PROVIDER BULLETIN

JUNE 2019

INSIDE

MEETINGS

Alliance Board Meeting

Wednesday,
June 26, 2019
3–5 p.m.

Meetings are held via video conference at the Alliance offices unless otherwise stated.

Physicians Advisory Group (PAG) meeting

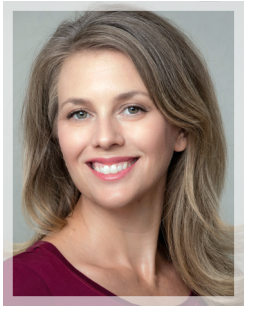
Thursday,
Sept. 5, 2019
Noon–1:30 p.m.

Whole Child Clinical Advisory Committee (WCCAC) meeting

Thursday,
June 13, 2019
Noon–1 p.m.

EXECUTIVE REPORT

Aligned Commitments to Care



The Alliance's Board met in April for its annual planning meeting focused on reviewing performance against the three-year strategic goals set for the health plan, as well as the environmental factors that will influence our work over the next 18 months. A commitment to action to support the needs of two different populations emerged.

First, it remains a high priority to better integrate services to improve the health of the 8 percent of Alliance members with complex needs who account for nearly 75 percent of our medical costs. Over the next 20 months, we will continue to explore how to better serve these members through our programs like Intensive Case Management, the Post-Discharge Meal Delivery Pilot and partnering with our counties' Whole Person Care pilots. Meanwhile, we will continue work on identifying opportunities for better-integrated care in 2020 and beyond.

Second, there is a renewed emphasis on the necessity of prevention, screening, early diagnosis and treatment to secure the wellness of the 50 percent of members who are children. The Alliance and our partners are engaging in conversations about how to better ensure the health and wellness of kids in the communities we serve. Whether the conversation is about children with special health care needs, children with mental health conditions, or those who are not receiving vital immunizations and preventive exams, the commitment of our partners is the same. We are all committed to partnering in aligned action to achieve better outcomes for the children in our communities.

This dual emphasis on effectively serving individuals with complex medical, behavioral health and social needs, as well as children, is also reflected in the California state revised budget for May 2019, as well as in much legislation which is pending. Clearly, there is alignment between our local assessment of needs and priorities and those of state policy makers. Action to improve the health of populations with different needs will require alignment, commitment and collaboration among all parties. We look forward to our continued work with you to improve the health of all Alliance members, this year and beyond.

Stephanie Sonnenshine

Stephanie Sonnenshine, CEO

PROVIDER NEWS

Measles Outbreaks Challenge Public Health

Reported cases of the measles virus are making headlines once again. Public health officials are concerned the U.S. is fast approaching the highest number of cases since 2014, when 667 cases were reported. The most before that was in 1994, when 963 cases were reported. The Centers for Disease Control and Prevention (CDC) noted that approximately 80 percent of cases reported are patients younger than 19 years old.

The measles virus is highly contagious and particularly challenging to manage in communities with low vaccination rates. Research indicates that approximately 90 percent of susceptible individuals exposed to the virus will be infected, and each infected person will in turn infect an average of 12–18 susceptible people. To illustrate the importance of immunization: among infected persons, about 1 in 4 will be hospitalized, 1 in 1,000 will develop encephalitis and 1 or 2 in 1,000 will die. An immunization rate of at least 95 percent is required to prevent measles outbreaks. CDC reports indicate the two-dose measles vaccination is 97 percent effective.

While most cases of measles produce mild to moderately severe illness, complications occur in approximately 30 percent of those infected. Children less than 5 years of age, adults over 20 years of age, pregnant women and individuals with compromised immune systems are at highest risk for severe illness. Complications from the measles virus include otitis media, bronchopneumonia, laryngotracheobronchitis or diarrhea. Pneumonia is the most common cause of measles-related mortality, accounting for approximately 60 percent of deaths.

Stay on the Alert

As of April 2019, California is one of 19 states reporting measles cases this year. It is important for local providers to remain vigilant. Review a patient's symptoms beginning with a fever and rash, and ask if they have traveled recently. Check for less specific symptoms like cough, coryza and conjunctivitis. Whether or not a patient has recently traveled is key to consider in assessing risk for measles, as a majority of cases are imported from areas of the world where the virus is still commonly transmitted.

Any suspected cases of measles should be handled in a clinical setting by immediately masking and isolating the patient. Providers should report the case to the local public health department's communicable disease unit as soon as possible.

In addition to accurately diagnosing and properly handling suspected cases of measles, providers are encouraged to assess every patient for measles immunity. If a patient's vaccination status is unknown, providers should draw a titer to determine their immunity. The Advisory Committee on Immunization Practices (ACIP) and CDC recommend—in addition to routine vaccination of children with two doses of the measles, mumps and rubella (MMR) vaccine prior to school entry—that adults without evidence of immunity should also receive at least one dose of the MMR vaccine.

MORE INFORMATION

For additional information on establishing evidence of measles immunity, consult CDC guidance at **morehealth.org/cdc/mmwr**. To learn more about identifying and testing for measles, review the California Department of Public Health's Measles Clinical Guidance at **morehealth.org/cdph.ca/measles**.

PROVIDER NEWS

Alliance Drug Formulary Changes Q1 2019

Additions to Formulary
Cyclosporine modified solution, Mycophenolate mofetil suspension, Xatmep (added to the formulary for children <12 years of age)
Heparin, Heparin flush, Lovenox
Nexplanon implant
Methergine (brand name)
Climara (estradiol once-weekly patch)
Yuvafem and generic estradiol vaginal tablet
Premarin cream (added for patients ages 3 and under)
Potassium citrate-citric acid, Sodium citrate-citric acid
Oxytrol for Women patch
Solu-cortef (brand-name injectable hydrocortisone)
Changes to Formulary
Nalocet (removed)
Butalbital/acetaminophen/caffeine 50/325/40mg tablet, Butalbital/acetaminophen 50/325mg tablet (changed quantity limit)

Prescriptions for legacy members taking a medication prior to its reclassification as nonformulary will be honored.

Urgent Visit Access 2.0

The Alliance's expanded Urgent Visit Access program offers members access to an alternative urgent visit clinic if the member's primary care provider (PCP) is not available. The biggest change to the program? Urgent care facilities no longer require a referral to see an Alliance member.

The Alliance encourages members to contact their PCP first for a same-day urgent visit appointment. If the PCP isn't able to accommodate an urgent visit, the member can call the Alliance's Nurse Advice Line (NAL) at **(844) 971-8907**. In addition to providing free medical advice 24 hours a day, seven days a week, the NAL can also help to arrange an urgent visit at a participating urgent visit access site. After the visit, the urgent visit access site faxes full clinical notes or an after-visit summary to the member's PCP.

The member's PCP is responsible for submitting any referrals required subsequent to the urgent visit. If the referral is urgent, the participating urgent visit site can contact the PCP right away to facilitate an immediate referral.

Interested in participating in this program as an Urgent Visit Access site? The general participation criteria are:

- Provide urgent visits to non-linked Alliance members;
- Open for an extended hour each weekday beyond the typical Monday–Friday, 8 a.m.–5 p.m.; or
- Open for a minimum of four hours on weekends.

Some exceptions can be made on a case-by-case basis.

For more information, please contact an Alliance Provider Relations Representative at **(800) 700-3874, ext. 5504**.

PROVIDER NEWS

Coding the Social Determinants of Health

Have you ever used the codes Z56 or Z59 to describe one of your patients?

These two code categories describe social determinants of health (SDOH) and specifically address a patient's employment, housing and economic circumstances. SDOH are defined by the World Health Organization as "the conditions in which people are born, grow, live, work and age … with the circumstances shaped by the distribution of money, power and resources at global, national and local levels."

Submitting SDOH diagnoses can assist the Alliance in identifying members who may qualify for care coordination or complex case management services. This distinction allows us to ensure the member has access to the care and resources they need.

Codes	Category
Z56	Problems related to employment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social behavior

Use the SDOH Codes More

We have found that the code categories are highly underutilized by clinicians, which limits opportunities to connect individuals to the help they need. Providers are encouraged to submit a code from the Z56, Z59 or Z60 category when the member's circumstance is identified. Per ICD-10 guidelines, these codes cannot be a primary diagnosis code and should be submitted on a claim with additional diagnoses.

Better data allows the Alliance to work more effectively with members to get the care and resources they need. This can reduce the amount of preventable emergency department visits, hospital readmissions and ambulatory care sensitive admissions.

Resources:
The World Health Organization—Social Determinants of Health—who.int/social_determinants/en

More Funds, Better Data Needed to Help Medicaid Patients—morehealth.org/medpagetoday/soc-determinants

Post-Discharge Meal Delivery Pilot

Food insecurity is a complex—but preventable—condition, especially when a patient is discharged from the hospital or care facility. In November 2018, the Alliance launched a new meal-based, two-year pilot that provides medically tailored meals to chronically ill patients with the goal of improving health outcomes and reducing hospital readmissions and emergency department utilization.

In the first five months, the pilot enrolled 108 members to receive 14 meals per week. The program would deliver meals for 12 weeks following hospital discharge to support their recovery by making access to nutritious food easy and convenient. The Alliance contracted with two vendors to provide home-delivered meals: Mom's Meals NourishCare in Monterey and Merced counties, and the Teen Kitchen Project in Santa Cruz County. The pilot, which is sponsored by the Medi-Cal Capacity Grant Program, will serve up to 450 Alliance members.

Who Is Eligible?

To determine eligibility, members participate in a brief screening while in the hospital and must meet all of the following criteria:

- Received a diagnosis of diabetes, congestive heart failure and/or chronic obstructive pulmonary disease;
- Considered high risk for hospital readmission; and
- Discharged to a place where the member (or a caregiver) can receive deliveries and safely store and heat the prepared meals.

For more information about the program, contact the Alliance Medi-Cal Capacity Grant Program at **grants@ccah-alliance.org** or at **(831) 430-5784**.

Reduce Opioid Misuse in Pregnancy

Opioid misuse has steadily increased since the 1950s, and recently, misuse among pregnant women has become increasingly prevalent. A variety of life experiences can lead to opioid-exposed pregnancies, such as chronic pain, misuse of prescribed or illicit medication, recovery from opioid use disorder (OUD) with medication-assisted treatment (MAT) and active abuse of heroin. A recent study found that 1 in 300 women becomes a persistent user of opioids from first use after cesarean sections, signaling the postpartum period as a potential trigger.

The Medi-Cal population is disproportionately impacted, with alarming rates of misuse among pregnant women and infants born with neonatal abstinence syndrome (NAS). Given that Medi-Cal covers approximately 48 percent of all births, providers should use caution and be aware of clinical recommendations that can optimize healthy outcomes for mother and infant.

How Providers Can Get Involved

1. Ask all women of reproductive age about their pregnancy intentions prior to initiation and continuation of any opioid, including MAT for OUD.
2. Routinely ask all pregnant women and women seeking pregnancy about opioid use, including appropriate and illicit use of prescription opioids and other illicit opioids such as heroin. Because polysubstance use is common, rely on short, validated tools that screen for other substance use.
3. For all pregnant women, avoid prescribing opioids when possible, using a multimodal approach and nonopioid pharmacologic treatments. If necessary, do so with safeguards in place. For prescription opioids for chronic pain, evaluate the patient for physical dependence and reevaluate the treatment plan. Inform the patient of potential obstetric and newborn risks associated with ongoing use. If it's medically appropriate to taper, and the patient is willing, taper her to the lowest effective dose of opioids and manage pain with other modalities.
4. Anyone taking chronic opioids, including pregnant women, should have access to naloxone. Pregnant women can safely use naloxone to manage an opioid emergency.
5. Avoid prescribing other sedating medications (e.g., benzodiazepines) to anyone using opioids due to the risk of enhanced respiratory depression.
6. Upon discharge after a delivery, encourage all women without an OUD who need ongoing pain treatment to use nonopioid therapies (i.e., NSAIDs). If opioids are indicated, they should receive no more than seven days of treatment.

PROVIDER NEWS

Best Practices to Reduce Patient No-Shows

No one appreciates a last-minute cancellation, whether it be for a professional or a social appointment. For a medical clinic, no-shows are particularly disruptive, as they can severely impact a clinic's schedule, affecting patients' access to necessary health care.

It is not uncommon for patients to forget about their appointments. Patients may lack reliable transportation to get to their appointment, or they may forget to cancel their appointment altogether.

One technique to reduce no-shows in a clinical setting is the art of "Tetris-ing." Like the game of Tetris, Tetris-ing means reviewing the clinic schedule for openings to move around appointments, allowing clinics to take appropriate action in real time. Clinic scheduling coordinators can move appointments across schedules, allowing for missed opportunities to be caught on time to increase access for patients seeking same-day appointments.

For more information, contact the Alliance's Quality Improvement department at **(800) 700-3870, ext. 2622**.

HEPATITIS B VACCINE: *Two or Three Doses?*

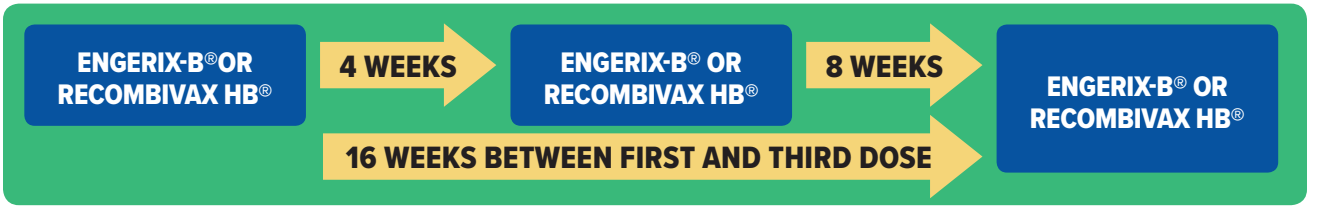
For adults 18+ years:

HEPLISAV-B® — 2 DOSES

Two doses of HEPLISAV-B® administered at least 4 weeks apart complete a series, even if doses of Engerix-B® or Recombivax HB® were given any time before, during or after the doses of HEPLISAV-B®.

Engerix-B® or Recombivax HB® — 3 DOSES

The intervals below also apply to any order of 1 dose of HEPLISAV-B® and 2 doses of Engerix-B® or Recombivax HB®.



For more information, see cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html
California Department of Public Health, Immunization Branch EZIZ.org

This publication was supported by Grant Number H23/CCH922507 from the Centers for Disease Control and Prevention IMM-1267 (3/19)

PROVIDER NEWS

Palliative Care Benefit Connects Members to Care

In January 2018, the Alliance introduced the palliative care benefit, designed to help members understand and cope with specific, burdensome disease conditions. This benefit connects members with clinicians and a palliative care team who are trained to focus on the goals of care and symptom management. This team understands advance care planning and end-of-life complexities, and the team consists of palliative care-specialized physicians, nurses, medical social workers and spiritual care providers.

Patients suitable for referral typically use the emergency department frequently to manage the later stages of disease; have declined or are ineligible for hospice care; or may have received appropriate medical therapy, but the treatment is no longer effective. Ideally, these patients demonstrate a willingness to attempt in-home, residential or outpatient disease management and participate with a palliative care team. Patients with expected survival of less than one year are also good candidates for the services that this benefit provides.

Making a Referral to Palliative Care

Primary care providers and specialists can recommend a patient for palliative care services. Patients should meet the disease-specific eligibility criteria in Figure 1 below. To refer a patient, log in to the Alliance Provider Portal and, in the "Authorization Entry" form, choose authorization class "Outpatient" and authorization sub-class "Palliative Care."

Figure 1: Disease-Specific Eligibility Criteria

Congestive heart failure (CHF)
Hospitalized due to CHF as primary diagnosis (no further invasive interventions planned)
or NYHA III or higher
and EF <30% or significant comorbidities
Chronic obstructive pulmonary disease (COPD)
FEV1 <35% predicted and 24-hour and O_2 requirement less than 3L/min
or 24-hour O_2 requirement ≥3L/min
Advanced cancer
Any stage III or IV solid organ cancer, leukemia or lymphoma
and Karnofsky Performance Scale score < 70 **or** treatment failure of two lines of chemotherapy

Child Developmental and Behavioral Screenings Best Practices

It is estimated that 15 percent of children in the U.S. have one or more developmental disabilities. Early identification of developmental delays helps ensure that children and their families receive necessary intervention services at a time when this support is likely to be most effective.

To ensure timely intervention, the American Academy of Pediatrics recommends that health care providers monitor child development at every well-child visit and periodically screen children with validated tools to identify areas of concern.

Developmental and behavioral screening with a validated tool should be performed with every child at ages 9 months, 18 months and 24 or 30 months. More frequent screening is recommended for children with additional risk factors such as preterm birth, low birth weight or lead exposure. Providers should follow up with comprehensive developmental evaluations for any child determined to be at risk for developmental delay.

The Alliance will soon be rolling out new measures and tools to help support providers in increasing developmental screening rates among our youngest members. Stay tuned for more information.

Data Submission Tool

The Alliance's Data Submission Tool (DST) allows providers to upload data files via the Provider Portal. The DST was created to support providers in submitting data from their electronic health record and medical records to achieve compliance in the Care-Based Incentive (CBI) program, Healthcare Effectiveness Data and Information Set (HEDIS) audit, and identify quality improvement projects. Submitting data is optional, but it is recommended to ensure that complete data sets are reported for CBI and HEDIS measures.

The DST is available to primary care providers to submit data for the measures below to increase their CBI and HEDIS rates.

- Alcohol Misuse Screening and Counseling (AMSC);
- Lab Panels for Members on Persistent Medications;
- Cervical Cancer Screenings;
- Depression Screenings;
- Diabetic Retinal Eye Exams;
- Diabetic HbA1c lab values;
- Immunizations—Children and Adolescents; and
- Initial Health Assessments (IHA).

The DST Guide is available on the Provider Portal. It includes lists of accepted codes, required information and step-by-step instructions. An email confirmation will be sent within one business day after each data submission to confirm receipt.

If you do not have access to the DST or if you have questions, contact a Provider Relations Representative at **(831) 430-5504** or email **portalhelp@ccah-alliance.org**.

PROVIDER WEBINAR CORNER

The Alliance invites you to take advantage of the resources on the Provider Webinars, Workshops and Training page of our provider website. Stay informed about upcoming trainings and view resources from past trainings at **www.ccah-alliance.org/workshops.html**.

For more information, contact a Provider Relations Representative at **(800) 700-3874, ext. 5504**.

CULTURAL CROSSROADS

Providing Culturally Competent Care: A Look at Cross-Cultural Communication

Enhanced communication among providers, staff and patients helps medical practices work effectively and provide quality care in cross-cultural situations. An important part is the ability to communicate across cultures. With cross-cultural communication skills, you can better understand the needs, values and preferences of your patients.

Here are some approaches that can help you build cross-cultural communication skills:

- *Improve cultural and linguistic appropriateness*—become knowledgeable about the cultural backgrounds of your patients.
- *Gain awareness of language differences*—become aware of the different expressions or idioms used or when the same word holds more than one meaning.
- *Consider how you communicate in writing*—be mindful of whether the standard language used on forms and in patient handouts may be seen as too formal, not welcoming or too complex to understand.
- *Do not make assumptions*—what you may perceive as your patient's communication style or level of health literacy may be incorrect. Ask your patients questions, and encourage them to ask you follow-up questions.
- *Avoid jargon*—do not use jargon or technical health and medical terms. Instead, explain terms and concepts using plain language.
- *Understand and recognize differences in communication styles, both verbal and nonverbal*—pay attention to your tone, volume and body language, such as posture, gesture, eye contact and facial expressions.

To learn more, visit "Think Cultural Health" with the Center for Linguistic and Cultural Competency in Health Care at **thinkculturalhealth.hhs.gov**. Additionally, the Alliance's Cultural and Linguistic (C&L) Services program strives to provide culturally and linguistically appropriate health care and services for all of our members. For information about this program, call the Alliance's Health Education department at **(800) 700-3874**, **ext. 5580**.

My Birth Matters! C-Section Patient Education Campaign

The California Health Care Foundation, *Consumer Reports* and the California Maternal Quality Care Collaborative have partnered on a consumer education campaign called "My Birth Matters" to educate low-risk, first-birth mothers about the overuse of C-sections and to encourage meaningful conversations between patients and their care team.

The Department of Health Care Services, California Department of Public Health, the California Medical Association, the California Hospital Association and many more key stakeholders collaborated to extensively vet and research the development of this campaign. Now, they are asking for your support in sharing it with your patients.

This campaign includes four animated videos, a patient-facing "My Birth Matters" web page and print materials—all of which are based on the results of rigorous research with pregnant women and new moms across California. To learn more about the research methodology or to download the campaign's communications toolkit and print materials, visit the campaign's outreach website: **morehealth.org/chcf/c-section**. All materials are available in both English and Spanish languages and at no cost.

The Alliance has shared with members the "My Birth Matters" materials through our member newsletter and with regional partner organizations, including WIC (Special Supplemental Nutrition Program for Women, Infants, and Children). We encourage you to share these materials with your patients—through conversation, prenatal packets, posters on exam room walls and more—so that all first-time, low-risk pregnant members will benefit from them.

For more information regarding the "My Birth Matters" campaign, visit **cmqcc.org/my-birth-matters**.

Required Interpreters Available to All Alliance Members

Federal and state laws require medical providers to offer qualified interpreters for patients when needed, and the Alliance can arrange for interpreters. The Alliance strongly discourages providers from using family members or any unqualified personnel as interpreters.

Contracted Alliance medical providers must:

- Offer qualified interpreters, at no cost, to limited English proficiency (LEP) and deaf or hard-of-hearing members;
- Refrain from requiring patients to bring their own interpreters or from suggesting that they use a friend or family member to interpret;
- Avoid using untrained interpreters;
- Document every patient's language in the medical record; and
- Document in the medical record if the patient refuses an interpreter and prefers to use a family member or friend.

The Alliance offers interpreter services at no charge for eligible LEP members or to members who are deaf or hard of hearing. To learn more about the Alliance's interpreting services, go to the Cultural and Linguistic Services Program page on the provider website at **www.ccah-alliance.org/cultural_linguistic.html** or contact the Alliance Health Education department at **(800) 700-3874, ext. 5580**.

CLINICAL CORNER

Congenital Syphilis on the Rise

The California Department of Public Health reports a significant uptick in cases of syphilis—and congenital syphilis (CS) in particular. Between 2012 and 2017, rates of CS increased by over 750 percent statewide. The majority of reported cases in 2017 were in the Central Valley. In 2018, Merced County reported six cases of congenital syphilis—a concerning and abrupt increase that warrants the attention of providers, patients and the broader community.

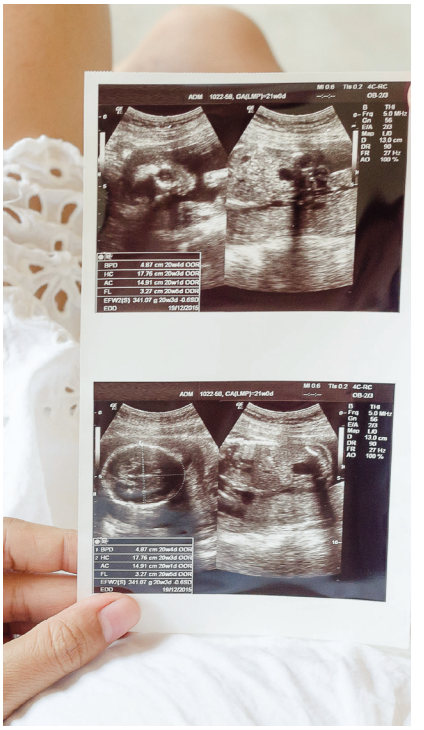
If left untreated, CS can have devastating effects on the developing fetus and may lead to such outcomes as preterm birth, low birth weight, congenital anomalies, blindness, hearing loss, stillbirth and death. Timely testing and treatment are key to preventing CS and associated complications. California law requires that health care providers perform serologic testing for syphilis at a patient's first prenatal visit and that women be routinely assessed for risk of infection throughout their pregnancy.

Testing Is Key

Repeat testing during the third trimester and at delivery is recommended for at-risk women, including those who:

- Have signs or symptoms of syphilis infection;
- Live in areas with high rates of syphilis;
- Were diagnosed with an STI during pregnancy;
- Received late or limited prenatal care;
- Were not tested in the first or second trimester;
- Have partners that may have other partners;
- Have a history of incarceration; or
- Are involved with substance use or have a history of exchanging sex for money, housing or other resources.

All providers, particularly those providing prenatal care, should be prepared to test for and treat syphilis. Providers are advised to adhere to the at-risk testing regimen in pregnant patients: testing at the first prenatal visit, during the third trimester and at delivery. Prompt treatment upon diagnosis greatly reduces the risk of adverse outcomes. For treatment of early syphilis in the pregnant patient, a single dose of benzathine penicillin G 2.4 million units given intramuscularly is the general recommendation. The dose should be repeated every seven days for three weeks (7.2 million units total) in those presenting with late latent syphilis or infection of unknown duration.



Providers should consult the Centers for Disease Control and Prevention 2015 STD Treatment Guidelines for complete recommendations, and all syphilis infections must be reported to the local health department within 24 hours of diagnosis.

Treatment for sex partners is also critical, and providers should discuss risk of re-infection with patients as well as potential risks to the fetus. With early diagnosis, treatment and effective collaboration among patients, providers and local health officials, this troubling trend can be reversed.

New Recommendations and Requirements

The U.S. Preventive Services Task Force recently updated its recommendations on perinatal depression screening, advising that cognitive behavioral or interpersonal therapy interventions may help prevent perinatal depression in women at increased risk. Clinicians are advised to provide or refer at-risk pregnant and postpartum women to these services.

State Bill AB 2193: Effective July 1, 2019, AB 2193 requires that practitioners providing prenatal and/or postpartum care confirm that patients have received screening, or indicate they directly screen patients for perinatal mood and anxiety disorders at least once during the prenatal or postpartum period.

IMPORTANT PHONE NUMBERS

Provider Services . . . . . .(831) 430-5504
Claims . . . . . .(831) 430-5503
Authorizations . . . . . .(831) 430-5506
Status (non-pharmacy) . . .(831) 430-5511
Member Services. . . . . .(831) 430-5505
Web and EDI. . . . . .(831) 430-5510
Cultural & Linguistic Services. . . . . .(831) 430-5580
Health Education Line . . . .(831) 430-5580

New Providers

Santa Cruz County

Primary care

- Blair Cushing, DO, *Family Practice*

Referral physician/ specialist

- Isaac Chankai, MD, *Surgery*
- Lorena Russo, MD, *Family Practice*
- Karen Wang, MD, *OB/GYN*
- Charlyce Davis, MD, *Internal Medicine*
- Stephen Gregorius, MD, *Orthopedic Surgery*
- Michele Hugin, MD, *OB/GYN*
- Nicole Meisner, MD, *OB/GYN*
- Jane Wang, MD, *Physical Medicine and Rehabilitation*

Monterey County

Primary care

- Andrea Rivas, MD, *Pediatrics*

Referral physician/ specialist

- Muneera Atcha, MD, *Rheumatology*
- Ronald Chaplan, MD, *Orthopedic Surgery*
- Elizabeth Clark, MD, *OB/GYN*
- Thomas Cunningham, MD, *OB/GYN*

Merced County

Primary care

- Lorraine Beraho, MD, *Pediatrics*
- Tony Simon Germans Gabriel, MD, *Pediatrics*
- Diana Oviedo-Cavazos, MD, *Family Practice*
- Joanne Spalding, MD, *Family Medicine*

Referral physician/ specialist

- John Abdulian, MD, *Gastroenterology*
- Diane Thomas, MD, *OB/GYN*

Sign up

to receive provider news by email

Three easy steps:

1. Text: CCAH.
2. To: 22828.
3. Follow the text prompts.

ALLIANCE HOLIDAY CLOSURES

The Alliance offices will be closed on the following days:

Thursday, July 4, 2019
Monday, Sept. 2, 2019