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On Rounds



Incentive Checks Arriving

Birmingham Practices Reaping EHR Rewards

The first incentive checks for implementing electronic health record (EHR) software are rolling into Alabama practices. "It's nice to see it come into play after all this waiting and talking about it," says Nancy Ellis, vice president of MediSYS.

In fact, just last week, Pediatrics Plus, P.C., an Anniston-based practice that had adopted the ONC-Certified MediSYS EHR last year, received \$21,250 in Medicaid EHR incentives.

"The momentum to get EHR has dramatically changed with the stimulus incentives," says Mike Jones, CEO of Evolution Technology. "They understand they have to do it now. But they should be doing it for the return on investment alone." ... **page 6**

HEALTH INFORMATION TECHNOLOGY

Mobile Devices Create Efficiency and Dangers for Practices

BY JANE EHRHARDT

"Fact is, technology comes at us so fast that we usually embrace it first then figure out the downside later when it hits us square in the jaw," says Russ Dorsey, CEO of Integrated Solutions.

For a regulated industry, like healthcare, data exposure tops the list of "downsides" for any tech. And now, mobile hardware opens a whole new layer of vulnerability for practices.

In 2010, an Intel study found that within 300 corporations, they had lost 86,455 laptops in one year. Being so new to the market, no study yet exists on the number of iPads lost yearly, or the even smaller smart phones.

Unfortunately, practices may not equate the

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Russ Dorsey's desk is topped with a cluster of mobile devices.

Recruiters See a Change in Physicians' Job Goals

The change in healthcare is shifting the recruiting market.

BY JANE EHRHARDT

"What physicians were interested in used to be about the dollar and their salary. Now it's about quality of life and how their partnership track is going to work," says Helen Combs of Alabama Allergy & Asthma Center. She's referring to a transformative shift in physician recruiting.

Combs chalks up the change to the young grads growing up in a generation where they "got medals because they were in the race, not because they won. So quality of life is important. They value their personal time, and that's a shift."



Karen Belk

Sheila McKenna, chief development officer at Brookwood Medical Center, agrees about the shift, but points to a different cause. "Look at the number of women coming out of med school. I think it's more than 50 percent now," she says. "It's absolutely changing the face of medicine."

But Combs stresses that the challenge still rests on "finding a good match for our practice." She's recruited five specialists for their practice in the last eight years, and estimates it absorbs about 200 hours

to recruit each one, but spread over years.

That's a common error made by practices in need of a

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CMS Rule Lowers Barriers to Telemedicine

BY: JENNIFER HOOVER CLARK

On May 5, 2011, the Centers for Medicare and Medicaid Services (CMS) released a final rule that will make it less burdensome for hospitals to use telemedicine when treating patients. The final rule, which takes effect on July 5, 2011, removes credentialing and privileging burdens for hospitals and critical access hospitals (CAHs). CMS anticipates that the final rule will provide more flexibility to small hospitals and CAHs that often have limited numbers of primary care and specialized providers. By removing unnecessary burdens in the credentialing of telemedicine providers, CMS seeks to improve patient care by increasing access to needed services, making necessary interventions more readily available, and enhancing patient follow-up in the management of chronic diseases. The smaller hospitals will now have the option to rely on data from the larger facilities when giving doctors permission to practice remotely, as opposed to conducting their own credentialing process.

Currently, Medicare conditions of participation (CoPs) require hospitals and CAHs to perform the same cre-

denialing and privileging procedures for both on-site physicians and those providing services by telemedicine. The current CoPs do not permit hospitals to rely on the privileging decisions of other hospitals. CMS concluded that its current requirements were often duplicative and unnecessarily burdensome, particularly for small hospitals and CAHs. It recognized that small hospitals and CAHs often do not have access to a medical staff with the requisite clinical expertise to evaluate and privilege the various specialty physicians that could provide the hospital with telemedicine services.

The final rule is consistent with The Joint Commission's (TJC) practice of privileging by proxy, which had been found not to comply with the current credentialing CoPs. Privileging by proxy allows one TJC-accredited facility to accept the privileging decisions of another TJC-accredited facility and had been used by TJC-accredited hospitals in the credentialing of telemedicine providers. If the final rule had not been adopted, TJC would have had to revise its standard to ensure conformity with the credentialing CoPs, and TJC-accredited hospitals would have to use the same rigorous standards when cre-

denialing both on-site and distant site telemedicine practitioners. According to TJC, removing the conflict between the CoPs and the TJC privileging by proxy standard lessens hospitals' and CAHs' regulatory burdens and provides them more flexibility.

The final rule amends the CoPs for both hospitals and CAHs to provide such facilities the option of streamlining their credentialing and privileging processes for telemedicine practitioners. While the current CoPs for credentialing and privileging of medical staff require the governing body of a hospital to make all privileging decisions based upon the recommendations of its medical staff after examination and verification of applicants' credentials, the final rule allows hospitals and CAHs to rely on the credentialing decisions of the distant site facility where the practitioner offering the telemedicine services is located.

The final rule allows hospitals and CAHs to rely on the credentialing decisions of both Medicare-certified hospitals and non-hospital telemedicine providers, such as ambulatory surgery centers, radiology interpretation services, and other telehealth vendors. CMS concluded that allowing hospitals and

CAHs to utilize the optional streamlined privileging process when contracting with nonparticipating distant site telemedicine entities, in addition to Medicare-certified hospitals, would help accomplish the stated goals of the rule, which are to increase patient access to care and reduce the burdens on small hospitals and CAHs.

Thus, under the final rule, a hospital or CAH may rely on the credentialing and privileging decisions of a distant site facility where the practitioner is located, provided that the governing body of the hospital or CAH ensures in a written agreement with the distant site provider that the following conditions are met:

1. The distant site provider is either a Medicare-participating hospital or a facility that, while not Medicare-certified, has a credentialing and privileging process that meets all of the applicable CoPs.

2. The practitioner providing the telemedicine services is privileged to do so by the distant site provider and a list of the telemedicine practitioner's current privileges is provided to the receiving facility.

3. The practitioner providing the

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According to the Alzheimer's Association, one in eight persons over age 65 has Alzheimer's, and that number increases to nearly one in two persons aged 85 and older. As the baby boomers age, the problems of Alzheimer's and dementia threaten to become widespread. Currently, 70% of people suffering from Alzheimer's disease live at home. When the stress of caring for these patients becomes too much, many family caregivers look for alternatives such as assisted living communities.

However, most assisted living communities are not designed for dementia residents. In fact, the State of Alabama requires communities to be licensed as a Specialty Care Assisted Living Facility in order to treat cognitively impaired residents. Ashton Gables and Lakeview Estates are both licensed Specialty Care Assisted Living Communities, specializing in care for dementia residents.

We have developed an innovative approach to memory care called Bridge to Rediscovery that helps residents rediscover the joy in everyday life. Instead of being defined by their disease, our residents

are celebrated for who they are - artists, doctors, mothers, fathers - and who they will always be.

Inspired by the Montessori-style approach to education, Bridge to Rediscovery encourages learning by experience, allowing residents the joy of rediscovering the activities they've always loved. Residents enjoy the comfortable feeling of home in a specially designed setting that provides the support and security they need.

The Goals of Bridge to Rediscovery Include:

- * Visual cues and themes to stimulate memory and assist residents in finding their way
- * Contrasting colors to help residents identify their surroundings
- * Electronic doorway security inside and outside to enhance safety
- * Comfortable, familiar furniture designed for the unique needs of seniors
- * A specialized food and beverage program



Dementia Specialists

Ashton Gables in Riverchase

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www.ashtongables.com

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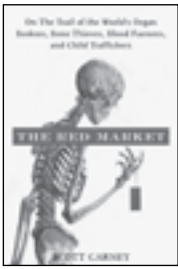
The Literary Examiner

by Terri Schlichenmeyer

The Red Market

by Scott Carney

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This week, you gave away part of yourself.

But that's just what we do, isn't it? There's a need somewhere, and we roll up our sleeves to donate blood. We see children with cancer, and we cut our hair to give them. Some people go further with kidneys or bone marrow.

Even in death, you can donate.

It seems like a good way of saving lives: you give, someone else gets. But author Scott Carney says there's much more to it than that. In his new book *The Red Market*, he shows the dark, hidden side of medical altruism.

Following completion of a graduate program at a Wisconsin college, Scott Carney's "short-lived professional academic career" abruptly halted with the death of one of his students who was studying abroad in India. Taking responsibility for her remains, Carney "confronted the physical nature of mortality," which forced him to see that "every corpse has a stakeholder."

In many cases, though, the stakeholders are varied and the body isn't dead. India, as it turns out, is a major world hub for what Carney calls a "Red Market" in which human organs become big-money commodities, despite social taboos.

We like to believe that altruism begets organ donations. Here, we freely give blood, sticker our driver's licenses, and sign up for registries, but there is no such thing as altruism in the Red Market. "Donor" is a misnomer.

Take kidneys, for example: in India,

entire towns are filled with people who've been promised the equivalent of several months' salary in exchange for kidneys, which are then sold to desperate buyers with the means to pay the price, usually a fraction of the cost of a kidney transplant back home.

Making families is a big business, too, and Carney uncovered sordid truths about in-vitro fertilization, surrogacy, and foreign adoptions. He looked into skeletal remains, their thefts, and their use in American medical schools. He recalls his college days, and a brief stint as a human guinea pig. He writes about the world's blood supply, its constant state of "low", and the hidden danger that could mean to your health.

Don't let anybody ever tell you that you're worthless. After reading *The Red Market*, you'll know that's not true.

Author Scott Carney warns readers early that some of what he writes about is disturbing, and he's right. It's hard to consider humans as commodities, difficult to think of women as little more than incubators, and horrifying to read about crimes committed in the name of money. Carney tells us about things we'd just as soon not think about.

In the end, he makes no bones about a solution to the Red Market but it, too, is controversial. Still, he says, though other scholars have come to the same conclusion, it "... won't solve every problem."

If you're mindful of your health and want to stay abreast of global issues that might affect you, this is a book you'll want to read. With *The Red Market*, being informed won't cost an arm and a leg.



Terri Schlichenmeyer. Terri is a professional book reviewer who has been reading since she was 3 years old and she never goes anywhere without a book.

CMS Rule Lowers Barriers to Telemedicine,

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telemedicine services is licensed or recognized in the state where she or he is located and in the state of the facility receiving the telemedicine services.

4. The receiving hospital provides to the distant site facility internal review information, which includes, at a minimum, all patient complaints and adverse events on the practitioner providing the telemedicine services.

Hospitals and CAHs that decide to take advantage of this less burdensome credentialing process should watch for further guidance from TJC, review and revise as necessary their medical staff bylaws to allow for this flexible creden-

tialing option, and work with counsel to prepare fully compliant written agreements with the distant site telemedicine facilities.

The final will take effect on July 5, 2011. TJC is expected to publish additional information on its privileging by proxy practice by the same date.



Jennifer Hoover Clark is an associate in Balch & Bingham, LLP's Health Care Law Practice Group.



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Contact Mike Jones at 205-985-2160
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