UNLOCKING THE MYSTERIES OF ROSACEA

08.2013

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DEAR READERS,

Efficiency in practice...

Seems to me that this is the signature of the decade, with each of us struggling to continue to do what we do well, but in a more streamlined way. So I loved Gilly Munavalli’s piece this month about handling pathologic and laboratory results in his EHR. I have implemented a similar process of scanning and communicating with the staff. At first the staff balked at the notion of scanning results into our EHR the same day that they are received. And physicians worried about the loss of security that would accompany a lack of paper. Understanding the importance of the flow of the notes once these results were reviewed also was baffling. But once the process was implemented, everyone found that it made the work of following up on lab results easier and safer. It is just a new and more efficient way to function in the 21st century. How nice to know the inflammatory papules, but in the dark about the most effective way to address the erythema.

Our clinical feature this month is on rosacea. For so long we’ve been fairly good at controlling the inflammatory papules, but in the dark about the most effective way to address the erythema. For patients, our clinical limitations in this arena have been frustrating. Our piece on rosacea is one that you won’t want to miss. We want to be sure that you are up to date on some of the latest treatments. Our article shines light onto these new findings.

High deductible health plans have come of age. While they’ve been around for a while it is only in the past year or so that they have become commonplace. I think that we all know the problem with them — people enjoy their lower premiums, but “forget” that they will be responsible for those first costs of health care. We’ve started to see these plans create new paradigms of health care spending as people feel the pain of the expenses of their visits, tests, and medications more personally. This is not a trend that is soon going to disappear, so we wrote one of our features this month on this topic. We will all need to think about how to adjust and accommodate this new-ish insurance reality.

Who amongst us has plans to take the summer off? Well, must reading for you (as well as the rest of us who wish we were taking the summer off) is this month’s coding column on billing for a covering physician. Understanding this technical aspect is critical to the success of vacation plans. When that long vacation finally beckons, remember that you can search this piece online at the DW website, www.aad.org/dw. Time for R and R is important for keeping us sane. Read the article and maybe start some planning.

Enjoy your reading!

ABBY S. VAN VOORHEES, MD, PHYSICIAN EDITOR
“Research conducted in the past few years is honing in on dysfunction of the innate immune system as an underlying factor in rosacea, and also examining the role of inflammation and neuroimmune communication.”

**COVER STORY**

**UNLOCKING THE MYSTERIES OF ROSACEA**

Molecular studies highlight possible pathways in pathophysiology

*BY JAN BOWERS*

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**HIGHER CO-PAYS, HIGHER STAKES**

As managed care moves to higher deductibles and co-pays, practices seek new ways to collect from patients

*BY JOHN CARRUTHERS*

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**ROUTINE MAINTENANCE**

Some dermatologists finding new MOC journey more helpful in practice

*BY RUTH CAROL*
Tenets for locums

Alexander Miller, MD, addresses important coding and documentation questions each month in Cracking the Code. Dr. Miller, who is in private practice in Yorba Linda, Calif., represents the American Academy of Dermatology on the AMA-CPT® Advisory Committee.

Finally, after several years in private practice, you courageously decide to reward yourself for your hard work and distance yourself from your office for a three-week vacation. As such a prolonged absence would also separate your patients from your practice for an equal amount of time, you decide to hire an independent dermatologist to attend to your patients in your absence. Now what? Does the substitute physician just have to show up and all is well, or are there statutory requirements that have to be met?

Medicare recognizes two types of substitute physician arrangements under which billing for services delivered in your office may be executed under your name and NPI. The first is locum tenens and the second is a reciprocal billing arrangement. Both are subject to very similar requirements, as listed below.

### LOCUM TENENS
- The regular treating and billing physician is absent from his/her office or medical group.
- A patient is treated in the regular physician’s office by a substitute physician.
- The locum tenens physician is an independent contractor, and not an employee.
- The locum tenens physician has no practice of his/her own.
- The locum tenens physician is paid for services on a per diem basis or similar arrangement.

### RECIPROCAL BILLING ARRANGEMENT
- The absent physician has an arrangement with another physician to replace him/her on an occasional basis.
- The substitute has his/her own practice.
- The reciprocal billing arrangement may be made with more than one physician.

### LOCUM TENENS AND RECIPROCAL BILLING REQUIREMENTS
- Your office or group bills for substitute services under your name and NPI along with a modifier to be entered in item 24d of the CMS-1500 claim form:
  - Q6 modifier for a locum tenens physician.
  - Q5 modifier for a reciprocal billing physician.
- You keep a readily accessible record of each service done and billed during your absence along with the substitute physician’s NPI.
- Your substitute must be a physician to qualify for locum tenens or reciprocal billing (not a physician assistant or nurse practitioner).
- If billing Medicare, the substitute physician must have a Medicare Provider Number (enrolled in Medicare as a provider).
- The substitute physician provides services for a continuous period of no more than 60 days.
- After 60 continuous days of providing covered services the substitute physician must start billing under his/her own name and NPI, rather than the absentee physician’s.
- The 60-continuous-day period starts with the first day that a substitute physician bills for services, and not from the first day that a physician is absent from his/her office.
- If a physician is called to active duty in the Armed Forces, then the 60-day limit does not apply.
- Once the absent physician returns and begins billing for services, any subsequent absence requiring a substitute will trigger a new maximum 60-day period.

Detailed Medicare regulations concerning substitute physicians may be found in the IOM Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 30.2.1 and 30.2.11, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf.

Note that private insurers may not necessarily follow Medicare guidelines. It is prudent to know the private insurers’ substitute physician billing requirements prior to submitting bills.

Ordinarily, your malpractice insurance will cover the substitute physician in your absence. Coverage may be automatic, requiring no prior notification of your insurer, or your insurer may require that you contact it in advance of your absence in order to credential a locum tenens physician prior to approving insurance. Clearly, it is imperative that you discover your insurer’s locum tenens requirements prior to your absence. Your insurer’s website is likely to provide information on locum tenens.
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coding tips

coverage and/or list a contact telephone number for information.

Example 1: Prior to your absence you excised an atypical nevus from a patient’s back. Five days later, once you are gone, the patient returns to your office concerned about redness and puffiness along the excision line. Your substitute physician examines the operative site, determines that there is a minor reaction to suture traction, and reassures the patient, giving additional care instructions. Your office bills a 99212 E/M code for the visit.

Answer: Incorrect. Although a physician different from you evaluated the patient, that physician was your substitute in your office. Your office may not bill for a separate charge, since you, the patient’s regular physician, were paid under a global surgical package rule, whereby there is a 10-day postoperative period during which services related to the surgery are included in the procedure valuation and are not separately payable. If the patient had gone to another, unrelated office for an evaluation then those services would have been payable, as they would have been provided by a non-locum tenens physician, and the billing would not have been done under your name and NPI identifier.

Example 2: You are called to active duty in the Armed Forces and are absent from your office for 92 continuous days. As you are serving your country, your office may continue billing for a locum tenens physician under your name and NPI during the last 32 days of your absence.

Answer: Correct. Public Law 110-54 created an exception to the 60-day limit for physicians called to active duty in the Armed Forces. Your office may continue billing under your name and NPI for the duration of your continuous absence.

Example 3: You have added a recent graduate from dermatology residency to your practice. While the new dermatologist’s Medicare enrollment is being processed you want to be paid for his/her services. So, you bill Medicare for the new physician’s services under your identifier as a locum tenens, with the Q6 modifier.

Answer: Incorrect. Locum tenens specifies a temporary replacement by an outside physician. In this case the new physician is neither a replacement nor an outside physician. It is inappropriate to bill for the new physician’s services under the locum tenens provision. dw
Dermatologist serves as Acting Surgeon General

Rear Admiral Boris D. Lushniak, MD, MPH, a dermatologist who has served as Deputy Surgeon General since November 2010, began serving as Acting Surgeon General when Regina Benjamin, MD, stepped down from her role in July. Dr. Lushniak, whose career has included roles with the Centers for Disease Control and Prevention, the Food and Drug Administration, and the U.S. Public Health Service, completed his dermatology residency at the University of Cincinnati in 1993 and then established an occupational skin disease program at the CDC’s National Institute for Occupational Safety and Health in the same city. He is an adjunct professor of dermatology at the Uniformed Service University of the Health Sciences. – RICHARD NELSON

AMA supports students’ right to sunscreen

At its June 15-19 meeting in Chicago, the AMA House of Delegates adopted several new positions of interest to dermatologists. Two resolutions related to skin cancer prevention and detection were actively supported by the Dermatology Section Council, which includes delegates from the American Academy of Dermatology Association and several other dermatologic societies along with dermatologists who represent their states or branches of the military. The first, which attracted widespread media attention, saw the AMA support the exemption of sunscreen from bans in schools on the possession of over-the-counter medications. If schools follow suit, students would be able to bring and apply sunscreen at school without restriction or a doctor’s note. The second resolution supports the education of hairdressers and barbers in skin self-examination and early referral to qualified health professionals.

The House of Delegates also voted on broad health policy issues, including a resolution that the AMA will work with the Centers for Medicare and Medicaid Services and private payers to ensure that quality measures used to determine payment will be limited to those under direct physician control and will only include subjective criteria, such as patient satisfaction surveys, as adjunctive rather than determinative. Other resolutions supported the right of physicians to determine their practice and payment models and refined the AMA’s position on the Affordable Care Act, noting its support for private contracting and the repeal and replacement of the sustainable growth rate (SGR) formula and its opposition to the Independent Payment Advisory Board (IPAB).

– RICHARD NELSON

Medicare announces proposed fee schedule rule for 2014

The Centers for Medicare and Medicaid Services released the proposed 2014 Medicare fee schedule rule online on July 8. Assuming Congress passes a fix to avert a 24 percent Sustainable Growth Rate cut, CMS estimates that dermatology will see a 2 percent drop in payments; results for individuals will vary. More information is available at www.aad.org/2014-fee-schedule.

The rule lists codes identified by Medicare contractor medical directors as potentially misvalued, including 17311 and 17313, the codes for the first stage of Mohs surgery on the head and neck and on the trunk and extremities. CMS noted that it believes “they may be overvalued.” In addition, the rule proposes to tie reimbursement for pathology in physician offices to the hospital outpatient prospective payment system’s rates, which could significantly reduce payment for the technical component of pathology services. CMS also proposes a method for determining if the Clinical Laboratory Fee Schedule should be adjusted to account for efficiencies gained through technological advances.

The rule also included proposed updates to the Physician Quality Reporting System, raising the number of measures that providers must report to earn a 2014 incentive from three to nine. CMS also proposed the addition of two dermatology-related measures, including one for atopic dermatitis and another for psoriasis. The atopic dermatitis measure, “Atopic Dermatitis: Overuse: Role of Antihistamine,” would gather data on the “percentage of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis, who did not have a diagnosis of allergic rhinitis or urticaria, who were prescribed oral non-sedating antihistamines.” The psoriasis measure, “Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier,” would evaluate “whether providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient’s history to determine if they have had appropriate management for a recent or prior positive test.”

The AADA will send an official comment letter to CMS before the Sept. 6 deadline. Visit www.aad.org/2014-fee-schedule and look for Member to Member and Dermatology Advocate in your inbox for more information about the AADA’s response to the proposed rule. – RICHARD NELSON
Compounding pharmacies a growing issue nationwide

STATE NEWS ROUNDUP

FOLLOWING THE HEADLINE-GRABBING OUTBREAK of fungal meningitis in 23 states stemming from unsanitary steroid injections from a compounding pharmacy in summer 2012, legislators, physicians, and patient advocates have opened the gates to a flurry of activity regarding the regulation of compounding pharmacies.

Legislators in Utah and Virginia have already passed bills that define the parameters of compounding pharmacies and update the frequency and standards of inspections. Bills have also been sent to governors in Georgia, Maryland, and Tennessee following successful passage in their state’s legislatures. The bill in Georgia provides for nonresident pharmacy permits. Maryland’s bill, on the other hand, requires a sterile compounding facility to hold a sterile compounding license issued by the state’s Board of Pharmacy. Tennessee’s bill requires an out-of-state pharmacy delivering drugs to the state to employ a pharmacist licensed by the state’s board.

Ten additional states have considered bills this year.

- California’s SB 294 would prohibit a pharmacy from compounding or dispensing, and would further prevent a nonresident pharmacy from compounding for shipment to the state, unless the pharmacy obtains a sterile compounding license from the state’s Board of Pharmacy.
- Hawaii HB 61 would require an out-of-state pharmacy delivering drugs to the state to employ a pharmacist licensed by the state’s board.
- Massachusetts has both house and senate bills that would tighten the regulation of compounding pharmacies in the state.
- Maine’s HB 394 provides a definition for “compounding pharmacy” and describes sterile and non-sterile compounding pharmacies. In addition, the bill will require the Maine Board of Pharmacy to add a physician and an advanced practice nurse to the Maine Board of Pharmacy and decrease the number of pharmacist members from five to three.
- Minnesota HB 1136 and SB 1208 would clarify requirements for compounding and make changes to the state’s prescription monitoring program.
- Mississippi SB 2735 defines “non-traditional compounding pharmacy” and requires entities engaging in the practice to register with the board of pharmacy.
- New Hampshire HB 313 provides for regulation of compounding pharmacists.
- New Jersey HB 3453 and SB 2365, introduced in 2012, require accreditation of compounding pharmacies.
- Oklahoma SB 522 requires nonresident pharmacies to submit applications for license issuance and renewal, and provides for fees related to licensure.
- South Carolina SB 3161 and SB 187 revise the minimum good compounding practices, require a final check from a pharmacist for products compounded by a pharmacy technician, and deal with expected features for ingredients used in a formulation. The bills also address space and sterility requirements.

AADA ACCEPTING APPLICATIONS FOR 2014 STATE ADVOCACY GRANTS

To encourage state dermatology societies to advance health policy initiatives across the country, the American Academy of Dermatology Association (AADA) will be accepting applications for its 2014 State Advocacy Grant Program. The program allocates grants on an annual basis through the AADA’s Council on Government Affairs, Health Policy, and Practice. Applicants submit a narrative background of a proposed advocacy project, a plan for advocacy efforts, and a budget proposal for the project. Priority review will be given to state societies applying for the first time, or those that have received only one prior award. The application for 2014 grants is Sept. 30, 2013.

For more information on the State Advocacy Grant Program, visit www.aad.org/members/aada-advocacy/state-affairs/state-advocacy-grant-program. - JOHN CARRUTHERS
**Q&A**

**DR. VAN VOORHEES:** Let’s review what has been known about the Sturge-Weber syndrome (SWS). What are the characteristic features? How often is this seen in the population? How often do children who are born with a port-wine (PW) stain have SWS?

**DRS. COMI, MARCHUK, AND PEVSNER:** The characteristic features of SWS are a facial PW birthmark in the V1 distribution (forehead and/or upper eyelid) associated with abnormal blood vessels in the eye, which frequently cause glaucoma and vision loss, as well as abnormal venous leptomeningeal blood vessels which impair drainage of blood from that area resulting in strokes, seizures, and neurologic and cognitive impairments. About 10 percent of individuals have the characteristic brain involvement but no birthmark. Approximately 1 in 20,000 individuals have SWS. PW birthmarks are much more common, occurring in about 1 in 300 newborns, and may occur anywhere on the head or body. PW birthmarks may be multiple or occur singly and in an isolated fashion, or may be associated with other underlying vascular and tissue malformations, such as in the case of SWS. An infant born with a facial PW birthmark in the V1 distribution has approximately a 20-50 percent chance of brain involvement depending on the size and extent of the birthmark and whether it is unilateral or bilateral. Usually the brain and eye involvement is on the same side as the PW birthmark. The PW birthmark, especially when extensive, is frequently associated with variable degrees of soft and bony hypertrophy of the underlying tissue.

**DR. VAN VOORHEES:** What has been hypothesized to cause SWS? How about what is thought to cause PW stains — is this thought to be the same pathologic development?

**DRS. COMI, MARCHUK, AND PEVSNER:** Our overall hypothesis was that SWS would be caused by a somatic mutation in a key gene.
gene regulating blood vessel structure and function. By somatic mutation, we mean a mutation that would not be present in the sperm or egg, but which was acquired later in time during fetal development. This mutation would then be present in affected tissue (affected vascular tissue) from the patient, but not in the blood (the typical source of DNA for genetic studies) or in any other unaffected tissue.

The hypothesis that SWS (and other vascular syndromes that are not inherited) might be caused by a somatic mutation has been around for many years. Over 20 years ago, Rudolf Happel suggested that the vascular malformations in SWS, Klippel Trenaunay Weber Syndrome, and others, would be caused by somatic mutations that would be lethal if passed through the germline. This somatic-only occurrence would result in a lack of clear familial inheritance of the trait. This lack of a clear inheritance pattern for nearly all vascular malformations, syndromic or not, fits with this hypothesis. If this hypothesis is true, the identification of the mutated gene would reveal the underlying cause of the vascular malformation and give us the first clue towards a scientifically-based approach to a treatment or cure.

Unfortunately, until very recently, the technology to test Dr. Happel’s hypothesis was not available. The last few years have seen an explosion in new genetic technologies, such that we are now finally in a position to rigorously search for the somatic mutation for vascular lesions. New DNA sequencing technologies have been developed that completely and irrevocably altered the ability to sequence genomes. These new sequencing technologies are being labeled “next-generation” sequencing, and they now sit at the cutting edge of genetic research. We employed these technologies to identify the somatic mutation causing SWS. It is important to point out to SWS patients and families that as these mutations are occurring somatically, they have no bearing on reproductive or other inheritance of the trait in other family members.

**DR. VAN VOORHEES:** Tell us about your experiment. What did you do, and what did it show?

**DRS. COMI, MARCHUK, AND PEVSNER:** We performed whole genome sequencing on six samples, using DNA purified from paired affected and unaffected regions of three individuals with SWS.

The presumed affected region consisted of a PW stain region obtained from biopsy, or surgically removed brain tissue. The unaffected region was either a blood sample, unaffected skin, or apparently unaffected brain. We identified a single variant that was predicted to be deleterious, involving a base pair substitution in the GNAQ gene on chromosome 9. Next we confirmed the finding by examining 97 samples from 50 individuals (we used two technologies — deep sequencing and a primer extension assay). Here are the highlights of what we found:

- 9 out of 9 PW stain samples from SWS patients had the mutation.
- 12 out of 13 PW birthmark samples that were not from SWS patients had the mutation, indicating that this mutation underlies both PW birthmarks and SWS.
- 16 of 18 SWS brain samples had the mutation.
- 0 of 6 control brains, as well as 0 of 4 cerebral cavernous malformation (CCM; an unrelated vascular disorder) samples had the mutation.
- Of 669 apparently normal blood or lymphoblastoid cell line samples from the 1000 Genomes Project, 0.7 percent had the mutation; this is consistent with the prevalence of PW birthmark in the general population.

The finding of a mutation in GNAQ was intriguing. The gene makes a protein, Gaq, that has a key role in cell function, including the regulation of blood vessels. When cell surface receptors (such as endothelin receptors) are activated by binding a ligand, Gaq is activated, binds and hydrolyzes GTP, and thus initiates an intracellular signaling cascade. The mutation we identified “locks” Gaq into a mildly activated state. We demonstrated increased ERK phosphorylation in mammalian cells transfected with the mutant construct.

**DR. VAN VOORHEES:** What other syndromes have similar somatic mosaic mutations? Is there a malignant potential to somatic mutations in some of these syndromes?

**DRS. COMI, MARCHUK, AND PEVSNER:** Other syndromes occurring by similar somatic mosaic mutations include CLOVES (congenital lipomatous asymmetric overgrowth of the trunk with lymphatic, capillary, venous, and combined-type vascular malformations, epidermal nevi, and skeletal anomalies) and Proteus syndrome. CLOVES syndrome is caused by a somatic mutation in the PIK3CA gene. Proteus syndrome is caused by a somatic mutation in AKT gene. Both of these disorders are somatic overgrowth disorders. PIK3CA and AKT fall along the Ras-Raf-mTOR pathway and both mutations overactivate this pathway. More studies are needed to determine if and how the GNAQ mutation, found to cause SWS and PW birthmarks, impacts this specific pathway.

There is not known to be an increased risk of cancer in patients with SWS or port-wine birthmarks although this has not been systematically studied yet. Each of the missense mutations observed in participants with CLOVES...
syndrome has previously been identified in several types of adult-onset cancer. Rather than directly causing cancerous transformation, the PIK3CA missense mutations increase the tumor’s growth or aggressiveness. When overexpressed, PIK3CA missense mutations identified in participants with CLOVES syndrome have the ability to transform cells. Wilms tumor (MIM 194070) was reported in two CLOVES-affected individuals. It has been hypothesized that the low rate of malignant transformation in individuals with CLOVES syndrome is due to the low level of endogenous PIK3CA expression in most cells. In Proteus syndrome benign tumors occur including lipomas, hemangiomas, vascular malformations, and lymphangiomas. Neoplasms that have been reported include mesothelioma, papillary carcinoma of the thyroid, ovarian serous cystadenoma, meningioma, optic nerve tumor, and endometrial carcinoma. The risk of malignancy is low.

**Drs. Comi, Marchuk, and Pevsner:** We speculate that the timing of the mutation is critical. Perhaps early mutations (e.g. those occurring in the first trimester) might be associated with SWS while relatively later embryonic mutations are associated with the milder phenotype of PW birthmark without SWS. It will be important to determine the cell type(s) that are affected by the GNAQ mutation, a problem we are working on now. It is remarkable that a mutation in the same gene, at the same nucleotide position, is associated with uveal melanoma. Thus the timing and location of the mutation critically affect the clinical presentation. *dw*

*Dr. Comi* is associate professor of neurology and pediatrics at Kennedy Krieger Institute and Johns Hopkins School of Medicine and director of the Hunter Nelson Sturge-Weber Center. *Dr. Marchuk* is professor and vice-chair in the department of molecular genetics and microbiology at Duke University Medical Center. *Dr. Pevsner* is associate professor in the department of neurology at Kennedy Krieger Institute and Johns Hopkins School of Medicine. Their article was published online May 8 in the *New England Journal of Medicine*, 2013; 368:1971-1979. doi:10.1056/NEJMoa1213507.
The telephone rings again in Bryan’s office. Taylor, a dermatologist who has been his client for years, is concerned about Jordan, a young patient who has had a less-than-optimal surgical result.

Taylor: I am really worried, Bryan. Jordan, a 17-year-old patient of mine, is quite upset about the appearance of a scar on his chest. I did surgery on a lesion about five months ago and he has developed a thickened scar at the surgery site.

Bryan: Did you get informed consent before you did the procedure?

Taylor: Yes, my nurse had him sign a written consent form before we did the procedure.

Bryan: Did one of Jordan’s parents sign the consent form? Was anything discussed with Jordan and his parents before he signed the form?

Taylor: No, Jordan’s parents were aware he was going to have surgery but they were not with him the day he had the procedure. Only Jordan signed the form. Since all of the possible risks were mentioned on the form and we were running behind schedule, we just had him sign the paper.

Bryan: First, in order for a patient to give his or her informed consent, the patient must have the legal capacity to consent. In most states a person must be at least 18 years old to do so unless there are specific legally extenuating circumstances that vary from state to state (e.g., emancipated, married, or pregnant minors). Furthermore, informed consent is not a signed piece of paper. It is the process of explaining to the patient the risks and benefits inherent in the procedure, including the risk of doing nothing. The signed sheet of paper is merely a written acknowledgment that the informed consent process has taken place. You should also be aware that in some states the person performing the procedure must be the one who obtains the informed consent.
**Taylor:** Does the fact that Jordan's parents were aware that he was going to have surgery matter?

**Bryan:** What matters is not that they were simply aware, but that they truly understood the risks and benefits of the procedure. Although they did not have to be physically present the day of surgery, their informed consent should have been obtained before the surgery was performed.

**Taylor:** Do I have to mention absolutely every possible risk?

**Bryan:** No. Courts have ruled that mentioning every possible single complication or risk ever reported is counterproductive to the intent of an informed consent. The patient needs to have a reasonable, realistic understanding of the risks the procedure entails, such as scar formation, allergic reactions, etc. Catastrophic complications, such as paralysis or death, and the risk of doing nothing should also be discussed.

**Taylor:** Is Jordan's signature on the form of any significance?

**Bryan:** In this case, no. Even if Jordan was of age, merely slapping a form down in front of him and hurriedly having him sign it is legally meaningless. The signed form may have the effect of causing Jordan or his parents to hesitate seeking legal counsel if they mistakenly assume it is valid, but any plaintiff lawyer will let them know that the “consent” is not worth the paper it is written on.

**Taylor:** Does the written consent form have to be witnessed?

**Bryan:** That is required by the laws of virtually every state. Even if it is not required, I would strongly urge you to do so.

**Taylor:** Are there instances when I do not need to get informed consent? Perhaps this situation qualifies.

**Bryan:** Yes, there are exceptions. The emergency exception, for example, allows you to treat a patient who is unconscious or otherwise unable to give consent when a delay in treating the patient would result in a major complication, such as paralysis or death. Even in an emergency situation, however, try to get a close relative to give consent.

**Taylor:** What if no relatives are nearby?

**Bryan:** Try to reach them by telephone and, if you are successful in doing so, have your nurse or another adult witness the conversation and then document it in the patient’s medical record.

**Taylor:** Is this the same as “therapeutic privilege?”

**Bryan:** No. Therapeutic privilege is when the physician withholds the information from a patient because disclosure to the patient is medically unwise. It is used almost exclusively in psychiatric situations. When it is used to avoid obtaining informed consent, the burden is on the physician to demonstrate that disclosure would have significantly harmed the patient and that this harm would have clearly outweighed the benefit of having obtained informed consent.

**Taylor:** That certainly doesn’t help in this case. What if a patient simply says he trusts me and does not want to hear about the risks of a procedure?

**Bryan:** Waiver is also an exception to the need for informed consent. The patient has the right to waive receiving the information, but in those rare instances you should document his denial in the medical record and have the patient sign that statement. If the patient refuses to sign, have a witness sign.

**Taylor:** One last question, Bryan. If I am in the middle of a procedure and find that it is medically advisable to go beyond the procedure to which the patient initially consented, can I do so?

**Bryan:** This situation has been referred to as the “extension doctrine.” This exception to the requirement of obtaining informed consent is most frequently invoked in situations where the patient is under general anesthesia and it is clearly inadvisable to terminate the surgical intervention knowing that further surgery is necessary, such as in the case of a metastatic cancer that has spread beyond the area suspected before surgery was undertaken. Since the vast majority of your procedures are done in the outpatient setting under local anesthesia, the extension doctrine would rarely be appropriate since the patients are capable of giving informed consent.

**Taylor:** What should I do now with respect to my unhappy patient?

**Bryan:** Treat his scar and try to minimize it. Not only will this hopefully improve the patient’s appearance, but it also shows your genuine concern. Remember, one of the strongest triggers of a malpractice suit is the patient feeling that the doctor doesn’t care or doesn’t have the time for him or her. Alternatively, even if you have an unsatisfactory result, patients usually hesitate to sue a doctor they feel cares.

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**KEY POINTS**

1. Informed consent is explicitly not a signed sheet of paper. It is the process of informing the patient of the risks and benefits of a procedure, including the risk of doing nothing.
2. Patients must have the legal capacity to give informed consent. Patients who are under age, heavily sedated, intoxicated, etc., cannot give informed consent.
3. There are exceptions to the need to get informed consent, such as the emergency exception, therapeutic privilege, waiver, and the extension doctrine. These exceptions should rarely be invoked in the outpatient dermatology setting.
4. If a therapeutic result is less than that desired or expected, treat the patient to obtain the best outcome under the circumstances. Let the patient know you care. Patients hesitate to sue a doctor they feel cares for them.

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**If you have any suggestions for topics to be discussed in this column, please e-mail them to me at loberc@gmail.com. See the February 2013 issue of Dermatology World for disclaimers. dw**
Keeping track

HOW ELECTRONIC LOGS OF BIOPSY AND LAB TEST RESULTS CAN MAKE YOUR PRACTICE MORE EFFICIENT.

I have found that how physicians store and retrieve information in the office is very individualistic. On our desks, we can potentially have a mish-mash of paper in progress, journals, articles from throw-away publications, patient charts, letters/correspondence, and other items. All of these can be in varying states of readiness. Several basic organizing strategies are employed. Some of us are spreaders, some are stackers, and some are filers. I tend to spread things out so I can see them, but I know deep down that is probably the worst strategy of the three. The same analogy holds true on our computer’s electronic desktop. It’s pretty sad when I can’t see my latest cool desktop background pic because of all the darned icons. When will I ever learn?

In the EHR world, things are supposed to be easier. Inbound reports are automatically directed into the patient’s virtual chart and we can retrieve at a moment’s notice. That’s the idea anyway, but often in “EHR-land,” things are not as they seem. In this month’s column, we will discuss ways to use EHR to tame the beast that is laboratory paperwork, arguably some of the most important papers on our messy desk.

One of the first tasks we desired to automate when we instituted our EHR was to look into methods for electronically importing lab work/reports — including items like pathology and blood work reports. I figured this wouldn’t be too difficult. It’s all electronic, right?

In retrospect, I couldn’t have been more wrong. We use an independent dermatopathologist for all of our biopsies, as opposed to a national pathology lab chain or university department. We are quite happy with our decision, but during the initial integration process, we realized this would be an obstacle. For starters, several of the national pathology chains offered to integrate their path reports into our new EHR system at their cost, if we
used their services. It was nice of them to show up right after we bought our system. I wonder how they knew? They even offered fancy graphical interfaces for inputting biopsy details and free label makers. We decided against this and tried to work with our independent dermatopathologist to incorporate his reports into our system. After months and months of working with his smaller pathology software-reporting company and more time/money/patience spent on HL7 data bridge interfaces and hassles with embedded PDF formatting, we were able to import most details. However, the format of the EHR-generated report was not very professional in its appearance. We had no control over the page layout and the report looked like a typewritten high school book report (remember those?). Ultimately, we reverted back to electronic faxing and scanning and operating within the confines of the EHR to develop a system that worked for us. I have described our system below, developed ingeniously by our office physicians and staff, knowing that it may not be applicable to other EHR users due to inherent differences in the software. Scanning and file importation are additional steps we would rather not have to do, but with practice it has become very efficient and works well for us.

Once we received the pathology report, it was immediately scanned or imported (in the case of eFaxes) into our EHR under the specified patient’s file. This pathology report was assigned to the provider that performed the biopsy. The pathology report was then immediately available for review. The provider then documented their recommendations for treatment in a document labeled “pathology review” under the patient’s file. This document is assigned to the assistant or surgical scheduler that is designated to notify the patient of their pathology results. This document also allows the assistant/scheduler to document each call attempt made to the patient giving the exact date and times of the call attempt. Once the patient has been notified, this is noted on the same document. This document can then be assigned to a surgical scheduler to coordinate surgery with the patient and one of our providers. All of the notifications are very easy to follow because they are on the same document. An electronic log is still kept for each biopsy taken, but it is again easily accessible.

If several call attempts are necessary, electronic documentation allows the pathology to be viewed by any of the employees at any time. This allows several assistants to make call attempts without having the physical copy of the pathology report as it is already in the EHR. Storing the pathology notification attempts in our automated task list allows us to receive daily reminders about notifying the patients. This means that patients do not slip through the cracks. We can see exactly which stage in the notification protocol that the patient is in.

With paper documentation and notification, the paper pathology report would transfer from the front office to the lab for logging, then to the provider for sign off, and finally to the person who would make the patient notification. The margin for error was a lot greater, and in a busy office, could cause the pathology report to become “lost.” This also would increase the amount of time from receiving the pathology report to patient notification. When paper documentation was used, it could take up to three to four days for the patient to receive their results from the time that the office received the pathology results. Whereas with electronic documentation, the patient can potentially receive their results the same day that the pathology report is received. Previously, in order to properly follow if all patients had been notified of their pathology results, a paper log book had to be used to closely watch for any “missing” reports. If a patient called back for their results before we called them, the actual pathology copy had to be located in real-time, in order to notify the patient.

We had to fight a similar battle with our clinical pathology lab. Since we are located in a large medical office building that has a pathology lab at the ground floor, our patients often find it convenient to go downstairs to get labs drawn after their office visit with us. We faced another obstacle because the lab, which is a mid-sized expanding national chain, was not able to send us results electronically. They refused, at the time, to implement any type of interface to help with our EHR integration. We considered just recommending to patients to use another lab that would send us results electronically, but ultimately relented because of the patient convenience. We found that the same aforementioned system also works for laboratory blood work, cultures, etc. Using the EHR system of “to-do” tracking and alerts, we can manage all inbound clinical pathology labs after they have been scanned or imported.

Ironically, I was the last to be converted away from the paper log. I liked having all the reports in hand and reviewing them on paper, all at the same time, to make sure I didn’t miss anything. When I realized that things still occasionally slipped through the cracks because of lost reports going from one person in the office to the next, etc., I saw it was a good time for change.
As Europe’s largest economy and the world’s first country with a national health insurance system, Germany balances the demands of universal coverage with the challenge of an aging population and low birth rate. For German dermatologists, that means a projected gap in physician supply and issues in both urban and underserved rural areas that closely mirror the challenges of declining reimbursement and difficulty accessing new treatments faced by U.S. dermatologists.

UNIVERSAL COVERAGE AND SPECIALIST ACCESS
In Germany, health insurance is mandatory for the entire population. As such, each citizen has access to both hospitals and physicians in private practice. For citizens with higher income, estimated at approximately 10 percent of the population by private practice dermatologist Matthias Möhrle, MD, there is the option to leave the public plan and purchase private insurance, with one’s employer covering roughly half the cost of the plan. These plans are for those with full-time employment who earn more than EUR 4,350 per month (about $6,000) in gross salary. The option allows people on private insurance to lower their premiums and receive reimbursement for a year of not using the insurance. In addition, some plans cover a broader array of diagnostic procedures and therapies. In both scenarios, he said, direct access to specialists is possible for patients without a referral. Many hospital dermatology departments, however, require a referral from an outside dermatologist, as they employ highly specialized dermatologists.

The insurance system is funded through a combination of employee contributions, employer contributions, and government subsidies that vary based upon income level. In most cases, according to dermatologist Christoph Löser, MD, direc-
tor of a community-based teaching hospital in the Rhine Valley, all costs related to serious illness are covered.

“You will never hear that anyone is ’not able to afford’ necessary treatment in Germany. All sorts of specialists are easy to access,” he said.

The health system operates on a decentralized model, with private practitioners providing ambulatory care and independent hospitals (the majority of which operate as nonprofits) providing inpatient care. Dermatologists operate far more frequently in hospitals in Germany than they do in the U.S. due to the reimbursement system.

Regulation of physicians in Germany is handled at the institutional level, which both Dr. Löser and Dr. Möhrle say creates a great deal of conflict. Rather than a national body, regulation is largely handled by the institutions that employ physicians.

“Medical doctors are a so-called ‘free profession,’ which means most regulation is done by our own institutions, not by the state. This is sort of democratic, but there is conflict of interest and lobbying involved regarding different specialties and differences between ambulatory care which is allowed to be given by hospitals as compared to service by private practice,” Dr. Löser said. “Regarding dermatology, especially in skin cancer treatment and follow up, current regulations regarding the level of care that ambulatory dermatologists are allowed to deliver can cause considerable problems in providing the quality of care patients are entitled to.”

In addition, Dr. Möhrle said, getting into private practice can prove difficult for many physicians because ambulatory care is reimbursed at a far lesser rate than inpatient care. Inpatient services rendered to public insurance patients are reimbursed through a system of diagnosis-related groups, while ambulatory care is paid for through a mixture of pre-paid capitated sums, lump treatment sums, and fee-for-service determined by the country’s point-based scale. Physicians’ capitation volume is tracked quarterly, and the volume itself varies between specialties, regions, and patient morbidities.

“The access to go into private practice within the public health system is limited. In most areas a doctor willing to go into practice has to succeed and buy an office from a colleague going into retirement. Ambulatory services offered by hospitals are better remunerated than in private practice. And in addition, hospitalization is far better remunerated, such as for surgery in skin cancer patients,” Dr. Möhrle said. “The ambulatory treatment of standard dermatologic patients with the normal public insurance is not cost-effective in private practice without fees of about 15 Euros per trimester regardless of how often the patient is seen. Dermatologists compensate for this by surgical procedures, microbiological testing, or allergological testing, which are covered by the public insurance, or by cosmetic procedures, which are paid for by the patients themselves and not by public insurance.” In addition, Dr. Möhrle said, the payment values in the German system have not been updated to reflect the cost of providing care since 1996.

**DEMOGRAPHIC SHIFTS AND CHALLENGES TO DELIVERY**

While access to both primary and specialist care is free to most anyone, the demographics of Germany society will pose ever-greater challenges to efficient and effective care delivery, according to Dr. Möhrle. With a low birth rate and an aging population (see sidebar) as well as low net immigration numbers, the social welfare system, including health care, will be under increased pressure. In addition, Dr. Möhrle said, the incidence of skin cancer is projected to rise significantly as the population ages.
“Facing the demographic evolution of the German population, dermatoses of the elderly will significantly increase, including rising numbers of skin cancer,” Dr. Möhrle said. “There will be a lack of physicians in the upcoming years. This shortage of doctors will be more pronounced in rural areas, and for general medicine rather than for specialists in cities and in more developed regions.”

In attempting to deliver more efficient care, Dr. Möhrle has found that the smaller team in his relatively new private practice setting allows him the autonomy to make quicker decisions and offer better and more efficient treatments.

“When I compare the work in private practice with that in a university hospital, I would say that a more personal contact, a better organization, and a smaller and qualified team makes patient care more efficient,” Dr. Möhrle said. “In dermatologic surgery and vein surgery the use of tumescent local anesthesia, endoveinous therapy, and micrographic surgery is quite efficient.”

**UNIQUE THERAPIES, INCREASED SPECIALIZATION**

As inpatient dermatology is much more pronounced in Germany than it is in the U.S., dermatologists training there have a unique perspective on the evolution of skin diseases, according to German-trained Boston University dermatologist Thomas Ruenger, MD, PhD.

“That is a big plus for the specialty and for specialty training because it gives the trainees opportunity to see skin diseases evolve day to day and see how their patient gets better there,” Dr. Ruenger said. “A U.S. resident can prescribe treatment and see a patient back in six weeks. How quickly something has improved cannot be monitored the same way.”

In addition, Dr. Ruenger said, residents training in a specialty receive far more autonomy than their U.S. counterparts.

“Residents in Germany are not as much regarded as trainees. They are hired as assistant physicians and learn by doing. There is not as much of a commitment to formally training those assistant physicians, so they do this by taking on many more responsibilities than the residents in the U.S. do,” Dr. Ruenger said. “In the U.S., every decision is still supervised by an attending. That attending sanctions every decision, which is much different in Germany. There, assistant physicians take on that responsibility much earlier.”

One of the significant differences in technique between German and U.S. dermatologists is the practice of Mohs micrographic surgery, according to Dr. Möhrle. In Germany, dermatologists utilize microscopically controlled surgery on paraffin-fixed sections, known colloquially as “slow Mohs.” This involves a patient’s wound being left open under a secure dressing for at least a day while the slides are analyzed. This can be a multi-day process of surgery and analysis. The process allows dermatologists to better analyze the roots of some tumors that might be difficult to see on regular frozen slides, he said. This includes lentigo maligna, sebaceous carcinoma with intraepidermal pagetoid spread, and acrolentiginous melanoma in situ.

In addition, the responsibility for treating skin cancer is much more incumbent upon dermatologists. “Dermatologists in academic centers also treat advanced skin cancers with chemotherapy, with immunotherapies, and don’t refer those advanced cases to oncologists,” Dr. Ruenger said. “Oncology for skin cancers and skin malignancies is handled by the dermatologists. That’s an experience that American dermatologists do not have.”

**ABOUT THE CONTRIBUTORS**

Christoph Löser, MD, is the deputy director of a community-based teaching hospital in Ludwigshafen.

Matthias Möhrle, MD, works in a private dermatology practice in the town of Tuebingen. Previously, he worked at the University Hospital in Tuebingen for 18 years.

Thomas Ruenger, MD, PhD, is the professor and vice-chair of dermatology in the department of dermatology at the Boston University School of Medicine. A native of Germany, he trained in that country before coming to Boston University in 1999.
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UNLOCKING THE MYSTERIES OF

ROSACEA

Molecular studies highlight possible pathways in pathophysiology
An estimated 16 million Americans have rosacea, one of the most common dermatoses of adults. Yet most of them don’t know they have it, and only a small fraction are receiving treatment, according to the National Rosacea Society (NRS). The disease is not life-threatening, but those who suffer from even the mildest form of rosacea report that it extracts a significant toll on their social and emotional well-being. According to results of a recent NRS survey of 801 rosacea patients, a strong majority of patients in all subtypes (ranging from 61 percent of those with erythematotelangiectatic rosacea to 85 percent of those with phymatous rosacea) said the disease had inhibited their social lives. The most common complaint was having to refuse food or drink for fear of triggering a flare-up, but respondents also cited receiving negative comments or stares and cancelling social events because of self-consciousness regarding their appearance. >>
Rosacea’s impact on patients’ quality of life underscores the importance of understanding the disease and finding more effective treatments. Despite its prevalence, the etiology and pathophysiology of rosacea, as well as the cure, have remained a mystery. It’s also unclear whether the four subtypes of rosacea, defined by an NRS committee of experts and described in the *Journal of the American Academy of Dermatology* (2002;46(4):584-87), truly represent a “march” from one stage to the next. Research conducted in the past few years is honing in on dysfunction of the innate immune system as an underlying factor, and also examining the role of inflammation and neuroimmune communication. The role of the Demodex mite remains under scrutiny, with topical ivermectin now being investigated as a possible treatment. In the meantime, as researchers have continued to test new therapies for rosacea, an agent that has proven effective against one of its most recalcitrant symptoms — the redness associated with erythematotelangiectatic (subtype 1) rosacea — may soon be available to patients.

### A Once-Daily Solution for Redness

The erythema of the central face that characterizes rosacea is thought to result from abnormal cutaneous vasomotor activity, according to a *British Journal of Dermatology* article (2012;166:633-41) describing two phase 2 studies of a topical gel with vasoconstrictive activity. Brimonidine tartrate (BT) is a highly selective alpha2-adrenergic agonist that has been used for about 10 years as an ophthalmic solution for the treatment of glaucoma, said the study’s first author, Joseph F. Fowler Jr., MD, clinical professor of dermatology at the University of Louisville. “It’s been investigated as a treatment for rosacea for probably six or eight years. Our studies looked at several dosage levels, as well as once-daily and twice-daily treatments, and compared the results with those of vehicle gel,” he noted. “We found that the highest dosage [0.5 percent] when given once a day, seemed to work better than the lower or middle dosages, even when those were given twice a day.” In both studies, the once-daily application of BT gel provided significantly greater efficacy and faster onset of action than vehicle gel, without evidence of tachyphylaxis, rebound, or aggravation of other clinical signs of rosacea. In the first study, in terms of a one-grade improvement on both a clinician’s and a patient’s assessment (on a scale of 0, clear skin to 4, severe erythema), the responder rate was 84 percent, 81 percent, and 75 percent for the three dosage levels of BT gel vs. 28 percent for the vehicle gel. In the second study, in which the profile of success was defined as a two-grade improvement in clinicians’ and patients’ assessments over 12 hours, the success rate of BT 0.5 percent once daily at three, six, nine, and 12 hours on day 29 was 30 percent, 28 percent, 32 percent, and 19 percent, respectively (vs. 4 percent, 7 percent, 4 percent, and 4 percent for vehicle gel once daily). All dose regimens of BT gels were safe and well tolerated during four weeks of continuous application. One subject requested discontinuation because of mild skin burning.

“We’re relatively good at suppressing the inflammatory components of rosacea, but up until now, we really didn’t have anything that would help much with the erythema,” Dr. Fowler said. “This will be the first actual treatment for erythema outside of laser procedures or cover-up with cosmetics. And it’s kind of nice that we’ve got a new chemical in dermatology instead of a repackaging of a previous drug.” Phase 3 testing of BT gel has been completed, and the results were recently published in the *Journal of Drugs in Dermatology* (2013;12(6):650-656). Dr. Fowler said the drug has been submitted to the U.S. Food and Drug Administration for approval.

Regarding the role BT gel might play in the long-term management of rosacea, Dr. Fowler said that for most patients, he envisions its daily use to treat erythema, “and then if and when they have some inflammatory lesions, they would use treatments we know are effective: systemic antibiotics, like doxycycline; topical azelaic acid; metronidazole in a variety of preparations, and others. They might go on and off the inflammatory treatments according to need and stay on the erythema treatment as long as they’re concerned about the redness.” Brimonidine begins to reduce redness as soon as 30 minutes after application, and “probably has its maximum effect somewhere between six and 12 hours,” Dr. Fowler said. “So if you have a day when you really don’t care if your face is red — say you don’t plan to go out — you might not use it that day. And that seems to be
perfectly fine; if you use it the next day, it works just as it did the previous day.”

Another vasoconstrictor, oxymetazoline, is currently under investigation in a cutaneous gel formulation, Dr. Fowler said. An alpha-1 and partial alpha-2 receptor agonist, it is currently available as an over-the-counter decongestant in the form of a nasal spray. Case reports have indicated that oxymetazoline is effective in reducing facial erythema, but phase 2 trial results have not yet been published.

**ANTIMICROBIAL PEPTIDES AND INNATE IMMUNITY**

A prominent researcher with a special interest in innate immunity was taken by surprise, he said, when he discovered that the skin of rosacea patients expresses excessive cathelicidin and its activating enzyme, kallikrein-related peptidase 5 (KLK5). “Overproduction of these seem to be triggered by a lot of environmental events [in rosacea patients],” said Richard L. Gallo, MD, PhD, professor of medicine and pediatrics and chief of the division of dermatology at the University of California, San Diego. “We’re all exposed to microbes, mites, ultraviolet light, and spicy foods. If everyone is exposed to all of these things, what are the genes that are hyperreactive that lead to rosacea? That’s what these really are, the genes that are reacting to these environmental events.”

In an article published in the *Journal of Allergy and Clinical Immunology* (2008;122(2):261-66), Dr. Gallo and co-author Jurgen Schauber, MD, describe cathelicidins as “unique antimicrobial peptides that protect the skin through two distinct pathways: direct antimicrobial activity and initiation of a host response resulting in cytokine release, inflammation, angiogenesis, and reepithelialization.” The article implicates cathelicidin peptides in atopic dermatitis and psoriasis, as well as rosacea, and notes that in patients with rosacea, they result from a posttranslational processing abnormality associated with an increase in protease activity in the epidermis. In mice, Dr. Gallo explained, “you can put the cathelicidins and KLK5 on the skin, and they will develop redness and extra blood vessels that look like a patient who has rosacea. So that’s part of the proof of the hypothesis. The next step is to test in patients, and find out: If you block their action, will patients improve?”

Interrupting the pathway can involve blocking the gene’s ability to make the peptide or, alternatively, blocking the function of the peptide molecule. Dr. Gallo said. “And that’s where we are today. We’ve just had a study accepted by JAAD that looks at whether or not existing medications used in the treatment of rosacea might be having a beneficial effect by acting on this pathway. We hypothesized that azelaic acid, even though we didn’t know it could do this, may be able to block that pathway — and maybe that’s the reason it works.” In a 16-week, multi-center trial involving 60 patients with mild papulopustular rosacea, “we found that azelaic acid did in fact block the pathway, we think by inhibiting the KLK enzyme.” Another study of 160 patients receiving slow-release, low-dose doxycycline tested the same hypothesis and the results of this study are currently under analysis, Dr. Gallo said. (The azelaic acid study was funded by Bayer; the doxycycline study was funded by Galderma.)

“When we measure these pathways in patients, we see different groups, so we’re getting biomarkers of disease,” Dr. Gallo said. Although the presence of biomarkers has not yet been matched against the genetic profiles of rosacea patients, “that’s what this data is supporting. All the studies to date are suggesting that once we understand enough about this, and we’re getting close, this will enable us to test the patient first and maybe predict what will be the best therapy. Right now we’re kind of at the cusp of being able to develop new treatments.”

**THE ROLE OF NEUROTTRANSMITTERS**

Another pioneer in the field is Martin Steinhoff, MD, PhD, professor of dermatology at the University of California, San Francisco, who has focused on the role of neurotransmitters in rosacea. “We study the interaction between the vascular system, the immune and the nervous system, and we have also studied in detail the genes which are upregulated or downregulated, and compared this to the skin morphology in the different subtypes of rosacea,” Dr. Steinhoff said. “So far we were a little bit in the dark; because we didn’t know which were the principal cells involved, and the principal mediators that drive the initiation of rosacea.” With particular interest in the flushing (erythema) that characterizes the early stages of rosacea, Dr. Steinhoff sought to understand what underlies the dysregulation of vasodilation and discomfort in rosacea patients. “We have some information from our gene studies, and currently we analyze the pattern of the more than 300 different genes we found to be involved,” he noted. “Now we know the critical immune cells and genes involved that include neuromediators, cytokines, chemokines, and proteases, for example.”

One neuromediator, pituitary adenylate cyclase activating polypeptide (PACAP), was found to be “20 to 30 times upregulated in rosacea, and we know that PACAP is one of the most potent vasodilators in humans, so if we put this together we have lots of evidence that this mediator and/or its receptor plays a role in the early phase of rosacea,” Dr.
Steinhoff said. In a study published in the Journal of Investigative Dermatology (2012;132(4):1253-62), Dr. Steinhoff and co-authors in Germany and France demonstrated the involvement of certain calcium ion channels in the pathophysiology of rosacea. “These also regulate vasodilation as well as inflammation and skin discomfort and many of them are activated by the trigger factors of rosacea, such as temperature changes, spicy food, ethanol, UV light, and exercise,” he explained. “So, we anticipate that dysregulation of ion channels may be at least involved in the flushing during the early stage of rosacea. Some of these ion channels are also upregulated in the gene array studies and are highly expressed on nerves in rosacea patients.” Understanding the key mediators and receptors involved in rosacea will lead to more targeted therapies with fewer side effects, Dr. Steinhoff said, and antagonists that act against those calcium channels and selected vasomediator receptors are currently under investigation.

DOES ROSACEA MARCH?

Dr. Steinhoff’s research has also shown that rosacea subtypes 1, 2, and 3 “have clear differences with respect to which kinds of genes are most upregulated,” he noted. “So we continue to confirm that these are different subtypes, but it’s also interesting that there are some genes that overlap, and so it looks like there is a march from one subtype to the next. Eighty percent of the genes are different, but 20 to 30 percent are identical. So I would say there are two different forms of rosacea: one in which there is a march from subtype 1 to subtype 2 to subtype 3, and another, mostly in male patients, where you don’t see clinical manifestations of the first two subtypes before phymatous rosacea occurs, although biopsy reveals inflammatory infiltrate and dilated blood vessels. “That tells us that people with rhinophyma who say they didn’t have the early stages of rosacea probably did, but it wasn’t clinically visible.”

Dr. Gallo noted that rosacea can progress from one subtype to the next, “but it doesn’t have to. It’s genetics that halts the progression, and if you get effective therapy you’re less likely to get more severe disease. But there’s also a school of thought that says some people with central redness of the face are misdiagnosed with rosacea, and it’s actually a separate type of disease that we can’t yet distinguish from rosacea.”

FIGHTING SKIN BARRIER DYSFUNCTION

Patients with rosacea frequently complain of dry, sensitive skin and often report burning and stinging sensations. In the view of a leading European rosacea expert, “all patients with erythematotelangiectatic and papulopustular rosacea have skin barrier dysfunction.” Frank C. Powell, MD, consultant dermatologist at Mater Misericordiae University Hospital in Dublin, Ireland, has studied the skin surface layer in rosacea and found that patients with papulopustular rosacea have reduced surface hydration levels in the presence of normal sebum casual levels, indicating that it may be the quality and not the quantity of sebum that plays a role in their rosacea. His group’s analysis of the sebaceous fatty acid composition of 25 patients with papulopustular rosacea and 24 age- and sex-matched controls, published in the BJD (2012;166(2):279-87), found that the rosacea patients had an abnormal sebaceous fatty acid composition, with reduced levels of long chain saturated fatty acids. To combat the effect of barrier dysfunction, Dr. Powell recommends that his patients avoid products with perfume, color, or alcohol, and moisturize daily. “In addition, because most are fair-skinned and sun-sensitive, they need to apply a sun block cream,” he added. “For simplicity, I advise the moisturizer be applied at night and the sun block in the morning.”

Although the skin care recommendations for rosacea patients are fairly simple and straightforward, “a lot of patients, left to themselves, don’t wash enough because their skin is sensitive, and feels dried out and burned,” said Mark Dahl, MD, professor of dermatology at the Mayo Clinic College of Medicine in Scottsdale, Ariz. and chair of the NRS Medical Advisory Board. “And they don’t moisturize, because papules and pustules of rosacea remind patients of the oily skin acne they had as teenagers. Plus, when barrier function is defective, as it is in rosacea, moisturizers tend to sting. Patients think stinging moisturizers are irritating their sensitive skin. Yet daily applications of a moisturizer are an important part of therapy. Barrier repair requires proper cleansing and regular applications of moisturizers and emollient sunscreens. Usually redness improves and stinging lessens within two months.”

Editor’s note: Dr. Fowler received grants from Galderma Research and Development, Inc. to conduct studies of brimonidine tartrate. dw
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HIGHER CO-PAYS, HIGHER STAKES

Managed care moves to high deductible plans, forcing practices to seek new ways to collect from patients
The managed care system in the U.S. is undergoing substantial and broad-reaching changes. Patients and physicians are personally feeling the effects of macro-economic adjustment by health plans. Independent providers and small practices find themselves undermanned at the negotiating table, feeling the pressure to merge and consolidate. And as accountable care organizations (ACOs) and health insurance exchanges wait just over the horizon, it’s vital for dermatology practices to remain cognizant of the changes that will impact the way they practice and be proactive in addressing them.

HIGHER PATIENT COSTS, LOWER PAYMENTS
As insurers look to provide maximum coverage at an economically feasible cost, one trend whose adoption is surging is coverage through high-deductible health plans (HDHPs). An HDHP offers patients much lower monthly premiums at the cost of significantly higher up-front payments when they receive care. The plans, coverage through which is a requirement for participation in health savings accounts (HSAs), are defined as those with a minimum deductible of $1,200 per year for self-coverage (or $2,400 for a family), and a maximum out-of-pocket limit of $6,050 ($12,000 for family coverage) under the 2013 tax code. The amount is modified each year by the Internal Revenue Service. >>
With the rising cost of health coverage, an increasing number of consumers — and employers — are opting for these plans. A 2013 report by business services company Towers Watson and the National Business Group on Health found that health plans combining higher deductible coverage and HSAs are offered at 40 percent of public sector companies. Among employers, 12.5 percent have already reached 100 percent enrollment in these plans. The report also found that companies with HDHPs and HSAs are more likely to provide cost-of-care information and other decision support tools for patients than those employers offering traditional plans.

Unfortunately, according to Owings Mills, Md., dermatologist Risa Jampel, MD, the public’s understanding of the parameters and cost of these plans has not expanded at a comparable rate.

“I had one patient who came with her teenaged sons. They were both on isotretinoin, and the co-pay for one visit is $60 for specialist care. So when she brings her two sons to me, it’s $120 out of pocket immediately. That’s not a small amount of money for people,” Dr. Jampel said. “It’s almost like they don’t have insurance for office visits. But she needs a dermatologist to administer the medication.”

In addition to patients seeing greater personal expense because of doctor visits, physicians are now dealing with much lower reimbursement rates from a number of plans offered to consumers at a lower price. Some, according to Dr. Jampel, even pay at rates below Medicare. Just this year, she said, her reimbursement for Medicare. Just this year, she said, her reimbursement for level two follow-up visits on one particular plan reached a level below that of the patient’s copayment.

“Let’s say it’s a standard follow-up acne visit at level two. You do that level two visit, the patient is completely fine, and their co-pay is $60. If the insurance only pays you $35 for that visit, you end up having to send that patient a refund check. It was something I’ve found absolutely extraordinary,” Dr. Jampel said. “There would be less paperwork if the patient came in and paid me $35. In my area, this has led a lot of dermatologists to not participate with a certain plan.”

**ADAPTING TO NEW ECONOMICS**

According to Murad Alam, MD, chair of the Academy’s Health Care Finance Committee, as the percentage of patients with HDHPs increases, it may now be advisable for physicians to communicate with patients about the cost of different diagnostic and therapeutic options.

“If patients do have a high deductible plan and they and their physician know that, it’s not unreasonable for them to have a discussion before embarking on therapies regarding the relative costs,” Dr. Alam said. “Sometimes I think there is a treatment that even though it’s more expensive might be really vital, and other times, the patient and physician might decide that a less expensive treatment is sufficient. You want to do what is best for the patient, but you’re in a situation where you don’t want to burden them with bills. We have to optimize the patient’s health without crippling their ability to manage their share of the expense.”

**ONE PRACTICE’S SOLUTION**

In dealing with the economics of a greater financial burden of patients, Angela Short, vice president of revenue management and compliance at The Dermatology Group in West Orange, N.J., said that her practice overhauled the patient check-in process in order to cut down on the increasing number of accounts past due. Now, she said, the patient checks in with a tablet, and part of the process is the system verifying the patient’s status and providing a reminder of the requirements of an HDHP.

“The key for any practice is staying on top of who has high deductibles and either keeping credit cards on file so you can charge it as soon as the claim adjudicates or having the patient pay out of pocket up front,” Short said.

To complete the check-in process, she said, patients swipe a credit card that can either be charged after claim adjudication or filed along with a request to enter a payment plan. While the version of this conversation that takes place between administrative staff and patients can be awkward and fraught, she said, taking her staff out of the equation by using the tablet for check-in has proved a success in educating patients on their plans, the potential costs, and the options for extended payment schedules.

“We are finding that patients are more readily providing that information in that environment than when we were asking for it through our staff. Because of 3010 our claims are adjudicating so quickly that by the time they come back for a stitch removal, that claim has already been adjudicated. We know exactly what that patient owes,” Short said. “If they don’t have a credit card on file, [the tablet] will prompt them immediately, ‘you have a standing balance of X.’ They can pay or enter a payment plan. The number of payment plans has increased from five a month to 200-250 because of the application. The nice thing about the technology is that it automatically charges the card when it’s due. I don’t have to have staff monitoring that on a daily basis.”

Employing this system, Short said, had allowed the practice to capture 50 percent of outstanding balances by taking the front desk employees out of the process. Total patient collections, she said, have increased by 42 percent. Adjusting to shifting economics, she said, has necessitated a flexible and technology-driven solution.
CONSOLIDATED MEDICINE AND THE FUTURE

The same market forces that place pressure on patients and physicians also drive the consolidation of existing practices. According to a 2012 report by Accenture, though the supply of physicians is increasing, the number of independent physicians is following a sharp downward curve — from 57 percent in 2000 to 39 percent in 2012. (Younger dermatologists, in particular, are part of the trend; only 18 percent of dermatologists under 40 and 31 percent between ages 40 and 49 are in solo practice. See April's Facts at Your Fingertips at www.aad.org/dw/monthly/april/dermatology-groups-poised-to-play-a-bigger-role.) The aforementioned decline in reimbursement is partially to blame, according to Short, in addition to the lowered contract negotiating power of smaller providers. The overall effect, she said, is lower reimbursement for smaller practices.

“Smaller practices are really challenged to come up with any kind of leverage for negotiating with managed care companies,” Short said. “It’s not necessarily because the managed care companies don’t want to give them attention, it’s akin to medical practices watching human resources expenses. There are fewer provider reps to service a larger population. They’re so stretched that they don’t really have the time to focus on smaller practices. That’s a reason that the big practices have so much leverage. They provide so much value at the table, securing 50 to 60 doctors with one conversation as opposed to one or two. You can’t compete in that environment — you’re going to see continued consolidation.”

The negotiating power of a practice, she said, depends greatly on the local supply of dermatologists. In northern New Jersey, Short said, even her 30-provider practice has little negotiating power with managed care. Yet some practices, she said, can command more attention with as little as five providers in more isolated areas. In addition, dermatologists in a multi-specialty practice, or those who are part of a national group, will always have significant negotiating power, according to Short.

In addition, providing efficient care for a lower total payment through coordination is one of the strategies of accountable care organizations (ACOs), in which a group of varied providers are given financial incentive to provide care at reduced cost.

“ACOs are a new way of trying to provide cost-effective care and efficient care by creating large organizations that have a financial incentive to be streamlined,” Dr. Alam said. “To the extent that there’s greater efficiency in the market, that’s a good thing. We should be cost-conscious, careful, and provide patients with excellent care. That’s true across the board in health care.”

While the structure and implementation is still in the formative stage, finding dermatology’s place in the eventual model is of paramount importance to the future health of the specialty, according to Short.

“We know that primary care is really getting on board with ACOs because there are a lot of incentives. We have started having conversations with the payers that we know are administering the ACO benefits to understand what our roles are with the ACO model and how we can get involved,” Short said. “It has been my experience thus far that the ACOs are looking for specialists to join, and the participation agreements are very vague in terms of obligations from the specialist or the specialist share in the cost savings. On the flip side, I have reviewed some of the ACO agreements with primary care that are very specific in terms of cost savings, bonus payments for achieving specific goals such as a percent of women over the age of 40 that have had their annual mammogram, as well as the percent of medications written/dispensed as generic versus brand.

The theme of these more comprehensive agreements is that they are centered on prevention and cost savings, so dermatologists should be thinking in the same regard.”

In reaching out to ACOs, Short said, her practice is attempting to be proactive while there is still time to explore options and consider a number of relationships.

“We’re trying to get into the system early, so we don’t miss a beat where referrals are concerned. We do believe that ACOs could potentially find more [patients being treated for skin conditions] in the primary care office than sent to the specialists. We constantly monitor our referral numbers to watch out for any signs that ACOs are turning inward for skin conditions instead of continuing to refer out.” If the numbers start to shift, Short said, “We would make every effort to listen to primary care to understand how our practice could modify our practices to gain their assurance of referring patients. Furthermore, we would offer to work as a partner, and teach the primary care providers some of the basic dermatology procedures, in an effort to secure the more complicated cases.”

Further underscoring the themes of consolidation and nationwide macroeconomic change in the health system, health insurance exchanges are required to be fully certified and operational by Jan. 1, 2014 under the Affordable Care Act. For physicians already dealing with significant patient loads and wait times, the potential increase in traffic might prove stark.

“The most apparent effect of health insurance exchanges will be a lot more patients to your door,” Short said. “If you’re a practice that is struggling from a volume standpoint, that’s a winning scenario. Though those rates are going to be at Medicaid level in many aspects, especially for subsidized plans,” she said. dw
Some dermatologists finding new MOC journey more helpful in practice
Think of Maintenance of Certification (MOC) as a long car ride with your kids. The destination, in this case, is the land of improved patient outcomes. Are we there yet? Not yet, but we expect to be there soon.

Seven years after the American Board of Dermatology (ABD) began its MOC program, progress has been slow, but steady. Simply put, data takes time to accumulate. But once it emerges, the data is expected to link MOC participation with improved physician performance and patient outcomes as it has in other specialties.

“Maintenance of Certification takes on a variety of competencies that, in theory, make people better physicians,” said Robert S. Kirsner, MD, PhD, vice chairman of dermatology at the University of Miami Miller School of Medicine and chair of the American Academy of Dermatology’s Council on Education and MOC. The six core competencies, adopted by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties, are professionalism, patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice. >>
Routine maintenance

The idea is that physician performance, which is the process part of MOC, will lead to better outcomes, whether that means fewer deaths from melanoma or improved quality of life for patients with acne, Dr. Kirsner explained. “While we’re beginning to scratch the surface on process, we still have a long way to get true outcomes data for dermatology.”

BEHIND, BUT MOVING FORWARD
This specialty is behind the others when it comes to quality data for several reasons. There are fewer dermatology-specific quality measures and guidelines. To date, many dermatologists do not participate in disease registries or have an electronic health record, hampering their ability to readily collect data about their practice that can be used to assess quality measures. Much of this has to do with the fact that dermatology is a relatively small specialty.

“The main reason we don’t have the data for improved patient care is that we don’t have a large number of national quality metrics or participants like those specialties that manage the big-ticket chronic diseases such as hypertension and diabetes,” said Erik Stratman, MD, chair of the department of dermatology at the Marshfield Clinic and past chair of the Academy’s Council on Education and MOC. It takes a while to accumulate data on enough patients treated for melanoma, for example, to determine whether an intervention implemented as part of MOC activities led to an improvement in physician performance or patient outcomes, he said, adding, “This information will come, and I think the leadership of AAD will help bring it forward.”

While the number of dermatologists available to contribute to the specialty’s data is not expected to grow, their rate of participation in MOC is. Beginning in 2006, successfully certifying and recertifying dermatologists were automatically enrolled in the MOC program. According to an article in the July issue of the *Journal of the American Academy of Dermatology*, it is anticipated that by 2015, nearly all board-certified dermatologists will be entered into the MOC program (2013; 69:1-11).

Additionally, the AAD may be poised to become the leader at demonstrating the impact of MOC on improving patient care because it manages one of the largest groups of approved part 4 activities that address the assessment of practice performance, Dr. Stratman said.

WHO HAS TO DO MOC?
Dermatologists who wish to remain certified by the American Board of Dermatology have to complete a maintenance of certification cycle (see sidebar for requirements) every 10 years —unless they hold a lifetime certificate. Dermatologists who completed their residency after 1990 hold time-limited certificates and are required to participate in MOC in order to remain board-certified. Dermatologists with lifetime certificates may still participate in MOC; so far only 8 percent are (*N Engl J Med.* 2010;362:948-52), perhaps because some states are considering allowing board-certified physicians to use MOC to maintain their licenses. (Medical societies, including the American Medical Association, favor states allowing physicians to use MOC to meet licensure standards, but oppose making it the only path to licensure.)

THE TIME AND COST
Of course, the MOC program is not without its critics, who say that it is too time-consuming and costly. “A key part of MOC is understanding that it’s critical for physicians to commit their time to ongoing or continuous learning to provide the best possible care for their patients,” said Nicole DeYampert, MD, a staff dermatologist in the Department of the Army, who is a Lean Six Sigma Black Belt. She points out that medical knowledge changes rapidly and it’s imperative that physicians keep current. Moreover, the literature shows that:

NEED ASSISTANCE? JUST ASK
Although the American Board of Dermatology administers MOC, the AAD offers members information, tools, and services to help dermatologists fulfill MOC requirements. The Academy’s goal is to try to help dermatologists improve their performance and patient outcomes in the easiest and most efficient way, noted Robert Kirsner, MD, PhD. “The Academy is only a phone call or click away to getting information,” he added. (Visit www.aad.org/education/moc to learn more.)

But don’t wait until the end of an MOC period to get started, particularly on part 4 activities, urged Erik Stratman, MD. And don’t hesitate to contact the ABD, whose staff is very helpful and ready to answer all levels of MOC questions. Additionally, he noted, the MOC tab on the ABD website (www.abderm.org) contains a listing of all local, regional, and national products and services designed to meet one’s MOC needs.
• the quality of care physicians provide deteriorates with time,
• traditional continuing medical education (CME) does not improve physician performance,
• physicians do a poor job of assessing their own skills, and
• there is variation in practice among physicians.

Dr. DeYampert noted the AAD has taken some measures to decrease the time commitment for dermatologists. For example, staff members are able to supply the clinical practice data for the Performance Improvement CME (PI CME) modules that fulfill part 4 while the dermatologist participates in the actual activity. Dr. Stratman believes that the most time-consuming activity is associated with the PI CME. But he points out that dermatologists can earn as many as 20 CME credits for this activity, and that it is far more closely connected to making real or lasting changes in practice than traditional CME.

Because the MOC program is designed to engage physicians in looking at their current state of knowledge and performance in areas relevant to clinical practice in an ongoing and deliberate fashion, he continued, it is more likely to decrease or prevent a decline in skills, knowledge, and performance than more passive CME, such as listening to a lecture. “By engaging the physician to self-reflect, self-identify, and make improvement efforts, it is reasonable to think that skills would be maintained or even enhanced in some cases,” Dr. Stratman said.

Over time, dermatologists will get more comfortable with interactive CME, Dr. DeYampert added.

Regarding the cost, she said that the AAD has worked diligently to keep costs nominal and that the ABD offers both a patient and peer communication survey for free. Dr. Stratman believes that as more options are developed each year by more organizations, the price for MOC activities will remain reasonable.

If MOC shows what it is expected to, that it improves patient outcomes, then the time and cost will be worth it, and the critics will be silenced, said Dr. Kirsner, who understands the criticism because the data doesn’t yet exist in dermatology.

RELEVANCE TO PRACTICE

Critics suggest that MOC is irrelevant to practice. However, supporters question how much more relevant an activity can be when it identifies clinical gaps in one’s own practice and/or compares oneself to colleagues.

Part 2 self-assessment activities allow dermatologists to identify clinically relevant gaps in their knowledge base followed by instruction to improve knowledge in these various areas, Dr. Stratman said. The first self-assessment modules offered when the MOC program began were very broad, covering pediatric, medical, and surgical dermatology as well as dermatopathology, all in one module. Those may hold minimal clinical relevance to the subspecialist dermatologist, Dr. Stratman acknowledged. However, the modules currently being developed by the AAD target specific topics such as contact dermatitis and infectious disease. “The creation of subspecialty and topic area modules will decrease concerns over relevance,” he said. “The same is true of practice improvement modules; the more options there are, the greater the chance that one of the choices will be relevant for each dermatologist to use to assess his or her practice.”

Dr. Stratman acknowledged. However, the modules currently being developed by the AAD target specific topics such as contact dermatitis and infectious disease. “The creation of subspecialty and topic area modules will decrease concerns over relevance,” he said. “The same is true of practice improvement modules; the more options there are, the greater the chance that one of the choices will be relevant for each dermatologist to use to assess his or her practice.”
Dr. DeYampert points out that most dermatologists have limited control over who comes into their practices. Consequently, they should be prepared to treat a broad patient population. Using self-assessments enables dermatologists to keep current with the conditions they routinely see — and those they don’t. “The farther removed from residency dermatologists are, the fewer opportunities they have to see different or unusual cases,” she said.

Comparing themselves to their colleagues, which they do in Part 4 activities, is another way for dermatologists to ensure that they are meeting quality standards and keeping current. “Many physicians may be practicing appropriately,” Dr. DeYampert said, “but they may not be using best practices.”

Dr. Kirsner agrees. “Regardless of how good of a physician you are, you can always be better,” he said. “Many of the components of MOC challenge you to be better.”

**MOVING BEYOND MEDICAL KNOWLEDGE**

Critics argue that the six competencies (professionalism, patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice) are too overarching as they go beyond medical knowledge. But Dr. DeYampert argues that this criticism indicates a too-narrow view of medicine.

“Being a physician is so much more than having a basic understanding of disease,” Dr. DeYampert said. “It requires one skill set to make a diagnosis and treat a condition and another skill set to communicate well with patients and peers.” Dermatologists may assume all of their patients are happy, but they don’t know until they obtain feedback. The same is true for colleagues.

“The best clinicians have great skill in each of the six competency areas, even if they were not trained in the era of the competencies,” Dr. Stratman said. “How you interact with your patients, how you attempt to improve areas in which you are weak, how you serve and interact with your colleagues and those requesting your consultation, and how you navigate the often complex system of care all impact the quality of your care and how your patients experience the care you deliver.” Part 4 activities help dermatologists recognize that many care issues needing improvement have little to do with a lack of knowledge, but rather are about processes of care delivery, such as a lack of reminder systems or evidence-based template use.

The criticisms of MOC miss an essential point, Dr. Stratman said. “It is important that we transition away from MOC as a ‘check box’ activity and instead turn it into what it is meant to be: continuing professional development,” he said.

Dr. Kirsner agrees. “There are two benefits of MOC. One is that it’s a continuous process, not an episodic one. The second is that it’s more comprehensive in its approach than recertification,” he said. Many physicians spend more time worrying or having angst about participating in MOC than the time it actually takes to do it. “Since we have to do this process if we want to maintain certification, I would encourage dermatologists to spend less time worrying about whether they should do it as opposed to doing it and trying to learn the most they can from it.”

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**MOC REQUIREMENTS FOR DERMATOLOGISTS**

The four components of MOC are as follows:

**Part 1: Evidence of professional standing**

The first MOC component simply requires ABD diplomates to hold a valid, full, and unrestricted license to practice medicine or osteopathy in the candidate’s state, territory, or province.

**Part 2: Evidence of commitment to lifelong learning and periodic self-assessment**

This component includes three aspects:

- Earn 25 AMA PRA Category 1 Credits™ in dermatology-related activities per year
- Complete 300 self-assessment questions during the 10-year MOC cycle
- Complete one patient safety module during the 10-year cycle

**Part 3: Cognitive expertise**

The third component requires successful completion of an examination. Beginning in 2011, the ABD moved to a secure, proctored, closed-book examination that is administered at Pearson Vue testing centers in the United States and Canada. The examinations are administered annually and diplomates may take the examination in the eighth, ninth, or 10th year of the MOC cycle.

**Part 4: Evaluation of practice performance**

The fourth component includes two aspects:

- Complete an evaluation of practice performance twice during the 10-year cycle. This evaluation will include completion of a practice assessment/quality improvement program approved by the ABD.
- Complete a patient communication survey and a peer communication survey twice during the 10-year cycle: one set by year five and again by year 10.
As the health care environment changes, dermatology faces a variety of challenges, along with opportunities that may present themselves if we position ourselves appropriately. To determine how the organization should prepare to address both, the American Academy of Dermatology Association held a Health Policy Strategic Retreat May 31 and June 1 at the AADA’s Washington, D.C., office.

The retreat included participants representing all elements of our specialty and included presentations on the changing landscape of health care by Jack Lewin, MD, previously the CEO of the American College of Cardiology, and Jack Resneck Jr., MD, a member of our Board of Directors and the former chair of the Council on Government Affairs, Health Policy, and Practice. Discussions focused on what the Affordable Care Act means for medicine in general and what it might mean for dermatology specifically. Among the points they noted:

• The U.S. spends more than other countries for health care, but outcomes are equal to or worse than those countries.
• New payment models incentivize patients to seek the best price for care, and every specialty will have to find ways to reduce costs. The AADA must gather data to demonstrate the unique value of care by a board-certified dermatologist.
• Dermatologists represent less than 2 percent of physicians, but we project a voice greater than our size through our involvement in organized medicine. Dermatologists have to be at the table at the local, state, and federal levels to ensure our voice is heard as decisions are being made.
• How we are perceived by other physicians and policy makers is critical and we need to acknowledge that we have an image problem. We are viewed by some as very smart, but overpaid and with an easy life. We need to take every opportunity to communicate the work we do within the community. Every opportunity to do a hospital consult, see a patient for a colleague, or volunteer at a cancer screening clinic or indigent clinic is a chance to show our specialty in a positive light. Every opportunity to do work for local, state, or regional medical societies is an opportunity to demonstrate the worth of our specialty in a changing world.

At the retreat, participants focused the challenges and opportunities ahead by working through possible scenarios for the future. Scenario planning is an engineering tool often used to prioritize work and resources in an uncertain environment. Workgroups considered the possibilities for dermatology under several different scenarios, including one where primary care cements a role as the hub of the health care system, another where accountable care organizations dominate the landscape, and a third where value-based purchasing becomes the prevailing paradigm. Each scenario helped us to identify things that need to be accomplished in order for dermatology to flourish.

Ultimately, the scenario planning produced six areas critical to the future success of our specialty. They include:

• Guidelines, metrics, and outcomes: Defining and demonstrating value by creating a set of quality metrics that facilitate meaningful outcomes research.
• Patients: Understanding their experience, increasing satisfaction, and improving adherence to treatment.
• Primary care: Collaborating to develop mutually beneficial relationships.
• Purchasers: Making the case for the value of dermatology.
• Team care business models: Developing best practices in dermatologic care coordination.
• Telemedicine: Advancing appropriate triage and teledermatology.

The Board of Directors, the Priorities Committee, and AADA staff will review the six areas and determine the best way to approach each of them. You’ll be hearing more about these plans and their advancement in the months to come.

Thank you to the planning team, which included our president-elect, Brett Coldiron, MD; the chair of the Council on Government Affairs, Health Policy, and Practice, Marta Van Beek, MD, MPH; the chair of our Workgroup on Innovative Payment and Delivery, Kathryn Schwarzenberger, MD; and our new executive director and CEO, Elaine Weiss, along with other key staff in our Washington, D.C. and Schaumburg offices. The outcomes of this retreat will help us chart a course that helps ensure the future of our specialty. dw
Applicants sought for translational biotechnology fellowship in France

The new AAD Translational Biotechnology Fellowship at Galderma is an opportunity for a dermatologist to advance science and explore career options within a pharmaceutical industry setting. The one-year fellowship provides a chance for a dermatologist to work in drug development and translational medical research at Galderma’s facility in Sophia Antipolis, France.

The fellowship will begin in fall 2014. The Academy will provide the selected candidate with a $150,000 stipend to cover costs during the term of the fellowship, including but not limited to travel, housing, food, insurance, and other applicable costs and expenses. Galderma will contribute the necessary staff, materials, and resources to support and mentor the fellow.

Applications for the fellowship are being accepted until Oct. 15, 2013. Detailed online submission information is available at www.aad.org/biotechfellowship; for more information contact Allen McMillen at amcmillen@aad.org.

– ALLEN MCMILLEN

Ann Haas, MD, appointed alternate AAD CPT advisor

ANN F. HAAS, MD, HAS BEEN appointed to serve as the Academy’s alternate advisor to the AMA CPT Advisory Committee. Her term runs through May 2016. “I am looking forward to joining the other members of the dermatology CPT team in making sure that our dermatology codes are timely, accurate, and well-defended,” she said.

The AMA CPT Advisory Committee has several responsibilities. It meets three times a year; its members serve as resources to the CPT Editorial Panel, which also meets three times a year to consider changes and updates to CPT codes, guidelines, and conventions. Advisory Committee members also provide the panel with advice regarding coding and nomenclature questions relevant to their specialty. Advisors also provide documentation regarding the medical appropriateness of medical and surgical procedures under consideration for inclusion in CPT, suggest revisions to CPT, and help to create educational materials related to CPT. – RICHARD NELSON

Screening volunteers needed

SINCE 1985, DERMATOLOGISTS have conducted more than 2.3 million free screenings and detected nearly 228,000 suspicious lesions, including more than 25,000 suspected melanomas. Although sun safety is usually top of mind during summer months, organizing a free skin cancer screening in the fall and winter months reminds the public of the importance of year-round sun protection. Visit www.aad.org/scs to learn more about the program or to order free materials to help you conduct your screening.

We need your help! You can make a difference and help put a SPOTlight on skin cancer in your community. Help us reach more people by educating your community, family, and friends about the ways they can prevent and detect skin cancer. Visit www.SpotSkinCancer.org to learn how. The National Skin Cancer Screening Program and SPOT Skin Cancer™ are supported in part by Sustaining Fund contributions.

– YVONNE URBKAS
Tech-based teaching grant applications sought

THE ACADEMY’S SULZBERGER INSTITUTE for Dermatologic Education Committee is interested in receiving proposals for technology-based teaching applications to further clinical education in dermatology and dermatologic surgery. Proposals from individuals with a clear association to dermatologic organizations will be given preference; however, all proposals to develop technology for dermatology education will be considered. The deadline for submission of requests is Jan. 10, 2014. Successful applicants will be notified of their award by June 2014 with funding to begin in 2014.

Grant categories include:

- Seed grants (up to $60,000 per year) for a period of one to two years.
- Small grants (up to $5,000) for a period of one year.
- Tuition support (up to $7,500) for education and accredited technology courses.

Proposals will be evaluated based on:

- Perceived value of the project to dermatologic education;
- Practical and innovative use of audiovisual and technology methods within the scope of the proposal;
- Clarity and completeness of the project abstract; and
- Willingness to grant the Academy the right of first refusal to partner with the grant recipient in the development and marketing of any potential products which may result from the research effort.

View application criteria and apply online at www.aad.org/education/awards-grants-and-scholarships/sulzberger-institute-grant. For more information contact Meredith Rund at mrund@aad.org. - MEREDITH RUND

Are you ready to lead?

THE AMERICAN ACADEMY OF DERMATOLOGY’S Nominating Committee will be accepting nominations for the 2014 AAD Election beginning Aug. 7 for officers and directors of the Board of Directors, and Nominating Committee member representatives.

Consider adding “Submission of Potential Nominees for 2014 AAD Election” to your upcoming local, state, and regional society meeting agendas. Reference materials to include with your agenda are available online at www.aad.org/aadnominations.

Starting Aug. 7, nominations and letters of support may be submitted online at www.aad.org/aadnominations or via email at callfornominations@aad.org. Nominations may also be mailed to:

Attn: Call for Nominations
Nominating Committee
American Academy of Dermatology
930 East Woodfield Road
Schaumburg, IL 60173-4729

For more information, contact Joan Tenut at callfornominations@aad.org or (847) 240-1046. -JOAN TENUT

DATEBOOK
WHAT’S COMING UP

| AUG 7 | Nomination submission opens for 2014 AAD election. See www.aad.org/nominate. |
| SEPT 1 | Registration scholarship applications due from international dermatologists for 2014 Annual Meeting. See www.aad.org/registrationscholarship. |
| SEPT 16 | Leadership Forum/ Academic Dermatology Leadership Program applications due. See www.aad.org/idp. |
| OCT 15 | Nominations due for humanitarian and specialty service awards, 2015 Annual Meeting named lectures. See www.aad.org/awards. |
Army dermatologist promoted to Major General

In recognition of excellent service in the U.S. Army Medical Command, dermatologist Nadja West, MD, has received a promotion to Major General, becoming the first African-American two-star general in the command. Dr. West came to dermatology following an initial residency in family medicine, completing two years of dermatology training at Fitzsimmons Army Medical Center and finishing at the University of Colorado when the center was closed. She said that her interest in dermatology began when she was still a medical student at George Washington University medical school.

“At George Washington, I had a rotation with Dr. Carmen Myrie Williams, and her enthusiasm and interest made it an interesting rotation that I thought could be a great specialty for me,” Dr. West said. “What really locked me on dermatology was the rotation I had with a military physician, Al Harrington, who was the dermatologist at Fort Benning during my family medicine residency. That rekindled my desire for dermatology. We have the opportunity to see and treat patients from all types of unique backgrounds.”

Following the completion of her dermatology residency, Dr. West served as the chief of dermatology at the U.S. Army Hospital in Heidelberg, Germany, as well as the division surgeon for the 1st Armored Division in Bad Kreuznach, Germany. Following that, she served in high level positions at Army medical facilities in Seoul, South Korea, Fort Eustis, Va., and Bethesda, Md. She is now serving as the Deputy Chief of Staff for the Army Medical Command.

“This new job will allow me to help improve the overall health of all our service members. Not just our soldiers, but our sailors, airmen, Marines, and coast guardsmen,” Dr. West said. “This is an outstanding opportunity to promote skin-smart behaviors.”

Media Highlight

Through May 2013, print and broadcast stories on dermatology generated more than 943 million impressions, with more than 40 percent of this coverage focused on skin cancer. This is due to Academy members contributing their time by participating in interviews with journalists.

In the June issue of *Family Circle* (circulation 4,143,942), “Diagnosis: Skin Cancer,” Susan Taylor, MD, Karen Burke, MD, and Debra Jaliman, MD, offer a step-by-step guide to detecting and preventing all types of skin cancer. The article also highlights the different types of skin cancer and positioning the dermatologist as the expert. You can find other media coverage in the Academy’s monthly Media Update newsletter available in the Academy’s Media Relations Toolkit at www.aad.org/members/media-relations-toolkit. Media Update can keep you current on the stories your patients may see in the media and ask you about when they visit your office. – ROSE HOLCOMB

Members Making A Difference: Karolyn Wanat, MD

UNIVERSITY OF IOWA DERMATOLOGIST

Karolyn Wanat, MD, has long been interested in building relationships with her community. As a child, her parents constantly involved the family in volunteer work. As a dermatologist, she has participated in the Academy’s Resident International program in Botswana, and recently worked with Puentes de Salud during her residency to help offer care to the underserved Hispanic population in Philadelphia.

“When I get back from the clinic, I feel so energized. Volunteering gives me back so much more than I give.”

• In choosing her residency program, Dr. Wanat said that she specifically searched for a program that offered local and international volunteer outreach. Even still, she said, the level of volunteerism at the University of Pennsylvania, where she eventually landed, left her floored.

• “We have such amazing role models in dermatology — Dr. Carrie Kovarik, Dr. Bill James, and a host of others — that make it easy to become involved in making a difference,” she said.

• Following her trip to Botswana, Dr. Wanat spent time interpreting the pathology from the cases seen on the trip. Interacting with and supporting the residents in that country, she said, made for a supremely rewarding experience.

• During her residency, Dr. Wanat helped implement a monthly dermatology clinic at the Philadelphia nonprofit Puentes de Salud. When the level of patient demand became clear, she said, she and her colleagues began implementing a weekly teledermatology program there as well.

• “Most of the patients at Puentes de Salud are immigrants with no access at all. We recently had a woman diagnosed with a melanoma early. She brought her children in to get checked as well, and we were able to treat her and educate her about skin health and using sunscreen,” Dr. Wanat said. “Getting to know her family and seeing how our ability to provide care impacted that family was a powerful moment.”

– JOHN CARRUTHERS

To nominate a physician, visit www.aad.org/membersmakingadifference.
**Closure Course, Fundamentals of Mohs Pathology, and Fundamentals of Mohs Surgery**  
*Fundamentals of Mohs Pathology is new this year!*

**DoubleTree Hotel San Diego, Mission Valley**  
San Diego, California

**October 28-30, 2013 – Closures Course for Dermatologists**
Course prerequisite is basic experience in cutting and sewing skin, with program designed to take dermatologists to the next level of dermatologic surgery practice. This is an intense learning experience in closure considerations for the surgeon with a primary interest in closing surgical defects. It will feature practical techniques, site specific discussions, and numerous reconstruction “pearls,” based upon presenter’s extensive derm surgery experience.

**October 29, 2013 – Fundamentals of Mohs Pathology**
This one-day course is tailored to the needs of clinicians performing Mohs surgery or desirous of performing Mohs surgery, who are returning to dermatopathology after a period of years or whose training may never have included significant exposure to skin pathology. Our goal is to familiarize attendees via multiple microscopic presentations with the most common entities treated by Mohs surgery: basal cell carcinoma and squamous cell carcinoma. The course will cover all variations of these two common cancers, as well as common mimics often found within surgical tissues usually excised during Mohs procedures – including normal histologic structures and inflammatory and reparative findings. Course work will include study sets viewed by attendees using high quality Mohs microscopes and didactic lectures by faculty dermatopathologists.

**October 31-November 3, 2013 – Fundamentals of Mohs Surgery for Dermatologists and Mohs Technicians**
Developed as a comprehensive introduction to Mohs surgery, the course provides an overview of Mohs indications, mapping techniques, office set-up and instrumentation, and interpretation of Mohs histopathology. Instruction in key concepts is facilitated by lectures, “pearls” discussions, interactive Q&A sessions, video microscope demonstrations, and challenging microscope electives. The Mohs technician program will feature hands-on training in Mohs laboratory techniques and incorporate important safety and regulatory guidelines and updates. A high faculty-to-student ratio helps ensure rapid skill development and advancement, and allows for discussion of critical troubleshooting techniques relative to tissue processing and slide preparation.

**Annual Clinical Symposium – Dermatologic Surgery: Focus on Skin Cancer**

**Hyatt Regency Tamaya Resort & Spa**  
Santa Ana Pueblo, New Mexico

**Memorial Day Weekend, May 22-25, 2014**
Top experts in the field will provide updates on a wide range of dermatologic surgery and Mohs surgery topics. Interactive forums and panels will discuss appropriate repair strategies for a variety of surgical wounds and innovative approaches to melanoma treatment. Both Mohs and non-Mohs cases will be featured in the microscope laboratory. Mohs support personnel accompanying physicians to the meeting will participate in a standalone session dedicated to important technical topics and updates, discussion of special advanced Mohs laboratory techniques, and sharing of patient care concerns encountered on a regular basis in their work.

**AMA PRA Category 1 Credit Available**

For additional information regarding ASMS educational activities, membership opportunities, and patient resources, please contact:

Novella Rodgers, Executive Director  
American Society for Mohs Surgery  
5901 Warner Avenue, Box 391  
Huntington Beach, CA 92649-4659  
Tel: 800-616-2767 or 714-379-6262  
Fax: 714-379-6272  
www.mohssurgery.org  
excdir@mohssurgery.org
Wonderful Dermatology opportunity in Central Florida for BC/BE Dermatologist

Central Florida Dermatology and Skin Cancer Center (CFD) is seeking a BE/BC Dermatologists and/or Derm-trained Dermatopathologist, interested in joining a successful and growing practice. CFD serves a growing community with offices in Winter Haven and Lake Wales. A physician who joins the practice will be busy immediately. We provide the very best for our patients through personalized patient experience and a world class operating environment.

A qualified candidate will enjoy a professional career that will allow for a balance of work-life and personal of personal interest which are unique to the Winter Haven/Lake Wales area. This position offers a competitive salary structure, productivity bonus, health and dental benefits, partnership opportunities, a generous PTO schedule, malpractice coverage, CME, and license and membership dues.

CFD is currently staffed with a fellow trained Mohs surgeon, a B/C Dermatologist, and four mid-level extenders. We have an in-office Mohs and Biopsy lab. The lab is CLIA certified and has CAP accreditation. CFD has secured a highly respected reputation in the Central Florida area, and is considered a go-to resource for Dermatology and Dermatological-Surgery care in the area.

We are seeking a highly motivated individual who has a strong work ethic, is conscientious, ethical, and committed to providing excellence in care. We are seeking individuals who have a strong interest in practicing medicine in the Central Florida area.

Please call Dan Lackey at (863) 293-2147 opt. 7, or email CV to Daniel@centralfldermatology.com. Visit us on the web at www.centralfldermatology.com.

CFD's office is within the beautiful Winter Haven/Lake Wales area of Central Florida. This area is well known for its warm winters and mild summers. A physician who joins the practice will be busy immediately. We provide the very best for our patients through personalized patient experience and a world class operating environment.

A qualified candidate will enjoy a professional career that will allow for a balance of work-life and personal of personal interest which are unique to the Winter Haven/Lake Wales area. This position offers a competitive salary structure, productivity bonus, health and dental benefits, partnership opportunities, a generous PTO schedule, malpractice coverage, CME, and license and membership dues.

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Please call Dan Lackey at (863) 293-2147 opt. 7, or email CV to Daniel@centralfldermatology.com. Visit us on the web at www.centralfldermatology.com.

Cambridge Health Alliance Dermatology

Cambridge Health Alliance (CHA) is a nationally recognized, award winning public health system and we are currently recruiting dermatologists to establish a Dermatology Division within the Department of Medicine. CHA is a teaching affiliate of both Harvard Medical School and Tufts University Medical School.

Our well respected health system is comprised of three campuses and an integrated network of both primary and specialty care practices in Cambridge, Somerville and Boston’s Metro North Region. As we transition to becoming an Accountable Care Organization, dermatology services will be essential to the success of our Patient Centered Medical Home Model.

These positions are primarily clinical and will practice general dermatology in an ambulatory setting as well as inpatient and emergency department consultations. For the right candidate, leadership opportunities exist and we will consider either PT or FT. Ideal candidates will be BC, possess two years of post residency experience and substantial interest in building a Dermatology Division, developing quality improvement projects, tele-dermatology services, as well as curriculum development for both medical student and resident education. Candidates must possess excellent clinical/communications skills, commitment towards our multicultural, underserved patient population and a strong interest in teaching. Ability to collaborate and work in a multidisciplinary team environment is required.

At CHA we offer a supportive and collegial environment with a strong infrastructure— including an EMR system, as well as the opportunity to work with dedicated colleagues committed to providing high quality health care to a diverse patient population. Excellent opportunities exist for teaching medical students/residents, and we strongly encourage both women and minorities to apply. Please forward CV’s to Laura Schofield, Director of Physician Recruitment, Cambridge Health Alliance, 1493 Cambridge Street, Cambridge MA 02139. Telephone (617) 665-3555, Fax (617) 665-3553 or via e-mail: Lschofield@challiance.org, EOE. www.challiance.org

New Hampshire

We are seeking a part or full time Dermatologist to join our group of ten Board Certified Dermatologists in a professionally run practice with Dermatopathology, Mohs, Medical Aesthetics, and consulting facial plastic surgeon. This opportunity would allow a highly qualified dermatologist to practice with excellent support staff in a collegial practice in New Hampshire with competitive salary, benefits and practice ownership. For more information please contact Glenn Smith, MHA, Administrator and Chief Operating Officer, at (978) 610-3701 or email to gsmith@apderm.com.

Please contact Glenn Smith, MHA, Administrator and Chief Operating Officer, at (978) 610-3701 or email to gsmith@apderm.com.

Please contact Glenn Smith, MHA, Administrator and Chief Operating Officer, at (978) 610-3701 or email to gsmith@apderm.com.

www.apderm.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 christine@greenbergcosmeticsurgery.com.

NEW YORK
FT/PT BC/BE dermatologist needed to join as associate. Excellent opportunity to join busy Plastic Surgery solo practice on LI. Forward CV to christine@greenbergcosmeticsurgery.com.

PORTLAND, OREGON
The Portland Clinic, a large partner-owned multi-specialty clinic, is seeking a BC/BE general dermatologist to join our eastside location. Please contact Jan Reid at (503) 221-0161 x4600 or email jreid@tpcllp.com.

NORTHERN VIRGINIA
Unique opportunity for a business oriented, motivated BC/BE dermatologist to take over or being partner of a well-established, highly respected integrated dermatology practice. Located in Tyson Corner of Northern VA, suburb of Washington DC. Practice offers entire spectrum of general/pediatric/es-thetic dermatology, with Palomar IPL/Fractional. Please send CV and a short bio to thdf402@gmail.com.

WASHINGTON DC
Seeking a full/part time dermatologist to provide medical dermatological care. Please call office manager for more information (202) 965-7546 or info@cosmeticskininstitute.com.

PROFESSIONAL OPPORTUNITIES

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SALES INFORMATION

UPCOMING DEADLINES FOR FUTURE ISSUES:
October ......................August 23
November ..............September 27
December .............October 25

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For 15 years, the American Academy of Dermatology has partnered with Major League Baseball and the Major League Baseball Players Association on the Play Sun Smart™ program to raise awareness about skin cancer. In 2013, rather than choosing a single spokesperson for the program, the partners launched the campaign with a series of in-ballpark events. Awareness-raising activities took place at every game across the country, 16 in all. Activities included pregame ceremonies, PA announcements about sun safety during the games, reminders to reapply sunscreen, and a sun-safety Jumbotron race. At some parks, a skin cancer survivor threw out the first pitch; others had the Play Sun Smart logo stenciled on the field. Many announcers wore a Play Sun Smart pin that was visible during TV broadcasts of the games, extending the event’s reach outside the ballparks.

Look below for a few stats from this year’s campaign. To learn more about Play Sun Smart, visit www.aad.org/skin-conditions/aad-programs/play-sun-smart. - RICHARD NELSON

**SUN-SAFETY AWARENESS ON THE JUMBOTRON**

15 teams participated in the June 2 launch.
30 teams conducted team skin cancer screenings.
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