
Final Recommendations of the Advisory Board February 6, 2011

The following report is provided as a summary of the debate and action that occurred at the Advisory Board Reference Committee hearing on Friday, Feb. 3, 2011, followed by a summary of discussion and final action on each of the resolutions presented for consideration to the full Advisory Board on Sunday, Feb. 6, 2011.

1. AAD01 (A-11) *Changing the Name of the AAD to Include Reference to Surgery*

Reference Committee Hearing Debate:

Your Reference Committee heard testimony largely in favor of the resolution. The focus of that testimony was that changing the name of the AAD would articulate and ensure visibility for the surgical training and expertise that is a part of the specialty. Testimony was heard about the Canadian experience in which it is illegal to identify yourself as a surgeon unless you are a diplomate of the Canadian surgical board. The testimonies in opposition were limited and based on the belief that adding surgery to the AAD name would actually be counterproductive, and imply that dermatology is non-surgical.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AAD01 as amended:

RESOLVED, that the American Academy of Dermatology/Association should set up a method to include the term “dermatologic surgery” in its logo, on its websites and letterhead; and be it further

RESOLVED that this change take place in the most economical fashion possible; and be it further

RESOLVED, the American Academy of Dermatology/Association should bring the idea of a name change to the full membership for a democratic vote.

ADVISORY BOARD ACTION: APPROVED AS AMENDED

Testimony was generally supportive of the resolution. It was noted that the Board of Directors had just considered the issue in 2010 and that after considerable thought and review of the projected financial, branding and other consequences, the Board voted to not approve the resolution. Testimony included the identification of several state societies that had moved to include “dermatologic surgery” in their societal names. One witness expressed that branding “dermatology” as all inclusive doesn’t work, so there is a need to look at the state societies who changed their names and learn from that experience. Another witness expressed that, just because the membership had voted on the name change twice in the past is not a good reason to reject the idea now. The general conclusion was that, while changing the name may not make a direct difference

in reimbursement/coverage, it is important that dermatologists are overtly identified as surgeons. Opposing testimony supported the belief that a name change would not make a significant difference. An amendment was approved by voice vote to include the words “name and” in the first resolved, directly before the word, logo, and the resolution was approved by a large majority.

2. **AAD02 (A-11) Position of the AAD on the Subject of Subcertification in Procedural Dermatology by the ABD**

Reference Committee Hearing Debate:

Testimony was largely in favor of the resolution. It was offered that perhaps a poll of the membership would be more appropriate than a vote, since the data would be used to influence the ABD, not the AAD.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AAD02 as amended:

RESOLVED, that the American Academy of Dermatology/Association should ~~set up a media campaign to~~ educate the membership as to the dangers of economic credentialing, disunity of the specialty, and the potential loss of surgical training and practice for the “plain” dermatologist; and be it further

RESOLVED, the American Academy of Dermatology/Association should poll the Membership on bring the decision to have a new surgical sub-specialty in ‘Procedural Dermatology,’ to the full membership for a democratic vote and share the results with the ABD.

ADVISORY BOARD ACTION: **TABLED INDEFINITELY**

The current President of the ABD was present and was recognized as the first witness, at his request. He explained the history of ABD’s consideration of procedural dermatology certification, noting that considerable review had been given to the process and nomenclature. He explained the nature of procedural dermatology as it is currently included in dermatology fellowship. He also noted that there is fellowship training called procedural dermatology under the American College of Mohs Surgery. The move to label the ABD certification as procedural dermatology was to ensure the certification captured more than just Mohs surgery, despite the fact that it was primarily a Mohs surgery fellowship. He offered that, in time, just like dermatopathology and pediatric dermatology, physicians, payers and patients alike will want to refer to a certified physician. He then confirmed that, at this time, there is absolutely no effort afoot to move forward with procedural dermatology. That is not to say that they won’t move forward with a certification at some point; however, it will most likely be Mohs surgery or some name to better reflect the actual fellowship. The Advisory Board was urged to table the resolution given its objectives were no longer relevant. There was some opposition expressed to tabling the resolution in favor of moving forward with a membership vote to measure member perspectives. A motion was made to table the resolution. The Resolution was tabled.

3. AAD03 (A-11) *Improving Dermatologic Curriculum to Enhance Quality of Care*

Reference Committee Hearing Debate:

Testimony on this resolution was divided, yet slightly more balanced in favor of the resolution. Comments in favor of this resolution supported the idea that having the Academy more proactively promote the inclusion of Mohs surgery in residency programs would ensure that dermatology is seen as a credible surgical subspecialty. Arguments against this resolution as written included the concern that it could potentially put an undue strain on residency programs and that it would draw too much attention to Mohs surgery. There was notable debate about whether residency programs should teach Mohs surgery to a level of proficiency vs. competency.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AADA03 as amended:

RESOLVED, that the American Academy of Dermatology/Association should support the concept that the teaching of Mohs micrographic surgery be included in the curriculum of all dermatology residency programs; and be it further

RESOLVED, that the American Academy of Dermatology/Association formally express to the ACGME its desire that all residency programs provide such training to insure that all graduates can perform this procedure with greater competence; and be it further

RESOLVED, that the AAD/A recommend that the American Board of Dermatology and APD include questions on its certifying exam to ensure this competence of new fellows residents in Mohs micrographic surgery.

ADVISORY BOARD ACTION: APPROVED AS AMENDED

Your Advisory Board heard very balanced testimony. Those in opposition argued that teaching Mohs surgery is already included in residency programs. There was a great deal of debate about whether it was feasible to teach to competence vs. proficiency. The argument was also made that there are already questions included on the Board exam regarding Mohs surgery. Those in support of the resolution strongly supported the need for greater instruction in Mohs. One witness suggested that dermatologists should be fully trained as dermatologists, and that if the residency program cannot be completed in 3 years to sufficiently cover Mohs, then perhaps we should move to a four-year program. There was solid agreement that consideration for quality patient care should be the first consideration. The Advisory Board voted to support the resolution as amended by the reference committee.

4. AAD04 (A-11) : *Educating Children about the Hazards of Tanning UV Radiation*

Reference Committee Hearing Debate:

The resolution was presented by the author with background on the Ohio Dermatological Association (ODA) efforts, and its motive for introducing the resolution. He talked about the value of having the AADA make the template and other successful state materials

available for use in other states. It was asked if this were being done on any level by the AAD currently. AADA staff shared that the hazards of indoor tanning is a priority of the AAD and AADA, and that resources are available to state societies and members, though not this type of campaign specifically. Staff noted that such materials would be complimentary to existing efforts and materials. Testimony continued and it was suggested that an amendment be incorporated to change the language to include both natural and unnatural UV radiation.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AAD04 as amended:

RESOLVED, that in order to help the AADA achieve their SCRIPT goal of reducing the incidence of skin cancer, the AADA suggests that the various State Dermatological Associations and the local Dermatology Societies work with their State Medical Association to recommend to their various State Boards of Education to urge their school districts teach about the hazards of ~~tanning~~ natural and artificial UV radiation.

ADVISORY BOARD ACTION: APPROVED AS AMENDED

Testimony was generally supportive, noting the resolution's compatibility with the AADA's efforts, to date, on skin cancer prevention. Staff noted that the AAD/A Website was scheduled for a re-launch in March and that materials on indoor tanning and skin cancer prevention generally were in the process of evolution. It was noted that the Website would include a page for more accessible materials and that this type of material would be complementary. Witnesses expressed that, in a practical sense, getting individual boards of education on board to make the issue a priority will be difficult to accomplish. A motion was made to amend the language to include the following at the end of the resolved: and provide a listing of source material and list of healthcare volunteers who would be willing to assist in the training of this. The resolution was approved as amended.

RESOLVED, that in order to help the AADA achieve their SCRIPT goal of reducing the incidence of skin cancer, the AADA suggests that the various State Dermatological Associations and the local Dermatology Societies work with their State Medical Association to recommend to their various State Boards of Education to urge their school districts teach about the hazards of ~~tanning~~ natural and artificial UV radiation, and provide a listing of source material and a list of healthcare volunteers who would be willing to assist in the training of this.

5. AAD05 (A-11) AAD Policy on the Use of X-Rays by TSA Scanners on Skin Cancer Patients

Reference Committee Hearing Debate:

There was no testimony for or against this resolution, though it was noted that the AAD/A has no position on the issue, nor has it explored taking a position on the issue.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AAD05:

RESOLVED, that the American Academy of Dermatology/Association should be at the forefront of determining whether the TSA scanners are harmful to skin cancer patients; and be it further

RESOLVED, the American Academy of Dermatology/Association should appoint a task force to investigate any risks to our patients and communities and report these findings to the membership of our organization and to the public.

ADVISORY BOARD ACTION: APPROVED

No testimony was heard on this resolution. The resolution was unanimously approved.

6. AAD06 (A-11) Accutane Legal Mangle

Reference Committee Hearing Action:

The testimony on this resolution was supportive of the idea but largely against the wording of the resolved.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AAD06 as amended:

RESOLVED, that the American Academy of Dermatology should ~~redouble an aggressive rebuttal to the attacks~~ promote a media strategy that reflects the importance of Accutane as a Dermatological medication.

ADVISORY BOARD ACTION: APPROVED AS AMENDED

Testimony generally supported the idea of moving more aggressively to counter the false claims being made in the media about the dangers of Isotretinoin. Opposing testimony expressed that, from a budgetary point of view, a media strategy might not be practical, nor the best use of the Academy's resources. It was noted that the Academy has a very good position statement about the links of Isotretinoin to adverse side effects, the science, etc. and that should be the AAD's focus—to educate about that position. A motion was made to replace the word Accutane with Isotretinoin. The motion was approved. The amendment was adopted. The resolution was adopted as further amended.

RESOLVED, that the American Academy of Dermatology should ~~redouble an aggressive rebuttal to the attacks~~ promote a media strategy that

reflects the importance of Accutane Isotretinoin as a Dermatological medication.

7. AAD07 (A-11) *EMR and EMR Prescriptions*

Reference Committee Hearing Debate:

Testimony was heavily against the resolution because it was felt that the health care environment has evolved too far and that the AAD cannot have a significant impact other than to try and influence. An amendment was offered to reflect that dermatologists who are close to retirement be able to be grandfathered.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AAD07 as substituted:

~~**RESOLVED**, that the American Academy of Dermatology should consider a concept of a grandfather clause to EMR implementation.~~

WHEREAS, older dermatologists may opt to retire rather than adopt EMR, causing a potential shortage of dermatologists. Therefore be it;

RESOLVED, that the AAD should recommend to the AMA that solo practicing physicians near retirement should be exempted from adopting EMR, and that the AMA lobby Congress to promote this exemption.

ADVISORY BOARD ACTION: APPROVED AS AMENDED

Testimony was heard from both sides. Those in support expressed the difficulty of small practices in general, not just solo practitioners, older physicians or those nearing retirement. Witnesses in opposition noted that EMR is here to stay, and that the AMA will never move to act on this recommendation. One witness suggested that the AAD Board will leave action up to the discretion of the dermatology delegation to the AMA House of Delegates. Other testimony reflected that “near retirement” is too nebulous, that parameters need to be established. A motion was made to amend the resolved to replace “solo practicing physicians” with “in small practices” and that after EMR, the words “until 2020” should be added. The amendment was adopted. The resolution was adopted as further amended.

~~**RESOLVED**, that the American Academy of Dermatology should consider a concept of a grandfather clause to EMR implementation.~~

WHEREAS, older dermatologists may opt to retire rather than adopt EMR, causing a potential shortage of dermatologists. Therefore be it;

RESOLVED, that the AAD should recommend to the AMA that ~~sole~~ practicing physicians in small practices near retirement should be exempted from adopting EMR, and that the AMA lobby Congress to promote this exemption.

8. AADA01 (A-11) ACOs Another Costly Objectionable System

Reference Committee Hearing Debate:

Testimony on this resolution centered on the impending uncertainty surrounding the implementation of Accountable Care Organizations (ACOs). Testimony was in favor of the message of this resolution, but not the wording of the resolves. It was noted that the AAD formed an ACO workgroup that is currently studying many of the concerns made in the resolution.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AADA01 as amended:

RESOLVED, that the AAD/AADA through the ~~ACO Task Force~~ advise the membership of the problems associated with ACOs (Accountable Care Organizations); and be it further

RESOLVED, that the AAD continue to work with coalitions of other specialties to educate physicians on ACOs.

RESOLVED, that the following points be included:

- ~~9) Within an ACO the hospital and physician (at least initially) will make money when they save the government money. This kickback creates a conflict of interest. How can the patient trust the hospital and physician to not adversely limit his/her healthcare in pursuit of a better bottom line for the hospital and physician? On the witness stand (or on the front page of the newspaper) how can the hospital and physician prove that their own interest was not placed ahead of the patient? This is the proverbial problem of trying to prove a negative; you can't! Also recall that there are no absolutes in medicine and that protocols/guidelines are starting points, not the end of physician or hospital responsibility.~~
- ~~2) The initial costs to set up an ACO are not funded.~~
- ~~3) The distribution of a portion of the savings is not defined. There are no guarantees that the individual physicians will be equitably treated or that the participants will agree.~~
- ~~4) Because there are no "any willing provider" provisions, restraint of trade is likely to occur.~~
- ~~5) ACOs function as gate keeping organizations.~~
- ~~6) ACOs will have to get around anti-trust law, anti-kickback law, and on physician self-referral law.~~

~~7) If the primary care physician joins an ACO, the patient is now under the auspices of the ACO whether the patient chooses to be or not. Although the patient could change physicians, this change could precipitate episodes of abandonment of care. The patient's freedom to choose his/her physician would be diminished to a more limited pool creating a more significant access to care problem.~~

~~8) ACOs most probably will institute versions of P4P with it's associated negative attributes, especially when it holds people unfairly responsible for factors beyond their control.~~

~~9) A common sense cost saving and anti-fraud measure would be a nominal amount paid by the patient to oversee the system...maybe even with a refund at the end of the year as the kickback!~~

ADVISORY BOARD ACTION: APPROVED AS AMENDED

Testimony was mixed. Witnesses noted that the regulations on ACOs haven't yet been released and, therefore, it is difficult to try and direct what our response might be as an organization. However, it was also noted that the GAHPP Council had appointed a workgroup to very carefully evaluate the potential consequences of various ACO structures, and to develop a position statement or set of principles for the AADA. A witness, who happens to sit on the ACO Workgroup, said that there is every intent to keep the membership informed as much as possible. The resolution was unanimously approved as amended.

9. AADA02 (A-11): State Dermatological Associations and State Medical Societies in a United Effort to Pass Legislation about the Hazards of Tanning UV Radiation

Reference Committee Hearing Debate:

The author framed this resolution as forming a stronger team towards fighting the effects of indoor tanning. Testimony was overwhelmingly in favor.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AADA02:

RESOLVED, that the AADA act as a co-catalyst to help coordinate the efforts of the many organizations that are trying to reduce the incidence of skin cancer through legislation; and be it further

RESOLVED, that the AADA function as a repository of information and guidance and share experiences via the web site such as that of the Ohio Dermatological Association www.ohderm.org so that each state would not have to reinvent the many spokes of the wheel in order to pass legislation that would promote the health and safety of children and reduce their

future cost of health care by prohibiting the sale of hazardous tanning parlor **UV** radiation to all minors; and be it further

RESOLVED, that the AADA encourage dermatologists and others to have patients and others sign a letter of support (similar to enclosure) for legislation that promotes the health and safety of children and reduce their future cost of health care by prohibiting the sale of hazardous tanning parlor **UV** radiation to minors during their most vulnerable years and be a co-catalyst in helping make a potential significant historical medical event happen.

ADVISORY BOARD ACTION: APPROVED

No testimony was heard and the resolution was adopted unanimously.

10. AADA03 (A-11) Approval of Cantharone

Reference Committee Hearing Debate:

There was anecdotal testimony about the current availability of Cantharone in the US, but overall was in support of the resolution

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AADA3 as amended:

RESOLVED, that the American Academy of Dermatology/Association make it a priority to engage the Food and Drug Administration and work toward approval of cantharone in the U.S., and be it further

RESOLVED, that the American Academy of Dermatology/Association approach insurance companies and urge them to provide coverage for the use of RetinA tretinoin or Aldara imiquimod as alternative treatments for pediatric moluscum in the outpatient setting until such time as cantharone is FDA approved.

ADVISORY BOARD ACTION: APPROVED AS AMENDED

No testimony was heard. The resolution was adopted as amended by the Reference Committee.

11. AADA04 (A-11) Congressional Financial Responsibility and Accountability AKA Addressing Unaffordable "Wants"

Reference Committee Hearing Debate:

Testimony was predominantly against this resolution. It was noted that the BOD would not pass this resolution, and that its resolved is not appropriate for the AADA. The resolution's author noted the intent of the resolution largely to facilitate discussion, and to draw attention to issues of importance to dermatology, and that it would be fine were it withdrawn.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends not to adopt AADA04:

RESOLVED, in regards to physician reimbursement discussions that the AADA utilize the ideas in the Wall Street Journal dated January 19, 2011 article (*attached*) detailing options for spending cuts. Utilization could include the September membership lobbying effort. The list includes:

1. Elimination of costly regulations
2. Repealing the PPACA and the individual mandate
3. Eliminating taxpayer funded bailouts
4. Privatizing Fannie Mae & Freddie Mac
5. Eliminating subsidies for ethanol and unproven energy technology
6. Scrap, phase out, or greatly downsize the Departments of Commerce, Education and Housing & Urban Development
7. Repealing the Davis-Bacon labor rule
8. Ending urban mass transit grants
9. Privatizing air traffic control and Amtrak
10. Reforming federal worker retirement
11. Ending AmeriCorps and the Small Business Administration
12. Encouraging personal savings to supplement Social Security
13. Scrutinizing the defense budget

ADVISORY BOARD ACTION: NOT APPROVED

The Advisory Board reiterated the points made at reference committee, and voted to not approve the resolution.

12. AADA05 (A-11) Request for Washington AADA Office to Attend, Monitor & Report on MEDPAC**Reference Committee Hearing Debate:**

The author of the resolution recognized that the AADA may already be doing this. The testimony centered around the need for the AADA to look into ways to more effectively communicate with the membership, specifically passing along information that the AADA office gleans from various federal legislative and regulatory events.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AADA05 as amended:

RESOLVED, that the Washington office of the AADA attend, monitor and report via executive summaries to the membership, Advisory Board, and interested staff, MedPac discussions that might impact dermatologists. Possible venues include emails and Derm World; and be it further:

RESOLVED that the Washington DC office use a variety of more effective methods to widely disseminate information to the membership including social media and other new and emerging technologies.

ADVISORY BOARD ACTION: APPROVED AS AMENDED

No testimony was heard and the resolution was adopted unanimously.

13. AADA06 (A-11) Identification Badges for Health Care Providers.

Reference Committee Hearing Action:

The resolution was introduced and brief background was provided on a recently adopted Pennsylvania law that will require physicians, physician assistants and other clinicians and non-clinical providers to identify their titles on a visible name badge. It was noted that this is one aspect of truth-in-advertising, which the AADA supports. Testimony was largely in support of the resolution. There was testimony against the resolution which noted that for many solo practitioners, the patients know who the physician is, making name tags unnecessary.

REFERENCE COMMITTEE ACTION:

Your Reference Committee recommends adoption of AADA06 as amended:

RESOLVED that the AADA provide model state legislation based upon the recent Pennsylvania Identification Badge Law. And be it further resolved that,

RESOLVED, to provide model state legislation to the AADA members and dermatological societies, so that they may be encouraged to pass similar laws initiatives in their states.

ADVISORY BOARD ACTION: APPROVED AS AMENDED.

No testimony was heard and the resolution was adopted unanimously.