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Did you know that November used to be the ninth month of the year?

Yet when Julius Caesar made January the first month of the year there was no talk of renaming November. Even today November sits in position 11 with a name that means number 9. Don’t know if the ancient Romans were a flexible lot or whether when Caesar spoke one just bit one’s tongue.

Flexibility, and the need to play well with others, has once again become the mantra as we move more fully into the 21st century. It is the code for success. We see it everywhere as we look around; workers of all stripes are re-inventing themselves in new occupations and positions. Getting fired has become the “opportunity” to reconsider and pursue another direction. In derm, losing our jobs has not been a worry for most of us. Yet being flexible and engaging others in the surrounding universes has become just as necessary for our survival. It strikes me that most of this month’s Dermatology World in one way or another concerns the need to be flexible as health care takes its turns.

Take for example, virtual microscopy. Though it seems sort of amazing, in Acta this month you will read about how microscopes are on their way out — replaced by computer images that are as accurate, facilitate storage, are cheaper to purchase, and more successfully preserve unique views of pathology. And most of all, these images are easily shared with those down the hall, across town, and on the other side of the globe. It’s not much of a leap to understand the benefits possible to clinical practice and medical education. Hard to imagine that the multi-headed scope that sits in the dermpath lab across the hall from my office is breathing its last gasps. Flexibility.

Another example — working with non-derms in the care of patients with skin disease. Always was a good idea to have a presence in the hospital. Now, however, the urgency for interfacing with the local physician community has become acute. Rob Sidbury, MD, points out the many benefits of hosting focused continuing medical education lectures for primary care physicians “It’s a short-term outlay in terms of time, but it will have a long-term benefit because you will become the go-to person in the group.” That is just the first step, though. As ACOs develop we see flexibility in novel ways. In this piece both Alexa Kimball, MD, and Randy Roenigk, MD, allude to the need for collaboration with their primaries. “The advantage of being in an ACO is that resources can be freed up when payment is not purely fee-for-service to allow for increased consultation in a way that still compensates dermatologists,” Dr. Kimball says. Dr. Roenigk speaks to us about trying out novel strategies such as virtual consults to help the primaries serve patients well. Flexibility.

It is everywhere in this issue: just check out our Legally Speaking column this month. The topic: who controls your patients’ health data, the EHR company or you? This is one I think that you will find extremely timely. Clearly learning to negotiate with the EHR company is key. Flexibility.

The days of being the sole captain of the ship are heaving their last sighs. However, if you were hoping to retire to get away from all this, be sure to read our piece on ending your practice. No such luck! Seems that retirement also requires lots of flexibility to pursue current passions and invent some others. I suppose there is always John Stanley’s solution of just getting lost in a book or two or more. It saved me from many nights of helping my sister with the dishes when I was young, so it might just be the winning formula once again.

Enjoy your reading!

ABBY S. VAN VOORHEES, MD, PHYSICIAN EDITOR
“The most important thing for dermatologists is to be realistic about the value of their practice.”

COVER STORY
DERMATOLOGISTS DISCUSS LOGISTICS OF CLOSING A PRACTICE
BY JOHN CARRUTHERS

22
THE AGE OF BROTOX
Noninvasive options lure more men to cosmetic treatment
BY JAN BOWERS

26
SYMBIOTIC COLLABORATION
Stronger networking between dermatologists and primary care providers can improve care patients receive
BY RUTH CAROL

FROM THE EDITOR

CRACKING THE CODE
What’s the difference between major and minor procedures?

ROUNDS
Real-time insurance verification coming in 2013, more.

ACTA ERUDITORUM
Can virtual microscopy replace glass slides for dermatopathology?

LEGALLY SPEAKING
EHR data control: a practical primer.

IN PRACTICE
Read to lead.

FROM THE PRESIDENT

ACADEMY UPDATE
Secretary Treasurer’s Report, more.

ACCOLADES

FACTS AT YOUR FINGERTIPS
Shade Structure Grant Program promotes childhood sun-safe behavior.
What’s the difference between major and minor procedures?

DIRK M. ELSTON, MD, addresses important coding and documentation questions each month in Cracking the Code. Dr. Elston, who serves as director of the Ackerman Academy of Dermatopathology in New York, has represented the American Academy of Dermatology on the AMA-CPT® Advisory Committee.

I volunteer as teaching faculty at the university dermatology clinic. I have been told that I have to be present for the entire procedure if it is a “minor” procedure. Does this mean any procedure with a 10-day global period?

First off: Thank you for volunteering, and giving back to the specialty. In regard to the question of whether you have to be present for the entirety of a minor (10-day global period) procedure, in an inpatient setting, Medicare states that for minor surgical procedures (lasting less than five minutes), the teaching physician must be physically present during the entire service. As for major procedures (lasting more than five minutes), the teaching physician must be physically present during the “key portion(s)” of the service and must be immediately available to furnish service during the entire procedure. The teaching physician must then document the extent of his/her participation during the procedure. However, your teaching faculty may have a different policy for services or procedures performed in an outpatient setting; check with the coding and compliance office at the university. It is likely that you only have to be present for the key and critical portion(s) of the procedure(s), unless there is a medical reason for you to be present for the entire duration of the procedure.

There has been considerable confusion over this point, as the Centers for Medicare and Medicaid Services (CMS) uses the terms “major” and “minor” in more than one context. In regard to use of the 57 modifier (decision to perform surgery), the code is used in conjunction with 90-day global period (major) procedures, but not for (minor) procedures associated with a 0- or 10-day global period. In a resident supervision situation, CMS uses the term “minor” in a different way. The guidance regarding resident supervision issued by CMS is as follows: “For procedures that take only a few minutes (five minutes or less) to complete, e.g., simple suture, and involve relatively little decision-making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.” (This policy can be viewed at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/RC2303CP.pdf.)

Many procedures with a 10-day global period take longer than five minutes to perform, and require significant decision-making after the need for the procedure was determined. For such procedures, the supervising attending physician must be present for the key and critical portion(s) of the procedure, but does not need to be present for the entire procedure.

Example 1:
You evaluate a patient with a large, ill-defined pearly plaque on the temple. A frozen section confirms a diagnosis of basal cell carcinoma. After an extensive examination, history, and discussion of the patient’s comorbidities, you determine that Mohs excision is appropriate. You clear the tumor by Mohs surgery and repair the defect with an adjacent tissue transfer.

The biopsy (11100-59) and frozen section pathology (88331-59) should be reported in addition to the Mohs surgery and the closure, if the lesion had not been biopsied previously (within the past 60 days or if biopsy was performed within the past 60 days and the histopathologic report cannot easily be obtained), the biopsy was interpreted prior to the definitive procedure, and the interpretation determined the subsequent procedure. In addition, depending on the documented cognitive services, it would probably be appropriate to code for E/M services and append the 57 modi-

DERMATOLOGY WORLD // November 2012 3
Medicare recognizes modifier 57 to indicate E/M services related to the decision to perform a medically necessary procedure associated with a 90-day global period. Medicare carriers have issued guidance that this modifier should not be used with procedures with a zero- or 10-day global period as they consider the decision to perform those procedures to be part of the usual pre-operative services bundled with the payment for those procedures. It should also be noted that modifier 57 should typically not be reported for prescheduled surgeries, as the decision to perform those was already reached in advance.

Example 2:
At a teaching hospital emergency department, you evaluate a patient with a very small laceration. You help the resident place a simple suture to ensure good wound approximation. It takes three minutes.

As this is a short procedure, lasting less than five minutes, that required little independent decision-making, it is appropriate that you are present for the entire procedure.

Example 3:
At a teaching hospital, you are asked to supervise two basal cell excisions simultaneously. Both require undermining and layered closure and last half an hour each. You move between the two rooms, making sure that you are present for the key and critical portions of each procedure.

As these are both longer procedures, lasting more than five minutes, that require significant independent decision-making during the procedure, it is appropriate that you are present for the “key and critical” portions of each procedure. Therefore, the “key and critical” portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, then the physician can become involved in the second procedure.
Real-time insurance verification coming in 2013

Practices will soon be able to tell patients their balance owed for a visit almost immediately due to a provision of the Patient Protection and Affordable Care Act that will take effect in January 2013. The provision, included as an effort toward simplification of the patient/physician transaction, requires insurers to give a practice real-time verification of a patient’s insurance status within 20 seconds of a request. It will require upgrades of existing software systems, and may, in the future, help physicians with collections.

Currently, those insurers that do offer verification can take up to an hour to respond to the request. Insurers must be compliant by Jan. 1, though many payers and software programs will not be ready to make the switch by then. Physicians should contact their insurers prior to the deadline to ensure that a compliance plan is in place and on schedule. A list of insurers that are currently compliant can be found at www.caqh.org/CORE_organizations.php. - JOHN CARRUTHERS

Dermatologic conditions included in screening, treatment plan for 9/11 first responders

THE WORLD TRADE CENTER HEALTH PROGRAM recently announced that it will provide $4.3 billion in treatment and compensation via the Zadroga Act to 9/11 first responders who were diagnosed with cancer after they inhaled toxic dust at Ground Zero. Included in the list of covered cancers are dermatologic conditions such as malignant neoplasms of the lip, tongue, salivary gland, floor of mouth, gum, and other mouth, tonsil, oropharynx, hypopharynx, and other oral cavity and pharynx; malignant neoplasms of the soft tissues (sarcomas); and malignant neoplasms of the skin (melanoma and non-melanoma), including scrotal cancer. About 40,000 responders and survivors will receive monitoring and 20,000 will receive treatment for their illnesses as part of the Zadroga Act’s health program. - LISA TOWERS

Dermatologists bring specialty’s concerns to Washington

THE LEGISLATIVE CONCERNS OF DERMATOLOGISTS and their patients rang through the halls of Congress during the American Academy of Dermatology Association’s annual Legislative Conference, held Sept. 9-11 in Washington, D.C. The event brought together 112 participants, including 91 physicians and 21 other advocates, including patient advocates, dermatologic nurses, dermatology practice administrators, and state dermatology society staff members. Among the participants were 17 dermatology residents who applied for and won scholarships to the event; they each committed to year-round involvement in the AADA’s advocacy efforts.

The focus of the event was its final day, when participants took part in 173 official congressional meetings covering representatives and senators from 31 states. This was 12 more than last year’s conference. The number of meetings in which participants met directly with a representative or senator increased by 10, from 54 to 64.

Prior to their legislative meetings, attendees heard a variety of expert perspectives about the important health care issues Congress has to address and the best way to make their voices heard. Speakers on the first topic included former Centers for Medicare and Medicaid Services Administrator Mark McClellan, MD, PhD; two members of Congress, Rep. Tom Price, MD (R-Ga.), and Rep. Vern Buchanan (R-Fla.); Maryland state senate majority leader Robert Garagiola (D); and CNN political analyst and former Clinton campaign strategist Paul Begala. Participants also learned tips for successful congressional meetings from Ed Barks of Barks Communications, PAC and grassroots expert Amy Showalter, and Brad Fitch of the Congressional Management Foundation.

To read more about the legislative conference, learn more about the issues discussed, and see photos, visit www.aad.org/member-tools-and-benefits/aada-advocacy/federal-legislative-affairs/2012-legislative-conference. - RICHARD NELSON
Can virtual microscopy replace glass slides for dermatopathology?

IN THIS MONTH’S ACTA ERUDITORUM COLUMN, Physician Editor Abby S. Van Voorhees, MD, talks with Ellen Mooney, MD, and Antoinette Foote Hood, MD, about their recent Journal of Cutaneous Pathology article, “Diagnostic accuracy in virtual dermatopathology.”

Q&A

DR. VAN VOORHEES: For those of us not in the know, what is virtual microscopy? Is it being used in dermatopathology? How so?

DR. HOOD: Virtual microscopy is the process whereby, with scanning machinery, you’re able to take a whole mount of a glass slide and get digital imagery of that entire specimen and then, with a computer program, can convert that into an image that can be placed online, sent on a DVD, or put on a computer. The person who is looking at it can go from low power, to see the whole mount, to higher power, to see individual cell detail. So it’s digital imagery of a whole mount of the glass slide, and it can be performed on any tissue. Dermatopathology is particularly well-suited to this process because our pieces of tissue tend to be a bit smaller.

DR. MOONEY: This technique is being used for medical student and resident teaching in the U.S. and Scandinavia. In addition it is regularly used for resident teaching and in conferences in Australia and occasionally in Europe, e.g., Austria, Germany, and the UK. The Biomedical Informatics Research Group in Finland has used virtual images in the European Congress of Pathology and at the Department of Pathology, University of Helsinki, Finland, they host their dermatopathology seminars online in virtual format. It has also caught on quite a bit in CME/continuing professional development, and in external quality assurance. In dermatopathology, it’s mostly utilized in CME.

DR. VAN VOORHEES: Have interpretations of virtual images been compared to those of glass slide readings?

DR. HOOD: Yes, and that’s well-documented in the literature, with one of the earlier
articles coming out of our medical school when they were looking at replacing a lot of microscopes for the histology laboratory and the thought was, instead of having to spend all this money on microscopes and old slides, can we digitize our images and teach histology to medical students without microscopes and glass slides? So they did the controlled study and found out that it didn’t really make any difference which way you taught histology.

We followed that study with a comparison of glass slides and virtual dermatopathology images using pathology and dermatology residents. We did a controlled study and found that once again the two techniques, glass or virtual, were interchangeable in the doctor’s ability to make a diagnosis. DR. MOONEY: There are a couple more studies from Austria that looked at melanocytic lesions and inflammatory lesions. They found, in the inflammatory lesions being studied virtually, that if the clinical information was not available along with the images, the concordance with the original diagnosis was not as good, whereas participants did better with tumors even without clinical information.

DR. VAN VOORHEES: What did your study find out about how virtual images compare to photomicrographs?
DR. MOONEY: There was basically no significant difference observed in the diagnostic accuracy using virtual dermatopathology compared with photomicrographs which, to me, was a bit surprising considering that the photomicrographs were taken to point the physician in the direction of the pathology, whereas with the virtual slides you just had to find it yourself. In one instance, there was almost a significant difference where in the first eight cases the photomicrograph group was doing better.

DR. VAN VOORHEES: It seems there’s a very big difference because a photomicrograph is a single picture of something you want someone to see whereas on a virtual image you can move around much as you can on a glass slide.
DR. MOONEY: The difference wasn’t as large as you might expect. We usually had four photomicrographs per case, and these were taken at different magnifications. The photomicrographs were taken by the faculty of the self-assessment exam at the Nordic Congress of Dermatology in 2008. These were the photomicrographs that they took in order to review the cases and give the diagnoses in their discussion after the exam was over. So, these were directed at the pathology.

DR. VAN VOORHEES: So you thought the photomicrographs should have an advantage and were surprised to see things were more equivalent.
DR. MOONEY: Yes, because with the whole mount you have to go looking, whereas with the photomicrograph they were directed toward the pathology. We had seven dermatologists, seven pathologists, 17 dermatopathologists, and two fellows. And we had 15 cases, with multiple-choice questions, two per case. Sometimes we’d interject a special stain or immunohistochemistry and then ask for the diagnosis again. Or we’d ask for a diagnosis and then ask a second question in relation to the disease or condition in that specific case.

DR. VAN VOORHEES: Were there any differences noted in the ability to interpret a slide using virtual microscopy for different pathologic diagnoses? Were there differences between the type of providers?
DR. MOONEY: Basically there was no difference. Everyone had a hard time with the tough cases regardless of the format. There were some tough lymphomas and inflammatory cases that people were missing, regardless of whether they were photomicrographs or virtual.

DR. VAN VOORHEES: Where do you see the benefits of digital microscopy?
DR. HOOD: It will likely replace microscopes in medical school teaching. Possibly you’ll see it replacing microscopes in undergraduate education as well. Just on a financial basis, maintaining the equipment and the study materials is increasingly expensive and difficult. There will always be microscopes because you’ve got to teach people how to do some things, but for educational purposes, a virtual image is in my opinion better than glass quality. I think you’re going to see that
happening in a lot of schools and, in certain circumstances, in residency programs. The other advantage for an educational setting is that it allows you to have an incredible library of permanent images that don’t break, fade, or disappear. It will also be a great thing for distance learning. It’s now possible to share images from Norfolk, Va., with people anywhere in the country and even any place in the world that has the right sort of equipment. So it has potential for libraries, for teaching cases, for distance learning, and for medical school.

In clinical settings, you could very easily put virtual images on a server and have them available to clinicians. I believe the surgeons in particular would like to be able to review original material before doing a second surgery, and the convenience of being able to pull up the original biopsy digitally, as opposed to finding and sending the slide, would be a wonderful and very powerful tool. I predict that that’s going to happen more and more. I’m currently doing some dermatopathology teaching in both Norfolk and Richmond. What we’re doing at Medical College of Virginia is that the interesting cases that the residents biopsy are being scanned, and they and I are able to look at them on a server and discuss them. This also has huge implications for telemedicine.

DR. MOONEY: And in CME it’s very useful. In the self-assessment exam in this study, we presented participants with clinical data, a clinical photograph, and the whole mount as a digital slide and asked questions that they could answer online. The software is now such that you can add annotations, e.g., circles, arrows, add little text boxes as you’re studying. Digital microscopy is also useful for storing slides — you don’t have to keep retrieving the glass slides, which may break, and there’s less cost involved because you don’t have to pay someone to retrieve them.

DR. VAN VOORHEES: Do you think that the use of this technology has contributed to your ability to do studies that have a global focus? Has the world truly gotten smaller?

DR. MOONEY: Yes, it has, and it really was an aid. Once the slides were scanned and digitized, at the Congress in Iceland, I was able to set up the questions through the software company in Ireland, and then connect with Toni and the reviewers — one in Switzerland — who reviewed them. The EVMS CME office subsequently approved the exam for CME credit. People across the world were participating including our two collaborators, Werner Kempf and Gregor Jemec in Europe, and others were taking the exam in Australia, in various places in Europe, and in the U.S. So yes, it certainly has helped me to do this type of study.

DR. VAN VOORHEES: Should readers expect to see virtual microscopy more and more in their futures, particularly as they consider recertification?

DR. HOOD: The American Board of Pathology is currently converting its glass slides to virtual images to be used on its examinations, and is increasing the number of virtual images on the exams each year. And similarly, the American Board of Dermatology has been using virtual images on the in-training exam as long as five years ago; we’ve been gradually using virtual images on the certifying examination with the idea that there will be a mixture of glass slides and virtual images over time. The American Society of Dermatopathology is currently using virtual images in its online MOC self-assessment. It’s also going to be important for recertification and maintenance of certification.

Given that, I should mention that there is an online library of virtual images at www.virtualdermpath.com that is available to everybody and has hundreds of images; residents use it to study before the exams. DR. MOONEY: Speaking of exams, the exam we used for this study is still available online if people want to take it and find out how they do. Visit www.nivdp.com/cme.htm to take it.
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EHR data control: a practical primer

THERE are a range of concerns when selecting and implementing an electronic health records (EHR) system: choosing the right one, considering its impact on practice productivity in the short and long term, and return on investment, to name a few.

There is also the negotiation process and the review of the end-user license agreement (or “EULA”), which may delay implementation as the practice and the vendor negotiate contract terms. However, the review of the EULA is an important early step in EHR implementation. It is at this stage that critical issues, such as those of data control and ownership, should be addressed. For a more general overview of evaluating EHR software, as well as common EULA terms and an analysis of the Medicare EHR incentive program, see the section of the Academy’s “HIT Kit” on EHR implementation, located at www.aad.org/member-tools-and-benefits/practice-management-resources/hit-kit/ehr-implementation.

DATA CONTROL: THE BASICS

What is “data control?” In a very basic sense, “data control” applies to the question of who owns, has access to, and has the ability to manipulate or otherwise use data which populates the EHR. To what “data” does the concept refer? Put simply, the “data” in question is the information generated by the practice’s use of software. This may be granular, specific bits of information, such as a patient’s name, address, age, etc. It may include larger blocs of data, such as progress notes, orders for laboratory studies, or prescription orders. It may also apply to data drawn from information practice personnel enter, as well as data that is de-identified, aggregated, and collated for further use, such as prescribing habits for certain demographic blocs, frequency of billed services, etc.

Not surprisingly, this information can have independent commercial value, as well as value from a practice compliance perspective. (We discuss this in depth on our website at www.gosfield.com/PDF/Ch5Shay.pdf.) For example, pharmaceutical companies will pay to know
a physician's prescribing habits. The billing records of the practice — and billing patterns derived from them — may prove essential in responding to insurer audits or investigations, or in addressing potential overpayments. Vendors often want access to this data, specifically because of its commercial value when de-identified and aggregated.

STRUCTURAL CONSIDERATIONS
Depending on the nature of the software involved, actual control over and access to the data may vary. For example, with Web-based software, the data (or at least a copy of it) is likely not stored on the practice's computers, especially when the software includes a remotely provided practice management component, such as data storage, billing, or computerized order entry. Because it needs access to the data to provide these services, the vendor will retain the data on its servers.

By contrast, if the software is resident on the practice's computers, the vendor will likely lack direct access to the data. The vendor may still, however, be able to access the data indirectly or remotely. For example, software resident on a practice's computer might still require an internet connection (similar to how Microsoft Windows requires such a connection to activate the software and push updates to the software). With such a connection, a vendor might be able to access the data through a built-in “back door” in the software itself.

The major benefit of the data being resident on the practice's computers, however, is that the practice has more ability to retain its data, and restrict vendor access if it chooses to. Moreover, the vendor has far less ability to “hold the data hostage” in the event of a contractual dispute. There may be tradeoffs, however. The software may offer limited options for remote access, which may mean the loss of access to the software from home, or may require a separate copy to be installed on a home computer (which can increase the cost of the software). A Web-based system suffers no such restrictions; access can be had from any computer with a compatible Web browser. In addition, the practice may lose the benefit of additional vendor services, if data is stored locally and the vendor has no access to it.

POINTS OF CONFLICT AND CONTRACT ISSUES
Three common areas of conflict may present themselves with respect to data control and ownership: (1) vendor use of practice data, (2) vendor audits of practice data, and (3) post-termination access to records. The best time to address these issues is during the negotiation process, before signing the EULA.

1. Vendor use
As noted above, vendors often want access to practice data, due to its commercial value. If the vendor intends to use the data, the EULA should specifically state as much. Such use of the data should also be only in a form rendering it “de-identified” within the definition of the HIPAA regulations. Moreover, the practice should receive something for the vendor’s use of its data. This may be a value-added service, such as the vendor using de-identified data to create clinical decision-making tools within the software, or it may take the form of a price decrease (or, more likely, a price increase if you refuse the vendor access to the data).

Assuming the matter is addressed in the EULA, the language may read something like this:

*Practice grants Vendor a nonexclusive license to use the Practice Data, in de-identified format in accordance with the definition of “de-identified” under 42 CFR 164.514. In exchange, Vendor shall grant Practice use of Vendor’s Clinical Quality Decision-Making Database (“CQDM Database”) described in Exhibit C, attached hereto and incorporated by reference herein. Practice may refuse to grant Vendor access to such data, but Vendor shall not grant Practice the use of the CQDM Database.*

In this case, the language means that the vendor has the right to use de-identified practice data. The practice can refuse, but it will lose access to the vendor’s clinical decision-making tools. Note that the language above does not describe the specific use of the data. Practices may want to inquire how their data — even if de-identified — may be used. Even if a practice has no objections to permitting the vendor to use such data, it may want to use the data for similar purposes. Without knowing how the vendor intends to use the data, the practice could find itself in competition with the vendor in the commercialization of its own data.

An alternative, more practice-friendly approach to data usage and ownership would look as follows:

*All business data obtained or created by Practice is the property of Practice, including patient clinical, financial, and insurance-related information. Vendor may, in the fulfillment of its duties, access Practice’s data. At no time shall Vendor copy or otherwise use any data obtained or created by Practice, without Practice’s explicit consent. Vendor shall maintain the exclusive ownership of all rights, title, and interest in and to the Software, Documentation, and other material provided by Vendor to Practice under this Agreement, and this Agreement does not provide Practice with title or ownership of the Software, Documentation, or other materials provided by Vendor to Practice hereunder.*

In this case, the vendor can only use the practice’s data with the practice’s explicit permission. This gives the practice leverage. This type of language, however, is far less common.
2. Vendor audit
In some cases, vendors may either offer auditing services/software functions, or demand that the practice permit the vendor to audit the practice’s records. The latter is more likely to be seen when dealing with an arrangement such as a health information exchange (HIE) or an organized health care arrangement (OHCA). These concepts involve otherwise disparate health care providers who may treat the same patient population, and therefore share electronic health records across a network. For example, a hospital system may provide EHR software to practices treating patients within the hospital’s system, thereby facilitating the sharing of records and improving continuity of care. A EULA for such an arrangement may include language such as:

Corporation reserves the right to audit, remotely or otherwise, use of the System by the Practice and its Authorized Personnel. Such audits will be conducted to ensure compliance with the provisions of this Agreement and Confidentiality Agreements. Suspected breaches, including without limitation any unauthorized use of the System, will be investigated promptly, and the Practice shall cooperate fully in connection with any such investigation.

The organizing entity is acting as the business associate of all of the various providers to which it gives the EHR software. Thus, it must ensure the privacy and security of those providers’ records. This, in turn, may require the organizing entity to periodically audit providers’ records to ensure no unauthorized access has occurred. Such audits are, in theory, beneficial to the provider, and should not be viewed as a “hostile” audit (such as a government audit of billing records). The goal here is to ensure that the practice’s records are protected, and that those with access to the software are using it properly.

In other cases, a software vendor may offer auditing services to assist the practice, or may tout the auditing functions offered by its software. This does not necessarily mean that the vendor will audit without the practice’s permission, nor should it. When the vendor is providing data storage and/or other practice management services, the vendor is, again, acting as the business associate of the practice. Unless the practice otherwise authorizes it, the vendor should therefore not audit practice records of its own volition.

3. Post-termination use
The last, and possibly most important, aspect of data control relates to handling of post-termination data. When a software license agreement terminates, the practice will usually be required to return the software (if it was installed on practice computers) or will simply lose access to the software. When this happens, the practice’s data will need to be returned and may need to be converted to a format readable outside of the software. The EULA should address this. For example:

At any time during the Term upon written request by the Practice and without request upon termination or expiration of this Agreement, within thirty (30) days of receipt by Vendor of a payment of a $XXX fee, Vendor shall send the Practice an electronic file of the Practice Data in a commercially reasonable flat file format on commercially reasonable media. After the thirty (30) day period commencing on the date of termination or expiration of this Agreement, Vendor shall have no obligation to maintain any copies of or provide any copies of the Practice data, except as otherwise required by law.

The language in this section includes a common feature of EULAs: a cost for data conversion. This is not unreasonable. “Flat file format” is industry jargon for a neutral, basic text format; in some cases, practices may request a specific file format (such as a searchable PDF) for the data, but that may come with additional charges. As a practical matter, the vendor likely will want to rid itself of the practice’s data (and free up server space) as soon as possible, but may be bound by the terms of a HIPAA business associate agreement to maintain the data. Bear in mind that state laws often require practices to maintain records for a specific number of years, so practices have a legal duty to obtain copies of the data even after termination.

Another consideration is what happens if there is a dispute about fees owed by the practice, and the vendor refuses to release the data. This poses a practical problem for practice owners: do they fight the dispute out in court, or pay what the vendor demands? As distasteful as it may be, in some cases the smart move is to pay what the vendor demands, simply because doing so may ultimately be less expensive than litigating, and will almost certainly achieve faster results. In any case, the EULA should clearly address the process by which data will be converted and returned to the practice.

As discussed above, the right time to address these issues is during the negotiation process following a practice’s review of the EULA. It is far easier to plan for the future than it is to resolve a dispute in the present when the EULA itself is imprecise. The EULA can provide a roadmap for how to handle issues of data control and data ownership, and when precisely drafted, can do so in a way that benefits — or at least identifies disadvantages to — the practice.
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As physicians, we always seem to have a pile of reading to do. Keeping up with the latest developments in a specialty can often feel like a full-time job in itself. Yet when I’m just about to turn in for the evening, the reading that I’m trying to finish before turning off the light isn’t about dermatology, or medicine at all. After a busy day in my academic practice, my favorite means to unwind is to dive in to a good book.

I picked up the habit from my grandfather, who always read at a tremendous rate. He used to tell me “no matter what you’re doing at work, no matter how busy you are, it’s important to make the time to keep reading.” He said that it was important for keeping perspective, and decades removed from that advice, I still believe him. So no matter what my day is like, before I go to bed, I read at least a few pages of something that’s completely unrelated to dermatology. It gives me perspective on life, which is crucial for a physician.

PERSPECTIVE AND BALANCE
We have grand rounds once a week at Penn. When I used to run rounds, back when I was chairman of the department, I used to begin by talking about a book I was reading and offering what I thought were the takeaways. It was always a work from my eclectic reading list that featured a topic outside of dermatology. It helped us to loosen up before rounds and think about related ideas in a completely different fashion.

I like to talk about books in groupings if I think they relate to each other thematically. For instance, a few years ago I had to travel to Singapore to give some lectures. So I gave an informal talk...
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on books about love and doctors to the medical students. It led to an enjoyable discussion of concepts of love and duty in different cultures (see sidebar). I try to draw wisdom or lessons from these books, and where I can, share them with my colleagues.

It used to be that physicians were part of the intellectual centers of their communities. Today, it can seem more like a trade than an intellectual pursuit sometimes with all the rules and responsibilities we have to manage all day. You have to know what you’re doing on a technical level, and that’s an absolutely vital part of becoming better dermatologists. But when I’m able to take the lessons of disparate fields and authors and apply them to my practice, or have a dialogue with a colleague, I feel as though I’m re-connecting with our roots as doctors.

PAGE TO PRACTICE

I can’t spend 100 percent of my time on my professional life — I already spend a great deal of time on it. Yet I can’t help but feel that reading has also enhanced my professional interactions. It makes me a better physician by helping me understand people and situations that are completely different from what I’ve experienced. It reinforces that people have different points of view and motivations.

In some cases, my reading has allowed me to make a better connection with a patient. I read a lot of history about World War II. I have some elderly patients, and when I have time, I do like to talk with them about their lives. I had one patient who had mentioned that he’d served under General Patton during the war, and I asked if he’d been in the Battle of the Bulge. He just looked at me, pleased and surprised that I knew something about what he’d done for the country and how difficult it was. It created an instant rapport with that patient. It doesn’t happen with every patient, because I can’t read up on every subject, but it’s very special when something like that happens. dw

RECOMMENDED READING

The books that stick with me most are those that offer a window into a new perspective or unique idea. Here are some of the books that have stuck with me long after I’d finished reading.

*Lyndon Johnson (Volumes I-IV)* — Robert Caro

*Steve Jobs* — Walter Isaacson

*Van Gogh: The Life* — Steven Naifeh and Gregory White Smith

I love to read biographies. There’s almost always an important lesson to be learned, no matter the subject. The Johnson biographies are a fascinating portrait of a man who was deeply flawed, but also an undisputable leader and central figure to American history.

The Jobs biography, while a fascinating read, also helped me think differently about leadership. In reading, it struck me that Steve Jobs was not at all the kind of person many of us would usually think of as a leader. Yet he was able to accomplish incredible things. Leadership often takes different forms than we would expect.

The Van Gogh biography was fascinating, especially from my point of view as a physician. He clearly had a mental illness — likely bipolar disorder — and had a very complex, very fraught relationship with his mother and brother. He was never really understood in his time, especially by his family. Even after he’d become renowned as a painter, his mother still professed to find his art terrible. The look at how the illness and his relationships influenced the course of his life is fascinating for a physician.

*Love in the Time of Cholera* — Gabriel Garcia Marquez

*Stein* — Haruki Murakami

*Super Sad True Love Story* — Gary Shteyngart

*A Game of Thrones* — George R.R. Martin

While these books offer more surreal and fantastic elements, they also offer unique insight into our world. Murakami’s book manages to present a story about how lives can be slightly divorced from reality through what is at times a love story, a thriller, and a science fiction novel. Shteyngart’s book builds off our filters to reality, offering a glimpse of humanity that’s crippling dependent upon technology for interpersonal communication. The *Game of Thrones* series, despite the setting, isn’t terribly different from today’s world. Power and ruthlessness often prevail, and we all have our own stories to tell.
For additional information regarding ASMS educational activities, membership opportunities, and patient resources, please contact:

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Upcoming CME Activities

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November 5 - 7, 2012 – Closures Course for Dermatologists
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November 8 - 11, 2012 – 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.

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A CAREER CHANGE IS IN YOUR FUTURE.
The decision to leave practice comes for a variety of reasons, and isn’t always an easy one. For every dermatologist who makes the transition, there are a number of key steps to consider, both administrative and emotional, before ending the current phase of a career in dermatology.

**FINDING MOTIVATION**

Whether the reason is age, other professional interests, or a general feeling of burnout, the key to a successful post-practice transition is to understand one’s motivations and intentions for leaving practice. Often, according to recently retired dermatologist Steven Shama, MD, it’s the aggregation of a number of small issues over the years.

“I’m a dinosaur, like many other physicians might consider themselves. They just want to see patients, have a conversation, and wish them a good day. The expense of running a business and dealing with increasing regulations was too much for me. There were too many things getting in the way of the doctor/patient relationship,” he said. “I realized that I didn’t want to die on the job. I do professional speaking about enjoying your life. You don’t wake up one morning tired of dealing with regulations and business. It adds up, you just have to face it.”

University of Massachusetts dermatologist Mary Maloney, MD, said that for some dermatologists, the stated intention to retire by a certain age can sneak up much faster than the physician might think possible.
“Ten years ago, I said I was going to retire at age 57. Then I said I was going to retire at 59. So you can see that I’ve already failed twice in what I said I intended to do,” Dr. Maloney said. “I want to make sure the person who steps into my job is the right person, and that I’ve done everything that I could to turn it over. Some of it is that time just plain slips by. I think that happens to all of us. If you ask me how I got to be 61, I’d have no idea. When you’re 50 getting to 60, you end up just wondering where the time went.”

Dr. Shama agreed, and said that societal norms in regard to retirement age influence the decisions of many physicians.

“What happens is that we’re told that retirement’s at 65, so you wait to even consider it until you hit 65. But then, people say “If you’re in good health, why not keep working?” Dr. Shama said. “So they push it to 67, 68 before considering again.”

Other times, dermatologists leave behind the business demands of private practice or group practice to spend time teaching in dermatology departments. Former American Academy of Dermatology President Stephen Stone, MD, began as a partner in a dermatology practice, and after two associates left for academia themselves, eventually decided that teaching was his desired career path.

“Between 1992 and 2000, I was in solo practice. I decided that after all those years in private practice, I did not enjoy solo practice. The negatives were the absence of somebody to bounce my ideas off of, the absence of coverage when I took off to go to a meeting or vacation while the overhead continued,” Dr. Stone said. “I really enjoyed working with young residents. I liked the idea of not having to do any hiring and firing, not having to get coverage when I went out of town. I elected to get out of private practice and move into academics. Now I work with the brightest young people in the world, and I really enjoy working with them every day.”

PRACTICAL CONSIDERATIONS
In comparison to other small businesses, physician offices are especially difficult to shutter on an administrative level. Patient charts must be stored, employees need to be given notice, and both insurance and payer contracts have to be examined. In addition, many physicians try and get a return on their equity by selling the practice. Las Vegas dermatologist Lucius Blanchard, MD, has seen how the process works as both a buyer and a seller: His current large group practice, Las Vegas Skin and Cancer Clinics, buys practices nationwide, and he sold a multi-office practice years ago. He said that the toughest part of the transition for many dermatologists is settling on a fair valuation of one’s practice.

“The first, most important thing for dermatologists is to be realistic about the value of their practice. A solo or two doctor office does not have a sale value over three or four months gross. Do they have a realistic expectation based on contracts, revenue, and location?” Dr. Blanchard said. “Some doctors think that their practice is worth millions of dollars because they have a big income, but there is a limit to what a practice is worth. I’ve had people saying they want a million dollars for their practice. Maybe they’re grossing that, but a lot of times, you could go next door and open a practice for $200,000. Why is a potential buyer going to pay a million for nearly the same thing?”

In one case, he said, a close colleague died unexpectedly of a heart attack. As a gesture of goodwill, Dr. Blanchard offered to buy the man’s practice for a modest but fair $100,000. His late colleague’s brother, an attorney, rejected the offer and countered with a million-dollar valuation. A month later, Dr. Blanchard said, the practice had essentially dissolved. Soon after, Dr. Blanchard purchased the office equipment for a flat $10,000.

The episode, he said, illustrates the disconnect between perceived and actual value in a dermatology practice. (The Academy offers a manual to help dermatologists address this issue, Valuing a Dermatology Practice. Visit www.aad.org/store/product/default.aspx?id=6370 to learn more.)

Other important aspects of a sale include outstanding contracts with insurers, location, and the dermatologist’s planned timeline for leaving daily practice.

“If a practice has an exclusive contract with an insurer, it makes the practice more valuable. Are there a lot of dermatologists in the area? If you’re selling a practice in San Diego, where there’s a dermatology practice on every corner, it’s not going to be as valuable as a practice in West Virginia, where scarcity can make things extremely valuable,” Dr. Blanchard said. “If an owner is able to stick around, work, and help the practice make money, it gives us a lot more time to come in and transition, and bring in new doctors.”

Another large commitment, in both the physical and professional sense, is the necessity to keep patient charts safe and accessible. In Dr. Stone’s case, moving to academia meant dealing with a literal mountain of patient charts.

“My original partner in private practice was in practice since 1946, and we had all of the charts in the basement of the building. That was a lot of paper,” Dr. Stone said. “One of my disappointments was that I thought the charts were going to be stored by the medical school in perpetuity, and was told after a couple of years that it wasn’t the case.”

Liability insurance is also an important concern when leaving practice. Tail coverage must be negotiated with the insurer. The entire process, whether it’s a sale, retirement, or a handover to a dermatology department, can take months, if not years.

“People say that you can’t really sell a practice in less than a year. It takes a while to develop a relationship with someone who may be interested in your practice,” Dr. Shama said. “I’d say two years from the time you’ve made your decision is probably a reasonable period of time. It can happen more rapidly, and I’ve heard of physicians with health problems transitioning in two to three months, but two years is a reasonable time.”

Texas Tech dermatologist David Butler, MD, who left private practice to teach at the university, said that while teaching is extremely fulfilling for a great many dermatologists, those physicians should be aware of the specific conditions and potential issues that come with academic employment.

“Moving to academics really relieved a great deal of stress in not having to worry about the overhead, employees quitting unexpectedly, and dealing with changing workload. To me, it was quite a bit less stressful, though not without its set of problems. When you go to an academic institution, the pay is about 30 to 40 percent less than private practice, and there’s also a little bit less work,” Dr. Butler said. “It’s somewhat of a stress reliever, but then you get involved with issues of the state. In Texas one year, there was a huge budget crunch, and the state came down with a 10 percent cut in pay that was laid on everybody. I didn’t ever anticipate that.”

TELLING PATIENTS AND EMPLOYEES
One of the most difficult aspects, according to dermatologists who have made the transition, is severing or greatly changing the relationship with employees, patients, and co-workers. Dr. Maloney, who maintains a number of interests outside of dermatology, said that many of her colleagues and patients who have managed to retire...
warn her about the difficulty in the loss of professional relationships. “I saw a patient recently who had been a nurse, and she was retired. I asked her about retirement, and she said it wasn’t what it was cracked up to be,” Dr. Maloney said. “Your relationships with the people you work with are so good, and so important to you. She missed those.”

David Shupp, MD, who moved somewhat unexpectedly from a large dermatology practice in east Tennessee to teach at his alma mater in Hershey, Pa., said that saying goodbye to his patients was an unexpectedly difficult part of the transition.

“Having been in practice 22 years in that location, I’d seen thousands of patients, several generations of families, and I got to know a lot of them. It was surprisingly difficult for me, saying goodbye to a lot of long-term patients who I’d become attached to, whose history and families I knew. Their kids grew up with my kids,” Dr. Shupp said. “Cutting the ties with the actual practice was pretty easy from a legal standpoint, but emotionally, I was surprised how difficult it was saying goodbye to so many patients. Some of them got emotional. I got a lot of cards and well-wishes. The whole process was much more difficult than I anticipated. It was the hardest part.”

Even in selling a practice, the transition can be difficult for the office staff, many of whom must acclimate to a new owner or move on to new employment. Dr. Shama said that he took his responsibility to his employees very seriously, having a number of conversations with the new owners about how and why his employee benefit structure was conceived.

“For my employees, I told them that I’d be here to support them, and with the new owner, I’d tell them how and why I paid them what I did and try to give the new owners the philosophy. Hopefully they would be taken care of the way I had taken care of them,” Dr. Shama said. “Someone who was interested in my practice told me that I was a very generous employer. I just tried to take care of people like they were part of my family.”

In handing his practice over to the Southern Illinois University School of Medicine, Dr. Stone said that some of his employees found it difficult to find a new role.

“I had 11 employees, and really wanted to help them get placed. A couple came over to the medical school. A couple had trouble finding satisfactory positions, and I felt bad about that,” Dr. Stone said. “In a private practice, everyone’s like one big family, and that was emotionally difficult to deal with.”

**FINDING A BALANCE**

Post-transition, there are an entirely new set of daily expectations for dermatologists, just as there are for anyone leaving a decades-long career. The key to a satisfactory conclusion, according to Dr. Shama, is embracing outside interests and identifying how to define oneself.

“‘When you decide to retire, make sure you maintain a passion for what you’re doing. You need to have a balance. Maybe you love fishing; maybe you love riding. Whatever your outside interests are, they have to be kept in your thought process, and have to be a close second to your profession,’ Dr. Shama said. “You want it to add richness to all the days of your life. When you retire, you have something to continue doing and expand. It shouldn’t be a second-tier interest; it should be right up there with what you love doing.”

In eyeing her own retirement, Dr. Maloney has cultivated a number of endeavors outside of dermatology.

“I’ve had retired people tell me that they missed having something that they had to do, someone relying on them to do something. As I think about retirement and what I need to do, I need to be sure that I have some meaningful work, whether medicine or something outside of medicine. I need to feel a sense of accomplishment,” she said. “One of the things that I started to do, I was asked to be a trustee of a small school that serves a particular population. I very much enjoy that, and feel like I’m contributing to something other than medicine.”

**MAKING THE DECISION**

Dermatologist James J. Leyden, MD, who transitioned from a dermatology professorship at the University of Pennsylvania to an emeritus role and greater time spent consulting for health care companies, shared the story of the moment he decided to undertake a career change.

“My memory of the moment I decided to do something different is crystal clear. It was one of those moments where you get a vision that says ‘this is what I need to do right now.’ There was a woman who had been in three different hospitals with a dermatologic condition. A diagnosis of some sort of infection was made. She was on antibiotics, and was eventually released. Finally, in the third hospital, a former student at Penn who was an internist there and had some training in dermatology called me up and said ‘this has to be pustular psoriasis. Nothing else makes any sense.’ I agreed, and asked him to transfer her to us. She was, and I was in with one of the residents, and the nurse came in and said there was a doctor on the phone who had to speak with me immediately.

I got on the phone, and it was a guy from the insurance company, and he said something to the effect of ‘I’m sorry, but we’re going to have to terminate your patient.’ And I said ‘you’re going to kill her?’ And he said that no, they just wanted to send her home. I asked for his name and location, and I said that I’d transfer her to them by ambulance, and they could decide what to do with her. If I sent her home, she could die. I went in and told the woman that the insurance company asked me to kill her, and she got her union involved, and they made trouble for the insurance company.

My thought at the time was that I was too old for this. Things are changing, and there’s going to be a lot of unrest and learning through new changes. But I didn’t need to be part of it anymore. For various reasons, I was entitled to become an emeritus professor, so I announced the next day that I would become emeritus and wished everybody in the department good luck. It was a very easy decision for me. I know it’s a very difficult decision for a lot of people.”
THE AGE OF BROTO

BY JAN BOWERS, CONTRIBUTING WRITER

Noninvasive options lure more men to cosmetic treatment

Smoothing, tightening, lifting, slimming — they’re not just for women anymore. Encouraged by the availability of noninvasive techniques that leave few telltale signs of having had “work done,” more men are opting for cosmetic treatments, say dermatologists who specialize in these procedures. “There’s been a certain stigma associated with cosmetic surgery in men, and historically they have stayed away from that,” said Mark S. Nestor, MD, PhD, voluntary associate professor of dermatology at the University of Miami Miller School of Medicine and director of the Center for Cosmetic Enhancement in Aventura, Fla. “What’s happening now is that as men realize that they can have nonsurgical procedures that look natural and help them look young, more and more are opening up to having them.”

The 2011 Plastic Surgery Statistics Report, published by the American Society of Plastic Surgeons (ASPS), shows a 56 percent increase in minimally invasive procedures in men. Meanwhile, it shows a 48 percent drop in cosmetic surgical procedures in men since 2000. Botulinum toxin type A injection has become by far the most popular cosmetic treatment among men, and the term “brotox” now appears in the online Urban Dictionary. The number of toxin procedures (363,018 in 2011) has leaped by 286 percent since 2000 and 8 percent since 2010. (The ASPS statistics represent procedures performed by member surgeons and other board-certified specialists, including some dermatologists.)
Nonetheless, men still represent only a small slice of the market for cosmetic procedures — and that presents an opportunity for dermatologists, say the experts. Results from the 2011 American Society for Dermatologic Surgery (ASDS) Survey on Dermatologic Procedures indicate that men accounted for about 10 percent of the overall total for injectable neuromodulator procedures, and 8 percent of the total for procedures involving soft-tissue fillers. The ASDS survey found that men accounted for 9 percent of all cosmetic procedures. Dermatologists point to a confluence of factors that are likely to further drive demand among men: an aging population, increasing acceptance of aesthetic treatment for men, competition in the workplace, and improvements in noninvasive products and techniques.

And, dermatologists are particularly well suited to address men’s needs, said Dr. Nestor, because noninvasive treatments are “where dermatologists live, as opposed to plastic surgeons. They’ll feel comfortable with us. We’re in a unique situation where men come to us with a rash or a growth, and we can educate them not only about how we can help them medically but how we can help them aesthetically.”

We’re seeing straight men come to view these kinds of treatments as completely acceptable and appropriate.

Key factors that affect men’s choice of procedure include expected results, degree of discomfort, required downtime, and longevity, the experts said.

HAIR, MORE OR LESS
Hair transplants, which Dr. Nestor called “the only cosmetic procedure that’s been totally male-driven over the years,” continue to be popular with men, and Tina S. Alster, MD, whose practice is located two blocks from the White House, maintained that “a ton of attorneys come in on their lunch hour for hair enhancement” via low-level diode laser treatments. Dr. Alster, who is clinical professor of dermatology at Georgetown University and director of the Washington Institute of Dermatologic Laser Surgery, noted that many younger men are as intent on removing hair as middle-aged men are on restoring it. “There’s a greater acceptance among young men to be groomed,” she said. “They want no hair in their private areas, and certainly laser hair removal is a better option than ongoing waxing treatments.” In fact, teenagers and college-age men can become “distraught over mild amounts of hair on their chest or back — that concern didn’t exist 10 years ago,” said Jeffrey S. Dover, MD, associate clinical professor of dermatology at Yale University School of Medicine and director of SkinCare Physicians in Boston.

FILLERS AND TOXINS
Fillers and toxins are gaining acceptance among men for a variety of reasons, in addition to the fact that they’re among the least obvious procedures to detect. Jonah Shacknai, chairman and chief executive officer of Medicis Pharmaceutical Corporation (which markets the Restylane family of fillers and Dysport, a toxin), said patients likely view these products as a better value than they were just a few years ago. “And, we know that with the toxins, there’s some relaxation of the muscle. So I think it’s perceived as a good bang for the buck, and it doesn’t require the expense and downtime of a facelift.” Longevity is key because unlike women, men are reluctant to come in for multiple treatments, Dr. Alster said. “I have women with standing appointments every month — I have no guys who do that,” she said. “They want one-stop shopping, easy in, easy out, and they don’t want to feel like they’re wed to you.”

Dr. Nestor warned that although men respond well to toxin injections, “it’s harder to treat men because a lot of them have low brows, and when you knock out the frontalis, the brows get lower and don’t look good. So you have to be careful, you have to know what you’re doing.” He also pointed out that men are now more open to treating their nasolabial and mesolabial folds because fillers, when used to replace volume in the cheeks, look more natural than earlier treatment approaches.

BODY SCULPTING
Like women, men are looking to dermatologists for noninvasive body sculpting. “Sometimes they’re way overweight, but often they’re very fit but have a tiny bulge over their belts, or love handles, or gynecomastia,” Dr. Dover said. “Zeltiq [coolsculpting] works beautifully for localized areas of fat reduction — we get 22 percent fat layer reduction per treatment.” Susan Weinkle, MD, clinical professor of dermatology at the University of South Florida and president of the ASDS, predicted that sodium deoxycholate, an injectable fat-dissolving agent now in clinical trials, may prove to be an effective weapon against the double chin that plagues many men as they age. Currently, men are opting for ultrasound and a variety of radiofrequency procedures to tighten jowls and other facial areas, Dr. Nestor said.

MEN ARE FROM MARS
To a certain extent, men are motivated to seek cosmetic treatment for the same reasons women are, but there are key differences. While women may view a more youthful appearance as a goal in itself, men tend to see cosmetic treatment as a means to an end, the experts said. “Everybody wants to look better for their mates, but you may see more men getting cosmetic treatment for socioeconomic reasons,” said Dr. Nestor. “Men do not say, ‘I’m doing this for myself.’” Men’s major motivation for seeking treatment

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“is either occupation or women,” agreed Mary P. Lupo, MD, clinical professor of dermatology at Tulane Medical School and director of the Lupo Center, an aesthetic and medical dermatology practice in New Orleans. “Either they’re divorced and they want to get into dating again, and they feel they look spent and tired, or they want to keep a competitive edge within their profession. Even teachers and college professors, because they interact so much with young people, want to look vibrant and energetic and relevant, not like old fogies.” Dr. Weinkle said she sees 50- to 60-year-old patients “who maybe lost a loved one, and want to look better in a competitive social environment.” Dr. Nestor cited a patient in his 60s who told him, “I’ve never had work done, but I’m engaged to a 27-year-old woman. I have to look younger.”

In Dr. Alster’s K Street practice, male (and female) patients who normally might not seek cosmetic treatment are coming in because it’s a presidential election year, and many are thrust into the spotlight of HDTV. “I am just inundated with politicians on both sides of the aisle, and with print journalists who may not normally need to be on TV,” she said. “All bets are off in an election year — I see everybody.” Apart from the election-year crowd, men focus on different cosmetic issues than women and tend to wait longer, she maintained. “Men are not as picky about lines; they’re not looking at crow’s feet, by and large, or lines around their mouth. A lot of them come in because they have a red nose, or scaly, pigmented bumps. I do more PDT for rosacea and photodamage treatments in men than in women — women would never let themselves get to the point that men do, with a lot of skin keratoses and discoloration. Regardless, the clinical success of treatment in men is very high.”

Often the motivation to seek cosmetic treatment doesn’t come from the men themselves, but from significant others and family members. “If they’re heterosexual, they usually come in with their wife or girlfriend, or the suggestion has been made very strongly that they come in,” remarked Dr. Dover. “I actually prefer that they come in with that person because sometimes, if they come in alone, they say, ‘I don’t know why I’m here, my wife told me I should come.’” In contrast, gay men and those Dr. Dover characterizes as "metrosexual" are more likely to come to him of their own volition. “And they’re actually a delight to take care of; they can be very particular, sometimes more particular than my female patients, which is interesting. They appreciate good results, so they appreciate our talent.”

WHO’S SEEKING TREATMENT
With the advent of noninvasive, natural-looking cosmetic procedures, the range of men opting for cosmetic treatment has broadened to include patients of all ages, ethnicities and sexual orientations. “I think that as gay men set trends in many markets, particularly in fashion and appearance, they have done so in this market, and now we’re seeing straight men come to view these kinds of treatments as completely acceptable and appropriate,” Shacknai said. Dr. Dover said he is seeing the biggest increase among “metrosexual” men: a “younger group, in general — men in their 30s, 40s, 50s — who care significantly about their appearance and want to be in touch with their feminine side.”

Among men of different racial groups, specific procedures may be dictated by how a particular group tends to age, said Dr. Lupo, who treats Asian, African-American, Hispanic, and Caucasian men. “My laser hair removal patients tend to be Caucasian, if it’s for cosmetic purposes, and white men also come in for jowl treatment and body sculpting,” she noted. “For Asian males, it’s usually toxin and midface fillers. For African-Americans, it’s usually cheek augmentation, because they get cheek flattening, and the nasojugal fold.”

TAPPING INTO THE MALE MARKET
In partnership with a young dermatologist who just completed his residency at the University of Miami and suggested the idea, Dr. Alster said she plans to open a men’s center in the same building as her current practice, but on the first floor, so men can walk in and out without feeling like they have to pass as many people. “I think you almost have to have a little bit of a ‘man cave,’” she said, suggesting that men seeking cosmetic work may be uncomfortable sitting in, or passing through, a waiting room full of women and fashion magazines. Instead, the waiting room is populated with other men and features magazines like Sports Illustrated, Men’s Health, and Esquire, Dr. Alster said. She views men as a “virtually untapped market,” and said a focus on males might be a point of differentiation for young dermatologists just launching their practice, “especially in a market saturated with cosmetic dermatologists.”

None of the other experts routinely target men in a formal way, but they offered a number of suggestions for dermatologists looking to address the cosmetic needs of their male patients. First, realize that men are more apprehensive than women about pain, reassure them that pain will be minimal, “and then follow through with that reassurance,” Dr. Lupo said. “I do that through the generous use of topical anesthetics, and I only use injectables with lidocaine.” Second, show them photos of real results after fillers “to let them know that the ‘Real Housewives’ are not a good representation of what filler results will look like. Men don’t want to look ‘done.’” And finally, enlist the wives and daughters as partners, forming a “conspiracy to get them to do things.” Such a strategy could allow cosmetic services to be purchased as gifts, she said.

Dr. Weinkle emphasized the importance of a “slow introduction,” keeping in mind that some men are still afraid of “not being manly” if they address aesthetic issues. She also suggested pointing out the value of cosmetic procedures — “for a small outlay, there’s much to be gained. Also, in this competitive market, removing their brown spots, their seborrheic keratoses, helping treat their rosacea, which is very much a cosmetic disorder, helps to get the male population to buy into why it’s good for them. We need to continue to teach the public and our patients about what we can do for them.”
SYMBIOTIC COLLABORATION

Stronger networking between dermatologists and primary care providers can improve care patients receive.
As the demand for dermatologic care grows and the number of dermatologists doesn’t, dermatologists will likely find themselves working more closely with their primary care colleagues. Dermatologists and primary care physicians agreed, though, that with a few simple steps, among which education is key, dermatologists can put their best collaborative foot forward.

Millions more people are expected to join the ranks of the insured through state-based insurance exchanges and the expansion of Medicaid as the Affordable Care Act rolls out. Add to that the aging of the population and growing skin cancer epidemic. Throw into the mix the creation of innovative care delivery systems and payment models such as patient-centered medical homes and accountable care organizations (ACOs). What is the result? A demand for services that couldn’t possibly be met by a specialty that is already experiencing an average national wait time of more than 29 days for new patient appointments and approximately 16 days for established patient appointments, according to the AAD’s 2012 Dermatology Practice Profile Survey.

But dermatologists can help fill the care gaps by strategically working with primary care physicians (PCPs), general internists, family physicians, and the like. >>
COMMON SKIN CONDITIONS PCPS TREAT

Randall Roenigk, MD, the Robert H. Kieckhefer Professor in the department of dermatology at Mayo Clinic in Rochester, Minn., points out that PCPs already treat many common dermatologic conditions such as acne, warts, and dermatitis. “They are usually willing to initiate therapy for common problems, but happy to refer complex cases,” he said.

Primary care physicians are quite capable of treating eczema, psoriasis, and acne as long as they are not severe or refractory cases, according to Robert Sidbury MD, MPH, associate professor in the department of pediatrics and chief of the division of dermatology at Seattle Children’s Hospital. The same is true for hives, warts, and molluscum lesions because if those are missed initially, they are not life-threatening and will become apparent soon enough. In fact, some dermatologists prefer that PCPs treat common skin conditions so that they can focus on their more complicated patients. Any conditions with pigmented lesions, however, should be treated with caution by PCPs because such lesions could be melanoma, he added.

Every PCP has his or her own comfort level in terms of diagnosing and treating dermatological conditions, noted Nerissa Collins, MD, an internist at Mayo Clinic. That comfort level is based on one’s knowledge of skin diseases and the availability of necessary equipment and supplies to diagnose and treat them. Minor and limited skin conditions can usually be handled within the realm of the PCP, she said. But skin conditions that are more generalized and widespread, or moderate to severe, as well as changing pigmented lesions or ones that have an unusual appearance, should be referred to a dermatologist, she said. Similarly, a patient who has a bullous disease, systemic symptoms in conjunction with a skin disease, or any condition that requires treatment with phototherapy or immunosuppressants should be sent straight to the dermatologist, Dr. Collins said.

Karen Edison, MD, chair of the department of dermatology at the University of Missouri, agrees that the type of skin conditions PCPs treat depends on their training, comfort level, and experience. “I know a PCP who has taught herself a lot about dermatology. She refers only the most acute cases or difficult-to-treat patients. I also know several other PCPs who admittedly don’t know much about dermatology and refer pretty much everything.”

EDUCATIONAL COLLABORATION

Internists and PCPs who haven’t rotated in dermatology are at a disadvantage when they go into practice, noted Dr. Edison, who routinely asks family and internal medicine graduates what they wished they had learned more about in training. “When asked what field they would like to know more about, dermatology is typically the first or second answer,” she said.

Because doctors are finding themselves poorly equipped to deal with skin issues once they graduate, there is a push to increase the number of medical students doing a dermatology rotation and to have residents do more dermatology training, Dr. Sidbury said. At the practice level, dermatologists can conduct focused continuing medical education lectures for primary care practices. “It’s a short-term outlay in terms of time, but it will have a long-term benefit because you will become the go-to person in the group,” he said.

Dr. Edison concurs. “This might be a good time to dust off those lectures you have on basic dermatology and volunteer to give a lecture at your staff meeting,” she said. Dermatologists tend to practice in solo or small groups and therefore are not as connected to the larger health care community. “It’s a good time to be seen as a part of the team and willing to educate others. It’s a good time to get out of the office and be more visible to the other medical staff, and remind others that we’re valuable physicians with a unique expertise. One of the easiest ways to do that is to give a lecture.” Dr. Edison, who also chairs the AAD’s Workforce Task Force, suggested asking referring physicians what they would like to know about dermatology and creating a lecture around that topic.

At Advocate Physician Partners, a system-based health care organization, educational sessions presented by dermatologists for family physicians about treating minor dermatologic conditions and providing follow-up care have been well received, noted Debra O’Connor, DO, a family physician at Glenview, Ill.-based Advocate Medical Group and medical director for Advocate Physician Partners at two medical centers. The sessions address up-to-date treatment options and medications as well as recommendations for when referrals are appropriate. It’s not uncommon for a family physician to spot a more serious dermatologic problem, such as a skin cancer or atypical mole(s). The trick is for him or her to recognize when a referral to a dermatologist is appropriate, she added.

Dermatologists at Mayo Clinic not only help educate primary care residents about recognizing and treating skin diseases, but also teach them how to perform simple punch and shave biopsies and use cryotherapy to treat precancerous lesions and warts, Dr. Collins said. She noted that the AAD’s Medical Student Core Curriculum
is an excellent resource. The updated curriculum, posted online at www.aad.org/mscc in March, includes 34 modules on a variety of dermatologic topics. Each module has been peer-reviewed, is based on the best available evidence, and includes clinical vignettes and questions providing a practical framework for learning. The information can also be used to generate lectures like the ones Dr. Edison recommends giving.

OTHER WAYS TO COLLABORATE
“Instead of just dictating treatment plans for referral cases, consider having a referring PCP spend time in your clinic,” Dr. Sidbury suggested. Although the latter requires more time on the dermatologist’s behalf, the PCP will gain a lot more knowledge about skin conditions. This scenario could also benefit medical students and residents. Another option is to designate one morning a week, for example, to schedule same-day referral appointments, he said. That will require ongoing communication with referring physicians and help build relationships.

As patients and physicians alike get more comfortable with technology, dermatologists can use teledermatology to triage patients, consult, and/or provide direct care, Dr. Edison said. In her experience, PCPs learn basic dermatology quickly from using teledermatology. Consider doing hospital consultations, she recommended, if not in-person then by using teledermatology or reviewing high-quality digital photographs.

ACOS REWARD NEW KINDS OF CONSULTATIONS, TREATMENT PATTERNS
It’s important to educate PCPs, but sometimes that creates more questions and referrals, noted Alexa Boer Kimball, MD, MPH, a dermatologist at the Medical Dermatology Clinic of Massachusetts General Hospital, which is a founding member of Partners HealthCare, an integrated health care delivery system-turned-ACO. She also points out that there is an impending shortage of PCPs and other physicians. “So simply shifting business from one type of provider to another may not be a particularly efficient way to solve the problem,” she said.

At Massachusetts General, providers are exploring different types of consultative models to manage dermatologic care. “If the patient only has a skin condition, I’m not sure that the PCP’s office is the right place to go because a visit to the PCP charges the system the same as a visit to the dermatologist. Where you start to see the efficiencies is when a patient’s simple dermatologic problem can be managed as part of the

WHEN DERMATOLOGISTS REFERENCE

Even a seasoned dermatologist may need to refer to a colleague who has a subspecialty or an area of expertise. Referral networks for dermatologists may include PCPs, family medicine physicians, and internists; other dermatologists; Mohs surgeons; plastic surgeons; oncologists; and ear, nose, and throat specialists.

Nerissa Collins, MD, an internist at Mayo Clinic, has received referrals from dermatologists to determine the cause of a patient’s itch when there are no skin findings. Skin conditions can be the manifestation of underlying disease, such as cancers, autoimmune disorders, or infections, she noted.

As a pediatric dermatologist, Robert Sidbury, MD, MPH, associate professor in the department of pediatrics and chief of the division of dermatology at Seattle Children’s Hospital, receives many referrals from pediatricians and dermatologists alike. “The latter typically refer when the children are very young or they are concerned that the condition is related to a congenital syndrome. They may not have seen enough of the latter to be comfortable treating the patient,” he said.

Regarding melanoma, patients with either Stage III or Stage IV disease should be referred to an oncologist as they may be eligible for adjuvant therapy or clinical trials, according to Michael Ming, MD, director of the Pigmented Lesion Clinic at the Hospital of the University of Pennsylvania in Philadelphia. Patients with a melanoma that is confined to the skin, but with unfavorable prognostic characteristics, could be considered for referral to a melanoma specialist to discuss the possibility of having a sentinel lymph node procedure. Also, “if the pathology diagnosis is ambiguous, or if the management plan is unclear, those would be circumstances where one might refer to a melanoma specialist,” he added.
routine visit to the PCP,” Dr. Kimball explained. The latter translates into one less visit to the system. One option being explored is the use of teledermatology to evaluate batch cases, as opposed to doing live teledermatology. Providing feedback to the PCPs has already resulted in a substantial improvement in the referral of urgent patients, she added.

One advantage of being in an ACO is that it allows exploration of alternative ways of managing patients that aren’t tied to the current fee-for-service model, Dr. Kimball said. For example, telephone or telederm follow up can be compensated, especially if it replaces what would otherwise require an in-person visit. Decreasing the regulatory burden is another alternative worth exploring, she said: if documentation requirements that did not affect the quality of care were reduced, for example, then physician time per patient could also be reduced and the expense per patient to the system would decrease.

Similarly, Dr. Roenigk maintains that payment mechanisms, such as global payment systems, foster collaboration among providers. “When dermatologists and PCPs work in the same health system there are no competitive issues,” he said. “At Mayo, we have elaborate care process models and an integrated referring system so patients get to the right doctor in a timely fashion.”

Dermatologists and PCPs have worked together to create criteria for how patients with acne, psoriasis, and dermatitis are best managed. In addition, they developed a nursing protocol to treat warts. Once the provider makes the diagnosis, the patient is seen by the nurse who treats the warts per the protocol. Helping PCPs by suggesting a care plan for common skin conditions, for example, will make them more likely to refer the complex cases or assist in providing follow-up care once the condition is under control, Dr. Roenigk added.

Additionally, dermatologists use electronic health records to perform virtual consultations to assist PCPs after the latter have performed biopsies, thus eliminating an extra consult, he explained. For example, if the PCP performs a biopsy that indicates a lesion is basal cell carcinoma, the dermatologist reviews the biopsy and pathology report electronically to determine how best to remove it, whether by excision, Mohs surgery, or electrodessication and curettage. Using a combination of protocols and electronic health records, the patient is scheduled for the right procedure in a timely manner, he noted. If the patient has an ongoing problem, then he or she should be scheduled to see a dermatologist. If not, the patient returns to the PCP for follow-up care.

Virtual consults, Dr. Roenigk said, are simply an attempt to make the care more efficient. “We are all on salary so there is no financial incentive for us to do this or anything else. The only incentive is getting the patient to the right doctor and not waste another visit or consult. It takes very little time for the MD to review the medical record but it saves the patient a lot of time. I can do three virtual visits in the time I do one face-to-face visit for a skin cancer check, and I can do it on my own time. The PCPs at Mayo who use this system do not abuse it, either, so it is not an onerous task and they, along with the patient, appreciate getting appropriately triaged to the right place.”

“Primary care physicians will be increasingly treating skin conditions,” Dr. Edison said. “We have a role in making sure that they know how to diagnose and treat basic dermatologic conditions. The most important thing is to start the dialogue with your PCPs and other referring providers to find out how you can best collaborate moving forward.”

**When PCPs Should Refer**

Robert Sidbury, MD, MPH, associate professor in the department of pediatrics and chief of the division of dermatology at Seattle Children’s Hospital, suggested that certain questions could trigger a referral. For example, if the PCP answers “yes” to any of the following questions, he or she should refer the patient to a dermatologist:

- Is the differential diagnosis list long?
- Does the diagnosis involve morbidity or mortality?
- Has the patient failed initial therapy?
- Does the treatment have a significant risk of adverse effects?

If the PCP is uncertain of the diagnosis, then he or she should refer the patient, as well.
When I promised to shave my head and beard if SkinPAC, the AADA’s political action committee, could raise $1 million for the current election cycle, some people thought I was kidding, or crazy. While the latter may remain a possibility in some of your minds, my photo this month should prove that I was very serious about my pledge.

I want to thank all of you who helped make my million-dollar haircut possible. I want to particularly thank Mark Lebwohl, MD, who covered the remaining amount when we got close to the milestone and was, as a result, the first one to grab the clippers on Aug. 17 in Boston. And thanks to all of you who have contributed the maximum $5,000 allowed in a year during the 2011-2012 election cycle, including Murad Alam, Rex Amonette, Andrew Bean, the late Darryl Bronson, Elizabeth Callahan, Clay Cockerell, Brett Coldiron, Brian Cook, Raymond Cornelison, Robert Durst, C. William Hanke, Hazle Konerding, Ronald Moy, Michael Mulvaney, Thomas Olsen, David Pariser, Sean Pattee, Helen Raynham, Sandra Read, Phoebe Rich, John Strasswimmer, Scott Warren, and Michael Zanolli.

I have bigger ambitions for SkinPAC going forward, though. We were able to raise $1 million with only 12 percent of the AADA membership contributing. What if every dermatologist in the United States gave the reimbursement for a single biopsy to SkinPAC each year? We’d be raising $3 million per cycle, further raising our visibility and presence among leaders in Washington. Add reimbursement for a single Mohs procedure from those who do them and we’d be one of the biggest medical PACs in the country.

What would that mean for us? A political action committee does not stand on its own, but it plays an important role in raising our visibility in Washington. Along with our grassroots efforts and meetings with lawmakers, we would have a bigger voice to express our concerns about the Independent Payment Advisory Board, a threat to fair reimbursement for physician services by Medicare. With the urgency of fixing the flawed Medicare physician payment formula, which dangles over us each year, threatening the vitality of our practices, it is essential that we seek every opportunity to raise the visibility of our profession and to educate policymakers about the care that dermatologists provide to patients. This would also mean further opportunities to increase awareness of the dangers of indoor tanning and encouraging better skin cancer prevention efforts.

Imagine the possibilities.

Thank you for your support and for making me a bald, clean-shaven man a few months ago. Elections are a biennial insurgency; as soon as one battle is over a new one begins. The only way we’ll ever achieve meaningful change is to maintain and increase our newfound strength.

And maybe, just maybe, you can convince Dirk Elston, MD, who will follow me as president, or Brett Coldiron, MD, who will follow him, to make some outlandish promise that he’ll fulfill if SkinPAC raises $2 million next time around. The bar has been set, gentlemen!

For more information, visit www.skinpac.org.

SkinPAC’s political purpose is to solicit and receive contributions to be used to make political campaign expenditures to those candidates for federal elective office, and other federal political committees, who demonstrate understanding and interest in the views and goals of the American Academy of Dermatology Association. dw
Academy budgets to maximize benefit to members

SECRETARY TREASURER’S REPORT

BY SUZANNE M. OLBRICHT, MD

2013 Annual Meeting registration and housing available online

Meeting includes celebration of AAD’s 75th anniversary

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

Online registration and housing opens at 12 p.m. CT Nov. 14 for physician members, including life, honorary members, and applicants for membership. It opens Nov. 20 for residents, medical fellows, AAD graduate members, and medical students, and Nov. 28 for all others.

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

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

AS THE AUDIT REPORT PRESENTED ON P. 35 of this issue of Dermatology World demonstrates, the Academy is in strong financial shape and is able to continue building an endowment fund. The figures show how we did in 2011, but the numbers that are currently coming in for 2012 are also strong, and the 2013 budget that the Board will finalize in early November promises another good year.

While carefully stewarding its resources and preparing for the future, the Academy is taking advantage of opportunities to serve the membership. Our budget process has become progressively more linked to our strategic framework, which has also recently been updated and streamlined. (See www.aad.org/about-aad/vision-mission-and-values/strategic-framework.) By using these documents in tandem, we ensure that the way we spend our money matches the priorities we have set for ourselves as an organization. We’ve also made it a priority to increase the transparency of the budget process, involving more members in more stages of the process. Together, these steps are making us a more member-driven, member-focused organization.

One of the benefits our members appreciate most is our Annual Meeting, which continues to be a strong driver for our financial success. The 2012 meeting in San Diego was a tremendous success, breaking attendance records, while 2013 will see us return to the previous record-holding site, Miami Beach, Fla.

Some of the other important benefits we offer to members are not revenue drivers, but we know that they bring value to our members. For example, we’ve created resources to help members meet the requirements of maintenance of certification because this is such a vital need. I know many of you would prefer to see us give these away to you! But you should know that these resources are not, currently, revenue generators for the organization. Despite the fact that members pay to purchase them, the proceeds from those purchases do not cover their significant development costs or the staff and volunteer time required to produce them. Likewise, our advocacy efforts have no revenue attached to them, but we know that one of our critical roles in the lives of our members is to advocate on their behalf, both in Washington and in the states.

We are budgeting to ensure a strong future for the Academy, in which the organization can continue to offer members the support you need regardless of what the changing health care environment may bring. The Board and I recognize that we are responsible for our stability and for adding value to your practice so that at this time next year, I am able to deliver a similarly positive report about our financial outlook.
Lisa Garner, MD, appointed AAD vice president for 2013

THE AMERICAN ACADEMY OF DERMATOLOGY’S Board of Directors has selected Lisa Garner, MD, of Garland, Texas, to serve as the organization’s vice president in 2013. She will complete the term of Darryl Bronson, MD, MPH, who died on Aug. 31. Dr. Garner recently served a four-year term on the Academy’s Board of Directors and has served as president of both the Women’s Dermatologic Society and the Texas Dermatological Society.

Since her time on the AAD Board, Dr. Garner has been involved on several ad hoc task forces related to key issues for the specialty and is therefore current on Academy issues. “The AAD has lost a dedicated member with the untimely death of Dr. Bronson,” Dr. Garner said. “I am honored to be given the opportunity to serve as the vice president for 2013.” – RICHARD NELSON

Include Dermatology in Action in your Annual Meeting schedule

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

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

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

For more information, visit www.aad.org/dermatologyinaction. – MARLENE BANIKE

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

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

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

academy update

Educate your community about the expert care of a dermatologist

**NOVEMBER IS NATIONAL HEALTHY SKIN MONTH.** Now is a great time for you to educate the public about why it’s important to seek the expert care of a board-certified dermatologist for the medical, surgical, and cosmetic treatment of their skin, hair, and nails. Working with your local media is a great way to get the message out to your community. When patients see you being quoted as an expert, they learn about your expertise, which enhances your credibility and raises your practice’s profile.

The Academy’s online Media Relations Toolkit, available online at www.aad.org/member-tools-and-benefits/media-relations-toolkit, has resources to help you build relationships with your local media and community. This year, the Academy is providing **National Healthy Skin Month** media relations materials, including a template news release, pitch letters, and radio announcements, which you can use to educate your community. These materials offer skin, hair, and nail care tips and encourage the public to view the Academy’s new Dermatology A to Z video series. You can customize these materials to best fit the needs of your patients, local media, and community. – **JENNIFER ALLYN**

Funding available for international volunteer and humanitarian projects

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

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

Exhibitors at Annual Meeting to request physicians’ NPIs

**PHYSICIANS WHO ATTEND** the Academy’s Annual Meeting in Miami Beach, Fla., March 15, 2013, 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/NationalProviderStand. – **RICHARD NELSON**
Audit report of the Academy and Association

THE 2011 AUDIT WAS CONDUCTED BY BLACKMAN KALLICK, LLP, certified public accountants. The firm rendered an unqualified opinion on the 2011 combined financial statements.

Members of the 2011 Audit Committee are: Kenneth J. Tomecki, MD, chair, Theodore Rosen, MD, deputy chair, Murad Alam, MD, Hazle Konerding, MD, Michael Scott, DO, MPH, Suzanne Olbricht, MD, secretary-treasurer, and Barbara Mathes, MD, assistant secretary-treasurer.

The following exhibits are derived from the 2011 Audit Report. The full audit report is available on the Academy’s website, www.aad.org.

### AMERICAN ACADEMY OF DERMATOLOGY, INC. AND AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION, INC. COMBINED STATEMENT OF FINANCIAL POSITION

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### AMERICAN ACADEMY OF DERMATOLOGY, INC. AND AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION, INC. COMBINED STATEMENT OF ACTIVITIES

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<td>Assets released from restrictions</td>
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<tr>
<td>Change in permanently restricted net assets</td>
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<td>Permanently Restricted Net Assets @ Beginning of Year</td>
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<tr>
<td>Permanently Restricted Net Assets @ End of Year</td>
<td>$2,343,115</td>
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ABD selects new executive director

The American Board of Dermatology (ABD) has selected dermatologist Thomas D. Horn, MD, MBA, as its new executive director, effective Jan. 1, 2013. He will succeed current director Antoinette Foote Hood, MD, to become the ninth director in the 80-year history of the organization.

“I’m really thrilled to be able to serve the board in its mission to work with and for patients as well as dermatologists to improve health care,” Dr. Horn said. “It is exciting to help dermatologists prove to the public that they attain and maintain the highest quality standards in medicine.”

Dr. Horn currently serves in the department of dermatology and the department of pathology at Massachusetts General Hospital and as the Medical Director of Massachusetts General Physicians Organization Dermatopathology Associates. He has previously served the ABD as assistant executive director and associate executive director. - JOHN CARRUTHERS

Members Making A Difference: Jennifer Tan, MD

DERMATOLOGIST FORGES COMMUNITY BONDS

Jennifer Tan, MD, was passionately involved in providing health care to Boston’s homeless population in her residency days, organizing the dermatology clinic at the South End Community Health Center and setting up integration with the residents. Later, she discovered the Boston Health Care for the Homeless Program (BHCHP) and helped integrate the program formally into the Harvard Dermatology residency training program, along with dermatologist Ernesto Gonzalez, MD. Presently, as the director of community outreach for Brigham and Women’s Hospital, she is able to help grow her prior volunteer passion in a formal role.

“Volunteerism and community outreach have been an important part of my life since my college years, when I first learned about the disparities present in health care.”

- The most important goal of BHCHP, Dr. Tan said, is to provide high-quality dermatologic and medical care in a compassionate environment.
- “I have volunteered because it was the best way that I could contribute toward correcting this issue,” Dr. Tan said. “It has also afforded me the opportunity to learn directly about the community around me, and has taught me important lessons in humanity, humility, and social awareness.”
- The response among the dermatology residents has been positive. In a survey, 90 percent rated their experience at BHCHP as good or outstanding. Further, 100 percent reported that they thought the experience provided a valuable service, and that they would like it to continue to be included in their residency education.
- “Dr. Gonzalez and I have worked together over the past two and a half years to build the collaborative dermatology clinic at BHCHP,” Dr. Tan said. “Such experiences in the community have enriched my life and professional development in ways that cannot be matched in any classroom, academic clinic, or hospital.”

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

- JOHN CARRUTHERS

Media Highlight

Through August 2012, print and broadcast stories relating to dermatology reached Americans more than 1.5 billion times, with 46 percent of this coverage focusing on skin cancer. This would not be possible without the many hours Academy members contribute by participating in interviews with journalists.

Health and beauty magazines continue to showcase the expertise of dermatologists. In the October issue of Redbook (circulation 2,224,418), dermatologists D’Anne Kleinsmith, MD, Dee Anna Glaser, MD, Paul Friedman, MD, Elizabeth Tanzi, MD, Kenneth Beer, MD, and Ranella Hirsch, MD, discussed wrinkle fillers and stressed the importance of choosing a board-certified dermatologist. Visit the Academy’s Media Relations Toolkit at www.aad.org/member-tools-and-benefits/media-relations-toolkit, and check out the Academy’s new monthly Media Update newsletter, which can keep you up to date on the stories your patients may see in the media and ask you about when they visit your office. - ROSE HOLCOMB

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

- JOHN CARRUTHERS
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85% Fee for Service, 15% traditional Medicare practice for sale, seeing 160+ new patients/month. Complete freedom from Managed Care and headaches. Can double income with use of lasers, fillers & surgeries being referred out. Will stay with practice for a smooth transition and retention of customers. Ideal candidate must be fluent in Spanish. houstondermsale@yahoo.com.

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Partnership available – no cash required. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

**MARYLAND**
Outstanding opportunity offering an immediate patient base for a BC/BE dermatologist to work with preeminent physicians in a large primary care based multi-specialty practice in Montgomery County, MD and surrounding areas. For confidential consideration, please email a CV to elliotrgoldstein@yahoo.com.

**GREATER CINCINNATI & KENTUCKY**
Two BC/BE Dermatologists wanted to join a growing, well-respected group with the full support of our award winning hospital system, St. Elizabeth Healthcare. Have you and a colleague ever wanted to practice together; this may be your opportunity. Join the St. Elizabeth Physicians Dermatology team and enjoy it all, a competitive compensation and benefits package, a great place to live and work, and a very substantial referral base. Relocation assistance is also available. This opportunity allows you to enjoy Kentucky’s natural charm and all that metropolitan Greater Cincinnati has to offer. Greater Cincinnati is on the banks of the Ohio River and boasts affordable costs of living, award winning schools, college and professional sports, exceptional fine arts, and is sixth in the nation for its number of Fortune 500 Company headquarters.

St. Elizabeth Physicians is the multi-specialty physician organization of St. Elizabeth Healthcare. With over 220 doctors and 50 mid-level providers, and more than 1,100 employees, St. Elizabeth Physicians delivers quality medical care to residents of Northern Kentucky, Greater Cincinnati, and Southeastern Indiana featuring 60+ conveniently located physician offices.

**CONTACT:** Kathy Robinson: kathy.robinson@stelizabeth.com, 859.344.7200

**St. Petersburg, Florida - Immediate Position Available on Florida’s Beautiful Gulf Coast:**
Immediate position available for a full or part time BE/BC general/cosmetic dermatologist to assume an existing busy dermatology practice within a large multispecialty group. This opportunity includes working alongside a full time Mohs Surgeon and comes with an unlimited potential for growth. An interest in dermatopathology is a plus. Expected annual income is based on productivity and is competitive. Office is moving to a brand new state-of-the-art facility in 2013.

Interested candidates should contact Kelli Drayton at: kelli.drayton@baycare.org or (727) 502-4176.

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

**Suncoast Medical Clinic**
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Immediate position available for a full or part time BE/BC general/cosmetic dermatologist to assume an existing busy dermatology practice within a large multispecialty group. This opportunity includes working alongside a full time Mohs Surgeon and comes with an unlimited potential for growth. An interest in dermatopathology is a plus. Expected annual income is based on productivity and is competitive. Office is moving to a brand new state-of-the-art facility in 2013.

Interested candidates should contact Kelli Drayton at: kelli.drayton@baycare.org or (727) 502-4176.
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

NORTHERN NEW JERSEY
Well established thriving dermatology practice in Parsippany, NJ seeking BC/BE dermatologist interested in providing medical and surgical care to a diverse patient population. Full-time position. Partnership opportunity. For more information contact Dr. Laila Almeida at (973) 335-2560 or lalmeida1@optonline.net. www.dermatologyassociatesofmorris.com

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

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COLUMBUS, OHIO
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PHILADELPHIA, PENNSYLVANIA
Partnership available – no cash required. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

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Mark Your Calendar –
Practice Management Webinars

Jan. 17, 2013  2013 Coding and Reimbursement Update
Feb. 21, 2013  Increase your Revenue with Correct Evaluation and Management Coding
May 16, 2013  Moving from Paper to Beyond: Transitioning to an EHR
Sept. 19, 2013  Get the Mohs Out of Coding
Oct. 17, 2013  Could you be a Target of the OIG?
Nov. 21, 2013  2014 Coding and Reimbursement Update

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FotoFinder Dermoscope STUDIO                                          15
NexTech EHR Software BC                                              
Officite AADDERMSonline.org IBC                                       

Recruitment Advertising
Cambridge Health Alliance Dermatology                                  38
CoxHealth                                                                38
St. Anthony’s Physician Recruitment                                     37

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SHADE STRUCTURE GRANT PROGRAM PROMOTES
CHILDHOOD SUN-SAFE BEHAVIOR

The Academy’s Shade Structure Grant Program, founded in 2003, has resulted in the building of more than 250 shade structures at pools, playgrounds, and recreation spaces located at schools and non-profit organizations focused on children across the United States. Those structures provide daily sun protection for more than half a million people. Each grant provides the chosen organization with up to $8,000 to build an approved shade structure.

The participation of Academy members is vital to the program’s continued success. Each application requires a recommendation letter from a member. This year’s application cycle runs through Feb. 1, 2013, with grant awards to be announced April 1 in conjunction with National Playground Safety Week. Members can proactively recommend that local organizations consider applying; application information is available at www.aad.org/ssp. More information about the program, including advice about helping an organization apply, is available at www.aad.org/member-tools-and-benefits/volunteer-and-mentor-opportunities/shade-structure-program.

While the program has grown from three grants in 2003 to more than 250 to date (see below), providing shade to more than 563,000 people each day, it needs financial support to thrive as the demand for the program continues to grow while the resources to support it become increasingly limited. Consider supporting the Shade Structure Grant Program with a Sustaining Fund contribution. Learn more at www.aaddevelopment.org/SustainingFund.html. – RICHARD NELSON, MD

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