



# Prescriptions *Medical Alert*

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*Differences in language, cultural values, and attitudes toward illness and medical care can lead to a potentially dangerous breakdown in communication between the physician and the patient.*

## Bridging the Cultural Divide in Your Practice

As the country becomes more ethnically and linguistically diverse, the challenges facing physicians in delivering quality care to all patients, regardless of cultural background, are mounting. Differences in language, cultural values, and attitudes toward illness and medical care can lead to a potentially dangerous breakdown in communication between the physician and the patient. Unlike large hospitals, small practices often lack the resources and interpreters to assist them in their interactions with immigrant patients. If your practice is providing care to patients from a variety of ethnic backgrounds, there are strategies you can use to ensure that the needs of these patients are met—even when the doctor and the patient do not speak the same language.

The potential for misunderstanding is considerable in treating patients with limited English proficiency (LEP), especially when patients are from countries with non-Western medical traditions. Because of communication difficulties, it may take longer for physicians to diagnose and treat these patients. Even when the patient speaks sufficient English to communicate on a basic level, the doctor may have to take additional time to explain the diagnosis and to issue specific instructions on how to adhere to the recommended course of treatment.

When presented with a patient who speaks little or no English, some practices rely on family members of the patient or staff members with some knowledge of the language to interpret. While adequate in some instances, this improvised approach to translation can lead to serious mistakes, especially when the language skills of the interpreter are limited.

*Continued on Page 2*

### Inside This Issue:

- 2 *A Successful Cafeteria Plan Provides "Just Desserts"*
- 3 *Charitable Giving—Diagnosing the Rules*

## Continued from Page 1 Bridging the Cultural Divide in Your Practice

Family members usually lack the medical knowledge necessary to be effective communicators in these situations, and staff members may not have a firm grasp of the language or sufficient experience in translation to do the job well. It is, therefore, advisable not to rely on family members to interpret, except when no other option is available. If your practice has a staff member who is charged with providing interpreting services on a regular basis, make sure the employee not only has strong language skills, but also has been trained to act as a medical interpreter.

If no staff member is available to interpret for an LEP patient, you can use a telephone-based language line to assist in translation. These services typically offer interpretation for a wide range of languages. It may also be possible to bundle appointments for patients who speak a particular language and have an interpreter on-site for certain days only. If your practice frequently serves members of a particular language group, you may want to order informational materials in that language to distribute to patients.

The federal government at one time required all health care providers to hire interpreters for all appointments with LEP patients covered by Medicaid or Medicare. The revised guidelines issued by the U.S. Department of Health and Human Services (HHS) in August 2003 allow for greater flexibility for smaller practices: While recipients of federal funds are, according to the guidelines, “required to

take reasonable steps to ensure meaningful access” to their services, the amount of language support each practice is obliged to provide may be related to the number or proportion of LEP patients from a particular language group the practice serves, the size and resources of the practice, and the nature and importance of the services provided. But even if LEP individuals access services from a provider on an unpredictable or infrequent basis, the guidelines advise providers to consider using telephonic interpretation services or sharing a contract interpreter with other small practices.

While language barriers alone can pose significant difficulties in treating LEP patients, physicians are also called upon to develop “cultural competency” in their interactions with members of diverse ethnic groups. Patients may bring to the examining room fears about certain medical technologies or practices, spiritual beliefs that could affect their approach to illness, or a desire to have their own traditional remedies integrated into their course of treatment. Without stigmatizing the patient, physicians should ask questions about any cultural practices or home remedies that could be relevant to the patient’s condition or treatment.

Whenever possible, physicians should strive to be respectful of their patients’ belief systems, acknowledging their individual perspectives and attempting to work with them to create a course of treatment acceptable within their own cultural context. *P*

## A Successful Cafeteria Plan Provides “Just Desserts”

Given the fierce competition for experienced nurses and other qualified health care professionals, it is essential that medical practices offer attractive employee benefits packages. One answer to satisfying valuable members of your team is the use of flexible benefits, often known as cafeteria plans. These flexible plans allow employees, within limits, to choose the benefits they want, including health insurance, pension options, dental coverage, etc.

The challenge to practice managers and physician owners is to design a cafeteria plan that satisfies employees, yet is manageable and makes economic sense. In the most effective plans, both the practice

and the participating employees share in the cost of optional benefits. The employer contribution often takes the form of spending credits. Using the credit system, employers signal their commitment to fund a benefit plan, while also setting a definite limit on what they will pay.

The challenge in designing a successful benefit program comes in pricing the credits and choosing the benefits to offer your employees. Surprisingly, some of the benefits that employees find most attractive are the same ones that work to control and stabilize a practice’s financial commitment. For example, many employees appreciate a health plan

*Continued on Page 3*

## Continued from Page 2 A Successful Cafeteria Plan Provides “Just Desserts”

with a higher deductible but lower premiums more than a plan with much higher premiums but no deductible; because of the savings, so do employers.

Practices can direct employees toward more economical choices by pricing the benefit credits accordingly. To encourage economy in the use of the medical plan, you can make several choices available but price the more expensive, less efficient plans at a higher percentage of their total cost than the economical HMO, often the least expensive option.

Generally, the most well-received cafeteria plans are those that include various life insurance benefits, a choice between traditional medical benefits and an HMO, a dual choice option offering co-insurance for those covered by a spouse’s plan, and employee-funded spending accounts for unreimbursed medical expenses and dependent care expenses, such as child care and elder care. Employees also like supplemental insurance for dependents, as well as short-term and long-term disability coverage. Many practices also offer managed care options, such as a higher-percentage reimbursement at preferred providers,

which can be added to—or substituted for—the traditional health coverage.

The dual choice option for co-insurance is a good example of how flexible options can benefit both employees and the practice. At a lower cost than full coverage, this option covers only those amounts otherwise excluded under the deductible and co-insurance provisions of the spouse’s medical plan. Employees get the additional coverage they want, plus a credit for choosing a lower-cost plan. In addition, the company gets a reduction in overall cost and reduced exposure to potential liabilities.

Selecting a menu of benefits is an exercise in providing enough choices to meet employer and employee objectives without building a system too complicated to understand or administer. A cardinal rule is to keep the program simple. Too many choices can produce errors, particularly in calculating the credit use, since each credit is priced differently. As you and your employees become more familiar with the way the chosen plan works, new options can be added. *P*

## Charitable Giving—Diagnosing the Rules

When contemplating making a significant gift, the charitably inclined are well advised to exercise some foresight. Similar gifts made in different ways will yield remarkably different results. The treatment of your gift for federal tax purposes will vary depending on the type of asset donated, the type of charitable organization receiving the gift, and your individual circumstances and overall tax status.

### Gift Classifications

Gifts funded with different types of assets are subject to different restrictions on deductibility. The Internal Revenue Code (IRC) generally classifies different types of property according to a four-tier system: 1) ordinary income property; 2) short-term capital gain property; 3) long-term capital gain property; and 4) tax-free property. Property is also classified as either being intangible property (securities, bonds, mutual funds, etc.) or tangible personal property (artwork, collectibles, jewelry, etc.).

There are also deductibility limitations imposed on donations depending on the structure of the recipient charity. Organizations are classified as public charities and private foundations. Gifts to private foundations are far more restricted because of concerns relating to the potential for abuse by donors or foundation officials.



### Valuation and Eligibility

Donors must categorize their donations in accordance with the above classifications in order to determine the valuation of their gift for the purpose of claiming a charitable deduction. For example, deductions for gifts of cash (including by check) are simply equal to the amount of the gift. Gifts of tangible personal property that can be directly used to advance the recipient charity’s tax-exempt purpose, or gifts of long-term appreciated intangible

*Continued on Page 4*

Continued from Page 3 **Charitable Giving—Diagnosing the Rules**

property, are eligible for a deduction based upon the fair market value (FMV) of the donated asset. Gifts of tangible personal property not for exempt use, short-term appreciated intangible property, or ordinary income property are eligible for a deduction based on the original cost (less depreciation) or fair market value of the donated asset, whichever is less.

There are additional limits on gifts of real estate, which may be reduced by any “depreciation” deductions taken over the years. There are also special restrictions regarding gifts of stock, based on the incorporation status of the company. You are not eligible to claim a deduction at all for contributing personal services to a charity or letting a charity use your property rent-free.

Any single contribution exceeding \$5,000 (except one funded with cash or publicly-traded stock) requires a qualified appraisal within 60 days of the date of gift. All gifts of \$250 or more require written acknowledgment from the recipient charity in order to claim a deduction, though it is prudent to obtain a receipt for gifts of any size.

### *Income Limitations*

The final factor affecting your ability to claim a charitable deduction pertains to limitations associated with the size of your adjusted gross income (AGI). Your deduction for gifts of cash to a public charity may not exceed 50% of AGI in any one year, while your deduction for cash gifts to a private foundation may not exceed 30% of AGI. For gifts of both long- and short-term appreciated property, your deduction is limited to 30% of AGI for gifts to public charities and 20% of AGI for gifts to private foundations. The limitations on both cash and appreciated property work in tandem, capping total charitable deductions for any one year at 50% of AGI. Deductible amounts above these limits may be carried forward for up to five additional, consecutive tax years. Higher income donors must also be wary of restrictions on total itemized deductions, which are gradually phased out above certain levels of AGI.

The rules governing charitable giving can be complex. If you intend to make a significant gift, give us a call for guidance. *P*

## Medicare Part D Saddles Physicians with Additional Burdens

Physicians and pharmacists are coming to grips with the new Medicare Part D prescription drug coverage, but concerns about administrative burdens and ongoing confusion among elderly patients remain, according to a survey by medical technology firm Epocrates, Inc.

In the April 2006 survey of more than 1,000 physicians and pharmacists, 70% of physicians claimed they have a better grasp of Medicare Part D than they did in October 2005. At the same time, however, more than 90% of the physicians surveyed reported finding some aspects of the plan confusing, especially those to do with drug coverage and coverage gaps.

In addition, 43% of physicians and nearly 70% of pharmacists reported an increase in the number of appointments made by seniors since enrollment in Medicare Part D began in January 2006. Respondents indicated that two-thirds of elderly patients were asking for alternative drugs or a change of prescription. Both the physicians and pharmacists surveyed said they believe confusion about the benefit persists among more than 95% of their patients.

More than half of the pharmacists surveyed reported a 40% increase in the time spent on administrative tasks since the start of the Medicare Part D program, and 70% of physicians reported an increase of 20% or more in administrative burdens. *P*