As states proceed toward maintenance of licensure programs, MOC may acquire a second role for dermatologists.
For the treatment of moderate to severe plaque psoriasis for up to 4 weeks in adults

The right delivery for a standout performance

With its unique formulation, Clobex® (clobetasol propionate) Spray, 0.05%, contains the only class 1 steroid that can be used for up to 4 weeks\(^1-4\)

- An average of 80% of patients were clear or almost clear at week 4 in two pivotal Phase III trials (n=120)\(^2\)*
- On average, patients rated CLOBEX® Spray a 9.1 out of 10 for ease of application (n=44)\(^5\)†

\*From two randomized, vehicle-controlled clinical trials that were designed to assess the efficacy of CLOBEX® Spray (n=120) or vehicle spray (n=120) in patients with moderate to severe plaque psoriasis for up to 4 weeks. Patients were evaluated on their Overall Disease Severity.\(^2\)

†From a 4-week, randomized study comparing efficacy, safety, quality of life and patient satisfaction with CLOBEX® Spray BID (n=44 per protocol) vs Taclonex® (calcipotriene 0.005%/betamethasone dipropionate 0.064%) Ointment QD (n=49 per protocol) in patients with moderate to severe plaque psoriasis. Dosing was according to approved labeling for each product, with a maximum dosage of 50 g/week for CLOBEX® Spray and 100 g/week for Taclonex® Ointment (n=93 per protocol). In the patient-reported satisfaction survey, patients rated their responses on a scale of 1 through 10 (1 being the worst, 10 being the best).\(^3,5\)

Important Safety Information

Indication: CLOBEX® Spray, 0.05% is indicated for the topical treatment of moderate to severe plaque psoriasis affecting up to 20% body surface area in adults 18 years of age or older. Adverse Events: In controlled clinical studies, the most common adverse reactions (> 2%) were burning, pruritus, nasopharyngitis and upper respiratory tract infection. Local adverse reactions may occur more frequently with the use of occlusive dressings. Warnings/Precautions: Clobetasol propionate has been shown to suppress the HPA axis at the lowest doses tested. Treatment should be limited to 4 weeks. The total dosage should not exceed 50 g (59 mL or 2 fl oz) per week. Do not use more than 26 sprays for each application or more than 52 sprays in 1 day.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088. Please see adjacent page for brief summary of Prescribing Information.
IMPORTANT INFORMATION ABOUT
CLOBEX® SPRAY, 0.05%  
(clobetasol propionate)

BRIEF SUMMARY
This summary contains important information about CLOBEX (KLO-bex) Spray, 0.05%. It is not meant to take the place of your doctor’s instructions. Read this information carefully before you start using CLOBEX Spray. Ask your doctor or pharmacist if you do not understand any of this information or if you want to know more about CLOBEX Spray. For full Prescribing Information and Patient Information please see the package insert.

WHAT IS CLOBEX SPRAY?
CLOBEX Spray is a prescription corticosteroid medicine used to treat adults with moderate to severe plaque psoriasis that affects up to 20% of the body’s skin surface. CLOBEX Spray is for use on the skin only (topical).

• CLOBEX Spray should only be used for the shortest amount of time needed to treat your plaque psoriasis.
• Do not use more than 26 sprays for each application or more than 52 sprays in 1 day.
• You should not apply more than 59 mL (2 fluid ounces) of CLOBEX Spray to your skin in 1 week.

You should not use CLOBEX SPRAY:
• on your face, under arms (armpits), or groin area
• if you have thinning of the skin (atrophy) at the treatment site
• to treat rosacea or perioral dermatitis (a rash around the mouth)

WHO IS CLOBEX SPRAY FOR?
CLOBEX Spray is for use in adults 16 years of age or older. Use in people under 18 years of age is not recommended because safety has not been established and because numerically high rates of HPA axis suppression were seen with other clobetasol propionate topical formulations.

Do not use CLOBEX Spray for a condition for which it was not prescribed. Do not give CLOBEX Spray to other people, even if they have the same symptoms you have. It may harm them.

WHAT SHOULD I TELL MY DOCTOR BEFORE USING CLOBEX SPRAY? Before you use CLOBEX SPRAY, tell your doctor if you:
• have a skin infection. You may need medicine to treat the skin infection before you use CLOBEX Spray.
• plan to have surgery.
• have any other medical conditions.
• are pregnant or plan to become pregnant. It is not known if CLOBEX Spray will harm your unborn baby.
• are breast-feeding or plan to breast-feed. It is not known if CLOBEX Spray passes into your breast milk. Talk to your doctor about the best way to feed your baby if you use CLOBEX Spray.

Tell your doctor about all of the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. Especially tell your doctor if you take other corticosteroid medicines by mouth or use other products on your skin that contain corticosteroids. Ask your doctor or pharmacist if you are not sure.

WHAT SHOULD I AVOID WHILE USING CLOBEX SPRAY?
• CLOBEX Spray is flammable. Avoid heat, flames or smoking while applying CLOBEX Spray to your skin.

WHAT ARE THE MOST COMMON SIDE EFFECTS OF CLOBEX SPRAY?
CLOBEX SPRAY can pass through your skin. Too much CLOBEX SPRAY passing through your skin can shut down your adrenal glands. Your doctor may need to do blood tests to check for adrenal gland function while you are on CLOBEX SPRAY. The most common side effects with CLOBEX SPRAY include:
• burning at treated site
• upper respiratory tract infection
• runny nose
• sore throat
• dry, itchy, and reddened skin

If you go to another doctor for illness, injury or surgery, tell that doctor you are using CLOBEX Spray. Tell your doctor if you have any side effect that bothers you or doesn’t go away. These are not all of the possible side effects of CLOBEX SPRAY. For more information, ask your doctor or pharmacist.

You are encouraged to report negative side effects of prescription drugs to the FDA at www.fda.gov/medwatch or call 1-800-FDA-1088. You may also contact GALDERMA LABORATORIES, L.P. AT 1-866-735-4137.

HOW SHOULD I USE CLOBEX SPRAY?
• Use CLOBEX SPRAY exactly as your doctor tells you to use it.
• Your doctor should tell you how much CLOBEX SPRAY to use and when to apply it.
• CLOBEX SPRAY is for use on skin only. Do not get CLOBEX SPRAY near or in your eyes, mouth, or vagina.
• You should not use CLOBEX SPRAY on your face, under arms (armpits), or groin area.
• Apply CLOBEX SPRAY 2 times each day.
• Apply only enough CLOBEX SPRAY to cover the affected skin area. Rub gently.
• Wash your hands after using CLOBEX SPRAY.
• Throw away any unused CLOBEX SPRAY.
• Do not bandage or cover your treated areas unless your doctor tells you to.
• Tell your doctor if your skin condition is not getting better after 2 weeks of using CLOBEX SPRAY. Your doctor may tell you to apply CLOBEX SPRAY to certain areas of your skin for up to 2 more weeks if needed. You should not use CLOBEX SPRAY for more than 4 weeks unless your doctor tells you to. This can increase your risk of serious side effects.

WHERE SHOULD I GO FOR MORE INFORMATION ABOUT CLOBEX SPRAY?
• Talk to your doctor or pharmacist
• Go to www.clobex.com or call 1-866-735-4137

GALDERMA LABORATORIES, L.P., Fort Worth, Texas 76177 USA


© 2012 Galderma Laboratories, L.P. GALDERMA and CLOBEX are registered trademarks.
Taclonex is a registered trademark of LEO Pharma

Galderma Laboratories, L.P., 14501 N. Freeway, Fort Worth, TX 76177
CLO-847  Printed in USA  06/12
DEAR READERS,

The end of the year is a good time to take stock.

2012 was a big year of growth for Dermatology World on every front. So what’s been new? Derm World saw the addition of three new columns — Technically Speaking, our column on international dermatology, and the expansion of our Legally Speaking column — as well as the redesign of DW online. I’m a big fan of these new columns and I’ve been delighted to hear that you like them too.

Take, for example, our column on international dermatology. This month’s column tells us about dermatologic practice in Japan. I found it very interesting to read about ways that it varies from practice here in the U.S. But most of all I was struck by the fact that we in the United States could learn a lot from studying the issues that Japan is wrangling with. The impending crisis over health care costs as the population ages is reaching a critical level in that country. We in the United States have been spared this issue thus far, but with baby boomers aging, we too will soon face it. Payment systems, while different between our countries, share many of the same economic principles … they are predicated on the idea that the young masses will pay for the welfare of the elderly. Aging population is also a problem in much of Europe as the average age of the population rises and birth rates fall. Paying attention to how Japan finesses this crisis may provide all of us with important lessons and strategies.

Our technology piece this month is also really relevant to our practices — which technologies to bring into the office. Maybe you’re one of the lucky few who feels that your practice is in perfect shape when it comes to computer-based technologies. Most of us, though, are probably still trying to figure out how to make things function more effectively. I hope that you find our piece on tablets versus laptops helpful in thinking about the choices in your practice.

In addition to all of the new stuff, we have also pushed forward on our features, making them even more in-depth looks at topics. This month’s feature on maintenance of licensure is certainly a good example and an important issue for each of us. This will impact each of us somewhat differently depending on where you reside. We’ve all been hearing for a long while about maintenance of certification, but some states have now started pilot programs to regulate this. For those whose certification in dermatology is not time-limited, there may be new reasons to reconsider participating in MOC. For those already involved in MOC, this month’s feature on maintenance of licensure and certification provides all of us with important tools.

And last, but not least, there is the reconfigured digital Derm World. This is a tool that too many of you are not taking advantage of, although the traffic is growing with each month. Let me remind you that there is lots of information located there — including additional stories, added content, and search capabilities — that does not appear in our print version. Do make sure that you give yourself a chance to browse the site at www.aad.org/dw and see for yourself.

So what’s coming in 2013? Lots of both new stuff as well as more of what you’ve already been enjoying. Expect to see more legal info coming down the pike — with information that is both overarching, at a policy level, as well as some that is “deep in the trenches” practical. I think that you’ll like this breadth. Also hope that you’ll keep reading my column. So cheers to what has looked, from my vantage point, to have been a most successful year! Wishing you each a happy holiday and a healthy new year!

Enjoy your reading.

Abby S. Van Voorhees, MD
Physician Editor
“For the majority of dermatologists, implementation of MOL will end up being seamless.”

features

COVER STORY
TWO FOR ONE
As states proceed toward maintenance of licensure programs, MOC may acquire a second role for dermatologists
BY RUTH CAROL

STRAW, STICKS, OR BRICKS?
Dermatologists have many practice structures to choose from
BY JOHN CARRUTHERS

THE COSMETIC CONVERSATION
Dermatologists offer advice for educating patients about the full breadth of available treatments
BY JAN BOWERS

depts

FROM THE EDITOR

CRACKING THE CODE
Using destruction codes appropriately.

ROUNDS
2012 Medicare quality reporting due Jan. 31, 2013, more.

ACTA ERUDITORUM
What treatments improve outcomes for port wine stains?

TECHNICALLY SPEAKING
Tablets vs. laptops vs. desktops.

IN PRACTICE
Dermatology in Japan.

FROM THE PRESIDENT

ACADEMY UPDATE
Executive Director’s Report, more.

ACCOLADES
PAs/NPs likely to be employed by half of all dermatologists by 2015.
I biopsied and curetted a suspected basal cell carcinoma, but the pathology report indicated that the lesion was simply a benign nevus. Do I bill this as a biopsy, or as destruction of a benign lesion?

It should be reported as a biopsy.

When a suspected basal cell carcinoma is biopsied and curetted, it is appropriate to hold the bill until the pathology report is received. Both the initial size of the lesion and the size of the curettage defect should be recorded in the medical record. If the lesion proves to be a basal cell carcinoma, the definitive procedure was the destruction, which would be appropriately reported using the size of the final curettage defect as the true size of the malignancy. The biopsy is regarded as a component of the destruction and may not be reported separately.

If, on the other hand, the lesion turns out to be benign, the only medically necessary service that was provided is the biopsy. We only report medically necessary services to the payer, so only the biopsy would be reported.

Destruction refers to the ablation of benign, premalignant, or malignant lesions by any method. This would include curettage, electrosurgery, cryosurgery, or laser or chemical treatment, but does not include removal by means of a blade or surgical scissors.

The destruction codes listed in the Integumentary section of the CPT manual are categorized by benign, premalignant, and malignant lesions, with different codes assigned to each category.

Please note that the injection of local anesthesia is included in the destruction, and may not be reported separately. Biopsy performed immediately prior to the destruction and prior to the receipt of a biopsy report is also considered a component of the destruction and may not be reported separately. Surgical supplies are included in the reimbursement for the procedure and no separate charge is appropriate for these supplies.

**RULES FOR DESTRUCTION OF BENIGN LESIONS**

Codes 17110 and 17111 are used to report the destruction of benign lesions, such as warts, by any of the methods listed in the code descriptors (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage). For destruction of up to 14 lesions, only code 17110 should be reported. For 15 or more lesions, only code 17111 should be reported. Skin tags and cutaneous vascular proliferative lesions are not reported with codes 17110 and 17111.

**Example 1:** I applied cantharidin to seven molluscum contagiosum lesions and reported it using 17110.

Correct: Cantharidin application to molluscum contagiosum lesions is chemosurgical destruction, and should be reported with codes 17110-17111, depending on the number of lesions treated.

**Example 2:** I froze two warts on the hands and three plantar warts. Do I report 17110 once for each location?

No. 17110 is only reported once for the destruction of up to 14 benign lesions. For the destruction of one to 14 benign lesions, other than skin tags or cutaneous vascular proliferative lesions, use code 17110. Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), of benign lesions other than skin tags or cutaneous vascular proliferative lesions up to 14 lesions.

**Example 3:** I electrodessicated a wart that had been refractory to other treatment. I had to inject xylocaine prior to the procedure. Do I report the injection separately?

No. According to the CPT codebook, destruction means ablation by any method, including any required local anesthesia. Any method includes electrosurgery, cryosurgery, laser, and chemical treatment.

**Editor's Note:** This is Dr. Elston’s last Cracking the Code. Dermatology World thanks him for two years of great columns and looks forward to his From the President column starting in March. Alexander Miller, MD, the AAD’s current AMA CPT Advisor, will take over this column starting next month. dw
Medicare fee schedule cuts surgical pathology code value

Includes 26.5 percent cut, provides ERX, PQRS, and Value-Based Modifier details

The Medicare Physician Fee Schedule for 2013, released Nov. 1 by the Centers for Medicare and Medicaid Services (CMS), calls for an across-the-board 26.5 percent reduction in payment rates, based on the current Sustainable Growth Rate (SGR) formula. This cut would reduce the Conversion Factor — the multiplier that determines the dollar value of a given service — to $25,008. The American Academy of Dermatology Association (AADA) is working with other medical societies to encourage Congress to act before payment rates are reduced on Jan. 1, 2013.

CMS did not accept American Medical Association/Specialty Society Relative Value Update Committee (RUC) recommendations on a number of shave skin lesion codes, as noted in CMS’ listing of interim work Relative Value Units (RVUs) for 2013, but only one — a shave code, 11306 — was reduced below its 2012 value. Some complex repair codes were reduced, including 13152 and 13132. Other codes that dermatologists may use did not fare well. Most notably, CMS reduced the technical component (TC) of the surgical pathology code 88305 by 52 percent, although it raised the professional component (PC) by 2 percent. Overall, pathology suffered a 6 percent decrease.

CMS did, however, accept the majority of the RUC recommendations on almost 30 dermatology codes that were surveyed in 2012, and the AADA is pleased that the RUC continues to see a majority of its recommendations accepted by CMS.

In addition, the final rule contains a number of refinements to policy initiatives, including some that will reduce burden on physicians. For instance, CMS will reduce the threshold for reporting the electronic prescribing measure, add an appeals process and two additional penalty exemptions for participating physicians, and allow group practices of two to 24 eligible professionals (EPs) to participate in the electronic prescribing (eRx) program in 2013. Moreover, physicians whose data will be publicly reported on the Physician Compare website will be afforded a 30-day preview period to view their data prior to its being posted on the public site.

While CMS states its commitment to applying the Physician Value-Based Payment Modifier (VBPM) to all physicians in 2017, initially, the VBPM will apply only to groups of 100 or more EPs. Providers in those practices will be subject to a VBPM adjustment in 2015 as determined by their 2013 Physician Quality Reporting System (PQRS) participation. To prepare for broader applicability of the VBPM, CMS is encouraging all providers to participate in the PQRS program. Providers who participate successfully in the PQRS program in 2013 will receive a 0.5 percent bonus and avoid a 1.5 percent deduction in overall Part B Medicare payments in 2015. Providers who do not participate in 2013, or do so unsuccessfully, will face a 1.5 percent penalty in 2015.

Additional details about the fee schedule are available at www.aad.org/member-tools-and-benefits/aada-advocacy/regulatory-affairs/payment-policy/payment-policy. – RICHARD MARTIN, JD

Report PQRS measures for 2012 by Jan. 31, 2013 to earn 0.5 percent bonus; registry purchase deadline is Dec. 14

Reporting in 2013 required to avoid penalty in 2015.

Dermatologists who report quality measures to Medicare’s Physician Quality Reporting System (PQRS) in 2013 will make themselves eligible for a bonus payment of 0.5 percent of their total Medicare Part B allowed charges. In addition to qualifying for the incentive, reporting PQRS measures in 2013 will help dermatologists avoid a 1.5 percent penalty to be assessed in 2015. Reporting the measures that are most applicable to dermatologists must be completed through an electronic registry.

Dermatologists in 2013 will have four measures, of which they must choose at least three, to report in order to make themselves eligible for a bonus payment. The four dermatology-appropriate measures were all part of the 2012 program. The biopsy follow-up measure, however, has changed to include only new patients whose biopsy results have been reviewed and communicated by the performing physician to the primary care/referring physician and patient.

There is still time to participate in the 2012 PQRS through the AAD registry and earn a bonus payment of up to 0.5 percent. Those still wishing to participate will have until Dec. 14, 2012 to purchase the registry and until Jan. 31, 2013 to enter and submit all of the information. More information about the measures for 2012 and 2013 and on purchasing the 2012 Physician Quality Reporting System Melanoma Reporting module is available at www.aad.org/education-and-quality-care/performance-measurement-and-quality-reporting.

– SCOTT WEINBERG
What treatments improve outcomes for port wine stains?

IN THIS MONTH’S ACTA ERUDITORUM COLUMN, Physician Editor Abby S. Van Voorhees, MD, talks with Jennifer K. Chen, MD, about her recent Journal of the American Academy of Dermatology article, “An overview of clinical and experimental treatment modalities for port wine stains.”

Q&A

DR. VAN VOORHEES: What is the frequency of port wine stains?
DR. CHEN: Port wine stains are the most common vascular malformation of the skin. They occur in about 0.3 to 0.5 percent of infants.

DR. VAN VOORHEES: What currently is the most commonly used treatment modality? How is it thought to work? How successful is it at clearing treated lesions? What are the most common limitations/risks of this modality?
DR. CHEN: The pulsed dye laser (PDL) is the most commonly used treatment modality. Lasers work by photocoagulating the blood vessels in a port wine stain. Full regional clearance is seen in about 40 percent of cases, with suboptimal clearance seen in about 20 to 46 percent of cases and no clearance in 14 to 40 percent of cases. The efficacy of the pulsed dye laser may be limited by darker skin types and by the presence of a tan. The most common risks include bruising, pigmentary changes of the skin, pain, incomplete resolution of the condition, and recurrence of the condition. Blistering and scabbing can occur and in some cases can result in scarring so it’s important not to be overly aggressive. We also tell our patients to prepare for multiple treatments.

DR. VAN VOORHEES: Is there an optimum age for the treatment of lesions?
DR. CHEN: At our institution we always try to treat earlier; we believe this results in a better treatment outcome. Also, you want to start before the child starts to feel different or socially stigmatized. The goal is to improve quality of life so we like to start early.
DR. VAN VOORHEES: Do we know what factors cause patients to have a poor outcome from treatment with the pulsed dye lasers? Have modifications been made to either the lasers or to protocols to try to enhance their response rates?

DR. CHEN: Several factors have been recognized in patients with a poor treatment outcome. We know that the extent of epidermal pigmentation plays a role, as well as shielding by blood and superimposed vessels. Large port wine stains and those with deep or dense vasculature are also harder to treat. Following treatment, blood vessels may also grow back within the treatment site.

Several modifications have been made to the pulsed dye laser to try to improve response rates. Initially the 577 nm wavelength was used; it was found that increasing the wavelength to 585 or 595 nm increased the depth of penetration. Increasing the spot size was also found to increase the depth of penetration and allow for more uniform energy transmission and shorter treatment times, as long as the spot size was not larger than the target lesion. Changing these settings may enhance the response rate. Epidermal cooling has also been used to decrease non-selective epidermal thermal injury to epidermal melanocytes, allowing the treatment of darker skin types and the use of higher fluences, and also decreasing the patient’s level of pain and discomfort.

DR. VAN VOORHEES: Can you predict which patients require these steps to ensure a response to treatment?

DR. CHEN: It’s difficult. Purple, hypertrophic port wine stains tend to not respond as well to the pulsed dye laser, but otherwise it can be difficult to predict which lesions will respond and which ones won’t.

DR. VAN VOORHEES: Do the modifications that have been made to the lasers to enhance their response rate, such as changing the wavelength and spot size or providing cooling, have disadvantages? Or have they only improved our techniques and strategies?

DR. CHEN: There is a clear benefit in going from 577 nm to 585 nm. Going from 585 nm to 595 nm the data was not as strong. Every patient is going to be different; there are variations in the anatomy from one area to another in the same patient. So it’s very difficult to predict the optimum wavelength. It’s not that you want to just increase the settings to get a better result. You want to tailor them to your patient. There’s no magic formula that tells you that a certain appearance equals a certain setting.

DR. VAN VOORHEES: Are there negative consequences to providing cooling to the skin?

DR. CHEN: We use cryogen spray cooling and we haven’t had any complications. There are some small potential risks: if cooling is excessive then it can decrease the temperature of the blood vessels, which may affect treatment. Also, some have argued that there is a slight risk of discoloration with cooling if it is excessive, but this has not been our experience.

DR. VAN VOORHEES: What are the other modalities used to treat port wine stains? Can you talk us through their advantages and disadvantages?

DR. CHEN: The alexandrite laser has been used in patients who have failed the pulsed dye laser. The greater wavelength allows for increased penetration, making it especially useful for hypertrophic or nodular port wine stains that may contain deeper blood vessels. The Nd:YAG has also been used in some patients. The main disadvantage of the alexandrite and Nd:YAG is that they’re associated with an increased risk of pigmentary changes and scarring, both due to the increased penetration and the decreased absorption by hemoglobin, which necessitates the use of higher fluences. The Nd:YAG especially can cause significant scarring and we recommend its use only to those who are experienced with it. Intense pulsed light has also been shown to be useful, although a head-to-head comparison showed that PDL resulted in significantly better lesional clearance.

DR. VAN VOORHEES: Let’s talk about the new treatments on the horizon. Maybe you can tell us from your perspective how these compare and what their advantages and disadvantages might be.

DR. CHEN: The strongest body of evidence is for photodynamic therapy (PDT). When treating vascular lesions PDT entails activation of an intravenously administered photosensitizer by a wavelength of light that in the presence of oxygen leads to the formation of reactive oxygen species. These cause direct damage to endothelial cells, leading to thrombosis and occlusion of the blood vessel. Damage is limited...
to areas containing sufficient photosensitizer concentration, imparting some degree of site-specificity. Some studies have shown that PDT is equivalent or even superior to PDL treatment, especially in the treatment of purple, flat lesions, but more studies are needed. There may be a role for combination therapy with PDT followed by PDL, which appears to act synergistically, and this is an area of active research. One particular advantage of PDT is the ability to treat all skin types. Disadvantages include the generalized photosensitivity that occurs after therapy, which can last from five days to four weeks depending on the photosensitizer used, and the expense of photosensitizers.

DR. VAN VOORHEES: If taken intravenously, how does the photosensitizer know to target the lesion?

DR. CHEN: You only get a treatment effect when you have both the photosensitizer and the selected wavelength of light in the same place. The photosensitizer is first given intravenously and then you illuminate only the area of skin that you are treating. Photosensitizers that have been used include benzoporphyrin monomethyl ether. Topical and oral photosensitizers have not shown efficacy.

DR. VAN VOORHEES: What other new treatments are on the horizon?

DR. CHEN: Angiogenesis inhibitors are another exciting new area of investigation. Angiogenesis is now thought to be a critical factor limiting treatment efficacy due to post-treatment vascular repair of PWS blood vessels. There have been some data showing that immune response modifiers such as imiquimod and rapamycin possess anti-angiogenic properties. Preliminary data suggest that these agents actually have potential to increase treatment efficacy when applied topically following pulsed dye laser treatment of port wine stains. The advantage of this treatment is that these topical treatments are well-tolerated with good safety profiles, although further study is required.

Another therapeutic option under investigation is the use of hypobaric pressure devices, or pressure cuffs, to alter the hemodynamics of PWS vasculature in order to increase susceptibility to photo-induced damage. With hypobaric pressure devices such as pressure cuffs or suction devices, blood vessel dilation can be induced in the PWS vasculature, making these vessels easier to target. It is still too early to know what the advantages and disadvantages of this would be, but preliminary data are promising.

Lastly, site-specific pharmaco-laser therapy is a treatment modality that targets vessels that are only partially occluded by PDL treatment, which may play a role in treatment failure. Following PDL treatment, liposomes are injected that contain pro-thrombotic and anti-fibrinolytic drugs. These liposomes accumulate in the thrombi of partially occluded vessels and drug release is triggered by heat via heating pad or near infrared light. This leads to complete occlusion of blood vessels, potentially improving lesional clearance rates. It’s still too early to know what the advantages and disadvantages of this system would be but this is another modality we may be hearing about more over the next few years.

DR. VAN VOORHEES: What advice would you give to dermatologists who are managing these patients about improving their clinical outcomes?

DR. CHEN: A good place to start would be the pulsed dye laser. Changing the wavelength, increasing the spot size, or varying the pulse duration might be helpful. The alexandrite laser might be useful for patients with purple, nodular port wine stains. It’s very important to be careful to avoid being overly aggressive as this can lead to scarring. It will also be important to keep up with the literature because it’s likely that there will be new data coming out in the future that may give us new protocols.

DR. CHEN is a resident at the Beckman Laser Institute and Medical Clinic at the University of California, in Irvine. Her article was published in the Journal of the American Academy of Dermatology, 2012 Aug;67(2):289-304. doi:10.1016/j.jaad.2011.11.938.
Treat Acne at It’s Root: the HORMONES!
Anti-DHT Acne Treatment

HOW IS CLEAROGEN DIFFERENT?
Clearogen fights the root cause of acne using a synergistic combination of FDA approved acne medications and natural anti-DHT ingredients to normalize oil production and prevent acne.

RESULTS

Before

After

- 95% Effective in Clinical Trials
- Time Released Medications
- Natural Anti-DHT Ingredients
- 60 Day Money Back Guarantee

INTRODUCTORY OFFERS AVAILABLE FOR WHOLESALE
CALL FOR DETAILS (877) 512-4247

Visit www.Clearogen.com | Call 877-512-4247

Scan the QR Code to request more information.
Jennifer@clearogen.com
Tablets vs. laptops vs. desktops

THE TIMES, THEY ARE A-CHANGIN'

Historic battles between contenders and challengers; the Spartans vs. the Persians, Kennedy vs. Nixon, Frazier vs. Ali — and, today, Apple vs. Samsung? As we continue our quest to integrate electronic health records (EHR) into our practices, we must make our own tough decisions on hardware platforms. Do we choose the classic (sessile, yet upgradable) desktop PC to compose electronic notes and e-prescribe or would we benefit from a more mobile tablet computer platform to use in patient rooms?

When deciding to outfit your office with computing power, cost, functionality, and compatibility with existing office infrastructure are the most important initial factors to consider. One of my favorite tech writers, Tim Bajarin of PCMag.com, noted recently that although the computer industry is still selling at least 300 million laptops and desktops a year, its growth has stalled. He quotes International Data Corporation (IDC) reports that desktop PC sales for 2012 will grow by only 1 percent. Most potential computer buyers are torn between tablets and laptops when it comes to buying a device to fit into their business or personal lifestyles.

The original tablet PCs ran a full, keyboard-centric operating system on a bulky touch-screen enabled laptop. This concept has largely vanished, as the touch-centric interface of newer tablets has replaced the need for constant keyboard or mouse interaction. Early adopters of new tablets, such as the iPad, quickly discovered that while they were marketed as media-consumption devices, they could also cross over to serve as a keyboard-optional productivity tool. Tablets were redefined as lightweight, portable computing devices.
As laptops are getting cheaper, thinner, lighter, and faster, physicians often defer upgrades as they try to identify what best fits their office needs and the ideal balance of tablet and laptop use in their professional lives. At the same time, tablet technology continues to improve, which raises the question of which is preferable. Most laptops on the market today are quite powerful with better hardware components to allow for better multi-tasking, keyboard entry, more powerful wireless radios for faster/more stable Wi-Fi connection, and better connectivity with peripheral devices.

But despite all these new advances in laptops, tablet computers, and smartphones, the desktop remains the go-to computing tool for many doctors. Survey data published in the July 2012 issue of the AMA newsletter, based on the responses of 1,190 physicians, found that 75 percent of doctors use their desktops for practice management tasks. By comparison, 25 percent used a laptop for such work, 10 percent an iPad or another tablet, and 6 percent a smartphone. Desktops were also the most common tool used for clinical tasks (59 percent of respondents), electronic prescribing (52 percent), and accessing an EHR (44 percent). Responding physicians cited the need for multitasking ability and larger screen real estate as factors why they would stay with a desktop. Lack of confidence in the security of mobile devices has also been cited as a concern.

**TABLET ADOPTION**

However, as Bob Dylan warned us long ago, the times, they are a-changin’. In 2011, 30 percent of doctors in the United States owned a tablet computer, compared to only 5 percent of the general public. According to *American Medical News*, “One year after Apple® launched its first iPad® tablet computer, 27 percent of primary care and specialty physicians owned an iPad or similar device — a rate five times higher than the general population.” As costs on some tablets fall into the sub-$200 range, their use is slowly but surely spilling over into the medical office.

In the context of the doctor/patient interaction, the traditional PC is still a Himalayan-size barrier, which screams of impersonability. It is very challenging to pay attention to a patient while rapidly typing or clicking and staring at a large screen to take notes, whether the PC is sitting on a desk or a rolling cart. Laptops are less cumbersome and present less of a physical barrier between patients and physicians, but still require typing and use of a mouse or trackpad that can make the physician seem detached.

These feelings of detachment can be amplified in dermatology because of the sheer number of daily patient encounters. Demand for dermatology services often dictates short appointments. But as my residency program mentors often reminded us, studies have shown that the short six-to-eight minute average patient encounter can be perceived by the patient as five to 10 minutes longer in duration if the physician spends that time sitting and interacting face to face. Laptops are better than desktops for this, but tablets allow us to maintain eye contact without a physical barrier, keeping the all-important doctor-patient bond intact, while letting our fingers do the charting.

**EHR INTERFACES**

Dermatology-specific EHR applications are catching on to the market desire for the less-intrusive nature and touch-input capability of tablets. Even though most EHR/practice management (PM) systems were created to run on desktops, at least eight of the 10 EHR applications that I reviewed for this article are able to utilize a tablet (specifically the iPad) for patient data entry using a touchscreen interface. Most of these utilize a professional remote desktop/terminal server client to connect the tablet to the desktop. Software such as Splashtop, Citrix, Logmein, or free apps such as Remote Desktop Lite or VNC are designed to connect to a local or remote cloud for interacting with the EHR application itself. (Make sure your connections are secure or you may run afoul of HIPAA.) Another solution is to use a tablet browser such as Safari on the iPad, or Google Chrome, Firefox, or Dolphin Browser on Android-powered tablets to securely interact with online forms that comprise Web-based EHR platforms.

Practical experience from our own office illustrates what hardware decisions many offices face in the near future. It also illustrates how companies can improve their products to meet the demands of their client base. We were caught right in the middle in the laptop/tablet paradigm shift and this was a true
Keep up-to-date with the latest in coding and reimbursement.

Available January 2013. Don’t wait, order yours before the new year!

To pre-order call the Member Resource Center at (866) 503-SKIN (7546).

Save $20 when you mention promo code DWCODE1212.

Copyright © 2012 American Academy of Dermatology. All rights reserved.

dilemma for us. We initially made a large investment in touchscreen laptops and licenses, to run a fully integrated EHR/PM software. The software relies on the enhanced computing power and touchscreen interface of the laptops for full navigation and use. The trade-off for our willingness to tote around six-pound laptops in the patient rooms was the ability to fully document, schedule, and bill our patient visits. Ironically, I noticed, much to my dismay, that almost all the medical assistants tended to use the laptops as keyboard-centric classic laptops rather than utilizing the built-in clamshell/stylus functionality. Since they input most of the history before I see the patients, I wanted them to do this rapidly by getting comfortable with the stylus/touch interface of the EHR application on the laptop. However, melding a touch interface into the current Windows-based application environment isn’t ideal and wasn’t easy for them to learn and master in the typical dermatology workflow of many patients with multiple complaints.

We are now moving to replace/repurpose these laptops to use iPads, running a new native iPad client. We can easily transfer the iPad app license from the laptop without penalty, and the new client incorporates all the functionality of existing laptops. With a new native touch-based interface and enhanced iPad functionality, we believe our workflow will improve. For example, HPI documentation should be faster because less typing will be required. The ability to capture photos from the iPad camera right into the patient record will help to eliminate snafus in surgical and biopsy site documentation. The ability to use the Siri voice recognition engine to uniquely voice-modify each note will also dramatically help workflow.

So, in this battle-royal between desktop PCs, laptops, and tablets, the fight rages on. First-adopter types such as myself will invariably spend more in money, time, and frustration to achieve the right balance of workflow and technology. Our patients will ultimately benefit by getting more of our time and attention and we can get back to the practice of medicine and use electronic documentation as the facilitating tool it was designed to be. dw
BY JOHN CARRUTHERS, STAFF WRITER

Dermatology in Japan

EACH MONTH DERMATOLOGY WORLD tackles issues “in Practice” for dermatologists. This month, dermatologists from Japan, Yoshiki Miyachi, MD, PhD, Satoko Minakawa, MD, PhD, and Masayuki Amagai, MD, PhD, discuss the positive and negative aspects of practicing dermatology there.

As health care reform has been a battleground issue in the last two U.S. election cycles, the current situation in Japan provides an illustration of universal care when the costs are combined with a rapidly aging population and the world’s longest life expectancy.

With its own set of opportunities and challenges, dermatology in Japan offers specialized care to a population of over 127 million, the 10th largest in the world.

PUBLIC CARE, RISING COSTS

One oft-reported notable fact about Japan is the above-average life expectancy of its population. The average lifespan for Japanese men is 79, and the lifespan for women in the country is 86. The country has had a system of universal health insurance since 1961. The system, according to Kyoto dermatologist Yoshiki Miyachi, MD, PhD, allows patients relatively easy access to any dermatologist.

“Everybody can enjoy a standard, reasonable, and less expensive health care, because 70-100 percent of the cost is covered by the insurance depending on your status, age, and income,” Dr. Miyachi said. “Poor patients under a national welfare system can enjoy any approved therapy free of charge.” However, most patients hesitate to receive expensive treatments such as biologics, he said, as the cost is not fully covered unless they are poor.

In most cases, Dr. Miyachi said, 30 percent of the cost of treatment is not covered by health insurance. Those over 65, however, pay only 10 percent of their own costs, while those unable to afford treatment are fully covered. In addition, if the total cost paid by the patient exceeds 70,000 yen ($1,000) per month, the additional cost will be reimbursed to the patient, providing patients with the security of knowing their medical expenses are capped.

As one might expect, however, this has led to significant health care costs as Japan’s population ages.

“The per capita medical expenses for those 75 and older are said to be approximately five times as high as those for people of working age,” Hirosaki University dermatologist Satoko Minakawa, MD, PhD, said. “As a result, the share of medical costs borne by people of working age grew increasingly unfair as the birthrate declined and society aged.”
Complicating the issue, Dr. Minakawa said, is the fact that the Japanese government is seeing a skyrocketing rate of health care spending, which presents a very significant danger to the current framework. Currently, nearly a quarter (22.9 percent) of the Japanese population is 65 or older. (In the U.S., 12 percent of the population is 65 or older, according to the 2010 census.) Health care spending represented 9.3 percent of GDP in 2009, a figure that will continue to rise in the short term.

“Japan needs a quick and revolutionary approach to save the failing system now in place,” Dr. Minakawa said.

ACCESS TO DERMATOLOGY
Patients can see dermatologists directly under the Japanese health care system. Primary care physicians, according to Keio University dermatologist Masayuki Amagai, MD, PhD, are usually bypassed by patients in favor of a dermatologist when seeking treatment for a skin or nail condition. Both Dr. Amagai and Dr. Sakoto said that it's not unusual for patients to visit dermatologists at their respective universities.

“In our university, doctors have to see six patients per hour because doctors have to see patients if patients with dermatologic problems want [to be seen],” Dr. Sakoto said.

Dr. Miyachi said that dermatologists in Japan are increasingly pursuing research or private practice to supplement their incomes.

“Since I am working in a national university, we are not allowed to see patients in private practice which makes our income low. In other words, our income is fixed irrespective of our clinical works, which reduces our motivation to contribute to clinical works,” Dr. Miyachi said. “This is [a] reason why we work more on basic research and recently more academic dermatologists go to private practice or industry.”

While Dr. Miyachi said that physician income is relatively lower than in the U.S., the cost to the patient is much lower since the inception of the public health system.

“My father was an office internist. I witnessed that he received no money from poor patients. However, after the development of the public health care system, everybody has an equal opportunity to visit doctors. This is partly why our medical cost is low. For example, if you receive an appendicitis operation in the U.S. with a few days admission, you may have to pay more than $30,000, but in Japan you will be charged only the equivalent of $5,000,” Dr. Miyachi said. “Since most of the patients are ‘brand-oriented,’ many patients visit our university hospital directly, even patients with contact dermatitis, though we charge them $70 per visit without a reference letter from local doctors,” he said.

“Also, we have to keep in mind that physician income is not so high in Japan.” The mean annual income of the private dermatologist may be 30 million yen ($400,000), Dr. Miyachi said, but the salary of doctors working in university hospitals is half of that figure — though he noted that academics do have additional income “from lectures and writings.”

The problem, he said, is that because patients are free to shop around for care, the system creates incentives for doctors to agree to request or order unnecessary care that patients may want, not realizing that it will not be helpful for them.

“The payment system allows doctors to order some needless exams and treatments. In Japan we have too many MRIs and CTs, four times more than other developed countries,” Dr. Miyachi said. “Some patients visit as many doctors as they want, receive as many CT/ MRI exams and drugs as they want, which is a great waste of money.”

In addition to these challenges, Dr. Miyachi noted that while Japanese dermatologists do enjoy direct access to patients, and many patients take advantage of this access, dermatologists also see many patients only after treatment by another physician has failed.

CHALLENGES TO CARE AND TREATMENT
The March 2011 Tohoku earthquake, one of the most dramatic events in recent Japanese history, continues to have a lasting impact on the state of care in the nation.

“When the earthquake went down, we were at Hirosaki University Hospital. We suffered a level-four quake on the Japanese earthquake scale. The earthquake left us without electricity and water for two days. In our district, we are now in almost back to normal living, but in a part of our prefecture and the nearest prefectures, the disaster had a larger impact," Dr. Minakawa said. (Japan is subdivided into 47 prefectures.)

“More than 450,000 people had crowded into shelters because their homes were damaged or destroyed by the quake, which had a magnitude of 9.0. Our university medical team is providing medical treatment to survivors. I have a lot to be thankful for.”
for, and good health is the most important of them all. I appreciate very much the mission by the United States Armed Forces, support, and people hoping for Japan’s early recovery.”

In addition to dealing with unique circumstances, dermatologists in Japan also see a range of diseases that differ from those in the U.S. Behçet’s disease, rare in the West, is fairly common in Japan. In addition, Dr. Amagai said, Japanese dermatologists see non-HIV related eosinophilic pustular dermatosis, prurigo pigmentosus, and nevus of ova. Japanese dermatologists have a well-documented history of identifying and treating new conditions, first describing conditions such as Kawasaki disease in 1967, prurigo pigmentosa in 1971, and papuloerythroderma in 1984, among others.

Unfortunately, Dr. Miyachi said, Japanese dermatologists often have a difficult time obtaining new drugs and treatments. The country’s Pharmaceuticals and Medical Devices Agency (PMDA), which serves many of the same purposes as the FDA in the U.S., must approve all medicines and techniques, and almost always requires clinical data. This creates an effect known in some circles as the Galapagos phenomenon. The moniker refers to how a segment of a society can evolve in seeming isolation from global advances, in reference to Charles Darwin’s observations of the Galapagos Islands. The agency’s conservative approach has led to nearly 30 percent of drugs available to U.S. dermatologists being unavailable to their Japanese colleagues, according to Dr. Amagai. dw

ABOUT THE CONTRIBUTORS
MAZAYUKI AMAGAI, MD, PHD, is a professor and the chairman of the department of dermatology in the Graduate School of Medicine at Keio University.

YOSHIKI MIYACHI, MD, PHD, is a professor of dermatology and the chairman of the Kyoto University Graduate School of Medicine.

SATOKO MINAKAWA, MD, PHD, is a professor of dermatology at the Hirosaki University Graduate School of Medicine.
TWO FOR ONE

As states proceed toward maintenance of licensure programs, MOC may acquire a second role for dermatologists
Ten years after the Federation of State Medical Boards (FSMB) began discussing the notion of ongoing physician competency, a handful of state boards have started conducting pilot projects to determine how best to implement Maintenance of Licensure (MOL). By the time the first state medical board (SMB) is ready to adopt MOL, dermatologists will likely be comfortable with the new paradigm of lifelong learning, continuous professional development, and maintenance of certification (MOC) and all that they entail.

States will likely try to implement a system for licensure that won’t have a dramatic effect on the physician workforce, which is already being tested in the wake of health care reform, according to Robert S. Kirsner, MD, PhD, vice chair of dermatology at the University of Miami Miller School of Medicine and chair of the American Academy of Dermatology’s Council on Education and Maintenance of Certification. States won’t want to lose any more physicians who might think that MOL is too arduous of a process and will either opt to retire early or retreat from patient care. >>
MOL ROLLS OUT
“From the beginning, we have taken an iterative and methodical approach to MOL. We want to be evolutionary in our approach, not revolutionary,” noted FSMB President and CEO Humayun J. Chaudhry, DO, MS. “There’s no need or desire to shock the system.”
Even before adopting a framework for MOL two years ago, FSMB has been working with key organizations involved in medical education and assessment including the American Medical Association, the American Osteopathic Association, the American Board of Medical Specialties, the AOA’s Bureau of Osteopathic Specialists, the Council of Medical Specialty Societies, the Accreditation Council for Continuing Medical Education, the National Board of Medical Examiners, and the National Board of Osteopathic Medical Examiners. These groups, among others, have representatives on the FSMB’s MOL Implementation Group and its CEO Advisory Council. The exchange of information is not only to inform, but to obtain input and insight, Dr. Chaudhry said.
Its biggest stakeholders, of course, are the nation’s 70 state medical boards that comprise the FSMB. (Some states have separate allopathic and osteopathic boards.) The challenge is to create an approach to MOL that is simple enough to appeal to all SMBs, yet substantial enough that medical licensure remains meaningful. It doesn’t make sense to have 70 different approaches, especially knowing that one-quarter of all physicians have more than one state license, Dr. Chaudhry said. But it does make sense to have an approach that is more similar than not across all SMBs. With SMBs around the country looking to implement MOL, Dr. Kirsner is optimistic a spectrum of approaches that will lead to best practices will emerge. Once they emerge, SMBs may want to spend a year educating their doctors and the public about how they will implement MOL and why, Dr. Chaudhry said. Then each component of MOL can be phased in during the course of two or three years. Some SMBs, however, may choose to streamline the process. “The FSMB is providing guidelines,” he said, “but it’s entirely up to the state as to what it wants to do.”

MOL COMPONENTS
The following three components comprise Maintenance of Licensure (MOL), a method for ensuring ongoing physician competency promulgated by the Federation of State Medical Boards:

REFLECTIVE SELF ASSESSMENT
(What improvements can I make?)
Physicians should participate in an ongoing process of reflective self-evaluation, self assessment, and practice assessment, with subsequent successful completion of tailored educational or improvement activities.

ASSESSMENT OF KNOWLEDGE AND SKILLS
(What do I need to know and be able to do?)
Physicians should demonstrate the knowledge, skills, and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

PERFORMANCE IN PRACTICE
(How am I doing?)
Physicians should demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

For the majority of dermatologists, implementation of MOL will end up being seamless.
PILOT PROJECTS
To that end, the first pilot project — a survey of SMBs to determine their readiness to begin participating in MOL — was launched in September. A second survey will launch soon that will determine what types of activities, beyond continuing medical education (CME), physicians engage in to keep their knowledge and skills current. Once the survey results are in, the SMBs will engage in more pilot projects to better determine how to move forward, Dr. Chaudhry said.

The nine SMBs expected to engage in pilot projects include the Osteopathic Medical Board of California, Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine, Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, Oregon Medical Board, Virginia Board of Medicine, and Wisconsin Medical Examining Board.

Meanwhile, other SMBs are beginning to look at what steps they need to take and what resources they have or will need to implement MOL, he explained. As an example, some states may have to make modifications to their licensing rules to incorporate MOL. In Minnesota, state delegates adopted a resolution to accept participation in ABMS’ Maintenance of Certification® (MOC) and the AOA’s Osteopathic Continuous Certification (OCC) as an acceptable means of meeting CME requirements for license renewal. “The hope is that other SMBs will do the same,” he said.

Because MOC and OCC are so robust, FSMB maintains that physicians engaged in either program should be recognized as being in substantial compliance with MOL, Dr. Chaudhry said. However, he is quick to note that neither specialty licensing nor recertification is a requirement to meet MOL, adding that “FSMB has always been focused on basic minimum competencies.”

In addition to meeting the three MOL components (see sidebar, p. 18), medical licensure renewal will most likely continue to require payment of a licensure fee and submission of demographic data as mandated by state law.

IMPACT ON DERMATOLOGISTS
To critics who argue that MOL will be burdensome to physicians, Dr. Chaudhry says that the vast majority already engage in activities to keep their knowledge and skills current, and that many of these activities are applicable to their fulfillment of MOL. Among these activities are practice-relevant CME courses that emphasize performance improvement (PI) and use pre- and post-testing, hospital credentialing processes, the ABMS’ Patient Safety Improvement Program, and the AOA’s Clinical Assessment Program (CAP). Organizations, such as the Institute for Healthcare Improvement, also offer applicable programs.

“Just about every specialty society we’ve been talking to offers these types of activities,” he noted. For example, both the AAD’s Performance Improvement

MOC COMPONENTS
The following four parts comprise Maintenance of Certification (MOC), promulgated by the American Board of Medical Specialties in 2000:

PART I — LICENSURE AND PROFESSIONAL STANDING
Medical specialists must hold a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories, or Canada.

PART II — LIFELONG LEARNING AND SELF-ASSESSMENT
Physicians participate in educational and self-assessment programs that meet specialty-specific standards that are set by their member board.

PART III — COGNITIVE EXPERTISE
They demonstrate, through formalized examination, that they have the fundamental, practice-related, and practice environment-related knowledge to provide quality care in their specialty.

PART IV — PRACTICE PERFORMANCE ASSESSMENT
They are evaluated in their clinical practice according to specialty-specific standards for patient care. They are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.

To learn more about MOC, visit www.aad.org/education-and-quality-care/moc.
CME (PI CME) activities and the American Osteopathic Board of Dermatology’s (AOBD) CAPs are Web-based modules designed for assessing performance in the care of acne, atopic dermatitis, and melanoma. (Learn more about PI CME activities at www.aad.org/education-and-quality-care/aad-professional-education/performance-improvement-cme-picme.)

Physicians who are neither board-certified in a specialty nor participating in MOC or OCC as they are voluntary programs, as well as those working in non-clinical roles, can also engage in these options. “Any activity physicians engage in that improves their area of practice, and impacts their ability to be more knowledgeable and skilled, is going to count,” said Dr. Chaudhry, who added that the FSMB is working with SMBs to develop guidelines for activities that can be used by physicians for MOL purposes.

Given that FSMB has indicated that MOC substantially complies with MOL, Thomas D. Horn, MD, MBA, who will become executive director of the American Board of Dermatology (ABD) in January, does not expect MOL compliance to have a significant impact on the majority of dermatologists. “We’re happy that the ABD can provide a resource for dermatologists to meet their MOL requirements and that it’s already in place,” he said. “I expect that dermatologists will just have to fill out an attestation and send it to their state medical board.” Practicing dermatologists who are lifetime certificate holders have the option to participate in MOC if they wish to use it to satisfy MOL requirements, he said.

Stephen Purcell, DO, chair of the AOBD, concurs. “In 10 years, most dermatologists will be well into continuous certification with either OCC or MOC, so I don’t think that meeting MOL requirements will have a significant impact on them.”

With MOL several years away from being adopted, dermatologists should keep a watchful eye on their SMBs as MOL evolves, Dr. Kirsner advised. “Lifetime certificate holders will want to be more vigilant because eventually they may have to do business a little differently,” he said. “For the majority of dermatologists, however, implementation of MOL will end up being seamless.”

**OCC COMPONENTS**

The following five components comprise Osteopathic Continuous Certification (OCC), developed by the American Osteopathic Association:

**COMPONENT 1 — UNRESTRICTED LICENSURE**
Requires physicians who are board-certified by the AOA to hold a valid, unrestricted license to practice medicine in one of the 50 states. In addition, they are required to adhere to the AOA’s Code of Ethics.

**COMPONENT 2 — LIFELONG LEARNING/CONTINUING MEDICAL EDUCATION**
Requires all recertifying physicians to fulfill a minimum of 120 hours of CME credit during each three-year CME cycle — though some certifying boards have higher requirements. Of these 120+ CME credit hours, a minimum of 50 credit hours must be in the specialty area of certification. Self-assessment activities will be designated by each of the specialty certifying boards.

**COMPONENT 3 — COGNITIVE ASSESSMENT**
Requires the provision of one (or more) psychometrically valid and proctored examinations that assess a physician’s specialty medical knowledge, as well as core competencies in the provision of health care.

**COMPONENT 4 — PRACTICE PERFORMANCE ASSESSMENT, AND IMPROVEMENT**
Requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for their medical specialty.

**COMPONENT 5 — CONTINUOUS AOA MEMBERSHIP**
Requires physicians to have continuous membership in the professional osteopathic community through the AOA.
SIGNATURE SERUMS FOR ANY SKIN TYPE

After exfoliation using the DiamondTome™, NewApeel® or NewApeel® Petite System, infuse the skin with one of our four signature serums using the Hydrowand®.

Perfectly formulated and designed for optimum skin penetration, the HydroSerums™ can be an effective way to improve skin imperfections. Choose from Acne, Deep Hydration, Even Tone and Vitamin C. See for yourself the difference in your skin when combining an Altair Microdermabrasion, Hydrowand® Infusion and the New HydroSerums™, a perfect way to end your signature treatment.

EXFOLIATION + INFUSION + SERUMS = HYDROPLUS+

Visit us at www.altairinstruments.com and find out how to get The HydroPlus® Treatment in your salon.
STRAW, STICKS, OR BRICKS?

BY JOHN CARRUTHERS, STAFF WRITER
The business element of running a dermatology practice, whether a solo practice, small partnership, or large multi-office practice, has only increased in importance for dermatologists hoping to thrive despite increased regulatory and economic pressures. Choosing the right management and legal structure for one’s practice can create the foundation for efficiency and success in maintaining profits and achieving ongoing growth.

**PROTECTING VALUE**

The dermatology practice of an individual or group represents a great deal of value and effort on the part of the practice principals. The most immediate benefit of finding the right legal structure, according to Philadelphia health care attorney Bill Kalogredis, JD, is shielding oneself and one’s partners from different forms of liability, whether medically originated or otherwise.

Practice owners have a number of options for legal structures, depending on their location and circumstances. Overall, there are four main distinctions — sole proprietorships, partnerships, limited liability entities, and corporations. Each offers a different level of tax benefit, organization, and liability shielding.
TRADITIONAL PROPRIETORSHIPS
Kalogredis, who advises physicians and practices, said the importance of protecting one's personal assets has taken on increasing prominence over recent years. Sole proprietorships and general partnership agreements are usually not advisable in terms of risk, he said.

Under an unincorporated sole proprietorship, a physician and his or her practice are treated as a single entity on Schedule C of IRS Form 1040. The physician pays debts from his/her own assets, and personal assets can be forfeit in judgments against the practice. It’s generally considered the highest-risk form of practice structure, which is why it’s fallen far out of favor as the medical field has become more sophisticated on matters of business structure and medical liability.

“Long gone are the days when a physician would just be in solo practice and not do some form of incorporated entity,” Kalogredis said. “There are obviously caveats, because different states have different regulations for practice ownership and different names for legal entities, but it all comes down to protecting the individual owners of a practice,” he added. “I would definitely not be unincorporated, and I would not be in the simple partnership arrangement that used to be more common.”

GENERAL AND LIMITED PARTNERSHIPS
In a general or limited partnership, two or more physicians associate to run the practice and share in both the profits and in potential liabilities of the practice, according to Miami board-certified health lawyer and former hospital administrator Sandra Greenblatt, JD, MBA.

In a general partnership, physicians share profit and may share management duties, as well as personal risk for the actions of partner physicians and employees. A malpractice judgment against one’s partner, for instance, can affect one’s personal assets regardless of fault for the triggering action.

In a limited partnership, all but one of the partner physicians are relegated to a non-management role in the practice and therefore are not personally responsible for negligent actions undertaken by partners or employees. Partnership assets, however, are still at risk under liability circumstances.

Earnings from both types of partnerships are taxed through the owners, much like a sole proprietorship, on each owner’s personal income taxes. The partnership entity pays no taxes on earnings.

“In general partnerships, each partner has unlimited liability for the partnership and the right to fully participate,” Greenblatt said. “In a limited partnership, there must be at least one general partner. All other limited partners are mere passive investors but have no liability to the limited partnership beyond their investment.”

Kalogredis advises against use of such partnerships, pointing to the risk involved for partners. “Look at a hypothetical dermatology practice with two or three owners and a couple of employed doctors in a limited partnership agreement,” he said. “They have a partnership agreement and do not have limited liability. If you have one of these entities, owned by doctors A, B, and C, if there’s any kind of a claim vis-a-vis the practice, whether it’s malpractice, a creditor, or even a slip-and-fall, not only would the entity have a risk of responsibility of liability and damages, so would doctors A and B. Their personal assets are at risk because they’re partners with doctor C. A partnership is probably the worst way to go.”

LIMITING LIABILITY
Most physicians, Greenblatt said, take things further when forming their practice structure, due to the benefits of liability protection offered by other practice types, including LLCs, LLPs, and S and C corporations.

“This shields them from third-party liability, other than for their own negligence/wrongdoing, and may have some tax advantages over sole proprietorship. Depending on the law of the state where they are located, solo physicians may also be able to form and work for other business entities that often permit non-physicians to be owners as well as the physicians,” Greenblatt said. “In states which do not prohibit the corporate practice of medicine, physicians may also joint-venture with hospitals and other providers and become employees of hospitals, managed care companies, and so on.” When reviewing these options, she said, it is critical to consult with a qualified health lawyer and accountant.

LLCS AND LLPs
Two of the more common legal entities for practice are a limited liability company (LLC) or a limited liability partnership (LLP), which are alternatives to corporations that protect an owner or owners from personal liability stemming from liability from partner physicians or employees.

In a limited liability partnership (LLP), partner physicians are protected from personal liability due to partner negligence while still allowing for each partner to take an active management role. LLP owners must be physicians in most states.

In a limited liability company (LLC), partners are also protected from liability and taxed like a sole proprietorship. LLCs, however, can have an unlimited number of owners, including non-physicians, another LLC, or a corporation. The distribution of profits can be structured however the partners desire.

LLCs, Kalogredis said, are advisable for the legal protection they offer partners.

“If you’re dealing with a small group, where there are other doctors in the practice, then the limited liability entity would protect the liability of the individual owner of the business as long as they are not the doctor who was involved in the care of the patient in the malpractice claim,” Kalogredis said. “Even as a solo practitioner, you would be personally protected against other liabilities, assuming that any of those creditors did not require the doctor to personally guarantee them. This would be something like a lease. If you sign as an individual, then you’re on the hook for that lease. If you sign as a corporation, or another limited liability type company, then the company is on the hook and the owner physician is not unless they guarantee it or the creditor can show that there’s fraud or misrepresentation.”

In addition, according to dermatologist Lucius Blanchard, MD, medical director of multi-state practice West Dermatology, LLCs can provide a way for larger practices to allow investment from non-physician owners in states that do not allow outside ownership of medical practices.

“One of the advantages of an LLC, as we found out, is that in an LLC, any person can become a stockholder or a member of the LLC. That gave us an overall structure that could be modified or used in different ways,” Dr. Blanchard said. “Our separate management LLC has a contract with the West Medical Corporation. There’s a 30-year management contract where the LLC gets a fee from managing the West Corporation.”

CORPORATE PRACTICE
Practices that have more than one physician are increasingly choosing to incorporate, according to both attorneys. The two main options for setting up a corporate practice each offer larger ownership pools and stratified management structure.
Incorporated practices are, in general, more technically complex arrangements than those listed above. They also provide more benefits for the physicians willing to devote the time and expense to forming them. The biggest benefit is that, other than personal negligence or malpractice judgments, each partner’s financial risk is limited to his or her stake in the practice; homes and other personal property would be unaffected by a corporate calamity unless they had been put up as collateral.

C corporations may issue stock, and must be operated under both a board of directors and corporate officers. Shares in a C corporation may be issued in both voting and non-voting denominations. Profits are taxed both to the corporation and to each individual owner. Profits can be allocated in varying denominations according to practice agreements between owners.

S corporations are limited to 75 stockholders and cannot issue non-voting shares. Profits are distributed according to each owner’s personal investment in the practice. Taxation is done directly to owners, and is not applied to the corporation.

Kalogredis said he recommends corporations for any practice with more than one physician, and that most of his clients choose to incorporate as an S corporation.

“The S corporation does not pay taxes on its income — it’s more of a pass-through type entity. If at the end of the year there’s $100,000 of profit, and there are two owners, they can split the parts of the income differently. But if they’re equal owners, they’d each get $50,000 taxable to them on that profit. The corporation itself doesn’t pay the tax, the owners do, even if they don’t take the money out. In a C corporation the taxes are paid by the corporation,” Kalogredis said. “A lot of our clients choose to go with an S corporation. It’s a way to differentiate between their pay as a practicing clinician and how they take out profit from the business. It’s still very much variable. You have to talk to each individual owner and go through the pros and cons in their state, and see what is recommendable in terms of your goals as a group and as individuals working together.”

In addition to profit and taxation benefits, Greenblatt said, incorporation, whether or the S or C variety, allows for owners to expressly outline the rights, duties, and responsibilities of each shareholder. “If a practice has more than one owner, I strongly recommend having a Shareholders’ Agreement or parallel governing document for other types of entities, including LLCs,” she said. “That sets out the rights and duties of the owners as to each other and to the entity, including governance, buy-outs, disability, retirement, dispute resolution, and so forth. Everyone has a roadmap to follow and this can avoid significant problems down the road.”

One significant difference in the operation of a corporate medical practice, according to Dr. Blanchard, is the designation of physicians as W-2 employees. This, he said, can have an effect on the practice’s benefits structure. “Almost all of our doctors are W-2 employees, though some are still independent contractors. The disadvantage for those doctors [who are W-2 employees] is that they come under the 401(k) plan the corporation has for all of our 400-plus employees. Because the doctors are employees of the corporation, they come under that umbrella,” Dr. Blanchard said. “Some of them would like to go out and set up their individual retirement plans, but as W-2 employees that would be frowned upon by the IRS.”

The disadvantage, in short, is that while owners or physicians might prefer otherwise, the physician employees of the practice get less benefit from retirement plans that are scaled to be competitive for employees at the medical assistant or administrative pay grade than they would under a separate arrangement of their choosing.

In choosing which practice structure to pursue, it’s important to carefully consider and weigh the costs and benefits of each option. “When you’re setting up your practice, the best advice is to consult with a good health care attorney and accountant,” Kalogredis said. “It’s important to know what’s going on with the laws at the time. Things can change quickly, especially at the state level.”

---

**STARK LAW CONSIDERATIONS**

According to Miami attorney and former hospital administrator Sandra Greenblatt, JD, MBA, the Stark Law (and many parallel state self-referral laws) have exceptions that permit solo practitioners and properly formed group practices to provide ancillary or “designated health services” ("DHS") to their patients within the practice that no longer can be done as outside investments by physicians. “If a physician intends to include DHS into his/her practice, compliance with the Stark Law and comparable state laws is a critical element that is best dealt with at the outset,” she said. "While the Stark Law deals only with Medicare patient referrals, many states have enacted similar self-referral laws that extend to all patients, regardless of payer source.

“There are explicit exceptions in the laws and regulations that must be followed precisely: the Stark Law is a strict liability statute with serious penalties. You either qualify for an exception or your DHS referrals will violate the law. There is no grey area and intent is not relevant to the analysis. Providing DHS can be very profitable for physician practices. Proper planning and structuring of practice ownership and physician compensation plans is far less costly in time, money and stress, than dealing with non-compliance at a later date.”

Dermatologists offer advice for educating patients about the full breadth of available treatments.
The demand for anti-aging procedures is burgeoning. For neurotoxins and dermal fillers alone, industry analyst GlobalData projects worldwide sales of $4.7 billion by 2018, of which the U.S. is expected to account for $2 billion. Yet on average, dermatologists spend less than 10 percent of their total patient care time on cosmetic treatment, according to the American Academy of Dermatology Association’s 2009 Dermatology Practice Profile Survey. Although nearly 60 percent of respondents reported performing some cosmetic treatments (mainly neurotoxin injections, collagen/filler injections, chemical peels, and cosmetic laser surgery), 51 percent of those said these treatments account for only 1 to 9 percent of time spent with patients.

Given their seminal role in the development and testing of the most popular cosmetic treatments — and the obvious consumer demand — why don’t dermatologists do more of them? Some may be perfectly content with their practice’s current mix of cosmetic and medically necessary care. But for those hoping to grow the cosmetic component, dermatologists who are successful in both areas say that a good way to start is to have the “cosmetic conversation” with patients who have come to their office for another reason. Understanding how to do that, when to do it, and with whom can help dermatologists strengthen their relationships with patients and avoid coming across as pushy or greedy. >>

BY JAN BOWERS, CONTRIBUTING WRITER
PATIENT EDUCATION

Patients can’t ask for anti-aging treatments if they don’t know their dermatologist provides them. “The worst thing is to find out that someone who’s been your patient for 20 years is going down the street for procedures you do, because they don’t realize you do them,” said Jeffrey S. Dover, MD, associate clinical professor of dermatology at Yale University School of Medicine and director of SkinCare Physicians in Chestnut Hill, Mass. “I've had that happen — every dermatologist has had that happen.” Thus, the first step is “educating patients as to what we do as dermatologists, whether it’s getting rid of brown spots or skin tags, or doing [botulinum toxin] or fillers, or blepharoplasties,” said Mark S. Nestor, MD, PhD, voluntary associate professor of dermatology at the University of Miami Miller School of Medicine and director of the Center for Cosmetic Enhancement in Aventura. “It’s what we’re comfortable in doing, and what we do better than anyone else. Many dermatologists don’t feel comfortable marketing, but they certainly feel comfortable educating their patients about what they do.”

In Dr. Nestor’s practice, the process starts in the waiting room, which is stocked with reading material explaining the cosmetic procedures he performs. In each exam room, a PowerPoint presentation runs continuously, showing before and after photos of patients who have had laser treatments, photorejuvenation, botulinum toxin and filler injections, and other procedures. While patients are waiting, “they’re enthralled to learn about the procedures, and then when I come in they feel comfortable saying ‘oh, I just saw this, can you tell me about it?’” he said. “It’s very, very effective. In fact, what often happens is that a mother will bring in a child for acne treatment and end up having a cosmetic procedure right then and there because she saw it on the screen.” As part of the initial evaluation of each patient, a medical assistant asks the patient if he or she has any cosmetic concerns, “and that often yields a positive response.” If the answer is affirmative, Dr. Nestor follows up in the exam room; if not, he doesn’t initiate a discussion of cosmetic treatment.

Dr. Dover’s practice developed a set of 20 single-sheet brochures and displays them in “custom-built, beautiful cherry racks in every exam room and in the waiting room.” When it’s evident that a patient has been looking at them, he takes the opportunity to ask if the patient has any questions about the procedures, providing the opening for a discussion of cosmetic treatment. Photo albums of patients before and after cosmetic procedures are also on display in the waiting room and in the exam rooms.

Amy J. Derick, MD, instructor of clinical dermatology at Northwestern University’s Feinberg School of Medicine and director of Derick Dermatology in Barrington, Ill., ascertains patients’ interest in cosmetic treatment before their first office visit. A staff member registers patients by phone, “and during that conversation we ask them if they have any cosmetic interests and basically give them options: skin care routine, wrinkle treatments, etc..” Dr. Derick said. If a patient doesn’t indicate interest during the initial phone call, “I never bring it up unless they bring it up. Our focus is truly on medical dermatology, though we also do a lot of cosmetics. You don’t want people to say, ‘I came in for a rash and they wanted to sell me [botulinum toxin].’”

Dr. Derick doesn’t display information about her services in the waiting room but does provide portfolios of before and after photos in the exam rooms, and remarked that the photos often prompt patients to inquire about cosmetic procedures even if they didn’t indicate an interest before. “For me, I don’t want to be seen as a product-pusher. I’m super-busy with my medical practice, and very happy with that. My cosmetic work is a nice addition.”

A full skin exam can provide the opportunity for a discussion of cosmetic treatment that doesn’t feel forced or unnatural, said Tina S. Alster, MD, clinical professor of dermatology at Georgetown University and director of the Washington Institute of Dermatologic Laser Surgery. “I’m a dermatologist first and a cosmetic dermatologist second, so I perform a complete skin exam for every patient the first time they present for treatment,” she said. “I don’t simply point out their cosmetic deficiencies, but as I’m going through their exam, I will mention my findings such as solar lentigos, skin tags, or telangiectasias that can be treated, if desired, but that it’s not a medical necessity to do so.” Dr. Alster further elaborated, “In the course of the skin exam, patients will often point out cosmetic problems that bother them. And, if they don’t, I use that as a sign to back off. If you start cross-selling a lot of procedures or products without patient initiative or enthusiasm, it makes you sound like a used car salesman.” Dr. Alster also routinely outlines a skin care regimen for each patient and sells the products she feels are most cost-effective. Although the products are available online, most patients prefer to purchase them at her office “because it’s easier for them, especially if they don’t think you’re price-gouging or pushing products on them. Selling them isn’t high priority for us, but what is high priority is for patients to understand what the better products are and how to use them.”

We can not only make patients feel better, but also feel better about themselves.
One prominent dermatologist said there’s nothing wrong with suggesting to certain patients that they might benefit from cosmetic treatment, as long as it’s done with tact and sensitivity. “I take care of their medical concerns first, and as we’re walking out I might say, ‘By the way, I notice you have a couple of ‘wisdom’ spots on your hands. If it bothers you, we have ways to treat them,’” said Cherie M. Ditre, MD, associate professor of dermatology at the University of Pennsylvania and director of the Skin Enhancement Center at Penn Medicine Radnor. “I’ve done it a couple of times with patients, and they’ve said, ‘I’m really glad you asked, I feel funny asking you.’” This approach doesn’t suit all dermatologists or all patients, however. “I don’t have a very aggressive personality; I do it in a very motherly, kind way,” Dr. Ditre said. “It’s not what you say, but how you say it. If you do it with concern and dignity, it’s more likely to be well received.”

The patients most receptive to considering anti-aging treatments are likely to be those who “are very well-kept, dressed to the nines, nails done, makeup on perfectly,” Dr. Ditre said. “Although you can’t always make assumptions based on outward appearance — sometimes the down-to-earth, middle-of-the-road people are interested also.” Dr. Dover noted that women “are much more attuned to their appearance, so the pickup is going to much higher with women than men. But there is a whole new group of men who care very much about their appearance, and they’re very interested.” (See “The age of Brotox” in last month’s issue or online at www.aad.org/dermatology-world/monthly-archives/november/the-age-of-brotox.)

Elderly patients may be just as receptive as the young and the middle-aged, Dr. Dover pointed out. “We have a 90-year-old patient who showed up recently without an appointment, and she wants to do everything. She’s come four times in the past month,” he said. Dr. Ditre calls her older patients “my gems” because they have realistic expectations and tend to be very pleased with the results of cosmetic treatments. “I suggest starting with a simple treatment, like a topical,” she said. “They maybe you get a peel or microdermabrasion and see how that goes, then maybe build up to fillers and [botulinum toxin]. It’s less aggressive, and when they see that one thing is working, they’re more apt to have other things done.”

TIMING IS EVERYTHING
Broaching the topic of cosmetic treatments at the wrong time is “a setup for disaster,” Dr. Dover said. “If the patient is in the office for a significant medical problem — for example, they think they have a melanoma, or a family member was diagnosed with melanoma — you just don’t bring it up, period. You wait for the next visit, or you just don’t do it.” Once the medical issue is under control, however, such patients may be very willing candidates for cosmetic treatment, he explained. “They’ve visited with you now a few times. You may have saved their life, if they had melanoma or squamous cell carcinoma. They’re relieved, they’re grateful. Then, if it seems appropriate, you can ask, ‘While you’re here, is there anything else about your skin you’d like to discuss?’ And they might say, ‘What did you have in mind?’ And at that point you say, not ‘You have a lot of wrinkles,’ but ‘We do a lot of other procedures in the practice, including taking care of skin as it ages. It’s something we can discuss next visit, if you wish.’”

Prioritizing the health of patients over their appearance is essential, say the experts, and the priority should be made clear to patients. When a male patient of Dr. Ditre’s came in requesting a neurotoxin, she recalled that she had noticed some precancers on his previous visit three years prior. “I asked, ‘Did you do anything about them?’ He said no,” she said. “Then I did an exam and found a melanoma! I’ve had a number of people come in who just want [botulinum toxin], and there’s a basal cell glaring at me in the glabellar area between their eyes.” On a similar note, Dr. Alster said, “I couldn’t sleep at night if I missed a melanoma on someone’s back because I was focused on the sebaceous hyperplasia on her forehead. That’s not being a good doctor.”

Dr. Dover noted that a Boston-area dermatologist gained notoriety when a newspaper reporter posing as a “mystery shopper” called her office and requested an appointment for evaluation of a possible melanoma. The reporter was told she would have a three-month wait. “She called back 10 minutes later, different voice, and said, ‘I’m considering [botulinum toxin], do you have any availability?’” he related. “They said, ‘How about later today?’ It was a fiasco, but when confronted, the doctor admitted that she prioritizes her cosmetic patients.” Dr. Dover’s practice employs “mystery shoppers” of its own to call the practice and make sure that anyone with a suspicious lesion is seen within 24 hours. “If you take care of new patients this way, you win them over and they become your patient forever,” he said.

Almost any basic dermatology patient can become a cosmetic dermatology patient, Dr. Alster said, “but it does require time. Cosmetic dermatology patients require extensive explanations and hand-holding, even before a procedure is performed, because it’s all new to them. If you can’t provide ample explanation and education, hire someone who can.” Dr. Ditre concurred, adding that some cosmetic patients “just unleash with all their problems, and you feel like you’re doing as much psychotherapy as skin therapy. If you really can’t stand listening to that, don’t do it.” That said, dermatologists who avoid cosmetic procedures are “missing the boat,” Dr. Ditre said. “We can not only make patients feel better, but also feel better about themselves. And that’s why it’s such a blessing to be a dermatologist.”
move toward more integrated care delivery has been on the mind of payers and the government for years. You can see it in the incentives Medicare has offered for adoption of electronic health records. At first all you had to do to earn bonus payments was have a functioning EHR. But new criteria require more data sharing, both between providers and with patients, and the intended path forward is clear: Interoperability between all providers, and seamless sharing of patient information between primary care doctors and specialists. It may take some time, but that’s where things are headed in the long term. Dermatologists who have many years of practice left who have thus far avoided EHR adoption are faced with the question of when, not if, they will go electronic — the incentives are rigged in that direction.

In the immediate future, though, dermatologists are faced with another pressing decision: Should they join an ACO? Accountable care organizations, or ACOs (some pundits think it stands for Amazing Consulting Opportunities as the legal rules are very unclear!), are a new twist on an old idea — make a group of doctors responsible for the overall health of a population of patients and pay them, at least in part, according to the results. ACOs create strong incentives for care coordination on the assumption that such coordination will lower overall system costs.

In August, the Academy’s Board of Directors held an in-depth strategic discussion of ACOs and their impact on dermatology. Were dermatologists already participating? Our most recent survey indicated only 4 percent were. Should more of them be? And what would members who wanted to be part of an ACO need to know, and do, to make that possible?

As a result of that strategic discussion, the Academy developed an online ACO Resource Center. You can visit it at www.aad.org/ACO. From this one page of our website, you can access all of the tools you need to make an informed decision about whether joining an ACO is for you. It includes links to a variety of information about where the idea of ACOs came from, how the Academy has advocated regarding them, and a summary of the rules related to ACOs that have been published by the Centers for Medicare and Medicaid Services. It brings together all of the ACO-related content that Dermatology World has published over the last two years, including advice from the magazine’s legal columnists, in-depth articles unpacking the most important considerations for dermatologists and the best ways to make themselves attractive to ACOs, and descriptions of the ACO experience of members who are already in one. And it includes the nuts-and-bolts information you can use to make your decision — whether you need to know what to do if an ACO approaches you or you’re wondering how to approach an ACO. The resource center can help you determine if you should accept an ACO’s terms. It can also help you make your case if you want to join an ACO, with a series of documents you can use to help demonstrate to your ACO of choice the value that dermatologists can bring.

Of course, dermatology’s participation in ACOs will evolve over time, and so will the Academy’s resources. Next month’s issue of Dermatology World, for instance, will include articles about legal considerations related to joining an ACO and negotiating with an ACO. These will be added to the resource center as soon as they are published. We’ll also add testimonials from dermatologists who are successfully participating in ACOs — if you’d like to offer yours, or have questions about ACOs, please contact ACO@aad.org.

The advent of ACOs may represent a turning point for health care, or it may be, like capitation and HMOs and so many other models, another stop on a long and winding road. Either way, your Academy is committed to making sure you have the information you need to make the right ACO decision for yourself and your practice.
The System for Digital Dermoscopy and Total Body Photography.

Call 888-501-0805
or visit www.fotofinder-systems.com

Check out our mobile solution handyscope.

The better choice in medical imaging.
Identification of critical priorities charts path forward for Academy

BY EILEEN MURRAY, MM, CFRE, CAE

As the Academy closes another successful year, it’s tempting for me to simply recap all of our achievements. There is great value in celebrating success. But a forward-looking organization is the only kind that can survive and thrive in today’s economic and regulatory environment. Fortunately for dermatologists, your physician leaders have their eyes on the horizon, scanning it for opportunities and threats and preparing accordingly.

A good example of this is the strategic retreat led by President-elect Dirk M. Elston, MD, earlier this year. At the retreat, a diverse group of dermatologists, including the Academy’s leadership and Board of Directors, the chairs of the councils and key committees, leaders of state and subspecialty societies, and past leaders, gathered to review the Academy’s strategic framework. Bringing all of these people together helped to ensure that the outcomes of the retreat reflected the broad concerns of dermatology.

They considered two things. First, how could the document be tightened and focused to make it a more meaningful guide to the work being done by the Academy? And, second, which priority issues on the horizon should be identified as critical to the future of the organization and the specialty?

With regard to the first question, the group looked at ways to reduce redundancy in the framework and make it more useful for focusing the Academy’s efforts. We are a large organization with extensive resources, including members, staff, and capital. But we cannot do everything that might be desirable in a world without the constraints of time and money. The updated framework lays out clear areas of focus while confirming that the key priorities we identified when we first drafted it remain the same. You can see the results at www.aad.org/about-aad/vision-mission-and-values/strategic-framework.

With regard to the second question, the group identified four critical priorities for development in the coming year. They include:

- **Health system reform.** How will various possible outcomes, from the best case to the worst, affect the way dermatologists see patients and run their practices, and what must the Academy do to support members under these scenarios?
- **The perception of the specialty.** How should dermatology operate most effectively within the broader house of medicine? How are dermatologists viewed and what actions can the Academy and members take to position the specialty most strongly?
- **Data that demonstrates the worth of dermatologists.** What data exists, and what needs to be gathered, to help show the value created by the effective and efficient care provided by dermatologists?
- **Innovation in the delivery of care in the future.** How will dermatologists participate in new delivery systems? How will new payment models affect access to dermatologic care? What can we do to influence these models as they develop? These four issues are interrelated and, together, how we address them will play a big role in the Academy’s, and our members’, success in both the near term and the long run. Your physician leaders, along with staff, are developing the strategies and tactics that will ensure that we address each one appropriately. You can be confident that there will be much success to report, both in 2013 and long afterward. dw
2013 Annual Meeting registration and housing available online

Meeting includes celebration of AAD’s 75th anniversary

REGISTER TO ATTEND THE ACADEMY’S 71ST ANNUAL MEETING in Miami Beach, Fla., being held March 1-5, 2013, and ensure you can attend the sessions you want by registering online at www.aad.org/meetings-and-events/2013-annual-meeting. Attendees will also be part of the celebration of the 75th anniversary of the American Academy of Dermatology, which was founded in 1938. A timeline in lobbies C and D of the convention center will give attendees a sense of the changes that have taken place over 75 years, with more information available online at www.aad.org.

Online registration and housing is now open. Early registration continues until 12 p.m. CT on Jan. 30, 2013, after which late registration fees will apply.

Guest rooms are being held at several major hotels in Miami Beach and Miami at AAD discounted meeting rates available only to those who book through the AAD. For a current listing of official AAD hotels, visit www.aad.org/meetings-and-events/2013-annual-meeting. Hotel reservations must be made online in conjunction with registration for the meeting. More information is available in the 2013 Annual Meeting Advance Program Book, which was mailed to all members in November and is also available online.

Consider adding a donation as you register for the Annual Meeting in celebration of the 75th anniversary. You can be a part of the Academy’s efforts to create a world without skin cancer by contributing to SPOT Skin Cancer®. You can also help support a unique summer camp opportunity for young patients by giving to the AAD Camp Discovery Endowment. - SUSAN TREECE

Grants for residency electives available

THE ACADEMY SEeks APPLICATIONS FOR GRANTS that give dermatology residents the opportunity to complete electives in Botswana and with the Indian Health Service in Chinle, Ariz.

RESIDENT INTERNATIONAL GRANT

The Education and Volunteers Abroad Committee will provide funding for U.S. or Canadian senior dermatology residents to participate in a four- to six-week elective in 2014 in Gaborone, Botswana. Participants will rotate between the Princess Marina Hospital and the Baylor International Pediatric AIDS Initiative. The grant allows dermatology residents an opportunity to learn about the care of tropical and HIV-related dermatologic conditions, as well as how to practice routine dermatology with finite resources. Residents are expected to prepare lectures and presentations, develop a database of photos, submit teledermatology consults, and present a report of activities to the Academy and their home programs. Rotations will take place in 2014.

NATIVE AMERICAN HEALTH SERVICE RESIDENT ROTATION

Funding is also available for four U.S. dermatology residents currently in their second or third year of residency to participate in a one- to two-week rural health elective in Chinle, Ariz. at the Indian Health Service. Residents will have an opportunity to provide dermatologic care to the Navajo Nation population. Rotations will take place in March, May, August, and November 2014. Applications are due April 30, 2012.

Previous scholarship recipients are not eligible for either elective. Visit www.aad.org/education-and-quality-care/awards-grants-and-scholarships for more details or to apply. - COURIA BADIANE
Include Dermatology in Action in your Annual Meeting schedule

HELP MAKE A DIFFERENCE in the Miami community by volunteering your time to participate in the American Academy of Dermatology’s hands-on volunteer project at the 71st Annual Meeting in Miami Beach, Fla.

This rewarding effort will take place on Thursday, Feb. 28, 2013 from 12 to 5 p.m. (time includes transportation to and from event). Volunteers will help with a project to improve and enhance the city of Miami. Projects may include:

- Volunteering at an area hospital.
- Planting flowers, gardening, or beautifying area parks.
- Painting, building, or cleaning community areas in need.
- Packing or serving food.

For more information, visit www.aad.org/dermatologyinaction.

– MARLENE BANIKE

Grants available for residents, fellows, junior faculty to attend 2013 IID meeting

GRANTS ARE AVAILABLE FOR U.S. AND CANADIAN DERMATOLOGY RESIDENTS, post-doctoral fellows, and junior faculty within two years of appointment to attend the 2013 International Investigative Dermatology (IID) meeting, being held May 8-11, 2013, in Edinburgh, Scotland. An applicant must be the presenting author on an abstract submitted to the IID meeting. Up to 20 awards will be made in 2013, each for up to $1,500.

The grants are supported by the World Congress Fund, which was established in 1992 to support travel to international clinical and scientific meetings. The fund is overseen by the American Academy of Dermatology’s World Congress Fund Review Task Force.


– COURA BADIANE

Academy Board revises divestment requirements for officers

AT ITS NOV. 3 MEETING, the AAD’s Board of Directors revised the requirements for officers to divest themselves of financial conflicts. Under the revised policy, “exception may be made in certain circumstances for provision of consultant or investigator expertise related to protocol development and/or safety monitoring as long as the activities are not related to marketing or promotional efforts. In this event, the Secretary-Treasurer must be provided with background information and approval must be provided in advance for an exception to the policy. In these circumstances, compensation to the individual must be less than $10,000/company/year. Verifying 1099 forms must be submitted to the Secretary-Treasurer when received.”

The new policy notes that the “exception may not be applied to the President, who shall remain free from any and all direct financial relationships during their term of office.” The complete Code for Interactions with Companies is available online at www.aad.org/Forms/Policies/ar.aspx.

– RICHARD NELSON

AADA Board approves position statements on therapeutic substitution, medication cost

THE BOARD OF DIRECTORS of the American Academy of Dermatology Association approved changes to the organization’s position statements on therapeutic substitution and controlling the cost of medications at its Nov. 3 meeting.

The updates to the therapeutic substitution statement address issues with biologic treatment substitution. The statement sets out key criteria a substitute biologic should meet before it can be allowed, including that “the prescribing physician provides explicit permission to the pharmacist that a generic therapeutic or biosimilar may be used as a substitute to the original therapeutic or biologic medication.”

The updates to the medication cost statement address concerns related to exclusivity contracts, step therapy requirements, and drug tiering. The statement notes that “it is the responsibility of every physician to be aware of the relative cost of prescriptions and/or over-the-counter products that are recommended to our patients,” but goes on to note that while “the AADA believes this awareness should help guide the treatment decision-making process,” it “should never limit options in such a way that patient outcomes could be negatively impacted.”

The full text of both position statements is available at www.aad.org/Forms/Policies/ps.aspx.

– RICHARD NELSON
Funding available for international volunteer and humanitarian projects
THE SKIN CARE FOR DEVELOPING COUNTRIES GRANTS provide funding for international volunteer and humanitarian projects. Requests for funding must demonstrate how the project/activity will support the Academy’s strategy for international leadership, which involves increasing knowledge generation and sharing throughout the world, improving patient care globally through volunteerism and humanitarian efforts focused on capacity building, and improving access to dermatologic care in underserved areas. Recipients must also show how their project will benefit recipients/beneficiaries and include detailed monitoring and evaluation plans. Requests will be reviewed by the Education and Volunteers Abroad Committee. Requests for 2013 are due Jan. 31, 2013 at www.aad.org/education-and-quality-care/awards-grants-and-scholarships/skincare-for-developing-countries. Only requests submitted online will be considered.

For more information, contact Coura Badiane at cbadiane@aad.org. – COURA BADIANE

Academy Board approves SPOT partnership policy
THE AAD BOARD OF DIRECTORS approved partnership guidelines at its Nov. 3 meeting that will be used as the organization seeks sponsors, strategic partners, and supporters for the SPOT Skin Cancer® initiative. The new guidelines are based on the “AAD Principles of Corporate Relations” policy and fully delineate the partnership relationship between prospective partners and the Academy, ensuring that no endorsement of the partnering company or product is conveyed. Partners will be limited to using the SPOT logo with the words “Proud Sponsor” or “Proud Supporter” to show their support for SPOT Skin Cancer.

Such partnerships are viewed as potential mechanisms for increasing the visibility of the SPOT initiative and creating funding support for its public education and service programs. They will also help the Academy to leverage SPOT to position dermatologists to the public and policymakers as the experts in skin cancer prevention, detection, and care. – RICHARD NELSON

Financial assistance available for members affected by Superstorm Sandy
THE AMERICAN ACADEMY OF DERMATOLOGY will provide financial assistance to dermatologists and dermatology residents who sustained physical damage to their property from Superstorm Sandy. Low-interest loans are available through a special fund established by the Academy for damage that is not covered by insurance, other forms of financial assistance, or other financial resources available to the dermatologist or resident.

The loans will be for a maximum of $25,000 for dermatologists and $5,000 for dermatology residents.

Affected dermatologists and dermatology residents who are members in good standing may apply for a loan by visiting www.aad.org/sandy.

Obituaries
The Academy recently learned with sorrow of the passing of the following members of the dermatologic community.


George Huntley Cameron, MD, 84, Ann Arbor, Mich. Completed dermatology residency training at University of Michigan. Died June 29.


Ruth Zuckerman, MD, 97, Teaneck, N.J. Completed dermatology residency training at New York University Medical Center. Died Aug. 3.

Obituaries are published in Dermatology World after information is submitted to the AAD. Information on member obituaries should be submitted in writing to Member Resource Center, AAD Member Services Dept., P.O. Box 4014, Schaumburg, IL, 60168-4014, via fax at (847) 338-1090, or via email at mrc@aad.org. dw
Dermatologist raises funds for shade structures

On Saturday, Aug. 18, during Summer Academy Meeting 2012, Suzanne Olbricht, MD, the AAD’s secretary-treasurer, chose to use her birthday to help raise funds for the Academy’s Shade Structure Program.

Dr. Olbricht, who has long been a proponent of shade structures as an effective form of sun protection, decided to throw a Mardi Gras-themed party and ask that attendees make a donation to the Shade Structure Program in lieu of bringing a gift.

“I knew I’d have friends coming in to Boston during my birthday, and I couldn’t imagine a better present than having a shade structure funded,” she said. “Not only does it protect our children, but it educates families to seek the shade and avoid standing out in the sun.”

In the end, Dr. Olbricht was able to raise more than $9,000, enough to fully fund a new shade structure. While the location of the structure isn’t finalized, she’s currently working with Washington, D.C.’s National Zoological Park to find a place for the structure. The zoo, she said, has proven a forward-thinking institution in terms of sun protection.

“We’re under discussion with the National Zoo, and that would be my first choice,” Dr. Olbricht said. “They’ve started a sun awareness program and they’ve put some sun protection information on their website. Programs like this encourage people to be positive about their own skin health.”

Applications for Shade Structure Program grants for 2013 are due Feb. 1; to learn more, visit www.aad.org/ssp. To make a contribution to support the program, visit www.aaddevelopment.org/SustainingFund.html. - JOHN CARRUTHERS

Members Making A Difference:

Dore Gilbert, MD

DERMATOLOGIST LEAVES PRACTICE TO SERVE COUNTRY

IN EARLY 2009, NEWPORT BEACH, CALIF., dermatologist Dore Gilbert, MD, began to take steps toward fulfilling something in his life that he felt he’d left undone. In his earlier days, Dr. Gilbert had very nearly joined the Army reserves, but found himself unable to make the time commitment with his career at its formative stage. But with his children raised and practice secure, Dr. Gilbert set his sights toward becoming a soldier at age 59.

“These people sacrifice so much on our behalf. It’s hard to fully appreciate just what they do.”

- As a physician, Dr. Gilbert was qualified to join the armed forces until age 60. He was inspired in part by his son, a member of the Marines.

- “Once I took my oath as an officer in the Army Reserve, the reality of basic training set in,” Dr. Gilbert said. “I had to make sure that I wasn’t going to wash out because of physical inability.”

- Dr. Gilbert’s physical training in preparation for basic training included daily sessions at the gym, timed runs, and 100 push-ups and sit-ups each morning. Though he was not required to pass the Army physical fitness test, he wanted to make sure he was as qualified as his younger colleagues.

- During basic training, Dr. Gilbert recounted, he had to deal with scorpions, narrow cots, and a lack of showers in addition to separation from his family and community. Yet at the end, he said, he recognized basic training as one of the best experiences of his life.

- “The fact that I was able to serve with such dedicated men and women was the highlight of my deployment,” Dr. Gilbert said.

To nominate a physician, visit www.aad.org/membersmakingadifference. - JOHN CARRUTHERS
Four Great Reasons to Read Dermatology World Online

1. **Easily Searchable**
   Improved search capability helps you find articles you remember seeing months ago and want to reference again or research topics of interest to you.

2. **Online-only Bonus Content**
   Audio, image slideshows, and more in-depth coverage of practical topics related to articles from the print edition provide a broader view of the issues.

3. **Catch Up on Areas of Interest**
   Every edition of Cracking the Code, Legally Speaking, and Management in Practice — just a click away.

4. **Versatile Viewing Options**
   View the flipbook edition on your tablet or laptop or download a PDF for future reference or printing.

PROFESSIONAL OPPORTUNITIES

ARIZONA OPPORTUNITY!

Associated Dermatologists, PC in Tuscon is seeking a board certified/eligible dermatologist to join our busy, well established practice. We offer:

- High patient volume
- Partnership opportunity
- Competitive salary and benefits

Email CV (please indicate availability) to Michele Snapp, Administrator mcsnapp@comcast.net www.assocdermpc.com
Phone: (520) 290-8555 • Fax (520) 290-6470

NORTHERN CALIFORNIA
Located midway b/w San Francisco, Napa, & Tahoe, we are seeking a BC/BE Dermatologist 3-5 days per week to join well established General & Cosmetic Derm practice. Outstanding staff, warm office environment, suburban setting, state-of-the-art surgery, laser & computer equipment. Partnership opportunity. Mentorship in advanced cosmetic & reconstructive procedures if desired. Productivity, hours, vacations all flexible based on your goals. Excellent opportunity for income and Family/Life Balance. To apply, please send CV, and short Bio with your goals to: NorCalDerm@gmail.com.

Boca Raton & Boynton Beach, FL
We are seeking a caring and motivated board certified dermatologist. We offer not only excellent compensation and benefits, but also an outstanding working and living environment on the southeast coast of Florida. Please contact Mary at macshane11@gmail.com or fax resume to 888-650-7801.

Rural Colorado
Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

We Buy Practices

FOR MORE INFORMATION:
Contact: Carrie Parratt
Phone: (847) 240-1770
Email: cparratt@aad.org
Web: www.aad.org

SALES INFORMATION

UPCOMING DEADLINES FOR FUTURE ISSUES:
February ............... December 21
March ...................... January 25
April ........................ February 22
May .......................... March 29
June .......................... April 26

Bonus Distribution Issues
February: AAD Annual Meeting
Carolina HealthCare System (CHS) is actively seeking BC/BE Dermatologists to join two thriving internal medicine multi-specialty practices in the Charlotte Metro area. Candidates should have experience in general dermatology, cosmetic dermatology, and lasers. CHS has been committed to providing excellent and innovative patient care. Competitive compensation, Signing bonus, One year salary guarantee, Outpatient surgery, High quality physician peers, Well managed and well established practices, Established supportive environment to guide physicians through healthcare reform EHR, Full time and part-time opportunities, Moving allowance and salary advance, Comprehensive benefit packages including health/dental plans, 401k matched savings and defined pension plan, disability/life insurance, malpractice insurance, attractive paid time off and a CME allowance. For more information or to submit a CV, please contact: Tracey Black, CHS Physician Recruiter, tracey.black@carolinashealthcare.org, 704-355-0159 Office / 800-847-5084 Toll Free / 704-355-5033 Fax.

MILLBURN, NEW JERSEY
Dermatologist needed to join busy practice. Beautiful state-of-the-art facility, EMR, lasers, great work environment. Medical, surgical and cosmetic derm. Competitive compensation. Send CV to me@somalaser.com.

NORTHERN NEW JERSEY
Well established thriving dermatology practice in Parsippany, NJ seeking BC/BE dermatologist interested in providing medical and surgical care to a diverse patient population. Full-time position. Partnership opportunity. For more information contact Dr. Laila Almeida at (973) 335-2560 or laalmeida1@optonline.net. www.dermatologyassociatesofmorris.com.

SOUTHERN NEW JERSEY
Great opportunity for BC/BE dermatologist in Medford, NJ. Beautiful community near Philadelphia, PA and Cherry Hill, NJ. Well-established busy dermatology practice in a brand new facility, with associated medical spa. Opportunity for competitive salary, benefits, and practice ownership. FT/PT position available. Email inquiry or CV to suzanne@accentderma.com.

WASHINGTON, DC
Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

We gratefully acknowledge the following advertisers in this issue:

Company
---
Advanced Skin and Hair................................................................. Clearogen........................................ 09
Altair Instruments................................................................. HydroPlus+........................................ 21
Care Credit........................................................................ Credit Services........................................ IBC
FotoFinder........................................................................ DermoScope STUDIO........................... 31
Galderma Laboratories........................................................... Clobex................................................ IFC-1
NexTech................................................................. EHR Software........................................ BC
Quantum Medical Billing, Inc............................................... Corporate.............................................. 15

Recruitment Advertising
---
Adult & Pediatric Dermatology, pc................................................. 38
Associated Dermatologists PC.................................................. 38
Carolinas HealthCare System.................................................. 39
CoxHealth................................................................. Hospital................................................. 38

Classified ads are welcomed from dermatologist members of the American Academy of Dermatology, from dermatology residents of approved training programs and institutions with which they are affiliated, as well as from recruitment agencies or organizations that acquire and sell dermatology practices and equipment. Although the AAD assumes the statements being made in classified advertisements are accurate, the Academy does not investigate the statements and assumes no liability concerning them. Acceptance of classified advertising is restricted to professional opportunities available, professional opportunities wanted, practices for sale, office space available, and equipment available. The Academy reserves the right to decline, withdraw, or edit advertisements at its discretion. The publisher is not liable for omissions, spelling, clerical or printer’s errors. For more information about classified advertising, visit www.aad.org/recruitment-opportunities, email cparratt@aad.org, phone 847-240-1770, or fax 847-240-8618.
PAS/NPS LIKELY TO BE EMPLOYED BY HALF OF ALL DERMATOLOGISTS BY 2015

Since the Academy began tracking the employment of physician assistants (PAs) and nurse practitioners (NPs) in dermatology, the specialty has seen steady growth in the number of dermatologists who employ such extenders. Indeed, as shown on the chart below, projections based on the Academy’s 2012 Dermatology Practice Profile Survey indicate that more than half of dermatologists will employ at least one extender by 2015.

Academy President Daniel M. Siegel, MD, noted in his July From the President column that the trend toward more dermatologists employing extenders, along with the growing U.S. population, means that “PAs and NPs will of necessity play an important role in the care of dermatologic patients going forward” and discussed the questions this raises about the role the Academy should play in the education of PAs and NPs within dermatology. In every survey where questions about extender education have been asked, dermatologists who employ PAs or NPs have been more likely to support the Academy offering educational sessions specifically designed for extenders.

The Academy has developed a position statement on the appropriate supervision of extenders. To review the position statement on The Practice of Dermatology: Protecting and Preserving Patient Safety and Quality Care, visit www.aad.org/Forms/Policies/ps.aspx. To read Dr. Siegel’s column, visit www.aad.org/dermatology-world/from-the-president/2012/july. To read more about the educational options available for PAs and NPs in dermatology, visit www.aad.org/dermatology-world/monthly-archives/2011/november/learning-to-teach.

– RICHARD NELSON  

= projections based on 2012 survey responses.
She only completed 40% of your treatment plan.

Wouldn’t you rather she complete 100% now?

86% of Dermatologists reported that every month they have patients modify their treatment plans due to cost.† You can avoid this by offering the CareCredit® card to every patient, along with other payment options, during your fee discussions.

CareCredit builds the cost of your care into the patient’s monthly budget, and is ideal for those getting cosmetic procedures or dermatologic procedures with high deductibles. Think of it as your patient’s beauty card they can use to pay every time they visit your practice.*

Plus, it’s great for your practice because you can avoid the hassles and stress of billing and collections. You get paid within 2 business days, regardless whether the patient delays or fails to pay.†

To enroll at no cost today call 866-247-3049 ext. 2

* Subject to credit approval
† Subject to Representations and Warranties in the CareCredit Acceptance Agreement for Participating Professionals.
©2012 CareCredit
Introducing Our Highly Anticipated Native iPad® EMR Application

Our new EMR iPad® app allows you to document the way you normally would with a paper chart while leveraging the power of one of the most widely used specialty specific EMR's in the dermatology industry. At a glance, you can quickly view your scheduled patients, labs, and charts that need attention. In addition, in one application you can capture patient photos, annotate notes quickly, and obtain Meaningful Use.

The release of NexTech’s EMR iPad app marks a milestone in our 15 year history of designing strong, well thought out, and innovative software for the medical field. Our 7,000 providers and future customers will see that our ground breaking technology is unlike any other EMR application, and is truly the closest thing to a paper chart.