FOREFRONT DERMATOLOGY®

THE FOREFRONT DIFFERENCE

A **physician group** led and operated by **Dermatologists**, for the benefit of **Dermatologists**

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Part 1

Who We Are

Forefront Dermatology is a best-in-class, physician-led dermatology practice with over 245 clinics across 28 states and the District of Columbia.

We provide general, surgical, and cosmetic dermatology services along with related laboratory services through a network of over 535 dermatologists, physician assistants and nurse practitioners.

The benefits of partnership with Forefront Dermatology include:

- Physician-centric culture: founded, led and operated by respected dermatologists
- Drive to deliver an exceptional patient experience through superior patient care and shared services
- Economies of scale with payors and suppliers
- Capital and other resources to support growth
- Ability to earn attractive income
- Unmatched collegiality with fellow dermatologists to share cases and solve problems

Current Footprint

Forefront Dermatology By the Numbers

1977

Year Founded

245+

Clinics

28

States + District of Columbia

535+

Dermatologists, Physician Assistants and Nurse Practitioners

3,500+

Number of Employees

4.8 Stars

Forefront Dermatology's average patient rating across four major platforms.

Part 2

Our Mission & Values

Forefront Dermatology is a practice built on values; values which we have never, and will never, compromise. Though we have grown, and continue to do so, we practice discipline and diligence to remain true to some common tenets. Our mission and values highlight some of our cultural pillars.

Our Purpose

To provide world-class skincare locally and preserve the private practice of dermatology.

Our Mission

To be the skincare specialist of choice in every community we serve.

Our Values

Physician leadership

Physician ownership

Ethical patient-focused mindset

Autonomy in clinics

Part 3

Physician Leadership

Forefront Dermatology's physician-centric culture is key to our success. Founded and led by dermatologists with excellent reputations, we focus on serving our communities and patients while preserving the integrity of dermatology.

Forefront physicians seek to combine the best of both worlds: the autonomy of private practice, and the collegiality and benefits of scale of group practice.

Forefront Dermatology's governance model includes the following elements:

- Eight member Physician Board of Directors - all board-certified dermatologists elected by the physician shareholders. The Physician Board guides policy setting for the physician group including matters affecting physicians, patients, clinical staff and more.
- Physician Advisory Committee that advises on and oversees the broad operations of the group. The committee includes 31 physicians across operational processes from scheduling to compliance
- All major decisions are voted on by the full physician group

Meet Dr. Betsy Wernli

Forefront Dermatology's President and practicing dermatologist in Manitowoc, Wisconsin

Undergraduate Degree

University of Oklahoma

Medical School

University of Oklahoma

Dermatology Residency

University of Iowa

Board-Certification

American Board of Dermatology

A Forefront Dermatology physician since 2011

Part 4

Our Proven Model

Forefront Dermatology enables its physicians to enjoy the financial and personal rewards of private practice, together with the professional support and stability of a large, successful physician-led dermatology organization.

Our shared service infrastructure exists to provide a headache-free environment in which physicians can operate efficiently and focus on patient care, while maintaining local and clinical autonomy.

We offer vast financial and operational resources to support practice growth while:

- Growing to become one of the largest dermatology practices in the United States with a superior balance sheet
- Developing and refining the best-in-class shared service platform, field-tested and proven over 20 years
- Providing access to efficient and cost-effective scheduling, billing and collections, pathology lab, information technology, accounting and more

We are passionate about being board-certified dermatologists. We believe physician assistants and nurse practitioners complement any services alongside proper physician supervision, never replacing a board-certified dermatologist.

> “Our scale and resources afford us a stronger position in negotiations with payors and suppliers, leading to better reimbursement rates and lower costs.
>
> - Betsy Wernli, MD, FAAD

Part 5

Regulatory & IT Support

Compliance with legal and regulatory requirements -- including Meaningful Use, PQRS, MACRA and more -- has become increasingly difficult and expensive. Forefront Dermatology has the scale and expertise to manage the costs and complexities of such compliance, as well as legal, regulatory, IT and other resources that ensure smooth, turnkey operations.

- Our combination of customized EMR templates, on-the-ground “scribe” support, and dedicated EMR support enables highly efficient clinical workflow

- EMR systems (EMA™) are seamlessly integrated with a comprehensive NextGen® practice management system, which has industry-leading capabilities and allows for the automation of customized processes, procedures and reporting

Forefront Dermatology’s proven resources and expertise allow physicians to operate efficiently and focus on patient care.

Part 6

Employer of Choice

Forefront Dermatology is the employer of choice for dermatologists, medical staff and ancillary professionals who share our aspiration to be at the Forefront of advancing dermatologic care. Although physicians are the “lifeblood” of our company, we recognize the importance and value of the support services team and actively promote an environment of respect for and empowerment of all employees.

Forefront is a family - from the dermatologists to the physician assistants, nurse practitioners and clinic staff. We take care of each other. Partner practices find:

- Dedicated support for their employees
- Competitive compensation and benefits
- Education and employee training
- Opportunities for career advancement
- A fun and rewarding workplace

Forefront Dermatology’s emphasis on development, training, and upward mobility enhances our ability to support physicians.

Part 7

How Forefront Can Support You

A partnership with Forefront Dermatology offers you access to a network of dermatologists and services that is unmatched in the dermatology industry.

- **Centralized Billing:** turnkey support that increases efficiency, and eliminates payor and collection challenges
- **Centralized Scheduling:** consistent, efficient customer service with local feel by utilizing a team-based system
- **Information Technology:** efficient workflow via a fully integrated EMR and practice management system; turnkey support for Meaningful Use and PQRS
- **Legal:** assurance regarding compliance with legal and regulatory requirements; professional guidance and support
- **Marketing:** strong branding; support for marketing collateral, local advertising and promotional activities
- **Human Resources:** professional management of employees and related administrative issues
- **Finance & Accounting:** unsurpassed access to capital; accurate and efficient reporting in a transparent environment
- **Facilities Management:** personalized team to source viable clinic location options along with negotiating lease terms, recommending layouts and more

Part 8

Summary

> Joining Forefront has resulted in fewer administrative duties for me, my partner and our staff. **I can now focus more of my attention on doing what I enjoy - seeing patients.**

- Jeffrey B. Richardson, MD, FAAD
Partnered with Forefront in 2015

Forefront Dermatology physicians are able to practice quality dermatology, while earning competitive incomes and working side-by-side with an unmatched group of dermatology colleagues.

Physician led and operated

Best-in-class shared services platform

Opportunity to be a partner

Ability to earn a high income

Significant economies of scale

Collegial environment

Vast resources to support growth

Employer of choice

FOREFRONT DERMATOLOGY®

Building and Growing Our Group Practice: The Role of Culture

So, how does a practice create a culture and successfully weave it into the patient experience? Here's what culture means to us:

What Does Culture Mean?

Too often, it's invoked but not explained—a "you'll know it when you see it" kind of thing—or else described in the vaguest terms possible ("a culture of excellence…").

Here we describe the bedrock values upon which our physician group, Forefront Dermatology, has built its culture and the programs established to sustain it—even, or especially, during periods of growth. You'll read testimonies from various Forefront dermatologists at different stages of their careers to convey the diversity across our practices and the single-minded focus on patient care that unites us. We've developed mentorship and training opportunities to support that focus and the continuous learning it demands.

The culture question is especially important today as dermatologists have so many practice options. Culture and fit have huge impacts on professional satisfaction, especially in the long term. We take the time to develop a practice foundation based on respect, training, and communication to maximize our growth and team satisfaction. Is our group the right fit for you?

"I still remember finishing up my residency and having to choose between Forefront and starting up my own clinic. No matter how big we have grown, we still have the same values I was first attracted to; total autonomy in the clinic and all the support services make it easy to be the best doctor I can be every day. Combine this with physician leadership and ownership, and we, as doctors, have built the perfect practice."

Betsy Wernli, MD, FAAD | President of Forefront Dermatology

Forefront's Values

Physician leadership ensures complete clinical autonomy and protects our commitment to excellence and board-certified care.

What does board certification mean to us? Our commitment to continuous learning and performance and an emphasis on collegiality that encourages even the most experienced physicians to seek and share advice with their colleagues.

At Forefront, we've found that the following values interrelate and reinforce one another:

Physician Leadership

We have the final say on everything from day-to-day operations to major business decisions.

Clinical Autonomy

We have the autonomy necessary to maintain our professional identities and meet our patients' needs while increasing the success of our practice.

Excellent Board-Certified Care

We are board-certified dermatologists committed to maintaining an appropriate ratio of dermatologists to physician assistants and nurse practitioners.

Culture of Collegiality

We leverage our collective experiences and knowledge to offer the best dermatological care in the communities we serve.

"What does being PE-Backed mean to me? It's invisible to me; honestly, I have almost no awareness of it. To me, Forefront is the doctors, and the non-physician administrative staff that are here to help me and take care of things that I would prefer not to deal with."

Victoria Negrete, MD, FAAD
Board-Certified Dermatologist

Physician Leadership: The Backbone of Our Culture

Behind every aspect of our culture, you'll find one thing: Physician Leadership. Our physicians drive every decision across the group, from how we recruit and who we hire to the specific offerings of our central services. Physician-led decision-making is enshrined in our structure as well as our culture. At Forefront, our central support services work in tandem with physician leaders so that the clinical perspective is always front and center, no matter the issue. This core value and corresponding structure have produced fundamental practice guidelines like our commitment to hiring board-certified dermatologists and maintaining the appropriate ratio of dermatologists to physician assistants and nurse practitioners.

These guidelines are essential to our identity, yet our practice continues to evolve based on physician needs and under the direction of our physician leaders. Recent examples of physician-centric improvements include the addition of social media support and the simplification of our compensation formula.

Bank vs. Backbone

At Forefront, private equity is treated like a bank. It makes it possible for us to open new clinics and bring existing high-quality practices on board. It supports our central services, spelling much-needed relief from overwhelming administrative obligations. Yet all of our practice decisions—what we think of as our backbone—are made by our physicians. We create the culture, we set the values, and we use those values to guide our decision-making.

What does that mean on the ground?

We're dedicated to our patients and the communities in which we practice. We're not interested in short-term profits or quick fixes. We're in it for the long haul, providing first-class care for our existing patients and finding ways to increase access to care for those who need it.

Collegiality & Communication

At Forefront, you have autonomy, but you're not alone. As any physician knows, clinical knowledge can be broadened immensely with the support of peers. "Has anyone seen this before?" is a question our physicians are happy to answer—both because it's a question they've also asked at some point and because answering it means better care for our patients.

But culture is more than just atmosphere. Recognizing that even the most experienced physicians can find value in how a colleague arranges their clinic or integrates new offerings, we've fostered various channels for seeking out and sharing these tips.

For example, after realizing that many early and mid-career physicians wanted more information about practice management, Forefront President Dr. Betsy Wernli responded by creating Practice Pearls—a series of videos that addresses things not formally covered during training, such as completing your EHR notes between visits, improving your scheduling template, and how best to utilize medical assistants for biopsy and excision procedures. These concrete tips can be accessed any time by any team member at Forefront Dermatology.

True communication isn't only from the top down or the center out; it's multi-directional. At our bi-annual retreats, physicians strengthen personal ties and relax with their colleagues, and they are also invited to share their concerns and goals with Forefront's physician leaders. At past retreats, we've investigated some of the concerns and myths around private equity's role in the field, evaluated and refined our Advocate Program, prepared for the growing importance of online reviews, and voted to add a new EHR to our practice. Working together on these issues helps increase knowledge and understanding across the practice—and often turns up new solutions.

"Our 210+ board-certified dermatologists utilize Facebook Workplace to communicate, collaborate, and stay connected. A colleague had a problem with a rash called lichen planus—her patient had a severe case, and the rash wasn't responding to anything. She dashed off a chat that probably took her 30 seconds—"Hey, I've got this problem, can anyone help me?"—and hit send. In 10 minutes, she got ten brilliant responses. With a simple chat, we can access years of dermatology experience."

Matthew Kelleher, MD, FAAD | Board-Certified Dermatologist

Owner Mindset

Our success depends on our performance—it's as simple as that. The people who work best in our culture are physicians with an ownership mentality. We understand that there is no "Forefront" beyond ourselves, no magic pot of money beyond what our practice generates. Our central shared services are funded by the money we make when we see and treat patients. When a Forefront physician wants to invest in a laser for their clinic, or any other new technology, the answer is always "yes—as long as you can make it work."

While revenue is certainly important, exceptional patient care is the essential metric here. That's why we only bring on responsible, ethical dermatologists who feel real accountability to their patients and their community—and why we protect their complete clinical autonomy.

Is "Efficiency" a Dirty Word?

For some, "efficiency" sounds like a code word for an assembly-line approach to dermatology—shortchanging patients for profit. We reject this connotation.

At Forefront, we understand clinical "efficiency" to mean taking patients' time seriously and ensuring that every minute spent with each patient really counts. That's why we offer resources like the Practice Pearls series and encourage physicians to talk to one another directly about their innovations.

Efficiency is about making sure 100% of your effort is focused on your patients. It comes when you're relieved of administrative burdens and when you and your support staff are empowered to use your physical space and technology the way you have determined will deliver the optimal patient experience.

Continuous Learning

At Forefront, we've created an environment that feeds our hunger to keep improving. This may happen informally in one-on-one chats or on our Facebook Workplace app or more formally when a physician invites colleagues in for shadowing or presents at our bi-annual retreats. We have a host of resources designed by and for our dermatologists including a Grand Rounds series presented by our in-house Dermatopathology Lab, Leadership Playbook on how to efficiently and effectively lead your clinic to success every day, Cosmetic Workshops, Quarterly Newsletter with articles written by Forefront clinicians in their areas of expertise, the list goes on. For those just launching their career or who want some extra guidance we also have Coding Training and an Advocate Program.

Coding Training

When you're a resident, you may get a bit of training on coding, but it's probably a tenth (or less) of the training you need. We've addressed this massive gap by offering our physicians training in coding as part of the onboarding process. Rather than simulating coding scenarios in some computer lab, our group's training program has you follow a Forefront physician through their real-life clinical practice, giving practical instruction for the correct coding of actual charts. Ensuring accurate coding for different office visits and procedures is an important component of ethical medical practice, and it keeps Forefront on the right side of the regulations.

Advocate Program

"Advocacy" may be the last thing you're interested in after so many years of schooling and apprenticeship. But many global skills benefit your patients—and your professional profile—that are not taught in medical school or most residencies. These include patient care tips, expertise in EHR usage, and time management advice for achieving work/life balance. By pairing you with more experienced (and highly accomplished) physicians, we provide a knowledgeable sounding board for your challenges and support for your continuous professional and clinical development.

How do we Sustain this Culture?

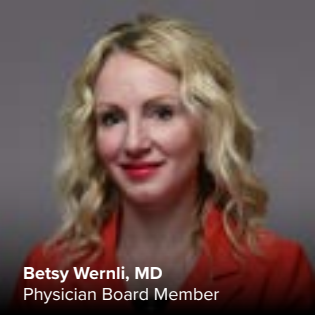
Across healthcare, the major trends point toward standardization, consolidation, and homogeneity. Forefront's culture is built to withstand those forces and safeguard the private practice of dermatology. From our governing structure to our administrative services, every decision we make and every service we offer is meant to help physicians do their job.

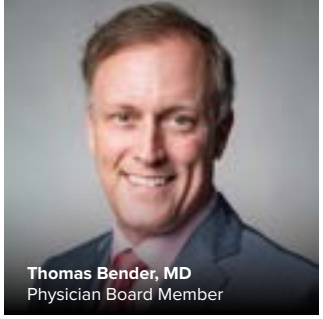
Through steadfast practice, ethics, and careful hiring, Forefront is highly selective in who we choose to partner with. Why? Because our culture and ethics are paramount, pairing with the right physicians ensures the strong backbone we've worked so hard to preserve.

In a broader culture that too often focuses only on the bottom line, we've stayed true to who we are since the beginning: A group of board-certified dermatologists who respect and push each other to provide the best possible experience and care for our patients.

"I looked carefully at other job opportunities out of residency, but I was attracted to Forefront because of its culture of physician autonomy and because they offered the ancillary services I'd need to run a successful dermatology practice. Now that I've joined, I see that Forefront delivers on all of those promises. Forefront really supports and trusts its physicians to give our patients the best care possible."

Nicholas Bontumasi, MD, FAAD | Board-Certified Dermatologist





Are you the one that fits?

At Forefront Dermatology, our team of physician leaders mentor and share their extensive knowledge and have created a culture in which our physicians, PAs, NPs, team members, and patients feel heard, valued, cared for, and respected.

Our leadership team has grown from just a handful of leaders to what we have today. And we never stop growing, adding new positions, and looking for new leaders—because progress is not possible without leaders who have the courage to imagine a brighter future for dermatology and guide us toward that vision.

FOREFRONT DERMATOLOGY®

Grow with Forefront and become a vital part of our physician leadership team today!

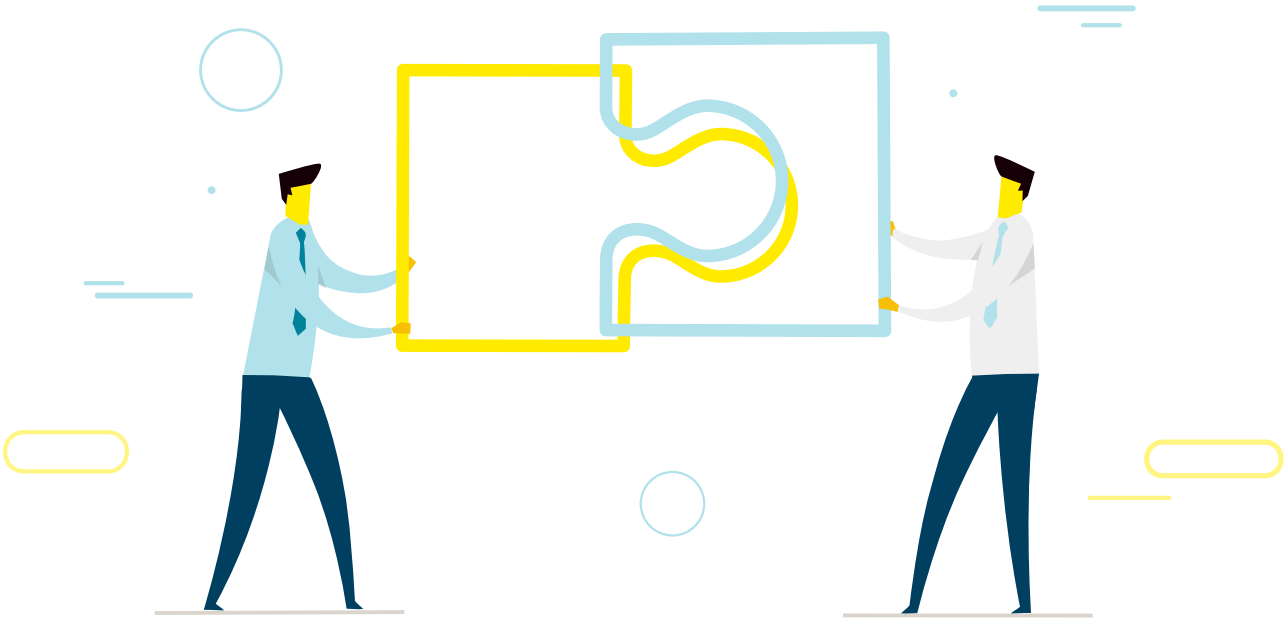
www.forefrontderm.com

FOREFRONT DERMATOLOGY®

Forefront Physician Perspectives 2021: Together we are greater than the sum of our parts.

An Interview with Thomas Bender III, MD, FAAD, ABD

Dr. Thomas Bender joined Forefront Dermatology in 2018 after establishing Advanced Dermatology's first location in Mobile, Alabama nine years prior. Coming from a military background (USAF), he believes that a cohesive group is greater than the sum of its parts—a philosophy that guided the founding, staffing, and expansion of his own successful private practice, and one he has sustained as a Forefront Dermatology physician owner and board member.



Deciding to Join Forefront

My decision was part chemistry, part practicality. Both were important.

First, our cultures had to match. In dermatology if you take excellent care of your patients and put them first—and you also take excellent care of your staff—you'll do very well financially. But you have to have your priorities in that order. When folks get those goals mixed up, they just don't do as well in the long run.

I learned pretty quickly that the dermatologists who started Forefront put patients first, and the ones who've joined it have absolutely sustained those same values.

My second reason for joining Forefront had to do with the terms and nature of the partnership. In the course of evaluating different groups, I ran into several that wanted to squeeze us into their already existing structure; we would essentially be an extension of their platform. Forefront was different—in large part, I think, because they are truly led by physicians. In addition to ensuring complete clinical autonomy, they genuinely valued the operational expertise we'd developed in our region.

Navigating the Transition

Even though we knew we were a strong cultural match, there's always going to be some anxiety around change. Forefront's onboarding process was such a relief in that respect. Having done this dozens of times before, they really have it down to a science. Everybody in my practice was impressed—they came in and set up at one of the local hotels, splitting us up into staff members and providers so they could explain exactly what the benefit structures were, how you sign up for things, all of the details we needed to make the transition as efficiently and painlessly as possible.

The onboarding team was knowledgeable and efficient, certainly, but what stood out to me most was how they focused on making my group feel comfortable with the transition. It wasn't some big, bad, ugly corporation coming in with people in black suits everywhere. It was more like, "We're a family, you guys are a family. Both families are going to get a little bit bigger, so we're here to see how we can help with that."

That's only one aspect of the transition, of course. Another is the switch from making unilateral decisions in your practice to being a part of a larger group, which is a challenging concept for some practice founders. I actually did not find it difficult. I really felt the opportunity—and not only opportunity, the invitation—to influence the overall group practice. There are definitely things that Forefront does better that we've incorporated into Advanced Dermatology. But there are also things we'd been doing pretty well that Forefront was interested in incorporating. And I think that's when you know it's a true partnership.

Physician Leadership

My experience running for Forefront's physician board is another great example of that two-way partnership—and of their commitment to physician leadership overall. At the first shareholder meeting I went to after I joined, our four board-certified dermatologist leaders encouraged me to throw my hat in the ring for a spot on the board.

So here's this new dermatologist from, at that point in time, the southernmost practice in Forefront, being allowed to join this longstanding group of leaders. In many practices—probably most!—they would have wanted to keep the decision-making power concentrated. But they thought, "Hey, if we're going to keep growing in the Southeast, then we need to have some representation on the board from that area of the country." That interest in diverse geographical representation speaks highly of the integrity of the group. And for my part, it's been really gratifying to visit with dermatologists from Wisconsin, Michigan, Kentucky... Working through challenges is so much more productive when we consider different perspectives to arrive at the right decision.

COVID-19: A Test of Leadership

Nowhere was that diverse expertise more important than in crafting our initial COVID-19 response.

When you have over one hundred and eighty physicians across eighteen states—and more than a few with master's degrees in public health—you have a lot of solid, well-grounded professional opinions about how to proceed during a pandemic. Forefront's physician-led COVID-19 Taskforce, which was established at the very outset of the pandemic, took in those opinions along with the relevant research to come up with the most rational, best-informed plan for our operations going forward.

I'm proud of what we produced in the Taskforce. I see our collaboration from a personal angle, too. It would have been so much harder—intellectually and financially—to deal with something like this on my own without Forefront's peer input and resources. The pandemic was in Michigan and Wisconsin before it was in Alabama, so we had early warning and early expertise from partners in those states about how to provide top-notch dermatological care while keeping our staff and our patients safe.

"Forefront figured that out right away. We needed to be prepared, we needed to protect patients, we needed to protect our staff, but we also needed to be available for our patients."

Balancing Safety with Access

Part of that early guidance was that we needed to empty our lobbies so patients couldn't pass the virus to each other. Another important protocol was that everyone had to wear N-95 masks so that we could diagnosis and treat patients, especially our most vulnerable, without exposing them or us to the disease. Forefront's supply chain made it possible for us to get those masks very early on, allowing us to provide access to our patients.

In my view, we had—and have—a professional duty to make our patients feel comfortable so they don't postpone or cancel much-needed checkups or treatment. We don't want a melanoma to go undiagnosed because people are scared that they aren't safe in our offices. Forefront figured that out right away. We needed to be prepared, we needed to protect patients, we needed to protect our staff, but we also needed to be available for our patients. Triaging dermatologic patients on the phone is just not adequate.

The Mission Behind the Care

Early on in the pandemic, physicians across the country were considering offering only emergency dermatologic care. Partly because I'm healthy and relatively young, and partly because of my military training, not being available for patients was never really an option for me. Forefront's Taskforce and physician board collaborated to make sure everyone had the information and supplies to take care of our patients. Our weekly zoom meetings provided the science and speed to ensure there was uninterrupted care for our patients who needed us most. And although Forefront never mandated anything to its physicians, the Taskforce gave clear information about best-practice safety measures and protocols. From my perspective, the result was that we all felt prepared and protected.

"The more first-rate dermatologists we can partner with—those whose top priority is patient care—the more we can speak as a collective voice on behalf of our patients, our staff, and our specialty."

Meanwhile, Forefront's administrative staff stayed on top of ever-changing local and federal directives as well as CDC guidelines. They also analyzed and managed CARES Act funding and other financial resources. All of their work meant that I could focus on patient care—and crucially, so could my staff. Because of Forefront's quickness and transparency, I was able to tell my staff what the plan was going to be and that they would be protected so we could fulfill our mission of care.

The Benefits of Integration: Costs

That mission of care has costs, of course. How do you pay for all the N-95 masks you need? For all the gloves? In the first six months of the pandemic, costs went through the roof with all the new supplies we needed. I saw firsthand the massive benefits of integration.

Before Forefront I had a large practice of more than ten providers, and I thought I was getting a great deal on cosmetic supplies and other items like sutures.

I wasn't getting quite the deal I thought I was! But you'd expect that. A practice with three hundred providers should have better pricing than one with ten.

Here's another example: having in-house training available when you're launching a new Electronic Medical Record system. If a practice tried to do that themselves, they'd have to pay for the system but also shell out thousands of dollars for a two-day training crash course. With Forefront, we had something like ten people stay with us for two weeks, answering questions as they arose and helping us get comfortable with the system.

Leveraging our Resources

When I was building my practice, I didn't want patients to have a reason to go anywhere else. I wanted them to come to us to receive the best, comprehensive care for their skin. I also never wanted patients to feel like I was pushing them in a certain direction because that's the equipment or procedure we had: I wanted to have all the options at hand so that they could make an informed decision about the right care for them.

I think the importance of that mix applies just as well to Forefront overall. Given the constant churn of reimbursement reform, fluctuating patient demand, and even something as unpredictable as a pandemic, it's just sensible to invest in multiple service lines.

Forefront's laboratory is an ideal model in this respect: we have eight or nine highly trained, highly collaborative specialists working only for us. They're all wonderful people. And they do a fantastic job—there's absolutely no medical reason not to trust them with our patients' care.

Tackling Misinformation

When folks consider partnering with another group—whether that's a private equity-backed group or some other entity—they're naturally concerned about maintaining their autonomy. But here's what I've noticed. Many of the nightmare scenarios I've heard have come from people outside of these partnerships. And a lot of that misinformation, in the media and especially in dermatologist journals, comes from folks who really have a conflict of interest. Referral-based dermatopathologists and Mohs surgeons are unlikely to support consolidation because they're afraid they may lose patients. So they try to discourage folks from joining together. And one of the first things that they'll say is that you'll lose your autonomy.

At Forefront, at least, that couldn't be further from the truth. No one here has ever told me or any of our providers how to take care of a patient. When we partner with a practice, we're partnering with them because we like what they're already doing. The reason we'd even entertain a partnership is that they're a strong practice with the right values, and they take good care of their patients. Why would we undermine that?

The Broader Landscape

The way I see it, consolidation does not threaten our autonomy; it sustains it.

Our specialty faces major external pressures from insurance companies and other people telling us how we can treat a patient in the exam room. At Forefront, we look to dermatologists to do what's right for patients. If there's a conflict of interest in terms of financial motivation, it certainly isn't with dermatologists.

The more first-rate dermatologists we can partner with—those whose top priority is patient care—the more we can speak as a collective voice on behalf of our patients, our staff, and our specialty. That's what consolidation is really about.

Let's Talk

To learn more about Dr. Bender or discuss with him how Forefront Dermatology could be the right partner for you, visit: **www.advanceddermclinic.com** or email him at **thomasbenderIIIMD@forefrontderm.com**

FOREFRONT DERMATOLOGY®

Forefront Physician Voices:

Not all PE-backed Dermatology groups are the same—*a firsthand account*

John Soderberg, MD, MPH, is a Board-certified Dermatologist with extensive experience in medical, surgical, and cosmetic dermatology. He joined Forefront Dermatology in 2018 and practices in South Boston, VA. Dr. Soderberg earned his Medical Degree from Yale University School of Medicine and Masters of Public Health degree from Boston University, and he completed his residency at Duke University.

When I was a dermatology resident, the discussions about our practice setting options were pretty straightforward. Mentors of mine certainly had their own personal preferences, but no one was pushing residents away from or toward any one setting. That objectivity wasn't absolutely necessary in my case—my heart was always in private practice—but it still made it possible for me to consider alternative options clearly. At the time, it was acknowledged that each setting would have its pros and its cons, and it was up to us as individuals to find the setting that best suited our particular style.

I believe it is critically important that residents receive this kind of balanced view of their options. Yet recently, the recognition that different paths will work for different people seems to vanish whenever the topic of private equity-backed group practices comes up. There are some loud voices out there telling residents that—no matter the details—these practices are bad for them and bad for the specialty, and should be avoided altogether. Having worked in private practice and at two very different PE-backed group practices, I wanted to correct some of the more sweeping generalizations I've heard. What I hope I can offer here is an informed and candid perspective on the diverse options available to residents today.

My professional path

After residency, my first two positions were at small private practices. I learned a great deal in both settings, gaining valuable experience in general, bread-and-butter dermatological care as well as cosmetic dermatology. While I relished the autonomy I found in these places, I gradually realized I would prefer working alongside more colleagues, and I was also becoming eager to find new opportunities for growth. I then set my sights on a larger group practice setting.

The first PE-backed group I worked for dissolved soon after I joined. And even though my medical director there was an excellent clinician and manager, the group's major decisions were not being made by physicians like him. Instead, they were being made by people with business backgrounds and good intentions—but when push came to shove, the physicians were not the ones on their mind.

Their decision to close could have been an acute loss for my patients, my staff, and the community I served. Instead, though, I joined Forefront Dermatology, which is also backed by private equity but is led by physicians. They understood how important it was to me, my staff, and my patients to re-open the clinic doors as fast as possible, and ended up working out those details (lease, new employee contracts, etc.) in less than two weeks.

"As I've seen first-hand, all PE-backed group practices are not created equally. Lumping them together is giving residents an inaccurate picture of their options—and may eventually exacerbate our specialty's access problem."

PE and the broader landscape

Most of us in dermatology understand our specialty's current landscape. We have a continued problem with patient access. For Dermatologists, that means we are in extremely high demand, especially in rural areas and smaller cities. This combination of patient need and physician scarcity has led health systems to add dermatology services or buy up existing clinics, and it has also opened the doors for new players like private equity groups to enter the specialty. Meanwhile, sole-owner private practices are on the wane due to increased regulatory pressures, more complex administrative responsibilities, the immense financial risk involved, and the chilling effect that combination has had on younger dermatologists.

I consider myself somewhat representative of this generational shift: I've always cherished the autonomy and pace of private practice, but I'm realistic about the financial uncertainty, personal trade-offs, and massive amount of time I'd spend on administrative tasks if I were to open my own clinic. Instead, then, I've sought out opportunities where I can enjoy certain aspects of private practice and patient care—but in a more stable, less stressful, and more patient-focused context.

With this landscape and these trends in mind, our goal as a specialty should be to expand access sustainably and responsibly, without diluting our value as Board-certified Dermatologists.

Well-resourced PE-backed group practices, when they are structured appropriately, answer many of these problems. They take care of the challenges that are keeping younger physicians from starting their own practices (e.g., administrative burden, financial risk) while placing experienced Dermatologists in underserved areas that can sustain the clinic.

Correcting the *record*

But what about the over-biopsying? The corporatization of dermatology? What about the requirement that Dermatologists in PE-backed group practices use a specific lab, or send patients to a specific Mohs surgeon? The critiques are well publicized, if often inaccurate, and residents have been hearing them a lot. My experience does not bear them out.

First, no one is dictating to me how many patients to see or how I should practice. I am never encouraged to perform unnecessary biopsies, and comparisons show that Forefront as a whole does fewer biopsies than its peers. Second, I do have the option to send my specimens to our dermatopathology lab, and would have the option to use one of Forefront's Mohs surgeons if there were one in my region. But unlike at an academic setting, where labs are automatically processed in house and surgical referrals invariably go to a surgeon on staff, I have never once been pressured to use our lab. (While our dermpath lab is excellent, if I feel that for some reason it's not in the best interests of my patients to use it, I don't.) Finally, and this applies to both PE-backed practices I've worked in, I have never felt like a cog in a wheel.

Ultimately, Forefront differs most from my earlier experience in that it is, and has always been, physician-led. Unlike that other group, every decision about Forefront's direction, growth, and backing is made by physicians. What that means on the ground is that this group is looking out for its Dermatologists, and it trusts us to look out for our patients. Our physician leaders will only partner with a private equity partner who respects that arrangement and understands the value it provides.

Conflict of interest?

Critics of PE often claim that views like mine come only from shareholders—and that their investments create an inescapable conflict of interest. While I firmly disagree with that view, I am not currently a shareholder in Forefront.

Private equity structures are creating opportunities for more physicians to be owners without having to take on the full burden of running a business and serving patients. In my view, that's a good thing. Being a shareholder fosters a sense of ownership in the practice, and that sense of ownership means that the group's Dermatologists have a greater stake in the reputation of the group and its future, which in turn means they are directly concerned with the overall care provided by the group.

I mentioned that I'm not currently a Forefront shareholder. For all of these reasons, though, I certainly aspire to be one in the future.

The *elephant* in the room

I don't ever want to sound like a cheerleader, but if it weren't for Forefront, the town I work in would not have a Dermatologist. I'm not sure what PE's loudest critics would say to that—have they shared a plan for meeting the massive access problem facing our patients?

If their answer is to encourage more young doctors to open solo practices, that may indeed be the right option for some of us (especially those who are entrepreneurially inclined). That path is simply less workable for others, though. The properly vetted PE-backed group practice can bridge some of the gaps residents and early career Dermatologists face today, by providing a mix of autonomy and administrative peace of mind, for instance, which allows us to focus more fully on caring for patients.

Having come from a public health background, I take great satisfaction in knowing I'm a part of a group providing complete dermatological care to underserved populations, and I'm personally happy that I can make that difference while honing my clinical skills and working alongside other dedicated physicians. I wouldn't be here if I had accepted the critiques without investigating for myself—or assumed that if you know one PE-backed group practice, you know them all. And that's why I'm writing—to encourage residents to keep an open mind and explore their options for themselves.

BY MATTHEW R. KELLEHER, MD BOARD-CERTIFIED DERMATOLOGIST

SELLING *or* SELLING OUT?

PARTNERING WITH PRIVATE-EQUITY

SELLING *or* SELLING OUT?

Selling or selling out?

There has been quite a bit of unsolicited advice directed at the owners of private dermatology practices recently. The advice comes from critics of private equity in dermatology, and its thrust is fairly simple: private practice owners should not sell their practice to a private equity-backed group. Doing so, these critics imply, is not just selling your practice. It's *selling* out.

This is an assumption I whole-heartedly reject.

The decision my partners and I made to combine our successful, multi-site private practice with the private-equity backed group Forefront Dermatology has proven enormously beneficial for us, our patients, and the rest of our team. As an illustration, I'm now a third more productive than I was before we joined Forefront, and I haven't added a single hour to my workweek.

I'm now a third more productive than I was before we joined Forefront, and I haven't added a single hour to my workweek.

For me, selling was never an exit strategy; it was a way to offload stress, secure the future of a practice I had spent my career building, and rebalancing how my professional time was spent. Still, I never anticipated how fully this decision would transform how I practice medicine. After three years in this new partnership I can confidently say I have become a far better physician than I was before—and what's more, I genuinely enjoy my work again. Having reliable and sophisticated administrative support has unburdened me and my partners, and the result is greater satisfaction for us, superior care and service for our patients, and a wider network of expert physicians to teach and to learn from.

Growth = success + stress

The journey my partners and I took from growing an independent practice to joining a larger family of practices began in 1992. Within ten years, our practice grew to thirteen providers in six offices. It was one of the biggest dermatology practices in the country at the time, and one of the most innovative. We were investing in lasers when private practices weren't buying them and they were only in academic settings. We were offering body contouring services when many in the field were just hearing about it.

Early on, growing at such a rapid rate presented a number of business and administrative challenges, but we were all doing what we loved—practicing medicine at the cutting edge and providing our patients with the best care possible. However, changes in the practice of dermatology meant that our success was both fueling our growth and creating a huge amount of stress for us as owner/practitioners. Another stress was the significant hazard of losing a provider. Because we were so dependent on our dermatologists to create and sustain the value of the practice, the possibility of losing one was a perpetual worry.

The worst part about this period was the uncertainty about how it would all end up. My partners and I knew that if we just continued with the status quo, when the time came to sell our practice, the likelihood of finding the right young doctors to buy it was low. As most private practice owners of my age will attest, we simply did not have the work-life balance that young doctors prize so highly today. We were also more flexible about where we practiced (i.e., we often worked outside of major metropolitan areas and their suburbs). Thinking through our options, my partners and I kept asking ourselves: What early career dermatologist would possibly have both the interest in running a major practice *and* the funds needed to make the purchase?

SELLING *or* SELLING OUT?

What we didn't want

Even when the current stresses and uncertainties about the future were at their worst, no one in my practice was ready for retirement. We still wanted to explore new procedures and techniques, and we cherished having a real impact on our patients' lives. Yet the facts remained: we were increasingly exhausted and exasperated by the mounting demands of the back office.

In looking to partner with a larger group, then, we weren't interested in wringing the value out of our practice—far from it. We were just looking to create a more tranquil existence. We wanted to focus more on medicine, have less variability in our days, and minimize our pressure and stress.

Joining Forefront freed us from that worry, and fortified us with the strength of over a hundred other like-minded board-certified dermatologists. The decision to sell to Forefront undoubtedly elongated my career.

Preconceptions about private equity

Anyone who reads our specialty's trade and academic journals will have some trepidation about private equity. My preconceived fears included the fear of losing control, fear of having my creativity constrained, and the fear that the practice we'd worked so hard to distinguish would become just another cookie-cutter office. *None of those fears came true.*

My sense before Forefront was that I wasn't the type of physician that private equity typically acquires: I've always had the owner mindset. It was unsettling (to say the least) imagining being treated like an employee in a setting my partners and I had built ourselves. But Forefront, as I've learned, isn't a typical private equity-backed dermatology group practice: its robust physician leadership ensures complete clinical autonomy for their colleagues. Nobody tells me how to run my practice, or how many people I can hire. There are some mundane administrative details that I don't really care about that are consistent across Forefront's locations, but the practice I spent my career building still has the feel of us. It's our practice but in a bigger context.

In fact, when patients see the Forefront name on the bill and say, "Hey, you sold your practice!", I always reply: "No, we combined our practice." They own us and we own them. Now I'm just part owner of a bigger organization—and what I think is a better organization." I'm not just saying that, either. The sale allowed my partners and me to realize our practice's value, tangibly and immediately. But it also gave us the opportunity to invest in the larger organization as shareholders, underscoring our position as owners going forward.

I'd be the first to say that I can only speak about my own experience, which may be unique. After all, Forefront is a selective group practice, and the ethos of Forefront is not to go out and acquire any practice they can. Their careful attention and vetting of prospective partners really shows; the practices that have joined since I've been on board have all been composed of like-minded professionals devoted to providing high-quality patient care.

SELLING *or* SELLING OUT?

What we deliver now

For patients, the beauty of a sizable single specialty practice like Forefront is that patients benefit from the collective experience and collaboration of over one hundred doctors. This network also benefits us physicians, as we have access to the wisdom of a highly engaged group of professionals. For the first time in my career I feel more collegial and collaborative than competitive. And yet Forefront's culture of excellence and my own orientation still motivate me to refine my skills and learn new techniques.

For example, when I joined Forefront my production would have put me in the top 1% of dermatologists in the country. As a part of Forefront, last year my productivity was up a third from a comparable period before we joined Forefront. When I spoke with some of my colleagues about this bump, they all said, "How'd you do that?" My reply was that I'm working smarter and more creatively now that I no longer have to field every administrative query and management problem (not to mention carrying the weight of the risks associated with those decisions).

Even though we were the sole owners before Forefront, our new freedom means that my partners and I have now been able to engineer the practice more how we want it to be. In particular, my goal has always been, particularly as time has gone by, to spend more of my clinical time doing procedural and cosmetic dermatology. Making that transition always seemed to stall out, though, and I couldn't get past the 50% mark. After joining Forefront, I'm spending more than 70% doing the work I want to do, and it feels great.

Looking back, moving forward

I began this journey by building a dermatology practice with my partners, but somehow we ended up running a business. Because I had never been trained in the business management side, though, I navigated it by gut feeling—a real hit-or-miss approach—and hoped the hits outweighed the misses.

My partners and I did well and we were successful. But as my first header reads, *Growth = Success + Stress*. The more successful you become, the more the business consumes you, and the further and further you move away from the medical part of dermatology. In our case, we ended up having six sites demanding our attention, and 120 staff members to manage. You may not be fully aware of just how far you're being pulled away from the practice of medicine until the pendulum has swung entirely in the opposite direction.

For someone starting out right now, it may sound exciting to make the investment to start a practice or to join a practice with the expectation of buying out a senior doctor down the road. But that road is a tough one, and you've got to be willing to devote your life to it.

Why I reject the question.

What should the life of a dermatologist owner look like, ideally?

To me, the move from my successful private practice to Forefront meant that I recaptured some of the excitement and artfulness I had started with—while giving me access to new and impressive peers and a host of good, smart operations people to help me in any way they can. Because of them and because of the particular nature of my partnership, I breathe more easily today than I ever did in private practice and yet I am more productive and help more patients. Finally, I've given up exactly zero control of what matters to me and to my patients. And there's nothing further from "selling out" than that.

MDedge Dermatology News

In defense of private equity

I was totally unaware that when I partnered my solo practice with Forefront Dermatology in 2018 I would be considered an accomplice in the destruction of the practice of dermatology. When I read the article "Private equity: Salvation or death sentence?" (Dermatology News, May 2020, p. 1), as a scientist, I found it unconvincing. If I am to be accused of this "crime," I would like to outline my defense.

First, I was trained as a PhD scientist at MD Anderson Cancer Center before I decided to go to medical school. We were very well trained to keep our opinions and personal desires for something to be true out of science. I was therefore incredulous when I read the referenced editorial (JAMA Dermatol. 2019;155[9]:1007-8) by Joshua Sharfstein, MD, where he suggested "Until meaningful data are available on what happens to the quality of care and affordability for patients and payers, dermatologists should stop selling their practices to private equity firms, and legislators should prohibit such transactions." It is then noted in the article that Dr. Sharfstein acknowledged that he has not tracked the issue closely and there is little data on the issues of quality or cost but that he has not changed his opinion. So there is no actual data, just a feeling, and these feelings should compel legislators to pass laws to prevent individual dermatologists (who have by their own toil over years built their solo practices) from partnering their practices with others with greater support and collegiality. We have all experienced the situation where although there is no data on a subject we have a feeling about it one way or another. Ask yourself though, have you always been right? Data however is impartial. It has no feelings. Until there is extensive data on the subject we should not draw conclusions that are based on feelings.

I also found the comments by Brett M. Coldiron, MD, to be unsubstantiated. There are many metrics available to our community in terms of number of biopsies per visit, number of biopsies needed to identify a melanoma or nonmelanoma skin cancer, average number of Mohs layers or similar that my practice measures. Again, without referencing any metric of this nature, he "believes investor-owners push for more biopsies, freezing of actinic keratosis, Mohs surgeries, and other well-paying procedures." I can unequivocally say that I have never been pressured by anyone from Forefront to perform more procedures and again that without data he makes such accusatory comments. There are of course bad apples in any group of people as outlined in the cited New York Times article, but to paint everyone partnered with a practice that happens to be backed by private equity with the same paint brush is just wrong and it's not based on any real studies, just some cherry-picked observations. The Forefront compliance department analyzes our coding of our procedures and EM visits and if there are issues they are addressed. When I had a solo practice I did not have a compliance department and no one was analyzing my coding.

I felt that I was alone against monolithic insurance companies and university systems that were surrounding me and threatening me with being excluded from their provider networks.

I then was confused by the conclusion drawn by first-year medical student Suhas Gondi and Zirui I. Song, MD, in the referenced viewpoint in JAMA (2019;321[11]:1047-8), "that investor-owned practices could drive up overall health spending in part because they extract better reimbursement from insurers." I have read multiple articles from Joseph S. Eastern, MD, in this very publication about negotiating better reimbursement from payers. Many of us feel at the mercy of Medicare, commercial payers, and university systems as they dictate the rates we get paid. It is a fact that, for me, Forefront's expert resources have been able to negotiate higher rates from multiple insurance companies in my area. I am having a difficult time seeing how obtaining competitive rates is actually a bad thing.

I also was shocked by the double standard of the statement by Dr. Coldiron where he states that "investor-owned practices are often urged to refer all dermatopathology to labs owned by the practice and often, a Mohs surgeon is employed to service all the practices and sometimes even being flown in from elsewhere." Just how is this different from every university-based dermatology department that has spread out over the community? Just how is it different from every hospital-based department that is ultimately controlled by an insurance company that has spread over the community? Why is one case acceptable and the other controversial? My patients who have been seen previously by a Mohs surgeon outside of Forefront and want to go back to that surgeon are referred to the physician of their choice.

The issues of private equity practices employing more mid-levels is also an example of drawing conclusions without all the data. What is the ratio of MDs to PAs in University-based practices? What about solo practices or large groups? In my personal case I had two well-trained PAs prior to my partnership and have the same two PAs now. Prior to partnering, I was told that Forefront prefers a 2:1 ratio (more dermatologists than PAs) but since I already had two I could keep them in my practice and I continue to work with Forefront on adding more board-certified dermatologist care to my practice.

I am by nature a careful and deliberate physician scientist – I did not partner with Forefront without careful consideration. I felt that I was alone against monolithic insurance companies and university systems that were surrounding me and threatening me with being excluded from their provider networks. I was also being regulated out of existence with all the Medicare regulations. I could not keep up and felt that the moment I was out of compliance I would be penalized and could do nothing about it. Has everything been perfect since I partnered with Forefront? No. Was everything perfect when I was a solo practitioner? No. There has been more good than bad since I partnered with Forefront. The practice of medicine is continually evolving. The sky is not falling so let us agree that we will be less dramatic in our conclusions and more reliant on actual data.

Brad Amos, MD, PhD
Cranberry Township, Pa.

FOREFRONT DERMATOLOGY®

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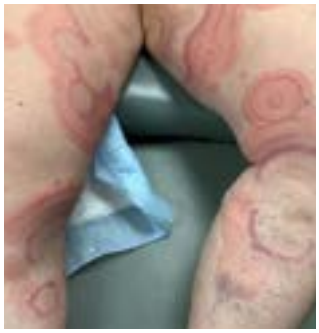
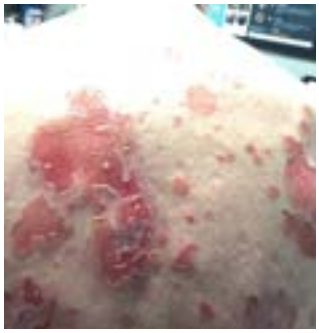
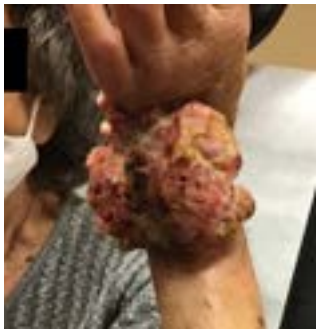
Test Your Knowledge: **Case of the Month Series**

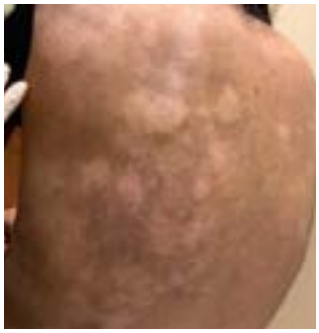
Improving skincare outcomes across all communities through inclusive and communicative dermatologic collaboration.

Each month we email our subscribers an interesting pathology case, contributed by our Dermatopathology Lab, with a short history and diagnosis question. We focus on unusual cases involving rare diseases or conditions with good educational value that you could encounter in practice and that can be diagnosed with a few patient photos. Join the conversation and test your knowledge!









FOREFRONT DERMATOLOGY®

LISTEN TWICE MONTHLY

FOREFRONT FIVE PODCAST

5 TAKEAWAYS

Hosted by

Betsy Wernli, MD, FAAD

Board-Certified Dermatologist &
President of Forefront Dermatology

The Forefront Five is medically minded and lifestyle focused, a perfect blend of useful information and unique conversation! From famous guests to Forefront Dermatologists, we cover a full range of topics. If you are looking for a no-rules podcast, that mimics a chat with your best friends, over a bottle of wine or whiskey, you found it here with Dr. Betsy Wernli at the Forefront Five. Take your mind off the daily grind and tune in; you will find yourself lost in an entertaining conversation!

TO HEAR OUR LATEST PODCAST, FIND US ON **YOUTUBE**, **APPLE PODCASTS**, OR **SPOTIFY!**

FOREFRONT DERMATOLOGY®

Workplace by facebook

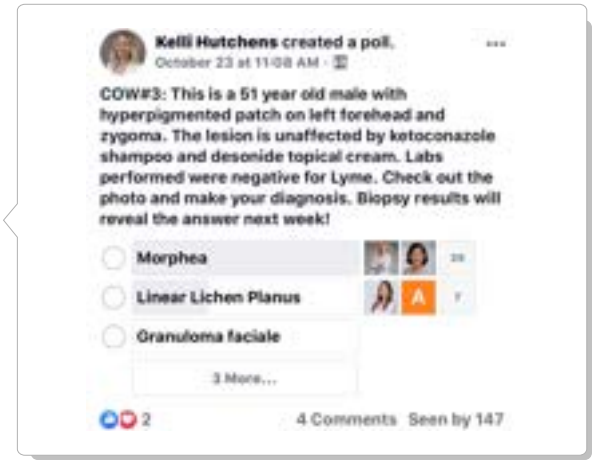
Our Physicians, PAs, and NPs have adopted Workplace by Facebook for internal communication to promote clinical and operational collaboration and education across our group practice. Facebook Workplace, a separate business app, uses familiar Facebook tools like News Feed, Chat, Groups, Video/Photo Sharing, and more.

Collaborate and Learn

Share clinical questions and best practices or source popular topics to promote continuous learning and self-improvement.

Post upcoming events like the Grand Rounds CME series or start a discussion on an interesting case study.

Share cases of the week, post details about clinic activities, follow group feeds, create polls, and view videos/photos.



Stay Informed

Access group news, share best practices and network with colleagues from across all states on the go.

Get the right information to the right audience with dedicated groups like Coding Corner, Forefront Fodder, Under the Scope, and more.

Feel the pulse of the group in real-time and get instant feedback on announcements and posts you share.

Build Group Culture

A dedicated and secure space for our group to connect, communicate and collaborate.

A platform to unite and inspire our group; creating a sense of warmth by sharing photos or day-to-day events.

Two-way conversations, not top-down communications. Everyone has a voice.

To learn more about Workplace, please visit http://workplace.fb.com/

Forefront Grand Rounds Series

Introducing Forefront Grand Rounds Case Presentation Educational Series

This monthly CME activity designed for physicians, PAs, and NPs is facilitated through case-based learning from our own patient treatment journeys encountered in our practice.

The objectives of these activities include:

- Gaining new knowledge through individual patients' diagnostic and treatment journeys.
- Standardizing patient care, providing quality assurance, and aiding in communication between pathologists and clinicians through discussion of difficult or ambiguous diagnoses.

FOREFRONT DERMATOLOGY
Grand Rounds Podcast

Wisconsin Medical Society

Ready to Start Earning CME Credit?

In support of improving patient care, Forefront Dermatology offers an easy way to complete about half of your CME (Continuing Medical Education) requirements annually by providing a series of cutting-edge education in treatment, clinical practice, medical research and quality improvement.

Can't make the live show?

No problem! Introducing the Forefront Grand Rounds PODCAST. Stay tuned for the release of this month's episode!

Session Title: Pigmented Skin Lesion Identification and Unknowns: Clinical Findings to Dermoscopy to Microscopy

Wednesday, May 1st, 2024, 6-7 PM CT (7-8 PM ET)

Join Drs. Kurt Grelck, DO and Chuck Schultz, MD as they discuss how what you see clinically transfers to the dermatoscope and then to the microscope. Dr. Grelck will give a primer on the algorithmic approach to pigmented skin lesion identification and unknowns. Then Dr. Schultz will provide an approach to microscopic evaluation by ranking histologic and immunostain findings by severity, along with notable exceptions.
This activity has been approved for *AMA PRA Category 1 Credit*™.

Statement of Accreditation
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Wisconsin Medical Society and Forefront Dermatology. The Wisconsin Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

AMA Credit Designation Statement
The Wisconsin Medical Society designates this live internet activity for a maximum of 1 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ADA Compliance Statement
Forefront Dermatology subscribes to the articles of Title III of the Americans with Disabilities Act of 1990. Should you or anyone accompanying you require special assistance, please notify us by calling 920-663-0547.

Wisconsin Medical Society

FOREFRONT DERMATOLOGY® GRAND ROUNDS

FOREFRONT DERMATOLOGY® | PHYSICIAN RETREAT

Physician, PA, and NP retreats—enhancing our group culture

Our culture goes beyond just the values, best practices, and history that set our group apart and drive our success. It's also very much about the wonderful individuals who make up the Forefront family. We strongly believe in ensuring that our physicians, PAs, and NPs feel a strong sense of connection with their colleagues and have the chance to collaborate in person. Our bi-annual retreats offer the perfect opportunity to reignite these connections within our group, alongside our shared purpose, mission, and culture. The true magic happens when this renewed energy and team spirit are carried back into their daily routines, becoming an integral part of their authentic culture.

Sharing ideas

The retreats are designed to be a safe zone where anyone can share ideas. Physicians determine the topics to be discussed, creating an authentic forum for discussion and collaboration. We put policies and new procedures in place based on your feedback and voting. Decisions are made by you and for you!

Coming together

The retreats bring together nearly 500 physicians, PAs, and NPs from across all states for a weekend to collaborate with colleagues and share best practices through a morning business meeting, afternoon recreational activities, and an evening social event. Shareholders meet on Friday evening to discuss practice proceedings and elect new leaders. The relaxed environment creates a space for awareness, exploration, and implementation of new practices.

UPCOMING RETREAT DATES:

SPRING RETREAT
April 19-21, 2024
Nashville, TN

MAGIC CONFERENCE
Sept 13-15, 2024
Phoenix, AZ

Working on yourself

The retreats provide the perfect occasion to work on yourself. In the hustle and bustle of your practice, personal development is usually a distant second to the here and now. This can be an opportunity to learn, grow, and be reminded of how important your role is in shaping and maintaining our group practice.

Relaxation and adventure

The retreats are an opportunity for physicians, PAs, and NPs to unwind, enjoy themselves, and revitalize their mind, body, and spirit. After a productive morning business meeting, participants are encouraged to explore the city—with options for golfers, spa lovers, foodies, and more.

foreFRONT AND CENTER

2024 Q1 NEWSLETTER SPECIAL EDITION

President's MESSAGE:

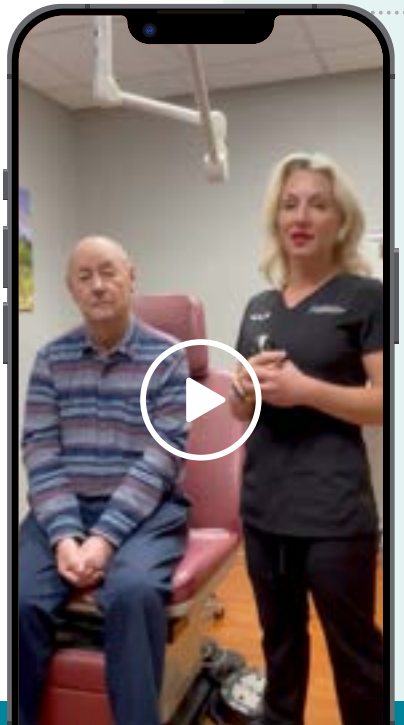
BY: BETSY WERNLI, MD, FAAD

As we step into 2024, we are bombarded with New Year's resolutions, with most focusing on aspects of wellness.

Starting with this quarter's Newsletter, we are embarking on a wellness journey at Forefront. What does this look like for us as the best-in-class Dermatology group? Whether you are in the clinic or supporting patient care from central services, wellness is what we do; we are a healthcare company! And what we have created as a group is truly special; what we do together is greater than what we do alone.

Though we face illness daily in our patients with autoimmune blistering disease, terminal melanoma, and more, we are also blessed with many victories. And we do it together. I encourage you to get back to the basics in your roles this year, reminding yourself daily of the impact your job has on the wellness of our patients and the power of the support of your team together. I hope this video of an actual patient at Forefront, someone that many of you have touched either personally or remotely, will remind you of what we do and the wellness happening every day at Forefront. So dig into the wellness issue to learn what some of Forefront's finest are focused on in 2024!

> **WHEN "I" IS REPLACED WITH "WE," ILLNESS BECOMES WELLNESS.**
>
> MALCOM X



Just tap to play!

BETSY WERNLI, MD, FAAD
PRESIDENT

WHAT'S INSIDE

MEET OUR *Contributors*

DR. ASHLEY DIETRICH | EDITOR

Ashley practices in Wauwatosa and Menomonee Falls, WI. After completing medical school at Medical College of Wisconsin, she completed her residency at the University of North Carolina, Chapel Hill. Her busy practice covers general, procedural, and cosmetic dermatology. Ashley also serves as a Physician Director of Education & Enrichment and enjoys leisure time with her husband, Peter, golfing, wine tasting, and their dog, Riesling.

Tap to send a message.

DR. BETSY WERNLI

Betsy has a busy practice in Manitowoc, WI. She completed her undergraduate at the University of Oklahoma where she stayed for medical school and completed her residency at Iowa. She has three boys, four if you count her husband, and enjoys all things sports. She is obsessed with her Peloton®, and loves serving the Forefront physicians. Betsy is always available by cell or email.

DR. GIACOMO MAGGIOLINO

Giacomo graduated from the University of Notre Dame, attended medical school at the University of Illinois in Chicago, and completed his residency at Cook County in Chicago. He now practices in Pleasant Prairie and Grafton, WI. He is kept busy at home with four young children, but he also enjoys traveling and cooking—especially making homemade pasta and Italian dishes. Giacomo is Forefront's Public Relations Chairperson.

DR. SAPNA VAGHANI

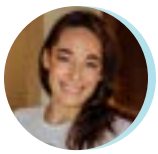
Sapna is a pediatric dermatologist working in the suburbs of Chicago. She completed her undergraduate work at Northwestern University, followed by medical school at MCP Hahnemann (now Drexel) in Philadelphia. She came back to Northwestern to complete her residencies in pediatrics, dermatology, and finally, a fellowship in pediatric dermatology. Sapna's free time is spent with her husband and two girls. They love to cook, eat, do arts and crafts, and travel!

DR. KATIE HUNT

Katie's career began in business and engineering at the University of Alabama. She worked as a patient flow consultant and supply chain leader before transitioning to medicine. Katie completed her medical education and dermatology residency at the University of Alabama, where she served as Chief Resident. Outside of medicine, she enjoys hiking, camping, running, and strategic board games.

DR. MOLLY MOYE

Molly is a fellowship-trained Mohs surgeon who practices in Elizabethtown and Louisville, KY. Her professional areas of interest are skin cancer detection and treatment, Mohs surgery, and performing cosmetic treatments including Botox®. Molly finds it very rewarding to follow patients over time and see improvements in their quality of life as their skin conditions are treated.



KATE CASEY

Partnership & Executive Coordinator

In her five years as Forefront's Partnership and Executive Coordinator, Kate thrives in connecting with partners for the Forefront Family and co-organizing semi-annual Retreats. Beyond her professional role, Kate, a licensed yoga teacher, owns Cats on Mats LLC, offering weekly classes at Waves Yoga Studio and charity sessions at Manitowoc Public Library to support the Lakeshore Humane Society. During quiet moments at home, Kate finds joy in walking, reading, knitting, and spending quality time with her spouse and two cats.

AIRED: JANUARY 18, 2024

FOREFRONT TOWN HALL

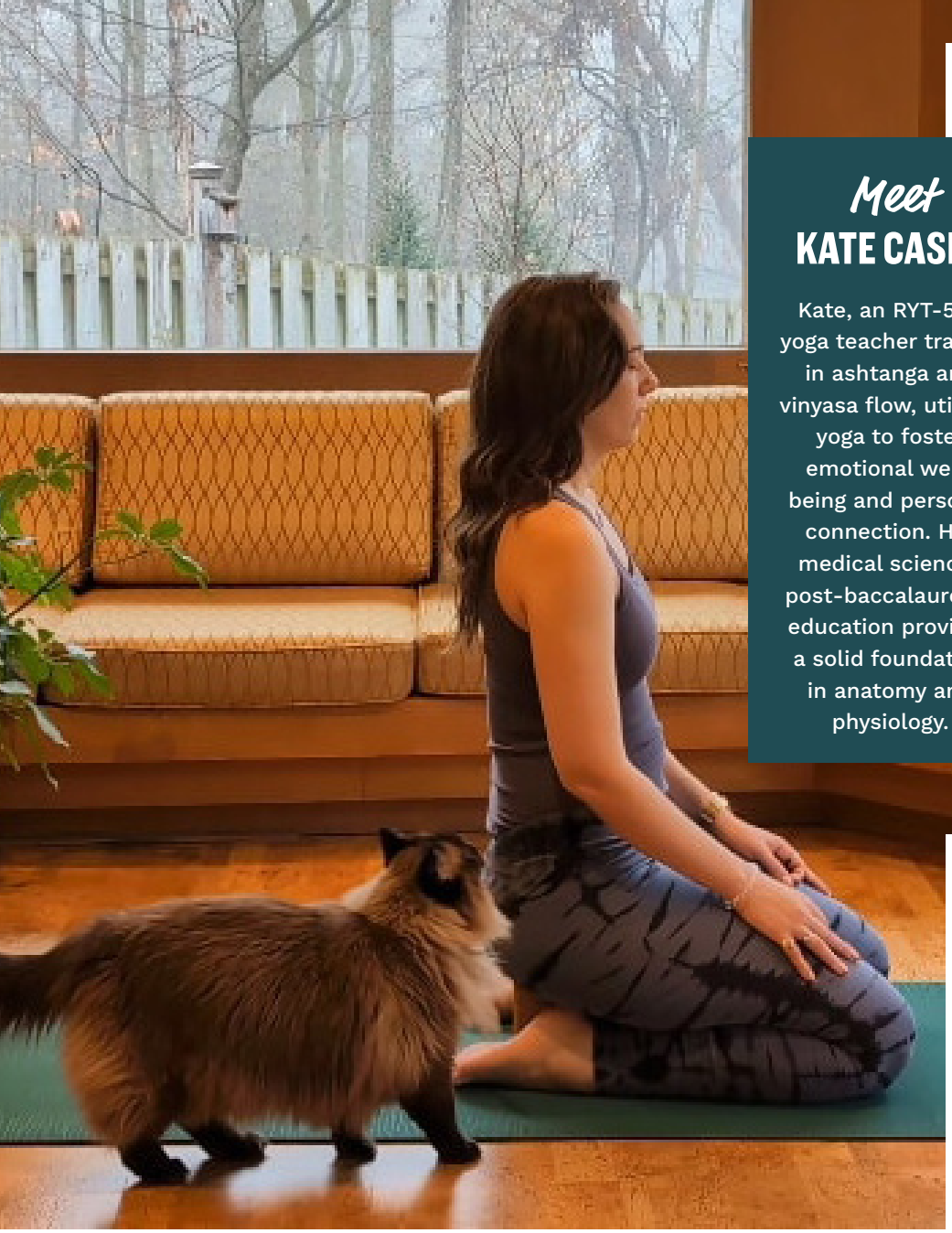
Featuring Matt Mellott (CEO), Dr. Betsy Wernli (President), and Jill Patterson (Chief People Officer)

KEY UPDATES & PLANS FOR 2024:

- 2023 Year in Review
- Clinical Milestones
- Mission & Strategic Pillars
- 2024 Operating Plan
- Our Why: Our Patients (with a special video)
- Engagement Plan

CATCH UP HERE

Missed the meeting? *No problem! You can catch up at your convenience by watching the video on SharePoint.*



Meet KATE CASEY

Kate, an RYT-500 yoga teacher trained in ashtanga and vinyasa flow, utilizes yoga to foster emotional well-being and personal connection. Her medical sciences post-baccalaureate education provides a solid foundation in anatomy and physiology.

Level Up Your Wellbeing in 2024

BY: KATE CASEY, PARTNERSHIP & EXECUTIVE COORDINATOR

New year, new you! Or really... new year, same you. Whether you made it through the holidays joyfully or felt a bit like the **Grinch**, the New Year offers us an opportunity to begin again. This may mean a new wellness routine like visiting your local yoga studio more often or simply working on slowing down and being more present during your day. As a yoga student for twenty years and now teaching for ten, I'd like to share some insights that help me get through the winter slump and back on track for a more peaceful and fulfilling life.

1 REVITALIZE YOUR ROUTINE

Practice once a week—90 minutes of yoga has been shown to cause an increase in GABA that **lasts about 8 days**. Yoga has also been shown to help those with Major Depressive Disorder who are **resistant to SSRIs**!

- **90 minutes a big ask?** Pop your earbuds in and listen to the **20-Minute Yoga Sessions** podcast to get your movement and meditation in for the day at home.
- **20 minutes still hard to squeeze in?** This **5-minute office sequence** can be done from your desk!

2 HARMONY IN SOUNDS

Finding the right music to help get you centered on your mat can be key. Start with Spotify's **Yoga and Meditation playlist**. The **OM Zone** by Steven Halpern is probably my favorite album of all time.

3 EAT MINDFULLY

Bring your yoga into your diet with **Ayurvedic eating**. In this winter season, increase light, airy, stimulating foods. Think whole grains, legumes, curries, fresh or dried fruit, spicy roasted vegetables, nut butter, fresh juice, and hot tea.

4 BREATHE WITH PURPOSE

One of my favorite tools in the yogic practice is pranayama, an ancient breath technique.

- If you're feeling anxious or out of balance, try **Nadi Shodhana**.
- If you're feeling sluggish, give **Kapalabhati** or "skull shining" breath a go.

5 MINDFUL MOMENTS

Most importantly, establish a daily meditation practice. Even 5 to 10 minutes has been shown to relieve symptoms of anxiety. Though **Headspace** has been popular over the last few years, I highly recommend **Insight Timer**. It provides all the same guided meditation content but at a much better price point (free!). The customizable bells and timer work great to keep me focused in my own silent meditation practice.

6 CONNECTING IN PERSON

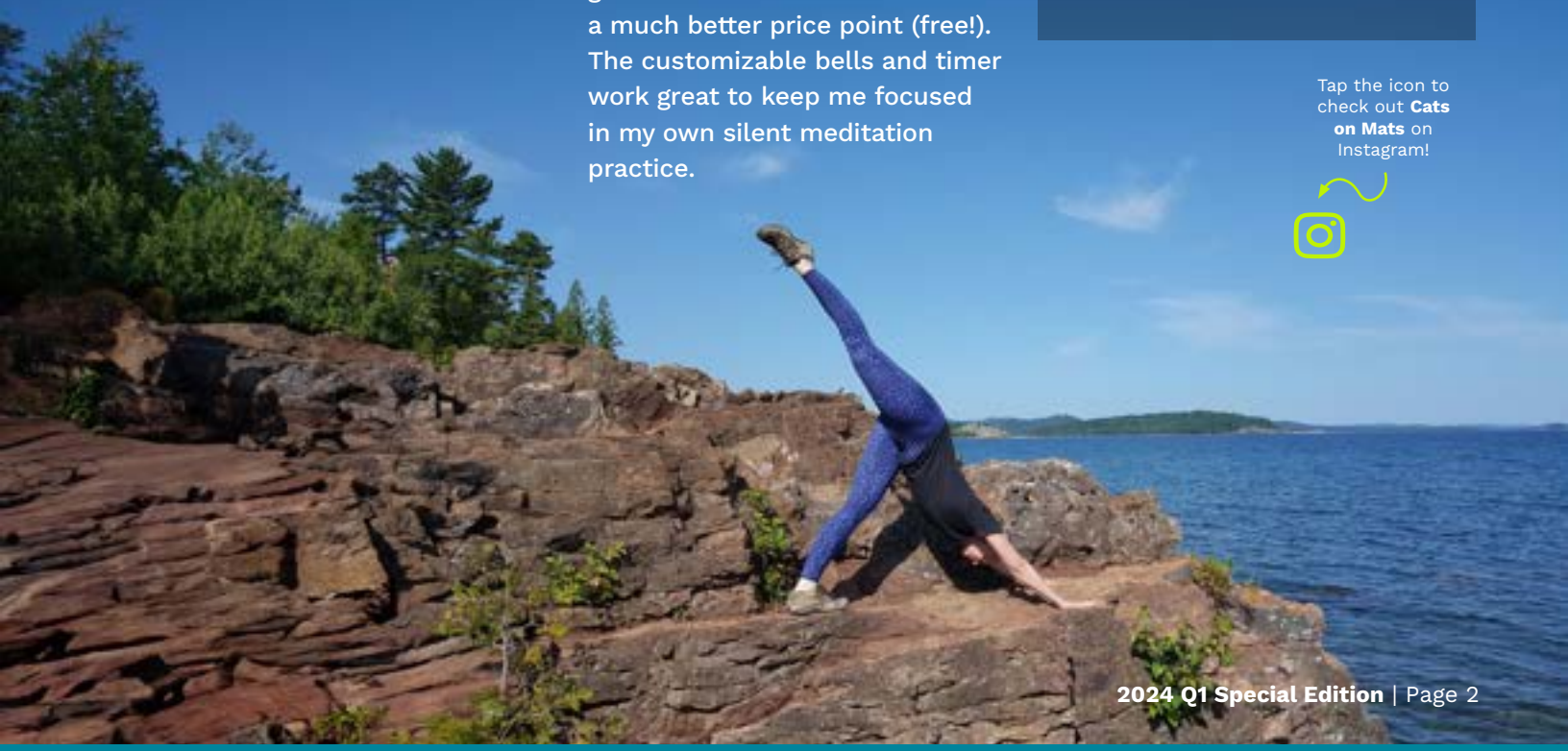
I always recommend checking out a local yoga studio (Use the **mindbody** app to find one near you). Even though it may be intimidating, the instruction during the in-person experience far exceeds any work you can do on your own. If you're local to Central Services, check out **Waves Yoga Studio**, where I am on staff. We're fully staffed with licensed professionals and just a block away from Forefront's headquarters! Wishing you peace and prosperity in 2024!

CATS ON *mats,* LLC.

ANIMAL-FRIENDLY YOGA SERVICES FOR ALL, BY KATE CASEY.

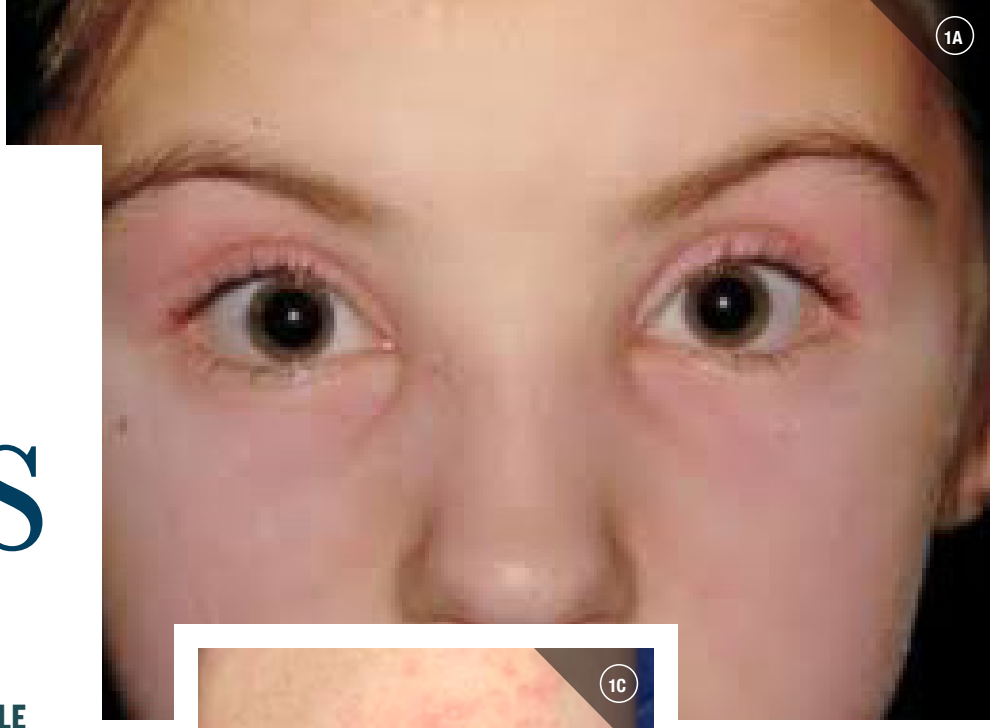
No matter where you're coming from or where you're going, **Cats on Mats** is ready to support you in your yoga journey. We offer both traditional and animal-friendly classes, in person or online. Browse our site and find a class that fits your needs or contact Kate directly to learn more.

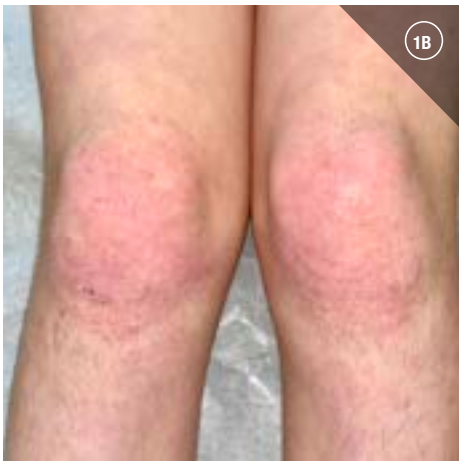
Tap the icon to check out **Cats on Mats** on Instagram!



keeping up with the Kids

BY: SAPNA VAGHANI, MD, FAAD

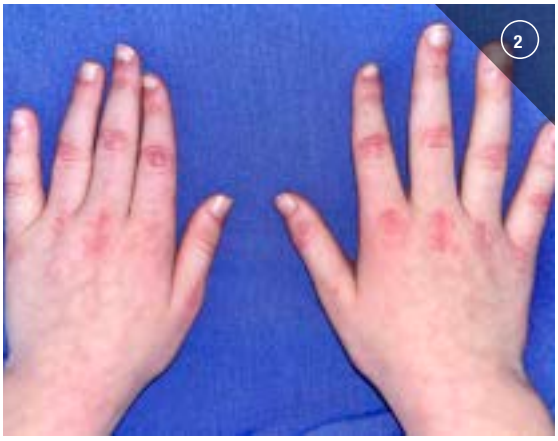




① A TWELVE-YEAR-OLD FEMALE PRESENTS WITH A THREE-MONTH HISTORY OF A PROGRESSIVE, ASYMPTOMATIC LESION ON HER FACE, ELBOWS, AND KNEES. SHE IS IN HER BASELINE STATE OF HEALTH AND HAS NO DIFFICULTY KEEPING UP WITH HER PEERS IN PE CLASS. WHAT IS THE NEXT BEST STEP IN MANAGEMENT?

PHOTOS 1A-1C

A. Refer to gastroenterology.
B. Order a lab workup including creatine phosphokinase (CPK), lactic dehydrogenase (LDH), and aldolase.
C. Start a high-potency topical steroid.
D. Perform a muscle biopsy.
E. Refer to pediatric rheumatology; the next available appointment is in 4 months.



Check your answers on page 9

② THE PATIENT ALSO HAS LESIONS ON THE HANDS. IN ADDITION TO THE LABS ABOVE, YOU ORDER VASCULITIS MARKERS, AN ANA, AND A MYOSITIS ANTIBODY PANEL. WHICH OF THE FOLLOWING ANTIBODIES ARE ASSOCIATED WITH THIS CONDITION IN PEDIATRIC PATIENTS?

PHOTO 2

A. Anti-PM/scl
B. Anti-SAE
C. Anti-EJ
D. Anti-Mi-2 and Anti-TIF1-y
E. Anti-signal recognition particle

③ WHICH OF THE FOLLOWING IS THOUGHT TO CONTRIBUTE THE MOST TO THE PATHOGENESIS OF THIS CONDITION?

A. A small vessel vasculopathy with complement deposition.
B. Microchimerism
C. Large vessel vasculitis
D. Mutation in STAT4
E. Overactivity of CD8+ T cells

EMPOWERING MELANOMA PATIENTS WITH COMPREHENSIVE CARE KITS

After a Melanoma diagnosis, the path ahead may seem overwhelming. That's why we collaborated with L'Oreal to create our Melanoma Care Kit. It offers skincare essentials, informative materials, and sun protection advice for patients to explore at their own convenience.

Ask your RCM how to get yours!

④ THE PATIENT IS SEEN BY A PEDIATRIC RHEUMATOLOGIST, WHO ORDERS AN MRI. WHICH OF THE FOLLOWING IS TRUE REGARDING IMAGING FOR THIS CONDITION?

PHOTO 4

A. MRI findings partly determine the criteria for an inactive disease.

B. MRI findings of muscle or fascia involvement at the time of diagnosis predict clinical outcomes in children.

C. Muscle inflammation can be detected on MRI in asymptomatic patients.

D. The shoulders offer the greatest yield in muscle MRI.

E. MRI is not indicated for this asymptomatic patient.

⑤ TREATMENT OPTIONS FOR THIS CONDITION INCLUDE:

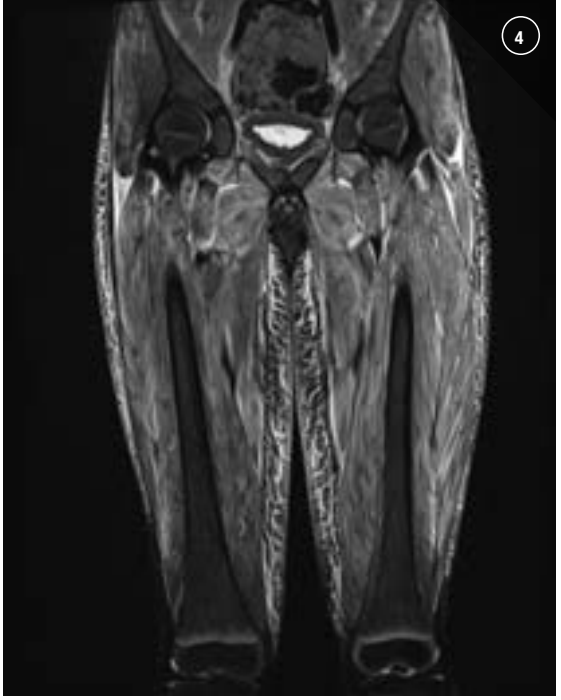
A. Cyclophosphamide

B. Hydroxychloroquine

C. Rituximab

D. Methotrexate

E. All of the above



SOURCES:

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UPCOMING SESSIONS

Graud ROUNDS

Did you know that your pathology lab sponsors CME every month? Participate via webinar from anywhere to learn about exciting topics that will enhance your practice of dermatology, and earn you one hour of CME!

02.21.24

@6PM CST

WHEN COLOR MATTERS IN DERMATOLOGY

Tune in as we explore the significance of skin of color in dermatology and provide practical insights for the care of our diverse patients!

03.21.24

@6PM CST

MIPS MADNESS

Discover actionable strategies and expert insights for improving your MIPS score and enhancing your overall practice performance.

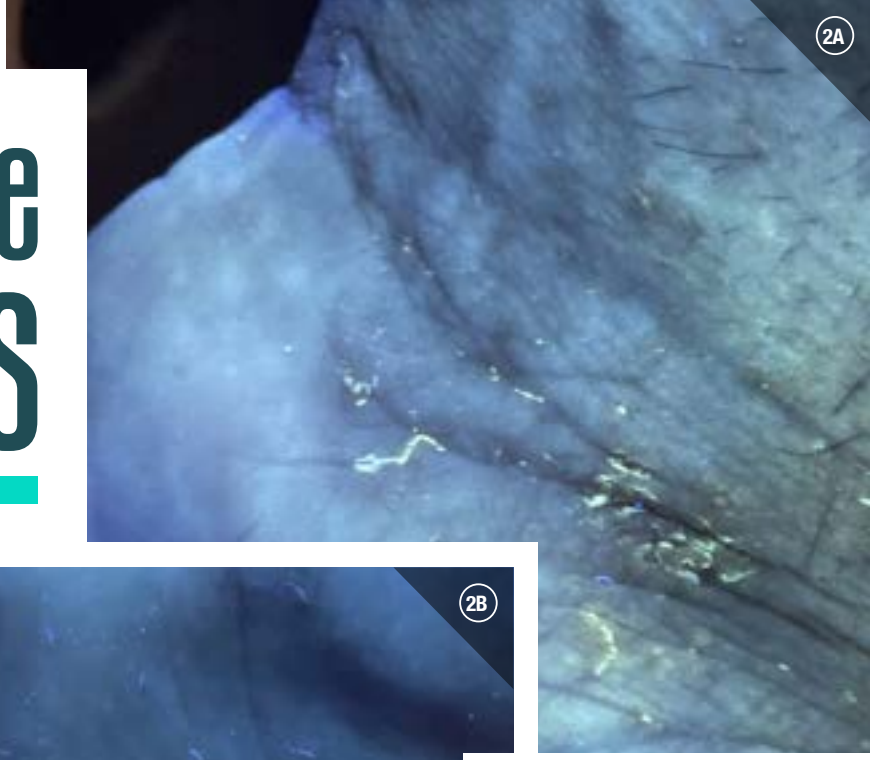
04.02.24

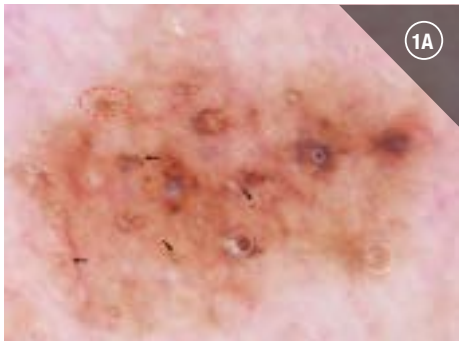
@6PM CST

CLINICAL QUALITY OUTCOMES (CQO)

Join us as we explore ways to make your profession smoother and elevate your patients' care experience!

Hot off the press





BY: KATIE HUNT, MD, FAAD

NEW CRITERION FOR FACIAL LENTIGO MALIGNA (LM)

Perifollicular linear projections (Figure 1A: black arrows and red dashed circle) improve specificity (96%) and sensitivity (61%) of LM diagnosis.

JAAD, JAN 2024

NOVEL ACNE TREATMENT

DMT310 (a powdered mixture of Spongilla lacustris sponge extract) performed superior to placebo when applied to the skin once weekly for 10-15 minutes.

JAAD, NOV 2023

DUPILUMAB FOR BULLOUS PEMPHIGOID

87% of patients achieved disease control within four weeks

- 31% relapsed during the 64-week observation period
- Infections and eosinophilia were the most common adverse effects

JAMA DERM, SEPT 2023

ANIFROLUMAB (SAPHNELO)

A novel infusion for systemic lupus, demonstrated rapid and highly effective relief for patients with various types of recalcitrant cutaneous lupus erythematosus.

LUPUS SCI MED, DEC 2023

DERMTECH TEST

The DermTech test was significantly discordant with histopathology.

- Led to biopsies of benign lesions
- The test could not reliably identify melanocytic lesions

JAAD, NOV 2023

SCABIES

Scabies sign via Wood's Lamp (Figure 2A & 2B). Scabies burrows may be quickly and easily identified with UV light.

JAAD, JULY 2023

SELF-SKIN EXAMS (SSE)

The importance of self-skin exams (SSE).

- 63% of early-stage (<1 mm thick) melanoma patients had performed SSE in the year before diagnosis versus
- Only 30% of late-stage (>4 mm) melanoma patients had done the same

JAAD, NOV 2023

ASK THE EXPERTS

Clinical CORNER

As winter sets in, our ask the experts article has you covered with quick tips and expert advice on beating dry winter hands. Discover top products and tricks for keeping your patients' hands comfy and moisturized in the colder days ahead.

SEMYON ZARKHIN, MD

Limit hand-washing with soap and water to only when necessary, opting instead for alcohol sanitizer gel for routine use. When venturing outside in cold weather, it is essential to protect your hands by wearing gloves, as exposure to cold temperatures can lead to dryness and discomfort. These practices collectively help in preserving the health and moisture balance of your hands.

CHAD BROWN, MD

Vaseline under cotton gloves at night after wetting hands with warm water; often, meds are unnecessary. I have patients do this nightly until clear and then 1-2 times weekly for maintenance.

NAIEM ISSA, MD

Bar hand soaps are recommended over liquid soaps due to the latter's alcohol content that can strip away moisture. Maintaining well-hydrated skin involves regular moisturization throughout the day with a non-greasy emollient like Vanicream or Cetaphil. Nightly application of Vaseline under occlusion with gloves can lead to significant improvement in 3-5 days. For those using active medication, applying the medication first, waiting 2-5 minutes, and then applying Vaseline on top of gloves is suggested. Inquiring about potential exposures and considering patch testing is crucial. Differentiating between hand dermatitis and psoriasis involves checking nails, inquiring about joint pains, and assessing skin/scalp involvement. Asking about the atopic triad in personal or family history provides insights. For severe hand dermatitis, the topical JAK inhibitor ruxolitinib cream has shown effectiveness.

KURT GRELCK, DO

My recommended skincare routine comprises the use of Vanicream facial cleanser as the primary soap product, providing a gentle and effective cleansing experience. For moisturization, I suggest using Cerave therapeutic hand cream or Neutrogena Norwegian hand cream, both of which have proven to be reliable choices. When it comes to dishwashing, I recommend 7th generation dish soap, and it is advisable to wear rubber gloves for added protection. For tasks that require gloves, n-dex free gloves are a preferred option. These product recommendations are based on their safety, with a success rate of over 90% after thorough patch testing and consideration of the ACDS safe products list.

JENNY SOBERA, MD

Krazy glue for fissures or cracks.

AARON DWAN, MD

AAD published an article last year showing we underutilized oral/topical antibiotics to address staph superimposition/overgrowth. In recalcitrant cases, I've had a lot of success with short courses of Doxy. I also love the good old-fashioned soak-and-seal method!

SOFT TISSUE VS LESION EXCISION

LESIONS (BENIGN/ MALIGNANT)

- Excision of cutaneous lesions like epidermal cysts, basal cell carcinoma
- 10-day global period starts the day **after** the procedure.
- Includes simple repair only.
- Specific codes for benign and malignant lesions.

SOFT TISSUE TUMORS

- Excision of soft tissue tumors like lipoma and desmoid tumor.
- 90-day global period starts the day **before** the procedure.
- Covers simple and intermediate repairs.
- Applicable to both benign and malignant tumors.

CODING CORNER

Coding for Soft Tissue Excisions

BY: MOLLY MOYE, MD, FAAD, FACMS

CPT codes are selected based on which code best describes the treatment performed. Coding a soft tissue excision may be most appropriate in a patient presenting with a lesion that originates in the soft tissue, such as a lipoma.

Soft tissue excisions are coded using a separate set of CPT codes from our typical benign and malignant excision codes. These codes are based on the body location, as well as the size and depth of the soft tissue tumor.

CAN SOFT TISSUE EXCISIONS BE DONE IN THE OFFICE?

At the end of this article you will find a resource tool from the AADA that identifies which soft tissue excisions and soft tissue excisional biopsies are "Payable in the office setting". It is highly recommended to obtain prior authorization from private and commercial payers before initiating the procedure. While this does not guarantee payment, it can be beneficial should the claim require an appeal.

GRAB YOUR COPY OF THE AADA SOFT TISSUE EXCISION QUICK CODER GUIDE FOR A VALUABLE RESOURCE!

Learn More

For questions related to documentation or coding for soft tissue excisions, email the coding team.

UPCOMING SESSIONS

DOWNLOAD ON DRUGS + DEVICES

Staying AHEAD

Listen to Download on Drugs + Devices, monthly, to stay ahead of the latest developments in dermatology and learn from your peers as they share essential information from their areas of expertise.

02.15.24

@6PM CST

ZORYVE®

Join us for engaging case presentations and peer discussions led by our very own Dr. Diego Dasilva!

03.14.24

@6PM CST

BIMZELX®

Enjoy an insightful speaker presentation, followed by a friendly peer panel discussion featuring our own experts!

04.17.24

@6PM CST

L'ORÉAL®

Get the latest on new product updates by our platinum Retreat sponsors.

Cultivating a culture of learning within your clinic

BY: GIACOMO MAGGIOLINO, MD, FAAD

Well-trained staff are an asset to your clinic; investing in their training is crucial to success. Staff who feel well supported with improved skills and product knowledge are likelier to drive conversations leading to increased revenue.

Here's the simple truth: when our team realizes they're a crucial part of our clinic's success, something special happens. Job satisfaction becomes more than just a phrase; it's what motivates everyone to give their best. Because, let's face it, when you know your role matters and you're contributing to something good, work becomes more than just a job—it becomes a place where everyone is working together toward success.

2 TAILORED TRAINING

Offer customized training programs to staff, recognizing their diverse learning styles and skill sets based on their responsibilities—whether they are visual or hands-on learners, or prefer other approaches.

3 OPTIMIZE STAFF TRAINING

Keep training sessions in smaller, more manageable timeframes that are easier for staff to absorb and retain.

1 CULTIVATE TEAMWORK

Create a culture of responsibility and teamwork that helps boost staff engagement and encourages them to do well.

4 DISPLAY AREA

Create a dedicated space in your clinic for product display where staff can take patients to discuss products and procedures.

5 FRIENDLY EXPERTS

Choose 2-3 friendly and well-informed staff members as your "go-to" leaders who can be available after medical visits to discuss cosmetic products or procedures.

keeping up with the Kids

ANSWER KEY

DIAGNOSIS: JUVENILE DERMATOMYOSITIS

① **B:** Order a laboratory workup including creatine phosphokinase (cpk), lactic dehydrogenase (ldh), and aldolase.
② **D:** Anti-Mi2 and Anti-TIF1-γ.
③ **A:** A small vessel vasculopathy with complement deposition and vessel destruction.
④ **C:** Muscle inflammation can be detected on MRI in asymptomatic patients.
⑤ **E:** All of the above.

Juvenile Dermatomyositis is the most common chronic, inflammatory myositis in children and typically presents with pathognomonic cutaneous findings and proximal muscle weakness. Despite this, it is rare. Girls are more often affected, and the average age at diagnosis is seven years. The cutaneous findings are typically quite distinctive and include a heliotrope rash, Gottron's papule, periungual telangiectasia, cuticular overgrowth, poikilodermatous erythema on sun-exposed sites (shawl sign or V sign) and non-sun-exposed sites (holster sign). Myositis typically presents with proximal muscle weakness but can also lead to fever, arthralgia, headaches, and abdominal pain.

Classic histopathology is notable for paucicellular interface dermatitis with a sparse superficial perivascular infiltrate and vacuolar alteration of the basal layer of the epidermis. Muscle biopsies, which are being replaced by imaging, demonstrate complement staining in areas without capillaries as well as atrophy of muscle fibers at the periphery of fascicles, suggesting complement-mediated capillary destruction. CD4+ T cells are thought to play the largest role in the pathogenesis of this condition. Although microchimerism, the presence of maternal cells in the child, may play a role in the pathogenesis of this condition, possibly by eliciting a GVHD-like process, further research is needed to understand its contribution to autoimmune diseases.

The diagnosis can further be supported by high serum levels of muscle enzymes (CPK, LDH, aldolase, AST, ALT). Anti-TIF1-□ antibodies are the most common autoantibody found in children with juvenile dermatomyositis. Anti-mi2 antibodies are associated with adult DM and JDM with hallmark cutaneous disease, milder myositis, and a good response to treatment. Anti-NXP2 antibodies are primarily associated with JDM with subcutaneous edema, calcinosis, and severe muscle disease with contractures but also with an increased risk of cancer in some adult DM studies. Anti-EJ antibodies are associated with dermatomyositis as well as interstitial lung disease. Anti-SAE autoantibodies are also associated with an increased risk of cancer in adults with dermatomyositis. Anti-mi2 antibodies are associated with milder muscle disease, less incidence of interstitial pneumonia, better response to therapy, and classic cutaneous features such as Gottron's papules, heliotrope rash, cuticular changes, and shawl sign (33). Recent adult studies have found that anti-TIF1-autoantibodies are specific to DM and present in 13% to 30% of adult diseases (45–49).

MRI has become an important tool in diagnosing JDM; however, the extent of findings at the time of diagnosis has not been found to predict one's clinical course, nor has MRI been used to monitor disease progression. The pelvis offers the greatest yield in muscle MRI, followed by the buttocks, the vastus medialis and lateralis, and the shoulders, thorax, and neck.

More common treatment options for JDM include pulse-dose systemic steroids, hydroxychloroquine, methotrexate, and azathioprine. Other modalities include cyclosporine, mycophenolate mofetil, TNF inhibitors, IVIG, and rituximab.

FOREFRONT DERMATOLOGY®

Forefront Dermatology, a leader in physician-driven skincare, offers board-certified expertise, clinical independence, and access to an innovative community. Committed to transforming patient care, we provide tailored treatments and customized organizational support, elevating practices to new heights. Experience the very best in skin and body care with Forefront Dermatology.

Fast Facts

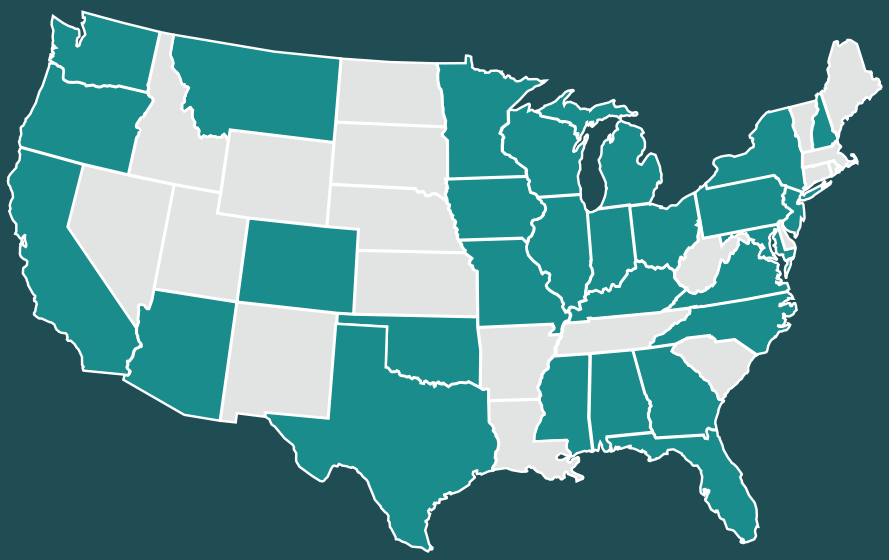
3300+
Employees

247
Clinics

520+
Clinicians

28+
States, including Washington, D.C.

Clinical development presence in the United States



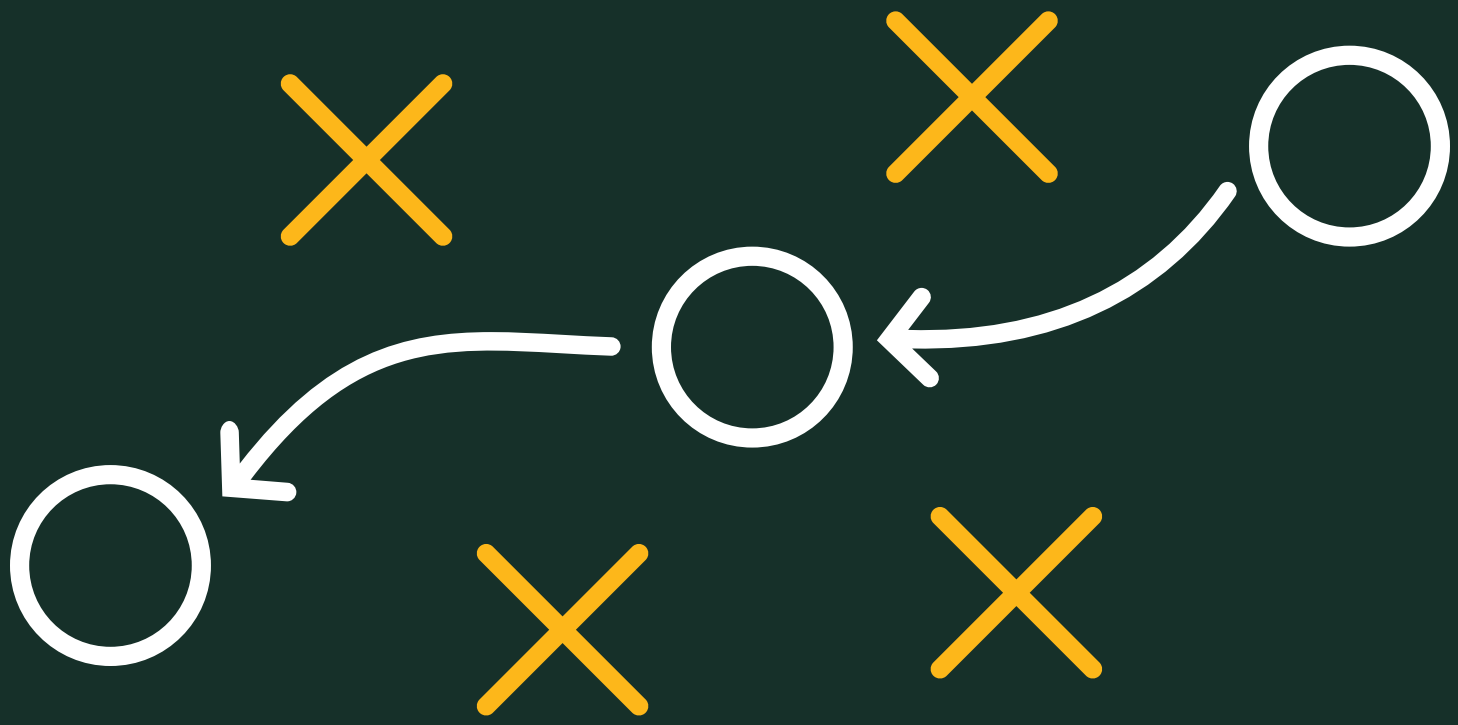
To learn more visit:
forefrontdermatology.com

Connect with us

FOREFRONT DERMATOLOGY®

Leading Your Team
Clinic Playbook

Mastering the blocking and tackling skills necessary to develop leadership in your clinic.



WRITTEN BY: BETSY WERNLI, MD, FAAD; MADE BEAUTIFUL BY: THE FOREFRONT MARKETING TEAM

THE BREAKDOWN

We all know that a happy workplace leads to a happy life. Honing your leadership skills is vital to success. Leadership ensures a happier team, days that run on schedule, and a workplace that is just plain enjoyable! But leading a clinic takes time, introspection, and intentional actions every day. Whether you are a well-trained and seasoned leader, or just starting your leadership journey, this training exercise will help you become a better leader for your clinic, for your team, and for yourself. This packet sets you up in the training room to start your journey as the clinic leader, provoking you to pause and evaluate your team to lead them to success. Practice this exercise in self-evaluation followed by team evaluation, and then position your team for daily success with the huddle sheets.

"Leaders are made, they are not born. They are made by hard effort, which is the price all of us must pay to achieve any goal that is worthwhile."

Vince Lombardi

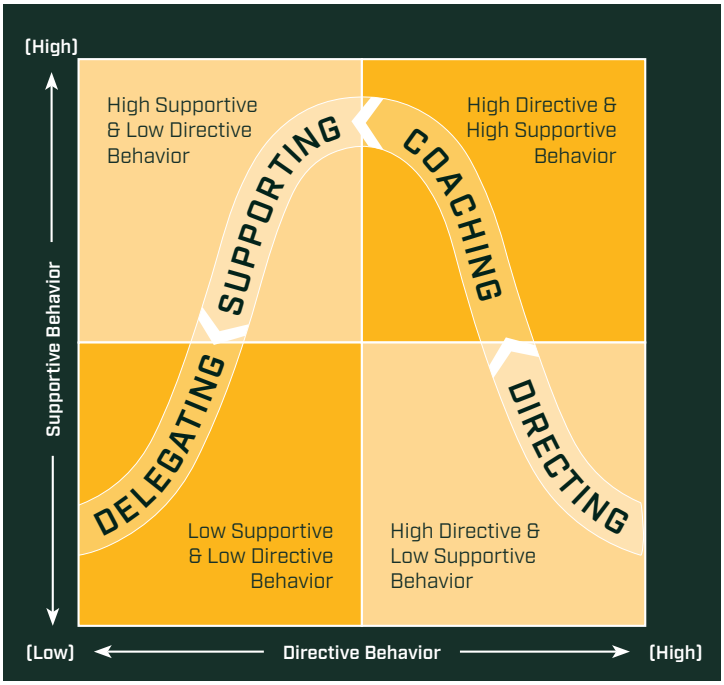
LEADER EVALUATION

All good leaders look inward to identify their personal strengths and weaknesses before evaluating the rest of the team. Take the first step in leading your clinic looking at yourself, defining who you are as a leader, setting your goals for your clinic (both short-term and long-term), and determining where you can improve. Become a better leader, because most problems at work can be solved with outstanding leaders, and that starts with you!

LEADERSHIP STYLES

Did you know there are four types of leadership styles? You may find yourself adopting many characteristics of each of these styles. **The four styles of leadership are: Direct, Coach, Support, Delegate.**

Take a look at the leadership graphic to evaluate your personal leadership style.



Source: Leighton, Becky. "Leadership styles: Four common types in business." https://masterstart.com/blog/business/the-four-styles-of-leadership-and-when-to-adopt-them-2/. 26th July.

ANSWER THE FOLLOWING QUESTIONS

1. How would you rank yourself as a leader (below average, average, or above average)?

2. What areas of leadership can you improve?

3. What kind of leader are you?

4. What characteristics from the other leadership styles would you like to adopt and why?

5. Are you intimidated by tough conversations?

6. Are you the first to dive into disciplining or do you depend on others?

7. Do you tend to be overbearing?

8. Do you let your team run all over you?

9. What is your personal goal for the year?

10. What is your team/clinic's goal for the year?

11. What barriers do you foresee in accomplishing either of the above?

12. What are your clinic's biggest strengths?

13. What are you clinic's biggest challenges?

14. How can you overcome these challenges?

PLAYER EVALUATION

After leader introspection, it is important to evaluate the players on your team: your staff. The best leaders know that a successful team is built on the relationships within that team. And to strengthen those relationships, you must be willing to invest time, effort, and attention. **Start by taking the L.E.A.D. (Listen, Engage, Assess, and Demonstrate) with each team member.**

LISTEN

- Who is your team away from work? Have you taken the time to know them?
- What are your team's strengths and weaknesses?
- What makes your team excited to work?
- Why did your team choose to work for you?

ENGAGE

- In what position or duties will your team be most successful?
- Is someone forced into a position that doesn't highlight her/his strengths?
- Define the positions that best work for the entire team.

ASSESS

- What does your team need from you as their leader?
- How can you empower your team?
- How can you let your team know they are valued and appreciated?

DEMONSTRATE

- Set the team morale for the day.
- Demonstrate the type of leadership you would want to follow.
- Be purposeful going in to each day.

TEAM ROSTER

Now let's look at your roster, the team that makes it all happen! **Evaluating your team members is where the L.E.A.D. steps come into play.** Leaders know that the first building block is the establishment of relationships with your team; listen to your team and figure out what each person needs from you as their leader to ensure all feel wanted, heard, appreciated, and motivated. And once relationships are formed, once a team member feels appreciated, you can position them for success and growth. You may find you have a running back working on the offensive line, and a small change or shift could change the entire flow of your day! But before you can position your team members, you must know them and form relationships.

LOOKING FORWARD

Fill out the following for each team member. You may be surprised how much or little you know about them; you may also realize that you are not optimizing their greatest strengths, placing them in the wrong position for success.

"Coaches who can outline plays on a blackboard are a dime a dozen. The ones who win get inside their player and motivate."

Vince Lombardi

TEAM ROSTER:

1. Team member name:

2. Current position:

3. Family members' names and other personal information:

4. Interests outside of work:

5. Interests at work:

TEAM ROSTER:

6. Strengths:

7. Weaknesses:

8. Communication style:

9. Potential positions for growth:

GAME DAY HUDDLE

To succeed long-term, we need short-term, daily reminders of team unity and success. This starts every morning. And though our days start with patients ready in rooms and staff ready for you to dive into dermatology, taking a two-minute pause with your staff before the day starts allows you to identify potential pitfalls for the day and unite as a team. These pre-game sessions will allow you to prepare for the blocking and tackling each day requires and potentially address some of the disasters before they start! By choosing a different team member to lead the huddle every week, you will develop other leaders within the clinic and create ownership.

LOOKING FORWARD

Starting each day intentionally will make all the difference. No team is successful without a huddle, see below for an example huddle from my clinic, print the empty worksheet, and assign a huddle leader every week to make sure your team is on track to win every day! Put in the time—just two minutes—to make the day a success!

"The only place success comes before work is in the dictionary."

Vince Lombardi

GAME DAY GOALS FOR AM/PM

- 11:45AM—done with morning patients and all charts have been assigned
- All inbox messages should be addressed by the time the last patient is roomed
- No patient waiting in the waiting room for more than 3-minutes past their appointment time
- 4:15PM—clock out together (after all worked is completed)

GAME DAY PLAY/SCHEDULE REVIEW

- 58 patients
  - 4 excision
  - 7 referrals
  - 20 new patients
- 27 F/U
  - 5 biologics
  - 2 Isotretinoin starts

BLOCKING & TACKLING

(Schedule review—challenging cases, unique visits, and how to help eliminate potential problems)

- 9:45AM—add-on, urgent referral for spreading rash
  - Kayla reviews to make sure we have labs and notes from the referring doctor
- 11:20AM—hair loss, wrinkles, and nail issues
  - Sara will prep with Botox®
- 12:45PM—excision MM plus spots of concern
  - Kayla will set up the tray, get photos, and biopsy supplies ready

handouts, have blood draw supplies, and patient education ready

GAME DAY INSPIRATION

(Fun challenge, idea, or quote for the day)

- Give a compliment to every patient we see.

GAME DAY HUDDLE

FOREFRONT DERMATOLOGY®

GAME DAY GOALS FOR AM/PM

GAME DAY PLAY/SCHEDULE REVIEW

BLOCKING & TACKLING

(Schedule review—challenging cases, unique visits, and how to help eliminate potential problems)

GAME DAY INSPIRATION

(Fun challenge, idea, or quote for the day)

Clinical Efficiency Observation

Finding your frequency to advance patient care.

CLINICAL OBSERVATION

Location: [redacted]

Provider: [redacted]

Date: August 14, 2019

KEY

RED - needs improvement
BLACK - Satisfactory
GREEN - Excellent

Encounter	Check in time	Wait time in WR	Interview time	Wait time in Exam room	Exit Exam room time	Total Encounter Time	Total time from Check in to exit exam room
1	12:50 pm	1 minute	2 minutes	2 minutes	12:58 pm	7 minutes	8 minutes
2	12:54 pm	5 minutes	6 minutes	2 minutes	1:19 pm	20 minutes	25 minutes
3	1:19 pm	10 minutes	3 minutes	4 minutes *	1:44 pm	15 minutes	25 minutes
4	1:55 pm	2 minutes	2 minutes	2 minutes	2:02 pm	5 minutes	7 minutes
5	2:30 pm	3 minutes	2 minutes	2 minutes	2:41 pm	8 minutes	11 minutes

Encounter 1: ([redacted]) Established Patient

- Need to introduce yourself to the patient when walking to the exam room
- Needs to include more detail in report to provider following the intake process
- Good charting pace while provider in the room
- There was table paper on the floor- ensure that exam room is kept neat between encounters
- Did not offer gown to the patient. (concerns mostly on head and neck)

Encounter 2: ([redacted]) New Patient

- Very friendly to the patient
- Be sure to introduce yourself and let the patient know that they will be seeing [redacted]
- Good, relevant questions during interview process
- Good completing the HPI while discussing with the patient
- Offered the patient a gown
- Filter quick exam diagnosis quickly by typing in first letter vs. scrolling
- Full skin template up and ready when the provider walks into the room. Ready to input diagnoses as the provider is talking.
- Patient has a very large med list. Quickly copy down to put into the chart

Encounter 3: ([redacted]) New patient *(patient was deaf so additional time was needed for POA to sign to patient)*

*- waiting for patient to get into a gown

- Good intake and questions
- Include more detail on the demo sheet (standard format)
- Offered patient a gown
- Did not introduce self

Encounter 4: ([redacted]) Established patient

- Bring computer when presenting to provider
- Did not offer a gown
- Did not introduce self

Encounter 5: ([redacted]) New patient

- Only one to complete full introduction and inform patient of provider they will be seeing
- Quick but thorough intake
- Pharmacy input during intake
- Asked for medication information sheet before leaving the exam room
- Good pace inputting diagnoses while provider in the room.

MAIN TAKEAWAYS

1. Staff need to ALWAYS introduce themselves and the provider the patient will be seeing. Even if it is an established patient. Example below.

"Hello, my name is [redacted]. I will be the medical assistant helping you today. You will be seeing [redacted] ."

   - If they can do this at McDonald's when taking your order in the drive- thru we can do it too!

2. We need to be offering *every* patient a gown
3. Input/confirm the pharmacy during the intake process
4. Filter quick exam diagnosis quickly by typing in first letter vs. scrolling
5. Strive to have the patient in the waiting room 5 minutes or less with a total encounter time of 10 minutes or less.

FOREFRONT DERMATOLOGY

Clinical Observation:

Location:

Provider:

Date:

Key:
Red- needs improvement
Black- Satisfactory
Green- Excellent

Encounter	Check in time	Wait time in WR	Interview time	Wait time in Exam room	Exit Exam room time	Total Encounter Time	Total time from Check in to exit exam room
1							
2							
3							
4							
5							

Encounter 1:

Encounter 2:

Encounter 3:

Encounter 4:

Encounter 5:

Encounter 6:

Main Takeaways:

2021 Coding Guide

For Physicians, PAs, and NPs

CONTENTS

Click on any section below to skip forward:

1

Coding Based on Medical Decision Making (MDM)

The new MDM table will continue to have three sections of criteria: problems, data, and risk. Two of the three criteria must be met in order to support a given level. ***In Dermatology, problems and risk will be used most often when choosing the MDM level.*** The following pages will further define the three sections of criteria.

Problems

The problem is the diagnosis. There are four problem types under the new guidelines: self-limited/minor, chronic, acute, and new, undiagnosed. Chronic and acute problems are further defined by the severity of the condition, as shown below.

Type of problem	Further defined as...
Self-limited or minor Runs a definite course, is transient in nature and is not likely to permanently alter health status.	*Examples: Nevi, Angiomas, Lentigines, SKs, etc.*
Chronic Expected duration of at least one year but can be present for less than that. *Example: a new patient, problem present 8 weeks but you believe it will last longer than 1 year.*	**Stable** Well controlled, treatment goal achieved. *Example: Acne, clear with Rx therapy.* **Exacerbated or having side effects from treatment** Acutely worsening/poorly controlled; may require treatment for side effects but does not need consideration of hospitalization. *Example: Psoriasis, recently flaring due to increased stress, Urticaria for 8 weeks.* **Severely exacerbated or having side effects from treatment** Significant risk of morbidity; may require hospital care. *Example: Pt on Isotretinoin with severely flaring cystic acne and elevated LFT.* **Posing a threat to life/bodily function** Poses a threat to life/bodily function in the near term without treatment. *Examples: Sezary Syndrome, Erythromderma.*

Type of problem	Further defined as...
Acute Short-term problem with low risk of morbidity, full recovery is expected.	**Uncomplicated** Short-term problem with low risk of morbidity, full recovery expected. *Example: Abrasion, Poison Ivy, etc.* **Complicated injury** Extensive injury; treatment requires evaluation of other body systems. *Example: Dog bite to hand with tendon involvement.* **With systemic symptoms** Problem that causes systemic symptoms, high risk of morbidity if not treated. *Examples: Abscess with fever, tick bite with myalgia.* **Posing a threat to life/bodily function** Poses a threat to life/bodily function in the near term if not treated. *Example: Abrupt change in neurologic status, severe rheumatoid arthritis.*
New, undiagnosed A new condition, likely to result in a high risk of morbidity if not treated.	*Examples: Rash suspicious for BP, new lump in breast.*

Note: "History of" diagnoses do not count toward medical decision making.

Data

This portion of MDM allows the Physician, PA, or NP to include test/workup that is performed and affect patient care when determining the MDM level. ***Data may not have as much influence on the MDM level as problems and risk, but it may be helpful for complex visits.***

- Ordering tests
- Obtaining details from an independent historian
- Discussing management or test interpretation with external Physician or QHP or appropriate source
- Reviewing tests
- Reviewing external notes
- Independent interpretation of test performed by another Physician/QHP

*Refer to the data column on the MDM table on page 6 for details on calculating data.

Examples:

1. *Ordering CBC, LFT and TG = 3 unique tests for category 1 and supports moderate MDM.*
2. *Ordering CBC, LFT and TG + called endocrinologist about chronic metabolic syndrome/labs supports high MDM.*

Risk

There will continue to be four levels of risk under the new guidelines: minimal, low, moderate, and high. The following table provides examples of management options used in Dermatology.

Level of risk	Examples
Minimal	• Counseling only • Applying a Band-Aid®

Low	• Over-the-counter (OTC) recommendations, including:
	  • Sunscreen SPF 15+
	  • Acetaminophen/Ibuprofen/Aspirin/Naproxen Sodium
	  • Hydrocortisone Cream
	  • Clotrimazole (Lotrimin)
	  • Permethrin 1% (Nix)
	  • Zyrtec®/Benadryl®/Claritin®
	  • Capsaicin
	  • Benzoyl Peroxide/Salicylic Acid
	  • Pyrithione Zinc (Head & Shoulders®/Selsun Blue®)
	  • Ketoconazole shampoo
	  • Vaseline®
	  • Aquaphor®
	  • Hydrogen Peroxide
	• Discussing potential need for biopsy of lesions, such as benign nevi, change.

Moderate	• Prescription drug management including continuing medication, refills, etc. • Decision regarding minor surgery with identified patient or procedure risks • Decision regarding elective major surgery without identified patient or procedure risks • Diagnosis or treatment limited by social determinants (e.g. homelessness, transportation limitations, etc.)

High	• Medication requiring intensive monitoring, such as:
	  • Isotretinoin
	  • Dapsone
	  • Azathioprine
	  • Mycophenolate Mofetil
	• Decision regarding elective major surgery with identified patient or procedure risks
	• Decision regarding emergency major surgery
	• Decision regarding hospitalization
	• Decision not to resuscitate or to de-escelate care because of poor prognosis

Sources:
"E/M Office or Other Outpatient Guidelines and Code Revisions for 2021: MDM—Part 1." AMA CPT Assistant. May, 2020. ocm.ama-assn.org/OCM/CPTAA/Newsletters.do. Accessed December 13, 2020.
"Drugs@FDA: FDA-Approved Drugs (database)." U.S. Food & Drug Administration. https://www.accessdata.fda.gov/scripts/cder/daf/. Accessed December 13, 2020.
"E/M Office or Other Outpatient Guidelines and Code Revisions for 2021: MDM—Part 2." AMA CPT Assistant. June, 2020. ocm.ama-assn.org/OCM/CPTAA/Newsletters.do. Accessed December 13, 2020.

2

Coding Based on Time

The new and established patient E/M levels may be billed using the total amount of time spent on the day of the encounter. Total time includes face-to-face and non-face-to-face time personally spent by the Physician, PA, or NP. It ***does not*** include time spent by clinical staff. Do not count time that is spent on a day other than the visit. Document the total amount of time and activities that were counted towards time-based coding in the visit note.

New patient E/M level	Total time	Established patient E/M level	Total time
99201	Deleted	**99211**	N/A
99202	15-29 minutes	**99212**	10-19 minutes
99203	30-44 minutes	**99213**	20-29 minutes
99204	45-59 minutes	**99214**	30-39 minutes
99205	60-74 minutes	**99215**	40-54 minutes

The following activities may be counted towards time-based coding:

- Preparing to see the patient (e.g. reviewing tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient, family, or caregiver
- Ordering medications, tests, or procedures
- Referring or communicating with other health care professionals
- Documenting in the medical record
- Independently interpreting results and communicating results to the patient, family, or caregiver
- Care coordination

Prolonged Service Coding

Only use the prolonged service code if billing the visit based on time and the duration of the visit has exceeded the time ranges for E/M level 99205 or 99215. The prolonged service code follows the same guidelines as time-based coding for the E/M level.

New patient visit	Code as
Less than 75 minutes	Not reportable as a prolonged service
75-89 minutes	99205 and 99417 x1 unit
90-104 minutes	99205 and 99417 x2 units
105 minutes or more	99205 and 99417 x 3 units, or more based on each additional 15 minutes spent
Established patient visit	**Code as**
Less than 55 minutes	Not reportable as a prolonged service
55-69 minutes	99215 and 99417 x1 unit
70-84 minutes	99215 and 99417 x2 units
85 minutes or more	99215 and 99417 x3 units, or more based on each additional 15 minutes spent

Sources:
"CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes." AMA. Accessed December 13, 2020.
Coding & Reimbursement Committee E/M Work Group. "E/M Coding for 2021: Major Changes Ahead." AAD. Accessed December 14, 2020.

2021 MDM Table

E/M level	Number and complexity of problem addressed	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient management
99202/99212 Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal** or none	**Minimal** risk of morbidity from additional diagnostic testing or treatment
99203/99213 Low	**Low** • 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1:** Tests and documents **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* **Category 2:** Assessment requiring an independent historian(s)	**Low** risk of morbidity from additional diagnostic testing or treatment
99204/99214 Moderate	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment or • 2 or more stable chronic illnesses or • 1 undiagnosed new problem with uncertain prognosis or • 1 acute illness with systemic symptoms or • 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1:** Tests, documents, or independent historian(s) **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian(s) **Category 2:** Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) **Category 3:** Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)	**Moderate** risk of morbidity from additional diagnostic testing or treatment *Examples only:* • *Prescription drug management* • *Decision regarding minor surgery with identified patient or procedure risk factors* • *Decision regarding elective major surgery without identified patient or procedure risk factors* • *Diagnosis or treatment significantly limited by social determinants of health*
99205/99215 High	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1:** Tests, documents, or independent historian(s) **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian(s) **Category 2:** Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) **Category 3:** Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)	**High** risk of morbidity from additional diagnostic testing or treatment *Examples only:* • *Drug therapy requiring intensive monitoring for toxicity* • *Decision regarding elective major surgery with identified patient or procedure risk factors* • *Decision regarding emergency major surgery* • *Decision regarding hospitalization* • *Decision not to resuscitate or to de-escalate care because of poor prognosis*

Source: "Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)." AMA. Accessed December 13, 2020.

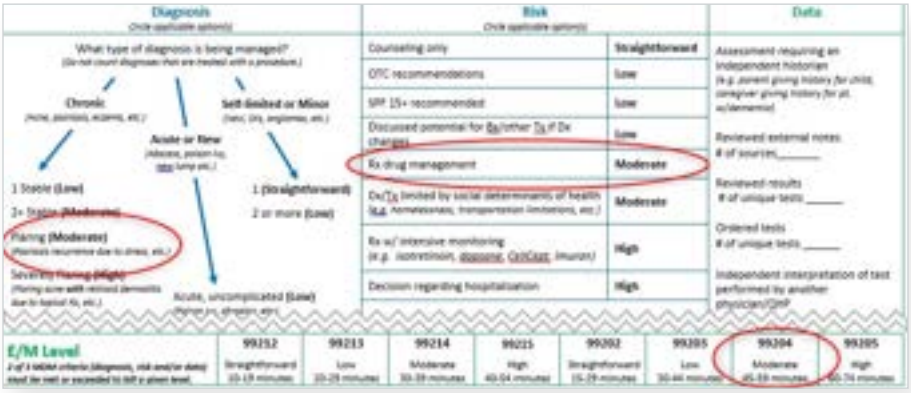
4

Good to Know

Rethink E/M leveling. It might feel funny at first, but some new patient visits will code higher and some established patient visits (especially skin checks) will code lower because “history of” diagnoses do not count toward medical decision making.

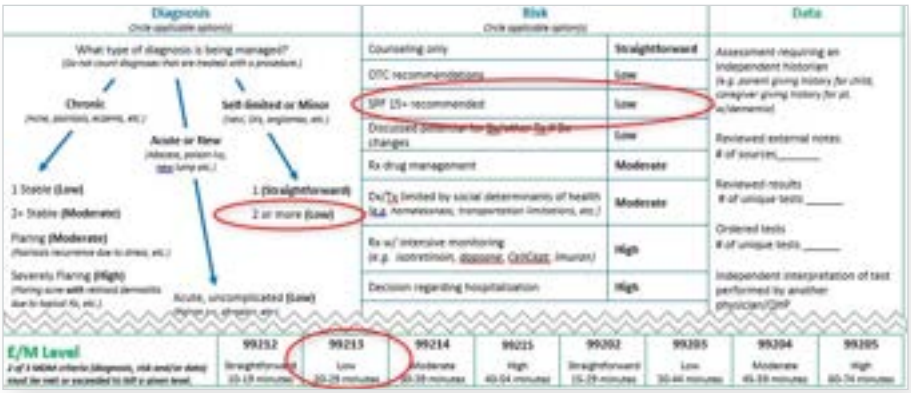
Example 1: New patient who reports chronic acne, comes in due to recent flaring. Doxycycline and topical Rx given.

- **2020 guidelines: 99203**
- **2021 guidelines: 99204**



Example 2: Established patient presents for their full body skin exam. They have a history of squamous cell carcinoma. Benign nevi and SKs are assessed and discussed during the exam and SPF 30 is recommended with application instructions.

- **2020 guidelines: 99214**
- **2021 guidelines: 99213**

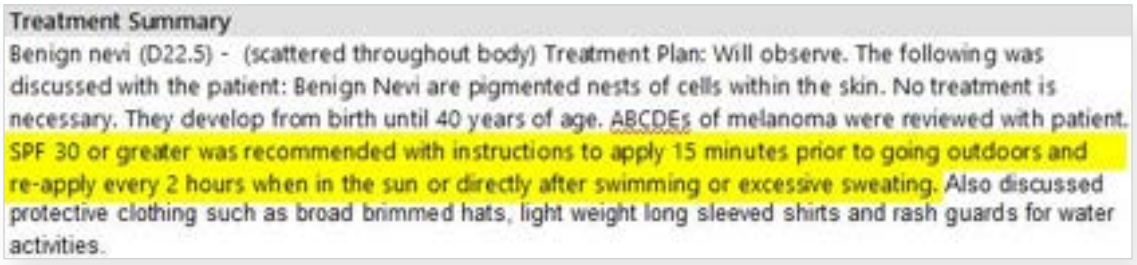


Documentation that impacts coding will now start at the assessment and plan. The new guidelines state that a relevant history and exam should still be reviewed and documented, but the information in these areas will no long impact the E/M level. Move the focus away from gathering "points" in the history and exam and start to think of documentation that demonstrates the brain power that is used for diagnosing and developing a treatment plan for the patient. This addition will bring the same visits from Straightforward MDM (99212/99202) to Low MDM (99213/99203)

SPF 15 or greater is considered an over-the-counter medication. If your standard practice is to provide sunscreen counseling during skin examinations then take the following steps to ensure your documentation reflects this work.

Templates

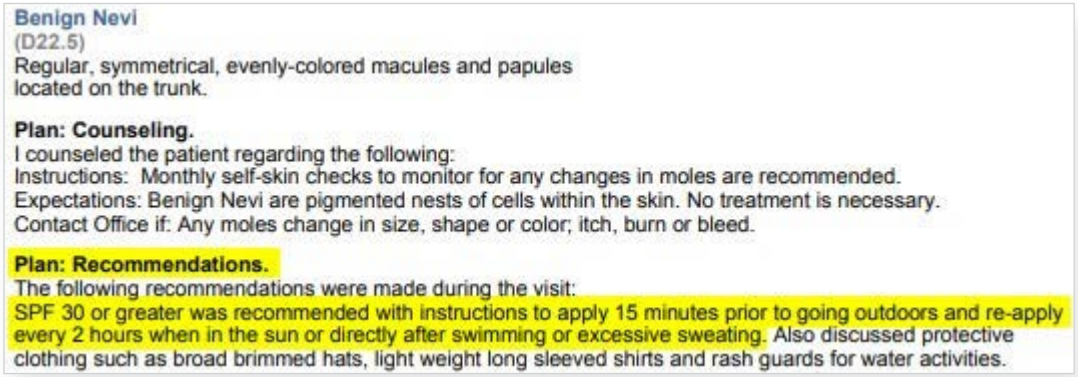
Make sure that your saved templates are up-to-date with the details you would typically discuss with your patients.



Treatment Summary

Benign nevi (D22.5) - (scattered throughout body) Treatment Plan: Will observe. The following was discussed with the patient: Benign Nevi are pigmented nests of cells within the skin. No treatment is necessary. They develop from birth until 40 years of age. ABCDEs of melanoma were reviewed with patient. SPF 30 or greater was recommended with instructions to apply 15 minutes prior to going outdoors and re-apply every 2 hours when in the sun or directly after swimming or excessive sweating. Also discussed protective clothing such as broad brimmed hats, light weight long sleeved shirts and rash guards for water activities.

If working in an EMR that calculates your code, in addition to the *Counseling* plan, clinical staff should start documenting sunscreen recommendations in the plan called, *Recommendations.* This will make it so that EMA includes the OTC recommendation when calculating the level of risk.

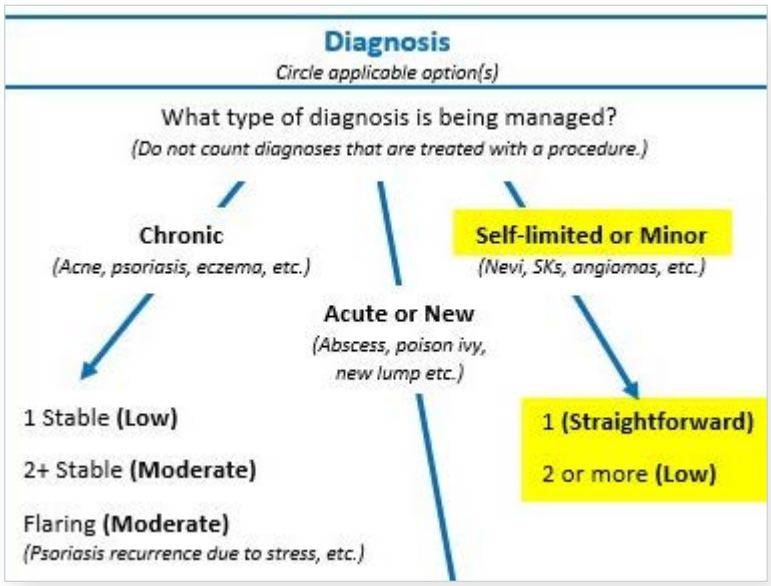


Benign Nevi
(D22.5)
Regular, symmetrical, evenly-colored macules and papules located on the trunk.

Plan: Counseling.
I counseled the patient regarding the following:
Instructions: Monthly self-skin checks to monitor for any changes in moles are recommended.
Expectations: Benign Nevi are pigmented nests of cells within the skin. No treatment is necessary.
Contact Office if: Any moles change in size, shape or color; itch, burn or bleed.

Plan: Recommendations.
The following recommendations were made during the visit:
SPF 30 or greater was recommended with instructions to apply 15 minutes prior to going outdoors and re-apply every 2 hours when in the sun or directly after swimming or excessive sweating. Also discussed protective clothing such as broad brimmed hats, light weight long sleeved shirts and rash guards for water activities.

If benign conditions are assessed and discussed with the patient during the visit, document them in the visit note. Managing one benign problem may help to support a level two visit, depending on other MDM criteria. Managing two or more benign problems may help to support a level three visit, again depending on other MDM criteria.



Sources:
"CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes." AMA. Accessed December 13, 2020.
Margaret Moye, MD. "Evaluation and Management Coding for 2021." Presented on November 18th, 2020
"Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)." AMA. Accessed December 13, 2020.

5

What to Use in Clinic

The worksheet on the following page was developed for clinical staff to fill out during the office visit. It will enable you to determine the correct E/M level for the visit and should be referenced when reviewing and finalizing the visit note in the EHR.

How to use the worksheet

Sections in **blue** should be filled out by clinical staff.
Sections in **green** should be filled out by the Physician, PA, or NP.

Step 1

- During the assessment and plan portion of the patient visit, clinical staff should fill in the **Diagnosis** and **Risk** section on the worksheet.
  - If coding based on time, staff will fill in the **Time** portions at the bottom of the page instead.

Step 2

- When the visit is over, the Physician, PA, or NP should circle the **E/M Level** that is supported.
  - The **Data** section may not apply for every visit. Consider using it for **complicated** visits, or visits where the diagnosis or risk are **straightforward.**

Step 3

- Set the worksheet aside and reference it later when reviewing and finalizing notes.
- If you notice a discrepancy in the code you believe to be supported and the code that the EHR calculated, override the code and enter appropriate data to support the override.

Tips for success

Do not assume that the EHR is calculating the E/M level correctly. E/M coding is changing significantly so it will be important to verify that the correct E/M level is being calculated by the EHR.

Use purposeful communication and phrasing. Think of ways to communicate with the patient that will also give the clinical staff clues on whether the diagnosis is chronic vs acute, or whether it's flaring vs stable.

*Example: I'm hearing that you've had this rash off and on for a long time. Psoriasis is a **chronic problem,** and can subside and then **flare up, as you're noticing now.***

FOREFRONT DERMATOLOGY®

2021 – New/Established Office Visit Worksheet

(Use this form when documenting the diagnosis and plan.)

Blue = clinical staff complete
Green = Physician, PA or NP complete

MRN_____ **Patient Initials**_____ **DOS**_____

Diagnosis

Circle applicable option(s)

What type of diagnosis is being managed?

(Do not count diagnoses that are treated with a procedure.)

Chronic
(Acne, psoriasis, eczema, etc.)

- 1 Stable **(Low)**
- 2+ Stable **(Moderate)**
- 1+ with exacerbation, progression or side effects of treatment **(Moderate)**
  (e.g. psoriasis flare due to stress)
- 1+ with severe exacerbation, progression or side effects of treatment **(High)**
  (e.g. erythrodermic psoriasis with systemic symptoms)
- Illness or injury that poses a threat to life or bodily function **(High)**
  (e.g. needs admitted to hospital)

Self-limited or Minor
(Nevi, SKs, angiomas, etc.)

- 1 **(Straightforward)**
- 2 or more **(Low)**

Acute or New
(Abscess, new lump etc.)

- Acute, uncomplicated illness or injury **(Low)**
  (e.g. poison ivy, abrasion, irritant dermatitis, low risk NMSC)
- Acute illness with systemic symptoms **(Moderate)**
  (e.g. abscess with fever, tick bite with myalgia)
- Acute, complicated injury **(Moderate)**
  (e.g. severe burn, head injury with loss of consciousness)
- Acute illness or injury that poses a threat to life or bodily function **(High)**
  (e.g. needs admitted to hospital)
- New, undiagnosed with uncertain prognosis **(Moderate)**
  (e.g. new lump, rash suspicious for BP)

Risk

Circle applicable option(s)

Counseling only	**Straightforward**
OTC recommendations	**Low**
SPF 15+ recommended	**Low**
Decision regarding minor surgery without identifiable patient or procedure risk factors *(e.g. Biopsy, destruction , low risk Mohs or excision)*	**Low**
Rx drug management	**Moderate**
Diagnosis or treatment significantly limited by social determinants of health *(e.g. housing or financial insecurity, transportation limitations, etc.)*	**Moderate**
Decision regarding minor surgery with identifiable patient or procedure risk factors *(e.g. Low risk Mohs, but pt. takes an anticoagulant)*	**Moderate**
Decision regarding major surgery without identifiable patient or procedure risk factors *(e.g. flaps, grafts, extensive excisions, complicated Mohs)*	**Moderate**
Decision regarding major surgery with identifiable patient or procedure risk factors *(e.g. flaps grafts, extensive excisions, complicated Mohs)*	**High**
Rx w/ intensive monitoring *monitoring must be at least quarterly* *(e.g. isotretinoin, dapsone, CellCept, Imuran)*	**High**
Decision regarding hospitalization	**High**
OTHER:	

Data

Assessment requiring an independent historian *(e.g. parent giving history for child, caregiver giving history for pt. w/dementia)*

Reviewed external notes
# of unique sources_____

Reviewed results
# of unique tests _____

Ordered tests
# of unique tests _____

Independent interpretation of test performed by another physician/QHP (not separately reported)

Discussion of management or test interpretation with external MD/QHP or appropriate source (not separately reported)

Refer to the 2021 MDM Table for leveling data.

E/M Level *2 of 3 MDM criteria (diagnosis, risk and/or data) must be met or exceeded to bill a given level.*	**99212** Straightforward 10-19 minutes	**99213** Low 20-29 minutes	**99214** Moderate 30-39 minutes	**99215** High 40-54 minutes	**99202** Straightforward 15-29 minutes	**99203** Low 30-44 minutes	**99204** Moderate 45-59 minutes	**99205** High 60-74 minutes

Use time if visit is complicated or taking longer than is typical. Only count time that the physician/PA/NP spends on the visit.

Time spent pre-service:	+	**Time spent intra-service:**	+	**Time spent post-service:**	=	**Total amount of time spent on DOS**

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7

New and Established Patient Scenarios

All scenarios assume that a relevant and medically appropriate history and exam were reviewed and/or performed and documented.

99202 and 99212—Straightforward MDM

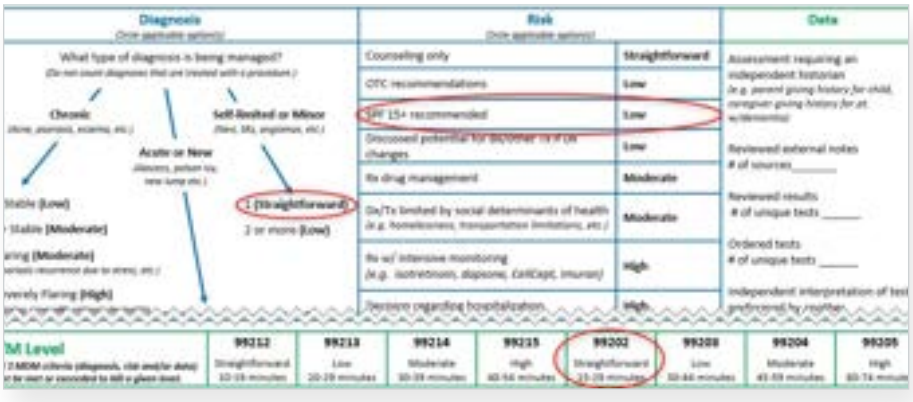
A 4 year old new patient presents with their mother for evaluation of a “birthmark” on the back that is asymptomatic and not changing.

Diagnosis: Benign congenital nevus on back
Plan: No intervention required. Parents counseled low risk of small congenital nevi and educated on ABCDEs of moles/melanoma. SPF 30 or greater reviewed and encouraged.

All criteria support or exceed the requirements for straightforward MDM:

Problems: 1 self-limited or minor problem (straightforward)
Data: None (straightforward)
Risk: OTC recommendation—SPF 15+ (low)

*If another problem had been asked about and/or identified and discussed then this would be a 99203.



99202 and 99212—Straightforward MDM

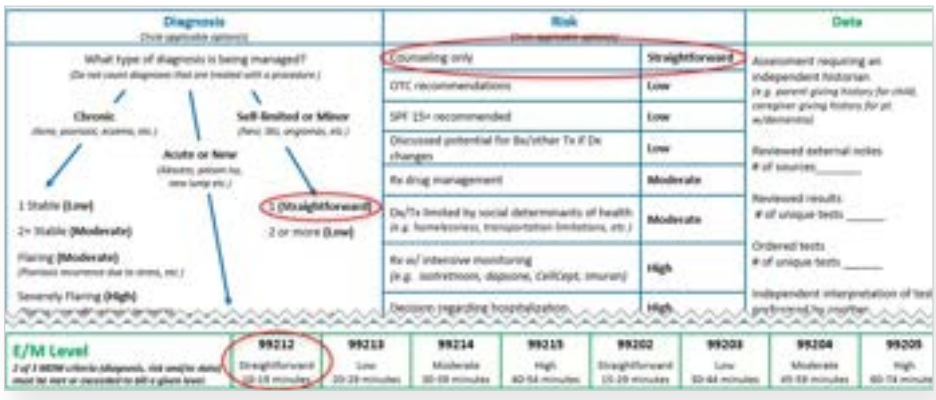
A 65 year old established patient presents with a new lesion of concern on the chest that is asymptomatic and has been present x4 weeks. They would only like to have this lesion looked at today and decline a skin exam.

Diagnosis: Seborrheic keratosis
Plan: Patient educated about benign nature of seborrheic keratoses; no treatment required.

All criteria support straightforward MDM:

Problems: 1 self-limited or minor problem (straightforward)
Data: None (straightforward)
Risk: Minimal risk—counseling only (straightforward)

*Because he declined a skin check, it would not be appropriate to add additional diagnoses for the visit.



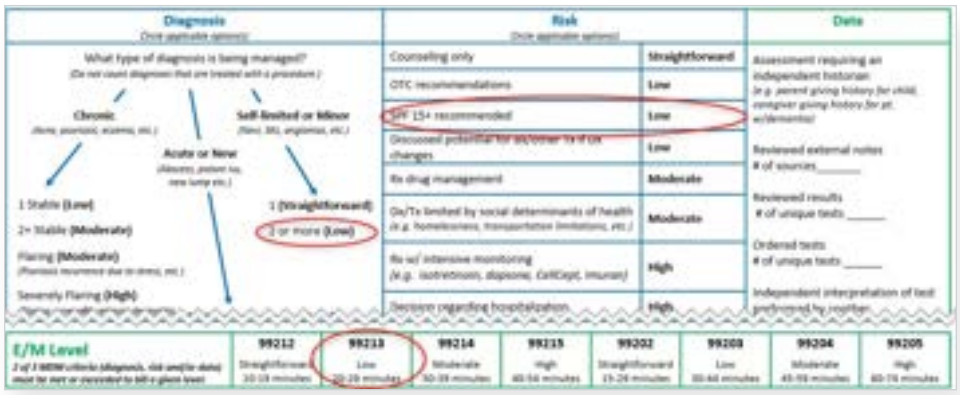
99203 and 99213 – Low MDM

A 52 year old established patient presents with a new lesion of concern on the chest that is rough and has been present x2 months. The patient would also like an upper body skin exam today to make sure there are no worrisome lesions.

Diagnosis: Seborrheic keratosis and benign nevi
Plan: Educated about benign nature of SKs and nevi. SPF 30+ reviewed and encouraged.

2 of 3 criteria support low MDM:

Problems: 2 self-limited or minor problem (low)
Data: None (straightforward)
Risk: OTC recommendation—SPF 15+ (low)



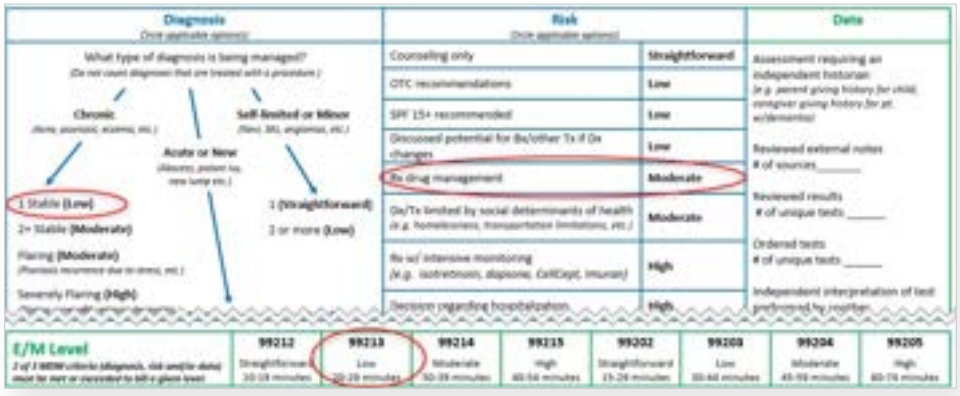
A 34 year old established patient with no personal or family history of skin cancer or dysplastic nevi presents for their annual, full body skin check. They have no specific concerns but wants to make sure there are no worrisome lesions, especially in areas they cannot see.

Diagnoses: Benign nevi, cherry angiomas, lentigines
Plan: Educated about benign nature of nevi, angiomas, and lentigines. SPF 30+ reviewed and encouraged. Education provided on ABCDEs of moles/melanoma.

2 of 3 criteria support low MDM:

Problems: 2+ self-limited or minor problems (low)
Data: None (straightforward)
Risk: OTC recommendation—SPF 15+ (low)

*If sunscreen is not recommended for these two visits they would be one level lower. It is important to add this recommendation to your documentation when provided.



Note: Compare with example #2 under 99202 and 99212 examples. Look at the similarities and differences between the two visits.

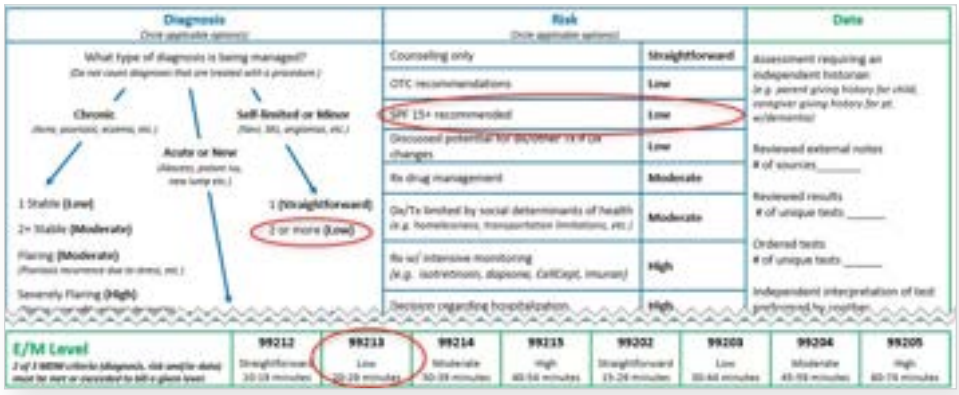
A 75 year old established patient with a history of BCC presents for their annual, full body skin check. They have new brown, scaly growths on the back that are asymptomatic.

Diagnoses: Hx of SCC (no evidence of recurrence), AKs, SKs, and nevi
Plan: Counsel on SCC risks and sun protection with broad-spectrum SPF 30+ discussed. Counseled on benign nature of SKs, benign nevi, and lentigines. ABCDEs of moles/melanoma reviewed and recommended self-skin exams.
Procedure(s): AKs treated with cryotherapy of 5 lesions

2 of 3 criteria support low MDM:

Problems: 2+ self-limited or minor problems (low)
Data: None (straightforward)
Risk: OTC recommendation—SPF 15+ (low)

* History of melanoma, SCC, BCC, or atypical nevi cannot be used to support the E/M level because they are not an active problem.

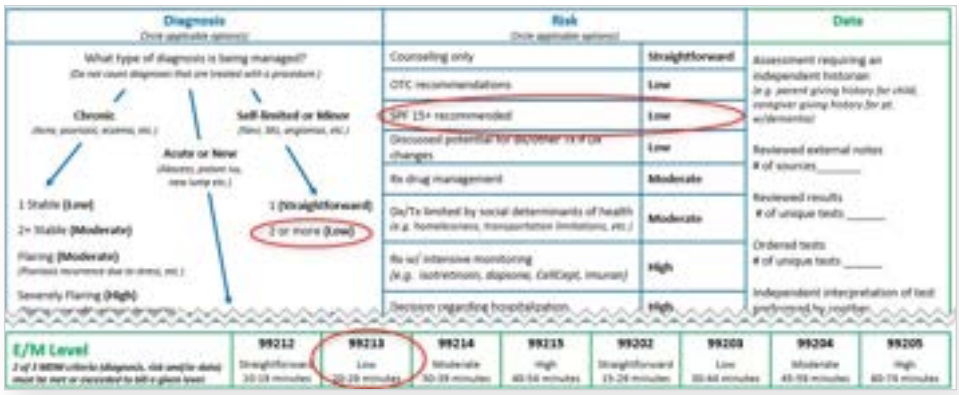


A new patient presents for an itchy red rash that started 1 week ago after hiking in the woods with their dog.

Diagnosis: Poison ivy
Plan: Topical steroid prescribed—risks, benefits, and side effects discussed. Follow up in 2 weeks if not improving.

2 of 3 criteria meet or exceed low MDM:

Problems: 1 acute, uncomplicated illness (low)
Data: None (straightforward)
Risk: Prescription management (moderate)

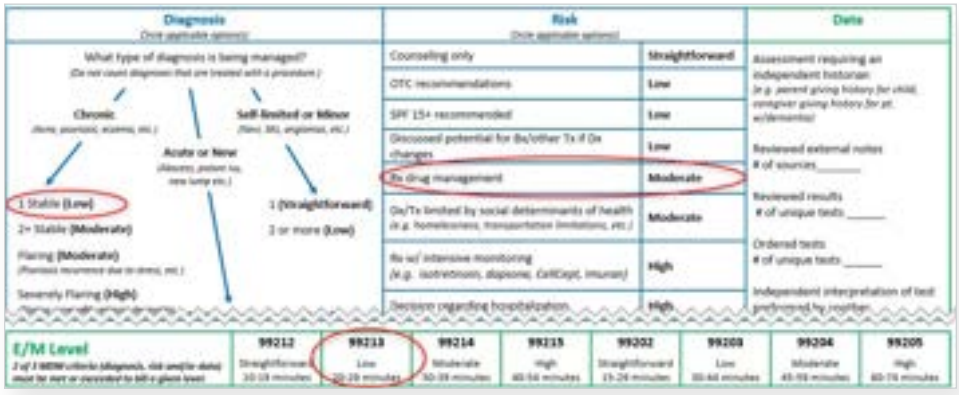


A 25 year old established patient is following up for acne that has been present for several years and is stable with Doxycycline and topical medications.

Diagnosis: Acne
Plan: Refills are given and patient is reminded of appropriate use and risks/benefits/side effects of therapy. Follow up in 3 months or sooner if needed.

2 of 3 criteria meet or exceed low MDM:

Problems: 1, stable chronic (low)
Data: None (straightforward)
Risk: Medication management (moderate)



A new patient with recently developed acne comes in for evaluation and treatment. They state they have never had acne in the past but have noticed it since starting to wear a mask more often.

Diagnosis: Papular and comedonal acne
Plan: Prescribed topical Clindamycin with benzoyl peroxide and a topical retinoid therapy. Risks, benefits, side effects, and appropriate use reviewed.

2 of 3 criteria meet or exceed low MDM:

Problems: 1 acute, uncomplicated illness (low)
Data: None (straightforward)
Risk: Prescription management (moderate)

* Acne is considered acute, uncomplicated at this visit because they have never had acne; it is a new onset likely due to irritants and may be manageable in a short period of time. If the acne continues or does not improve as expected, or the patient has had the acne for years, it's possible that it may be considered chronic, exacerbated at a future visit. This demonstrates how the status of acute vs chronic and stable vs flaring may apply to the same condition, but differently given the individual patient's condition.

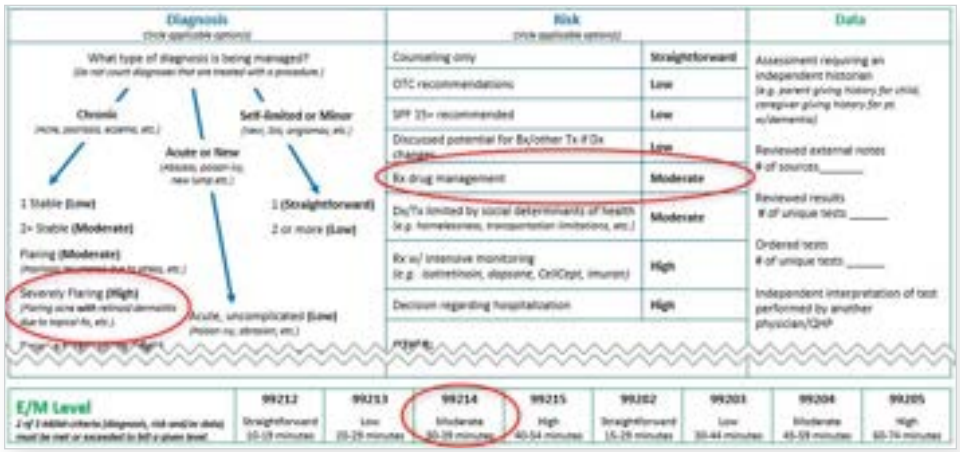
99204 and 99214—Moderate MDM

25 year old female is following up for acne that is inadequately controlled despite OCP and topicals, including Tretinoin and Clindamycin-BPO. She is very compliant with her treatment regimen but is still developing jawline acne that reliably worsens around her menstrual cycle. She admits moderate dryness from Tretinoin use.

Diagnosis: Acne vulgaris with hormonal exacerbation
Plan: Start Spironolactone 100 mg daily; potassium level ordered, risks and benefits of treatment discussed. Continue OCP. Continue Clindamycin-BPO and decrease strength of Tretinoin.

2 of 3 criteria support moderate MDM:

Problems: 1 chronic problem with exacerbation and side effects of treatment (moderate)
Data: 1 unique test ordered (straightforward)
Risk: Prescription management (moderate)



New patient is referred to you for nodulocystic acne that has been present for the past 2 years. The outside records that were sent by the primary care provider are reviewed just before the visit and reveal that the patient has tried multiple OTC products, topical prescriptions and oral antibiotics with minimal improvement.

Diagnosis: Acne, inadequately controlled
Plan: Prescribed isotretinoin 30mg QD, counseled on risks, benefits, side effects, and ordered CBC, LFT, and triglycerides.

2 of 3 criteria meet or exceed moderate MDM:

Problems: 1 chronic, exacerbated problem (moderate)
Data: Review of prior external notes and ordering of unique tests (moderate)
Risk: Drug therapy requiring intensive monitoring (high)

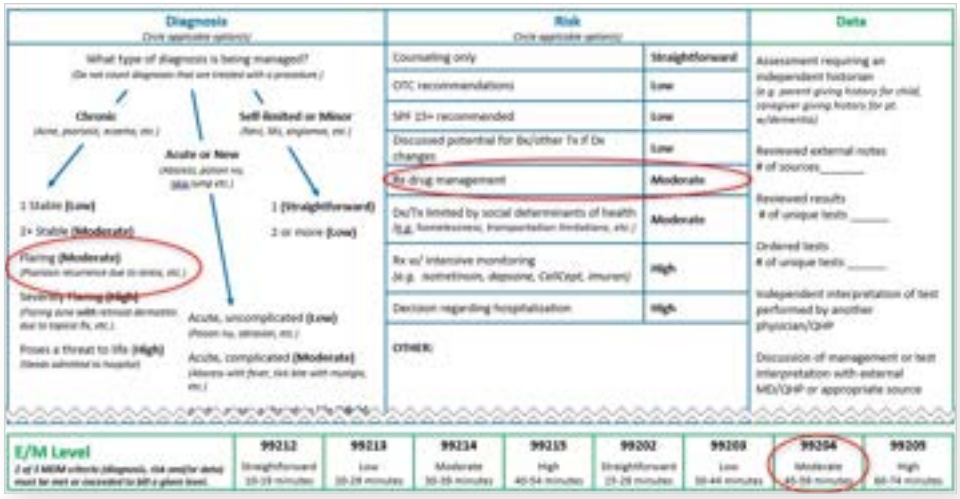
*E/M level would be the same if prescribing Doxycycline, as the risk level would be moderate.

45 year old new patient presents for an itchy rash on their neck, present for 1-2 years and has been worsening with cold weather. Exam reveals lichenified plaque on the right neck, no rash elsewhere.

Diagnosis: Lichen simplex chronicus
Treatment: Fluocinonide cream BID, reviewed risks of steroid use. Counseled that it will take time for thickened skin to return to normal and to minimize manipulation of area.

2 of 3 criteria support moderate MDM:

Problems: 1 chronic, exacerbated problem (moderate)
Data: None (straightforward)
Risk: Prescription drug management (moderate)

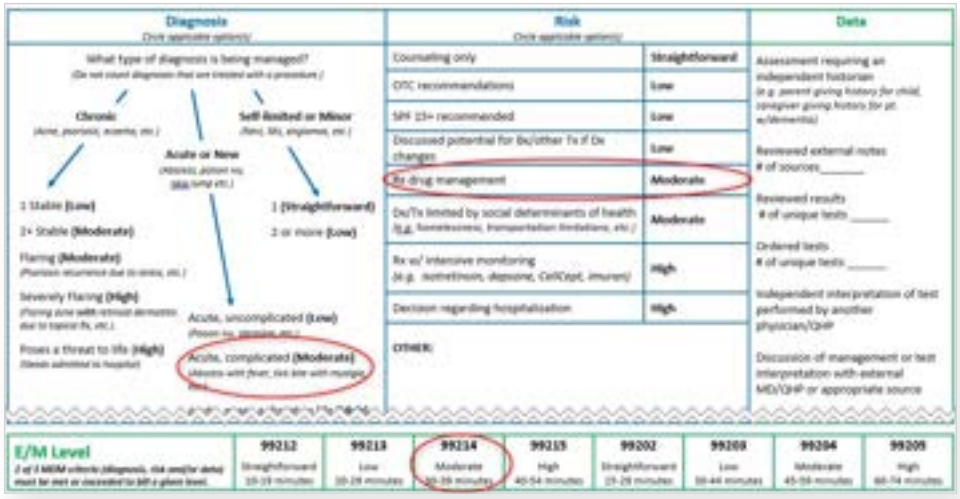


An 18-year-old established male patient presents for evaluation of a wound on his right forearm and an acute onset of malaise. He states that he was attempting to pet his girlfriend's cat, who (the cat) then became agitated and bit him. Physical exam is notable for a 3mm ulceration consistent with a puncture wound with surrounding ill-defined erythema, edema, warmth and mild tenderness with palpation. He admits having chills currently and his temperature is taken as 100.4 degrees F.

Diagnosis: Infection caused by animal bite with associated pain, erythema and edema.
Plan: Amoxicillin-clavulanic acid is recommended and ordered.

2 of 3 criteria support moderate MDM:

Problems: 1 acute illness with systemic symptoms (moderate)
Data: None (straightforward)
Risk: Prescription medication management (moderate)



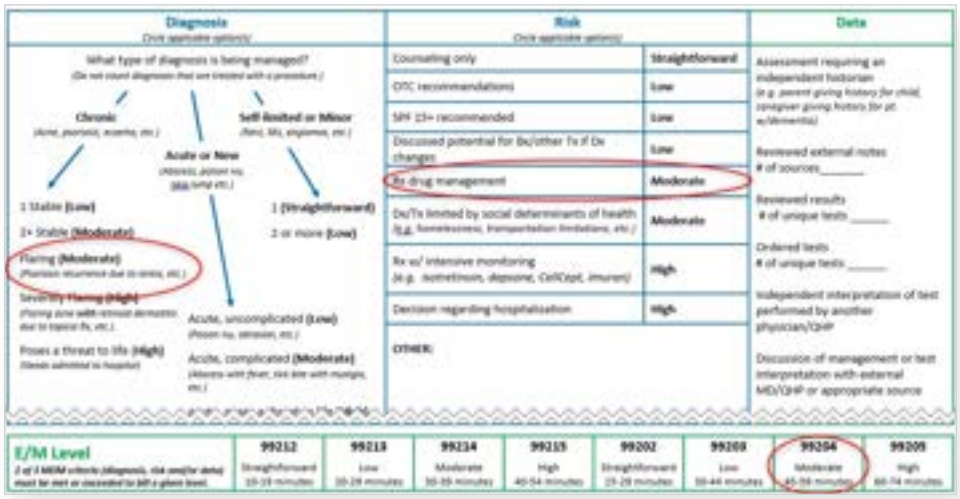
40 year old female presents for an 8 week history of itchy red papules that come and go within 24 hours. Over-the-counter antihistamines have not helped.

Diagnosis: Chronic urticaria
Plan: Prednisone taper, Allegra 180mg TID discussed risks, benefits, and side effects.

2 of 3 criteria support high MDM:

Problem: Chronic, flaring (moderate)
Data: None (straightforward)
Risk: Prescription drug management (moderate)

*Even though the condition has only been present for 8 weeks, it is expected to wax and wane for over a year, thus this new problem is considered a chronic flaring condition bringing you to moderate MDM.



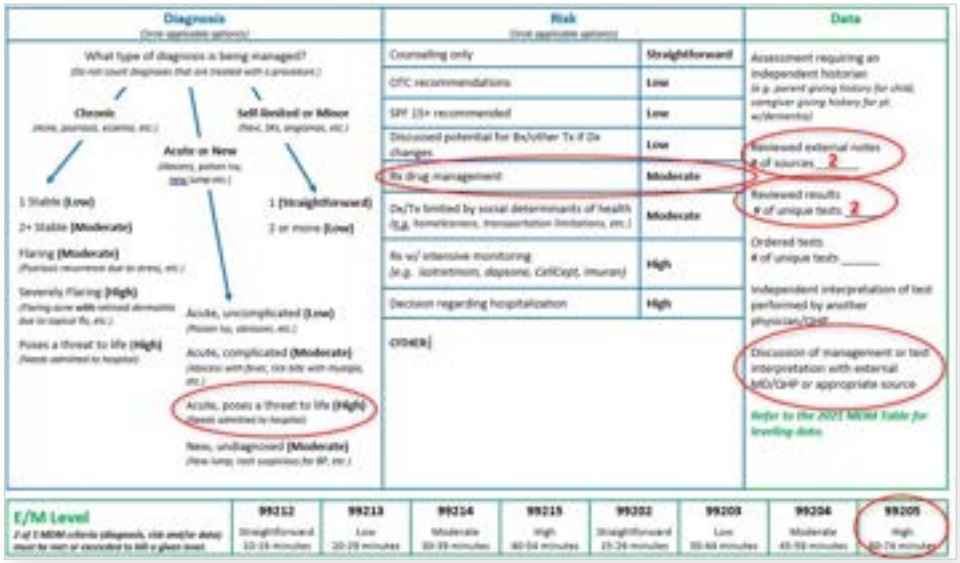
99205 and 99215 – High MDM

76 year old diabetic male presents as an urgent consult from local ER for evaluation of new-onset diffuse blistering and peeling rash x2 weeks including sores in mouth. He is a new patient. Records reviewed from PCP indicate that PCP prescribed oral antibiotics 10 days ago. ER records reviewed indicate that patient presented to the ER today because he had no improvement and difficulty eating due to mouth pain. Vitals stable in ER after being given IV fluids and a single dose of IV antibiotics. CBC and CMP were normal after fluids. Exam shows dozens of erosions and flaccid bullae and scattered pink patches of similar size diffusely scattered on trunk and extremities. Several large gingival erosions. Eyes and genitals unaffected.

Diagnosis: Pemphigus vulgaris vs cicatricial pemphigus vs paraneoplastic pemphigus vs other
Plan: 4 mm punch biopsy for H&E with adjacent punch sent for DIF. Discussed with patient and spouse possible diagnoses and potential causes, including possibility for long-term immune suppression and potential for further work-up after biopsy results. Start prednisone 60 mg po daily to continue until 1 week follow-up—risks, benefits, alternatives discussed. Start calcium and vitamin D supplementation as you anticipate long-term steroid use. Gentle skin care reviewed. Spoke with PCP on the phone regarding potential diagnoses, pending biopsy results, initiation of systemic steroids and possible need for additional diabetes management, potential need for hospitalization if patient does not improve in the next few days or cannot tolerate PO intake.

2 of 3 criteria support high MDM:

Problems: 1 acute illness that poses a threat to life/bodily function (high)
Data: Category 1 – Reviewed records from 2 outside sources, reviewed external labs AND Category 3 - spoke with PCP regarding management (high)
Risk: Management with Rx drugs (moderate)



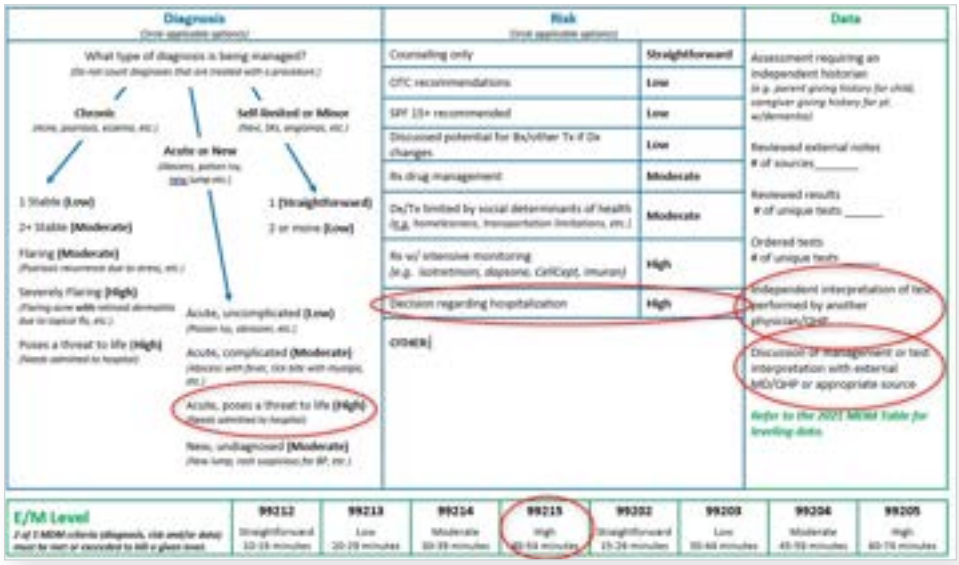
Note: there are dozens of variations when it comes to using data as a criteria to support the MDM level. It will be necessary to reference the complete MDM table for leveling data prior to selecting the E/M level for the visit.

80 year old established female with history of non-specific eczematous eruption brought to clinic by family members with diffuse erythroderma, weight loss, and subjective fevers. Family notes that she has not been acting like herself lately and is very itchy. Her eczema had previously been treated with UVB therapy and topical steroids. On exam she is diffusely erythrodermic and xerotic, shivering in exam room and appears unwell. No clear signs of cutaneous infection. A few approximately 1 cm palpable lymph nodes in bilateral axillae. Vitals taken show that she is tachycardic and blood pressure is 98/65. She is afebrile.

Assessment: Concern for sezary syndrome
Plan: Punch biopsy to be sent for H&E and T-cell gene rearrangement. Called to discuss case with local oncologist to arrange hospitalization immediately from clinic given unstable vitals and need for further work-up for sezary syndrome including examination of peripheral blood, possible imaging and lymph node biopsy.

2 of 3 criteria support high MDM:

Problems: 1 acute/chronic illness that poses a threat to life/bodily function (high)
Data: Category 3—spoke with PCP regarding management (moderate)
Risk: Decision for hospitalization (high)



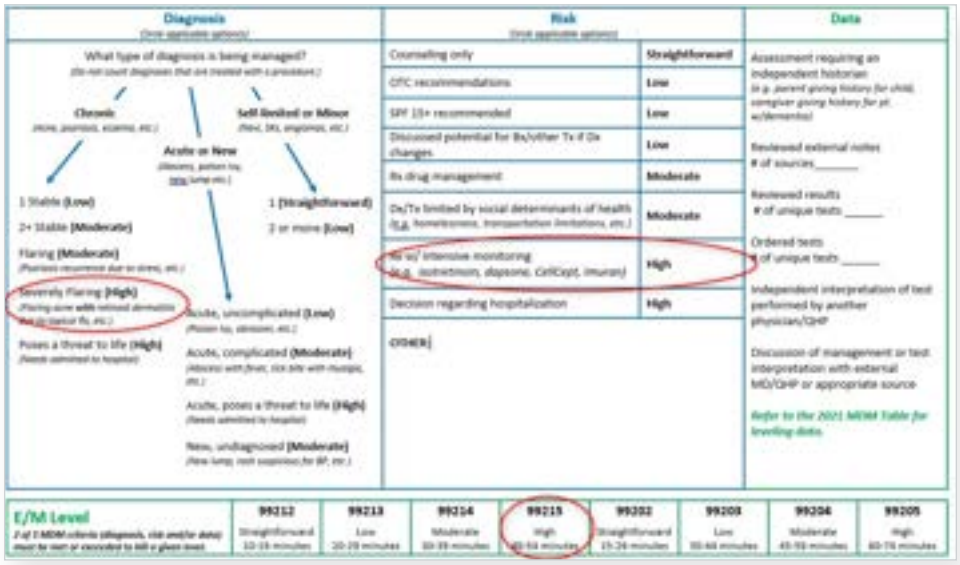
A 16 year old male patient has been on isotretinoin 40 mg po BID for 2 months. He presents for follow-up with concerns about dry, itchy skin on his face, as well as his hands and arms, for which lotion is not helping. His lips are dry, cracked, and bleeding. He denies other side effects of medication.

Diagnosis: Acne, with side effects from therapy and retinoid dermatitis
Plan: He is scheduled to have CBC, LFT, and triglycerides rechecked today. Triamcinolone and bland emollients recommended for retinoid dermatitis, hydrocortisone ointment prescribed for lips, and dose of isotretinoin is reduced to 30 mg po BID for the next month until dermatitis has improved.

2 of 3 criteria meet the requirement for high MDM:

Problem: Chronic problem with severe exacerbation (high)
Data: 2 unique lab test ordered (low)
Management: Prescription drug management requiring intensive monitoring (high)

*Chronic acne with severe exacerbation on isotretinoin could be severe retinoid dermatitis, hypertriglyderidemia or other systemic side effects from therapy, supporting a high level of MDM. Most routine isotretinoin visits will be a level 4.



Coding based on time

In Dermatology, most instances of coding based on time will arrive at the same E/M level using MDM. For completeness though, the following will serve as examples.

An established patient is referred to you for psoriasis that has been present for years and is inadequately controlled on topical steroids. You spend 10 minutes prior to the visit reviewing the visit notes and lab results that were sent from the PCP. The patient prefers to take a holistic approach to therapy and has also been applying coconut oil and patchouli essential oils to her psoriatic patches. Exam reveals moderate thick flaky patches on the trunk elbows and lower legs.
Diagnosis: Psoriasis
Plan: 25 minutes spent in deep discussion regarding biologic therapies; including Otezla® vs Humira®. Patient is concerned about side effects and decides that she would like to think about her options. Also discussed potential for UVB light therapy.

Coding based on time: This visit supports a 99214. (10 minutes pre-service + 20 minutes intra-service = 35 minutes)

An established patient presents for follow up for a burning sensation in the mouth.
Diagnosis: Burning mouth syndrome
Plan: You spend 30 minutes reassuring the patient regarding the condition and discussing long-term management, refill gabapentin. You spend 5 minutes on your notes, documenting the details that were discussed.

Coding based on time: This visit supports a 99214. (30 minutes intra-service + 5 minutes post-service = 35 minutes)

*If this visit was coded based on MDM then it would have supported a 99213 instead.

Sources:
Margaret Moye, MD. "Evaluation and Management Coding for 2021." Presented on November 18th, 2020
AAD – Derm Coding Consult - CODING FOR OFFICE VISIT EVALUATION AND MANAGEMENT (E/M) IN 2021 AND BEYOND: FREQUENTLY ASKED QUESTIONS (FAQS)
AAD – Cracking the Code - EVALUATION AND MANAGEMENT IN 2021: Part 2