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DEAR READERS,

Finding your sweet spot...seems like the perfect expression to think about in February.

The first time I heard this expression was in sports. My coach — I was doing a bunch of speed skating at the time — used it to refer to that most perfect form where resistance in skating would be at the minimum, and hence you could move the fastest. It always seemed to me to be the art of trying to defy nature and outsmart her gravitational forces. In essence, it was what allowed you to skate your best. I found it a sort of scary spot, but exhilarating as well. I've since often thought of this concept in other parts of my life. Like the moments I've pushed myself in my career. Again I felt the same adrenaline rush as I'd realize that I could push my boundaries a bit further, thereby expanding my horizons. Not always a comfortable spot and hard to reach, but always satisfying once I got there.

I like the notion of Dr. Hensin Tsao's that scientific discoveries have sweet spots too, that spot where we can outsmart one of our adversaries, cancer. His formula about getting there really intrigued me. The three parts are: the need to scientifically identify the target, develop the ability to interrupt what is malfunctioning, and ensure an economically viable solution, so that companies will develop medications that meet those specifications. Sweet indeed to think that as personalized medicine comes of age we will have drugs that allow us to turn cancer into a chronic disease that can remain under our control for decades. The early progress of our recent weapons against non-melanoma skin cancers and melanoma are exciting, but the subsequent recurrences are frustrating. Still, it is so exciting to think that we may be on the verge of this new ability of science to move medicine to the next level. Sort of like my skating...it takes so much to become better than we already are, but the effort is always well worth it.

This month I am happy to report that we will now be running our Legally Speaking column every month and adding a new author to the mix. You, our readers, have clearly liked this information. We noticed, though, that our view was from on high. So the staff and I thought that you might like some legal views from down in the trenches too. Cliff Lober, MD, JD, will provide this information. We noticed, though, that our view was from on high. So the staff and I thought that you might like some legal views from down in the trenches too. Cliff Lober, MD, JD, will provide this information. I think that as personalized medicine comes of age we will have drugs that allow us to turn cancer into a chronic disease that can remain under our control for decades.

More sweet spot this month; I am excited about our practice management column. Included in Rachna Chaudhari's piece is a monthly calendar of tasks to keep our practices flowing. As a devoted list-maker, I find that anything that winds up on my lists actually has a pretty high likelihood of getting done. So, her list of what needs doing to manage our practices broken down month by month really appealed to me. The article reminds us that February is the month to plan your budget for 2013. While I can't really say that budgets in general thrill me, I do know that I get a certain peace of mind once they are done since I can then tell if I'm on track with my plans or not. So, despite the pain of its assembly, I encourage you to get going if you've been functioning without one! And take a glance at Rachna's suggestions for the rest of the year too while you are at it.

And so, in closing I will wish you each a very sweet February. Happy Valentine's Day! Enjoy your reading!
“Although implementation of the ACA will continue, significant opportunities to influence its direction remain.”

features

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BY ALEXANDER MILLER, MD

Complex repairs

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.

You excise a basal cell carcinoma on the cheek. In order to optimize functionality and cosmesis you undermine the surgical edges and suture the wound in a layered fashion. Do you bill for an intermediate repair (layered closure) or a complex repair?

This type of question often challenges dermatologists and their coding and billing staff. Complex repair (CPT codes 13100 – 13153) is defined as a repair that requires more than layered closure, such as scar revision, debridement (as of traumatic lacerations), extensive undermining, stents, or retention sutures. In dermatology the overriding use of the code is for repairs of surgical excisions of malignant and benign tumors. Such repairs may require extensive undermining or retention sutures.

WHAT IS EXTENSIVE UNDERMINING?
The American Medical Association Current Procedural Terminology (AMA/CPT) does not define the term “extensive undermining.” Interpretation of extensive undermining is left to the judgment of the surgeon to determine, and the payer to apparently confirm via reimbursement for the procedure. Any attempt to further define extensive undermining risks imposing rigid and impractical values that would not reflect real-life work. There are, however, some common-sense concepts that may aid in coding.

Clearly, the breadth of undermining done on a nose or eyelid will be different from the amount of undermining needed on a scalp or back to fulfill the concept of extensive undermining. It is up to the surgeon to ethically decide when undermining has reached the “extensive” category. The billing of complex repair codes has steadily increased over the past several years. For example, according to Medicare data for 2011, utilization of CPT code 13101 (Repair, complex, trunk; 2.6 cm to 7.5 cm) increased by almost 9 percent from 2010. Continued high utilization risks regulation and focused chart audits. To report complex repair codes, the medical record must document that extensive undermining was done and should provide justification for its need.

Retention sutures are occasionally necessary for wound closure. The characteristic patient is elderly and has a large lesion excised from an upper or lower extremity with severely photodamaged and atrophic skin. Such atrophic skin may be too thin to hold buried dermal sutures and will readily rip. Yet, due to tension across the excision wound, simple interrupted stitches alone would also tear the skin and would fail to hold the wound shut. Exteriorized broad horizontal mattress retention sutures placed far from the wound edge and padded with a material of choice to prevent notching are successfully used to reduce tension and approximate the skin edges.

HOW DO STENTS RELATE TO DERMATOLOGY?
The present-day concept of “stent” usually refers to a material inserted into a tube-like body structure, such as a vessel or a duct, for the purpose of maintaining patency of the tube. This definition does not make any sense in the context of complex repairs. Charles R. Stent, an English dentist, invented and patented a moldable dental impression compound in 1856. This same compound was subsequently used by a Dutch plastic surgeon during World War I for the fixation of intraoral and cutaneous grafts and called a “stent.” The term has stuck and is used widely. You may read more about the history of “stent” at www.fauchard.org/history/articles/jdh/v49n2_July01/charles_stent_49_2.html.

For dermatologic purposes, a stent is a moldable material used for tissue compression for the purpose of holding down the tissue, such as a skin graft. Repair scenarios where a stent compression may be required would be lacerations with a partial thickness skin avulsion where the laceration itself would be sutured shut and then the partially avulsed skin draped over the dermis and fixated with a compression stent.

Complex repair codes do not include the excision of the lesion. The excision
should be billed separately with the appropriate malignant (11600 – 11646) or benign (11400 – 11446) excision code.

Finally, the repair location and the measured length of the repaired wound are used for selecting the proper complex repair CPT code. Note that when the repair length reaches beyond 7.5 cm in any location an additional code, marked by a “+” sign in the CPT, is used to specify the increased length. This add-on code specifies increments of up to 5 cm beyond a 7.5 cm closure length, and may be used in multiples to list the appropriate closure length. When more than one wound is closed in the same CPT-defined anatomical grouping, the lengths of the repairs are added together to produce the appropriate billing code. Complex repairs done on sites lying within separate CPT anatomical groupings are measured and reported separately, with the less complicated repair assigned a 59 modifier.

Example 1
You excise a cheek basal cell carcinoma with two stages of Mohs surgery, leaving a 1.5 cm diameter defect. The wound is fashioned into a vertically oriented 4 cm long fusiform shape via excisions of skin triangles bordering the superior and inferior Mohs defect edges. The wound edges are undermined to facilitate skin edge eversion and a layered repair is done. You bill 17311 and 17312 for the Mohs surgery and 13132 for the complex repair.

Incorrect. The act of undermining alone does not justify a complex repair code. The undermining has to be “extensive” to qualify for a complex closure. The excision of redundant skin required to facilitate a linear repair following the Mohs surgery is not separately billable as an excision, and by itself does not determine a complex repair, as per the CPT definition. In this scenario the undermining was minimal, and a layered repair was done. Consequently, this falls into the intermediate repair category. The length of the repair generated by the final closure determines the intermediate repair code selection, which in this case would be 12052.

Example 2
A patient has a squamous cell carcinoma excised from his thigh resulting in a 3.3 cm maximum excision diameter and a basal cell carcinoma excised from his dorsal nose with a 1.2 cm maximum excision diameter. Both are repaired linearly, with extensive undermining needed to close both surgical defects. The nasal undermining extends to the nasofacial sulcus bilaterally. The lines of closure measure 9 cm on the thigh and 3.2 cm on the nose. The bill lists 11604 for the thigh excision and 13121 plus 13122 for the complex repair along with 11642/59 for the nose excision and 13152/59 for the repair.

Correct. The excisions are billed separately, as the complex repair codes do not include valuation for the excisions. Since the complex repairs are located on separate anatomic site CPT groupings (scalp, arms, and/or legs in one grouping versus eyelids, nose, ears, and/or lips in the other grouping) the lengths of the repairs are reported separately, with the less complicated, secondary procedure appended with the 59 modifier. Note that an add-on code, 13122, was used to specify that up to an additional 5 cm of thigh closure length was done beyond the 7.5 cm length specified by the primary code, 13121.

Example 3
A melanoma is excised from the left arm with a 1 cm margin producing a 3.5 cm maximum excision diameter that, after extensive undermining in order to facilitate skin edge apposition, is closed linearly in a layered fashion, resulting in a 9.5 cm length of repair. A separate atypical nevus is excised from a tight scalp and the 1.9 cm maximum excision diameter defect requires broad, extensive subgaleal undermining in order to reduce tension and allow for a layered linear repair measuring 6 cm in length. The CPT coding is as follows: 11604, excision malignant lesion, arm, 11422, excision benign lesion, scalp, and 13121 plus 13122xx for the complex repairs.

Correct. Site and tumor type-specific (malignant and benign) excision codes are listed appropriately to differentiate between the melanoma and the atypical nevus excisions. The repairs are both complex, and although located in disparate sites, they fall under the same anatomical complex repair site grouping, that being scalp, arms, and/or legs. Consequently, the lengths of the two repairs are added to determine the proper CPT complex repair code, 13121 (2.5 to 7.5 cm length) and the add-on code 13122xx indicates that two units of each additional 5 cm of closure length are billed to specify the sum total closure length of 15.5 cm. dw
Fiscal cliff deal averts SGR cut for 2013

2 PERCENT CUT DUE TO SEQUESTER DELAYED UNTIL MARCH 1

The American Tax Relief Act of 2012 (ATRA), which became law Jan. 3, included a one-year “fix” of the flawed sustainable growth rate (SGR) formula for Medicare physician payment. Dermatologists will see their Medicare claims in 2013 reflect changes due to the overall physician fee schedule, but not the 26.5 percent cut that was scheduled to take effect.

The one-year fix did not eliminate the 2 percent cut to all physician payments that was included in the Budget Control Act of 2011. Instead, the ATRA delayed the cut until March 1. Negotiations regarding how it and other cuts included in the BCA, collectively known as sequestration, would be handled were ongoing at press time, along with discussion about increasing the debt ceiling before the U.S runs out of borrowing authority in early March. The AADA will continue to work with the physician community to advocate for congressional action to avert next month’s 2 percent cut and for permanent repeal of the SGR.

Contrary to rumors, the ATRA does not repeal the in-office ancillary services exception provided under the Stark law, meaning that dermatologists can continue to provide pathology services. The law also increases the statute of limitations to recover Medicare overpayments from three to five years. — RICHARD NELSON

Academy names Elaine Weiss, JD, new executive director and CEO


“On behalf of the more than 18,000 members of the American Academy of Dermatology, we welcome Elaine Weiss as our new executive director and CEO,” said Daniel M. Siegel, MD, the Academy’s president. “The past year has been one of steady strategic and operational growth for the Academy, and we look forward to continuing our momentum and service to our members in the years to come,” he said.

“I am honored to be selected for this position with the Academy,” Weiss said. “Today, the dermatology profession is facing an array of challenges related to health care reform and the rapidly changing health care environment. The Academy has a critically important role to play in helping its members navigate through these changes while continuing to provide quality education to its members and keeping the public informed about an array of relevant health concerns and the importance of dermatologists in addressing these issues. The Academy has a reputation as a premier association and serving as its executive director and CEO is a true privilege,” she said.

Weiss joins the Academy from the Illinois CPA Society (ICPAS) where she has served as president and CEO since 2002. In 2004, Weiss was identified by Accounting Today as one of the 100 Most Influential People in the CPA Profession, and in 2012 she was honored as one of the Most Powerful Women in Accounting by CPA Practice Advisor and the American Society of Women Accountants. Prior to joining ICPAS, Weiss served as associate executive director for the American Bar Association.

Weiss also brings to the Academy a strong understanding of and experience in the world of health care related issues. In 1993, Weiss was appointed by President Bill Clinton to serve as Regional Director for the United States Department of Health & Human Services (HHS). In this position, Weiss represented the Administration on all health care policy matters and served as a liaison with Midwest governors, mayors, congressional delegations, special interest groups, and the public on health care matters as well as other HHS related initiatives and programs.

Weiss holds a bachelor of science degree from Northwestern University’s Medill School of Journalism and a juris doctorate from the National Law Center at George Washington University.
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AADA awards advocacy grants
STATE NEWS ROUNDUP
THE AMERICAN ACADEMY OF DERMATOLOGY
Association has chosen the state societies that will receive grants through the 2013 State Advocacy Grant Program. The program runs on an annual basis, and helps support state societies in their advocacy efforts to influence legislation, address regulatory issues, or lay the groundwork for these initiatives.

In all, nine state societies were awarded grants to assist in their pursuit of state legislative advocacy: the Florida Society of Dermatology and Dermatologic Surgery, the Idaho Dermatology Society, the Illinois Dermatological Society, the Indiana Academy of Dermatology, the Missouri Dermatological Society Association, the Nebraska Dermatology Society, the New York State Society of Dermatology and Dermatologic Surgery, the North Carolina Dermatology Association, and the Ohio Dermatological Association. The most common issues brought up by these societies were scope of practice, truth in advertising, and indoor tanning. The Illinois Dermatological Society will use the grant to host a free skin cancer screening for state legislators and staff at the state capitol in Springfield, Ill.

For a look at the 2013 applications from participating societies, go to www.aad.org/state-society-application-review.

PENNSYLVANIA DERMS, ALLIES, PUSH FOR TRUTH IN ADVERTISING
The Pennsylvania Academy of Dermatology and Dermatologic Surgery is working with a number of physician groups in the state to introduce legislation for the 2013 session that would require transparent disclosure of one’s degree, certification, and licensure in all advertisements. In 2010, the group successfully advocated for the adoption of legislation that required employees of state health care facilities to wear photo identification badges that disclose their name and title. – JOHN CARRUTHERS

Appeals of e-prescribing penalty due Feb. 28
MEDIUCARE WILL DEDUCT 1.5 PERCENT FROM PAYMENTS IN 2013 to providers who did not complete the required number of electronic prescriptions for Medicare patients either during 2011 or between Jan. 1 and June 30, 2012. Providers who did not do so were able to file for a variety of exemptions based on hardships such as being in a rural area without high-speed Internet access, not having access to pharmacies that accept e-prescriptions, or writing fewer than 100 prescriptions during the six-month period being measured. (Providers for whom office visit codes comprised less than 10 percent of total claims, or who had fewer than 100 claims with eligible codes, should have been automatically exempted.)

If you are having the penalty applied to your Medicare claims and believe you should be exempt from it, you have until Feb. 28 to contact the Centers for Medicare and Medicaid Services (CMS) for an informal review. Requests for such a review should be sent via email to eRxInformalReview@cms.hhs.gov, and should include the provider’s National Provider Identifier (NPI), contact information (including email, phone, and mailing address), and justification for the review request. More information about the program is available at www.cms.gov/ERxIncentive or www.aad.org/hitkit. – RICHARD NELSON
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Can mycophenolate mofetil help urticaria patients?

IN THIS MONTH’S ACTA ERUDITORUM COLUMN, Physician Editor Abby S. Van Voorhees, MD, talks with Nicholas Soter, MD, about his recent Journal of the American Academy of Dermatology article, “The use of mycophenolate mofetil for the treatment of autoimmune and chronic idiopathic urticaria: experience in 19 patients.”

Q&A

DR. VAN VOORHEES: Can you remind us about the differences between autoimmune urticaria and chronic idiopathic urticaria? What are their distinguishing features? Are there laboratory studies that should be utilized to help distinguish between these two types of chronic urticaria?

DR. SOTER: Autoimmune urticaria is a clinical subset of patients with chronic urticaria in whom there is greater pruritus (itching), a greater number of wheals, and a wider distribution of those wheals. They also appear to have more flushing and gastrointestinal features, such as nausea, vomiting, and abdominal pain. There is also an increased prevalence of autoimmune diseases in other family members such as Hashimoto’s thyroiditis, vitiligo, type 1 diabetes, rheumatoid arthritis, and so on.

These patients can also be distinguished by the fact that they have autoantibodies in their serum that, when incubated with mast cells or basophils, release histamine. This is called the chronic urticaria test. These autoantibodies are directed, for the most part, against a receptor on the mast cell called the high-affinity IgE receptor or against IgE itself. In all patients with chronic urticaria, one ought to order the chronic urticaria test. There’s now also an ELISA test available for the autoantibody against IgE.

DR. VAN VOORHEES: Are the treatments for autoimmune urticaria and idiopathic urticaria the same initially? Can you walk us through your first-line treatments for both of these conditions?

DR. SOTER: In both autoimmune urticaria and chronic idiopathic urticaria, one should always begin with the administration of oral H1 antihistamines.
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Many of my patients end up on three to five different oral antihistamines, often at doses up to four times the normal dose. H1 antihistamines are very safe, and there are European guidelines stating that four times the normal dose of second-generation H1 antihistamines is perfectly acceptable. Second, I would use leukotriene inhibitors. They’re particularly valuable for individuals with salicylate hypersensitivity, but they are also of value in patients with chronic idiopathic urticaria and autoimmune urticaria. We have two of them. The first, montelukast, is active against the receptor. The other agent, zileuton, blocks the enzyme 5-lipoxygenase. In my experience zileuton appeared to work better than does montelukast. Then I move on to the second-line agents, such as other anti-inflammatory agents, particularly colchicine and dapsone. Finally we get to the immunosuppressive agents, such as methotrexate, cyclosporine, mycophenolate mofetil, intravenous immunoglobulin, and omalizumab.

**DR. VAN VOORHEES:** Your study looked at the role of mycophenolate mofetil as a second-line agent. Tell us what you have found — was it useful? Was there a difference between the two types of urticaria? Did patients completely clear? What dose did you use and how quickly did patients respond?

**DR. SOTER:** Mycophenolate mofetil was used in 19 patients, and both autoimmune and chronic idiopathic urticaria patients were included. Autoimmune patients responded, by which I mean improved, in 91 percent of instances, as did 88 percent of patients with chronic idiopathic urticaria. However, those with autoimmune urticaria seemed to come under complete control more readily. Seventy percent of the patients with autoimmune urticaria achieved complete control, whereas only 30 percent of chronic idiopathic urticaria patients achieved complete control. One presumably can attribute this to suppression of the autoantibodies. Improvement was achieved in three of the other patients with autoimmune urticaria and four of the other patients with chronic idiopathic urticaria. There’s another paper from Israel in which mycophenolate mofetil was used, and significant improvement in urticaria was achieved.

My starting dose of mycophenolate mofetil is 500 mg twice a day, and I increase the dose by 500 mg twice a day every two to four weeks. It’s a much slower onset-of-action drug than are some of the others. The median time to initial improvement in the patients in the study was four weeks, with a range of one to nine. Complete control was achieved by 12 weeks, with a range of one to 31 weeks. The dose that achieved initial improvement was 1000 mg twice a day with a range of 1000 to 4000 mg a day. The dose to achieve complete control was 2000 mg twice a day, with a range of 1000 to 6000 mg a day. So the doses were rather high.

**DR. VAN VOORHEES:** Of those who responded to treatment with mycophenolate mofetil, were you able to stop therapy or is it necessary to continue treatment without interruptions?

**DR. SOTER:** We were able to discontinue mycophenolate mofetil in six of the patients who were in complete remission. After discontinuing the drug, complete remission lasted for two to 16 weeks, which was the end of our chart review. However, it tended to recur in all of the patients over time.

**DR. VAN VOORHEES:** Was this medication regimen well tolerated? What were the side effects that you frequently encountered? Can they be managed?

**DR. SOTER:** The side effects were few. The most frequent was involvement of the gastrointestinal tract, especially diarrhea. We could often control this, however, with use of H2 antihistamines. Very few patients required discontinuing mycophenolate mofetil because of the diarrhea. There was not an increased risk of infection. We only had one case of viral gastroenteritis, and very importantly when we monitored the patients with laboratory tests there were no changes in complete blood counts, renal function, or liver function tests. This appears to be a very safe drug; in fact, I would say it’s safer than either prednisone or cyclosporine.

**DR. VAN VOORHEES:** Do you think this medication will bump dapsone and colchicine, some of the first-line therapies you’ve listed?

**DR. SOTER:** No, I think we should still use drugs like leukotriene inhibitors, dapsone, and colchicines before we attempt immunosuppressive agents. "dw"

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**DR. SOTER** is professor in the Ronald O. Perelman department of dermatology at New York University School of Medicine. His article was published in the *Journal of the American Academy of Dermatology, 2012 (May); 66:767-70.* doi: 10.1016/j.jaad.2011.06.004.
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Current list of diplomats effective as of 11/2012
When does a doctor-patient relationship begin?

Bryan was sipping his second cup of coffee one morning in the plush law offices of James, Williston, and Hand, when the telephone rang. It was Bryan’s client, a dermatologist named Neal, who was worried about a patient he had referred. Neal explained to Bryan that a month ago he had seen Sam at his office, but quickly referred him to Marie, the dermatologist with the office down the street. Sam has been calling his practice ever since and threatening to sue him for abandonment because he didn’t like the care he had received from the physician assistant who he had seen at Marie’s office. Neal was concerned about any liability he might
have. After listening to Neal’s story, Bryan started the discussion.

Bryan: Well, Neal, let’s start with the basics. How long were you in the room with Sam, how extensive a history did you take, how thoroughly did you examine him, and did you charge him?

Neal: I went into the room and was with Sam for less than five minutes. As you know, I only treat skin cancer. I looked at Sam’s rash and told him that Marie would be the best physician in the area to treat him. I had my nurse give him their phone number and we didn’t charge him a dime. Aren’t medical services like any other contract? Don’t I have to offer my services and doesn’t the patient have to accept them for me to be his physician?

Bryan: That’s basically correct. Traditionally courts have viewed providing medical services like any other contractual situation and required offer, acceptance, and a promise to pay (consideration). Courts look closely at the interaction that doctors have with the person. Did the doctor’s conduct show that he voluntarily accepted the individual as a patient? If you had charged Sam that would almost certainly have established a doctor-patient relationship. A court will look at not only how long you were with the patient but, most critically, the extent of your interaction. Courts tend to look at doctors as being in a relatively authoritative position and patients, or prospective patients, as being in a more vulnerable position. What it boils down to is this: did your conduct indicate that you were willing to accept Sam as a patient? It sounds like you may be in the clear here, but you know lawyers these days.

Neal: With my malpractice premiums, I sure do! So what can I do to protect myself in the future?

Bryan: Some of my other clients limit their dermatology practices to specific areas, such as dermatologic surgery, psoriasis, or pediatric dermatology, and have screening procedures to make sure that only qualified patients get into the examination room with the doctor. Any medical practice with particular limitations on new patients can benefit from having those patients sign an intake form acknowledging the restrictions prior to seeing the physician. Although this isn’t iron-clad, it goes a long way with the courts to show that the doctor did not intend to enter into a doctor-patient relationship unless the patient met the restrictions of the practice.

Also, when referring someone you do not wish to accept as a patient, consider providing the names of a few physicians or sending the patient to a local physician referral service. Sending that person to one specific medical specialist can be seen as having evaluated the patient’s needs and the referral itself might be viewed as a treatment recommendation. Although this is not a particularly strong legal argument, it is easily avoided by following my suggestion.

Neal: What about the fact that Sam was seen by Marie’s PA? Can I be liable for anything her assistant may have done wrong?

Bryan: Relax, Neal. In virtually all situations the supervision of the assistant is Marie’s responsibility. Unless you had a prior basis for knowing that Marie’s assistant was incompetent, an accusation of negligent referral would be hard to prove.

Neal: That sounds pretty good, but now I have another question. I have a patient who has a melanoma on his face and who makes it clear that he will not tolerate a visible scar. What should I do?

Bryan: Great question, but we’ll talk about that next time.
Meaningful use reporting
GETTING YOUR SYSTEM TO DELIVER INFORMATION IN A WAY THAT ENSURES YOU’RE MEETING THE REQUIREMENTS

By Morris W. Stemp, CPA, MBA, CPHIMS

By now almost every physician is aware of the federal government’s financial incentives to providers who implement a certified electronic health record (EHR) system and use the EHR in a “meaningful way.” As described on the Health Resources and Services Administration’s website, the concept behind encouraging the meaningful use of an EHR is to enhance health care in five key areas:

- Improve the quality, safety, and efficiency of care while reducing disparities;
- Engage patients and families in their care;
- Promote public and population health;
- Improve care coordination; and
- Promote the privacy and security of patient information.

The government knew, however, that changing the way physicians practice medicine was not going to be easy or quick and thus phased in the adoption of new meaningful use workflows to achieve these goals over a period of years spanning three stages. Stage 1 started in 2011. Stage 2 was supposed to start in January 2013 but has been postponed until January 2014. Stage 3 is expected to begin in 2016 but is as likely to be delayed as the other two stages. Each stage both expands the thresholds of the prior stage and adds new measurement criteria. For example, in Stage 1, providers must collect demographics on 50 percent of unique patients while in Stage 2, this percentage has increased to 80 percent. In Stage 2, a totally new requirement is to use secure electronic messaging to communicate with more than 5 percent of unique patients.

A number of new measures and increased thresholds are already being proposed for Stage 3. These include the following updates from the Stage 2 requirements:
• Allow patients to request amendments to their medical record;
• Send automatic electronic alerts to the care teams of 10 percent of patients when a significant health care event for a specific patient occurs;
• Send electronic summary of care documents to 30 percent of patients (up from 10 percent); and
• Use of computerized order entry by providers for 60 percent of all labs and radiological orders (up from 30 percent).

(For more information on the Stage 2 criteria, see a sidebar to this month’s article on smartphones, p. 30.) Some of the more mundane measures are being considered for removal, including collection of demographic data and recording of vital signs and smoking status.

**FUNDAMENTALS**

The most fundamental requirement of meaningful use (MU) is the implementation of a certified EHR system. The certification process, created by the National Institute of Standards and Testing, is designed to certify an EHR’s ability to collect and report on data required to comply with meaningful use. For example, one requirement of Stage 1 is to maintain an active medication allergy list. An EHR, before it can be certified, must demonstrate that the software has the functions and screens to collect and retrieve this information.

As the requirements of MU change from stage to stage, it makes sense that the EHR software requirements must also change. Thus, all EHR systems must be recertified under the new 2014 certification guidelines and all practices will be required to use a 2014-certified EHR to qualify for MU bonuses and avoid Medicare penalties. For most practices that have an EHR system, this will not be a problem, as most EHR companies will achieve their 2014 certification during 2013 and work to upgrade their customer base upon final release of their 2014-certified version.

In the first year of Stage 2 compliance, providers must only demonstrate MU in accordance with Stage 2 for a period of three consecutive months. This will give providers who upgrade to 2014-certified EHR technology time to implement the new systems.

**USE IT OR LOSE IT**

The certification process is designed to make sure that all providers use an EHR system with the functionality to at least enable the provider to enter the data required to be a meaningful user. It’s up to the provider, however, to modify his/her patient visit workflows and to properly use the functionality of the certified EHR system to achieve MU. A certified EHR does not necessarily mean an easy-to-use EHR. Thus selecting an EHR designed to make MU compliance easy is critical. An EHR system can do this through the use of simple end-user data entry screens and effective warnings when required data is omitted.

For example, as noted above, providers must record demographics for 50 percent of patients, going up to 80 percent in Stage 2. According to the rule, this specifically includes preferred language, sex, race, ethnicity, and date of birth. Race, ethnicity, and language are three new fields that generally were not collected before Stage 1. I have seen EHRs handle the addition of these three fields in different ways, from hiding them in “additional patient info” screens to placing them right up front and setting them as required fields.

This variability may explain the differences I read recently suggesting that almost 50 percent of medical practices will replace their originally selected EHR system. Ease of use (sometimes euphemistically referred to as a “[mouse] click count”) is most certainly a contributing factor in this figure. But so is the accessibility and ease of use of the MU compliance data-entry screens and functionality. If a practice has to dramatically and unexpectedly change its workflows to conform to some programmer’s idea of MU data-entry, it may be more effective, even if painful and costly, to switch EHR systems, perhaps during the 2014 certification upgrade cycle.

**DASHBOARD YOUR WAY TO COMPLIANCE**

Perhaps the most important MU feature of a certified EHR is a feature not even required under the certification rules. This feature is commonly referred to as a MU Compliance Dashboard or MU Wizard and is offered by many, if not all, of the major EHR systems. This dashboard or wizard basically provides a list of all the MU measures along with the compliance status of each measure, so that it is possible to monitor the progress of MU compliance in real time. For those measures based on percentages of patients or visits, the dashboard also presents the number of compliant units (numerator) compared to the total population of units (denominator).

Who would have thought that the words numerator and denominator, math terms we all learned in elementary school, would become so important?

For example, one of the Stage 1 measures calls for e-prescribing at least 40 percent of permissible prescriptions. An effective dashboard would show the total number of prescriptions which were e-prescribed (numerator) compared to the total number of eligible prescriptions written (denominator). If the percentage is above the MU threshold (in this case 40 percent)
a green light or check mark might display next to the measure description. Otherwise, a red light or an “X” would appear. Every dashboard or wizard has a different user interface, but all should at least provide this MU status information.

More importantly, an effective dashboard can assist in holding providers accountable for their actions, leading to MU compliance. The dashboard could allow the practice administrator to click on a specific measure and drill down into more details regarding the population of that measure. In the e-prescribing example above, clicking on the denominator might make the dashboard present a list of all the eligible prescriptions by the provider. This list can then be filtered to just those that were not e-prescribed (and thus not part of the numerator and thus out of compliance). The provider can then be asked why he/she did not e-prescribe in those specific cases. This would also help the practice determine if additional EHR workflow training is needed.

In the example of e-prescribing, it is obviously too late to remedy the out-of-compliance action; the solution can only come through improved future performance. But with other measures, such as missing demographics, the out-of-compliance condition can be fixed. Assuming the staff can drill into those patient charts with missing demographics, staff with appropriate security and knowledge of the patient’s demographics could open the patient demographic screen and enter the proper values at any time. In other cases, such as MU measures related to visit summaries, only the physician can update any missing information.

Given the effectiveness of this tool as described above, I believe a practice should designate a MU compliance officer (most likely the practice administrator) to regularly monitor the dashboard and take proactive measures to ensure that providers and staff are using the EHR system in a compliant manner. Catching out-of-compliance entries close to the time of the patient encounter allows the doctor to fix the omissions while the encounter is still fresh in his/her mind.

IT’S NOT JUST ABOUT THE SOFTWARE
It’s a common misconception (and one not frequently disclaimed by the EHR vendors) that a practice can be in full compliance with MU simply by diligently using all the MU features of its EHR system. In fact, in the early days of Stage 1, software companies used to “guarantee” MU compliance to any practice using that company’s EHR. The truth is that at least one element of Stage 1 compliance and a number of Stage 2 elements are not software-related at all and thus not under control of the EHR system.

Stage 1 Measure 15 and Stage 2 Measure 9 require that a practice protect electronic health information via the conduct and review of a security risk analysis and by having a risk management process. These requirements are all under the direction of the practice IT and administrative staff. None of these are under the purview of an EHR system. As I described in “Crisis management: Planning for a systems crash,” (www.aad.org/dermatology-world/technically-speaking/2012/february), it is not sufficient to just have a plan. The plan must be documented as a set of written policies and procedures.

Stage 2 Measure 7 requires a practice to provide more than 50 percent of its patients with online access to their health information. But a second requirement of Measure 7 is that more than 5 percent of patients “view, download, or transmit to a third party their health information.” While the first requirement is easily accomplished via the patient portal offered by most EHRs, the EHR cannot force patients to “view, download, or transmit.” It will be solely up to the practice to educate and induce patients to take these actions. Admittedly, 5 percent is a very small population — but as with all measures, you can expect the population requirements to increase in later stages. (Note: Stage 1 only required an “electronic copy,” not “online access,” so a patient portal is a requirement for Stage 2 but not for Stage 1.)

CONCLUSION
Let’s get serious about compliance, earn incentive payments, and avoid future penalties. Choosing an EHR that makes it easy to complete the required fields, has an engaging patient portal with an easy-to-use interface (for the patient!), and has an informative, navigable MU dashboard, will simplify meeting the majority of the MU requirements. Once you attest that your practice is MU compliant and cash your incentive check, you basically sign off that you allow the government access to your medical records to audit your compliance. (Note: Audits of MU attestation have already started.)

Thus, it is imperative that you are indeed both compliant, and that you can produce the evidence of your compliance. A well-designed EHR system will make it easy to be MU-compliant with small changes to your workflow by providing effective MU dashboards to self-audit and review your level of compliance, and will provide detailed reporting to support your compliance claim that you can submit to the government should your practice be audited. dw
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Upcoming CME Activities

Annual Clinical Symposium – Dermatologic Surgery: Focus on Skin Cancer

Omni Amelia Island Plantation
Amelia Island, Florida

Memorial Day Weekend, May 23-26, 2013
Top experts in the field will provide updates on a wide range of dermatologic surgery and Mohs surgery topics. Separate interactive 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 nursing staff, technicians and other Mohs support personnel will increase their knowledge of skin cancer treatment and develop a greater appreciation for their unique roles in supporting high quality dermatologic care. Fly in to Jacksonville just 30 minutes from Amelia Island and a relaxing but event-filled holiday weekend.

AMA PRA Category 1 Credit Available

Closure Course and Fundamentals of Mohs Surgery

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 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.

AMA PRA Category 1 Credit Available

$85 Million Renovation Now Under Way

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

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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
execdir@mohssurgery.org
Planning now can ensure a successful 2013

BY RACHNA CHAUDHARI

Planning now can ensure a successful 2013

EACH MONTH DERMATOLOGY WORLD tackles issues “in Practice” for dermatologists. This month Rachna Chaudhari, the Academy’s practice management manager, offers tips on an area she commonly receives questions about from members.

NOW that you are fully entrenched in the New Year, you should take this time to perform a checkup of your practice and plan all of your key strategic projects and goals for the year. Assessing the health of your practice is a necessary precaution to ensure you will have a successful year. Members of the Academy often ask its practice management staff how they should set up a yearly planning schedule to avoid last-minute time crunches and improve practice performance. The following calendar, which is adapted from the Academy’s Starting and Marketing a Dermatology Practice Manual (available at www.aad.org/store), is intended as a baseline that the practice can use to modify and tailor to meet the practice’s preferences.

JANUARY: CLOSING FINANCIAL RECORD OF PRIOR YEAR AND BEGINNING NEW YEAR

Many practices have a corporate and tax year that conforms to the calendar year—i.e., Jan. 1 to Dec. 31. Therefore, closing the books for the prior year will involve discussions and planning with the practice’s tax accountant to minimize tax risks and optimize results. You should discuss and finalize the following issues in January:

- Employee IRS W-2: Jan. 31 marks the deadline for employers to issue their employees the preceding year’s W-2 form. Make sure to work with your accountant to meet this deadline and distribute the form to all practice staff.
- Patient accounts: Analyze all patient accounts to determine who has not paid their co-pays and deductibles from the previous year. Start the collections process for outstanding claims found during this review.
- Fee schedule: Create your fee schedule for the new year. Check out Physicians Practice for guidance on setting a fee schedule at www.physicianspractice.com/fee-schedule-survey.
- Physician scheduling: Prepare your 2013 physician and non-physician provider schedule. You want to schedule...
for vacations or other personal needs (as much as is possible) for at least a six-month period.

FEBRUARY: PREPARE YOUR BUDGET FOR THE YEAR
If you have never established a yearly budget, it is recommended that you begin immediately and ask your accountant for assistance. Your accountant can help you design and develop your own budget forms and processes. Analyze previous years’ expenses and revenue to estimate your yearly budget. Ensure your office manager periodically compares your actual revenue and expense ratios to those budgeted so you stay on track to meet your financial goals for the year.

MARCH: CONTINGENCY PLANNING
The past decade has witnessed disasters nationwide, many of which resulted in major damage to many businesses. Practices should make every effort to prevent or, at least, minimize potential damage from disasters. In addition, an overlooked part of HIPAA requirements is that every medical practice must have a disaster plan, which must focus on the preservation of all patient data. This includes, but is not limited to, medical records and financial data, which are also required to be protected under HIPAA’s privacy rules.

Appoint one of your staff to develop a comprehensive contingency plan for your practice. It should take into account how your practice would react in the event of such a disaster and how the practice can ensure the protection of its patient and financial data.

APRIL: ANALYZE REFERRAL PATTERNS
Take the time to determine your practice’s current referral base. All practices should be concerned about how they are perceived by their patients and referring sources. Take the following steps to ensure you maintain a healthy referring pattern:

- Patient satisfaction survey. Ask your patients about their experience. Not only may it provide your practice with important feedback, but conducting a survey tells your patients that you care about their views. (Some survey instruments also help dermatologists fulfill part of component 4 of MOC.)
- Referring office survey. Specialists depending on other physicians for their business would do well to consider surveying them to gauge how they view your service. Your practice may wish to conduct face-to-face visits, both physician to physician and office manager to office manager.
- Staff meetings. Your practice may find it productive to have staff discuss ways that the practice could improve its service, and the perception of its service, to both patients and referring offices.
- Newsletters/emails. Some practices have newsletters emailed periodically to active patients. Content can include health tips, news on staff and physicians, and services the practice may wish to promote.

MAY: TAX PLANNING
Corporate taxes have likely been paid in March and many tax accountants say that an ideal time to consider tax planning is in May or June each year. Take this time to meet with your accountant or practice attorney to plan out your tax filings.

JUNE: UPDATE STAFF JOB DESCRIPTIONS
The practice manager should devote time to updating employee job descriptions. In too many practices, job descriptions are not updated and become outdated and less useful to the goal of improving personnel performance. Ask each staff person to provide a comprehensive list of the tasks they accomplish. Carefully review these task lists. It could lead to job redesign, reassignment of tasks, and retraining. More details on employee management are available in the Academy’s Dermatology Employment Manual: A Guide for Personnel Policies and Procedures; visit www.aad.org/store for more information.

JULY: MID-YEAR ASSESSMENT
Take the time to perform an assessment of your practice’s financial health at the mid-year mark. Ensure you are meeting your financial goals for the year and collecting any outstanding co-pays and deductibles. Also take a look at your fee schedule to see if any updates are required. Additionally, review your physician and non-physician provider schedules as well as whether any changes are required in your patient appointment scheduling calendar. Finally, take the time to perform a yearly review of your practice’s personnel policies and procedures. A yearly reassessment and update is helpful to keep your practice healthy and humming. More guidance on personnel policies and procedures is available in the Academy’s Office Policy and Procedures Manual; visit www.aad.org/store for more information.

AUGUST: REVIEW YOUR COMPLIANCE PLAN
You should continually assess your practice’s compliance with the rules of Medicare and third-party payers to avoid potential fraud and abuse in billing for the services you provide. Take this time to perform a yearly review of your compliance plan and whether there are any gaps in complying with these regulations. You may want to train your staff on these gaps if necessary. Your yearly compliance plan should include more frequent reviews of compliance issues; however, it is vital that you have someone in your practice serving as the compliance officer responsible for this review. More guidance on protecting your practice and forming a compliance plan is available in the Academy’s Maintaining Compliance in Dermatology Manual; visit www.aad.org/store for more information.

SEPTEMBER: ANALYZE VENDOR CONTRACTS
It is important for your practice to evaluate your vendor contracts to ensure you are receiving the best rates possible. Look over the terms of each of your existing contracts and negotiate more favorable terms, including lower costs for bulk items like office supplies and medical supplies. Ask for your leasing costs for equipment to be reduced or learn about discounts on your malpractice insurance that you can become eligible for by implementing quality...
control methods. The Academy’s Buyer’s Guide, mailed with this issue of Dermatology World, includes a comprehensive list of other vendors who may provide similar services for a reduced cost. Your yearly goal should be to reduce the cost of at least some of these items.

OCTOBER: PERSONNEL PERFORMANCE REVIEWS
Begin preparing for your personnel performance reviews by reviewing each personnel file and drafting an assessment of the job performance of each staff member. Schedule one-on-one meetings with each person to go over his or her review and determine whether any salary adjustments or bonuses are needed. Ensure all staff are aware of the process and distribute any applicable raises or bonuses before the end of the year.

NOVEMBER: STRATEGIC BUSINESS PLANNING
Take this month to look over your performance and fully analyze how you want your practice to move forward in the coming year. Have a meeting with all of the practice leaders and determine whether any new sources of revenue should be investigated, such as hiring a physician extender or adding a new line of service. Strategic planning is vital to your practice’s growth and should be performed continually.

DECEMBER: PREPARE FOR THE COMING YEAR
Prior to year-end, it would be wise to project the current year’s income and expenses to help in your tax planning. Many managers and physicians work with the practice’s accountant to determine whether certain expenditures should be undertaken before year-end or deferred into the next year. This planning should also involve determination of bonuses, profit-sharing plans, 401(k), and any other distributions to physician(s) and staff.

Your practice also needs to be aware of all the regulatory changes going into effect the following Jan. 1. Check the Academy’s website or with your local carriers to determine all of the regulatory changes affecting reimbursement and compliance issues. You should also prepare any updates to the new fee schedule and perform a year-end analysis of any outstanding claims. dw

For those
“...it’s, um, sore... irritated... uncomfortable to wipe...”

conversations

Some skin is simply more sensitive. Balneol is formulated to gently cleanse, soothe and protect the delicate skin of the vaginal and perianal areas. For everyday use, dryness and irritation; every bottom needs Balneol®.
In October, Dermatology World asked if the then-upcoming election was the most important ever, noting its potential impact on health system reform and on the American Academy of Dermatology Association’s key legislative priorities.

With the 2012 election over, President Obama re-elected, and Democrats retaining control of the Senate, implementation of the health system reform law they worked together to pass in 2010 will continue. But Republicans maintained control of the House of Representatives and, as AADA President Daniel M. Siegel, MD, noted in a message to the membership following the election, “Although implementation of the Affordable Care Act (ACA) will continue, significant opportunities to influence its direction remain.” How will the AADA achieve that influence? And how will dermatology ensure that its key advocacy priorities, which relate to Medicare physician payment, the Independent Payment Advisory Board (IPAB), and indoor tanning, are advanced given the outcome of the election? >>
PHYSICIAN PAYMENT
Immediately after the election, as they have almost every year for more than a decade, the AADA and the rest of the house of medicine faced the challenge of ensuring that cuts to Medicare payments required by the sustainable growth rate (SGR) formula, a relic of 1997’s Balanced Budget Act, did not come to pass. The Academy joined more than 100 other medical associations in proactively recommending a path forward toward a permanent fix, signing on to a letter to the chairs of the relevant House and Senate committees that offered suggestions for replacing the SGR designed to guide the discussion about new payment models while ensuring that physicians can continue to provide optimal care to patients.

The letter acknowledged that “new payment models are needed that can offer physicians opportunities to lead changes in care delivery while being rewarded for improving the quality of patient care and lowering the rate of growth in costs,” noting that, as the system currently works, those “who

lower total health care costs through delivery improvements are not rewarded and may actually lose revenue.”

“We’re working very hard, both as an Academy and with the rest of medicine, to make sure that dermatology is not left out of the loop and that the payment reforms and systems that have been proposed will make it possible for us continue to practice dermatology and be reimbursed fairly,” said Sabra Sullivan, MD, PhD, chair of the AADA’s Congressional Policy Committee.

Indeed, according to Marta VanBeek, MD, MPH, chair of the AADA’s Council on Government Affairs, Health Policy, and Practice, “The Academy has moved beyond just asking for a fix to the SGR to really trying to explore other innovative payment options. We now have a workgroup on innovative payment and delivery reform, which is looking at other payment options besides fee-for-service, and our advocacy efforts are looking more long term instead of just at short-term fixes to the SGR. Of course, we want that, but we also want a stable payment system and that is going to take quite a bit of work. The Academy is working hard on looking at Medicare claims data to figure out, what would alternative fair models of payment be instead of fee-for-service?”

That hard work is being led by Kathryn Schwarzenberger, MD, a member of the Academy’s Board of Directors who chairs the Workgroup on Innovative Payment and Delivery. The Academy is in the process of developing data that will help individual dermatologists determine the potential impact of various proposed payment and delivery models, including patient-centered medical homes, accountable care organizations (ACOs), bundled episodes of care, and capitated payments, on their practices, she said. “The data, when it’s ready, should let people determine how their practice mix would be affected by each of the proposed models,” she said. “We want to provide information that will allow dermatologists who, for example, are approached about joining an ACO, to assess the impact of that proposal on their practices and how they can provide the best care for their patients in the changing market.”

That work may take some time. So the medical societies also stressed in their letter to Congress that new payment models “must be developed during a defined and robust transition period that can fill in the gap between elimination of the SGR formula and implementation of a new system nationwide,” as “physician practices of every size and specialty must be supported and encouraged to develop the needed infrastructure and begin adopting the most appropriate model for their patients and their practice.”

With the SGR cut ameliorated for another year as part of the overall fiscal cliff deal, the AADA will continue to work with the rest of medicine to push Congress to adopt a permanent solution. “People on both sides of the aisle agree that they don’t want the cuts to happen,” according to Shawn Friesen, the AADA’s director of legislative, political, and grassroots advocacy — that’s why the two sides eventually agree on payment freezes or slight increases each year. However, he added, “there’s a divergence of opinion on how to pay for and implement a permanent fix.” The intent expressed by both parties to achieve real solutions this year rather than once again kicking the can down the road could finally open the door to such a fix, though.

“It’s possible that a larger SGR fix could be part of a grand-bargain-type deal if there is agreement to arrive at some kind of deal in 2013,” Friesen said. “It could happen as part of a big package. And there’s no election for almost two years — there’s a lot of potential for deal-making, depending on how the parties perceive their political capital and incentives.”

IPAB
According to Dr. Siegel in his post-election message, “The AADA is working to influence various changes to parts of the law that may mitigate the negative effects on our specialty and our patients.” One of the key areas of focus in this regard is IPAB, a board charged with controlling Medicare spending by making annual cost-saving recommendations that Congress must accept as a slate or amend to achieve the same savings. The model is similar to the commission used to determine which military bases can be shut down.

IPAB’s first recommendations are scheduled to be due to Congress on Jan. 15, 2014, with a public report due July 1, 2014. However, the trajectory of overall Medicare spending has been lower in the last few years than it was during the reform debate of 2009 and 2010, and CMS now projects that IPAB’s cost-saving recommendations will not be necessary until 2018. Nevertheless, the board’s potential power to make
recommendations for cuts to spending that would not be subject to the normal legislative process makes it a significant concern for physicians.

“As far as repeal of IPAB, we’re still thinking it through,” Dr. VanBeek said. “It is an uphill battle because the people who voted for IPAB are still in power. It wasn’t necessarily a bipartisan provision so there is some possibility of it getting repealed, but it’s unlikely. Repeal remains our number-one priority, but we are also trying to figure out how we can best function if that doesn’t happen,” she said. In his message to the membership, Dr. Siegel stressed the same thing: “While some members of Congress will continue to work to repeal IPAB, we are also working with our colleagues across the medical profession to prepare for the possibility of IPAB’s formation and to develop strategies to ensure that the perspective of physicians is represented should it move forward as envisioned in the ACA.”

The unchanged post-election environment creates an interesting situation for IPAB in the near future, Friesen said. “At this point, repeal is unlikely,” he said, though he acknowledged that there are Democrats and Republicans who do not support the IPAB. “But whether there are tweaks that will happen — that’s where it gets interesting. What does Senate confirmation mean? What if there aren’t 60 votes to fill an IPAB slot? Are recess appointments a possibility?”

If the Obama administration chose to make such appointments, which allow the president to fill vacancies when the Senate is in recess, the composition of the IPAB would, hypothetically, allow it to convene and begin making recommendations without any Republican support. The IPAB’s 15 voting members are to include:

- three members chosen by the president in consultation with the top-ranking Republican in the House,
- three members chosen by the president in consultation with the top-ranking Democrat in the House,
- three members chosen by the president in consultation with the top-ranking Republican in the Senate,
- three members chosen by the president in consultation with the top-ranking Democrat in the Senate, and
- three members chosen by the president on his own.

The nine members who could be appointed without consulting Republicans at all would give IPAB a quorum to operate. IPAB will also include, in non-voting capacities, the secretary of Health and Human Services (HHS), the administrator of the Centers for Medicare and Medicaid Services (CMS), and the administrator of the Health Resources and Services Administration (HRSA).

Republicans in Congress could still influence IPAB, though, according to Friesen. “How can they impact its recommendations? Congress does have the power of the purse; it’s possible they would try to find ways to cut IPAB’s funding and inhibit its operations.”

For more detail on how IPAB is designed to function and its potential impact on dermatology, visit www.aad.org/dermatology-world/monthly-archives/2012/reform/ipab.

### Indoor Tanning

One bright spot for dermatologists dismayed by the prospect of continued implementation of reform is the possibility that the Academy’s work on indoor tanning will bear fruit under the current administration.

“Indoor tanning is still a priority at the state and federal level,” Dr. VanBeek said. “Our State Policy Committee is working very hard to support state societies that introduce bills to ban underage tanning. We’re also making progress on the FDA reclassification of tanning beds.” But in addition to working with the FDA, she said, “we’re also still supporting the Tanning Bed Act, which has been introduced several times before in Congress and would reclassify tanning beds and provide better warning labels that would be more obvious in appearance.” Dr. VanBeek said that momentum is on the side of those who see the danger of tanning, as more countries and international organizations label it a carcinogen. “We’ll keep getting broader support for tanning legislation as more data comes out and the rest of the world recognizes it for the carcinogen it is,” she said.

Work to make that happen is ongoing, according to Leslie Stein Lloyd, JD, the Academy’s director of regulatory and payment policy, and continuing to deal with the same administration increases the likelihood that progress to-date will continue. With regard to tanning beds, she said, the FDA still has to determine whether it will recommend reclassification of tanning equipment based on the hearing it held in 2010 and the evidence it has received since then. “We are hopeful that reclassification will happen. We’ve been advocating throughout the rulemaking process, encouraging the FDA to reclassify, and when new studies regarding the impact of indoor tanning on melanoma and other skin cancers have come to light, we have shared those studies to ensure that the FDA is kept abreast of the latest developments.” The rule that will determine whether tanning equipment is reclassified is moving through the usual regulatory process, she said, and without changes at the top of the Department of HHS or the FDA, an announcement by mid-2013 seems possible.

Whether or not the FDA acts on tanning beds, Lloyd said, the Academy has other work planned to spread its message about indoor tanning. “We have contracted with the Research Triangle Institute to study the impact of indoor tanning on melanoma and the costs associated with indoor tanning. They’re in the process of doing an economic analysis on a state-by-state basis; we look forward to it being another tool to help persuade policymakers; we can use it both in the states and nationally, with legislators and with regulators.”

Beyond pushing for legislation and regulation, Lloyd said, “The next step for us is to work with the Surgeon General’s office to create a call for action to stop indoor tanning.” To that end, Dr. Schwarzenberger recently met with dermatologist Boris Lushniak, MD, MPH, the deputy surgeon general.

“We discussed our mutual concern about tanning as a significant public health issue,” Dr. Schwarzenberger said. “Clearly the Surgeon General’s office is aware of this issue and shares our zeal to do something about it. We were reassured that they understand the importance of promoting healthy behavior, including reducing the incidence of indoor tanning.”
The discussion also turned to the government’s Healthy People 2020 initiative and the role of dermatologists in the improvement of public health in the country in general. “We agreed that anything we can do to improve participation among dermatologists in the improvement of public health in the country in general would be valuable,” she said. Such efforts could include work with the Public Health Service, perhaps in the prison system, where treatment of prisoners using a teledermatology system could develop and prosper, or in the Medical Reserve Corps. Such activities would have the added benefit of increasing dermatology’s ties to the rest of medicine, she said, a critical element in helping the specialty define its role in the changing health care environment.

HELPING MEMBERS WITH REFORM
As reform moves forward, the Academy has tasked itself with helping members figure out what it means for them as individuals and as a specialty.

“Because of the election results and the ACA, dermatologists have to think very hard about how we fit into the rest of medicine and what kind of critical component of medical care we provide our patients,” Dr. VanBeek said. “We will no longer be in isolated silos of specialty care. We have to think of a more integrated approach and be innovative in thinking about how we complete the full medical care of our patient,” she said, pointing to the efforts of the Workgroup on Innovative Payment and Delivery.

While that work continues, Friesen also noted that “now that we know that health reform will go forward, we’re going to be helping our members adapt to a changing environment.” As implementation of reform continues and new rules and requirements take effect, dermatologists can continue to look to the Academy for help understanding what the changes mean for them. But Dr. Schwarzenberger warns that there is no one-size-fits-all answer.

“In an ideal world we’d be able to come out with clear information saying, health care reform is going to do X to you,” she said. “But what’s clear to all of us working on this is that the face of the market will be different in every community. How reform will impact your practice will be very personal depending on your practice environment. You’re less likely to have the care pattern dictated to you, for instance, if you are the only person in the community available to provide the care.” To help the Academy generate the most meaningful resources possible, she said, members should let the Academy know about their experiences with new payment models; email ACO@aad.org to share your story.

Currently available resources for coping with reform are already robust. The AAD website is adding resources designed to help members with implementation and includes a new ACO Resource Center at www.aad.org/ACO. Dermatology World has produced a variety of resources related to both ACOs and to the broader impact of reform; the former are part of the ACO Resource Center, while the latter are available at www.aad.org/dermatology-world/monthly-archives/2012/reform.

MOVING FORWARD
As they address reform’s impact in their practices, Academy members can keep up to date on the latest advocacy news related to reform via the Academy’s bi-weekly e-newsletter, Dermatology Advocate. Even since the election, Dr. Sullivan said, the Academy has been fighting for its members.

“We’ve been supporting legislation to make sure that the EHR rules and regulations are administered fairly and people aren’t penalized without due process,” she said. The EHR Improvements Act, introduced in the House of Representatives in the last Congress, would create a hardship exemption from upcoming Medicare penalties related to EHR use for small practices and physicians approaching retirement and establish an appeals process before any penalties would be applied. Both provisions could benefit numerous dermatologists.

That example is one of many to come, Dr. Sullivan suggested.

“It’s going to be critically important for us to be there at every step as the law is interpreted to ensure that it doesn’t have a negative impact on our community,” she said. “We had contingency plans regardless of who won the election, and we’re trying to put forth strategies that ensure that our patients get the best care possible, protect and foster the specialty of dermatology, and help move our nation forward out of the chaos we’ve been in while protecting our ability to provide care. We’re trying to work within the system to move it forward.”

The Academy can provide resources and advocate on members’ behalf, Dr. Schwarzenberger said, but individual dermatologists also need to get involved to understand and affect their unique circumstances.

“It’s important for dermatologists to be active in their medical communities so they can see the changes that are coming and be proactive and involved,” she said. “Stay in touch with your colleagues, go to your medical society meetings. We can’t ignore the infrastructures of medicine. Those days are over.”

The bottom line, Dr. Sullivan said, is that members cannot become complacent.

“We all have to be very involved in the process. The Academy will keep working. Even if the outcome isn’t what you hoped for, instead of gnashing your teeth, we have to sit down and figure out the best way to protect ourselves and our patients and then get going to do the best we can.”

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One of the most significant societal shifts of the past decade has been the rise of mobile computing technology, smartphones in particular. As physicians and patients use new tools and applications, dermatologists, along with their colleagues throughout medicine, are participating in a rare bit of futurism as they consider how these technologies will impact physician-patient relationships.

SMARTPHONES AND MEDICINE
The ability to not only communicate but access almost any conceivable information using a device that fits in a pocket has resonated strongly with the American public — a 2012 Nielsen survey placed smartphone adoption rates among all U.S. adults at 50.4 percent. Among physicians, the numbers are far less studied, but seem to surpass the general median. A 2010 study by Manhattan Research found that 72 percent of doctors reported that they used smartphones, and the firm predicted an increase to 81 percent in 2012. Among the next generation of physicians, the trend is even more pronounced. An October 2012 study in the Journal of Medical Systems found that among those in ACGME training programs, 85 percent reported smartphone use.
Among patients, use is similarly robust. The Pew Internet and American Life Project reported that 85 percent of U.S. adults own a cell phone, and 45 percent of adults own a smartphone. Rates of use are especially high in the urban and suburban areas where dermatologists most often practice. (For more on cell phone use, its behavioral impact, and its effect on the doctor-patient relationship, see this month’s online-exclusive bonus content at www.aad.org/dw).

Stanford University internist Errol Ozdalga, MD, who wrote on the use of smartphones among students and physicians for the Journal of Medical Internet Research (2012;14(5):e128) said that many of today’s physicians and physicians-in-training are comfortable integrating smartphones into both their personal and professional lives, and that the growth in smartphone utilization among doctors is largely an outgrowth of a younger generation’s entry into the medical workforce.

As a medical student, Dr. Ozdalga said, he was given the use of a slightly older generation of technology — a personal digital assistant manufactured by defunct hardware brand Palm. Having received that accompaniment to his training (he graduated in 2008), he said, he was conditioned to embrace evolving technology as part of the practice of medicine.

“I can’t emphasize how important it was for me to have that Palm Pilot with me during medical school and have something that would tell me exactly what the physical exam findings should be, and what the questions to ask were,” Dr. Ozdalga said. “Technology made me a better student, a better resident, and today it’s making me a better physician every day I use it. A greater number of physicians are using their phones like this, and I think that number still needs to grow.”

EDUCATION
The smartphone, according to dermatologist Jeffrey Benabio, MD, director of physician innovation at Kaiser Permanente, and a frequent speaker on technology and social media, has applications in multiple areas of a dermatologist’s professional life — from interacting with colleagues to educating patients about their conditions to keeping one’s public profile relevant.

“When I have spare time, I’m able to use the New England Journal of Medicine app and a few others for reading the materials that are recommended to me,” Dr. Benabio said. “When I’m with a patient, there’s point-of-care software available to offer patients additional information. And when I want to have discussions with my colleagues, I can use email informally to discuss medical issues, or a physician networking app like Sermo or Doximity to begin a conversation with dermatologists from all over the country.”

As an internal medicine physician admitting patients from the emergency room, Dr. Ozdalga said, he’s able to update himself on an incoming patient’s condition in the time it takes him to walk across the hospital.

“There’s so much to know these days, and to have that much information in your phone is powerful. When I’m walking down the hallway toward the ER, maybe a three-minute walk, questions come up to my head depending on what the staff has told me about the patient,” Dr. Ozdalga said. “The patient may have certain cardiovascular disease, and I can literally look [information about it] up on my phone. I can answer almost every condition-specific question I have within 60 seconds or less. It’s immensely powerful, and it really has made me a better physician.”

Even for dermatology, which has seen slower EHR adoption than some specialties due to its higher percentage of smaller practices, Dr. Benabio said, smartphone applications offer value to practices through patient-directed safety and prescription programs.

“I don’t use a lot of point-of-care apps, but I like that I have the e-prescribing ones available to me. Drug interactions directly impact patient care, and I like that I can quickly enter, say, ‘minocycline and isotretinoin’ into an app and trip the alarm that tells me that the drugs are contra-indicated,” he said.

While physicians are making greater use of mobile applications, most patients are as well, with general smartphone use among the population taking a similarly sharp uptick over the last five years. With the sheer number of applications available to patients, it’s also vital to communicate to them that a piece of smartphone software is in no way a substitute for medical expertise or regular visits. Some of the medical software available to the public makes impressive claims for what remains a non-medical consumer technology device.

“A lot of applications marketed to patients are really just games, so to speak. For example, there’s an app that uses red and blue light to ‘treat’ acne. Another one says that you can take a picture of a mole and it will tell you the risk level. It can’t deliver on that promise with the level of technology available,” Dr. Benabio said. “Those kind of apps explicitly say ‘only for entertainment purposes,’ and you should direct your patients to more educational resources.”

For more of Dr. Benabio’s thoughts on how he believes smartphones and other mobile computing solutions will change the future of medicine, find a link to his TEDx PennQuarter presentation at www.aad.org/dermatology-world/monthly-archives/2013/february/smart-medicine.

FOLLOW UP AND PATIENT COMMUNICATION
The idea of the smartphone as a physician tool and traditional communication tool may make some physicians uncomfortable. The separation of career and personal life, Dr. Ozdalga said, is always a concern, and communicating with patients via email on one’s phone can seem uncomfortably like giving them a line to one’s personal time. Yet with the services available, he said, he’s been able to effectively partition patient communication while improving patient satisfaction scores.

“I don’t give my patients my number, but I have an account set up where they can dial a number and leave a message that’s emailed to my phone,” he said. “I can check my emails and call them back when I’m available, and it
doesn’t disrupt my day. My patients love it — it’s worked really well, and I’ve never had a single complaint. Thanks to that, there’s not a full disconnection with patients once they leave the hospital.”

In addition, Dr. Ozdalga said, he can encourage patients with interesting cases to call often and keep him apprised of changes. In practice, he said, the setup has proven not only convenient, but more intellectually stimulating than the old model of office calls (he’s often away from his desk) and more frequent follow-ups. In addition, he said, he’s able to make more time available to new patient appointments, acute care patients, or other professional pursuits.

Cardiologist Ariel Soffer, MD, who runs a number of phlebology practices in the south Florida area, worked with developers at AppWorx to create an application specifically for his patients to monitor the appearance of their veins with the iPhone camera and text him updates and inquiries through the app between visits. Rather than taking away reimbursement by eliminating a number of routine follow-ups, Dr. Soffer has seen his patient satisfaction scores (the practice runs its own regular surveys) improve dramatically, leading to more visits.

“When my patients could see on their iPhones the difference in appearance with a HIPAA-compliant photo between sessions of a multi-session treatment, the compliance increase was so dramatic that it increased my practice volume by 38 percent year over year,” he said. “A picture’s worth a thousand words.”

New patient participation metrics will be part of stages 2 and 3 of EHR meaningful use requirements, meaning physicians will be expected to have online interaction with more of their patients through a secure portal. (See sidebar.) Dr. Benabio said that, in addition to helping them meet those requirements, smartphones offer physicians the opportunity to better educate their patients and get them more involved in the tracking of their care.

“Under your direction, a patient could take a picture of a mole and load it into a mole map to see if there are changes or violations of criteria. Directing your patients to make good educational use of apps and learn more about their condition is far more constructive than a patient trying to diagnose themselves with a phone. You can engage and provide that direction,” he said. “There are also great apps that you can use during the patient visit to talk to the patient about different types of surgeries. You can actually use graphics

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**APP-SPLOSION**

At the Summer Academy Meeting 2012, University of North Carolina dermatologist Craig Burkhart, MD, presented a number of dermatology-related applications for smartphones and tablets. They cover a wide variety of both physician and patient medical issues. For one application, MelApp, Dr. Burkhart fed 100 pictures of classic melanomas taken under clinical conditions. The app diagnosed 11 of the melanomas as “high risk,” recommended monitoring 88, and classified one as “low risk.” The results he said, demonstrated that while the application has potential as a tool for teaching, it’s not yet ready to accurately detect melanomas — especially in photos taken by untrained patients.

Overall, he said, the number of mobile applications related to health and dermatology published by Apple on the iOS platform has grown at an exponential rate. He presented the data below.
on a smartphone to talk them through a procedure and demonstrate what you’re going to be doing. It can then be sent to the patient’s email so that they can follow up later and educate themselves.”

**SOCIAL MARKETING**

In addition to the higher-level functions of smartphones, Dr. Benabio said, the popular social networking capabilities of smartphones allow one to produce original content and maintain patient and public connections throughout the day, and even while traveling. In addition, he said, it can also serve to humanize a physician and forge a deeper connection with engaged patients.

“Your smartphone has a video camera that makes it extremely easy to produce and publish patient education content for your patients. In the context of social networking and creating content for one’s practice as part of building a platform, the smartphone is the best tool we’ve seen,” he said. “I use Twitter mostly to engage in discussions about health care and dermatology, but I also use it to talk about going to Voodoo Donuts in Portland. To some extent, that makes it more effective, because it makes me a real person. People learn more about me, which is part of marketing your practice and engaging with your community.”

**FUTURE APPLICATIONS**

In the near future, both Dr. Benabio and Dr. Ozdalga said, the capabilities of smartphones in medical situations will take another impressive leap. According to Dr. Ozdalga, technology that is currently in development will allow physicians to attach a simple ultrasound device to a commercial smartphone and allow the physician to do bedside ultrasound exams.

“The idea of bedside ultrasounds was never even dreamed of with the technology we had just a couple of years ago,” Dr. Ozdalga said. “Developers and physicians will continue to come up with more ways to use the smartphone in ways we haven’t thought of.”

Dermatologist and application developer Manabu Inuzuka, MD, who created the photo database application tkDerm, said that the future of medicine lies in physicians having flexibility to manage their patient interactions and data in a way that allows for maximum efficiency.

“Dermatologists, and doctors in general, are going to look for more flexibility in device choice and storage options that maximize their ability to interact with data in multiple formats,” Dr. Inuzuka said. “We’re already seeing this with the automatic backup and syncing of photos over the cloud across multiple devices. Compared to technologies of even the recent past, it’s like magic.”

The FDA, according to Dr. Benabio, has been cautiously optimistic on the use of technology to augment physicians’ expertise and efficiency. While dermatology hasn’t seen any specialty-specific applications approved by the FDA for medical use, the agency has approved software that addresses other areas of medicine. A company named Asthmapolis received approval in July for an asthma sensor system and complimentary mobile. Earlier in 2012, the FDA cleared a device that allowed patients to take and send electrocardiographical signals to their physicians. An Andon Health subsidiary received clearance to sell a wrist-worn blood pressure cuff that interacts with iOS devices over Bluetooth technology. What used to be considered science fiction, he said, is coming ever closer to reality. Dermatology, he said, isn’t far behind.

“Outside the world of dermatology, there are FDA-approved apps that can be appropriately used in a medical setting. They’re coming, and I think that dermatology would see a primary value in evaluating skin lesions for malignancy,” Dr. Benabio said. “There’s nothing now that fulfills that function that I’m aware of, but in the next five to 10 years, that’s something you’re likely to see.”

**MEANINGFUL USE AND PATIENT COMMUNICATION**

Some of the most significant changes to come with stage 2 of meaningful use deal with patient access to their health information and communication between physicians and patients. The strong emphasis on online engagement with patients marks the beginning of a new era in electronic health records (EHR). Provisions for meaningful use stage 2 include the following:

- Secure electronic messaging (i.e. secure email) to communicate health information to patients. This could include lab results or a list of current medications.

- Provide patients the means the view, download, and transmit their health information within four days of the information’s availability through a secure online portal. Half of all patients must be given access; 5 percent must take some sort of action, by viewing or downloading information or electronically transmitting questions or information.
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BRAF INHIBITOR PROGRESS AND PITFALLS

“It’s often difficult to define how personal is ‘personalized,’” said Hensin Tsao, MD, PhD, associate professor of dermatology at Harvard Medical School and director of the MGH Melanoma and Pigmented Lesion Center at Massachusetts General Hospital. “Personalizing medicine goes beyond the genetic dissertation of what the tumor has; it’s much more about finding the precise signature that comes with an action which will, with high probability, influence an outcome. Technology has allowed us to identify a broad spectrum of markers that helps us define the tumor in the individual with precision. That’s the personalization part. Now we have to be able to balance that with the medicine part.”

The investigation of the V600E BRAF mutation and subsequent development of drugs that target the mutation illustrate both the benefits and challenges inherent in personalized medicine, and selective inhibitors in particular. BRAF is a version of RAF in the MAP kinase signaling pathway of RAS-RAF-MEK-ERK. The V600E BRAF mutation was first identified as an oncogene in melanoma in 2002, and is found in about 50 percent of primary and metastatic melanoma tumors. “In the early days, we didn’t have potential drugs that we could give patients, but now the first two such drugs have gone through phase III clinical testing as single therapy for patients whose melanoma has the BRAF mutation,” said Keith T. Flaherty, MD, associate professor in the department of medicine at Harvard Medical School and director of developmental therapeutics at the Massachusetts General Hospital Cancer Center. “The results are quite impact: You can get a very reliable, reproducible early impact on advanced metastatic tumor in 90 percent of patients treated, to a varying degree.”

In August 2011, the Food and Drug Administration approved vemurafenib as the first targeted genetic therapy approved for melanoma, along with a diagnostic test to determine if a patient’s tumor has the V600E mutation (see “Targeted therapies take aim at skin cancer,” www.aad.org/dermatology-world/monthly-archives/2012/march/targeted-therapies-take-aim-at-skin-cancer). A year later, the manufacturer of the second BRAF inhibitor, dabrafenib, and an MEK inhibitor, trametinib, submitted new drug applications for those agents to the FDA. In the year since the approval of vemurafenib, “it seems that it’s been fairly rapidly adopted as a treatment standard for patients with the BRAF mutation,” Dr. Flaherty said. Testing for the mutation “seems to be happening not only in the big hospital-based practices but in private practice as well. It’s certainly close to being universally adopted.”

In an abstract updating results of the BRIM-3 trial, which compared vemurafenib to another therapy, submitted to the 2012 annual meeting of the American Society of Clinical Oncology, Chapman et al. reported that median overall survival rates in previously untreated patients with unresectable Stage IIC or IV melanoma were 13.2 months with vemurafenib and 9.6 months with dacarbazine. “Some patients maintain benefits for two or three years,” noted Dr. Flaherty, but then, “as might be anticipated, over time many patients develop resistance to single-agent therapy because these are genetically advanced tumors that have multiple aberrations other than BRAF.”

Dr. Tsao remarked that resistance could theoretically take the form of “multiple different metastases in the lung, all taking different routes. Then you don’t know what to do.” A better approach than single-agent therapy, he suggested, might be “giving cocktails up front based on what you think the most likely mechanisms of proliferation, survival, and resistance. For now, one obvious therapeutic pathway suppresses the cell’s reliance on BRAF(V600E)-based signaling. Going forward, maybe you want to look at a few markers, and they may not even be mutational — they could be levels of protein, levels of gene X, Y, whatever it is. Because once you start chasing resistance mechanisms, it may be very hard down the line to get them all.” Dr. Flaherty said he has focused his efforts on finding alternative therapies targeting other points in the pathway, to be able to suppress the emergence of metastasis or treat it once it manifests. One strategy involves targeting MEK, the point immediately downstream of RAF in the MAP kinase pathway. In a phase 1 and 2 trial combining the BRAF inhibitor dabrafenib with the MEK inhibitor trametinib, published in the New England Journal of Medicine (2012;367(18):1694-703), Dr. Flaherty’s team found that median progression-free survival was 9.4 months in the group of patients receiving both drugs, as compared with 5.8 months in the group receiving only dabrafenib.

Another approach to treating advanced melanoma, Dr. Tsao pointed out, is “combining
molecular control with immune control. Now those two large areas of research are beginning to converge, the idea being that you can have very quick, early control that almost everyone will experience with a BRAF inhibitor, and combine that with longer-term immune control of the tumor.”

**FINDING THE SWEET SPOT**

The difficulty in finding agents effective against the NRAS mutation, also common in melanoma, illustrates the current limitations of personalized medicine, Dr. Tsao said. “We’ve known about NRAS for two decades; it was one of the first oncogenic mutations discovered in melanoma,” he said. “But RAS is not a kinase, it’s an activated G protein, and it’s hard to develop agents against it.” Nevertheless, researchers continue to target the NRAS mutation, Dr. Flaherty said, pointing to an early trial of combined pharmacological inhibition of MEK and CDK4 in mice, published in *Nature Medicine* (2012;18(10):1503-10).

Dr. Tsao views the “engine of personalized medicine” as “expanding your mutational and genetic landscape but finding molecular targets that are druggable,” and defines the intersection of the two as “the sweet spot in that marriage. Personalized medicine has to be precise and it has to be actionable.” At the same time, “you don’t want to be so personalized that there’s a very small market for what you do. So I think testing these regimens is a challenge down the line, the more personalized you get.” In the future, personalization might take the form of “a melanoma chip that looks at certain single-nucleotide polymorphisms from your blood DNA and certain markers on the tumor, combined into some model that allows you to make a treatment decision.” The model will consider germline variations as well as somatic mutations. “For instance, we know that if you inherit certain variants in thiopurine methyltransferase (TPMT) or HLA subtypes, you’re going to be predisposed to toxicity in certain drugs, and

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**MOLECULAR DIAGNOSTIC TESTING COMES OF AGE**

A variety of molecular technologies are being increasingly utilized in clinical practice, including polymerase chain reaction (PCR), comparative genomic hybridization (CGH), fluorescence in situ hybridization (FISH), DNA/oligonucleotide microarrays, and DNA/RNA sequencing. But for the most part, the day-to-day performance of molecular testing in dermatology has lagged somewhat behind that of other specialties, particularly oncology, infectious diseases and clinical genetics, said a dermatopathologist who edited a textbook on the topic (*Molecular Diagnostics in Dermatology and Dermatopathology*, Humana Press/ Springer, 2011). “Our specialty has been a little slow in adopting molecular testing. In many ways, we’re victims of our own success,” remarked Michael J. Murphy, MD, associate professor of clinical dermatology at the University of Connecticut School of Medicine and attending dermatopathologist at the University of Connecticut Health Center. “Amongst other contributing factors, the skin is readily accessible, so diseases are detected at early stages or repeat biopsies can be easily performed in equivocal cases. We have become very good at correlating histopathological findings with clinical information. Thus, there has been less impetus for us to embrace new technologies quickly.”

While some dermatologists might question the immediate clinical relevance of molecular diagnostics, it’s incumbent on them to stay abreast of these technologies and their developing applications, and incorporate such testing into diagnostic, prognostic, and therapeutic algorithms of patient care when appropriate, Dr. Murphy maintained. “If we don’t become more educated and involved, we risk relinquishing the management of patients with certain skin diseases to other medical specialties. If future treatments are based not only on the clinical-histopathological features of a disease but also on its molecular changes, other physicians who are more informed may assume greater roles in patient care. We need to move to the next stage.” Toward that end, many national and international dermatology and dermatopathology conferences are offering lectures and symposia dedicated to these advances, he remarked. “Recognizing the need and opportunity to integrate this growing discipline into a structured approach, we lecture on this subject as part of the dermatology residency curriculum here at UConn,” he added. “This ensures that our residents are familiar with the applications of cutting-edge laboratory-based and dermatology-focused tests as part of their training.”

In an article published in the *International Journal of Dermatology* (2012;51:1292-1302), Dr. Murphy and co-authors Zendee Elaba, MD, and Amanda Phelps, BA, explored the potential uses of molecular diagnostics in dermatology. In addition to testing for BRAF gene mutations in melanoma, they noted that recent studies have demonstrated a role for CGH and FISH in the evaluation of melanocytic tumors that are difficult to classify by conventional light microscopy. They also cited studies suggesting that CGH, FISH, and DNA microarray technologies “may potentially be used to stratify patients into prognostically relevant groups and provide biomarkers of treatment response and/or survival in patients with melanoma.” Molecular technologies will also begin to play a greater role in the “diagnosis and management of other non-melanoma skin cancers, inflammatory dermatoses, and inherited skin disorders, in addition to dermatologic infections” the authors said, adding that nucleic acid-based testing could efficiently characterize “microorganisms that are difficult to culture, and uncover genetic determinants of disease outcome and/or treatment response, such as drug resistance genes.”

Inflammatory dermatoses pose a particular challenge, Dr. Murphy said. “These are complex, often multifactorial and chronic, immune-mediated disorders with both polygenetic and environmental influences.” However, he suggested that “atopic dermatitis and psoriasis are two conditions where the concept of ‘personalized medicine’ (i.e., tailored therapy) is likely to be realized first.” An article discussing how genetic variation affects psoriasis patients’ response to therapy, co-authored by two British researchers and published in *Expert Review of Clinical Immunology* (2010;6(6):957-966), noted that to date, there has been limited pharmacogenetic research regarding treatments for psoriasis. Based on the studies they reviewed, the authors concluded that developing targeted therapies for psoriasis...
would involve “the combination of several genetic markers (polymorphisms) identified by large-scale gene association studies, each with a small but significant effect on treatment response, used in combination with additional clinical parameters, to reliably prospectively predict drug response.” (One potential psoriasis target, REG3A, has since been identified; see www.aad.org/dermatology-world/acta-eruditorum/2012/september.)

Molecular diagnostic testing should not be employed in isolation, Dr. Murphy emphasized, and both the choice of test and significance of results must be determined in the context of available clinical and histopathological findings. This approach promotes even greater cooperation between dermatologists and dermatopathologists (and pathologists), for economic as well as clinical reasons, he said. “Closer ties among clinical and laboratory-based physicians will be necessary to ensure proper test platform selection with an understanding of test advantages and limitations, appropriate specimen handling, and accurate assessment of test results.” As more molecular diagnostic assays become available, dermatologists will need to consider if a particular test is both clinically useful and cost-effective, Dr. Murphy added. “Broader acceptance of molecular diagnostics in dermatology will be linked to the timely acquisition of sensitive and specific actionable results which improve patient care and outcome.” He noted that in studies from the dermatology literature which focus on comparative cost analyses in specific conditions, researchers found that in the setting of suspected dermatophytoses and cutaneous T-cell lymphomas, the costs of PCR-based diagnostic tests are similar to those of standard investigations, such as tissue culture and immunohistochemistry.

In the future, the most significant developments in molecular diagnostic testing will come through the use of next-generation sequencing, Dr. Murphy predicted. “Molecular diagnostics in dermatology will continue to evolve as a result of rapid technological advances and the acquisition of more affordable whole-genome data,” he added. “Every few years, we can expect the discovery of novel disease-related genes for many skin disorders, the development of more reliable, robust, and accurate but less expensive molecular assays, and the introduction of more targeted, less toxic, single or combination therapies.”

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AAD Annual Meeting - Booth 2421

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MONTHLY COLUMNS ARE FUN FOR THOSE FANS WHO READ THEM,
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PRESIDENTIAL CITATIONS ARE FOR THOSE WHO’VE LOOMED LARGE,
LIKE EAGLE SCOUTS, NOT LIKE MADAME LAFARGE.

If you like where this is going, read on my friend,
If not — read anyway! It’s not far to the end.
With apologies to Bill Shakepeare and to Ogden Nash,
Here comes the “rappin” text of my final Prez splash.

The ABCs of Accredited CME — An Online Ed Activity,
Shows us off as the best that we ever can be,
We owe it to Anderson, Green, and Ilona Frieden,
No one is as clever, they cannot be beaten!
Kahn, Kaufmann, Kirsner — all guys with a K
Also helped to create this extraordinary ePlay,
Sober and Taylor, Erik Stratman and Chris Spock,
All did their bit to make derm CME rock!

Susan C. Taylor sure helped out with SPOT,
While Henry Lim’s Sci and Research achieved an awful lot.

Camp D and progeny are such fun for participants all,
It wouldn’t exist without inspired Mark Dahl!
It’s alive with the work of lots of kind folk,
Who do dressing changes and listen to many corny jokes,
Too many to name as all do great and fine,
A call out this year to Sherill Rudy and Andy Zaenglein.

For teaching the residents, our next generation,
A certain large group deserve our standing ovation,
Berger and Garg and Garcia and Burgin,
Made this whole budding derm effort a superstar win!
McCleskey and Buzney, Cipriano and Ailor,
With Lio and Loo, each gave their best and then more,
Birnbaum and Luria and Swearingen and ol’ Neil Shear,
For them we offer a champagne toast and say “Hear, hear!”

DOLEV AND DUNNICK, WICKLESS AND DANIela KROSHINSKY,
Rounded off the great effort that made this a win-sky!

WHen it comes to raising money, we have the knack,
This shaven leader gives Sandy Read a pat on the back.
SkinPAC’s one million dollars, a new first for derm,
I hope we repeat for each congressional term.

Protecting fair payment we thank the RUC team,
Who put up with stuff that makes sane people scream,
Scott Collins, our sitting member at AMA RUC,
Makes it look easy like driving a truck,
Coldiron, Deitchman, and Bigby — “the inscrutable Buddha”
They plan and they think and the young folks they tutor!
Kaufmann, Goldman, Sanchez, and Mollie MacCormack,
Are all part of the team — they’ve got our back!

Health Care Fin Com, we needed someone incredibly smart,
The specialty has lucked out with old Scott Dinehart,

KALYNne Harris, friend, scholar, thinker: we miss you young lass,
Tears were shed for you, incredible human at the top of the class!

When it comes to skin cancer, two folks get top billing,
Their efforts may make melanoma less killing,
Hal Rabinovitz, master of dermatoscopy,
Enhances the way we look and we see,
While ACS VP Len Lichtenfeld,
Always makes sure the skin cancer story is...telled.

Liaising to others, important for sure,
Liz Kanof, an AMA delegate, helped cover the HOD floor,
While Rob Kirsner helped guide us through, tirelessly,
Reaccrediting our Academy via ACCME.

A year of transitions, with active ad hoc task forces,
Moved along with the power of thoroughbred horses,
For Comms we had Ceilley, Farris, and Rich,
In response to a diplomate suggestion, the ABD will credit you with 60 CME hours on your MOC table in the year following successful completion of the certifying or recertifying (MOC) examinations. You do not need to pay the AMA fee to have the CME credits recognized by the ABD. We will do so automatically. If you wish to have the credits recognized by any other organization, such as the American Academy of Dermatology, application to the AMA is still necessary.

Visit the ABD booth (#1070) at the March 2013 AAD meeting in Miami to answer all your questions about maintenance of certification.

Boni Elewski, she led the charge,
Aided by past presidents, in person and on the phone,
Bergfeld, Cornelison, and Stephen P. Stone.
It wasn’t enough, they needed some help,
So we gave David Butler a loud noisy yelp.

Many others have helped; you know who you are,
So say hurrah, ’cause you too are a star!

Like all great poems, from Paradise Lost to The Wasteland, this one may require footnotes. Visit www.aad.org/dermatology-world/monthly-archives/2013/february/from-the-president to read a celebration of this year’s Presidential Citation winners — in prose — and to hear a recording of Dr. Siegel reading the poem above. dw
academy update

2013 Academy election opens March 2

GET TO KNOW THE CANDIDATES!
The Academy’s election page (www.aad.org/election) will be accessible starting Tuesday, Feb. 26. View the candidates’ background materials, the ballot book, and the proposed amendments to the bylaws. The president-elect speeches delivered at the Annual Business Meeting and videotaped candidate statements will also be posted to the election site by Monday, March 4.

VOTING OPENS MARCH 2
The 2013 AAD election opens on March 2 at 12:01 a.m. (ET). Members can conveniently access the Academy election site at www.aad.org/election or use the direct link at https://www.esc-vote.com/aad2013 to vote online — anywhere, anytime.

SECURE ACCESS CODES WILL BE SENT TO ELIGIBLE VOTING MEMBERS
Election Services Corporation (ESC) will send access codes to all eligible voting members on Wednesday, Feb. 13 via email or mail (for those without email addresses). When voting, use your secure access code and AAD member identification number. ESC will continue to provide access codes via email each week through April 1.

If you require assistance with your secure access code during the Annual Meeting on Saturday, March 2 or Sunday, March 3, please contact ESC between 8 a.m. and 4 p.m. (ET) at their toll free number, (866) 720-4357 or via email at aadhelp@electionservicescorp.com. After the meeting, ESC will be available for support Monday through Friday from 9 a.m. to 5 p.m. (ET).

VOTING DEADLINE IS APRIL 1
Paper and online voting concludes on Monday, April 1. Ballots must be received or electronically posted on April 1 by 11:59 p.m. (ET). – JOAN TENUT

ACCME reaccredits AAD for six years
THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (ACCME) informed the American Academy of Dermatology on Nov. 30, 2012, that it had been awarded Accreditation with Commendation for six years as a provider of continuing medical education for physicians. ACCME accreditation is intended to assure the medical community and the public that the AAD provides physicians with relevant, effective, practice-based continuing medical education that supports health care quality improvement. Maintaining its ACCME accreditation is what allows the AAD to offer members CME credits for their attendance at the Annual Meeting and participation in other AAD-sponsored CME activities. The new accreditation will last until Nov. 30, 2018. – RICHARD NELSON

Annual Business Meeting agenda
THE AMERICAN ACADEMY OF DERMATOLOGY’S Annual Business Meeting will be held on March 3, 2013 in the Fillmore Theatre of the Miami Beach Convention Center at 8 a.m. It will follow the agenda below:

8:00 A.M. BUSINESS AND BAGELS
AMERICAN ACADEMY OF DERMATOLOGY (AAD) Business Meeting
I. Call Assembly to Order
II. Establish Quorum
III. Introductions and Acknowledgements
IV. President-Elect Candidates’ Statements
V. Recognition of Industry
VI. Awards Acknowledgements
VII. Secretary-Treasurer’s Report
VIII. Unfinished Business
IX. New Business
X. Announcements
XI. Adjournment

AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION (AADA) BUSINESS MEETING
I. Call Assembly to Order
II. Establish Quorum
III. Secretary-Treasurer’s Report
IV. Unfinished Business
V. New Business
VI. Recognition of Retiring Board Officers
VII. Adjournment

INFORMAL DISCUSSION OF ISSUES OF IMPORTANCE FROM THE FLOOR*
Pursuant to the Administrative Regulations of the American Academy of Dermatology and American Academy of Dermatology Association, during any debate at a membership meeting each speaker must introduce himself or herself by name and professional position. He or she must also identify any potential conflicts of interest.
*No CME Credit.
On-site registration available for Annual Meeting
Meeting includes celebration of AAD’s 75th anniversary

REGISTER TO ATTEND THE ACADEMY’S 71ST ANNUAL MEETING in Miami Beach, Fla., being held March 1-5, and ensure you can attend the sessions you want by registering online at www.aad.org/meetings-and-events/2013-annual-meeting. Online registration will continue through Feb. 20 at 12 p.m. CT; after that date, those who wish to attend will have to register on-site beginning Feb. 28. More information is available in the 2013 Annual Meeting Advance Program Book, which was mailed to all members in November and is also available online.

Attendees will also be part of the celebration of the 75th anniversary of the American Academy of Dermatology’s founding on Jan. 14, 1938. A timeline in lobbies C and D of the convention center will give attendees a sense of the changes that have taken place over 75 years, with more information available online at www.aad.org.

EXHIBITORS AT ANNUAL MEETING TO REQUEST PHYSICIANS’ NPIS
Physicians who attend the Annual Meeting will be asked to provide their National Provider Identifier (NPI) in their interactions with exhibitors during the meeting. The NPI is a 10-digit unique identifier used in health care transactions; medical device and pharmaceutical companies are required to collect it by the Sunshine Act provisions of the Patient Protection and Affordable Care Act, 2010’s health system reform law. The law requires companies to report any “payment or other transfer of value” given to a physician.

To reduce the burden of this change on members going forward, the Academy will allow them to submit their individual NPI along with their membership update. Members who do so will have the NPI included in the information that exhibitors can automatically obtain via their ExpoCards in the future. In the meantime, if exhibitors request your NPI, keep in mind that they are doing so to comply with the law.

All NPIs are public information; a searchable registry is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. More information about the NPI is available from the Centers for Medicare and Medicaid Services at https://www.cms.gov/NationalProvIdentStand. - SUSAN TREECE

Advisory Board policy resolutions sought
THE AMERICAN ACADEMY OF DERMATOLOGY’S ADVISORY BOARD looks forward to hearing the voices of the Academy’s grassroots through the submission of proposed policy resolutions. The Advisory Board convenes every year to deliberate on issues of importance to individual practitioners, and bring proposed new policies to the Academy’s Board of Directors for consideration.

If there is an issue of interest and/or concern, now is your opportunity to submit a resolution from which an official Academy position might arise. To ensure full consideration, all resolutions must be received by Feb. 18. The author or his/her representative must be present at the Reference Committee Hearing on Friday, March 1 at the Academy’s 71st Annual Meeting in Miami Beach, Fla., to introduce and discuss the resolution. The full Advisory Board will vote on resolutions at the General Business Meeting on Sunday, March 3. All resolutions and/or questions regarding the process should be directed to Abigail Osborne, staff to the Advisory Board, at aosborne@aad.org. - ABI GAIL OSBO RNE

Datebook

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<td>Dermatology in Action project in Miami Beach, Fla. See <a href="http://www.aad.org/dermatologyinaction">www.aad.org/dermatologyinaction</a>.</td>
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<td>MARCH 1-5</td>
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<td>MARCH 1</td>
<td>ABD certifying exam applications due for July exams. See <a href="http://www.abderm.org">www.abderm.org</a>.</td>
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<td>MARCH 2</td>
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<td>APRIL 1</td>
<td>ABD pediatric dermatology subspecialty exam applications due for October exam. See <a href="http://www.abderm.org">www.abderm.org</a>.</td>
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<tr>
<td>APRIL 1</td>
<td>2013 AAD election closes. See <a href="http://www.aad.org/election">www.aad.org/election</a>.</td>
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<td>MAY 15</td>
<td>ABD dermatopathology subspecialty exam applications due for September exam. See <a href="http://www.abderm.org">www.abderm.org</a>.</td>
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<td>JULY 31</td>
<td>Summer Academy Meeting in New York.</td>
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Timothy G. Berger, MD, named Pearson Award winner

The American Academy of Dermatology’s Council on Education and Maintenance of Certification has named Timothy G. Berger, MD, professor of clinical dermatology at the University of California, San Francisco, as the 2013 winner of the Thomas G. Pearson, EdD Memorial Education Award. The award was created to recognize dermatologists who demonstrate outstanding commitment to the Academy’s educational efforts through the development and coordination of educational programs.

Dr. Berger was recognized for his tremendous involvement in education both at UCSF and with the AAD. At the university, he serves as the associate director of the residency program, the executive vice chair of the department, and the director of the dermatology clinics. He was awarded the institution’s Teacher of the Year recognition, bestowed by dermatology residents, in both 1991 and 2001, and its Henry J. Kaiser Award for Excellence in Teaching in 1989. With the Academy, Dr. Berger has been involved in a number of task forces, as well as serving as a member of the Council on Education and chaired the Medical Student Core Curriculum Work Group. Along with other Academy members and staff. Dr. Berger helped create a series of informative, up-to-date medical student lectures available free to any Academy member at www.aad.org/mscc.

Dr. Berger said that he was surprised to win the award, and extremely thankful for the contribution of his fellow educators to the Academy’s educational mission.

“I’m incredibly honored and astonished to be given this award. I’m very grateful to the Academy and to all the other educators in the Academy who have helped with the curriculum that we developed. There were approximately 40 of them, and it was a huge group effort,” Dr. Berger said.

Dr. Berger will be presented with the award at the 71st Annual Meeting in Miami Beach, Fla. - JOHN CARRUTHERS

Media Highlight

In 2012, the Academy and its members generated more than 2.2 billion media impressions. That’s the equivalent of reaching each American more than six times. With your help, the Academy continues to educate the public about the importance of skin, hair, and nail care. The two most popular topics of the year were acne and skin cancer, accounting for more than 41 percent and more than 40 percent of media stories in 2012, respectively.

In the Dec. 13 New York Times article , “Perchance To Make You Look Rested,” Elizabeth Hale, MD, Anne Chapas, MD, Ilyse Lefkowicz, MD, and Julie Karen, MD, discussed how board-certified dermatologists are using fillers to enhance the appearance of the eyes, reaching the paper’s circulation of 1,586,757.

You can find other stories of interest in the Academy’s new monthly Media Update newsletter available in the Academy’s Media Relations Toolkit at www.aad.org/member-tools-and-benefits/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:

Terrence Cronin, MD
DERMATOLOGIST TREATS UNINSURED SKIN CANCER PATIENTS

MELBOURNE, FLA., dermatologist
Terrence Cronin, MD, in addition to running his successful practice, also serves a population of uninsured skin cancer patients. The commercial fishing community in his area, he said, leaves him with a number of patients who spend their working days in the sun and who more often than not lack insurance. Dr. Cronin has made it his mission to treat this population and convince others to volunteer their time for the uninsured.

“How can you turn away someone who has cancer?”

• Dr. Cronin began treating uninsured patients free of charge from the early days of his practice. At a relatively steady pace of a handful of cases per month, Dr. Cronin estimates that he's performed over 1,000 surgeries for uninsured patients. In addition, he said, he has found a pathology group in the area that performs pathology services for these patients free of charge.

• “I’ve seen some very advanced cases with these patients. I used to give a presentation for the Florida Society of Dermatologic Surgery every year, and it would be a series of slides of the worst cancers. It got to the point where regular, smaller cancers wouldn’t even make the presentation.”

• One of Dr. Cronin's commercial fisherman patients, he said, came in following a long absence and Dr. Cronin found that he had to remove and biopsy seven skin cancers, one of which turned out to be a melanoma. In exchange for the life-saving surgery, Dr. Cronin said, his patient returned later that week with a freshly-caught fish.

• Dr. Cronin’s son, dermatologist and Mohs surgeon Terrence Cronin Jr., MD, has been in and around his father’s dermatology office since he was a child. Now, Dr. Cronin said, they both work on uninsured skin cancer patients, and convince other physicians to take similar cases.

• “A lot of people think if they give a free operation, they’re giving away a thousand dollars or something of that nature. But you’re not doing that, you’re giving away a half hour of your time that you may not have done much with anyway.”

to nominate a physician, visit www.aad.org/membersmakingadifference.

- JOHN CARRUTHERS
We’re looking for a full-time Dermatologist

PIH Health is a nonprofit health and wellness network consisting of a 550+ bed acute care hospital, multi-specialty medical group, hospice, home health and other services. Located in Whittier, California, just 30 miles east of Los Angeles, our exclusively-affiliated medical group is rapidly growing to meet community needs. In response to this growth, we have an immediate opening for a full-time Dermatologist.

Successful candidates will be well-trained, board-certified (or pending if new graduate) and interested in general medicine dermatology. We are looking for motivated team players who want to work in state-of-the-art facilities with other well-trained physicians and advanced practice professionals. In exchange, you will enjoy a work-life balance, great benefit and compensation package, and a grateful community of patients.

Whether you’re interested in surfing, skiing, hiking, biking, art or culture, we’ve got it all at our doorstep.

Find out why physicians commit to work for PIH Health:

PIH Health Physician Recruitment 562.698.0811 Ext. 81843 or 81125 Submit CVs to MDjobs@pihhealth.org PIHealth.org
NORTHERN CALIFORNIA
Located midway b/w San Francisco, Napa, & Tahoe, we are seeking a BC/BE Dermatologist 3-5 days per week to join well established General & Cosmetic Derm practice. Outstanding staff, warm office environment, suburban setting, state-of-the-art surgery, laser & computer equipment. Partnership opportunity. Mentorship in advanced cosmetic & reconstructive procedures if desired. Productivity, hours, vacations all flexible based on your goals. Excellent opportunity for income and Family/Life Balance. To apply, please send CV, and short Bio with your goals to: NorCalDerm@gmail.com.

SAN JOAQUIN VALLEY, CA
Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

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

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

FT. LAUDERDALE, FLORIDA
Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

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

SOUTH SHORE, MASSACHUSETTS
Partnership available. Established practice. Contact Jeff, (866) 488-4100 or hr@mydermgroup.com.

Employment Opportunity in Central Florida

Central Florida Dermatology and Skin Cancer Center (CFD), with two locations near Lakeland, Florida, is seeking qualified BC/BE Dermatologists and fellowship-trained Dermatopathologists and Mohs surgeons. The practice area runs along the I-4 corridor, is near many popular family vacation resorts (Disney, Universal Studios), and provides 45 min access to the cities of Tampa Bay and Orlando with the all family-friendly amenities of a smaller town. CFD is within 1-2 hours of the world’s best beaches. The practice area is a referral center for skin cancer treatment and has a large “snowbird” patient population. Both practice locations have been present in their respective communities since 1982.

CFD consists of 3 physicians, including a fellowship-trained Mohs surgeon, and 3 ARNPs. One physician is near retirement. We offer competitive salary, generous benefits, productivity bonus, partnership track, paid vacation. Interested candidates should send an email with attached curriculum vitae to Daniel at daniel@centralfldermatology.com. CFD will assist interviewees with travel expenses.

HAWTHORNE

SARASOTA FLORIDA
Unique opportunity for a Mohs Surgeon/General Dermatologist to lead established dermatology division in a collaborative multispecialty group practice. Current practice has CLIA certified dermatopathology laboratory. Outstanding staff, warm office environment, state of the art facility. Family oriented and culturally rich living environment on the Gulf Coast of Florida. We offer excellent compensation and bonus incentive as well as benefits with an aggressive partnership track.

Please contact Ellie Messina at emessina@hawthorneclinic.com or call 941.953.5050 ext 715.

Beautiful Cape Cod, Massachusetts
Immediate opening for BE/BC General Dermatologist. Employed position with a competitive salary and incentive program. In order to meet patient demand, Cape Cod Healthcare will be establishing a brand new office for 3 dermatologists (2 new and 1 existing dermatologist) in West Yarmouth, MA. Enjoy coastal living and work in one of Reuters Top 10 Health Systems in the Country. For more information please contact:

Jolia Georges,
Director of Physician Recruitment
508-862-5481 (direct)
508-816-8858 (cell)
jgeorges@capecodhealth.org

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 CVs 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
PROFESSIONAL OPPORTUNITIES

Concord, MA and Wolfeboro, NH

Two opportunities for part or full time Dermatologists to join a group of nine Board Certified Dermatologists in a professionally run practice with Dermatopathology, Mohs, Medical Aesthetics, and consulting facial plastic surgeon. The opportunities would allow highly qualified dermatologists to practice with excellent support staff in a collegial practice in an attractive Boston suburb or a resort area of New Hampshire with opportunity for 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.

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North Carolina

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A recap of one of the American Academy of Dermatology’s first meetings, held in 1938, includes a note regarding a dinner for all attendees: “Wives were invited.”

Such a note would represent quite a typo today. As the chart below shows, women have steadily made up a larger and larger proportion of practicing dermatologists within the Academy’s membership, and they have taken on more and more leadership roles within the organization. Margaret A. Storkan, MD, served as vice president in 1973, the first of seven women to hold the role thus far. Wilma F. Bergfeld, MD, served as president in 1992, setting the stage for three other women who have since been elected. And June K. Robinson, MD, served as secretary-treasurer from 1998 to 2000, with two women taking the role since and a third poised to take it over when the incumbent completes her term.

Female dermatologists outnumber their male counterparts among the Academy’s younger members; 63 percent of respondents to the AAD’s 2012 Dermatology Practice Profile Survey under 40 were women, as were 52 percent of respondents between 40 and 49. The future is clear: Women will continue to play an increasingly important role in dermatology’s future, and the majority of dermatologists are likely to be women within a decade. – RICHARD NELSON

Proportion of women in Academy membership

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