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And to think I thought dermatology would be boring.

I will be the first to admit that I was completely wrong. I never did a dermatology rotation as a medical student, and somehow got the impression that dermatology could be a boring specialty. Looking back, I suspect the joy of dermatology was a well-kept secret. After all, how could any specialty that sees so many diverse diseases, some of which may only come around once in a lifetime, be boring? Moreover, no two dermatology careers are alike, and there are many different paths through which we can pursue personal and professional interests.

While we may suffer from a lack of racial diversity in our field, our members have an amazing diversity of professional interests and skills. And with this, they have an incredible wealth of expertise. This really struck me as I read this month’s Dermatology World. We have colleagues such as Drs. Lindy Fox and Lauren Madigan, who have helped build the subspecialty of inpatient consultative dermatology from its infancy to its now valued maturity. Work such as this helps highlight the value of our specialty in the entire house of medicine. Dermatologists, such as Drs. Seth Matarasso, Suzanne Bruce, and Robert Anolik, share their expertise about therapeutic and cosmetic use of toxins, and Dr. Beth Santmyire-Rosenberger offers words of wisdom about the practical realities of expanding the cosmetic side of your practice. We have colleagues who are active in the political arena, fighting for any number of things legislative, including tanning regulation. Read Assistant Managing Editor Allison Evan’s enlightening article on the state of in-office compounding. Not only will you finally understand what the USP (United States Pharmacopoeia) is and does, but you will learn more about the AADA’s ongoing advocacy efforts to ensure that our patients continue to have access to safe, in-office preparations of medications we use every day, including buffered lidocaine and intralesional triamcinolone. We owe a debt to our colleagues, including Drs. Murad Alam, Larry Green, and Seemal R. Desai, as well as dedicated AADA staffers, who have spent countless hours fighting on our behalf. Their voices are being heard, but there is work yet to be done.

For many of us, the advent of electronic health records has changed the very way we practice medicine. While we could debate ad infinitum whether these changes are good or bad (or probably both), the reality is that they are here, and we will use them. I am grateful for the interest and efforts of our colleagues, including Dr. Erin Gardner, who chairs the AAD’s EHR Taskforce, for trying to make their use as efficient (and painless) as possible. We have all been well versed in using EHRs on the front end, but it is important to consider what will happen with these records when you leave a practice or retire. Or, what if you change EHR systems? How, and at what cost, will you access and maintain these archived records going forward? Make sure you prepare for this in your practices.

Dermatology is many things, but it should never be boring. Ask any of our colleagues in this month’s DW!

KATHRYN SCHWARZENBERGER, MD, PHYSICIAN EDITOR
In your inbox every Wednesday with the most important news for dermatology. Missed an issue? We keep an archive of recent issues online.

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FROM THE EDITOR
Physician Editor Kathryn Schwarzenberger, MD, previews this month’s issue.

WATER COOLER
This column features the thoughts of readers like you! This month we asked, “Do you offer your office staff paid vacation, and if so, how much?”

ASKED AND ANSWERED
You asked, we answered: How do I claim CME credits from the Annual Meeting?

WHAT’S HOT?
Members of DW’s Editorial Advisory Workgroup share exciting news from across the specialty.

ADVOCACY NEWS
Tracking legislation and regulations at the state and federal levels.

ACTA ERUDITORUM
Inpatient consultative dermatology: Where are we now?

LEGALLY SPEAKING
You suspect a colleague is committing health care fraud. What next?

ANSWERS IN PRACTICE
Beth Santmyre-Rosenberger, MD, PhD, offers advice on how to expand the cosmetic side of a practice.

BALANCE IN PRACTICE
Victoria Williams, MD, shares how self-confidence (and sun protection) can impact people with albinism.

FROM THE PRESIDENT
Academy President George Hruza, MD, MBA, discusses the Academy’s new strategic plan.

IN YOUR CORNER
What is the Academy doing to protect patients from the dangers of indoor tanning?

ACADEMY UPDATE
2020 committee appointment applications are now open.

CLASSIFIEDS

FACTS AT YOUR FINGERTIPS
What are the cost-savings associated with inpatient dermatology? Flip to the back to find out.
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Do you offer your office staff paid vacation, and if so, how much?

“We do offer paid vacation. New hires get approximately two weeks paid vacation, and up to six weeks for senior employees.”
— Jamie Hopkins, director of practice operations, the Skin Surgery Center, Winston-Salem, N.C.

“On average, most dermatology clinics start with two weeks of PTO for the first two years of employment, three weeks for years three through five of employment, and four weeks after five years of employment. Some clinics offer additional weeks of PTO for employees that reach significant terms of service such as 15 to 20 years of employment.”
— Tony Davis, executive director, Dermatology Specialists, Edina, Minn.

“30 days.”
— Husain Juma, MD, Manama, Bahrain

“Yes, our office offers paid time off — sick, personal, and vacation all rolled into one. PTO is earned based on years of service: 0-4 years (up to 128 hours per year), 5-9 years (up to 169 hours per year), 10+ years (up to 208 hours per year). Non-exempt employees accrue time per hour worked, whereas exempt employees earn a flat rate per pay period. Up to 40 hours can be rolled over into a new calendar year. Physicians and mid-levels earn an additional one to two weeks of CME time.”
— Jessica Pape, practice administrator, Chicago Cosmetic Surgery and Dermatology, Chicago

“We use ‘Paid Time Off’ instead of separate vacation and sick time, which has significantly reduced unexpected absences. Full-time staff get 16 days per year, with an additional day added after every five years of service, up to a maximum of 21 days.”
— Robin Sigismondi, CMPE, practice administrator, Central Dermatology Center, Chapel Hill, N.C.

Next month’s question

Dermatology World’s Water Cooler shares responses from readers on the question: Does your institution or practice provide child care?
How do I claim CME credits from the Annual Meeting?

A

Your CME credits are just a few clicks away! To claim AAD meeting credits:

1. Visit www.aad.org/evals, or select the CME/Evals icon on the AAD meeting app. If you do not have your registration code, email aadcmce@aad.org.

2. To begin claiming credit, select which meeting you attended from the dropdown menu (e.g., “2019 AAD Annual Meeting”) and enter your registration code and last name.

3. Search for sessions you attended and click add button. Then click submit and complete the session evaluation.

4. Repeat Step 3 until all sessions have been added. A record of all added sessions can be found next to the star icon at the top of the page. If you make a mistake, you can always click remove to get rid of a session.

5. Click review and confirm next to the star icon at the top of the page. Check and confirm that all sessions you wish to claim credit for are listed and the credit claimed for each session is correct.

6. Click finalize record.

7. After you click submit, the system will automatically generate a PDF of your CME Certificate of Participation.

8. Your CME credits will be reflected on your member transcript 2-3 weeks after you finalize your record in the Online Learning Center.
What’s hot?

In this monthly column, members of the Dermatology World Editorial Advisory Workgroup identify exciting news from across the specialty.

**Rosalie Elenitsas, MD**

A BRCA1-associated protein (BAP1) inactivated melanocytic lesion has also been termed “BAPoma.” The initial description of these lesions included a clinical presentation resembling a dermal nevus and histopathology of a “combined nevus,” displaying a mixture of small nevus cells and large epithelioid/spitzoid cells, both associated with a lymphocytic infiltrate. The cells show loss of immunohistochemical staining with BAP1. In a recent study of 102 such lesions, the mean age of onset of these lesions was 30 years (*J Am Acad Dermatol*. 2018; 79:525-34). Patients with BAPomas may have germline BAP1 mutations and may be part of an autosomal dominant syndrome that is associated with increased risk of uveal melanoma, cutaneous melanoma, renal cell carcinoma, mesothelioma, meningioma, lung adenocarcinoma, and nonmelanoma skin cancer. At this point, indications for germline testing are not clear, but they should be considered in all these patients, especially if there is a personal or family history of BAP1-associated tumors (excluding nonmelanoma skin cancer). Identification of this population of patients is important, as BAPomas are detected earlier in life than the more life-threatening tumors such as uveal melanoma, mesothelioma, and renal cell carcinoma, which generally present in the fifth and sixth decades. Enhanced cancer screening protocols may benefit this population of patients.

**Mallory Abate, MD**

Having trouble managing your patients with burning mouth syndrome? In the February edition of *Dialogues in Dermatology*, Dr. Roy S. Rogers III, professor at the Mayo Clinic in Scottsdale, Arizona, offers some excellent tips on how to approach these patients, as well as his workup and management pearls. Burning mouth syndrome most commonly occurs in women, middle-aged and beyond, and is often multifactorial in etiology. Dr. Rogers first recommends having the patient see the dentist to optimize dental health and rule out any dental trauma and ill-fitting hardware like dentures. Next, he recommends checking basic lab work for things like anemia, nutritional deficiencies, and diabetes. For treatment, he often starts with low-dose amitriptyline and titrates up to 30mg over several months, reminding us that all treatments with burning mouth syndrome take 12 weeks to note improvement. Other treatments include alpha lipoic acid and sublingual clonazepam. For all the details on this challenging disorder, check out the full interview at *Dialogues in Dermatology*. 

**Dialogues in Dermatology**

Cases of primary and secondary (P&S) syphilis in the United States more than quintupled from 1999 (N = 5,979) to 2017 (N = 30,644), with men who have sex with men (MSM) disproportionately affected. However, a recent CDC report documents an alarming increase in syphilis among heterosexuals associated with use of methamphetamine, injection drugs, and heroin [www.cdc.gov/mmwr/volumes/68/wr/mm6806a4.htm](http://www.cdc.gov/mmwr/volumes/68/wr/mm6806a4.htm).

The CDC report analyzed national disease surveillance data, including behavioral risk factors of persons diagnosed with P&S syphilis, from 2013 to 2017. During those years, P&S syphilis rates among women and men increased 156% and 66%, respectively. Increases in drug-related behaviors, however, occurred only among women and men who have sex with women (MSW). Reported methamphetamine use more than doubled from 2013 to 2017 among women (from 6.2% to 16.6%) and MSW (from 5% to 13.3%). Similar increases occurred with injection drug use, heroin use, and having sex with a person who injects drugs. Drug-related behaviors were more common in the West and less common in the Northeast.

Heterosexual transmission of syphilis has previously been linked to drug use (crack cocaine in the late 1980s and early 1990s). Drug use is associated with sexual behaviors that increase risk for sexually transmitted diseases and with decreased access to health care.

From a public health perspective, CDC recommends integrating substance abuse and STD programs. In the meantime, dermatologists should be aware of evolving trends in syphilis epidemiology and be vigilant for increases in syphilis among heterosexuals.

I love this study [J Am Acad Dermatol. 79(2): 360-61], since it validates what I have been doing for years. In this prospective, randomized study, the authors compared elliptical excision to punch incision in 40 patients with truncal 1-3 cm epidermal inclusion cysts [aka follicular cyst, infundibular type]. The primary objective was to compare the two techniques on the basis of recurrence over 16 months. The secondary objectives were to compare scar length, procedure time, postoperative complications, patient satisfaction, and skin-specific quality of life. **Compared with elliptical excision, punch incision significantly reduced scar length with no significant difference in recurrence rates.** Punch incision has similar rates of postoperative complications and skin-specific quality of life improvements as those of elliptical excision. The authors conclude that punch incision is an effective method to remove epidermal inclusion cysts. The authors do not mention the size of the punch instrument. I most often use 8 mm and 10 mm punches to remove large cysts on the trunk.
Trouble getting off-label meds? Flawed compendia are causing coverage denials for dermatologic conditions.

A group of researchers reviewed two compendia used to make Medicare Part D coverage determinations for off-label prescribing in *JAMA Dermatology*, and found the compendia “incomplete, outdated, idiosyncratic, and unpredictable” for some chronic dermatologic conditions (doi:10.1001/jamadermatol.2018.5052).

When making coverage determinations for off-label prescribing, Medicare Part D recognizes two compendia: the American Hospital Formulary Service (AHFS) Drug Information and the DRUGDEX Information System. Deficiencies in the accuracy and completeness of these compendia could result in coverage denials for necessary, effective, evidence-based treatments leading to worse outcomes for patients. Off-label use is common in dermatology for both common and rare skin conditions. Evidence and FDA approvals for rare or refractory skin diseases are limited.

To assess the magnitude of the problem, Barbieri and his colleagues evaluated a list of 238 accepted treatments for 22 chronic, noninfectious, nonepidermal dermatologic conditions that had at least four systemic therapies, including one considered first-line, but many not approved by the FDA. Only 73 treatments were listed in either compendium. Additionally, the literature used was often based on decades-old sources from the early Reagan era of 1984.

Researchers found the compendia disagreed with each other almost a quarter of the time, which suggests the approach used to develop them is incomplete and inconsistent. Additionally, more than two-thirds of the medications evaluated were not included in these compendia, including half of the medications with the highest evidence grade (double-blind clinical trial).

The researchers recommend new policies be put in place to better serve patients with rare diseases and diseases with few FDA-approved therapies. These policies should aim to reduce reliance on the compendia so that patients can access much-needed treatments.

The AADA’s Drug Pricing Task Force plans to submit a letter to CMS highlighting several cases of this coverage issue with potential recommendations. If you have experienced adverse coverage determinations due to the compendia, please contact ajohn@aad.org.

When prescribing isotretinoin to adolescents, a common concern among patients and parents is the risk of depression or suicidal behavior with the use of this medication. If patients and parents were not already aware of this association, they are after signing the standard iPLEDGE consent form, which specifically comments on this risk. The first report of depressive symptoms with isotretinoin use was in 1983, and since then several studies have tried to elucidate the real relationship with various results. Huang, et al, in their article “Isotretinoin treatment for acne and risk of depression: A systematic review and meta-analysis,” sought to clarify this relationship by collating 31 previous studies on the matter. Their conclusion was that depression scores were no different for acne patients treated with isotretinoin versus alternative treatments (*J Am Acad Dermatol*. 2017 Jun;76(6):1068-1076.e9). In addition, the overall prevalence of depression decreased in patients treated with isotretinoin which indicates a protective effect. As dermatologists, we understand better than anyone the psychological impact that acne has on our patients, especially adolescents. To find that the presence of depression is more likely due to the acne itself instead of the treatment seems reasonable, as does the apparent protective effect of isotretinoin which we see when our acne patients respond to this medication. Although there were no randomized clinical trials in this analysis, it should prove useful in providing more context to our patients. *dw*
Increasing access to treatments through PBM transparency

STATE NEWS ROUNDUP

BY VICTORIA PASKO, MANAGER, STATE POLICY

The AADA recognizes the need for a comprehensive solution across the drug supply chain to preserve access to treatments and address rising drug costs. To preserve patient access, the AADA supports regulation and transparency of pharmacy benefit managers (PBM) — intermediaries contracted by payers to manage prescription drug plans on behalf of beneficiaries. They gained attention in 2017 and 2018 when several states passed legislation to prohibit pharmacist “gag orders” — provisions in contracts between a PBM and pharmacy that prohibit pharmacists from informing patients about less costly payment options or prescription drug alternatives. In October 2018, President Trump signed legislation to apply this concept to all federally regulated plans. The spotlight on PBMs continues to intensify in 2019 as nearly 70 bills have been introduced across the nation to establish oversight of these largely unregulated entities.

Requiring transparency and regulation of PBMs is an essential component to an all-of-the-above solution to preserving access to treatments.

State: Hawaii
Bill #: SB 1401
Summary: Prohibits PBMs from engaging in self-serving business practices (penalizing, requiring, or providing financial incentives, including variations in premiums, deductibles, copayments, or coinsurance, to covered persons as incentives to use a specific retail pharmacy, specific mail service pharmacy, or other network pharmacy provider in which a PBM has an ownership interest or that has an ownership interest in a PBM). The bill increases pharmacy benefit manager reporting requirements to the insurance commissioner.
Status: Passed House and one committee in the Senate

State: Iowa
Bill #: HF 489 and SF 347
Summary: Requires PBMs to submit an annual report to the insurance commissioner that provides information on prescription drug prices and rebates received by the PBM, including the prior calendar year and encompassing prescription drug benefit provided to covered persons of each health carrier. The commissioner would be required to make the information provided by PBMs available on a public website. Further, formularies would be required to be published on a website accessible to the public.
Status: Passed committees in each chamber

State: Minnesota
Bill #: HF 728 and SF 278
Summary: Requires PBMs to be licensed by the Board of Pharmacy under a new chapter of law in order to operate in Minnesota, establishes requirements for PBMs related to fiduciary and other duties, network adequacy, transparency, and ownership interests.
Status: Referred to the Committee on Government Operations
Action: AADA submitted a letter of support for HF 728.

State: Montana
Bill #: HB 344
Summary: PBMs operating in the state would be...
required to submit to the insurance commissioner a transparency report containing the aggregate amount of all rebates and fees that the pharmacy benefit manager received from all pharmaceutical manufacturers for all health insurance issuers and for each health benefit plan in the state.

**Status:** Passed House; Senate Committee on Business, Labor, and Economic Affairs

**State:** New York

**Bill #:** A 2970 and S 1705

**Summary:** Provides that PBMs must exercise good faith and fair dealing in the performance of contractual obligations to covered entities, and shall perform its duties with care, skill, prudence, diligence, and professionalism. PBMs must notify covered entities in writing of any activity, policy, practice, ownership interest, or affiliation of the PBM that presents a conflict of interest that interferes with the requirements to exercise good faith and fair dealing. PBMs must also report the wholesale acquisition cost for each drug on its formulary, the total number of prescriptions that were dispensed, the amount of rebates, discounts, and price concessions that the pharmacy benefit manager received for each drug on its formulary, and the nature, type, and amount of all other payments that the PBM receives from a manufacturer in connection with a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other function.

**Status:** Referred to Assembly and Senate Committees on Insurance

**State:** Ohio

**Bill #:** SB 14

**Summary:** Prohibits health plan issuers, PBMs, or other administrators from requiring cost-sharing in an amount — or direct a pharmacy to collect cost-sharing in an amount — greater than the amount an individual would pay for the drug if the drug were purchased without coverage under a health benefit plan.

**Status:** Referred to Senate Committee on Insurance and Financial Institutions. 

Academy launches new public grassroots advocacy action center

FEDERAL NEWS ROUNDUP

BY VICTORIA HOUGHTON, MANAGING EDITOR

Dermatology World breaks down the latest highlights of AADA advocacy activities at the federal legislative and regulatory level.

The advocacy arm of the Academy, the American Academy of Dermatology Association (AADA) provides a voice to dermatologists, ensuring that public policies address the ever-changing needs of practices and patient care. The AADA provides members with valuable resources and tools to adapt to the shifting health care landscape while contributing to policies that protect the quality of, and access to dermatologic care.

Not sure which topics are important to the specialty right now? Review the AADA’s top advocacy priorities at www.aad.org/advocacy/advocacy-priorities.

New public grassroots advocacy action center

The AADA has launched a new public-facing grassroots advocacy action center, where Academy members, physicians from other specialties, members of the public, and patients can take action on issues that impact dermatology practices and patients. During the launch, visitors to the site can ask their representatives to advocate for skin cancer awareness by joining the Congressional Skin Cancer Caucus. The site allows users to plug in their information and send a letter directly to their member of Congress and senators. Check out the new Grassroots Action Center at www.aad.org/advocacy/action-center/grassroots-action.

Become an advocacy insider

Want weekly updates on what the AADA is doing to advocate for you? Subscribe to the ‘Advocacy’ section of the Academy’s DW Academy Insider e-newsletter. Visit www.aad.org/account/communication and select ‘Advocacy’ under Dermatology World Academy Insider.
Drug pricing and patient access to treatment

The AADA advocates for patient access to affordable care and drug price transparency. Recently, the AADA:

- Sent letters to members of the House and Senate in support of bipartisan legislation that would ensure coverage for children born with congenital anomalies or birth defects. S 560/HR 1379, the Ensuring Lasting Smiles Act, will address the issue of insurance denials for procedures that functionally repair or restore any body part that is medically necessary to achieve normal body functioning or appearance.

- Issued a letter of support for HR 985, the FAST Generics Act, which would address an aspect in the Risk Evaluation and Mitigation Strategies (REMS) program that some brand-name pharmaceutical companies have used to avoid sharing samples of drugs with generic manufacturers that can produce more cost-effective drugs. Under this bill, generic manufacturers would first seek authorization from the U.S. Department of Health and Human Services before submitting a request and authorization to a brand manufacturer to secure samples of their drug to conduct equivalency testing. HR 985 would provide injunctive relief to generic manufacturers and allow them to seek damages from manufacturers that have improperly denied them access to product samples. dw
Inpatient consultative dermatology: Where are we now?

BY KATHRYN SCHWARZENBERGER, MD

In this month’s Acta Eruditorum column, Physician Editor Kathryn Schwarzenberger, MD, talks with Lauren Madigan, MD, and Lindy Fox, MD, about their recent JAAD article, “Inpatient consultative dermatology: Where are we now? Assessing the value and evolution of this sub-specialty over the past decade.”

Dr. Schwarzenberger: Thank you for your informative article about the status of inpatient dermatology consultation and for the excellent work all of you are doing. Some of us are old enough to remember inpatient dermatology units. What happened to them, anyway? For those who may not be familiar with the concept, can you explain what a dermatology hospitalist is and what he or she does?

Drs. Madigan and Fox: As you mentioned, inpatient dermatology units were not uncommon prior to 1985 and are now exceedingly rare. While the reasons behind this change are multifactorial, one of the most significant contributors was the adoption of the diagnosis-related group (DRG) system in 1983. This drastically changed health care financing and metrics for hospitalization — including end points. Time constraints, structured outpatient practices, and often cumbersome inpatient electronic medical records also made it increasingly challenging for outpatient clinicians to care for these complex patients. A “dermatology hospitalist” is a committed individual, or group, that addresses this need at an institution. They are providers uniquely adept at delivering high-level care to hospitalized patients through their expertise in the acute management of severe skin disease, increasingly varied therapeutics, and comorbid disorders. They are dedicated to bettering care for this subgroup of patients and promoting education within the larger health care system. Many are also involved in research to improve how care is delivered to this subset of patients.

Dr. Schwarzenberger: How big is the burden of skin disease in the inpatient setting and what conditions would you say you most frequently see? Is there any disease or group of diseases you feel we can particularly impact?

Drs. Madigan and Fox: While there is certainly a need for dedicated providers to manage dermatology patients requiring escalation of care, a greater number of consults come from the general medical population. In a recent publication, it was estimated that one in eight hospitalized adults are diagnosed with skin disease, either as a primary or secondary disorder (J Am Acad Dermatol. 2019;80(2):425-432). Data like this highlight the high burden of cutaneous disease among inpatients, a need which was previously underrecognized. Taken in aggregate, the most common final diagnoses rendered by dermatology hospitalists fall within five general categories: Drug eruptions, cutaneous infections, chronic dermatoses (including psoriasis and eczema), contact dermatitis, and vascular disorders.

Dermatology consultation has a dramatic impact on patient care — as demonstrated by the fact that treatment is changed in 58-82% of consults. This impact is even greater for complex cutaneous conditions where expertise in management is essential. This is not to say, however, that more common conditions cannot benefit from early evaluation. Investigations surrounding cellulitis misdiagnosis and management have estimated that dermatology consultation could prevent hundreds of millions in avoidable health care spending annually.

Facts at your fingertips

Flip to Facts at Your Fingertips in the back of this issue of DW to learn more about the cost-savings associated with inpatient dermatology.
**Dr. Schwarzenberger:** How does your involvement impact the care of these inpatients with dermatologic disorders?

**Drs. Madigan and Fox:** The importance of expertise cannot be understated. The most common reason for consultation is often ill-defined (“skin lesions,” “rash,” “unknown”). Thus, dermatology consultants not only impact management but are also necessary to help formulate an appropriate morphology-based differential diagnosis. As noted, the rate of concordance between primary teams and dermatology consultants is very low, resulting in a significant opportunity for treatment change. Studies have also demonstrated reductions in adjusted length of stay and readmission rates for patients with inflammatory skin disease who were seen by dermatologists during their hospitalization. Finally, data now exist supporting a significant financial cost to patients, payers, and the larger health care system when dermatology evaluation is lacking.

**Dr. Schwarzenberger:** If a dermatologist doesn’t provide this care, who does?

**Drs. Madigan and Fox:** When dermatology consultants are not available, the responsibility of care falls to the primary admitting service (i.e., internal medicine, surgery, oncology, etc.). While these providers aim to provide high-level care, general medical training in the recognition and management of uncommon and severe skin disorders is deficient. As a result, there is concern that a lack of dermatologists might lead to the inappropriate management of patients with cutaneous disease.

**Dr. Schwarzenberger:** If you had a crystal ball, what would you envision for the future of inpatient dermatology?

**Drs. Madigan and Fox:** The field of inpatient dermatology is still in its infancy. As mentioned above, we are gathering manpower, and data now demonstrate the value of inpatient dermatology to the care of hospitalized patients with skin disease. However, most established inpatient dermatologists are in academic centers. Ideally, the future would include active inpatient dermatology expertise being delivered as routine in community hospitals and areas that have traditionally had much less access to inpatient dermatologic care. Data would continue to emerge regarding the value added of having inpatient dermatologists. Evidence-based guidelines to evaluate and treat the rare, but severe, diseases we see would be developed. We would also continue to develop post-graduate training programs for those interested in pursuing a career in inpatient dermatology. We still have a lot of work to do and can’t wait to see where it all goes.
You suspect a colleague is committing health care fraud. What next?

BY CHRISTINA L. KRYINSKI, JD, AND ROBERT M. PORTMAN, JD

Fraudulent billing practices cause tens of billions of dollars in financial losses each year for both federal health care programs and private insurance plans. In addition to these financial losses — and for government programs, a misuse of taxpayer funds — health care fraud undermines trust in the health care system, increases overall health care costs, and can be detrimental to patient care. Under the AAD Code of Ethics, it is unethical for dermatologists to engage in fraudulent billing or coding.

What can, or should, you do if you suspect that a colleague might be submitting fraudulent claims? This article covers how to report suspected fraud — with situations in which physicians are required to report fraudulent conduct by other physicians — and protections for whistleblowers.

What kind of conduct constitutes fraudulent billing?

Common types of fraud include billing for services that were never rendered, billing for higher cost services than were actually performed (otherwise known as “upcoding”), and misrepresenting non-covered services for the purposes of obtaining payment. The AAD Code of Ethics provides several examples of potentially fraudulent billing activities. For example, it is unethical for dermatologists to bill individually for services that are properly considered a part of a “global service” package (i.e., services that are a necessary part of a surgical procedure). It is also unethical for dermatologists to submit billing codes that reflect higher levels of service or complexity than those that were actually required, or to charge for services not provided.

Am I required to report Medicare or Medicaid fraud under federal law?

It is illegal for a physician to submit claims for payment to Medicare or Medicaid that the physician knows or should know are false or fraudulent. Federal law does not explicitly require physicians to report suspected Medicare or Medicaid fraud committed by other physicians, but physicians are encouraged to report suspected fraudulent conduct to the U.S. Department of Health and Human Services Office of Inspector General (OIG). The OIG accepts complaints from all sources about potential fraud, waste, abuse, and mismanagement in federal health care programs through their tip hotline at 1-800-HHS-TIPS or online at https://oig.hhs.gov/fraud/report-fraud/index.asp. Medicaid fraud should also be reported to your state’s Medicaid agency and/or Medical Fraud Control Unit.

The False Claims Act (31 U.S.C. §§ 3729-33) makes individuals who submit false or fraudulent claims to the government liable for between $5,000 and $10,000 per claim. The False Claims Act contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. These lawsuits are referred to as “qui tam” actions. A
Take the pledge!

Are you an ethical dermatologist? Let the world know. Take the pledge and learn more at www.aad.org/form/ethicspledge.

whistleblower can potentially receive between 15% and 25% of the money recovered by the government in the lawsuit. You should consult an attorney if you are thinking about filing a qui tam action.

Am I required to report suspected fraud by a colleague under state law?
Many states require physicians to report fraud committed by other physicians. However, these requirements may only apply when there has been a conviction or other finding of fraud. For example, in New York, physicians, hospital administrators, and health maintenance organizations have a legal obligation to report fraudulent practices to the state board for professional medical conduct, regardless of whether there has been judicial determination of unlawful activity. In Washington, health care providers are required to report fraud committed by other providers when there is a conviction, determination, or other finding that the provider has committed an act that constitutes “unprofessional conduct.” As discussed below, these state laws generally provide for exemptions from reporting requirements where the reporting provider is a member of a peer review organization conducting an investigation.

Am I required to report fraud under the ethics rules?
Under the AAD Code of Ethics, if a dermatologist reasonably believes that a physician or other health care provider has been involved in any unethical or illegal activity, the dermatologist is encouraged to talk to the physician or other provider to try to stop the activity and/or identify the provider to a duly-constituted peer review authority or the appropriate regulatory agency. The reporting dermatologist should cooperate with peer review and other authorities in their efforts to prevent the continuation of unethical or illegal conduct. Members of the AAD are also expected to report knowledge of violations of the AAD Code of Ethics through a confidential written communication to AAD’s Secretary-Treasurer or Executive Director. The information will then be further investigated and processed according to the provisions of the AAD Bylaws and Administrative Regulations. Finally, the AMA Code of Ethics states that grievances against another medical professional who you believe is acting unethically should be directed to your state medical licensing board. The AMA Code of Ethics is incorporated by reference in the AAD Code of Ethics.

What can I do if I am retaliated against for reporting a colleague’s fraudulent behavior?
The OIG accepts and investigates complaints from whistleblowers who believe they have been retaliated against by their employers because they reported suspected wrongdoing. Read more at https://tips.oig.hhs.gov/report-whistleblower-retaliation. In addition, under the False Claims Act, a whistleblower who has been retaliated against for trying to stop illegal conduct can seek remedies for the harm suffered as a result of the retaliation. Many state laws also protect whistleblowers. For example, under the Maryland Health Care Worker Whistleblower Protection Act, employers are prohibited from taking any “personnel action” against an employee as retaliation for disclosing or threatening to disclose information regarding conduct that the employee believes is illegal to a supervisor or supervisory board, for providing information or testifying before any public body conducting an investigation, hearing, or inquiry, or
for objecting or refusing to participate in practices that the whistleblower believes are illegal. Other states have similar whistleblower protection laws that allow physicians to bring claims for money damages against their employers.

What protections do I have if I report a colleague to a professional peer review body?
The Health Care Quality Improvement Act of 1986 (42 U.S.C. §§ 11101-52) (HCQIA) protects whistleblowers who provide information to a professional peer review body regarding the competence or professional conduct of a physician, unless the information is false, and the whistleblower knew that the information was false. Under the HCQIA, whistleblowers cannot be held liable for damages resulting from actions taken as a result of the information that they provided to the peer review body. The HCQIA also protects members, staff, and consultants of professional peer review bodies, as well as any other person who participates with or assists the body, from liability for actions taken by the body that meet the statutory standards for peer review.

Many states also have laws that seek to protect the integrity of peer review processes. For example, the Illinois Medical Studies Act protects information generated by peer review and hospital quality control committees as privileged. This means that information generated by these committees during their investigations generally cannot be used in litigation. In Washington, physicians participating in a professional review organization are exempt from the general requirement to report fraud committed by other health care providers referenced above during the investigative phase of a professional review organization’s activities, as long as the organization completes the investigation in a timely manner. dw

Legally Speaking clarification
In the January 2019 Legally Speaking, we wrote about the requirement that recipients of federal financial assistance take reasonable steps to make their services available to individuals with limited English proficiency. We noted in the article that while Medicaid, CHIP, or Medicare Part A payments are all considered “federal financial assistance,” Medicare Part B payments are not. While this is true, we want to make sure to note that most physicians do receive some kind of federal financial assistance other than Medicare Part B payments — for example, federal grant funds for community health centers, the National Health Service Corps, or NIH research grants. Physicians may also have contractual requirements with private insurers or Medicare Advantage plans to provide language-assistance services. Therefore, CMS indicates that almost all physicians are subject to the interpretation/translation rules. As noted in the article, state law may also require you to provide interpretation services and/or translate documents. View the original article at www.aad.org/dw/monthly/2019/january/language-assistance-services-for-non-english-speaking-patients.
Expanding your cosmetic services

BY VICTORIA HOUGHTON, MANAGING EDITOR

Dermatology World talks with Beth Santmyire-Rosenberger, MD, PhD, from Appalachian Spring Dermatology, PLLC, in Fairmont, West Virginia, about how to expand the cosmetic side of a practice.

Q DERMATOLOGY WORLD: Tell me about your practice — both medical and cosmetic — and what are your plans?
Dr. Rosenberger: I started a solo dermatology practice straight out of residency in 2005. We have always offered both medical and cosmetic services — about 25% cosmetic, 25% private pay, and the rest Medicare. Throughout the past two years I have been working to boost the cosmetic portion of my business. Many of the physicians’ offices in our area have been purchased by large hospital organizations. These large organizations have extreme bargaining power, and because of that, I have been anticipating the decline of the medical commercial portion of our practice.

Q What factors do physicians need to consider before offering or expanding cosmetic services?
Dr. Rosenberger: Patient demand. I recently purchased two CoolSculpting® machines because patients were asking me to start providing those services. In addition to patient demand, you need to consider your competition — many cosmetic procedures are being performed in medispas and by non-dermatologists, so it is important to consider the breadth of competition.

Q How should a physician get started and what is the natural progression in terms of which cosmetic services should be offered and when?

Dr. Rosenberger: Starting with botulinum toxin is often a normal first step. It can be performed with no additional office space. Within my first year of practice, I purchased an NdYAG, IPL, and a nbUVB light booth. I trained in Washington, D.C., where the technology was widely available, but when I opened my practice, no one owned a laser in my area. Even the university didn’t have standard technology. I felt I needed to have certain devices to practice modern medicine as I had been trained to do. It was a good differentiating factor for my practice.

Q What basic aspects of the practice will need to be addressed?
Dr. Rosenberger: Space. Most device-based cosmetic procedures require dedicated space and extra medical supplies to keep on hand. We have a room dedicated to CoolSculpting and a whole closet of CoolSculpting supplies.

Need help with prior authorizations? Coding? Teledermatology? Check out the Academy’s Practice Management Center at www.aad.org/practicecenter.
with a procedure, and if the physician is unable to handle the volume, then and only then, train your staff and delegate.

**Q. What are the regulatory considerations when offering cosmetic services?**

**Dr. Rosenberger:** In our state, a physician needs to be on site to supervise laser procedures. Physicians should check the laws in their state regarding the specific procedure you are adding to the practice. What licenses are required and what are the supervision requirements if delegating? Last year, we added facials to our cosmetic services. I checked extensively with the board of cosmetology, the medical board, and my malpractice company regarding who can perform facials and if an aesthetician license is required. In the end, I requested a response from all entities in writing that I had notified them of our intent.

**Q. In addition to space and staff, what are other costs that physicians should be aware of?**

**Dr. Rosenberger:** Major costs include the purchase and maintenance of equipment, facility square footage costs, and property taxes. Two major costs that can be overlooked are warranties and consumables. Many devices only come with a one-year warranty. Extending the warranty on a laser can easily cost $1,000 per month. Additionally, most devices now have significant consumable costs. Microneedling consumable supplies, for example, can cost between $75-100 per procedure.

**Q. How should a physician go about determining if the cost of providing cosmetic services is worth the investment?**

**Dr. Rosenberger:** First, consider the cost of using the machine, including warranty and consumables. Next, consider how much time it will take to perform the procedure. Knowing what your average appointment nets should allow a cost-for-time price for the service. One quick way to determine this is to divide gross collections by the total number of visits per year. That number will tell you how much you need to collect per appointment slot to make as much as you are currently making on other visit types.

Then, if a room is dedicated to a procedure, consider the cost of that square footage in lease costs: Lease

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**Beth Santmyire-Rosenberger, MD, PhD**, is the owner of Appalachian Spring Dermatology, PLLC, in Fairmont, West Virginia.
cost divided by square footage utilized = square foot cost. Square foot cost divided by the number of viable appointments that can occur in that space gives your per appointment space cost.

The revenue from the procedure needs to at least equal the cost of: Equipment and consumables + time + space allocation.

It all starts adding up very quickly. I would also consider the risk of a procedure and the amount of follow-up required. Each of those follow-ups cost an appointment slot.

Q What are some best practices for marketing cosmetic services?

Dr. Rosenberger: When I first started, phone book and newspaper ads were common. I also did talk radio, local TV — anything that was free. I mostly built my practice doing community events — skin cancer screenings, health fairs, bridal fairs, you name it. It is a great way to introduce yourself to a community. That was before I had kids!

The most important and effective marketing dollars are now spent marketing to current patients. In the entrepreneurial world, it is often called your “tribe.” Building your cosmetic tribe occurs every day as you build trust and provide great care with each patient. My practice is active on social media, mainly Facebook, because that fits my demographic, but also Instagram. Initially, I tried to do it myself, but I now have a virtual assistant who manages social media and most of my marketing.

I also have a blog and an email list of almost 3,000 people who receive a professional weekly email from the practice. I write an article on a new topic each week for the email, and it also includes little ads about procedures and other practice news. This has really served us well.

I also spend a lot of time on our website adding as much information as possible. It helps patients get a feel for me and my practice before they arrive for their appointment.

Q At the end of the day, what factors should physicians consider when evaluating whether adding cosmetic services is right for them?

Dr. Rosenberger: I feel that it is important for us as dermatologists to be the primary provider of cosmetic procedures in our community, as opposed to medispas and unqualified practitioners. There is the potential for financial gain; however, when it is all said and done, cosmetic procedures usually aren’t nearly as lucrative as it appears on the surface once all the costs are considered. Regardless, I don’t think anyone should do anything solely for financial gain — that is my personal conviction. Ultimately, I prioritize enjoying my work day and making patients smile. If you don’t love doing something, don’t do it. It won’t be worth it! dw

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Albinism awareness gets a makeover

BY EMILY MARGOSIAN, ASSISTANT EDITOR

Each month, Dermatology World addresses issues “in practice” for dermatologists. This month Dermatology World talks with Victoria Williams, MD, about how some self-confidence (and sun protection) can impact the lives of those living with albinism.

“People with albinism should be seen just like anyone else. They can be beauty queens; they can be models; they can be doctors; they can be anything they want to be.”

- Victoria Williams, MD

“What really struck me was that there were no dermatologists on the ground there,” recalls Victoria Williams, MD, assistant professor of clinical dermatology at the University of Pennsylvania, of her first visit to Botswana as a resident in 2014. Beyond the lack of established dermatologic care in the region — which was primarily composed of visiting residents — Dr. Williams was also profoundly impacted by the poor quality of life of patients with albinism. “These patients were basically being torn apart by skin cancer — just the worst sun damage I’ve ever seen,” she said. “Often they’re also nearly blind and don’t have access to glasses. It affected me greatly to see people having to live like this with a disease where all the comorbidities should be completely preventable.”

What was more heartbreaking, however, were the effects of the region’s extreme social stigmas regarding albinism. “What struck me the most was that these patients had such low self-esteem that they couldn’t even look me in the eye,” said Dr. Williams. “In Botswana, most of the general population still has absolutely no idea what albinism is. They think it’s a curse, that they’re not human, or if they touch them, they’re going to catch it. There are just so many misconceptions.”

Moved by the plight of these patients, Dr. Williams assumed a full-time position as a dermatologist in Botswana for two and a half years following residency. “I was employed through the Ministry of Health of Botswana, and fully integrated into the health care system like a truly local Botswana doctor,” she said. To address the immediate need for adequate sun protection, Dr. Williams launched a sunscreen program in the country in 2017 through the help of the AAD’s SkinCare in Developing Countries Grant. “People with albinism should be able to live a normal life if they’re given access to the right resources and medical care,” she said. “Botswana is a desert climate; it gets really strong sun and most people have to work outdoors. I researched access to bulk sunscreen and was able to find a supplier in South Africa. I started making trips down there and would package it myself to distribute to patients during clinic. Along with sunscreen, they would get counseling on albinism, counseling on sun protection, and a wide-brim hat.”

After tackling the issue of sun protection, Dr. Williams decided to go a step further to address the social stigmas faced by Africans with albinism. “I started working with the local albinism association, the Tshimologo Association for People Living with Albinism, and one of the things we did was organize the first celebration for International Albinism Awareness Day.

Want to get involved?

Dr. Williams welcomes questions about how dermatologists can assist with albinism awareness and future albinism events. Email Dr. Williams at tori22@gmail.com.

Want to get involved?
in Botswana,” she said. After a successful launch in 2017, the following year it was decided that in addition to an albinism awareness day, a Miss Beauty with Albinism Pageant would be launched to further increase public awareness of albinism and social inclusivity. “I’ve never seen such a transformation in people,” said Dr. Williams. “These men and women with albinism have gone through their whole lives just feeling like they are hideous and worth nothing, and the event basically gave them the chance to feel beautiful and be perceived by others as beautiful for the first time in their life.”

According to Dr. Williams, the first Miss Beauty with Albinism event was able to come together on a near-shoestring budget through the help and support of local businesses. “Different boutiques agreed to sponsor outfits, and the venue was provided by one of the local universities,” she said. “I also donated whatever I had in terms of makeup and nice clothes, and we just put it together with whatever we could.” However, for many participants, this Cinderella moment went far beyond just putting on a pretty dress. “Before the pageant, we did a little boot camp where we taught them how to walk with confidence, how to speak in public, how to present themselves to other people. To watch the process of these people going from the first day of boot camp to seeing them on stage — I’ve never seen such a transformation,” said Dr. Williams.

Now an annual event, the next Miss Beauty with Albinism Pageant will be held this May. “It’s just an amazing gift to be able to give to people, and to make the society aware that people with albinism should be seen like anyone else,” says Dr. Williams. “They can be beauty queens; they can be models; they can be doctors; they can be anything they want to be.”

Dr. Williams with pageant volunteers and participants.
In-office preparations

Where will dermatology land after USP publishes its updated Chapter 797 standards for sterile compounding?
For many years, dermatologists and their clinical staff have safely performed low-risk, low-volume in-office preparations for biopsies, skin cancer excisions, and other dermatologic procedures. Preparing medications in the clinical setting allows physicians to cater to the individual needs of patients. Since the New England fungal meningitis tragedy and the subsequent passage of the Drug Quality and Security Act (DQSA) in 2013, various federal and state policymakers and standard-setting organizations have increased oversight and regulation of medication preparation by not only pharmacists but also physicians. Congressional intent for the DQSA was presumably to regulate large-scale, high-risk compounding operations — but the unintended consequences of the regulations may jeopardize physicians’ ability to produce in-office preparations, and ultimately patient care. >>
In-office preparations

What is the USP?
The United States Pharmacopeial Convention (USP) is an independent, scientific, non-governmental body that sets public standards for identity, strength, quality, and purity of medicines. USP wields much power over compounding practices with its Chapter 797: Pharmaceutical Compounding – Sterile Preparations, contained in the United States Pharmacopeia and National Formulary (USP–NF) and published in the USP Compounding Compendium. In 2004, Chapter 797 was published as a legally enforceable standard.

USP standards are not law. However, specific standards are recognized in various provisions of the federal Food, Drug and Cosmetic Act (FDCA) and by state pharmacy boards. More recently, the DQSA clarified the FDA’s authority over compounding and USP is revising its sterile and non-sterile compounding standards.

While the safety and effectiveness of drugs are generally regulated at the federal level, states have jurisdiction over the practices of medicine and pharmacy. Nearly all states have laws, regulations, or policies specific to compounding, enforced primarily through pharmacy and health boards. “USP chapters only apply when a policymaker, like a state pharmacy board, adopts the chapter,” said Natasha Pattanshetti, JD, MPH, AADA’s manager of regulatory policy. Even if USP adopts new or revised standards, it doesn’t necessarily become law; it only applies when a policymaker in your jurisdiction adopts it, she said. It depends on the state whether the state pharmacy board has jurisdiction over physicians preparing medications. (See the sidebar to learn more about state oversight of in-office preparations.)

What does all this regulation mean for dermatologists? “As dermatologists, our fear is that standards on how we see patients and patient safety are being set by a group [pharmacists] that doesn’t see patients or participate in clinical practice,” said Lawrence Green, MD, chair of the Academy’s State Policy Committee.

A seat at the table
Allison Vidimos, MD, RPh, chairman of the department of dermatology and program director of the micrographic surgery and dermatologic oncology fellowship at the Cleveland Clinic, was nominated by the American College of Mohs Surgery to serve as an Expert Consultant to the USP’s Compounding Expert Committee in 2018. While obtaining an appointment to this committee was no easy feat, now that she has a seat at the table, she has seen just how critical and helpful it is to have physician consultants on board. An anesthesiologist (also a pharmacist), allergist, pulmonologist, and Dr. Vidimos serve as non-voting Expert Consultants to this USP committee.

“If there are not significant revisions [to Chapter 797], we will not be able to continue to conduct practices that we have safely done for many years in ways that help our patients and are cost-effective and an integral part of our practices.”

USP Chapter 797 revisions
Currently, USP is in the midst of revising Chapter 797, which was last updated in 2008, before the renewed regulatory focus on compounding. USP’s first draft proposal, published in 2015, received more than 8,000 public comments from 2,500 stakeholders; Academy members submitted nearly 900 letters to USP throughout the draft revision process. The overwhelming and energetic response to USP’s first revisions sent the Expert Committee back to the drawing table to work on a second round of revisions, which were published in 2018. The second round of revisions had minor improvements for the specialty, but would still impact most dermatology practices if further revisions are not made before the publication of the finalized chapter.

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Becoming a pharmacy...almost
The 2018 proposed USP standards are extremely onerous to physicians who conduct in-office preparations, said Murad Alam, MD, MBA, chair of the AADA Congressional Policy Committee and vice chair of dermatology at Northwestern’s...
Feinberg School of Medicine. Under certain circumstances, practicing physicians would be required to function as a mini-pharmacy with a laminar airflow system, an ISO Class 5 cleanroom, and other burdensome standards — a virtual impossibility for physicians, he noted. “Dermatologists want what’s safe for patients more than anyone, but for us this isn’t a question about safety,” said Seemal R. Desai, MD, a member of the FDA Pharmacy Compounding Advisory Committee (PCAC), chair of the AADA’s Compounding Workgroup, and a member of the Academy Board of Directors. “This is a question about blanket rules and policies that are being made for procedures that don’t pose a risk to patients.”

Dermatologists prepare buffered lidocaine syringes at the beginning of the day to facilitate patient access. “If there are not significant revisions [to Chapter 797], we will not be able to continue to conduct practices that we have safely done for many years in ways that help our patients and are cost-effective and an integral part of our practices,” said Dr. Alam.

**Urgent-use exemption**

Among the Chapter 797 proposed revisions, the issue that will have the most impact on dermatologists is the urgent-use exemption, which would allow clinicians to avoid the burdensome Chapter 797 requirements. “The proposed revisions say that in order to remain exempt from Chapter 797 standards, the compound sterile product must be prepared and administered within one hour; otherwise it must be discarded,” Pattanshetti said.

Not being able to maintain compounded medications for longer than one hour would disrupt clinic flow and patient care, Dr. Alam said. “The proposed new rules are so onerous and impossible to implement that it would result in patients losing access to medications.”

**Buffering lidocaine**

Most per-patient dilutions will likely fall within the proposed one-hour timeframe, such as diluting Kenalog (triamcinolone acetonide), said Dr. Desai at the Academy’s 2019 Annual Meeting session, ‘The Future of Dermatology: What Changes are Coming and How Can We Prepare?’

The issue that is mission-critical for dermatologists, however, will be the ability to buffer lidocaine with sodium bicarbonate with or without epinephrine. The current 797 revision being considered by the USP Compounding Expert Committee would allow use of buffered lidocaine for up to 5 cleanroom, and other burdensome standards — a virtual impossibility for physicians, he noted. “Dermatologists want what’s safe for patients more than anyone, but for us this isn’t a question about safety,” said Seemal R. Desai, MD, a member of the FDA Pharmacy Compounding Advisory Committee (PCAC), chair of the AADA’s Compounding Workgroup, and a member of the Academy Board of Directors. “This is a question about blanket rules and policies that are being made for procedures that don’t pose a risk to patients.”

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**State oversight**

Traditional compounders have been under state jurisdiction since 1997. According to a February 2018 report by the Pew Charitable Trusts and National Association of Boards of Pharmacy, in 2015, only 26 states required Chapter 797 or equivalent quality standards for sterile compounding. Currently, about 32 state boards of pharmacy require full compliance with USP’s Chapter 797 standards, according to Lisa Albany, JD, the AADA’s director of state policy. You also need to closely review the state board of pharmacy rules to determine if physicians are subject to their laws.

For example, the Ohio Board of Pharmacy requires many physicians who compound dangerous drugs to obtain a Terminal Distributor of Dangerous Drugs license.

“The state laws vary in which version of the chapter they follow as well as whether states will incorporate any updates,” she said. “We have been weighing in with a number of states explaining why they should refrain from adopting USP’s current standards. We’re in an area of uncertainty, and USP standards are not yet finalized,” Albany said. Despite this uncertainty, Albany believes it will be tough to convince states not to adopt a recognized standard. “There will be a continued push [for pharmacy boards] to adopt the final revisions of Chapter 797, as I think state boards may seek to adopt uniform standards.”

Because state pharmacy boards regulate the preparation and administration of drugs, in-office compounding by physicians falls with the realm of pharmacy regulation, Albany said. In 2005 the Virginia legislature carved out compounding in physician offices from the board of pharmacy, and placed the responsibility for oversight with the medical board. This was a positive move since the AADA wants state medical boards to view physician compounding as the practice of medicine, she said. “But in Virginia, even though inspections were under the jurisdiction of the medical board, they hired pharmacists to inspect physician offices. This was something we hadn’t seen before.”

In addition to seeking a preparation-specific exemption, the AADA Compounding Workgroup is also monitoring individual state legislative and regulatory activity, asking states to hold off on adopting or updating any standards until Chapter 797 and hopefully the preparation-specific exemption is finalized. The AADA is seeking to work with the rest of the house of medicine to monitor and respond to state policymaking affecting the practice of medicine.
In-office preparations

four hours after compounding. USP intends to publish the revised chapter by June 1.

“Dermatologists need the ability to prepare and mix lidocaine and buffer it with sodium bicarbonate for hundreds of skin procedures done weekly in the office—and it's what dermatologists have been doing very safely for decades. Ultimately, this leads to better patient outcomes and more patient comfort during the injection process. Without buffering, the injection becomes very painful and uncomfortable,” said Dr. Desai. “Here, we have a completely safe, tolerable, patient-friendly, and inexpensive way of mitigating pain,” added Dr. Alam. “I have operated on a lot of children — awake,” said Dr. Vidimos, “and one reason that I have been able to do that is because I use buffered lidocaine; it makes the injections hurt so much less. We’re fighting for this because we care about our patients. We want them to have timely access to safe and comfortable care.”

In addition to disrupting clinic flow, the issue of wastefulness is also of concern—particularly considering the ongoing shortages of lidocaine with and without epinephrine as well as sodium bicarbonate. For Dr. Green, who is a single private practice practitioner, he confirmed the wastefulness and inconvenience this proposal would cause. “I probably wouldn’t go through an entire bottle of lidocaine in one day — maybe half to three-quarters of a bottle of lidocaine for seeing a single doctor’s worth of patients. We cannot be mixing new bottles of lidocaine with sodium bicarbonate in such a short time frame. Think of how much lidocaine would be wasted,” he said.

Dr. Vidimos has presented evidence to the USP that buffered lidocaine may protect against infection in comment letters to USP. “There are a number of articles about the antibacterial properties of lidocaine in the medical, dental, and veterinary medicine literature. When you add sodium bicarbonate to lidocaine, it has been shown to increase the bacteriocidal properties of the lidocaine,” said Dr. Vidimos.

We’re really all focused on the same things—developing solutions that will keep our patients safe and provide them with the best care.”

Federal regulation

Under the DQSA, no drugs may be compounded under insanitary conditions, Pattanshetti said. In 2016, the FDA issued a draft guidance on insanitary conditions, and then revised this draft guidance at the end of 2018. The FDA’s 2016 draft guidance proposed to require physicians’ offices to maintain a certified International Organization for Standardization (ISO) Class 5 area or cleanroom with a buffer area, HEPA filters, and conduct routine sampling of airborne particulates and surface areas, among other requirements.

The advocacy efforts of the AADA, along with others throughout the house of medicine, made significant gains in reaching the FDA. In January 2018, the FDA published its 2018 Compounding Policy Priorities Plan in which it recognized the hardships faced by dermatologists and others—a notable win for the specialty:

This [revised] guidance will address concerns raised by some providers who compound small quantities of drugs in their offices for patient use, and as part of their routine clinical practice. This came up in the setting of certain dermatological procedures, for example. The FDA plans to better define the circumstances under which we believe drugs are being mixed and applied in a manner that creates negligible patient risk, and therefore wouldn’t be subject to the same compliance policy.

In the September 2018, FDA guidance revision, Insanitary conditions at compounding facilities, a footnote further clarifies its intent: “FDA generally does not intend to take action under section 501(a)(2)(A) against a physician who is compounding or repackaging a drug product, or who is mixing, diluting, or repackaging a biological product, provided that such activities occur in the physician’s office

The AADA together with sister societies ACMS, ASDSA, and ASMS through the Compounding Workgroup, is pushing to lengthen the exemption to 12 hours for the final revision, said Pattanshetti. Dr. Desai noted that this would essentially allow most dermatologists to get through a regular working day, and even with a longer day, 12 hours would suffice. “We are still fighting the battle,” he said.

“We are also advocating for a specific exemption for buffered lidocaine, separate from the urgent-use exemption, so that physicians are able to prepare it at the beginning of the day and discard whatever remains at the end of the day,” said Pattanshetti. Dr. Alam believes the USP standards are well intentioned. However, he sees it as, “overstepping into the practice of medicine and attempting to solve a problem—namely, the safety of mixed drugs in a physician’s office—that simply doesn’t exist.”

Read the AADA’s most recent comment letter to the USP in response to its 2018 proposed Chapter 797 revisions at www.aad.org/usp-comment-letter.
During the December meeting, it was made clear that in response to concerns of microbial contamination, AADA and its members have been doing and will continue to do: “— and that is exactly what the AADA and its members have on us in dermatology to do the parts that we can do,” he said. “We’re really all focused on the same things — developing solutions that will keep our patients safe and provide them with the best care.”

From this meeting, Dr. Alam believes there is a hopeful path forward for dermatologists, although final decisions will not be revealed until the June publication. “The onus is on us in dermatology to do the parts that we can do,” he said — and that is exactly what the AADA and its members have been doing and will continue to do:

1. **Antimicrobial testing**
   In response to concerns of microbial contamination, the USP has agreed to perform USP <512> antimicrobial testing on buffered lidocaine prepared in a clean segregated compounding area (non-ISO 5) to duplicate in-office preparation. This will be done in a compounding facility and certified testing lab. The study entails taking the mixed preserved lidocaine with epinephrine and sodium bicarbonate and systematically injecting different pathogens into it, and then seeing how rapidly the pathogens grow. “If the growth rate is very slow, then you can store it for longer, and if the rate of growth is faster, it can be stored for less time,” Dr. Alam said. If the initial antimicrobial testing is favorable, all of the Academy’s efforts will likely lead to a USP monograph for buffered lidocaine,” said Dr. Vidimos. The monograph would not be timed with the publication of Chapter 797 revisions, but if published, it would supersede Chapter 797 standards, allowing dermatologists to treat their patients in a safe and effective way.

2. **Join the USP**
   Historically, physicians have not taken part on USP Expert Committees as voting members. These committees set USP’s standards. “We have hardly any representation on these state pharmacy boards, which apparently now have the ability to reach into doctors’ offices and modify and restrict practices, noted Dr. Alam. The Academy and its sister organizations have recently gained approval to apply for membership in USP. “Once you’re on the inside, you’re perceived as one of them, not as an external agent who’s trying to modify what they’re trying to do,” he said.

3. **Draft a position statement**
   During the December meeting, it was made clear that regulatory authorities wanted “guidelines from our societies showing that we had a useful and customary way of mixing things in a sterile and safe manner,” said Dr. Alam. “We developed a position statement on how lidocaine should be buffered and prepared in-office. This statement will allow us to have more standardized methods of doing this and will demonstrate to USP and FDA what we’re doing,” Dr. Desai said. View the position statement on ‘Safe In-Office Preparation of Buffered Lidocaine as a Local Anesthetic’ at www.aad.org/practicecenter/compounding. A work in progress
   “Part of what we are learning in this regulatory area is that sometimes there are clearly things you are forbidden to do, and there are some things you are clearly allowed to do. Then there’s a large gray area between them,” Dr. Alam said. “We have been trying to enlarge that gray area. We are forestalling the absolute prohibition that would make it impossible for us to do something. Within this gray area, now we have some wiggle room to try and come up with some long-term solutions.” These changes, however, occur slowly, and you can’t get them done exactly the way you want in exactly the time frame you want, he said.

Despite the difficulties and challenges in advocating to various regulatory authorities, Dr. Alam believes it’s been an important lesson for the specialty. “It’s been a really useful exercise for our whole profession in terms of increasing our interaction with various regulatory authorities. The AADA has spearheaded the effort, but other associations and organizations in medicine have participated intensely as well, and it’s helped unify our specialty,” he said. “In addition, we’ve learned a lot more about key stakeholder groups that we have been less knowledgeable about in the past, which will serve us well moving forward.” 

Can you compound or prescribe it?
Answer a few questions to determine whether the type of compounding you are performing is in compliance with FDA regulations, and how to access a drug product if it cannot be compounded in-office at www.aad.org/practicecenter/compounding.
Entering a golden age of toxins

As more drugs and treatment indications receive FDA clearance, how do the new arrivals compare to industry heavyweights?
It all started with some bad sausage. Despite making a successful clinical and commercial debut on the consumer market nearly two decades ago, botulinum toxin owes its discovery to some less-than-savory roots. During the Napoleonic Wars, German physician Justinus Kerner observed a mass food-poisoning following the consumption of blood sausage, during which he was able to accurately identify the toxin as the causative agent. Although unable to isolate the toxin in its pure form during his lifetime, Kerner nevertheless served as the inspiration for its etymology — “botulus” being the Latin word for sausage.

In the two centuries since, what was once a killer case of food poisoning has become an increasingly popular therapeutic and cosmetic treatment. According to the American Society for Dermatologic Surgery, public consumption nearly doubled between 2013 and 2017, with the number of procedures involving neurotoxin injections jumping from 1.2 to 2.1 million in less than five years. “This has truly changed the face of aesthetic medicine. I think we are really just beginning to touch on the different indications available for toxins,” said Seth Matarasso, MD, clinical professor of dermatology at University of California, San Francisco School of Medicine.

This month, Dermatology World consults with toxin experts to highlight exciting new developments in the field, including:

• New drugs in the pipeline
• New cosmetic and therapeutic indications
• The legacy of botulinum toxin — has it sustained safety and performance?
• How patients and physicians can steer clear of counterfeit products >>
Entering a golden age of toxins

What’s new
After years of market dominance by Botox® manufacturer Allergan, 2019 is so far shaping up to be an exciting year for competing alternatives. In February, toxin manufacturer Evolus received FDA clearance for its new product “Jeuveau.” While reportedly similar to Allergan’s Botox in terms of performance, the newcomer may offer patients a better option in terms of price, suggested Suzanne Bruce, MD, a dermatologist in private practice in Houston. “I believe it’s going to be roughly 25% lower in price, which some patients will certainly find to be a more attractive option if the efficacy and safety are the same — which it certainly seems to be based on studies,” she said.

Dr. Matarasso agrees that Evolus’s lower price point will likely be a major draw for patients. “Botox was first to market, Dysport® was second, Xeomin® was third, and Jeuveau™ will be fourth. As the other three toxins have therapeutic indications, they cannot really alter the cost. With Jeuveau only having one aesthetic indication — for glabellar lines — they can come to market with a competitive price point,” he explained. “I think that is going to be a very powerful influence. All the other toxins are expensive. A single vial can cost upwards of $600. If Evolus can reduce that fee to physicians, hopefully we can carry that cost savings on to our patients.”

Another emerging contender in the toxin world is Revance, which recently made headlines for a new neurotoxin with a duration reportedly double that of those currently available on the market. While Revance’s product is still currently pending FDA approval, its six-month treatment duration has already created some mixed feelings among dermatologists. “Some of my dermatology colleagues are not too happy about that, because they prefer to have the patient coming in three times a year, as opposed to twice a year, because they can have another face-to-face interaction,” explained Dr. Bruce.

Another topic of debate among dermatologists is whether Revance’s increased duration is due to a distinction of the drug itself, or simply a higher dosage, suggested Robert Anolik, MD, clinical assistant professor of dermatology at New York University School of Medicine. “There was a rebuttal of sorts in a recent study that used a higher concentration of Botox, and similarly got a longer duration as well. So, is there really something distinct with this formulation, or is it just a different concentration? Regardless, I think it’s pretty exciting that we may have something that lasts longer,” he said.

On the opposite end of the spectrum, a new offering by Bonti (acquired by Allergan in September 2018) would instead offer patients a shorter duration — with the trade-off of a much more rapid onset. “It’s still in clinical trials, but instead of being a botulinum toxin type A, it’s botulinum toxin type E,” explains Dr. Anolik. “It acts on the similar proteins on the nerve ending that affect the ability of acetylcholine to be released to cause a muscle contraction but works a little differently. The expectations are if this is successful and comes to market, it can cause onset within 24 to 48 hours instead of waiting one to two weeks — which is how much it takes all the other formulations of botulinum toxins out there — but it lasts only two to four weeks.”

According to Dr. Anolik, this rapid onset and shorter duration could serve as an option for patients looking for a “trial run” of toxins’ effects without committing to an aesthetic result they may not ultimately like. Dr. Matarasso, however, is skeptical of its popularity with patients, although he does see it as having potential for pain management. “Due to its very brief duration, I don’t imagine that it will be a player in the aesthetic arena,” he said. “Where it might have its followers is in the therapeutic arena. Pain management is so hard to get a handle on and having something that will diminish discomfort is a really nice adjunct for our patients. You can potentially reduce post-procedure discomfort if you can weaken site-specific striated muscles.”

Botox: Looking back
With a nearly 20-year legacy of market dominance, how does Botox compare to the new arrivals? According to Dr. Matarasso, beyond its long-
standing reputation for safety and efficacy, Botox users can still find inspiration in a variety of new treatment indications. “One of my favorite expressions is that botulinum toxin is like the aspirin of the 2000s. We’re always finding new indications for it. I just think we’re really seeing this product come of age,” he said.

Currently, Botox is FDA-approved for the treatment of chronic migraines, dystonia, hyperhidrosis, and can also be used for the off-label treatment of scars, itch, and reconstruction following Mohs surgery. “I have patients with migraine headaches and grinders — with temporomandibular joint syndrome associated pain — and it has dramatically improved their discomfort,” said Dr. Matarasso. “I also have patients who suffer from hyperhidrosis, and their hands, feet, and axillae are literally drenched with excess sweat. With all three of these indications, it has dramatically improved the quality of life.”

Dr. Bruce also believes botulinum toxin will grow in popularity as a form of medical treatment. “It’s also approved for overactive bladder and muscle spasticity due to conditions such as stroke and cerebral palsy,” she said. “For things like hyperhidrosis and migraines, it’s become very mainstream, and insurance does cover to various degrees for indications that have FDA approval.”

Dr. Anolik agrees. “There could be potential indications for the treatment of depression, as well as scarring. There are some really great studies from outside the United States showing that sporadic injections of botulinum toxin have caused improvement in hypertrophic, thickened scars.”

Is botulinum toxin still safe?
Given the number of repeat users of botulinum toxin over the years, some questions have emerged regarding its long-term safety profile. “Although botulinum toxin is generally considered safe, its widespread use and the constantly expanded indications raise safety issues,” noted a 2015 Pharmacology article. “Botulinum toxin may cause serious adverse events, which are more common after its therapeutic use, but can also be noticed after its cosmetic use” (95:65-69). Pharmacology also adds that resistance to the drug can occur in long-term users following therapeutic use, and

How do you know if your botulinum toxin is really botulinum toxin?

1. Check product packaging — Most toxin boxes have certain authenticity markers to distinguish them from counterfeits, which can include holographic markers, verifiable lot numbers, and expiration dates, and should list ‘OnabotulinumtoxinA’ as the active ingredient (If ‘Botulinum Toxin Type A’ is listed, alarm bells should go off).

2. Check the pricing — Suspiciously low pricing is a common red flag that the toxin you’re getting is not legit. “First off, don’t get Botox from a cut-rate place or a Groupon. If it’s too good to be true, you are asking for trouble,” said Ava Shamban, MD. Dermatologists themselves may also want to consider price point as a sign of authenticity, said Dr. Matarasso. “There was a very famous case a few years ago of a non-dermatologist who bought veterinary botulinum toxin. There were deaths. I appreciate the cost of the product, but you do not want to sacrifice nor put your patients in harm’s way. It is always prudent and the best standard of care to purchase it, have a conversation with the manufacturer, to make sure you’re getting the real product.”

3. Pay attention to symptoms — Unusual pain, persistent redness with swelling, deep bruising, and hard, irregular contours are all signs that the filler injected may be inauthentic.
a Toxins study likewise found that “the efficacy of a single dose of BoNT-A diminishes with time and repeated injections may be required to sustain the clinical effort...While BoNT-A has been widely used since the 1970s, there are still concerns about long-term safety and resistance with repeated administration” (2015; 7:4283-4293).

Other potential complications can include generalized diffusion of botulinum toxin. “Indeed, diffusion of botulinum toxin in the injected muscle and injected muscles has been well-documented,” according to Pharmacology, although “the effects of generalized diffusion are not well studied” (2015; 95:65-69). Indeed, research regarding the long-term effects of botulinum toxin remain limited partially due to underreporting of adverse events, as per the Journal of the American Academy of Dermatology. “Given the voluntary nature of reporting by clinicians or others (except manufacturers), AEs reported to MedWatch represent only a subset of the actual number that occur. Multiple factors, including publicity, may influence reporting” (2005; 53: 407-415).

Overall, should long-term users of botulinum toxin have cause for concern? No, said Dr. Matarasso, who cites poor outcomes as a rarity during his 25-year career. “I rarely see adverse events. When they occur, they are often the result of ill-trained paraprofessionals, not by physicians. One of my mottos is ‘a little bit is good; a lot is not necessarily better.’ I think those who don’t know the power of the toxin can get carried away, so you will see people who have no facial mobility, and that is not aesthetically appropriate. The biggest complication I see is people coming in with a non-emotive face from too much toxin.”

Dr. Anolik agrees. “From a medical standpoint, I have not seen any complications. My biggest concern for patients is being treated by unskilled injectors. Botulinum toxin has such a long history now, that public confidence can often be inappropriately high. It’s amazing to me that some people have begun to associate this with having their hair colored, despite being a medical procedure where a drug is being injected into the body. I joke that some people are being treated by individuals who are not dermatologists, and frankly could have been working retail last week at the Gap. Who knows what they’re using? Are these non-dermatologists using counterfeit products?” (See sidebar for patient and provider tips on how to verify toxin authenticity.)

The future of toxins
As popular demand for toxins continues to keep the manufacturing pipeline running, dermatologists can expect to see more options available to them — and their patients in the future. “Other countries like in Europe, Asia, and Canada tend to get things before we do. They have more toxins than we do; they have more fillers than we do,” said Dr. Bruce. “The FDA process is a little slower, but this is an exciting time. I think it’s good to shake up the market now and then. I think it’s healthy to have competitors and let the marketplace decide.”

Dr. Matarasso agrees. “What I find interesting is that the other previous toxins — the second, third, and even fourth to market — haven’t been able to really make that much of a dent on Botox’s hold on the market.”

“Entering a golden age of toxins

“What I find interesting is that the other previous toxins — the second, third, and even fourth to market — haven’t been able to really make that much of a dent on Botox’s hold on the market.”
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¹Path to Purchase Research 2018 - Cosmetic Category.
²Survey of Healthcare Specialties practices that are not part of the CareCredit network, conducted by Chadwick Martin and Bailey, December 2017.
³CareCredit Healthcare Payments Benchmark, December 2017.
*Subject to credit approval. Minimum monthly payments required. See carecredit.com for details.

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Is your EHR high maintenance?

Now that electronic health records (EHRs) are a staple in nearly all dermatologists’ offices, what is involved in maintaining them?
Office-based physician adoption of EHRs is up from 42% to 87% in the United States between 2008 and 2015, according to the Office of the National Coordinator for Health Information Technology. Similarly, according to the AAD’s 2016 Electronic Health Records Survey Final Report, three-fourths of all dermatologists have now adopted EHRs, noted Swapna Bhatia, MPH, the AAD’s manager of health technology and informatics. “The adoption of EHRs has increased tremendously because the advantages of having an EHR outweigh the advantages of using paper records,” she said. Those advantages include easier access to health care records with a more user-friendly system, less paper in the office/less storage, better clinical workflow and efficiency, and increased quality of care.

The passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009 kick-started EHR adoption, followed by the Meaningful Use (MU) incentive program that created incentives for EHR use and then penalties for non-EHR use. Although MU is phased out, most practices that adopted EHRs continue with them because it was replaced with the Merit-based Incentive Payment System (MIPS), stated Erin Gardner, MD, chair of the Academy’s EHR Task Force. In order to receive a portion of the points in the now-compulsory MIPS program, physicians must employ EHRs to provide patients access to their health care information and to electronically prescribe, Dr. Gardner said. >>
Maintaining EHRs

Physicians who have implemented EHRs need to maintain their systems. What that entails depends, in part, on whether the EHR is hosted in the cloud or hosted on servers in the medical office. In general, EHRs require regular updates to software, operating systems, cybersecurity measures, and antivirus software, among others. Most practices either have an outsourced information technology (IT) company or in-house IT personnel to perform maintenance tasks.

Server-based EHR systems require the additional task of server management, Dr. Gardner said. A practice should follow a server maintenance plan that may be designed by an IT service management company. The plan should include hard disk maintenance, network integrity checks, data backup execution, software installation, service pack patches, and security software updates, he said.

“Even if you are using a cloud-hosted system, you still need IT support to make sure your internal network, Wi-Fi, internet, and workstations are all functioning and supported to ensure connectivity to the cloud,” noted Morris Stemp, MBA, director of EHR Integration for Slingshot Health. Early EHRs were all locally hosted in the physicians’ office, but today the majority are in the cloud or hosted by large entities, such as very large physician practices or health systems. The switch is due, in part, to EHR vendors incentivizing cloud-based systems to avoid having to deal with their clients’ server issues, he added.

“In the old days when a server went down, the office couldn’t function,” Stemp said. “Now if one workstation goes down, everyone else can still work.”

Updates vs. upgrades

When it comes to maintenance, there are updates, which may be included as part of the subscription service, and there are upgrades, which often require additional financial investment, Dr. Gardner noted.

EHR vendors publish patches and updates to the operating system for a few reasons, Stemp said. One is for providing optimal security protection because breaches can occur when the software and/or firmware is not patched. Another is for improving performance, making the system faster or better functioning. A third reason is for ensuring compatibility among the various programs after they are updated. Updates may also be installed to improve battery performance for handheld devices, Dr. Gardner said. He recommends instituting a regular check and/or installation of available updates as a best practice. IT professionals often recommend updates be performed on a quarterly basis.

Upgrades feature changes to system functionality or performance that are on a much larger scale than updates, Dr. Gardner noted. Software upgrades are typically new versions of a program. Operating system upgrades generate significant changes in system functionality or user interface. The latter may feature the use of a different operating system or inclusion of functionality that meets new regulations.

After approximately four years, a workstation’s performance begins to degrade, as parts start malfunctioning and slowing down, Stemp said, adding, “The new hardware is just so much faster.” Sometimes upgrades can’t be installed on older hardware, requiring the server and software to be updated. The latter is a large expense and another reason why cloud-based servers are preferred. “As EHR vendors make upgrades in the cloud, physician practices don’t have to make changes to their internal hardware, saving the practice money,” he said.

The most substantial upgrades often involve regulatory changes. For example, physicians who want to report for the 2019 MIPS performance year must use the 2015 Certified EHR Technology Edition. The 2014 Edition is no longer accepted.

Cybersecurity and HIPAA

“Cybersecurity must be a high priority for practices,” Dr. Gardner said, “not only for the Health Insurance Portability and Accountability Act (HIPAA) purposes, but as an obligation to patient privacy.” Practices can enhance cybersecurity by performing regular updates on operating system software, maintaining firewall and antivirus system protection and updates, and educating staff about potential sources of breaches into the system. Cybersecurity is a never-ending challenge, he added.

Both HIPAA compliance and successful participation in MIPS require physicians to perform a security risk assessment, Dr. Gardner explained. Unfortunately, the same assessment cannot be used for both HIPAA and MIPS. Furthermore, a HIPAA risk assessment is not a one-time exercise. Assessments should be reviewed periodically and whenever new work practices are implemented, or when a new technology is introduced. The Department of Health and Human Services does not specify a frequency for such reviews other than to suggest that they may be conducted annually, depending on an organization’s circumstances, he said.

The importance of training staff to recognize and combat phishing and ransomware threats cannot be overstated, said Julie Dooling, director of practice excellence for the American Health Information Management Association (AHIMA). A common practice is for the IT vendor to send fake phishing emails to staff to determine which employees could cause a potential breach in the system. Staff also need to be trained regarding password management to ensure security, Stemp said. For example, they should be using complex passwords that include lower- and upper-case letters, numbers, and
symbols. Change passwords every three months and do not reuse passwords. Enforcing password policies is easier on a cloud-based system, he noted.

Encryption is another important security issue that must be addressed under HIPAA. When physicians download protected health information (PHI) to their laptop, or make it easy to access the EHR from their laptop, the laptop must be encrypted to ensure that the PHI is protected if the laptop gets stolen, Stemp said. “If the laptop is not encrypted, having it stolen or lost would be considered a reportable security breach,” he noted.

Backup, contingency, and recovery plans
The two most important considerations for EHR use may be protecting the medical records and data as well as maintaining connections, Dr. Gardner said. Dermatologists must have a disaster recovery and contingency plan in place to address disruptions to the functioning of the EHR system, per the HIPAA Security Rule. It calls for the following:

- A data backup plan for creating and storing copies of electronic health information,
- A recovery plan to restore lost data,
- An emergency-mode operation plan that enables facilities to continue performing required operations (i.e., relying on paper records or a read-only version of the EHR that is based off site),
- An assessment of all applications that would be affected, including the impact of a widespread outage, and
- A protocol for testing and revising the contingency plan.

It is imperative to have accessible backup data on separate systems, Bhatia stated. The backup system should be tested regularly to make sure it is effective. “Make sure all staff knows what to do in an emergency, especially with the medical records and data,” she added. If the EHR is hosted in the cloud, the cloud vendor is responsible for all these critical activities.

The United States Computer Emergency Readiness Team recommends using the 3-2-1 Rule for Backups: Keep three copies: One primary and two backups. Keep the files on two different media types to protect against different hazards. Store one copy off site. The primary copy of data may be on a server-based system’s hard drive and a cloud-based server for cloud-computing EHR systems, Dr. Gardner said. For on-site server-based systems, consider using both a cloud-based secure storage vendor for one of the backups and a removable storage medium, such as an external hard drive or solid-state drive, for the second backup, he said.

A recovery plan to restore data is equally as important. Other devices that could be impacted by an interruption in EHR service should also be catalogued, and an emergency mode for continued functioning of operational processes and equipment during a shutdown should be designed and ready to be deployed, Dr. Gardner noted. Some EHR vendors offer a disaster recovery system that automatically shuts off if a major threat is detected, and a failover system that is initiated for use during the unexpected downtime, said Dooling — adding that AHIMA publishes a Disaster Planning and Recovery Toolkit that focuses on collecting and protecting health information.

The cost of maintaining EHRs
Technical support costs for EHRs range from $12,000 to $22,000 a year, according to the Academy’s 2016 Electronic Health Records Survey Final Report. This includes upgrades due to regulatory requirements, such as MIPS. However, according to the Academy’s survey results, these upgrades increase in smaller increments and remain between $1,000 and $2,000 annually, regardless of practice size, Bhatia said. Adoption of an EHR, however, is associated with increased personnel, specifically medical assistants, scribes, and administrative staff, she said.

A survey by the Medical Group Management Association (MGMA) puts the cost higher. The average health IT costs per physician in a multispecialty practice — which includes IT support staff and maintenance — was $32,500 in 2015, according to the MGMA survey. That’s up 40% since 2009 before the HITECH Act was passed. Larger practices are spending more money to gain greater customizability for software, Dr. Gardner said, since EHR subscription services may offer fewer options for individual user configurability. Similarly, Stemp estimates that a practice would pay approximately $3,000 per physician per year for its IT budget for maintenance (not including EHR licensing). Additionally, physicians closing a practice and/or retiring will need to consider the costs associated with EHR custodianship, which can vary drastically depending on the custodian.
Practicing a disaster contingency plan, which should address both natural and man-made disasters, is essential, she emphasized. Not only do these plans have to be routinely tested, HIPAA requires written policies detailing the plans, Stemp added.

A contingency plan should also address such scenarios as a dermatologist retiring or leaving the practice unexpectedly. In both cases, the medical records must be transferred to an official custodian, which could be another physician practice or a commercial storage firm, Dr. Gardner said. Patients must be notified and given the opportunity to obtain a copy of their health records or transfer them prior to the office closing, Dooling added. Patients should be contacted via email, written letter, and electronic posting. In Missouri, where Dr. Gardner practices, he must notify patients going back seven years.

Custodianship and retention requirements for medical records vary by state, as well as by federal and accreditation agencies, Dooling said. Find out your state medical record custodian and retention requirements at www.healthit.gov/sites/default/files/appa7-1.pdf. A records destruction firm that can guarantee confidentiality — if, and when, the records are eventually destroyed — is a must, Dr. Gardner said.

Maintaining records during transitions

Whether transitioning from paper records to an EHR, or from one EHR system to another, PHI must be protected and properly converted. “Your data integrity in the new EHR system depends on a clean data conversion,” Dooling said. “It's extremely important to get it right the first time.”

Dermatologists moving from paper records to an EHR must make sure that the paper records are easily accessible. In the past, the entire paper record was scanned into the EHR, a very time-consuming and laborious task. Today, physicians are selectively entering important patient history, medication, and allergy information into the new EHR while archiving the paper record, Dr. Gardner said. Another option gaining in popularity is point-of-service scanning, whereby the service vendor indexes the records and then prepares them to be put into the EHR, Dooling said. The documents are scanned on an on-site server and sent to a central repository that assigns the records to the right patient, she explained. The next generation of record scanning involves data mining of the unstructured medical documents to identify relationships and traits that match them to the correct patient, Dooling said. Amazon Comprehend Medical is an example of this emerging technology.

After the paper records are converted into the EHR, the paper version should only be used as a reference, Bhatia said. How long the paper records are maintained really depends on those using the converted data and how much they trust the EHR. Once staff members are confident that the transition was successful, it is safe to destroy all paper-based records that have been converted, she said. Stemp recommends that practices consider scanning just the last two years’ worth of paper records and then putting them into storage for seven years. Retaining and destroying records must be done in compliance with state and federal and accreditation agency requirements, Dooling added.

Two EHRs?

Ideally, when changing EHR systems, there would be a complete data migration or conversion from the old system to the new one, Dr. Gardner said. However, interoperability challenges continue to make an effective migration or transfer challenging, if not impossible. Consequently, transitioning to a new EHR may require maintaining the old system for a while after the new one has been implemented. Practices occasionally have to run a legacy system on the computer network or in the cloud, alongside the newly implemented EHR, allowing toggling between the two systems, he said.

How long it’s necessary to maintain both systems depends on what transition provisions are in the EHR contract, Bhatia said. It behooves dermatologists to negotiate specific transition rights and obligations in the contract to minimize the disruption and risks that may occur when switching vendors. It's critical to have enough time to make the transition to the new EHR and options to renew service/support at reasonable prices for the old EHR. Another option is to negotiate caps on future price increases upfront, thus limiting the amount of money the vendor can charge for renewing the contract. Remember, the software is good only as long as the EHR vendor supports the system.

“If you convert all of the information over, and have verified that it’s all converted, there’s no reason to retain the old system for too long,” Stemp said. He recommends retaining it for two years to make sure there are no glitches with the new EHR system. It’s best to retain them both for seven years, but that can be quite costly, he noted. Another option is to move the PHI to a hosted environment, eliminating the need to maintain the old server. Hosting the data in a “terminal services environment” in the cloud could cost $300 to $400 a month, Stemp said, but at least the records will be accessible if needed and it’s cheaper than maintaining the old server. If converting from one cloud-based EHR vendor to another, HIPAA requires the vendor to maintain the data, although they will charge for a “read only” environment, he said.

Maintaining an EHR system does require some diligence and dollars (see sidebar), but with a qualified IT company or good in-house IT support, dermatologists can get the most out of their EHRs. dw
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I believe in the joy of dermatology and look ahead with optimism to the future. However, keeping up with the latest payment and compliance regulations and the explosion of new treatment options and literature can be exhausting and overwhelming.

One of the major questions posed to us as we implement the AAD 2019 Strategic Plan is how can we — as dermatologists and AAD members — provide the highest quality and compassionate dermatologic care if, at times, it seems we’ve lost the joy that brought us to this profession? Through advocacy, education, practice management support, and the new strategic plan, the AAD is here to help us maintain, increase, and recapture our joy.

So how does joy show up in the strategic plan? While it’s a roadmap for the Academy that is based on member needs and shifts in the health care environment, the strategic plan is very much patient-centric. Dermatologists — no matter what stage in their career — find joy in being a leader in providing superior and compassionate patient care. That’s why, before finalizing the plan, we sought feedback from members and stakeholders representing all corners of the specialty — young to experienced physicians; from those in health systems to those who practice in academia, private practice, or private equity-backed groups; from active to inactive Academy members; from industry partners to state dermatology societies.

Like all of you, I love taking care of my patients. I want to help AAD members to continue having a fulfilling professional life in dermatology. I am confident that the new strategic plan will be the pathway to help achieve this. As I work with leadership to bring the strategic plan to life, I invite you to share in my greatest lesson: to never forget that we work in a field that brings real joy not just to ourselves, but to others. dw
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What is the Academy doing to protect patients from the dangers of indoor tanning?

In this new column, Dermatology World digs into an issue that is affecting the specialty and discusses the Academy’s key activities to address and advocate on the issue.

As one of its top advocacy priorities, the American Academy of Dermatology Association (AADA) advocates that federal and state legislative and regulatory bodies pursue greater oversight of the indoor tanning industry. Additionally, the Academy has developed several tools and resources to educate patients about the dangers of indoor tanning.

**Advocacy activities:**
The AADA consistently works with state dermatology societies and state legislatures to introduce and support laws and regulations that place restrictions on indoor tanning, including restrictions on indoor tanning for minors 18 and younger.

**Academy position statement**

Read more on the Academy’s position on indoor tanning at www.aad.org/indoor-tanning-ps.
Currently:

- California, Delaware, the District of Columbia, Hawaii, Illinois, Kansas, Louisiana, four counties in Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New York, North Carolina, Oklahoma, Rhode Island, Texas, Vermont, and West Virginia have passed laws that prohibit minors under the age of 18 from indoor tanning.
- Oregon and Washington have passed laws prohibiting minors under the age of 18 years old from using indoor tanning devices, unless a prescription is provided.
- Connecticut, New Jersey, and Pennsylvania have passed legislation banning minors under the age of 17 from using tanning devices.
- Minors under the age of 16 are prohibited from using tanning devices in Indiana and Wisconsin, while minors under the age of 14 are prohibited from using tanning devices in Alabama, Georgia, Idaho, Maine, and North Dakota.

**Resources for physicians and patients:**
The Academy also offers several educational resources for physicians and the public:

- A list of current research that highlights the risks associated with indoor tanning. Check out these resources and more at www.aad.org/indoor-tanning-stats.
- A list of state regulations and legislation related to youth access to indoor tanning. Learn more at www.aad.org/YouthAccessLaws.
- An indoor tanning advocacy toolkit that includes a model bill for states seeking to restrict indoor tanning for minors, as well as other tools for physicians to educate, advocate, communicate, and collaborate on this issue. Access the toolkit at www.aad.org/indoor-tanning.
- A list of 10 surprising facts about indoor tanning for patients at www.aad.org/10-facts-about-skin-cancer.
- Tips for the public on protecting their skin at www.aad.org/protect-yourselfie.
Kenneth J. Tomecki, MD, of Cleveland, is the American Academy of Dermatology’s 2020 president-elect; Neal Bhatia, MD, of San Diego, is the 2020 vice president-elect. Murad Alam, MD, MSCI, MBA, Cheryl M. Burgess, MD, Naomi Lawrence, MD, and Amy McMichael, MD, were elected to the Academy’s Board of Directors. Mark Lebwohl, MD, was elected a member representative on the Nominating Committee. A total of 4,090 members voted in the election.


The Academy membership also passed a bylaws amendment that creates a new International Associate category of membership and re-aligns other international membership categories to address inconsistencies in the current application process and aligns international categories with U.S. categories. – VICTORIA HOUGHTON

### 2020 committee appointment application now open

Members are essential to every association and the American Academy of Dermatology and AAD Association are no different. The Academy is one of the most influential medical organizations in the world because its members are willing to offer their time and energy to activities to further advance the Academy’s strategic framework.

Every year, hundreds of dermatologists serve the Academy through its organizational governance structure and through other service opportunities. The Appointment Selection Committee, chaired by Bruce H. Thiers, MD, FAAD, has begun accepting applications to fill 2020 open appointments.

The [2020 online appointment application](http://www.aad.org/applications/cctf) is available at [www.aad.org/applications/cctf](http://www.aad.org/applications/cctf).

Applications must be submitted by June 30, 2019. Members who are selected to serve will be contacted in the winter of 2019. Letters of recommendation are strongly encouraged, however not required.

Information outlining the specific committees and task forces, committee member responsibilities, and other opportunities, is available in the Governance Handbook at [www.aad.org/about/cctf/cctf-resources](http://www.aad.org/about/cctf/cctf-resources).

For more information, contact Christine Siwik, the Academy’s governance manager, at (847) 240-1061 or csiwik@aad.org. – CHRISTINE SIWIK
Registration, housing for the 2019 AAD Summer Meeting opens this month

Registration and housing for the 2019 AAD Summer Meeting, July 25-28, in New York at the New York Hilton Midtown hotel, will be available online at www.aad.org/summer19 beginning at 12 p.m. (CT), May 1 for physician, life, and honorary members, and May 8 for all others. Housing reservations at the New York Hilton Midtown hotel and the London New York City hotel must be made online in conjunction with meeting registration to receive the discounted housing rate. See the AAD registration website for hotel deadlines, cancellation, and change policies. **Experient is the official AAD Housing Provider. You should only make your housing reservations through the AAD Meeting website.** More information about the 2019 AAD Summer Meeting is available on the Academy website and in the Advance Program Announcement, which was mailed in late April.

**Make an impact**
When you register for the 2019 AAD Summer Meeting, you can also make a donation and join in helping us change lives through two vital AAD programs:

**AAD Resident Education Grants** help to ensure that more than 1,300 dermatology residents are able to experience the AAD meetings and build a bright future for the specialty. This program is applicable to AAD Graduate Members in AAD-approved U.S. and Canadian residency programs.

**Camp Discovery** gives children with chronic skin conditions a life-changing summer camp experience, where they can build self-esteem and learn they are not alone in their daily struggles.

Your donation will positively impact patients, the public, and our communities. Make your donation as you complete your online registration for the meeting. – **TIM MOSES**
Recognition of member contributions to dermatology

Every year, the Academy bestows a series of prestigious awards to its members in recognition of the important work they contribute toward the development of dermatology. Highlighted below are this year’s recipients. To learn more about the Academy’s awards, grants, and scholarships, visit www.aad.org/awards.

Jean Bolognia, MD, wins Academy Gold Medal

In recognition of her extensive leadership contributions to dermatology, both within and outside the Academy, as well as her dedication as an educator and clinician, Jean Bolognia, MD, has been awarded the American Academy of Dermatology’s Gold Medal award.

Dr. Bolognia currently serves as professor of dermatology at the Yale School of Medicine. She is honored with this award for her previous work on the Board of Directors of the AAD and her current involvement with the International League of Dermatological Societies, where she serves as secretary general. She is also recognized for her extensive past service as president of the Medical Dermatology Society, the Women’s Dermatologic Society, and the American Dermatological Association, in addition to serving as vice president of the Society of Investigative Dermatology, the American Board of Dermatology, and the International Society of Dermatology.

Dr. Bolognia is also honored for her significant academic contributions to the specialty as the senior editor of the comprehensive textbook *Dermatology*, now in its fourth edition, as well as *Dermatology Essentials*, with the two textbooks having been translated into nine languages. Dr. Bolognia is also recognized for her mentorship of young women in dermatology throughout the world. The Gold Medal award is the Academy’s highest honor.

William D. James, MD, recognized with Master Dermatologist award

In recognition of his significant contributions to the field of dermatology, William D. James, MD, has been selected to receive the Academy’s Master Dermatologist award.

Dr. James currently serves as Paul R. Gross professor of dermatology, vice chair, and director of the residency training program of the department of dermatology at the University of Pennsylvania School of Medicine.

Dr. James is recognized for his career-spanning academic and leadership contributions to the specialty. In addition to his past service as president of the AAD, Dr. James has delivered more than 300 invited lectures, published more than 265 articles and 35 book chapters, and has written or edited 24 books, including the 8th, 9th, 10th, 11th, 12th, and 13th editions of the standard textbook *Andrews’ Diseases of the Skin*. He is the founding editor of the internet-based *Emedicine Textbook of Dermatology*, and currently serves as editor in chief of *Medscape Dermatology Reference*.

For 35 years, the Master Dermatologist award has recognized Academy members who have made significant contributions to the specialty of dermatology throughout the span of their careers, in addition to leadership and/or education programs of the American Academy of Dermatology.
Katrina Abuabara, MD, MA, MSCE, and Tamia Harris-Tryon, MD, PhD, receive AAD awards for Young Investigators in Dermatology

Katrina Abuabara, MD, MA, MSCE, and Tamia Harris-Tryon, MD, PhD, have been chosen as the 2019 recipients of the Young Investigators in Dermatology award. These awards recognize outstanding basic, translational, and clinical research efforts by young dermatology investigators in the U.S. and Canada and are intended to acknowledge significant research advances in the science and practice of dermatology by those beginning their research careers and who demonstrate the potential to become established, independently funded investigators in dermatology.

Dr. Abuabara received the award for clinical research on demographic, immunologic, and genetic factors and the age of atopic dermatitis onset through midlife; her paper is currently under review for publication. Dr. Abuabara currently serves as assistant professor of dermatology at the University of California San Francisco. She received her medical degree at Harvard Medical School and completed her dermatology residency at the University of Pennsylvania.

Dr. Harris-Tryon received the award for basic research on the role of dietary vitamin A in microbial skin health; her paper is currently under review for publication. Dr. Harris-Tryon currently serves as assistant professor of dermatology and immunology at the University of Texas Southwestern Medical Center. She received her medical degree, doctorate in cellular and molecular medicine, and completed her dermatology residency at Johns Hopkins University School of Medicine.

Kelley Pagliai Redbord, MD, named Academy’s Advocate of the Year

Kelley Pagliai Redbord, MD, has been selected as the 2019 American Academy of Dermatology Advocate of the Year in recognition for her outstanding leadership and commitment to advocating for our profession and our patients at the state and federal level. Each year, the Academy recognizes one member for their outstanding grassroots advocacy efforts. Dr. Redbord was recognized for her leadership on issues such as indoor tanning, patient safety, and public education including her SUNucate initiative, which proposed model legislation that would eliminate barriers to the use of sun protection at schools and summer camps.

Dr. Redbord is the deputy chair of the AADA Congressional Policy Committee and a member of the SkinPAC Board of Advisors, the AAD Advisory Board, and the Professionalism and Ethics Committee. Dr. Redbord was the founding chair of the AADA Grassroots Advocacy Workgroup, chaired the AADA State Policy Committee, and is past president of the Washington D.C. Dermatological Society. Dr. Redbord is currently an associate clinical professor of dermatology at George Washington University and practices in Rockville, Maryland, Vienna, Virginia, and Fairfax, Virginia.
Warren R. Heymann, MD, earns Thomas G. Pearson Award

Warren R. Heymann, MD, is the 2019 recipient of the Academy’s prestigious Thomas G. Pearson, EdD, Memorial Education Award. The Pearson award recognizes a member of the Academy who has advanced the organization’s education mission through significant contribution of time, development of educational programs, coordination of educational activities, and more. Currently professor of dermatology and pediatrics, and head of the division of dermatology at Cooper Medical School of Rowan University, and clinical professor of dermatology at the Perelman School of Medicine at the University of Pennsylvania, Dr. Heymann is a tireless educator who engages medical students, residents, and practicing physicians, teaching by example to capture the heart of dermatology as a healing profession supported by science. His popular website, Dermatology Insights and Inquiries, has now transitioned to Dermatology World Insights and Inquiries, summarizing the literature and packing pearls of wisdom that can be read in a few minutes, helping to meet the needs of today’s learners.

Dr. Heymann is a past editor of the Academy’s Dialogues in Dermatology and has served as chair and deputy chair of the AAD Organizational Structure Committee, and as a member of the AAD Distance Learning and Enduring Materials Committee, Priorities Committee, and Named Lectureship Task Force.

Established in 2002, the Pearson Award memorializes the late Dr. Thomas G. Pearson, who served as the Academy’s director of education from 1987 to 2001.

Daniel M. Siegel, MD, and Ellen S. Marmur, MD, receive AAD awards for philanthropy

Daniel M. Siegel, MD, and Ellen S. Marmur, MD, have been chosen as the recipients of the 2019 Philanthropy Award, which was established this year to acknowledge and recognize individuals who have made a significant contribution to both the Academy and the specialty of dermatology.

Dr. Siegel is recognized for his re-envisioning the Academy’s annual Presidents Dinner into the President’s Gala, which was established during his tenure as Academy president in 2013. Since then, the gala has generated more than $5 million in much needed resources to support the AAD’s humanitarian and other critical programs and services. Dr. Siegel is additionally recognized for his commitment to philanthropy through his continued involvement with the Academy’s Corporate Relations Committee, the stewardship of corporate partners and members, as well as his own personal generosity.

Dr. Marmur is recognized for her philanthropic leadership in establishing Skin Cancer: Take a Hike!™ — a participant-driven fundraising event dedicated to raising funds and engaging members’ commitment to volunteerism for the American Academy of Dermatology’s SPOT Skin Cancer™ Program. Since its inaugural hike to Mt. Kilimanjaro in 2014, ‘Skin Cancer: Take a Hike!’™ has raised more than $1 million. Dr. Marmur’s fundraiser has engaged not only new members in supporting the Academy, but also their employees, family, patients, and the public, while helping to raise the Academy’s profile in its commitment to reducing the incidence of skin cancer.
**William D. James named inaugural Mentor of the Year**

William D. James, MD, is honored as the first recipient of the William D. James, MD, Mentor of the Year Award, which was established in recognition of Dr. James for his career-spanning dedication to mentoring of students, residents, and junior faculty. Dr. James currently serves as Paul R. Gross professor of dermatology, vice chair, and director of the residency training program of the department of dermatology at the University of Pennsylvania School of Medicine.

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**Five granted honorary membership**

The following five dermatologists were granted honorary membership in the AAD for “leadership and service that affirms an uncommon and sustained dedication to dermatology.”

- Robert L. Baran, MD
- Ilona J. Frieden, MD
- Ernesto Gonzalez, MD
- Evangeline B. Handog, MD
- Marcia Ramos-e-Silva, MD, PhD

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**FULL-TIME FACULTY**

Brown Dermatology is recruiting full-time faculty for the 2020 academic year. Candidates must be board-eligible/board certified in dermatology, and be eligible for appointment at Brown at the level of Assistant Professor, Associate Professor, or Professor. We seek enthusiastic general and procedural dermatologists looking to build and further their careers in a highly supportive environment! We are the only academic dermatology service in the State of Rhode Island, and the largest group providing comprehensive dermatologic care in the region extending to Southern Massachusetts and Northern Connecticut. Our patient-mix is broad, transcending general dermatology and complex medical and procedural dermatology. We take pride in our growing dermatopathology service and our expanding Division of Pediatric Dermatology. We are also extremely proud of our faculty who lead community out-reach programs regionally (Rhode Island Free Clinic) and internationally (Jordan and Kenya). There are myriad teaching opportunities available to faculty across two dermatology residency training programs in the State (Rhode Island Hospital and Roger Williams Medical Center) and through advanced fellowships in development, e.g. Dermatology-Rheumatology/Complex Medical Dermatology Fellowship. The Clinical and Translational Research Program within the Department provides core services to all faculty including support with study design and biostatistics, IRB application preparation and submission and grant submissions. Our clinical trials unit is growing rapidly and highly supportive of faculty interested in leading trials.

Located in Providence, the historic ‘creative capital’ of Rhode Island, Brown University was founded in 1764 and is an Ivy League university offering a world class college, graduate school, medical school, school of public health, and school of engineering. Affiliated with multiple area hospitals within Lifespan and in other systems, including Care New England (Memorial Hospital of RI, Women & Infants Hospital) and the Providence VA Medical Center, we offer a large variety of patient care and research opportunities. Faculty will receive appointments from Brown University’s Warren Alpert Medical School and Rhode Island Hospital/Hasbro Children’s Hospital/Miriam Hospital.

Interested candidates should send a brief letter of interest and curriculum vitae to Abrar A. Oureshi, MD, MPH, Professor and Chair, Department of Dermatology, Warren Alpert Medical School and Rhode Island Hospital/Miriam Hospital via katarzyna_lada@brown.edu.

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Calculating the cost savings of inpatient dermatology

BY EMILY MARGOSIAN, ASSISTANT EDITOR

Despite an increasing need for skin expertise in hospital settings, focus on inpatient consultative dermatology can often fly under the radar. However, new data from JAAD (https://doi.org/10.1016/j.jaad.2019.01.031) indicates that dermatologists’ unique strengths in the recognition and management of uncommon and severe skin disorders are not only of value to patients who can expect improved care and outcomes — but also to payers and health care systems from a cost-savings perspective.

The article estimates that dermatology consultation for patients with inflammatory skin conditions is not only associated with a 10-fold reduction in the odds of readmission but may also reduce the length of hospitalization by approximately 2.64 days.

Authors also looked at data relating to the cost savings of dermatology consultation for suspected cellulitis in a hospital setting. For a more complete breakdown of the estimated economic impact, see the graphic below.

Estimated impact of inpatient dermatology

- Avoid 50,000 to 130,000 unnecessary hospitalizations annually
- Prevent 97,000 to 256,000 of avoidable inpatient days
- Save $195 to $515 million in avoidable health care spending annually

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