthma Medication Ratio." Finally, the title "Medical Attention for Nephropathy" replaces the "Diabetes Monitoring for Diabetic Nephropathy" that was part of the Diabetes bundle in the Quality of Care measures.

Electronic Data Submissions
We have added a new target measure for the submission of referrals through the Alliance web portal. Providers who submit 75% of eligible referrals through the web portal will receive 2 points. The electronic claim/encounter data measure was reduced from 5 to 3 points.

Asthma Action Plans
In the past this measure had been restricted to members up to 18 years old. In 2012 asthma action plans submitted for members between the ages of 3 and 56 will be eligible for this fee-for-service award.

Healthy Weight for Life Program
We have expanded the BMI-related measures into the new Healthy Weight for Life Program. Providers will be eligible for a total of $30 per member who participates in the program, half upon referral of a member whose BMI is at or above the 85th percentile and half for a follow-up visit at six months, all to be documented on the Alliance's form. Members referred to this program will be contacted by Alliance case managers and enrolled in programs emphasizing dietary and exercise improvements.

Changes to Calculations and Payment

Several other procedural changes are worth noting:

- Claims and forms must be received by January 31, 2013 to be included in the CBI payment for 2012.

- Due to the greater intensity of resources used in providing services to some members, particularly the population of Seniors and Persons with Disabilities, we will weigh the number of member months for members in those aid categories by a 4:1 ratio compared to those in all other aid categories.

- We have adjusted the Member Reassignment threshold so that in 2012 any provider whose approved reassignments exceed two standard deviations from the Alliance mean will have their earned points reduced by half rather than being eliminated from this portion of the incentive payment plan.

We believe that these changes will strengthen the Alliance's incentive program for providers, and we are grateful to you for the feedback that you have provided and that has led us to the changes we have made. This continues to be a "work in progress." We welcome your input and comments.

Provider Alert: Lipoid Pneumonia from Home Remedies

In the last few weeks we have learned of two infants who were hospitalized in Monterey County with the diagnosis of lipoid pneumonia. This unusual condition is most often caused by the aspiration of oils that are given by mouth or trans-nasally as traditional home remedies for perceived problems with upper airway congestion or constipation. The Alliance wants to alert you to this condition, explain the background against which this is happening, and guide management and expectations.

Lipoid pneumonia presents generally as a community-acquired pneumonia in otherwise healthy children, although some children can have persistent symptoms for weeks or months before the diagnosis is made. Common symptoms are cough and tachypnea, often accompanied by low-grade fever and oxygen desaturation. Radiologic studies are often non-specific, although high-resolution CT can provide clues such as are seen in aspiration pneumonia: consolidation affecting the right upper lobe of the lung and a central and posterior distribution of lesions. The diagnosis can depend on either obtaining information from parents about the use of oils at home as treatments for various common ailments or, if necessary, the finding of lipid-laden macrophages on bronchoalveolar lavage. Treatment is supportive; the most important step is to stop the administration of the oil. Generally recovery is complete, but an ongoing inflammatory response to continued exposure to oils can potentially lead to the development of interstitial lung disease.

Uses of various animal or vegetable derived oils (mineral oil, olive oil, and cod liver oil) are cited most frequently as a cause of lung disease. These home remedies are highly prevalent in a number of different cultures; reports have come from Saudi Arabia, southern India, Brazil, and Mexico. Two cases reported in the *Archives of Pediatric and Adolescent Medicine*[1] in 2005 and the two local cases all involved olive oil, and all were in families with roots in Mexico. Caregivers at home rarely see this as a practice associated with any danger, and therefore are less likely to report it to the examining practitioner. This is another example of why it is important to query caregivers not only about prescription medications but also over-the-counter medicines and alternative treatments.

Supportive treatment with oxygenation and, if indicated, antibiotics is generally all that is required. However, what is most important, for both identification and prevention, is to identify the practice and convince an infant's parents and caregivers that there are better and safer ways to treat common ailments in young children.

1. Hoffman LR, et al. Lipoid pneumonia due to Mexican folk remedies. *Arch Pediatr Adolesc Med* 2005; 159:1043-1048

Formulary Changes

Additions: Dulera
Losartan
Losartan/HCTZ
Renvela
Colcrys
Pantoprazole
Temovate (clobetasol)
Divalproex ER
Venlafaxine ER (quantity limit of one per day (two per day for IR))
Lansoprazole
Levofloxacin

Nutritional Supplements– Starting October 1, 2011 nutritional supplements will no longer be covered by Medi-Cal or the Alliance for members 21 years of age and older except when certain criteria are met such as administration via a feeding tube or a diagnosis of malabsorption or inborn errors of metabolism.

New Provider Services Staff

Rita Petherbridge –
Provider Services Data Specialist
(831) 430-5674
rpetherbridge@ccah-alliance.org

Rita is a recent transplant to California from Portland, Oregon. She has a BS in Mathematics and an interest in decision theory. Rita comes to us with a research and data background.

Provider Satisfaction Survey

In August, the Alliance concluded its annual Provider Satisfaction Survey. The survey was faxed to all Alliance primary care providers and specialists. We would like to extend our sincere gratitude to all providers who took the time to complete a survey. Your feedback is extremely valuable!

Key results from the survey were:

- 98.5% of PCPs and 98.3% of specialists indicated their satisfaction with the Alliance.
- 85% indicated that they were more satisfied with the Alliance than with other health plans.
- 89% indicated that they were more satisfied with the Alliance than other health plans.

As a way to thank providers for their participation in the Provider Satisfaction Survey, the Alliance entered all providers who returned a survey into a drawing for an office pizza party. Congratulations to our winners!

- Pediatric & Adolescent Medical Associates of the Pacific Coast, Inc. (Monterey County)
- James Woods, M.D. (Santa Cruz County)
- Samuel Loredo, M.D., Inc. (Merced County)

HIPAA 5010 Preparation and Compliance

Beginning on January 1, 2012, the HIPAA federal mandate requires health plans, clearinghouses, providers, business associates, and all HIPAA covered entities to upgrade from ASC X12 version 4010A1 to version 5010 standards for conducting administrative health care transactions electronically. These transactions, as they apply to Alliance-provider communications, include the following:

- Institutional Claim (837I);
- Professional Claim (837P);
- Claims Payment Advice (835);
- Eligibility Inquiry / Eligibility Response (270/271), and;
- Claims Status Inquiry and Claims Status Response (276/277).

The Alliance has begun testing 5010 transaction sets, such as 837 (Inbound Claims) and 835 (Outbound Remittance). Please contact us if you are ready to test 270/271 and 276/277 transactions as the Alliance is prepared to start testing these communications. All health care entities must convert to version 5010 standards by the federal compliance date. The Alliance will support 5010 transactions from January 1, 2012. Reimbursement

delays and resubmission costs could occur, so it is important to prepare now. If you are currently submitting paper claims or submitting claims via direct data entry, we encourage you to consider electronic data interchange (EDI). Electronic transactions offer efficiencies in claims filing and inquiries, which results in faster payment processing. And, electronic remittance information allows for automated posting to your accounts receivable system(s). For more information regarding Electronic Processing or 5010, please contact our Web & EDI Specialist at (831) 430-5510.

Claims Corner

Knock your socks off customer service

Customer Service; two words that we take seriously here in the Alliance Claims Department. Your time is valuable. When you call,our goal is to answer that call within 20 seconds. And that's just the first step. The next is to answer questions, help solve problems and get you on your way. We extend that same care and concern to provider in-services. An in-service is designed to specifically address your billing issues. The Outreach Coordinator and Adjudicators run reports, do research, and come prepared to look at your billing in depth. We routinely hear comments like this from a recent in-service: "Thank you for taking time with the staff here. We really appreciated the feedback and the effort it took to prepare for a face-to-face meeting." If this sounds like something your office would benefit from, please contact your Provider Services Representative.

Antepartum services billed with postpartum diagnoses

Medi-Cal instituted a correction for antepartum services that inappropriately allowed reimbursement when billed with a postpartum diagnosis code. This correction went into effect for any claim received on or after May 1, 2011. Unfortunately, that correction was ***not*** included in a Medi-Cal Provider Bulletin nor has it been published in the appropriate Medi-Cal Manual section(s). If you have received denials with explain code 3V (Diagnosis Not Valid Or Related To Procedure Billed) for any of the following procedures (Z1030, Z1038, Z6200- Z6206, Z6300-Z6306, Z6400- Z6408, Z6410, Z6412, and 59025), please contact the Claims ACD line at (800) 700-3874 ext. 5503. Our Adjudicators can supply more details for correct claims submission for these services.

Claims correction procedure reminder

Claims and Finance departments will no longer accept claims corrections over the phone. In addition, previously submitted claims cannot be reprinted for the purpose of reprocessing with EOBs, refund checks, overpayment forms asking for partial adjustments, EOBs attached to refund checks, DME items returned, or SOC not noted on claims. To correct a claim, use the Web Resubmit capability ***or*** resubmit the claim with a note in Remarks indicating "corrected claim" (adding details such as "reverse Claims Control Number (CCN) 20110203XXXXXXXX" if applicable).

The Alliance must conform to industry standards and auditing requirements. Please contact your Provider Services Representative with any questions or concerns at (800) 700-3874 x5504 for Santa Cruz and Monterey providers and (800) 700-3874 x5514 for Merced providers.

Help Stop Health Care Fraud, Waste and Abuse

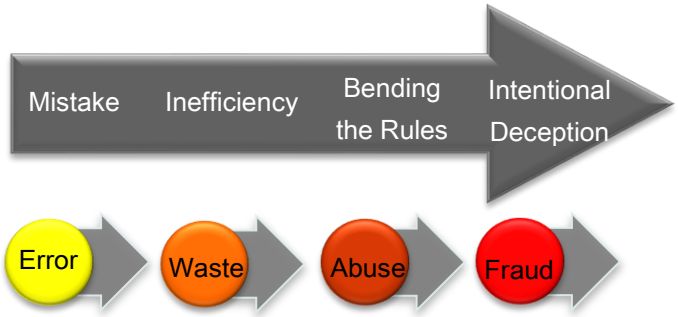
The Alliance is committed to joining with our community partners to reduce the incidence of health care fraud, waste and abuse. The Fraud Prevention Institute estimates criminal activity – fraud, waste and/or abuse – in the Medi-Cal system at approximately 25% (David J. Gibson, 2010). The Alliance's Fraud, Waste and Abuse Prevention (FWAP) program can help.

The Alliance is dedicated to promoting transparency in provider delivery, member receipt, and Alliance administration of health care services by practicing objective and systematic methods for:

- **Prevention** – Ongoing quality improvement of anti-fraud mechanisms.
- **Detection** – Multi-pronged monitoring and evaluation methods**.**
- **Investigation** – Prompt, discrete and multidisciplinary investigation of suspected fraud, waste and/or abuse.

- **Reporting** – Reporting of suspected fraud and/or abuse to appropriate government and/or law enforcement agencies.
- **Resolution** – Taking action to rectify non-compliance and mitigate future exposure to fraud, waste and/or abuse.

Fraud, waste and abuse defined



Fraud, waste and/or abuse includes any qualifying act under applicable Federal or State law.

Key anti-fraud laws

False claims:
The Federal False Claims Act (FCA) (31 U.S.C., § 3729) and California False Claims Act (CFCA) (CA Code § 12651) impose civil liability on any individual or business entity knowingly representing, or causing to be represented, a false or fraudulent claim for payment to the government or contractor of the government. Penalties include civil fines between $5,500-$11,000, per false claim and up to triple the damages which the government sustains.

Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C. 3801-3812) establishes as an administrative remedy to process low-level FCA violations. The PFCRA prohibits the submission of false claims or written statements to certain federal agencies, including the Department of Health and Human Services. Violations are subject to civil penalties of not more than $5,000 per claim.

Whistleblower (or "*Qui Tam*") provisions provide a mechanism for private individuals, known as "relators", with evidence of FCA or CFCA violations to file lawsuits on behalf of the Government to recover funds. A relator filing a successful *Qui Tam* lawsuit may be entitled to 15-30% of the recoveries.

Anti-kickback:
The Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b) stipulates that whoever knowingly and willfully solicits, receives, or gives any remuneration to induce, or in return for, referrals of items or services reimbursable by a Federal health care program, is guilty of a felony and eligible for fines up to $25,000 and/or imprisonment up to five years.

Physician self-referral:
The Physician Self-Referral Law (or "Stark Law") prohibits a physician from making referrals for certain federally reimbursable designated health services to an entity with which the physician (or physician's immediate family member) has a financial relationship, unless an exception applies.

Fraud, waste and abuse increases health care costs for everyone and impacts our community's well-being. If at any time you suspect fraud, waste and/or abuse, or if you have general questions about our FWAP program, please contact your Provider Services Representative. With your help, we can fight health care fraud, waste and abuse.

To review our FWAP Policy for Alliance Contractors please go to http://www.ccah-alliance.org/policies.html.

David J. Gibson, M. (2010). *Estimating the Magnitude of Fraud Within the California Medi-Cal Program.* Fraud Prevention Institute.

Claims Submission Reminder for CBI 2011, UMI and QBI

The Alliance's Incentive Programs provide an opportunity for primary care physicians to be financially rewarded for outstanding performance on clinical measures and access to care. The 2011 incentive calculations will be conducted in the first quarter of 2012 and distributed in second quarter 2012 as part of the annual incentive distribution.

Remember, your CBI, UMI and QBI performance is measured solely from claims data. We want you to receive credit for the quality care you provide Alliance members, so please submit your 2011 claims as soon as possible.

2011 claims must be submitted no later than January 31, 2012 in order to be counted toward your 2011 CBI, UMI and QBI totals.

HEDIS Recognition

The Alliance conducts HEDIS studies annually that conform to the National Committee for Quality Assurance (NCQA) standards. HEDIS is the industry standard for assessing the delivery of medical care. These studies are based on our Medi-Cal line of business. A physician must have a minimum of 5 eligible members to qualify for a particular measure.

The Alliance is very thankful for another year of hard work and excellent care you have provided our members. The following providers met or exceeded the NCQA 90th percentile in one or more measures of their individual Quality Performance based on the results of our 2011 HEDIS studies. These studies are for services performed during or before calendar year 2010. Congratulations to all!

Adam O. Yarme, MD
Alan Rosen, MD
Alisal Health Center
Allison Herman, MD
Amy Culver, MD
Amy Solomon, MD
Apex Medical Group
Ariel Martinez, MD
Arunasree Chinnakotla, MD
Atwater Medical Group
Beach Flats Health Center
Bernard Hilberman, MD
Big Sur Health Center
Brennan Medical Group
Capitola Pediatrics
Carmen Hsu, MD
Castle Family Health Center - Bloss
Castle Family Health Center - Castle
Castle Family Health Center - Winton
Children and Family Medical Care
Christopher J. Ogrady, MD
Clayton R. Mcdaniel, MD
Clinica De Salud Del Valle De Salinas - Castroville
Clinica De Salud Del Valle De Salinas - Circle Dr
Clinica De Salud Del Valle De Salinas - Greenfield
Clinica De Salud Del Valle De Salinas - King City
Clinica De Salud Del Valle De Salinas - Sanborn Rd
Clinica De Salud Del Valle De Salinas - Soledad
Clinica Del Valle Del Pajaro
Conrad J. Castellino, MD
County Of Santa Cruz Health Services Agency
Daniel Hardy, MD
Danielle Acton, MD
David Stark, MD
Dominican Hospital Pediatric Clinic
Dos Palos Memorial Rural Health Clinic
Drew E. Maris, MD
Edgar H. Castellanos, MD
Elias Rodriguez, MD
Family Doctors Of Santa Cruz
Gael Decleve, DO
George L. Mee Memorial Clinic - Greenfield
George L. Mee Memorial Clinic - King City
George L. Mee Memorial Family Medical Center
Gettysburg Medical Clinic
Golden Valley Health Center - Dos Palos
Golden Valley Health Center - El Portal
Golden Valley Health Center - Le Grand
Golden Valley Health Center - Los Banos
Golden Valley Health Center - Merced
Golden Valley Health Center - Newman
Golden Valley Health Center - Obanion
Golden Valley Health Center - Planada
Gonzales Medical Group
Homer W. Harris, Jr., MD
Horisons Unlimited Healthcare Center - Gustine
Horisons Unlimited Healthcare Center - Livingston
Horisons Unlimited Healthcare Center - Los Banos
James Riley, MD
James W. Michel, MD
Jeffrey Roisman, MD
Jeffrey Solinas, MD
Jose M. Pauda, MD
Josefa Simkin, MD
Karen E. Lynch, MD
Kevin J. Hasenauer, MD
Larry Nutting, MD
Laurel Family Practice Health Clinic
Laurel Internal Medicine Health Clinic
Laurel Pediatrics Health Clinic
Lena N. Malik, MD
Leo J.C. Jou, MD
Leslie S. Galloway, MD
Livingston Medical Group
Long Thao, MD
Madhu Raghavan, MD
Maryam Jalali, MD
Marylou Romo-Gritzewsky, MD
Meghan Thomas, MD
Melinda White, DO
Melissa Z. Lopez-Bermejo, MD
Memorial Hospital Los Banos Rural Health Clinic
Merced Faculty Associates Castle Site
Merced Faculty Associates El Portal

Merced Faculty Associates Hilmar Family Medical Clinic
Merced Faculty Associates Lifetime Health Care
Merced Faculty Associates Main Site
Merced Faculty Associates Parkside
Michael Suval, DO
Monterey County Health Clinic at Marina
Nancy Jacobsen, MD
Newman Medical Clinic
Pacific Coast Pediatric Center
Palo Alto Medical Foundation, Aptos Site
Palo Alto Medical Foundation, Santa Cruz Downtown
Palo Alto Medical Foundation, Santa Cruz Main
Palo Alto Medical Foundation, Santa Cruz Westside
Palo Alto Medical Foundation, Scotts Valley Site
Palo Alto Medical Foundation, Watsonville Site
Pediatric & Adolescent Medical Assoc. of The Pacific Coast
Peninsula Primary Care
Planned Parenthood Watsonville
Planned Parenthood Westside
Rafael O. Siqueiros, MD
Robert Weber, MD
Roberto C. Tongson, MD
Roger L. Fife, MD
Salinas Pediatric Medical Group
Salud Para La Gente
Santa Cruz Womens Health Center
Seaside Family Health Center
Steven Magee
Sumana Reddy
Thomas Silverman
Vilma Aguas
Watsonville Health Center
William G. Koehne

New Alliance Providers

Merced County

Primary Care
Noshaba Chughtai, MD (Family Medicine)
Rafael Li Jimenez, MD (Pediatrics)
Marylou Ostrea, MD (Pediatrics)

Referral Physician/Specialist
Felix Sanchez, MD (OB/GYN)

Monterey County

Primary Care
Josee Belanger, MD (Family Medicine)
Russell Brunet, DO (Family Medicine)
Mary Chen, MD (General Medicine)
Umberto D'Ambrosio, MD (General Medicine)
David Davis, MD (General Medicine)
Jacqueline Delyaei, MD (Internal Medicine)
Tye DePena, MD (Family Medicine)
Linda Eglin, MD (Internal Medicine)
Maria Falcocchia, MD (Family Medicine)
Miki Joy, MD (Family Medicine)
Trupti Kapatkar, MD (Family Medicine)
Becky Kroll, MD (Family Medicine)
Cecilia Loleng, MD (Family Medicine)
Inez Munoz de Laborde, MD (General Medicine)
Julia Nyquist, MD (General Medicine)
Scott Prysi, MD (General Medicine)
Santhi Raja, MD (Internal Medicine)
Steven Schumann, MD (General Medicine)
Jacqueline Sedgwick, MD (General/Preventative Medicine)
Linda L. Smith, MD (Internal Medicine)
Mary Sweet, MD (Family Medicine)
William Tong, MD (General Medicine)
Sara Velasco, MD (Family Medicine)
Trinh Vu, MD (General Medicine)
Leann E. Watson, MD (General Medicine)
Timothy Wilken, MD (General Medicine)

Santa Cruz County

Primary Care
Kevin Coldwater, DO (Family Medicine)
Maria Greaves, MD (Family Medicine)
Hossein Hassani, MD (Family Medicine)
Natalie Marino, MD (Family Medicine)
Scott Schneiderman, DO (Family Medicine)
Amrita Stark, MD (Pediatrics)

Referral Physician/Specialist
Edgar Gamboa, MD (Surgery)
Thuan-Hau Trinh, MD (Anesthesiology)
Mark Goldin, MD (Emergency Medicine)
Mathew J. Katics, DO (Emergency Medicine)
Kevin Keet, MD (Internal Medicine)
Vidya Nagarajy, MD (Internal Medicine)
Gregory Nee, MD (Emergency Medicine)
Bruce Robison, MD (Orthopaedic Surgery)
Robin Roland, MD (Emergency Medicine)
Timothy Smith, DO (Emergency Medicine)

Out-of-Service-Area Specialists
Jeffrey Young, MD (Pathology)

Health Programs Update

Weight Watchers Scholarships Available

Since June 2003, the Alliance has been providing Weight Watchers scholarships to eligible members in Santa Cruz and Monterey Counties. With the recent expansion into Merced County, the Alliance is offering a limited number of scholarships for eligible members to attend Weight Watchers meetings in Merced County as well. To participate in the Weight Watchers Scholarship Program, members must be referred by their primary care physician.

A 2008 study in the **International Journal of Obesity** found that more than half of the patients who were referred to Weight Watchers by their physicians were able to complete a 12-week Weight Watchers course and lose 11.5 lbs. on average (Poulter & Hunt, 2008). Since the inception of this scholarship program, the Alliance has provided over one hundred Weight Watchers scholarships.

Eligibility

- Only members with Alliance as their primary insurance are eligible for the scholarship. Please note that weight management is not an Alliance benefit or Medi-Cal benefit guaranteed to all members.
- Only members with a Body Mass Index (BMI) equal to or greater than 30 are eligible.
- Members with significant obesity-related morbidity (e.g., diabetes, asthma, depression, sleep apnea) and a commitment to sustained lifestyle change will be given highest priority. Weight Watchers does not accept patients with anorexia/bulimia, or pregnant women.
- Members must demonstrate motivation to participate fully in this self-directed program.

Reference: Poulter, J. & Hunt, P. (2008). Weight Change of Participants in the Weight Watchers GP Referral Scheme. *International Journal of Obesity*, 32 (S1), S233.

Eligibility, *Continued*

- In general, the Alliance requires candidates to be at least 18 years old. However, younger candidates will be considered on a case by case basis. Candidates under 18 years of age must have a doctor's letter stating a weight goal and if a scholarship is granted, a parent or guardian must attend all meetings with the minor.

Referral Process

- Primary care physicians may recommend members for the Weight Watchers scholarship program by faxing an application to the Alliance. You can download the application from our website at http://www.ccah-alliance.org/healthprograms.html. Scroll down to "Weight Watchers Scholarships" under the "Adults, Seniors, and Persons with Disabilities" section.
- The physician agrees to follow the patient for medical supervision of weight loss.

For more information about the Weight Watchers Scholarship Program, please contact the Alliance's Health Education line at (800) 700-3874 x5580.

Cultural Crossroads

Tips and Resources to Help You Communicate Better with Alliance Members

Using Bilingual Staff as Interpreters

"Communicating with patients who have limited English proficiency requires more than simply 'finding someone who speaks their language.'"

This quote begins an article from the **American Academy of Family Physicians (AAFP)** Family Practice Management website entitled, *Getting the Most from Language Interpreters* (Herndon & Joyce, 2004). The authors go on to say, **"Trained language interpreters have formal education in interpreting and abide by a professional code of ethics that includes confidentiality, impartiality, accuracy and completeness."** To help improve provider-patient communication and quality of care, the Alliance offers free, qualified interpreter services to all Alliance members at all points of contact. We strongly encourage providers to take advantage of this valuable service.

Conversation vs. Interpretation

Bilingual staff members can usually communicate directly with patients without special training. Generally, knowledge of the health care system and medical terminology in both languages are sufficient. However, communicating with a patient directly in a shared language—versus interpreting between two or more people who speak different languages—are actions that are worlds apart.

Accurate, objective, and respectful interpretation of critical medical information between a doctor and a patient requires special training, aptitude, and practice.

Qualified interpreters are trained in ethics, conduct, language conversion, and integrated interpreter skills, such as using mnemonic devices to assist with memory, and managing the flow of communication. Most training programs also include a practicum in which students are closely instructed, monitored, and evaluated as they develop the knowledge and skills that are required to serve in the critical role of interpreter.

Training Bilingual Staff

There are many interpreter training schools and agencies throughout the U.S., but unfortunately, there are few in our service area (Santa Cruz, Monterey, and Merced counties). Some agencies offer interpreter training courses by telephone or online, which work well for providers who want to minimize staff time away from the office. Fees vary widely from several hundred dollars per person for a basic short course, to a thousand or more for a comprehensive course. This may seem costly, but it could be a valuable investment when compared to the cost of potential adverse medical and/or legal outcomes due to language barriers.

Without question, anyone serving in the role of interpreter should undergo formal training. **At a minimum, staff acting as interpreters should understand and follow established health care interpreter standards of practice.** Standards can be downloaded from the following websites:

- **California Healthcare Interpreting Association (CHIA) www.chiaonline.org**
- **National Council on Interpreting in Health Care (NCIHC) www.ncihc.org**

It is a good idea to ask staff interpreters to sign and date an attestation verifying that they have read, understand, and follow the CHIA or NCIHC standards of care. And if you haven't already done so, consider having staff tested on bilingual skills. The following local agencies can do this for a fee:

- **Healthy House within A MATCH Coalition**
  Merced, CA (209) 724-0102
  www.healthyhousemerced.org
- **Language Line University**
  Monterey, CA (877) 351-6636
  www.languageline.com/page/llu

Cultural Crossroads continues on next page →

Cultural Crossroads *(Continued)*

Interpreter Qualifications

There are currently no state or national certifications in place for medical interpreters (although actions are underway to implement a national certification in the near future). However, the Alliance only contracts with interpreter agencies that have strict screening and hiring procedures in place and ensure that all interpreters have the appropriate qualifications, including:

(1) Documented and demonstrated proficiency in both English and the other language;

(2) Fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and

(3) Education and training in interpreting ethics, conduct and confidentiality.

In addition, all Alliance interpreter vendors implement quality control procedures to ensure that potential quality issues are addressed and corrected.

Telephone vs. Face-to-Face Interpreters

If you have used Alliance interpreter services, you know that there is no cost to members or providers. You may also know that services are typically provided by telephone. This is primarily due to efficiency and cost. **Telephone interpreters are available 24 hours a day, 7 days a week, and can begin interpreting within a minute of dialing the toll-free number (the Alliance does not require prior authorization for telephone interpretation).** In addition, our contracted telephone interpretation agency can accommodate 170 different languages. Conversely, face-to-face interpreters can be difficult to schedule due to high demand, travel, and cancelled appointments. And the costs can be quite high; a 30-minute visit with a telephone interpreter is approximately $50-$75, whereas the same visit with a face-to-face interpreter can cost up to $175-$200.

Reference: Herndon E. & Joyce, L. (2004). Getting the Most from Language Interpreters. *AAFP Family Practice Management,* www.aafp.org/fpm/2004/0600/p37.html, accessed 4/21/10.

If you do not have a telephone in your exam room, simply use the speaker function on a portable or cell phone (you can also lease or purchase a dual-handset phone). Conversations over a speakerphone tend to be louder than others, so be sure to keep your patient's privacy in mind during the call.

To hear an automated demonstration of a telephone interpreting session, call Language Line Customer Service at 1-800-821-0301 (press 2 to hear a Spanish-speaking interpreter assisting with a medical questionnaire).

There are special circumstances when face-to-face interpreters are more appropriate than telephone interpreters. For a brief list of these circumstances and instructions on obtaining prior authorization (required 4-5 days prior to the appointment), you may download our **"Interpreter Services Quick Reference Guide"** from the Alliance website at www.ccah-alliance.org/interpreter/html. This guide also includes the toll-free number and code to access our free telephone interpreter service for Alliance members.

It's Never Too Late to Ask for an Interpreter

If you are fluent in your patient's language and well-informed about his or her culture, it is not necessary to use an interpreter. **But if you are not entirely sure that everything discussed during the visit was fully understood, consider bringing in an on-staff or telephone interpreter at the end of the visit.** Take this opportunity to ask your patient if they have any other questions. Ask them to repeat back any instructions and next steps. As the authors state in the previously referenced AAFP article**, "You may be surprised to discover that you and the patient were not communicating as well as you thought!"**

For more information about working with interpreters, state and federal language access regulations, or other resources, please go to our website at www.ccah-alliance.org/interpreter.html or contact Lynn Meier, Senior Health Educator, at (831) 430-5570 or lmeier@ccah-alliance.org.

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Upcoming Meetings

Physician Advisory Group
Wednesday, December 15th, 2011 - 12:00 PM to 1:30 PM

In Santa Cruz County:
First Floor Meeting Room
Central California Alliance for Health
1600 Green Hills Road, Ste. 101
Scotts Valley, CA
(831) 430-5500

In Monterey County:
First Floor Meeting Room
Central California Alliance for Health
339 Pajaro Street, Ste. E
Salinas, CA
(831) 755-6000

In Merced County:
Suite B Meeting Room
Central California Alliance for Health
530 West 16th Street, Ste. B
Merced, CA
(209) 381-5300

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