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There through every stage.

Whether it’s a teenager with acne, a young adult with an eczema flare-up, or a mom with skin cancer, high self-pay costs can be a barrier to treatment. The CareCredit healthcare credit card with promotional financing options gives patients a financial resource that’s always there to pay for:

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*Subject to credit approval. Minimum monthly payments required. See carecredit.com for details.
**FDA-approved skin cancer treatments only.
Burnout of dermatologists is at record levels.

We used to think that we were immune to it. We thought we had the “goose that laid the golden egg” with controlled hours, minimal night call, and small practices over which we had much control. Things have changed. We have witnessed changes to our practices marching in step by step with each passing year. And with it, we’ve all seen our colleagues getting more mentally tired and jaded. We all know someone who is leaving medicine early because the hassles are too great. Others are just dejected. Perhaps you have these feelings yourself. What is causing this disaffection amongst U.S. physicians? When and why did dermatology fall prey to this crisis?

We write this month about the many factors contributing to burnout. It’s been an incendiary mix. Our practices have gotten bigger with the associated loss of control. The reduced reimbursement by insurers has resulted in more emphasis on billings no matter the practice setting. The push by our government to have all of us using an electronic medical record has made seeing patients ever more challenging. This has been coupled with hassles of the unrelenting pre-authorizations of medications and procedures. Add in to the mix the loss of respect of physicians overall. It is no wonder we feel as we do. Gone are the days when you could just see a patient. Now it takes an army of employees to do the very same task. When my staff is busy, no longer can I simply bring a patient back to the next room and get started. We all need to read this piece, think about it, and start talking about this problem.

The first step is at your local dermatology meeting. If you’ve not taken the time to go of late, this is a wake up call...get going. A discussion of these issues with your local colleagues would be a good beginning. After all, we all need to vent a little about the hassles of the unrelenting pre-authorizations we face? Reach out to your congressmen/women about this issue. It is not hopeless; it can work. We are seeing a little bit of favorable response from CMS to physician concerns about the frustrations of the government programs. After all, why should we as dermatologists walk away from our careers without a fight? And who’s causing this disaffection amongst U.S. physicians? When and why did dermatology fall prey to this crisis?
A Publication of the American Academy of Dermatology Association
Navigating Practice, Policy, and Patient Care

09.2017 | CONTENTS

ONLINE at aad.org/DW

TRENDING

Coming soon, Nada Elbuluk, MD, discusses new research on the role of cannabinoids in dermatology.

CODING QUIZZES

Like Cracking the Code? You’ll love the online version, which includes a quiz about the topic at hand so you can test your knowledge.

DERMATOLOGY WORLD WEEKLY

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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A TANGLED WEB
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FEELING THE BURN
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SHORT SUPPLY
Dermatology hospital consults can spare patients from days or weeks of suffering — and even save their lives. Read stories of great saves made by dermatologists — and find out how you can fit consults into your schedule.

Don’t miss bonus online content at www.aad.org/dw!
NEW NeoStrata® ProSystem RETINOL PEEL

First of its kind, 3% Retinol Peel is clinically proven to exfoliate and improve the appearance of fine lines and wrinkles, help reduce acne and improve skin laxity.

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Week 12 (after 2 peels)

Week 0
Week 6 (after 1 peel)
Week 12 (after 2 peels)

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Physician Editor Abby Van Voorhees, MD, previews this month’s issue.

Our newest column features the thoughts of readers like you! This month we asked, “What do you ask your psoriasis patients at follow-up visits?”

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

If you’ve ever spent more than 30 minutes reviewing a patient’s chart, you’ll want to read this month’s coding column.

Federal action has stalled, but state level progress in the battle against indoor tanning continues.

Some melanomas are tougher to diagnose. Find out what histologic features make the difference.

You want to use a patient photo in an ad—do you need a signed release? Learn all the rules for using patient photos in this month’s legal column.

Social media can be a great way to market your practice. Hear from a colleague who uses it about how to succeed.

How should you build a solid financial future for yourself?

Academy President Henry Lim, MD, on what the AADA is doing to promote truth in advertising by medical providers — and what you can do to help.

The Academy’s CEO addresses the big changes in health care and how the Academy is changing its operations to help you.

Do you know how much the prescription you just wrote costs? How about the procedure you’re about to do? See how you compare to your colleagues.
What do you ask your psoriasis patients at follow-up visits?

\[ \text{The most important question to me is one that will help to understand how they feel about the state of their psoriasis, and specifically to know whether we are achieving the goals we have set. So simply stated: ‘How are you doing?’ and ‘Are you satisfied with the treatments?’ For patients on systemic therapies or on biologics, I also ask about any side effects, and ensure they are up-to-date on their vaccinations.} \]

– Richard G.B. Langley, MD, FRCPC, Halifax, Nova Scotia

\[ \text{I always ask: How do you feel? Has there been improvement? Overall, I’ll also ask about general health and improvements in their mood and outlook. If they are responding, I will also bring up weight reduction, lifestyle issues, and comorbidities, if applicable.} \]

– Erin Boh, MD, PhD, New Orleans

\[ \text{Are you getting new lesions, especially tiny red lesions around the existing ones? Are your lesions itching? These may indicate active psoriasis. For those on methotrexate — are you getting any oral ulcers? Are you taking it in prescribed weekly doses? (Some take it daily!) Are you taking any complementary alternative meds that may interact with our meds?} \]

– Ajit Barve, MBBS, DDV, Mumbai, India

\[ \text{I see mostly pediatric patients, and so my questions focus on coping, impact on school performance, sports and other activities, as well as peer interactions/bullying.} \]

– Kara Shah, MD, PhD, Cincinnati

\[ \text{Are you able to live your life and do everything you want without psoriasis interfering? Are you able to comfortably afford your treatment? Do you have any questions or concerns about our plan for your treatment?} \]

– Colby Evans, MD, Austin, Texas

Next month’s question

Next month, Dermatology World’s Water Cooler column wants to know...

How does your practice handle decorating the office for the holidays?

Send your response to watercooler@aad.org.
**What’s hot?**

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

---

**Body contouring in dermatology offices is growing.** Increased awareness of technologies like cryolipolysis for unwanted fat and vacuum-assisted tissue release for cellulite is driving more patients into our practices and more inquiries from our existing medical patients. Because the removal of fat and treatment of cellulite often exposes overall tissue laxity, interest in tissue tightening is also increasing. Unwanted bulges or cellulite often have tissue laxity as the main cause, and there is a frustrating lack of data for consistent non-surgical tissue tightening protocols on the body.

A quick search of published literature shows a wealth of radiofrequency, needling, ultrasound, microfocused radiofrequency, and even injectables to address tissue laxity on the body, but surprisingly few devices show a reproducible protocol with consistent results. Even less is written about combination multi-modality treatments for body contouring — to address both larger and smaller pockets of unwanted fat, smooth cellulite, and tighten the skin. All these factors are typically brought up as patient concerns in a body contour consult. At CME meetings, everyone seems to have their own little cocktail of devices, injectables, and procedures to address certain areas, but little is published with consistency. As leaders in non-invasive body sculpting, we need to come together as a field to share more knowledge on addressing tissue laxity so we can deliver consistent and complete results. Multi-modality treatment of facial aging has helped dermatologists achieve tremendous patient satisfaction. As the body sculpting market continues to increase, we will need to start similar education for both the field and patients for a similar approach to the body.

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One of the most exciting new developments in procedural dermatology has been the introduction of non-surgical body contouring for unwanted fat reduction. Three different technologies have been used to address this problem including selective cold injury, selective heat, and ultrasound. The first introduced and most studied of these is selective cold injury using cryolipolysis. Originally used to treat unwanted localized fat in the abdominal area and then extended to treat areas such as the back, thighs, and the submental region, most recently an applicator has been introduced to treat unwanted fat of the upper arms. In a recent study both arms were treated with a prototype treatment that took 35 minutes per application at -11° C (*Dermatol Surg.* 2017;43(7):940-949). One hundred percent of the 30 women enrolled in the trial completed. Ultrasound measurements found a mean fat layer reduction of 3.2 mm and blinded independent photograph review found 85 percent correct identification of baseline photographs by at least two of three of the reviewers. There were no unexpected side effects. Numbness was seen in four of the patients beyond the 12 weeks visit but resolved entirely with that intervention. **This new applicator extends our ability to safely and effectively treat localized areas of unwanted fat in almost every area of the body.** Its small size and fat configuration will also allow us to treat areas other than the arm.

---

Vitiligo remains a therapeutically challenging disorder. Rothstein et al investigated the twice daily use of ruxolitinib 1% cream in 11 adult patients (*J Am Acad Dermatol.* 2017;76:1054-60). At week 20, eight (73 percent) patients had some response, with the most clinically significant improvement seen on the face. Other sites such as the acral surfaces (1/8 responded) were predictably more stubborn. There were no serious adverse events noted though some erythema, peripheral hyperpigmentation, and transient papules were noted at treated sites. Any conclusions based upon this study are limited by the small sample size, loss to follow up (18 percent), and lack of laboratory monitoring; however, **the need for better vitiligo treatments is such that even modest evidence, when there is biologic plausibility for effect as in the case of JAK inhibition, warrants further study.** Would that better response were seen at sites like the hands and feet where currently available treatment options routinely fail.

---

Annie Chiu, MD  
Jeffrey S. Dover, MD, FRCPC  
Rob Sidbury, MD, MPH
“Redheads” have fair skin that is more susceptible to skin cancer than their darker counterparts, and this is a consequence of impaired signaling through a mutated melanocortin 1 receptor (MC1R). As a result, melanocytes largely ignore the pituitary-derived hormone α-MSH, which is supposed to activate MITF, a key transcription factor for the production of eumelanin. Because there are a number of signaling steps between MC1R and MITF, a group of researchers led by Dr. Fisher at MGH hypothesized that small molecules could be developed to modulate and rebalance this pathway as a treatment strategy (Cell Rep. 2017 Jun 13;19(11):2177-2184). They previously found that a chemical activator of the pathway darkened the skin of “redheaded mice” that had an MC1R mutation. However, the chemical didn’t penetrate human skin, so they then developed “inhibitors of an inhibitor” of this pathway, which also resulted in activation of MITF and darkened the skin. They were then able to modify these chemicals to penetrate human skin, and now have a promising topical treatment that could darken the fair skin of redheads and potentially other fair-skinned patients, protecting them from skin cancer. The authors didn’t comment on whether these treatments altered the redheaded mouse’s fiery temperament as well...

A prospective study of 1,972 subjects revealed that 43 percent had acne scarring and that acne scarring occurred across all levels of acne severity (J Drugs Dermatol 2017;16(2):97-102). The study showed that acne scarring is a common phenomenon even with mild-to-moderate acne. Several factors were associated with an increased likelihood of acne scarring. The most highly correlated factor was severe acne. However, the elapsed time between the onset of acne and effective treatment was also strongly correlated. Acne onset was around the age of 15 years and there were 1-2 years before initiation of any treatment and 3.7 years before initiation of effective treatment.

Both practitioners and patients should be made aware that acne scarring occurs in all acne severities and it is of utmost importance to begin effective acne therapy early in the course of the disease. Even though there are a large number of treatments for acne scarring, it is currently impossible to completely resolve acne scars. Prevention of acne scarring is key. Practitioners should start effective therapy early in the course of the disease, because delay of effective treatment is a significant modifiable risk factor for scarring. (Acknowledgment: Adam Rees, MD, for sending me this article to validate my low threshold for initiating highly effective acne treatment.)

Three recent articles remind us to take a second look at the ubiquitous, and often ignored seborrheic keratosis (SK). Mesinkovska et al identified 162 cases over 11 years of squamous cell carcinoma (SCC) occurring in an SK (J Am Acad Dermatol. 2017;76:1146-50). These lesions had histopathological features of both SKs and SCCs and occurred most commonly in elderly men with a history of immunosuppression from organ transplantation.

Zalaudek et al collected 134 cases of melanomas that clinically mimicked SKs and provide dermatoscopic clues for diagnosing these clinically challenging melanomas (JAMA Dermatol. 2017;153(6):544-551). Finding any hint of dermatoscopic signs of melanocytic lesions and/or melanoma specific structures including blue/black sign, pigment network, pseudopods or streaks or blue-white veil should prompt biopsy.

Cockerell et al analyzed 4,361 dermatopathology samples clinically identified as SK or irritated SK (ISK) for accuracy of the clinical diagnosis (J Cutan Pathol. 2017;0:1-2). Greater than 86 percent were identified accurately and approximately 11 percent had other benign diagnoses. The remaining 136 that were identified as malignancies — 91 were SCC or in situ SCC, 33 were BCC, and 12 were melanomas.

My take-home message is that SKs are mimickers and masqueraders and should command our respect during an exam. I am much more likely to biopsy than use a destructive method on any “SK” with any unusual features, especially in patients who are immunosuppressed.
A Medicare patient new to you with a complicated history of autoimmune disease with cutaneous involvement comes in for an evaluation of new skin lesions. You evaluate the patient and request a copy of past medical records. A thick stack of printed narrative extruded by the referring physician’s electronic health record system along with a multitude of laboratory results arrives at your office, and you spend 45 minutes examining the materials and integrating their data into your patient treatment plan. Are those 45 minutes you spent reviewing and integrating the data reimbursable by Medicare? Prior to this year, it was not, as such services were considered included (bundled) in the reimbursement for face-to-face Evaluation and Management (E/M) services codes. However, as of Jan. 1 of this year your efforts are both billable to Medicare and payable, provided proper criteria for billing the service are satisfied (see MLN Matters® Number: MM9905).

The CPT® offers two E/M codes that specifically describe prolonged services that are not components of face-to-face office/outpatient E/M and are not extensions of E/M work done on the hospital floor or nursing unit. These codes may be used when the physician work is more extensive than that already captured in the selected E/M code reported, such as chart/data review or detailed discussion of a patient’s condition with an authorized relative, is done at a time separate from a face-to-face patient service. The prolonged service must relate to a prior patient care encounter or to subsequent care (E/M). Chart/records review alone, without previous or subsequent direct patient contact, does not qualify for coding as a prolonged service.

The Federal Register Vol. 81, No. 220 states “these codes would provide a means to recognize the additional resource costs of physicians and other billing practitioners, when they spend an extraordinary amount of time outside of an E/M visit performing work that is related to that visit and does not involve direct patient contact (such as extensive medical record review, review of diagnostic test results or other ongoing care management work).”

Below are the CPT codes describing prolonged E/M services.

99358 Prolonged evaluation and management service before and/or after direct patient care; first hour

+99359 each additional 30 minutes (List separately in addition to code for prolonged service)

According to CPT convention, time values are rounded up once they reach a midpoint between zero and the target time value specified in the code definition.
Thus, for prolonged evaluation and management services, the time partitions are as follows:

<table>
<thead>
<tr>
<th>Prolonged Service Time</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>Not separately reportable</td>
</tr>
<tr>
<td>30 – 74 minutes</td>
<td>99358</td>
</tr>
<tr>
<td>75 – 104 minutes</td>
<td>99358, 99359</td>
</tr>
<tr>
<td>105 – 134 minutes</td>
<td>99358, 99359X2</td>
</tr>
</tbody>
</table>

**Example 1**

You, the dermatologist, receive a thick stack of patient records that you partially review in the morning and then finish reviewing at night. Sixteen minutes are spent in the morning, and 25 minutes in the evening. You feel that your thorough review deserves reimbursement, and bill the patient’s Medicare contractor CPT 99358 for the sum total of 41 minutes that you spent working on the records.

**Answer: Correct.** The CPT allows for summing the total time spent doing a prolonged service on one particular date.

**Example 2**

A new patient with a past history of malignant melanoma and multiple previously biopsied atypical nevi is evaluated by you. The patient brings a manila envelope filled with past medical records, including biopsies, imaging studies, and surgical reports. You take a comprehensive history, do a complete skin, eyes, and oral mucosa examination, palpate the lymph node basins and then spend 35 minutes with the patient reviewing the records and discussing their implications and any treatment plans. You code a new patient visit, CPT 99204 and 99358 for the 35 minutes of records review.

**Answer: Incorrect.** Only the E/M service, CPT 99204, is appropriate. The chart review was done in association with an active, face-to-face patient evaluation, and as such, is considered to be a component of the new patient visit and is bundled into the E/M code. Coding for prolonged services is appropriate only when these are done without associated direct face-to-face patient contact.

**Example 3**

Your office staff has scanned a new patient’s complex past medical record into your electronic health records system, which you may access from outside your office facility in a HIPAA-compliant fashion. You access the records at night from your home and spend 30 minutes reviewing them. You then bill CPT 99358 for your time. The patient is scheduled to be seen the next day in the office.

**Answer: Correct.** The CPT states that prolonged service codes are applicable regardless of the location of the service. You could be inspired to review records while sitting on top of the Himalayas, and as long as the service is medically necessary and appropriately documented, it is appropriately billable.
Example 4 You review a Medicare patient’s records for 60 minutes on Tuesday and then for 20 minutes on Wednesday. You submit a bill with CPT 99358 and 99359 for the total of 80 minutes of time spent reviewing records. The patient was seen in the office on Monday.

Answer: Incorrect. The prolonged service time accrues only for one given date. Time spent on different days is not additive for the purpose of code selection. In the above scenario, Tuesday accrued 60 minutes of prolonged service time and Wednesday, 20 minutes. Only code 99358 is appropriate, and is billable for the Tuesday service. The 20 minutes of time on Wednesday fall below the reportable code threshold, and are therefore not separately billable.

Example 5 Fifty minutes of time spent reviewing a patient’s records at a time separate from a face-to-face patient evaluation are billed to Medicare with CPT 99358. As your utilization of code 99358 had jumped from zero to well above two standard deviations beyond the norm for the year, you are selected for a focused chart audit by your Medicare Administrative Contractor. Argh! All of your 99358 charges for the year are disallowed, and you receive a demand for repayment. What happened? You did the work, and you felt that you had billed appropriately.

Answer: Document the time spent doing the prolonged service in the patient record. Connect the data review with the appropriate E/M encounter and the date the service was performed. The service may consist of speaking (by phone or in person) to an authorized family member about a patient’s disease state and treatment plan, or it may involve extensive records and/or laboratory tests review. In any case, the work done and the time spent doing it must be documented. Although there are no specific documentation requirements, one should record what prolonged service was done, and the time that it took to do it. Of course, the service must also be both reasonable and necessary, per Medicare regulations.

Example 6 Following a Medicare patient’s visit you spend an additional 20 minutes grappling with data entry into an electronic health record, which you finalize. You then take another 11 minutes generating letters to the patient’s primary care physician and to a referring physician. You bill CPT 99358 for your efforts.

Answer: Incorrect. The data entry and letters to physicians constitute an extension of the face-to-face E/M service and are not separately reportable. The CPT Evaluation and Management (E/M) Services Guidelines specifies that pre- and post-encounter time, such as reviewing chart data and communicating with other professionals via reports and telephone, is included in calculating the total work inherent to an E/M service. Consequently, this work is not separately reportable or billable.
In the 300-mg arm of the ERASURE study at Week 12:
- 82% of patients achieved PASI 75 at Week 12; of those, 7 out of 10 achieved PASI 90.
- The majority of patients achieved clear or almost clear skin.
- Over 80% of patients on COSENTYX 300 mg in the ERASURE and FIXTURE studies who achieved PASI 75 at Week 12 sustained their response at Week 52.

*In ERASURE, % of patients achieving an end point on 150 mg vs placebo at Week 12 were: PASI 75 (71 vs 4), IGA 0 or 1 (51 vs 2), and PASI 90 (39 vs 1). In FIXTURE, results on 300 mg vs placebo at Week 12 were: PASI 75 (78 vs 5), IGA 0 or 1 (62 vs 3), and PASI 90 (64 vs 2). In FIXTURE, results on 150 mg vs placebo at Week 12 were: PASI 75 (67 vs 5), IGA 0 or 1 (61 vs 3), and PASI 90 (42 vs 2). P<0.001 for all comparisons. Similar results seen in FEATURE and JUNCTURE.

†In ERASURE, 59% of patients achieved PASI 90 on 300 mg vs 1% for placebo at Week 12.
‡In ERASURE, 80% of patients on COSENTYX 300 mg achieved IGA mod 2011 0 or 1 vs 2% of patients on placebo at Week 12.
§In the COSENTYX 300-mg treatment arm, 81% and 84% of patients in ERASURE and FIXTURE, respectively, who achieved PASI 75 at Week 12 sustained their response at Week 52.

See Study Design details on page 2.

**INDICATIONS**
COSENTYX® (secukinumab) is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

**IMPORTANT SAFETY INFORMATION**
CONTRAINDICATIONS
COSENTYX is contraindicated in patients with a previous serious hypersensitivity reaction to secukinumab or to any of the excipients.

Please see additional Important Safety Information on following pages. Please see Brief Summary of full Prescribing Information on adjacent pages.
Study Designs: The ERASURE and FIXTURE studies were multicenter, randomized, double-blind, placebo-controlled trials. ERASURE evaluated adult patients who received COSENTYX 300 mg (n=245), COSENTYX 150 mg (n=245), or placebo (n=248). FIXTURE evaluated adult patients who received COSENTYX 300 mg (n=327), COSENTYX 150 mg (n=327), placebo (n=326), or a biologic active control (n=323). All patients were adults with moderate to severe plaque psoriasis who had a BSA $\geq 10\%$, PASI score $\geq 12$, and IGA mod 2011 score $\geq 3$, and were candidates for systemic therapy or phototherapy. Patients received treatment at Weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter. Patients randomized to receive placebo who were nonresponders at Week 12 were then crossed over to receive COSENTYX 300 mg or 150 mg. All patients were followed for up to 52 weeks. Coprimary end points were PASI 75 and IGA 0 or 1 (clear or almost clear) response at Week 12, evaluated using nonresponder imputation analysis (NRI).1

ERASURE/FIXTURE Extension study is a multicenter, double-blind, randomized, uncontrolled, withdrawal study of COSENTYX in patients completing 52 weeks in the core studies. Patients treated with COSENTYX 300 mg or 150 mg during the maintenance period in either of the core studies and exhibited PASI 75 at Week 52 were eligible to be rerandomized 2:1 to continue the same COSENTYX dose or receive placebo (withdrawal from active treatment). Placebo patients who experienced relapse (defined as loss of >50% of maximum PASI improvement compared to baseline of the core study) at any visit were retreated with 5 weekly doses of COSENTYX 300 mg (n=136) or 150 mg (n=123), followed by 1 dose every 4 weeks.3

The SCULPTURE Extension study is a multicenter, uncontrolled, double-blind and open-label (from Week 156 through Week 260) extension study (n=642). Patients who completed 52 weeks of the SCULPTURE study were eligible to continue the same COSENTYX dose and regimen in the extension to Week 156. At Week 156, the study was unblinded and, based on investigator judgment, patients could switch dosing regimens (from SoR to FI regimen and from COSENTYX 150 mg to 300 mg). Results shown are for COSENTYX 300 mg FI patients who were followed for up to 208 weeks (n=168 at extension baseline, n=131 at Year 4). Primary and secondary end points were long-term safety and PASI 75/90 responses over time in PASI 75 responders at Week 12 from the core study, respectively.2†

For PsA patients without moderate to severe plaque psoriasis, starting dose is 150 mg.1

*Double-blind from Year 1 to Year 3, open-label from Year 3 to Year 4.
†Response rate PASI 90 at Year 1 (68.5%) and Year 4 (66.4%).
BSA=body surface area; FI=fixed interval; IGA=Investigator’s Global Assessment; IL=interleukin; PASI=Psoriasis Area and Severity Index; PsA=psoriatic arthritis; PsO=psoriasis; SoR=start of relapse.

PASI 90 response rates were maintained from Year 1 to Year 4—OLE*; as observed analysis2

95% of patients who relapsed during a drug holiday regained PASI 75 at Week 12 after restarting COSENTYX3

The only IL-17A antagonist indicated for PsO and PsA1
IMPORTANT SAFETY INFORMATION (cont)

WARNINGS AND PRECAUTIONS

Infections

COSENTYX may increase the risk of infections. In clinical trials, a higher rate of infections was observed in subjects treated with COSENTYX compared to placebo-treated subjects. In placebo-controlled clinical trials in patients with moderate to severe plaque psoriasis, higher rates of common infections such as nasopharyngitis (11.4% versus 8.6%), upper respiratory tract infection (2.5% versus 0.7%), and mucocutaneous infections with candida (1.2% versus 0.3%) were observed with COSENTYX compared with placebo. A similar increase in risk of infection was seen in placebo-controlled trials in patients with psoriatic arthritis. The incidence of some types of infections appeared to be dose-dependent in clinical studies.

Exercise caution when considering the use of COSENTYX in patients with a chronic infection or a history of recurrent infection.

Instruct patients to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and COSENTYX should be discontinued until the infection resolves.

Please see additional Important Safety Information on previous and following pages.

Please see Brief Summary of full Prescribing Information on adjacent pages.

"Thank you for prescribing COSENTYX. I can’t believe my skin looks so good for so long."
IMPORTANT SAFETY INFORMATION (cont)

Pre-treatment Evaluation for Tuberculosis
Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with COSENTYX. Do not administer COSENTYX to patients with active TB infection. Initiate treatment of latent TB prior to administering COSENTYX. Consider anti-TB therapy prior to initiation of COSENTYX in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Patients receiving COSENTYX should be monitored closely for signs and symptoms of active TB during and after treatment.

Inflammatory Bowel Disease
Caution should be used when prescribing COSENTYX to patients with inflammatory bowel disease. Exacerbations, in some cases serious, occurred in patients treated with COSENTYX during clinical trials in plaque psoriasis and psoriatic arthritis. In addition, new onset inflammatory bowel disease cases occurred in clinical trials with COSENTYX. In an exploratory study in 59 patients with active Crohn’s disease, there were trends toward greater disease activity and increased adverse events in the secukinumab group as compared to the placebo group. Patients who are treated with COSENTYX should be monitored for signs and symptoms of inflammatory bowel disease.

Hypersensitivity Reactions
Anaphylaxis and cases of urticaria occurred in patients treated with COSENTYX in clinical trials. If an anaphylactic or other serious allergic reaction occurs, administration of COSENTYX should be discontinued immediately and appropriate therapy initiated.

The removable cap of the COSENTYX Sensoready® pen and the COSENTYX prefilled syringe contains natural rubber latex which may cause an allergic reaction in latex-sensitive individuals. The safe use of the COSENTYX Sensoready pen or prefilled syringe in latex-sensitive individuals has not been studied.

Vaccinations
Prior to initiating therapy with COSENTYX, consider completion of all age appropriate immunizations according to current immunization guidelines. Patients treated with COSENTYX should not receive live vaccines. Non-live vaccinations received during a course of COSENTYX may not elicit an immune response sufficient to prevent disease.

MOST COMMON ADVERSE REACTIONS
Most common adverse reactions (>1%) are nasopharyngitis, diarrhea, and upper respiratory tract infection.

Please see additional Important Safety Information on previous pages.
Please see Brief Summary of full Prescribing Information on adjacent pages.

This advertisement contains pictures of actual COSENTYX patients who have been compensated for their time.

COSENTYX® (secukinumab) injection, for subcutaneous use
COSENTYX® (secukinumab) for injection, for subcutaneous use

Initial U.S. Approval: 2015

BRIEF SUMMARY: Please see package insert for full prescribing information.

1 INDICATIONS AND USAGE

1.1 Plaque Psoriasis
COSENTYX® is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

1.2 Psoriatic Arthritis
COSENTYX is indicated for the treatment of adult patients with active psoriatic arthritis.

1.3 Ankylosing Spondylitis
COSENTYX is indicated for the treatment of adult patients with active ankylosing spondylitis.

4 CONTRAINDICATIONS
COSENTYX is contraindicated in patients with a previous serious hypersensitivity reaction to secukinumab or to any of the excipients [see Warnings and Precautions (5.4)].

5 WARNINGS AND PRECAUTIONS

5.1 Infections
COSENTYX may increase the risk of infections. In clinical trials, a higher rate of infections was observed in COSENTYX treated subjects compared to placebo-treated subjects. In placebo-controlled clinical trials in patients with moderate to severe plaque psoriasis, higher rates of common infections such as nasopharyngitis (11.4% versus 8.6%), upper respiratory tract infection (2.5% versus 0.7%) and mucocutaneous infections with candida (1.2% versus 0.3%) were observed with COSENTYX compared with placebo. A similar increase in risk of infection was seen in placebo-controlled trials in patients with psoriatic arthritis and ankylosing spondylitis [see Adverse Reactions (6.1)]. The incidence of some types of infections appeared to be dose-dependent in clinical studies [see Adverse Reactions (6.1)]. Exercise caution when considering the use of COSENTYX in patients with a chronic infection or a history of recurrent infection. Instruct patients to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and COSENTYX should be discontinued until the infection resolves.

5.2 Pre-treatment Evaluation for Tuberculosis
Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with COSENTYX. Do not administer COSENTYX to patients with active TB infection. Initiate treatment of latent TB prior to administering COSENTYX. Consider anti-TB therapy prior to initiation of COSENTYX in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Patients receiving COSENTYX should be monitored closely for signs and symptoms of active TB during and after treatment.

5.3 Inflammatory Bowel Disease
Caution should be used when prescribing COSENTYX to patients with inflammatory bowel disease. Exacerbations, in some cases serious, occurred in COSENTYX treated patients during clinical trials in plaque psoriasis, psoriatic arthritis and ankylosing spondylitis. In addition, new onset inflammatory bowel disease cases occurred in clinical trials with COSENTYX. In an exploratory study in 59 patients with active Crohn’s disease, there were trends toward greater disease activity and increased adverse events in the secukinumab group as compared to the placebo group. Patients who are treated with COSENTYX should be monitored closely for signs and symptoms of inflammatory bowel disease [see Adverse Reactions (6.1)].

5.4 Hypersensitivity Reactions
Anaphylaxis and cases of urticaria occurred in COSENTYX treated patients in clinical trials. If an anaphylactic or other serious allergic reaction occurs, administration of COSENTYX should be discontinued immediately and appropriate therapy initiated [see Adverse Reactions (6.1)].

5.5 Risk of Hypersensitivity in Latex-sensitive Individuals
The removable cap of the COSENTYX Sensoready pen and the COSENTYX prefilled syringe contains natural rubber latex which may cause an allergic reaction in latex-sensitive individuals. The safe use of COSENTYX Sensoready pen or prefilled syringe in latex-sensitive individuals has not been studied.

5.6 Vaccinations
Prior to initiating therapy with COSENTYX, consider completion of all age appropriate immunizations according to current immunization guidelines. Patients treated with COSENTYX should not receive live vaccines. Non-live vaccinations received during a course of COSENTYX may not elicit an immune response sufficient to prevent disease.

6 ADVERSE REACTIONS

The following adverse reactions are discussed in greater detail elsewhere in the labeling:

- Infections [see Warnings and Precautions (5.1)]
- Inflammatory Bowel Disease [see Warnings and Precautions (5.3)]
- Hypersensitivity Reactions [see Warnings and Precautions (5.4)]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Plaque Psoriasis

A total of 3430 plaque psoriasis subjects were treated with COSENTYX in controlled and uncontrolled clinical trials. Of these, 1641 subjects were exposed for at least 1 year.

Four placebo-controlled phase 3 trials in plaque psoriasis subjects were pooled to evaluate the safety of COSENTYX in comparison to placebo up to 12 weeks after treatment initiation. In Trials 1, 2, 3, and 4, in total, 2077 subjects were evaluated (691 to COSENTYX 300 mg group, 692 to COSENTYX 150 mg group, and 694 to placebo group) [see Clinical Studies (14) in the full prescribing information].

Table 1 summarizes the adverse reactions that occurred at a rate of at least 1% and at a higher rate in the COSENTYX group than the placebo group during the 12-week placebo-controlled period of the placebo-controlled trials.

Table 1 Adverse Reactions Reported by Greater Than 1% of Subjects with Plaque Psoriasis Through Week 12 in Trials 1, 2, 3, and 4

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>COSENTYX 300 mg (N=691)</th>
<th>COSENTYX 150 mg (N=692)</th>
<th>Placebo (N=694)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urticaria</td>
<td>4 (0.6)</td>
<td>8 (1.2)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>8 (1.2)</td>
<td>7 (1.0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>79 (11.4)</td>
<td>85 (12.3)</td>
<td>60 (8.6)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>28 (4.1)</td>
<td>18 (2.6)</td>
<td>10 (1.4)</td>
</tr>
<tr>
<td>Oral herpes</td>
<td>9 (1.3)</td>
<td>1 (0.1)</td>
<td>2 (0.3)</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>17 (2.5)</td>
<td>22 (3.2)</td>
<td>5 (0.7)</td>
</tr>
<tr>
<td>Rhinitis</td>
<td>10 (1.4)</td>
<td>10 (1.4)</td>
<td>5 (0.7)</td>
</tr>
<tr>
<td>Colds</td>
<td>176 (25.4)</td>
<td>171 (25.3)</td>
<td>86 (12.2)</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>8 (1.2)</td>
<td>8 (1.2)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Otitis</td>
<td>13 (1.9)</td>
<td>13 (1.9)</td>
<td>11 (1.6)</td>
</tr>
<tr>
<td>Photophobia</td>
<td>4 (0.6)</td>
<td>4 (0.6)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Mucocutaneous infections</td>
<td>21 (3.0)</td>
<td>21 (3.1)</td>
<td>5 (0.7)</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>34 (4.8)</td>
<td>34 (4.8)</td>
<td>21 (3.1)</td>
</tr>
<tr>
<td>Otitis externa</td>
<td>14 (2.0)</td>
<td>14 (2.0)</td>
<td>7 (1.0)</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>6 (0.9)</td>
<td>6 (0.9)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Arthritis</td>
<td>2 (0.3)</td>
<td>2 (0.3)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>10 (1.4)</td>
<td>10 (1.4)</td>
<td>5 (0.7)</td>
</tr>
<tr>
<td>Erythema</td>
<td>6 (0.9)</td>
<td>6 (0.9)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Urticaria</td>
<td>4 (0.6)</td>
<td>8 (1.2)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Rhinorrhea</td>
<td>8 (1.2)</td>
<td>2 (0.3)</td>
<td>1 (0.1)</td>
</tr>
</tbody>
</table>

Adverse reactions that occurred at rates less than 1% in the placebo-controlled period of Trials 1, 2, 3, and 4 through Week 12 included: sinusitis, tinea pedis, conjunctivitis, tonsillitis, oral candidiasis, impetigo, otitis media, otitis externa, inflammatory bowel disease, increased liver transaminases, and neutropenia.

Infections

In the placebo-controlled period of the clinical trials in plaque psoriasis (a total of 1332 subjects treated with COSENTYX and 694 subjects treated with placebo up to 12 weeks), infections were reported in 28.7% of subjects treated with COSENTYX compared with 18.9% of subjects treated with placebo. Serious infections occurred in 0.14% of patients treated with COSENTYX and in 0.3% of patients treated with placebo [see Warnings and Precautions (5.4)].

Over the entire treatment period (a total of 3430 plaque psoriasis subjects treated with COSENTYX for up to 52 weeks for the majority of subjects), infections were reported in 47.5% of subjects treated with COSENTYX (0.9 per patient-year of follow-up). Serious infections were reported in 1.2% of subjects treated with COSENTYX (0.015 per patient-year of follow-up).

Phase 3 data showed an increasing trend for some types of infection with increasing serum concentration of secukinumab. Candida infections, herpes viral infections, staphylococcal skin infections, and infections requiring treatment increased as serum concentration of secukinumab increased.

Neutropenia was observed in clinical trials. Most cases of secukinumab-associated neutropenia were transient and reversible. No serious infections were associated with cases of neutropenia.

Inflammatory Bowel Disease

Cases of inflammatory bowel disease, in some cases serious, were observed in clinical trials with COSENTYX. In the plaque psoriasis program, with 3430 patients exposed to COSENTYX over the entire treatment period for up to 52 weeks (2,725 patient-years), there were 3 cases (0.1 per 100 patient-years) of exacerbation of Crohn’s disease, 2 cases (0.08 per 100 patient-years) of exacerbation of ulcerative colitis, and 2 cases (0.08 per 100 patient-years) of new onset ulcerative colitis. There were no cases in placebo patients (N=793; 176 patient-years) during the 12 week placebo-controlled period.
One case of exacerbation of Crohn’s disease was reported from long-term non-controlled portions of ongoing clinical trials in plaque psoriasis [see Warnings and Precautions (5.3)].

**Hypersensitivity Reactions**
Anaphylaxis and cases of urticaria occurred in COSENTYX treated patients in clinical trials [see Warnings and Precautions (5.4)].

**Psoriatic Arthritis**
COSENTYX was studied in two placebo controlled psoriatic arthritis trials with 1003 patients (703 patients on COSENTYX and 300 patients on placebo). Of the 703 patients who received COSENTYX, 299 patients received a subcutaneous loading dose of COSENTYX (PsA1) and 404 patients received an intravenous loading dose of secukinumab (PsA2) followed by COSENTYX administered by subcutaneous injection every four weeks. During the 16-week placebo-controlled period of the trials in patients with psoriatic arthritis, the overall proportion of patients with adverse events was similar in the secukinumab and placebo-treatment groups (59% and 58%, respectively). The adverse events that occurred at a proportion of at least 2% and at a higher proportion in the COSENTYX groups than the placebo groups during the 16-week placebo-controlled period were nasopharyngitis, upper respiratory tract infection, headache, nausea, and hypercholesterolemia. The safety profile observed in patients with psoriatic arthritis treated with COSENTYX is consistent with the safety profile in psoriasis. Similar to the clinical trials in patients with psoriasis, there was an increased proportion of patients with infections in the COSENTYX groups (29%) compared to placebo group (26%) [see Warnings and Precautions (5.3)].

There were cases of Crohn’s disease and ulcerative colitis that include patients who experienced either exacerbations or the development of new disease. There were three cases of inflammatory bowel disease, of which two patients received secukinumab and one received placebo [see Warnings and Precautions (5.3)].

**Ankylosing Spondylitis**
COSENTYX was studied in two placebo controlled ankylosing spondylitis trials with 590 patients (394 patients on COSENTYX and 196 patients on placebo). Of the 394 patients who received COSENTYX, 145 patients received a subcutaneous load of COSENTYX (study AS1) and 249 received an intravenous loading dose of secukinumab (study AS2) followed by COSENTYX administered by subcutaneous injection every four weeks. During the 16-week placebo-controlled period of the trials in patients with ankylosing spondylitis, the overall proportion of patients with adverse events was higher in the secukinumab groups than the placebo-treatment groups (66% and 59%, respectively). The adverse events that occurred at a proportion of at least 2% and at a higher proportion in the COSENTYX groups than the placebo groups during the 16-week placebo-controlled period were nasopharyngitis, nausea, and upper respiratory tract infection. The safety profile observed in patients with ankylosing spondylitis treated with COSENTYX is consistent with the safety profile in psoriasis. Similar to clinical trials in patients with psoriasis, there was an increased proportion of patients with infections in the COSENTYX groups (31%) compared to the placebo group (18%) [see Warnings and Precautions (5.3)].

In the ankylosing spondylitis program, with 571 patients exposed to COSENTYX there were 8 cases of inflammatory bowel disease during the entire treatment period (5 Crohn’s (0.7 per 100 patient-years) and 3 ulcerative colitis (0.4 per 100 patient-years)). During the placebo-controlled 16-week period, there were 2 Crohn’s disease exacerbations and 1 new onset ulcerative colitis case that was a serious adverse event in patients treated with COSENTYX compared to none of the patients treated with placebo. During the remainder of the study when all patients received COSENTYX, 1 patient developed Crohn’s disease, 2 patients had Crohn’s exacerbations, 1 patient developed ulcerative colitis, and 1 patient had an ulcerative colitis exacerbation [see Warnings and Precautions (5.3)].

**6.2 Immunogenicity**
As with all therapeutic proteins, there is the potential for immunogenicity. The immunogenicity of COSENTYX was evaluated using an electrochemiluminescence-based bridging immunosassay. Less than 1% of subjects treated with COSENTYX developed antibodies to secukinumab in up to 52 weeks of treatment. However, this assay has limitations in detecting anti-secukinumab antibodies in the presence of secukinumab; therefore the incidence of antibody development might not have been reliably determined. Of the subjects who developed antidrug antibodies, approximately one-half had antibodies that were classified as neutralizing. Neutralizing antibodies were not associated with loss of efficacy. The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of incidence of antibodies to COSENTYX with the incidences of antibodies to other products may be misleading.

**7 DRUG INTERACTIONS**
Drug interaction trials have not been conducted with COSENTYX.

**7.1 Live Vaccines**
Patients treated with COSENTYX may not receive live vaccinations [see Warnings and Precautions (5.6)].

**7.2 Non-Live Vaccines**
Patients treated with COSENTYX may receive non-live vaccinations. Healthy individuals who received a single 150 mg dose of COSENTYX 2 weeks prior to vaccination with a non-U.S. approved group C meningococcal polysaccharide conjugate vaccine and a non-U.S. approved inactivated seasonal influenza vaccine had similar antibody responses compared to individuals who did not receive COSENTYX prior to vaccination. The clinical effectiveness of meningococcal and influenza vaccines has not been assessed in patients undergoing treatment with COSENTYX [see Warnings and Precautions (5.6)].

**7.3 CYP450 Substrates**
A role for IL-17A in the regulation of CYP450 enzymes has not been reported. The formation of CYP450 enzymes can be altered by increased levels of certain cytokines (e.g., IL-1, IL-6, IL-10, TNFα, IFN) during chronic inflammation. Thus, COSENTYX, an antagonist of IL-17A, could normalize the formation of CYP450 enzymes. Upon initiation or discontinuation of COSENTYX in patients who are receiving concomitant CYP450 substrates, particularly those with a narrow therapeutic index, consider monitoring for therapeutic effect (e.g., for warfarin) or drug concentration (e.g., for cyclosporine) and consider dosage modification of the CYP450 substrate.

**8 USE IN SPECIFIC POPULATIONS**

**8.1 Pregnancy**

**Pregnancy Category B**
There are no adequate and well controlled trials of COSENTYX in pregnant women. Developmental toxicity studies conducted with monkeys found no evidence of harm to the fetus due to secukinumab. COSENTYX should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

An embryofetal development study was performed in cynomolgus monkeys with secukinumab. No malformations or embryofetal toxicity were observed in fetuses from pregnant monkeys that were administered secukinumab weekly by the subcutaneous route during the period of organogenesis at doses up to 30 times the maximum recommended human dose (MRHD; on a mg/kg basis at a maternal dose of 150 mg/kg). A pre- and postnatal development toxicity study was performed in mice with a murine analog of secukinumab. No treatment related effects on functional, morphological or immunological development were observed in fetuses from pregnant mice that were administered the murine analog of secukinumab on gestation days 8, 11, and 17 and on postpartum days 4, 10, and 16 at doses up to 150 mg/kg/dose.

**8.3 Nursing Mothers**
It is not known whether secukinumab is excreted in human milk or absorbed systemically after ingestion. Because many drugs are excreted in human milk, caution should be exercised when COSENTYX is administered to a nursing woman.

**8.4 Pediatric Use**
Safety and effectiveness of COSENTYX in pediatric patients have not been evaluated.

**8.5 Geriatric Use**
Of the 3430 plaque psoriasis subjects exposed to COSENTYX in clinical trials, a total of 230 were 65 years or older, and 32 subjects were 75 years or older. Although no differences in safety or efficacy were observed between older and younger subjects, the number of subjects aged 65 years and older was not sufficient to determine whether they responded differently from younger subjects.

**10 OVERDOSAGE**
Doses up to 30 mg/kg intravenously have been administered in clinical trials without dose-limiting toxicity. In the event of overdosage, it is recommended that the patient be monitored for any signs or symptoms of adverse reactions and appropriate symptomatic treatment be instituted immediately.

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Gains made in state indoor tanning restrictions

STATE NEWS ROUNDPUP

BY VICTORIA PASKO, MANAGER, STATE POLICY

After the disappointing news that the U.S. Food and Drug Administration would not finalize its 2015 proposed rule to prohibit minors from using indoor tanning devices, the American Academy of Dermatology Association (AADA) doubled down on its efforts to protect minors at the state level in 2017 and advocated in a number of states for youth restrictions on indoor tanning. The AADA helped several states who worked on the issue through AADA State Advocacy Grants.

Enacted

West Virginia and Oklahoma became the 17th and 18th states to prohibit minors under 18 from using indoor tanning beds. Prince George’s County in Maryland also passed an under-18 ban, making it the third county in Maryland to pass such an ordinance. With these three county ordinances, a good portion of the state’s minors are protected. The Maryland Dermatologic Society, the AADA, and the American Cancer Society-Cancer Action Network worked in a coalition to advance this bill and will continue to look for opportunities to push this legislation in more Maryland counties and cities.

Vetoed

Maine’s Gov. Paul LePage vetoed an under-18 tanning restriction bill for the second time in his Administration — he previously vetoed the legislation in 2013. In his veto message, Gov. LePage stated that the under-14 ban currently in place already significantly limits minors’ abilities to access the devices, adding
that the proposed bill to prohibit minors under 18 is an unnecessary overreach of government.

**Dead**

Several states considered legislation to restrict minors from using indoor tanning beds. **Arizona, Arkansas, Iowa, Kentucky, Mississippi, New Mexico,** and **New York** all considered bills that would restrict minors under 18. The **Arizona Dermatology and Dermatologic Surgery Society** and the **Arkansas Dermatologic Society** funded their advocacy efforts in part by an AADA State Advocacy Grant. An under-18 prohibition bill and a bill to allow for parental consent for minors under 16 were both introduced in **Montana.** However, both bills died, and Montana currently has no youth restrictions on indoor tanning. **California’s legislature** saw the reintroduction of legislation that would move the regulation of tanning beds to the Department of Public Health, whereby inspections would be required every year as well as upon injury or complaint.

**State Advocacy Grant Program applications due Sept. 30**

The AADA State Advocacy Grant Program is accepting applications for 2018. The State Advocacy Grant Program provides financial assistance to state dermatology societies for the advancement of their health policy initiatives. To learn more about the program and to access the web-based application, visit [www.aad.org/advocacy/state-policy/state-advocacy-grants](http://www.aad.org/advocacy/state-policy/state-advocacy-grants). Applications are due Sept. 30, 2017.

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**State Advocate Spotlight**

**Dermatology World** features a grassroots advocate and their efforts to support the specialty’s advocacy agenda at the state level each month in ‘State Advocate Spotlight.’

**Name:** Timothy Chang, MD  
**State:** Ohio  
**Issue:** Compounding

**Spotlight:** In 2016, the Ohio Board of Pharmacy voted to retract and redraft low-risk sterile compounding rules. New rules require physicians to obtain a terminal distributor of dangerous drug (TDDD) license in order to possess, have custody or control of, or distribute dangerous drugs that are compounded or used for the purpose of compounding. Additionally, the new rules state that providers would have six hours to administer a compounded drug without the need for an ISO class 5 environment.

As legislative chair at the Ohio Dermatological Association, Dr. Chang has been active in opposing the rules and explaining dermatology’s perspective to policymakers.

**Dermatology World:** Since the rule is finalized, what are the next steps in terms of advocacy for overturning the rule so dermatologists can continue compounding drugs in their office?

**Dr. Chang:** At our annual Ohio Dermatological Association Legislative and Advocacy day this year we had dermatologists from throughout our state meet with various legislators asking them to intervene with the board of pharmacy to re-visit these new regulations and allow dermatologists to continue compounding drugs in their office.

**Dermatology World:** Compounding is a difficult subject for the layperson to understand. What are some of the best strategies for explaining safe dermatologic compounding to a legislator?

**Dr. Chang:** One of our members, Dr. Brett Coldiron, created kits that we brought to our meetings with legislators to show them how we actually compound medications for the benefit of our patients. We also emphasized our long track record of patient safety in dermatology with compounding drugs, and that the original problem was with a compounding pharmacy (New England Compounding Center) that was making tainted drugs for patient use.

**Dermatology World:** What are the implications of the Ohio Board of Pharmacy’s rule on other states/regulations, and what can physicians do to combat this issue?

**Dr. Chang:** Given the ongoing negative press regarding compounding pharmacies, other pharmacy boards may want to enact restrictive regulations because they feel they are protecting the public from the dangers of compounding. Dermatologists need to be aware of upcoming proposals or regulations that are being considered by their state pharmacy boards. If they are not proactive and engaged in the process, new regulations could be enacted that will negatively affect patient care and increase costs for dermatologists in their practices.
What features are most helpful in diagnosing challenging melanoma cases?

BY ABBY S. VAN VOORHEES, MD

In this month’s Acta Eruditorum column, Physician Editor Abby S. Van Voorhees, MD, talks with Garth R. Fraga, MD, about his recent Journal of the American Academy of Dermatology article, “Histopathologic features of melanoma in difficult-to-diagnose lesions: A case-control study.”

Dr. Van Voorhees: We all recognize that a subset of cases of melanoma can be challenging to diagnose. How frequently is this an issue?

Dr. Fraga: Most invasive melanomas are straightforward to diagnose, but about 5 percent have unconventional features. For example, nevoid and spitzoid melanomas are challenging to diagnose even for experts. However, in my daily practice, most of my “problem” cases are either incisional biopsies of broad pigmented lesions or peculiar nevi with features that mimic melanoma.

Dr. Van Voorhees: Tell us about your study. Where did you get your cases? Who participated in the study? How did you determine the “correct” answer for these cases?

Dr. Fraga: We performed a retrospective study of 100 challenging pigmented lesions extracted from a community dermatopathology practice. These were cases in which the primary dermatopathologist was unsure of the diagnosis and requested an expert opinion from a nationally recognized expert in melanocytic tumors. If the expert was able to make a definite diagnosis of benign nevus or malignant melanoma we included the case in the study. The expert could not make a definite diagnosis approximately a quarter of the time, so we had to review 133 cases before we could find 100 with definite benign and malignant diagnoses. In some instances the expert utilized molecular techniques such as comparative genomic hybridization to arrive at a definitive diagnosis. We asked each of the five observers to independently review the glass slides from these cases and identify which ones were positive for the 10 histopathologic features of melanoma we were interested in. The five observers in our study were all dermatopathologists and included a mix of community practice, Veterans Affairs, and academic dermatopathologists with primary training in either dermatology or pathology.

Dr. Fraga: What histologic features are generally used to distinguish between benign and malignant pigmented lesions? What are the limitations of these features? Have they been studied in all types of melanoma? How much intraobserver reproducibility is there when it comes to these features?

Dr. Fraga: The histologic features used to distinguish benign from malignant pigmented lesions include attributes common to clinical dermatology such as asymmetry, sun damage, and broad surface diameter, and others that are only evaluable with microscopic examination such as cellular atypia, aberrant mitotic activity, pagetoid melanocytosis, irregular distribution of melanocytes, and predominance of solitary over nested melanocytes. We found that some of these features were much more reproducible than others. For example, there was good agreement between the observers in our study on broad surface diameter but poor agreement on consumption (thinning associated with proliferating melanocytes) of the epidermis.

What’s Trending?

Want more clinical news? Visit www.aad.org/dw and search for “Trending” to watch short videos about exciting new research.
Dr. Van Voorhees: What were the histologic features studied?

Dr. Fraga: We studied broad surface diameter, pagetoid melanocytosis, single cell melanocytosis (predominance of singly dispersed melanocytes over nested melanocytes), cellular atypia, irregular nesting, aberrant mitotic activity, solar elastosis, asymmetry, absence of vertical maturation, and consumption of the epidermis.

Dr. Van Voorhees: What did this study demonstrate? What features did you find to be most influential in identifying melanomas? How much interobserver agreement did you see in these challenging cases? Did anything you found surprise you?

Dr. Fraga: This study demonstrated that asymmetry, broad surface diameter, single cell melanocytosis, pagetoid melanocytosis, and solar elastosis, were most influential in a final diagnosis of melanoma. Whilst we found fairly good interobserver agreement on final diagnosis, there was a broad range in agreement on the individual attributes — some like broad surface diameter were identified consistently, whereas others like consumption of the epidermis had very poor interobserver agreement. I was surprised that cellular atypia was not a more robust feature of melanoma. This might have been due to the high content of Spitz, Reed, special site, and dysplastic nevi in the study set. Interestingly, irregular nesting was more predictive of nevus than melanoma in this context of difficult to diagnose melanocytic tumors.

Dr. Van Voorhees: What are the practical implications for the practicing dermatopathologist? Do you anticipate that an algorithm could be developed to assist in these challenging cases? Did any single histologic feature stand out as the sole important feature in leading a dermatopathologist to the correct diagnosis? Was the sum total of the features more diagnostically helpful?

Dr. Fraga: This study shows that dermatopathologists integrate multiple findings in arriving at a diagnosis, not all of which are equally reproducible or influential. Cognitive decision-making research has shown that whilst our gut instincts are good for common situations, when we are confronted with difficult decisions an analytic approach may be best. I believe the findings in this study could be used to create a diagnostic algorithm for difficult to diagnose lesions that weights the more influential criteria whilst also assigning value to both the dermatopathologist’s and the clinical dermatologist’s intuitive judgement. Among the 10 variables we studied, asymmetry was the most accurate indicator of melanoma. Dermatologists should be aware that incisional samples of broad lesions prohibit assessment of asymmetry and may lead to inaccurate diagnoses. dw
According to the unbiased survey conducted by Black Book™, EMA™, our Cloud, Mobile, Touch EHR solution, is the best in the business yet again. For four consecutive years, EMA leads the industry in delivering dermatology-specific insight at the point of care to speed up exams and drive healthier outcomes.

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“When one of our physicians was seeing over 100 patients per day with our previous EHR system, he would have to spend a few hours each evening and almost seven hours over the weekend to catch up on dictations. With EMA, he now spends about 30 minutes per day finalizing electronic notes and his weekends are free.”

— SOM PHIMMASONE, OPERATIONS MANAGER

BACKGROUND

Ada West Dermatology, located in Meridian, Idaho, had been using an EHR system that lacked dermatology-specific content and impeded efficiencies. In their search for a replacement, the leadership team performed thorough due diligence in an effort to provide an easy transition for their 14 providers and over 70 staff members.

Som Phimmasone, Operations Manager, shared, “Although our previous server-based EHR system wasn’t perfect, we decided to try it out for two years. Unfortunately, after a respectable effort, we realized it wasn’t going to work for our practice. The system was geared towards primary care and was not customizable to our distinct dermatology needs. We then reviewed 45 different systems and our lack of trust in a vendor made us leery to pursue any.”

“EMA is programmed to think like a dermatologist and intuitively adapts to its users’ preferences while effortlessly generating thorough documentation and billing codes. The real-time data collection and dynamic functionality EMA enables allows the providers at Ada West Dermatology to work faster and more efficiently, saving them time and money.

“The physician at our practice who initially was the most skeptical of EMA has become its biggest advocate. When he was seeing over 100 patients per day with our previous EHR system, he would have to spend a few hours each evening and almost seven hours over the weekend to catch up on dictations. With EMA, not only has he cut out dictations and transcriptionists and the wasteful paper trail, he now spends about 30 minutes per day finalizing electronic notes and his weekends are free,” Som shared.

“EMA has not only saved time but has also increased revenue due to its automatic coding. In our retrospective analysis when coding on paper, we realized we under coded visits for fear of being audited. With EMA, our coding is more accurate therefore we receive higher reimbursements and our revenue has increased by 15% without any changes to provider behavior.”

EMA CODES LIKE AN EXPERT

“EMA automates quality documentation and has made our lives so much easier, in particular in helping us attest for Meaningful Use and PQRS. We have a dedicated advisor that monitors our progress, which has made what can be a difficult task quite simple,” said Som. “We could potentially lose $320,000 in 2017 due to MIPS so we made the decision to enroll in Modernizing Medicine’s MIPS Assistance program, which guarantees we will not receive a negative payment adjustment. If so, we’ll get our money back. From a clinical standpoint we can focus on our patients as opposed to regulatory aspects, which is a huge relief.”

Modernizing Medicine is all about the relationships they have with their clients and it shows. They always strive to improve and we feel they take care of us. We’ve never reconsidered our decision to choose EMA.”

TIME AND MONEY SAVED

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Legal issues surrounding the use of patient images

BY ROBERT M. PORTMAN, JD, MPP, D. BENSON TESDAHL, JD, LLM, AND SARAH J. IMHOFF, JD, MHSA

From time to time, dermatology practices may want to create and share some of their patient images (such as photographs and video recordings of procedures) with third parties for treatment, training, research, marketing, and other purposes. For instance, dermatologists may want to post images on their practice websites, include them in presentations or journal articles they prepare, or share them with third-party researchers. While such image sharing is common and has great educational value, particular care must be taken to ensure that the proper legal protections are in place before sharing the images. In the absence of such safeguards, liability for improper sharing of patient images could arise under HIPAA or state law. Improper image sharing may also violate medical ethics.

HIPAA considerations and authorization
The regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protect the privacy and security of protected health information (PHI), which affects how patient images may be used by “covered entities.” Covered entities include health care providers such as hospitals, physician practices, or individual physicians that submit electronic transactions, such as claims and eligibility information. PHI is defined as “individually identifiable health information transmitted or maintained by a covered entity or its business associate in any form or medium.” “Individual identifiable health information” is information, including demographic data, that relates to:

- The individual’s past, present, or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and
- Identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.

The HIPAA regulations identify 18 types of PHI, which include full-face photographic images and any comparable images and any other unique identifying characteristic. Thus, if a photograph contains an identifying characteristic of a patient, such as a patient’s face, a tattoo, or a unique abscess, it is PHI. In general, a patient’s authorization is required before sharing images containing PHI with third parties. However, there are some circumstances where a patient image does not constitute PHI and circumstances when PHI may be shared without patient authorization.

A. Circumstances when a patient image is not PHI
If a patient image does not contain PHI, it may be freely shared with any party for any purpose. For example, it may be published in a journal article or uploaded on the internet in a public blog post.

- De-identification: An image of a patient can be “de-identified” in a way where the image cannot be used to identify an individual and therefore is not PHI. For example, an image of a patient’s face to show a lesion on a cheek for a journal...
article could blur out the patient’s eyes, mouth, and hair. Or, the image of a patient’s face could be cropped to only show the image of the lesion. These actions would remove identifiers from the image and the image could be freely shared without patient authorization.

- **50 years after a patient’s death:** An image of a patient is no longer PHI after the patient has been deceased for more than 50 years. Therefore, similar to de-identification, the images of such patients can be freely shared for any purpose.

B. Circumstances when authorization is not required

Even when a patient image is not PHI, patient authorization is not required when the image is used for treatment, payment, and health care operations purposes.

- **Treatment:** An image may be shared with a third party for treatment purposes without patient authorization. Treatment is the provision, coordination, or management of health care and related services for a patient by a health care provider, including consultation between providers regarding an individual and referral of an individual by one provider to another. For example, a physician can share a patient image regarding a rare rash with a physician at a different practice for a second opinion. In addition, a physician may share an image of a patient with a nurse within his or her practice. A dermatologist may also send a melanoma patient’s medical records that contain images to an oncologist for a referral if the patient’s cancer has spread to other parts of the body.

- **Payment:** An image may be shared with a health insurance company or other payer in order to obtain reimbursement for a specific treatment without patient authorization.

- **Health care operations:** Images may be shared with consultants for specific purposes related to the business of a physician practice or hospital or education of professionals without patient authorization. Health care operations include the following activities, among others: quality assessment and improvement activities, including case management and care coordination; conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; business planning, development, management, and administration; and training professionals, accreditation, certification, licensing, or credentialing activities. For example, patient images may be shared with the department of dermatology’s medical staff during the weekly grand rounds. In cases where PHI is shared with outside entities for health care operations purposes, a dermatology practice will usually need a “business associate” agreement with the third party in order to share PHI, including patient images, with them. For instance, dermatology practices should have business associate agreements with billing and

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coding consultants, accountants, and electronic medical record companies with which they share PHI, including patient images.

Dermatology practices may also share patient images with researchers without patient authorization if the researchers have obtained a waiver of authorization from an institutional review board.

C. Circumstances where authorization is required

If a patient image is PHI and is not used for treatment, payment, or health care operations purposes, patient authorization is generally required to share the image with third parties. An authorization must be written and contain the following elements:

- a description of the PHI,
- the names or class of persons permitted to make a disclosure,
- the names or class of persons to whom the provider may disclose,
- an expiration date or event,
- an explanation of the individual’s right to revoke and how to revoke, and
- a statement about potential redisclosures.

After a provider has obtained an authorization, the image may be used in accordance with the authorization. Examples when a patient authorization is required include the following:

- **Marketing:** A provider must obtain a written authorization for any use or disclosure of a patient image containing PHI for marketing, unless the marketing communication consists of a face-to-face communication made by a provider to an individual or a promotional gift of nominal value, such as calendars, pens, and mugs with logos, provided by the provider. Marketing is defined by HIPAA as any communication about a product or service that encourages recipients to purchase or use the product or service. Thus, a dermatology practice would need patient authorization to use an identifiable image on the practice’s website or in any promotional materials.

- **Sale:** A provider must obtain an authorization for any disclosure of a patient’s PHI if the disclosure is in exchange for direct or indirect remuneration from or on behalf of the recipient of the PHI, with a few limited exceptions. The written authorization must state that the provider will receive remuneration as a result of the disclosure. Remuneration includes financial payment and nonfinancial benefits. It does not, however, include grants, contracts, or other payment arrangements to perform activities such as research.

- **Research:** In the absence of a waiver of authorization as discussed above, a provider must obtain written authorization from a patient to use PHI in a research study. A provider must also obtain a patient’s informed consent to participate in the research study, which may be combined into a single document with the authorization.

State law issues and consent

Even if a patient image does not contain PHI or meets the requirements under the HIPAA regulations for sharing the image without patient authorization, it often is necessary or prudent to obtain patient consent to comply with state privacy laws or avoid other liability risks. State laws can apply to patient images that are shared with others though a number of common law and statutory theories, and a disgruntled patient who discovers that his or her image was shared may have a claim of invasion of privacy, public disclosure of private facts, implied breach of contract, unauthorized use of personal property, and/or breach of fiduciary duty. Because state privacy laws are complex and vary from state to state, and because such laws can sometimes also vary according to the type of medical information involved (such as HIV or substance abuse information), dermatology practices are well-advised to consult with legal counsel on how to comply with these complex web of state laws when sharing patient images.

If patient consent is obtained, it should be in a written document that covers several key issues, including the following:

- a detailed list of the exact images involved;
- a summary of all intended purposes and uses of the images;
- a statement that the patient is not entitled to any compensation for the use of the images;
- a clause holding the physician practice and its owners harmless from liability for the permitted uses of the images;
- a clause indicating the patient’s understanding that third parties viewing the images may further disseminate the images;
• a statement that the consent of the patient is voluntary;
• a description of when and how the consent can be revoked and a statement that refusal of the patient to sign will not affect the patient’s right to medical care; and
• anything else that may be required by state law.

In some cases, such as video-taping of a patient specifically for educational purposes, the consent should also include a clause assigning the copyright to the video to the dermatology practice.

Medical ethics

The use and sharing of patient images also implicates medical ethics. According to the Code of Medical Ethics of the American Medical Association, filming (and by analogy, photographing) a patient without consent is a violation of the patient’s privacy. Consent is an ethical requirement for both initial filming and public viewing, regardless whether the patient’s face or other identifying features are shown. Therefore, the use of any medium to film, videotape, or otherwise record patient interactions with health care providers requires the utmost respect for patient privacy and confidentiality. The use of a HIPAA-compliant authorization and/or appropriate liability consent should satisfy a dermatologist’s ethical duty with respect to the use and sharing of patient images.

Conclusion

Physicians distributing patient images to third parties must carefully consider whether the image contains PHI, whether it meets an exception to allow free sharing of the images, or whether patient authorization is required. Even after a physician has made a determination as to whether or not patient authorization is required to share the images, it is often prudent to consider obtaining the patient’s written consent to avoid any possible legal concerns under applicable state laws and medical ethics.

This article is provided solely for educational and informational purposes. It is not intended to provide legal advice and should not be treated as such. qw
Getting social
Tips on how to integrate social media into a practice

BY VICTORIA HOUGHTON, ASSISTANT MANAGING EDITOR

Dermatology World talks with Corey L. Hartman, MD, Haley Isbell, and Deborah Youhn, MD — from the Skin Wellness Center of Alabama — for best practices on integrating social media into a practice.

DEERMATOLOGY WORLD: When did you start using social media in your practice and why?
Dr. Hartman: We started our practice in 2009 and we have had social media from the very beginning. I was previously with a multi-specialty group. There were many reasons why I wanted to do my own thing, but one of them was the lack of engagement with patients and restrictions on how we were able to engage with them. Social media was just starting to be something that everybody engaged in and really was the go-to solution.

Isbell: We do monthly Facebook Live events, although we’ve done two per month a couple of times. These events are great for engagement but they’re also really good educational tools for people who have questions about a procedure. We try to marry our Facebook Live events with what our promotion or focus is for the month.

Dr. Hartman: I think the older way of engaging patients would be to invite them to the office and have refreshments and do a presentation at lunch time. However, people are busy. So instead we’ll do a procedure on a patient through Facebook Live and get the patients’ reactions to everything that we’re doing to demystify the procedure and show you exactly how it feels, how it looks, and how long it takes. While we’re doing that, we’re taking questions from patients live on Facebook. It’s very interactive. If you miss the event, you can just go to Facebook and check it out and you can see every question and answer.

What other social media platforms are you on?
Dr. Hartman: We have a Twitter account that we don’t use quite as much. It’s a good tool for getting the word out about quick things that come up. It’s not good for visual items or for polls and questions. YouTube is also a great place to upload videos from media clips that aren’t good enough quality for our website.

Isbell: On Instagram we do our Insider Essential where we feature our product of the month. It’s a product that we have all tried and believe in and we want to get the word out about it.

Dr. Hartman: We all maintain a personal Instagram account. I share things about my family and vacations and funny things that I think of. I keep it apolitical and nothing controversial. Just to give them a different sense of me. I think when they come in now, they must be seeing that because they’re ready to let me put needles in their lips and I just met them. Patients will say it’s from Instagram or Facebook Live and that’s why they’re here.

Tell me about the blog on your website.
Dr. Hartman: I’ve always wanted to have a blog. I think it’s a good way to communicate with patients. Patients may also see the posts about a condition and if they know someone who’s suffering from that condition they’ll share that. As a result, we’ve

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amassed a following that is much greater than the area that we serve. I have people from all over the country sending us questions and emails about things that we have blogged about.

Isbell: People like to receive information in different ways. It’s amazing to me how little people know about what dermatologists can treat, so the blog is a great resource for people who are searching for answers and don’t know where to get a solution.

Q When deciding on content for your social media platforms, how do you strike a balance between cosmetic and medical?

Dr. Hartman: We try to listen to what patients are really interested in. Most of the time, they’re interested in cosmetic procedures. Medical procedures aren’t always as exciting and I’m not sure anybody really wants to see a biopsy of a mole on Facebook Live, but if they did, we would do it.

We use the blog more for medical issues and non-cosmetic problems. The blog is a good way to get information out that won’t be taken as an advertisement. We’re not going to be making any money by telling you about autoimmune disease.

Q How do you encourage followers to engage with your practice via social media?

Dr. Hartman: You can’t post just silly photos in the office and you also can’t always write about, for example, connective tissue disease. You have to find a good mix to keep people engaged. We also try to build content on each platform that encourages people to interact. For example, for our Insider Essential on Instagram we feature a product that we have all tried and believe in, so we’ll give one away. In order to get it, you have to play along, usually through a game. On Facebook one of the most popular things that we do is the patient of the day where we post a photo of some skin condition and ask people what they think it is. People go crazy. They want to guess. They want to know. If you don’t post the answer they’ll post again asking for the answer.

Q How do you manage your social media outlets?

Isbell: We work with Scout Branding which helps with some of our graphics work. We also have a digital marketing team, Bell Media, which helps us with our Facebook page. However, we manage almost all of our social media activities in house.

In terms of content, many times the most popular posts are fun things that we do on the fly or things that feature staff members. We try to have a good mix of both so it doesn’t look so regimented.

Q What are several best practices for utilizing social media to promote your practice?

Dr. Youhn: When I came to the area looking at practices, what really struck me was how the social media aspect really matched this office. The office has that same crisp, clean feel to it.

Dr. Hartman: I also think frequency is important. You don’t want to bombard people with too much. One post on Instagram per day is probably enough. You never want people to think, ‘How do I unsubscribe from this Instagram account?’ On Facebook I think you have more flexibility and more than one post is okay. In terms of length, we keep our Facebook Live events very short because people have short attention spans. Our goal is always about...
15 minutes. On Twitter, you can tweet all day. **Isbell:** You don’t want to be too sales-ey because then you lose your credibility. People very much value our providers’ opinions so we don’t abuse that on our social media. We’ve become more fine-tuned as a society to suss out what’s authentic and what’s not, so we only promote things that we genuinely believe in.

**Q** What are some things to avoid on social media?

**Dr. Hartman:** For the Patient of the Day posts, we never identify the patient’s name and there’s never an identifying feature. We have forms in the office that we use for all patient photography if we have any intention of using it in any place that’s not their chart. Also, you want to make sure that if you’re photographing the office, you don’t capture any patient data.

As far as good online reviews, we like to encourage them and thank the reviewer on Facebook. The ones that are not so good, while you want to apologize and acknowledge the fact that the experience was less than desirable, if you can’t do that in a way that’s authentic and makes you feel good about the way that you answered it, then you should just say nothing.

Some patients will ask you to provide medical advice. I don’t think they know that they’re asking you to provide a service to them that you should get paid to do — no one goes up to a nephrologist and starts asking about their kidney problems. So, I always turn it back to a call to action to the patient. “I would love to help you with that. If you go to our website and make an appointment, we can address that.”

**Q** Why do you think social media is a valuable component of your practice?

**Isbell:** Social media is what the yellow pages were for so many generations. It’s a trust thing. It’s an authenticity thing. It’s about quality. It’s your first impression with people who are looking for you.

**Dr. Hartman:** Being on social media serves two purposes: It helps patients learn more, but is also helps the search engine optimization for your website. It all goes to one common goal of greater outreach for the practice.

**Q** What has your social media presence done for your practice?

**Isbell:** When Dr. Youhn came on in January, we had tons of new patients who came in and knew her because we plastered her face everywhere—the website and social media.

**Dr. Hartman:** Social media allowed us to do that in a way that was way more economical. We looked at sending out mailers and it was about $20,000 just in the ZIP code around our office. Also, something I have noticed more recently is that I’m getting new patients whom I’ve never met. It used to be that all of my cosmetic patients were once medical patients. Now, patients will say they’re here because of Instagram or Facebook Live. They get to see how you interact with patients.

**Isbell:** We are getting great return on investment. We can follow patients and we know they saw us on Facebook Live and came in and got the filler we were talking about that day. That’s hard to do with traditional media, so we’ve pulled back on some traditional media and have put more resources toward things that we know will make an impact. Is it worth what we’re spending? It definitely is. *dw*
A New Patient’s Journey Can Start In Many Places.

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In our last article, we mentioned that having long-term financial goals and a corresponding strategy to achieve them is the best way to tune out and ignore the noise that causes poor investing decisions.

What if you don’t have a wealth management plan? How do you determine your long-term financial goals and craft your investment strategy? There are hundreds of books that cover this topic, but in this article, we will touch on a few basics to help dermatologists get started—or help you assess your current plan and goals.

Retirement
Generally, the most common long-term financial plan a dermatologist will consider is retirement—or the purchase of a practice. Retirement planning can feel so big and so far off that it is difficult to wrap your mind around. Buying (or selling) a practice includes many additional details, so for this piece we will focus on retirement—not an easy topic, but as Warren Buffett’s right-hand man, Charlie Unger, says, “everything should be made as simple as possible...but not simpler.” Let’s give it a shot.

First, if you’re an employee and your employer has a retirement or pension plan, review it closely. Understanding the tax and savings advantages will assist you in determining what else you need to do outside of your employer-sponsored plan to ensure you hit your goals.

Life will move fast, and the sooner you get started the simpler it will be for you to determine and achieve your goals. Don’t make your wealth management planning so complex that it’s too hard to get started or too hard to follow or understand—but don’t make it so simple that it can’t realistically achieve its goals. Strike a balance and don’t let perfect be the enemy of good enough. We make very few guarantees in our business, but a good wealth management plan that you actually implement will beat a mythical perfect plan that you keep trying to find, but never really start.

Also, don’t avoid planning now just because you’re upset with yourself for not getting started earlier. Do not compound your errors by waiting. Many dermatologists start out with burdensome education loans and additional debt. It’s a difficult decision regarding whether to pay off all the debt before saving—or saving what you can while keeping up with loan payments. A quick way to make the decision on debt is to review the interest rate on your debt/loans versus the rate of return you reasonably believe you could get leveraging the funds elsewhere. For example, if you have any outstanding student loan with a low interest rate between 3-4 percent, it may make sense to make minimum monthly payments while investing additional funds in your portfolio (if you expect a higher 6 percent return) or in building your practice. There are dozens of other factors to consider, like whether you are okay carrying debt or it stresses you out. If it stresses you out, pay it off as soon as possible, then concentrate on saving. Either way, have a plan and get started now. Even a little can pay off big down the line—and it also fosters habitual saving and planning which will carry over once you’ve paid off much of your debt.

Where to start
While there are some basics to consider, your wealth management plan will be specific to you (and your family and/or your practice). Also, your plan will evolve over time. Your strategy should not be a static, set-it-and-forget-it, autopilot plan. You should review your plan (with your advisor if you have one) at least annually, to make sure you’re still on track, or if you need to amend due to life changes like getting mar-
ried/divorced; having children; or employment/business changes or health/physical condition changes with you or your spouse. Further, a strong wealth management plan will eventually have many components like asset protection, insurance, tax planning, education planning, estate planning, etc. Here we are just focusing on saving and investing.

There are a few basic items every individual dermatologist’s wealth management plan must consider. First, what is your *timeline*; i.e. how long will you be saving and investing? For many, the timeline is the day they start saving up until a planned retirement date. If you start saving at 30 years old, and plan to retire at 60, your timeline is 30 years. You have 30 years to accumulate enough to retire.

Next, you must determine *how much you will need* in retirement to fund your lifestyle. Some experts estimate you could need 70-90 percent of your preretirement income, but this will vary depending on how you envision your postretirement life. Will you have a mortgage? Will you travel more? Will you have a vacation home? Will you continue practicing (or running a practice) on a part time or consultant basis...or in another field altogether? Note: what you think retirement will look like will change over time — but even if it is many years off, give it some thought now so you can at least hone in on a number.

Once you have a timeline and an estimated amount — figure out what you need to regularly put away to hit your goal. Simple, but not quite that easy. There are a number of other factors to take into consideration; inflation, taxes, investment performance, and life throwing you a few curveballs. On one hand, it is relatively simple equation — but life is not simple and life’s variables will alter your equation frequently. A good wealth management plan will attempt to plan for as much as possible — but again, there is no perfect plan. It will change over time.

That said, consistent saving, investing, and compounding interest will take you far — especially over the course of a long timeline. Albert Einstein called compound interest the eighth wonder of the world. Consistently saving and investing over a long timeline will help level out the bumps and obstacles life will throw your way. If you haven’t already, get started — the sooner the better.

**Investment performance and your risk tolerance**

Many clients ask us what is a reasonable performance figure they can assume for their investments. It’s tough to say. You can look at the markets and average out a rate of return over a specific timeline and try to assume it — but you will quickly note the average doesn’t really happen that often. The market is prone to swings and the swings are what often hurt people the most...especially if they don’t have a wealth management plan.

This is where we consider your *risk tolerance*. A simple way to think about your risk tolerance is what are you willing to stomach during large swings in the value of your investments. If the market tanks, do you panic, or do you smell opportunity? What is the degree of variability in investment performance you are willing to withstand before doing something outside the parameters of your plan?

Capturing your risk tolerance is obviously subjective. It is often difficult to measure the true risk tolerance of an investor until something upsets their plan or the market takes a downturn. It is in these times you get a clearer picture of how you will behave.

Determining your risk tolerance is an extremely
important factor in building your portfolio, but it is also important in designing a wealth management plan that will help you sleep at night. Note: often spouses will have different comfort levels with risk as it relates to their plan and their investments. It is important to spend time educating each spouse on the plan to make sure everyone is on the same page.

Stages and phases
Like your wealth management plan, your risk tolerance will evolve. Most people can afford to take on more risk earlier in their timeline because they have time to make up for losses.

Your plan and tolerance will evolve with you from the accumulation phase to the distribution phase. Your accumulation phase is the stage of building up your assets. These assets don’t just include your investment portfolio. It also includes building a practice, equity in your home or other real estate, and other appreciating assets. This phase continues until you are ready to start drawing down. It does not end until you actually retire. You can generally afford to be more aggressive in your investing in the early stages of your accumulation phase, but as you get closer to retirement, you should throttle back — be a little less aggressive, and better leverage the assets you have accumulated until you finally do retire. Essentially your risk tolerance should gravitate toward less risk as you get closer to your distribution phase.

Upon retirement, you will enter your distribution phase, and start drawing money from the retirement income sources that you set up during your accumulation phase. Your plan does not stop when you move into your distribution phase.

Most take a conservative approach throughout their distribution phase to ensure their assets last as long as necessary. The makeup of your portfolio will change throughout the course of these life stages, and it is just as important to plan during your distribution because you want to have a course to stick to when things get rocky to ensure you can continue to live the lifestyle you and your family are accustomed to.

Never a wrong time
There is never a wrong time to start, or reassess, your wealth management plan. The absence of a plan opens the door to lack of saving, excessive spending, performance chasing, and compulsive activity driven by fear and greed.

The famous French writer, journalist, and pioneering aviator Antoine de Saint-Exupéry coined the phrase, “a goal without a plan is just a wish.”

Are you planning for your long-term wealth management and retirement…or hoping and wishing everything works out? There are many additional resources out there to help.

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What’s happening with drug prices and what’s being done to bring costs down?
A trip to the pharmacy. Years ago, it was simply another errand on the Saturday to-do list for many Americans. In recent years, however, this once benign activity has morphed into an often frustrating and fruitless mission. According to a 2017 Consumer Reports survey, within the last year four million Americans walked away from the pharmacy empty-handed because the cost of their medications was too much to bear. Physicians are well aware of this problem. “Not a day goes by where I don’t see one or more patients who are unable to fill a prescription because the out-of-pocket costs are too high,” said Bruce Brod, MD, chair of the Academy’s Congressional Policy Committee.

When it comes to dermatology, many patients are denied coverage for expensive specialty medications and can’t afford the out-of-pocket costs for the medication. However, “It’s not just the high-cost specialty drugs,” Dr. Brod said. “We see it frequently with commonly used generic drugs.” A 2016 U.S. Government Accountability Office (GAO) report detailed the pricing trends for generic drugs under Medicare Part D from 2010 to 2015 and found that several generic dermatology drugs experienced at least a 100 percent increase more than once throughout the five years studied. However, dermatology patients are not alone: The Consumer Reports survey indicates that at least 28 million Americans have seen the cost of their medications go up in the last 12 months. The question remains: Why? Dermatology World examines the factors that contribute to high drug costs, as well as the efforts to bring those costs down. >>
Following the thread

Unfortunately, the root of the drug pricing problem in the United States does not lie at the feet of one perpetrator. In fact, there are multiple players and factors that contribute to the ultimate cost of a drug — from generic to specialty.

Pharmaceutical companies

“There’s plenty of blame to go around for sure,” said Colby Evans, MD, chair of the Academy’s Drug Pricing and Transparency Task Force, and chair of the Board for the National Psoriasis Foundation (NPF). “Of course, a lot of the blame gets directed at the pharmaceutical company who manufactures the drug and to some degree sets the price of the drug.”

According to Dr. Evans there are two types of pharmaceutical companies in the United States. First, “there are manufacturers who spend a lot of money on research and development when producing a drug, and a lot of money on getting the drug approved.” For some, the costs associated with developing and bringing a drug to market justify the high cost of new drugs. “The average cost to bring a drug to market is $2.6 billion,” said Lori Reilly, executive vice president of policy and research for the Pharmaceutical Research and Manufacturers of America (PhRMA) at a drug pricing panel at the 2015 AAD Summer Meeting. However, not every drug makes the cut. “There’s also the truth of the matter that many drugs seem promising at first but then for whatever reason don’t turn out to be viable, so you have to spend a lot of money that you don’t get a return on,” Dr. Evans said. According to Reilly, roughly 90 percent of drugs never make it to market, and only two in 10 drugs that do reach the market earn enough to recoup their research and development (R&D) costs.

Conversely, there is a second type of pharmaceutical company that appears to be riding the coattails of the R&D manufacturers. “There are private equity companies who will buy up an old drug and immediately jack up the price hundreds and thousands of percent. They’re not necessarily doing any research and development or working on getting it approved. They’re just trying to maximize profit.”

Federal regulators

While R&D costs may contribute to the cost and access issues for specialty and brand-name drugs, when it comes to generics, other factors may be in play. For years, the FDA has struggled with the pace of generic approvals — possibly leading to less competition and therefore higher prices. “It currently takes something like four years for a new generic manufacturer to be able to manufacture a drug going through the FDA process,” Dr. Evans said. “The market can only function if players can come in to compete.” However, with FDA scope constraints, unsurmountable workloads, and safety standards, the FDA’s hands are often tied. “We understand that drug prices have a direct impact on the ability of people to cope with their illnesses as well as meet other expenses. However, FDA has no legal authority to investigate or control the prices charged for marketed drugs. Manufacturers, distributors, and retailers establish these prices,” said Sandy Walsh, press officer at the FDA’s Office of Media Affairs within the Office of External Affairs.

Additionally, according to the FDA, there are so many drugs in the approval pipeline that it’s challenging to keep up. “In 2012, 2013, and 2014, we received over 1,000, nearly 1,000, and nearly 1,500 applications for generics, respectively, which was a much higher workload than anticipated. As of April 1, the current workload of generic drug applications in progress is 2,640.” Finally, a key factor in the FDA approval process, ensuring safety, is hard to ignore. Although the FDA has been called on by Congress and various health care groups to pick up the pace on drug approvals, the public isn’t so keen on that plan. According to a 2016 poll conducted by STAT and the Harvard T.H. Chan School of Public Health, six out of 10 patients opposed
efforts to increase the rate of FDA drug approvals — citing concerns over safety and efficacy standards. “The FDA is obviously trying to protect the public,” said Amy Paller, MD, chair of the Academy’s Patient Advocate Taskforce. “It’s an important job. The FDA needs to have sufficient studies to determine that a drug is safe and efficacious — and that can take a while.”

In addition to the approval backlog, according to Dr. Brod, some branded drug manufacturers may be blocking other companies’ attempts at entering the market. “They can be very aggressive in trying to extend the patent for a drug by a number of tactics: pay for delay, sometimes they make minor tweaks in the formulation, and sometimes there are outright lawsuits against the generic companies for trying to enter the market too soon,” Dr. Brod said. “Those are tactics that can keep costs high and potentially more affordable generics from coming on to the market.”

Pharmacy benefit managers While R&D and the approval process may be contributing to pharmaceutical company expenditures, the price tag on many drugs may also reflect the costs associated with drug distribution. “I think that pharmaceutical companies are more inclined to place a larger sticker price on their drug because that gives them a little bit more leverage with the pharmacy benefit managers [PBMs],” Dr. Brod said. PBMs are companies that manage the drug benefits and formularies for employers and health insurers. Increasingly, PBMs are receiving rebates from pharmaceutical companies in exchange for supplying the companies’ drug to an insurer or employer’s formulary. As a result, a premium is added to the ultimate cost of the drug to compensate for that rebate. “Oftentimes those rebates aren’t passed on to patient savings,” Dr. Brod said.

Unfortunately, according to Dr. Evans, there isn’t a lot of wiggle room for manufacturers when negotiating drug distribution. “There definitely are a couple of very large PBMs like CVS Caremark and Express Scripts that control a large portion of the market,” Dr. Evans said. “Once they control a large number of insured lives, it gives them a lot of power to move drugs off and on the formulary, and to demand rebates and other concessions from the manufacturers in order to make the drug available. If you control all of the lives for Blue Cross, for example, that’s a tremendous number of customers who either will or won’t have access to a drug. The PBMs use that power to create profit for themselves.”

Insurers Undoubtedly, the cost of R&D, FDA approval, and drug distribution add to the cost of a drug which often falls in the laps of patients. However, for Dr. Brod the issue goes beyond expense. “It’s not really the cost of drugs per se that should be our main focus,” Dr. Brod said. “It’s the impact it has on the access our patients have to those drugs.”

Ultimately, the padded cost of medications and the negotiations made between pharmaceutical companies and PBMs are reflected in insurance formularies. As a result, patients may regularly endure changes to their formularies where a drug is not covered, requiring them to pay out-of-pocket or forgo the medication entirely. “I am regularly seeing people who cannot get the drugs that we want them to get because they’re not approved [by insurers],” Dr. Paller said. “The cost to my patients has increased because the copay is so much higher than it used to be.” Additionally, the patient may be required to switch drugs, or try and fail several medications before being granted access to the physician’s preferred drug for that patient — a process known as step therapy. “In many cases, I have patients who have been on a drug for quite a while and doing very well, and then they can’t get the drug anymore. That is very hard because people know that there are medicines that work for them and they can’t get them because they are taken off of formularies.”

Efficacy aside, according to Dr. Evans sometimes the substitutions required by the formulary are simply not safe. “I have had, for example, insurers ask that I put young women of childbearing potential on methotrexate before they would allow for a biologic treatment,” Dr. Evans said. “Obviously, the safety level of treatments is different for different patients but I certainly have had situations where I didn’t think the drug that they wanted me to put the patient on was a safe choice.”
Clearing the cobwebs
Fortunately, efforts are underway at several levels to address various aspects of the drug-cost problem. Additionally, specialty and patient advocacy groups are also taking steps to alleviate some of the burden.

Competition
While increased competition and market forces aren’t a silver bullet for driving drug prices down, Dr. Brod maintains that it could make a dent. “There’s still the opportunity to reduce generic drug prices by increasing competition in the generic market.”
At the regulatory level, the new FDA commissioner, Scott Gottlieb, MD, has indicated that he plans to take action on drug costs, stating that the FDA “can take steps to facilitate entry of lower-cost alternatives to the market, and increase competition.” Recently, Dr. Gottlieb announced that the FDA is currently drafting a “Drug Competition Action Plan.” As part of this plan, the FDA will allow generic drug applications to get prioritized review until there are three approved generic alternatives for a specific drug. This new policy is based on data that show a significant decrease in generic prices when there are at least three FDA-approved generic alternatives available.

On the legislative side, a Senate amendment to the FDA User Fee Reauthorization Act sponsored by Sens. Susan Collins (R-Maine) and Claire McCaskill (D-Mo.) — based off of the Increasing Competition in Pharmaceuticals Act — would allow the FDA no more than eight months to “prioritize the review and act on applications where there is inadequate generic competition.” The amendment was adopted unanimously by the Senate HELP Committee. “Hopefully market forces would then prevail and some of the costs would go down because it is very costly for generic companies to enter the market these days,” Dr. Brod said. Similarly, Reps. Gus Bilirakis (R-Fla.) and Kurt Schrader (D-Ore.) proposed the Lower Drug Costs through Competition Act, which was included in the health subcommittee of the House Energy and Commerce Committee’s version of the FDA User Fee Reauthorization Act. It would require the FDA to work with manufacturers looking to develop generic alternatives for drugs that don’t have competition or alternatives.

At the judicial level, a recent court decision may bring more competition onto the market for biologic medications. The Supreme Court has ruled unanimously in favor of generic manufacturer Sandoz in a case against Amgen regarding when Sandoz can market a biosimilar product of an Amgen biologic drug. A provision in the Affordable Care Act required that biosimilar manufacturers provide notice to a brand-name manufacturer 180 days before taking the brand-name drug’s biosimilar to market. Per a federal appeals court decision in 2015, Sandoz was previously barred from selling a biosimilar version of Amgen’s drug Neupogen — a white blood cell booster — until 180 days after the FDA approved the biosimilar. However, the Supreme Court ruled that biosimilar manufacturers do not need to wait an additional 180 days after FDA approval. The court’s decision could open the door for more biosimilars to be marketed in the U.S. sooner than expected. However, it remains to be seen how much biosimilars will affect the cost of drugs.

Transparency
Price transparency is a concept that has been tossed around for both generic and brand-name drugs. With regard to brand-name drugs, the American Medical Association’s (AMA) House of Delegates (HOD) recently voted in favor of a
resolution advocating for the FDA, Federal Trade Commission, and Federal Communications Commission to institute rules requiring pharmaceutical companies to list the suggested retail price of a drug on direct-to-consumer advertisements for that drug. Currently, the United States and New Zealand are the only countries in the world where it’s legal to advertise prescription medications to the public, and according to the resolution language, drugs that have been advertised directly to consumers have seen a 34.2 percent increase in prescription rates compared to a 5.1 percent increase with other drugs. Essentially, the resolution contends that patients may be less likely to seek out a specific medication they’ve seen in an advertisement if they know the cost of the drug.

The push for more drug cost transparency has not gone unnoticed by policymakers on both sides of the aisle. “There are bills that would require some sort of justification if the price of a drug goes up,” Dr. Brod said. For example, Sen. John McCain (R-Ariz.) has introduced The FAIR Drug Pricing Act which would require drug manufacturers to inform the U.S. Department of Health and Human Services (HHS) of a price increase — for a drug that costs at least $100 — of more than 10 percent in one year or 25 percent over three years. The bill would also require manufacturers to submit a transparency and justification report regarding the price hike 30 days before the price increase occurs.

Similarly, “At the federal level, we’re seeing a couple of bills try to shed some sunshine on the PBMs,” Dr. Brod said. The Academy has supported Sen. Ron Wyden’s (D-Ore.) Creating Transparency to Have Drug Rebates Unlocked (C-THRU) Act that would require PBMs to disclose the amount of rebates they receive from manufacturers for Medicare plans. On the House of Representatives side, the AADA has supported Rep. Doug Collins’s (R-Ga.) Prescription Drug Price Transparency Act which also calls on PBMs to offer details on their process for setting pharmacy reimbursement prices. “That bill doesn’t directly address the rebates and discounts, but it would provide a lot more transparency with drug pricing and accountability in that space,” Dr. Brod said.

**Step therapy**

While several pieces of federal legislation have been introduced in an attempt to get to the bottom of rising drug costs, efforts have been made to tackle the fallout as well. In particular, these efforts have focused on step therapy policies at the state level. As a charter member of the State Access to Innovative Medicines (SAIM) Coalition, the AADA helped draft model legislation that requires an insurer’s step therapy exemption process to be transparent and available to the provider and patient. Additionally, the model bill allows automatic medical exceptions to step therapy if the patient meets certain criteria, such as if the patient is stable on medication or if the required drug is contraindicated. Finally, the model bill aims to ensure step therapy programs are based on clinical guidelines developed by independent experts.

“This is a hot issue for legislatures right now. We’re seeing a desire from the states to regulate the process of step therapy so that patients aren’t denied the latest therapies,” Dr. Evans said. “You can advocate in any state for patients with chronic disease and so far legislators have been willing to listen.” And listen they have. Legislation based on the SAIM model bill was enacted in six states since 2016 — Illinois, Indiana, Missouri, New York, West Virginia, and Iowa — bringing the total number of states with step therapy laws to 14. In the 2017 legislative sessions, 14 states have taken up some form of legislation to improve the step
therapy process. At the federal level, the AADA is supporting H.R. 2077, the Restoring the Patient’s Voice Act of 2017, which would require health insurers to expeditiously grant a step therapy override determination if in the professional judgment of the prescribing physician step therapy would be medically inappropriate for the patient.

Physician and patient assistance

Reining in the rising costs of drugs at the policy level will take time. Meanwhile physicians are often left to fend for their patients who can’t afford their prescriptions. Fortunately, the AADA has developed physician resources for managing step-therapy policies and coverage denials that require prior authorizations. The AADA’s Practice Management Center’s online prior authorization toolkit includes an interactive letter generator for physicians seeking to get prescriptions approved. Physicians can also find information about existing and pending step therapy laws in their states, and tips on how to take action. Learn more at www.aad.org/priorauth.

For patients, there are several outlets available that can offer assistance and/or financial relief. “I think the discount programs like GoodRx, Blink Health, and others are a good stop-gap measure for patients who have no other viable option because their insurance company tiers a drug too high,” Dr. Brod said. However, “These can be hit or miss. It can help with some drugs, but doesn’t help with all drugs.” Similarly, the Partnership for Prescription Assistance (PPA) program connects patients to more than 475 public and private programs that offer cheap or free medications, depending on the patients’ eligibility. Much like the PPA program, another resource, RxAssist.org, runs a comprehensive database of programs where patients can search for their drug and see if they are eligible for financial assistance. However, Dr. Brod warns, “Those can be helpful for patients on the lower end of the spectrum. It’s the middle-income folks that often fall through the cracks.”

Finally, patient advocacy organizations, such as the NPF, have devoted resources to assist patients in gaining access to care, medications, and other resources. “The NPF Patient Navigation Center is at our headquarters in Portland, Oregon with trained patient navigators who can answer a wide variety of questions,” Dr. Evans said. “One of their primary roles is to help patients in this situation where they aren’t able to afford or get access to their treatments. The NPF has access to patient assistance programs through manufacturers. They have experience coaching patients through these kinds of problems, and they sometimes have access to foundations or other sources of help for patients.”

While efforts at the policy level are underway and patient assistance programs are available for patients to tackle the rising costs of drugs, Dr. Evans maintains that there is still an important role for physicians to play beyond the clinical setting. “Physicians need to be advocating through their state and county medical societies. Our involvement is really important because our patients are sometimes competing with billion-dollar companies. We need to advocate for them to help level that playing field.”

Learn more
The Academy has collected resources to help dermatologists address the drug pricing issue at www.aad.org/advocacy/drug-pricing-and-availability.
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Feeling the BURN

Sources of dermatologist burnout and mitigating strategies
“I think if you would have asked me earlier in my career, I might have thought it was silly to feel burnout as a dermatologist,” admits Peter Lio, MD, a dermatologist in Chicago. “Many people view our specialty as the ‘cushiest’ and from an objective standpoint, we have it pretty good. That said, people are feeling it, and I can honestly say that I’ve felt it.” Dr. Lio is not alone. As burnout among physicians has continued to rise, dermatologists have also found themselves victims to its spread. In a legislative climate that shows no immediate signs of slowing or steadying, practitioners have increasingly grappled with destabilizing feelings of loss of control and helplessness to meet professional and regulatory demands. “I think in the past we were fortunate because we didn’t have to take night ‘call’ as the conditions we treat are not usually urgent. That certainly added a large component of gratefulness regarding our specialty, and played a large role in our overall perception of wellbeing,” explains Kathleen Hectorne, MD, an Austin, Minnesota dermatologist. “The loss of autonomy, the decrease in efficiency caused by EHR, and the burden of complying with regulations that increase hours of work, but don’t add to the true quality of care for our patients, all contribute.”

While information on the prevalence of burnout among physicians remains limited, available data suggests dermatologists are burning out at a more rapid rate than that of the general physician population. A recent Mayo Clinic Proceedings study found that while overall physician burnout levels rose from 45 percent to 54 percent between 2011–2014, burnout among dermatologists during that same time frame rose from 32 percent to 57 percent (2015;90[12]: 1600-1613). Why is this, and what can be done to address it? In this feature, dermatologists from across the specialty tackle these questions, discussing:

- **Common drivers of dermatologic burnout**
- **The impact of burnout on patient care and physician well-being**
- **Mitigating strategies for reducing burnout >>**
Feeling the BURN

Fire starters: triggers for burnout
With the right conditions, a small spark can turn into a devastating wildfire. And many of the economic, social, and regulatory changes within dermatology over the past several years have provided the right kindling for full-scale burnout among practitioners of all career stages.

High demand
Some of this tension is regionally based. In dermatology’s scarce and rural areas, patient demand can easily overwhelm the number of available providers. Alternately, a subsequent influx of non-physician clinicians to meet these care gaps can further overwhelm supervising physicians, and foster resentment due to a perceived sense of replacement within the health care system. Dr. Lio attests that navigating patient volume as a dermatologist can at times be an unwieldy endeavor. “I think that in dermatology, we see and interact with a tremendous volume of people compared to some other specialties, and certainly compared to many other professions,” he says. “I often say that just shaking hands with 35 to 40 people every day is a lot!”

High expectations
Additionally, as online reviews and other feedback channels gain popularity with patients, physicians are increasingly subject to asymmetric rewards in that they’re much more likely to only hear from patients who are upset with their care. “There is the sense that the patient is the customer, but standards of courtesy and professionalism in medicine do not translate to ‘the customer is always right,’” explains Neal Bhatia, MD, a dermatologist based in San Diego. “Patients and customers are not the same, the stakes and the rules are different, but patients still demand really good customer service even as physicians are burned by increased regulation and documentation, and subject to patient ire over things like high deductibles, which the physician cannot ultimately control.”

Heavy regulatory burden
While demanding patients have always been a part of the job, physicians may be finding themselves more exhausted by especially difficult individuals in light of increased burdens elsewhere in practice. “Even in the most purely medical dermatology setting, there are still patients who are unhappy with their surgical scar, disappointed they are still getting some acne lesions, or frustrated by having to keep coming in for phototherapy for their cutaneous T-cell lymphoma,” says Dr. Lio. “However, while ‘the usual suspects’ have been more or less a part of the specialty since its inception, what has changed for me, most importantly, within my 12 years of practice, has been the administrative burden. From ever-increasing documentation standards, to chart audits from payers, redundant and oftentimes maddeningly boring mandatory education webinars, to prior authorizations until the cows come home.”

The sense that regulatory measures have become overwhelming, and seemingly prohibitive at times to the delivery of care, is hardly unique among dermatologists. “Burnout is a system-wide problem,” says Andrea Murina, MD, associate professor in the department of dermatology at Tulane Medical Center, who directed a session on burnout at the 2017 AAD Annual Meeting. “What I tried to emphasize in the session is that while our work-life balance is very important, the biggest contributor to burnout is our health system itself.”
**Challenges of EHRs**

Mark Kaufmann, MD, associate clinical professor of dermatology at Mount Sinai School of Medicine, echoes this sentiment. “Government programs have certainly contributed to this loss of autonomy. Specifically, EHRs, which should ideally ease the physician’s workload, have done exactly the opposite.”

For many physicians, technology — and EHR specifically — has emerged as the primary boogeyman behind their burnout. “I think the burdens of EMR on a high-volume specialty such as dermatology have significantly contributed to burnout,” says William L. Waller III, MD, a dermatologist from Hattiesburg, Mississippi. “I have dermatology colleagues who see nearly twice as many patients as I do, simply by using paper charts instead of complying with the burdensome requirements of EMR and meaningful use. EMR is not the only issue though, as MIPS requirements, MOC requirements, and other regulatory burdens have weighed substantially on the spirit and productivity of dermatologists.”

**Hurdles to access**

Further demoralizing are the frequent roadblocks imposed by prior authorizations and other insurance processes, which often leave physicians with feelings of inefficacy and helplessness when it comes to getting patients the care they need. “I went to school; I know how to treat dermatologic disease; and this administrator is saying no,” explained Brian Berman, MD, PhD, voluntary professor of dermatology at the University of Miami Miller School of Medicine, in a recent webinar. This can be particularly devastating to the core morale of physicians as purveyors of positive change in their patient’s health. “Beyond the extra paperwork, what a prior authorization or a medication denial means for us now, is that the patient won’t get the medicine that they need. They may have to settle for either an alternative, something with different side effects, or nothing at all. So we’re less satisfied with our ability to deliver care than before because we are not seeing the fruits of our labors,” says Dr. Murina.

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**Catching burnout early**

“One of the main problems with burnout is we don’t realize we’re getting burned out until it’s too late,” says Andrea Murina, MD. Fortunately, there are tools available to self-test for burnout and its accompanying side effects.

The Physician Well-Being Index (WBI), invented by the Mayo Clinic (J Gen Intern Med. 2013 Mar;28(3):421-7), can be a good starting place for physicians looking to figure out where they fall on the burnout spectrum. Take the seven-question quiz below, adapted from the Physician WBI, to self-assess whether you’re on track, or showing signs of burnout.

1. Have you felt burned out from work in the last month?  
   - YES  
   - NO

2. Have you worried that work is hardening you emotionally in the last month?  
   - YES  
   - NO

3. Have you often been bothered by feeling down, depressed, or hopeless in the last month?  
   - YES  
   - NO

4. Have you fallen asleep while stopped in traffic or driving in the last month?  
   - YES  
   - NO

5. Have you felt that all the things you have to do are piling up so high that you could not overcome them in the last month?  
   - YES  
   - NO

6. Have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable) in the last month?  
   - YES  
   - NO

7. Has your physical health interfered with your ability to do your daily work at home and/or away from home in the last month?  
   - YES  
   - NO

**Total number of “Yes” responses**  

To interpret your WBI Score (number of “Yes” responses), turn to page 49 to view results.
The heat is on: effects of burnout
Once burnout has taken root, its seemingly unrelenting hustle can result in a variety of negative effects on both the personal well-being of physicians and the care they provide. “If you ask some dermatologists, they may say, ‘I’ve never been burned out.’ But most people don’t even know what burnout means,” explains Dr. Murina. “They think burnout is just stress, and stress certainly plays a part, but burnout is the projection of apathy, cynicism, and exhaustion to your patients and the rest of the world. You don’t have empathy to give anymore, and just don’t feel that you’re making a difference at the end of the day.”

Often linked to a variety of negative physical and mental health outcomes, burnout can result in exhaustion, depression, anxiety, disrupted sleep, lack of morale, even escalating to substance abuse, departure from medicine, or physician suicide. Interpersonal relationships can be compromised as a result of the accompanying emotional exhaustion, potentially diminishing long-term career prospects. “Amongst dermatologists, what’s been particularly hard-hitting is the decreased sense of personal accomplishment,” says Dr. Murina. “EHR and other regulations over time have eroded our sense of what we’re able to do as dermatologists. I hear dermatologists say, ‘In the past, I could see 50 patients, now I can only see 30, and I can’t even get medicines covered anymore.’ Both of these limitations give you the sense that you’re not able to accomplish what you used to.”

While physician well-being may not be a major priority for the general public, patients nevertheless want physicians who are attentive, well-rested, present, and caring, whereas burned-out physicians are more likely to see a drop in productivity and quality of care, higher medical error rates, lower patient satisfaction, and higher staff turnover (Acad Med. 2013;88: 301-303). “We are inundated with these other burdens to such a degree that at times I feel like the patient care is ‘in the way’ so to speak, of completing all the things I have to do in a day. This divided attention and constant fretting takes a toll,” says Dr. Lio.

“When we are burned out, we’re not only giving patients burned out care, but we also exacerbate system-wide problems. Decreasing work hours or choosing early retirement puts the burden back on the medical system, so if doctors start cutting back, then all of a sudden there’s more work for everyone else,” says Dr. Murina. “So it becomes this worsening problem over time because you have fewer doctors who want to work in a diseased system. We went into medicine to help people, and burnout is changing the way we think about ourselves and our purpose.”

Fire prevention: strategies for combating burnout
Resiliency, adaptability, and creativity all play key roles in helping put out — and prevent — the emotional and professional fires triggered by burnout. Focusing on what you can control, while deprogramming harmful work habits and attitudes, can help lay the groundwork for regaining a sense of job satisfaction and personal agency. “The biggest driver of burnout for me personally is the feeling of doing meaningless work that is required by organizational, insurance, or government regulations, that does not truly elevate the patient experience or patient safety,” explains Dr. Hectorne. “The most helpful measure I have found is to accept that in this environment, I will not be able to see the number of patients I used to, and to stay focused on the ones that I can see. I think it’s important for physicians to realize that by taking an active role in trying to change our system, we may re-energize ourselves and find a focus that efficiently delivers excellent patient care without the burden of excessive documentation and regulation.”

Below are seven key areas where dermatologists can look to reduce their burnout.

Don’t procrastinate
“You may delay, but time will not,” warned founding father Benjamin Franklin. Likewise, even though the daily pile-up of tasks facing physicians may seem overwhelming at times, overcoming the impulse to procrastinate by tackling minor to-do items head-on can help offset creeping feelings of burnout. Embracing a “touch it once” philosophy adopted from his wife (a fellow physician), Dr. Lio makes a daily effort to complete small administrative tasks immediately upon receiving...
them, with the idea that it is more rewarding — and less guilt-inducing — to get them out of the way as soon as possible. Citing the examples of answering emails or filling out paperwork, he explains, “filing these things away, or adding them to a to-do list, isn’t a good way to go about it. You’ll have to spend time re-familiarizing yourself with the content, and it creates another little distraction dogging you, cycling over and over in your mind until it’s done. It doesn’t take more than a few of these nagging issues to ruin a day, at least for me. Like a few pesky flies at a picnic, just quickly squashing these little burdens allows me to focus and keeps my sanity in a better place.”

In addition to tackling administrative tasks head-on, setting aside designated time in the day to complete specific tasks can be an effective way to stay on-track throughout the day and prevent burnout-inducing build-up. “If you’re having trouble squeezing such activities into your packed schedule, give yourself a week to assess exactly how you’re spending your time,” recommends a 2016 Harvard Business Review article, “4 steps to beating burnout.” “For each block of time, record what you’re doing, who you’re with, how you feel, and how valuable the activity is.” Dr. Murina also highlights the value of this approach. “We should make sure that we have protected time for administrative tasks, although the amount of time required can depend on your workplace,” she says. “A lot of dermatologists are now employed instead of self-employed which equates to having less administrative burden; however, it is important for everyone to have control over their day-to-day.”

**EHR evolution**

While the triggers of burnout are multi-factorial, most physicians agree on a primary culprit: EHR. Why have electronic records failed to deliver on their promises — and how can they be improved

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**Interpreting the burnout quiz by probability percentage**

To determine where you fall on the burnout spectrum, find your score (total number of “yes” responses from page 47) in the first column of the table below. Results are listed according to probability percentage — for example, a person with a score of 4 is projected to have a 35 percent likelihood of experiencing poor mental quality of life, a 49 percent chance of high fatigue, a 10 percent chance of suicidal ideation, etc.

<table>
<thead>
<tr>
<th>Score (total number of “Yes” responses)</th>
<th>Low Mental Quality of Life</th>
<th>High Fatigue</th>
<th>Suicidal Ideation</th>
<th>Career Satisfaction</th>
<th>Intent to Leave Job</th>
<th>Intent to Reduce Work Hours</th>
<th>Self-perceived Recent Medical Error</th>
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[Adapted from *J Gen Intern Med.* 2013 Mar;28(3):421-7.]
Feeling the BURN

in order to succeed? “The spectacular revolution in computing that we experience daily on our smartphones has remained elusive to our EHRs,” Dr. Kaufmann said. But if EHRs can follow a similar path to smartphones, becoming more intuitive and user friendly, “we could start to see the real promise of EHR. The ability to learn from what happened to similar patients in the past with a given condition, or using EHR data to develop predictive analytics — add to this a more intuitive user-interface, and we might eventually get to an EHR that helps to decrease burnout,” he explains.

In the meantime, making the effort to find the right fit with the right EHR system, and staying up to date on its features and how to make best use of them, can make a profoundly positive impact on a practice’s workflow, says Dr. Lio. “Our EMR was built by a dermatologist, for dermatologists and it shows. All of my notes are completed and signed at the time of the visit, which has changed my life and changed my workflow. No more staying until 9 pm finishing notes that I sometimes only had a vague memory of.”

Get technical

Indeed, while technology can be a source of burnout, when used creatively it can also be a cure. “Technology can come to the rescue in a number of ways to combat burnout,” says Dr. Lio. “The power of the internet has changed so many things in our lives, but one thing that strikes me as important to helping avoid burnout is the idea that instead of having piles of handouts and informational brochures that need to be organized and tended, technology can allow us to search for them and print them on demand and just when we need them. When I see a patient, I can quickly call up a relevant informational handout and print it for them right then and there. These have the added benefit of often being much more up-to-date than those dusty brochures ordered 5 years ago in the back room!”

Creative software solutions to evergreen annoyances, such as re-filling cancelled patient appointments, can also help physicians make the most of their available time even when faced with stress-inducing constraints such as a large patient load or limited clinic hours. “Our practice uses a product developed by a small startup here in Chicago,” explains Dr. Lio. “It allows the schedule to be filled ‘automagically’ without taxing staff and, by its nature, tends to favor the folks most motivated to come in — who often, coincidentally, are the most grateful.” (For more solutions like this one, refer to June’s “There’s an app for that” at www.aad.org/dw/monthly/2017/june/theres-an-app-for-that.)

Dr. Lio also advocates for the value of implementing a patient portal on a practice’s website in order to reduce unnecessary communication between patient and provider — and help patients get information and answers to their questions faster. “I find that emailing with patients adds to my burnout — it makes me feel that I sometimes cannot escape work and patient responsibilities, even in the evening hours or when away from the office, but good electronic communication models, such as a patient portal, can be helpful in eliminating some of the list of calls to do each day, cutting down on instances of phone-tag and allowing for a more thoughtful answer, sometimes even with links to information or products that can solve the problem or question more readily,” he says.

“What I try and teach dermatology trainees is the importance of saying no, to really put their priorities in line in terms of their home life and work life, and to understanding that everything is a choice.”
One strategy to avoid burned-out physicians? Make sure they don’t flame out early. “I think young dermatologists are particularly susceptible, since we tend to be extreme overachievers out of residency,” says Dr. Waller. “The reality of practice is somewhat disheartening compared to the altruistic goals as a resident. I think workflow management is key.”

Dr. Murina agrees that a messaging shift during residency can help stop the development of burnout in early-career physicians. “What I try to teach dermatology trainees is the importance of saying no, to really put their priorities in line in terms of their home life and work life, and to understanding that everything is a choice. I think it’s important for residents to come out of training knowing that they need to give themselves a break and not worry about having it all at once,” she says. “If they find good strategies early on about how to manage burnout and how to prioritize tasks while they are in residency, they will be less burned-out physicians in the future.”

**Track quality of care**
Maintaining a sense of pride and satisfaction in your work is a critical defense against burnout. Physicians who feel hindered or ineffective in delivering care are often high-risk candidates for feelings of apathy and exhaustion. While quality reporting requirements are one of the causes of burnout for many physicians, implementing strategies to track the quality of care can also be a source of burnout-preventing personal satisfaction, suggests Dr. Murina. “There have been studies showing that physicians are more satisfied when they perceive that they’re delivering high-quality care, and that they’re doing a good job,” she explains. “One way to do that is by making sure quality improvement is a focus in your practice. Even if you do something very small to improve your practice in a meaningful way, you’ll find that other things get better as well. Constantly driving toward higher quality and higher performance, by maintaining medical knowledge and prioritizing life-long

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**Maslach’s three stages of burnout**

Over the past decade, one of the leading measures of burnout has been the [Maslach Burnout Inventory (MBI)](http://www.mbi.org), a three-stage progression established by psychologist Christina Maslach. The three main symptoms of burnout according to the MBI are:

**Exhaustion** – The central symptom of burnout. Physical, cognitive, and emotional fatigue undermines individual’s ability to work effectively and feel positively about the work that they’re doing. Individuals in a state of exhaustion find previously enjoyable and even routine tasks arduous, and concentration begins to suffer.

**Cynicism and depersonalization** – Once exhaustion sets in, a sense of cynicism and depersonalization starts to manifest, triggering an erosion of engagement with one’s work. A sense of callousness or detachment from patients, colleagues, and staff often begins to develop during this phase.

**Inefficacy** – Inefficacy is the final stage in the burnout process, in which feelings of incompetence and lack of achievement begin to take root. Physicians with this burnout symptom feel a sense of helplessness in certain situations, or when trying to accomplish certain tasks that were previously executed with no difficulty. (For example, feelings of frustration stemming from prior authorizations for drugs that were previously easy to obtain for patients can result in feelings of inefficacy among physicians.)
learning, can impact the way we feel about our personal satisfaction on a day-to-day basis."

**Keep connected**

Feelings of burnout can fester in isolation. However, a network of peers can help put challenges in perspective and provide a forum for solutions to professional challenges. “I think having a network of support amongst colleagues is important, including attending meetings both locally and nationally to foster a spirit of camaraderie. Staying involved and trying to contribute to better solutions, and not just complaining about the situation, has helped me,” says Dr. Waller.

Dr. Murina agrees. “The impact of community is not emphasized enough when we discuss burnout. With technology we have become increasingly alone at our desk with a computer, and we’re looking at screens more than human beings. We need to actively pursue more social networking live and in-person. Opportunities outside of work such as journal clubs or live CME events are great so that dermatologists can meet others who are facing similar problems, and come up with solutions,” she says.

**Eat, sleep, meditate**

Last but not least, making sure to meet basic physical and mental health needs is an important first step toward practicing self-care and staving off the effects of burnout. “First-rate musicians and athletes know that attention to the self is key to optimal performance,” notes *Academic Medicine* (2013;88: 301-303). “Their training explicitly includes development of skills in self-monitoring, self-awareness, and resilience. In medicine, where the stakes are arguably higher, this kind of training is lacking.” Reframing physician attitudes toward their own health by prioritizing adequate sleep, healthy diet, and time off to recover from illness are important, but likewise so is maintaining good mental health practices, suggests Dr. Murina. “I don’t like to emphasize that you can meditate your way out of burnout, but I believe that meditative practice, exercising, gardening or anything that takes your mind off of work, is a good idea.”

**Rising from the ashes**

While burnout can at times feel insurmountable, not all is lost. According to a March 2017 American Medical Association (AMA) survey, nine in 10 physicians are satisfied with their career choice, despite challenges common to each career stage, while 61 percent of all respondents still indicated that they would encourage others to enter the field of medicine. While this suggests that providers haven’t completely succumbed to burnout just yet, it remains in the best interest of the public, health care institutions, and legislators to promote a more self-aware, resilient, health care workforce, as “physicians who care for themselves do a better job of caring for others, and are less likely to commit errors, be impaired, or leave practice — all of which are costly to the healthcare system," suggests *Academic Medicine* (2013;88: 301-303).

Staying vigilant, catching burnout early, and not being afraid to admit that you’re overwhelmed is key to staying afloat, says Dr. Murina. “I think it’s a big deal that doctors are even willing to admit that they’re burned out. There’s the perception that physicians are hard workers who can handle tons of demands, and never burn out,” she says. “But many physicians don’t realize or don’t want to admit what’s happening until they’re completely burned out and they want to leave medicine, and that’s not what we want.”

“Feeling the BURN

“The biggest driver of burnout for me personally is the feeling of doing meaningless work that is required by organizational, insurance, or government regulations, that does not truly elevate the patient experience or patient safety.”

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Need for inpatient dermatologic care increases
A gentleman presented to another hospital with what he thought was just a bug bite on his hand, which had swelled up. Physicians at that hospital thought it was an infection, and gave him antibiotics. Then his skin started to break down, so they took him to the operating room and performed debridement. They kept taking him back to the OR and doing more procedures, although there was never any real evidence of infection. By the time he was transferred here, they had amputated his arm. There were similar ulcers on his body; he was quite sick and was admitted to our ICU. Pyoderma gangrenosum is an inflammatory condition that can mimic infection, but it’s an ulcer that expands and expands; when you debride it or do any kind of surgical procedure, that can often make it worse. Within the first few hours of his admission, we dermatologists had made a presumptive diagnosis of pyoderma gangrenosum, and started him on steroids. Within probably 24 hours, he was well enough to be transferred from the ICU to the floor. Over the next days and weeks the ulcers healed completely.

— Robert G. Micheletti, MD, assistant professor of dermatology at the Hospital of the University of Pennsylvania

If there were ever a doubt that dermatologists can have a powerful, even life-saving impact on the care of hospitalized patients, the stories related by hospital-based dermatologists, whose viewpoints are bolstered by a growing body of research, demonstrate the critical importance of dermatologic expertise in the inpatient setting. “I look at this role as being an ambassador for dermatology,” said Dr. Micheletti. “Our medical colleagues really value what we bring to the table. When you put yourself out there, you get to see interesting cases, converse with your colleagues, and have tremendous ability to shape patient care. But you have to be there, be in the game.” On the following pages, five dermatology hospitalists share their experience and discuss the issues underlying the shortage of dermatologists willing to do inpatient consults. >>
We see allergic contact dermatitis misdiagnosed as cellulitis several times each summer at my institution. Recently, a cancer patient was hospitalized with a diagnosis of cellulitis and administered antibiotics. When she didn’t respond after four days, a consult was placed to dermatology. We noted diffuse microvesicles and bullae on one extremity. Upon taking her history, we learned that after receiving a small scrape, she had applied Neosporin to her entire leg and wrapped it, over the course of several days, which caused severe allergic contact dermatitis. With this new information, we stopped her antibiotics and got her discharged almost immediately.

— Benjamin Kaffenberger, MD, specialist in hospital dermatology, assistant professor and director of the Inpatient Consult Service at The Ohio State University Wexner Medical Center

The impact on inpatient care
If there’s a poster child depicting the frequency with which dermatologists correct or head off a misdiagnosis, cellulitis may be it. “Cellulitis is an arena where dermatology expertise can play a tremendous role in better outcomes for patients, hospitals, and the health care system as a whole,” said Daniela Kroshinsky, MD, director of inpatient dermatology and pediatric dermatology at Massachusetts General Hospital. Dr. Kroshinsky co-authored a study (JAMA Dermatol. 2017;153(2):141-146) examining the costs and consequences resulting from misdiagnosed lower extremity cellulitis. The study included 259 patients admitted with presumed cellulitis from the emergency department of a large urban hospital. Among the findings: of the 259 patients, 79 (30.5 percent) were misdiagnosed with cellulitis. Of those misdiagnosed, 52 were admitted primarily for cellulitis treatment; 44 of the 52 did not require hospital admission, and 48 received unnecessary antibiotics. The authors estimate that misdiagnosis of cellulitis results in $195 million to $515 million annually in unnecessary spending in the U.S., “exclusive of the costs of antibiotics and complications resulting from inappropriate treatment.” In another cellulitis study not yet published, Dr. Kroshinsky said she was able to demonstrate that “having a dermatologist intervene and assess these patients within 24 hours of their presentation resulted in reduced length of hospital stay and antibiotic use. In addition, we found that patients felt they were better cared for and had better outcomes if they saw a dermatologist during their stay.”

Another JAMA Dermatology study (2017;153(6):523-528), co-authored by Dr. Kaffenberger, examined the impact of dermatology consultation for patients with inflammatory skin conditions on hospital length of stay and readmission. Multivariable modeling showed that dermatology consultations were associated with a reduction of 2.64 days in hospital length of stay (as measured from the time of the consult to discharge). In addition, “if you had a dermatology consult, your chances of being readmitted were one-tenth of those who did not receive a consult,” Dr. Kaffenberger noted.

Sometimes the biggest impact we can have is when everyone in the hospital setting assumes a condition is infectious, but it’s really inflammatory. We had a woman present with high fever, an extremely itchy rash, and lymphadenopathy. She was bed-bound and unable to walk. People suspected it was infection, because of the high fever, or a malignancy, because of the elevated lymph nodes. We did a skin biopsy, which revealed a very distinctive pattern for a specific kind of autoimmune disease. As it turned out, she had adult-onset Still’s disease, the first presentation of the disease for her. This is a serious disorder that can progress to hemophagocytic lymphohistiocytosis. We put her on prednisone, and 24 hours later she felt like a new person. She needed ongoing treatment over time, but we were able to provide her with almost immediate relief.

— Amy Musiek, MD, associate professor of dermatology, Washington University School of Medicine in St. Louis

In addition to correcting the misdiagnosis of common skin disorders, dermatologists frequently identify rare disorders that the primary care team didn’t suspect. These conditions may be primary disorders, or they may result from immunosuppression or reaction to a drug. “Stevens-Johnson syndrome is kind of the classic dermatologic emergency,” said Dr. Micheletti. “It’s a very severe drug reaction, and a number of medications can cause it. It can result in blistering of the skin, eyes, and mouth, and the average
A patient in his 70s is in our hospital right now with endocarditis, and had previously had a rash on his legs. The primary care team thought he had cellulitis, or maybe a skin infection. They called us, and we noted palpable purpura — jagged, reticulated purpura, in two different patterns, mostly distal on the toes and tips of the body. It was very suspicious for cryoglobulineamia. This can happen in patients with endocarditis, where the infection triggers more antibodies, and those antibodies can precipitate in the cold. The reason that’s important is that it doesn’t just precipitate in the skin; we also had worsening creatinine, worsening renal function, and he was heading towards dialysis. Literally, upon walking in, we said, you know what, this doesn’t look like cellulitis, it looks like cryoglobulins. There are special treatments for cryoglobulineamia which can remove those proteins and save the kidneys. This is someone who, at another hospital, would have been diagnosed with just a “rash,” or would have been thought to maybe have bland emboli from endocarditis, and would have potentially ended up on dialysis.

— Misha A. Rosenbach, MD
A way forward
For some dermatology residents, the work they do with inpatients during their residency propels them toward a career as a dermatology hospitalist. “I like the hospital setting; I like to be actively doing things,” said Dr. Musiek. “We certainly see a ton of cases that are very routine, and we try to be as helpful to the team as possible. But there are a lot of opportunities to come in and make the big diagnosis that no one was thinking of, and I think that’s a fun opportunity too.”

Dr. Kroshinsky was one of five founding members of the Society for Dermatology Hospitalists, a group formed 10 years ago that has grown to more than 90 members. She noted that one of the society’s missions is to think of ways to bring dermatology consults to community hospitals and other institutions that can’t support a full-time dermatology hospitalist. “If we think creatively of how to utilize those individuals who are interested in hospital dermatology but can’t do it full-time, or don’t see hospital dermatology as their main focus, we can be integrating them in different ways. One approach is to partner with community hospitals, coming in perhaps once or twice a week or on an as-needed basis, being amenable to triage and assessment via teledermatology and then working with the full-time primary care teams in those hospitals.” There could be an arrangement whereby a dermatologist sees the inpatient “but is not necessarily responsible for the administrative component that would result from that visit.” Regarding issues like credentialing and billing, “there’s going to have to be some flexibility on both sides. It’s not realistic to expect outpatient dermatologists to be credentialed in 10 different community hospitals and facile with five different EMRs.”

By engaging other specialties within the hospital to think through the problem, dermatology hospitalists “may be able to advocate for our outpatient colleagues to be able to participate in a way that does overcome a lot of these barriers. You need dermatologists in the hospital. We just have to be constantly reconsidering how we can deliver that care in response to how the face of medicine is changing.”

Teledermatology is one possible avenue for private practitioners to provide inpatient consults, the hospitalists said, but reimbursement varies, and dermatologists are advised to confirm with their malpractice carriers that their policy includes coverage for it. “Recent research shows that in the hospital setting, diagnosis via teledermatology is very similar to in-person diagnosis,” said Dr. Kaffenberger. “We tried to do it with one of our affiliates, but there’s no insurer that will pay for it in the hospital setting in our area. That being said, we still do it as a service for our affiliate hospital; we just don’t bill for it or get paid for it. I think we’re getting more traction for it over time, though; that’s our goal.”

Dermatologists with an outpatient practice can always turn to full-time dermatology hospitalists as a resource if they’re considering doing inpatient consults, said Dr. Rosenbach. “Engaging with a local hospital can be incredibly valuable, not just in enhancing the perception of our field, but from a private practice standpoint,” he noted. “You develop a great relationship with a whole host of doctors, and suddenly those doctors are willing to treat your patients on short notice because you treat their patients on short notice. It helps everyone.”

A patient with terrible systemic and cutaneous lupus was admitted to a community hospital for treatment of zoster, and a month later was readmitted and transferred to us with a diagnosis of recurrent and disseminated zoster. The primary care team had decreased her immunosuppression, as they were concerned that excessive immunosuppression had led to a recurrence of zoster. She was in our hospital for several days, without improvement, when the infectious disease group asked for our assistance. Once we saw her, without even doing a biopsy we could explain that this was the isotopic phenomenon, and her discoid lupus was developing within her previous zoster scars, in addition to other areas. Thus, we started her on a much higher dose of immunosuppression for control, immediately took her out of isolation, and soon discharged her. Her lupus was under control by the time of her follow-up appointment.

— Benjamin Kaffenberger, MD
Upcoming CME Activities

Basal Cell and Squamous Cell Cancer Dermatopathology and Fundamentals of Mohs Surgery

DoubleTree Hotel San Diego, Mission Valley – San Diego, CA

November 7-8, 2017 – Basal Cell and Squamous Cell Cancer Dermatopathology
- Introductory (Day 1) and Advanced (Day 2) discussions
- Pure pathology approach to understanding BCC and SCC characteristics
- Examination of reactive changes commonly visualized at biopsy sites
- Identification of non-BCC and non-SCC structures in Mohs-excised tissue

November 9-12, 2017 – Fundamentals of Mohs Surgery
- Basic Mohs surgical, histopathologic, and laboratory skills for physicians and technicians
- Practice efficiencies including office/laboratory design, management of patient flow and tissue specimen transfer
- Appropriate indications for Mohs, based on histologic subtype and anatomic location
- Critical mapping considerations for proper orientation, correlation of histologic findings to surgical wound
- Multiple microscope laboratory sessions featuring small group and independent Mohs case reviews

ASMS Annual Meeting and Focus on Skin Cancer

Location – TBD

May 24-27, 2018 – Dermatologic Surgery: Focus on Skin Cancer
- Current topics for dermatologic surgeons and cutaneous oncologists at all levels of training and experience
- Expert panel discussions: complex closure approaches, melanoma treatment options and management of other challenging tumors
- Review of dermoscopy advances in melanoma diagnosis
- Comprehensive literature reviews
- Small-group histopathology discussions; Mohs and non-Mohs cases available for review

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

Novella Rodgers, Executive Director
American Society for Mohs Surgery
6475 E. Pacific Coast Hwy., Box 700
Long Beach, CA 90803
Tel: 800-616-2767 or 714-379-6262
Fax: 714-362-9540
www.mohssurgery.org
nrogers@mohssurgery.org
As dermatologists, ensuring quality care and patient safety is at the root of every treatment we provide. However, when it comes to quality and safety we are only in control of the treatments that occur within the walls of our own practices. Unfortunately, in many instances non-physicians advertise themselves as skin care doctors or experts. We have all heard the cringe-worthy news reports about patients who have suffered irreversible consequences from a botched treatment provided by a non-physician. Our patients deserve better.

The American Academy of Dermatology Association (AADA) has a firm position on truth in advertising and we are aggressively fighting for the implementation of direct and concise regulations and enforcement against fraudulent, deceptive, or misleading advertising. We are also pushing for regulations that require transparency and disclosure of a provider’s degree, field of study, board certification, and state licensure. We are not alone in this fight. The AADA has worked with the American Medical Association (AMA) and other specialty societies to push for legislation that requires health care practitioners to identify the license under which they practice — and this legislation has been enacted in 20 states.

Additionally, the AADA along with the AMA, the American Society for Dermatologic Surgery Association, and other medical specialties are advocating for legislation that restricts the inappropriate use of “board certification” in advertisements, and only allows physicians to use the term if their certifying board meets certain requirements. This legislation has been introduced in 12 states. The AADA also introduced a resolution in the AMA House of Delegates that supports transparency of health care provider profiles in commercial and federal physician comparison databases — the resolution was adopted in 2015. While this issue is generally addressed at the state level, the AADA’s federal legislative team has also pressed for action on truth in advertising with the U.S. Congress.

Truth in advertising goes hand-in-hand with scope of practice regulations, and the Academy has not let up on that issue either. The AADA’s position firmly states that non-physician clinicians are to be supervised by a dermatologist in the practice. Non-physician clinicians should not provide dermatology care without supervision by a dermatologist; we are doggedly fighting non-physician efforts to expand their scope of practice.

In the last three years alone, the Academy positively influenced scope of practice legislation in more than 20 states. To name a few, we have blocked scope-of-practice expansion bills in Indiana, Louisiana, and Pennsylvania, defeated optometry scope expansion efforts in Maryland, North Carolina, Connecticut, and California, and quashed a nurse practitioner scope expansion bill in Indiana with the Indiana Academy of Dermatology. Again, we are not alone on this issue. The Academy is an active member in the AMA Scope of Practice Partnership coalition, and we are teaming up with other physician groups to fight these inappropriate efforts to expand non-physicians’ scope of practice.

This is simply a snapshot of the work that your Academy has done over the last few years on truth in advertising and scope of practice. Because scope of practice and most truth in advertising laws are governed by state regulatory bodies, partnership with state medical and dermatological societies is a must. While we have made significant gains on this issue, there is still a long road to travel. Together with state societies, I can assure you that we will continue to monitor and fight legislation that puts patient safety and quality care at risk.

I call on all of my colleagues to join the Academy in its efforts to promote truth in advertising and fight scope of practice expansions. Fortunately, the AADA has made it easy for you to get involved. We have developed resources for members that include model legislation, talking points, as well as template media tools that you can personalize and use in your local communities. We are also expanding on these resources by providing state-specific information on how to report potential violations, and additional tools on how to get involved at the grassroots level. Find them at www.aad.org and keep an eye on your inbox for updated materials and information.

Together, we need to intensify our efforts to strengthen scope of practice regulations and fight for truth in advertising. We are not simply taking these steps to defend our specialty. We are taking a stand for our patients because when it comes to patient care, quality and safety are non-negotiable.
RENEW YOUR
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Get Started at
aad.org/account/dues
Executive Director’s Report

Turning the page to September always makes me think of going back to school. Time to buy some new supplies, sharpen some new pencils, and get to work.

With all of the change in the health care environment of late, though, every day may feel like your first day in a new school. From quality reporting requirements to prior authorization requests to wondering if you’re even in the right classroom — I mean, practice — dermatologists have a lot on their minds right now.

In the old days of associations, this would be your concern to manage. But as things change for you, they’re changing for your Academy as well. In a changing environment, your association needs to do more than provide policy statements. It needs to offer you pragmatic tools that can help you be more effective in the day-to-day business of being a dermatologist. Your Academy is doing just that.

We know that complying with the quality reporting requirements of MACRA’s Quality Payment Program is a challenge for many of you. We continue to advocate for streamlining and eliminating reporting requirements — but we’ve also developed a clinical data registry, DataDerm™, that can help you meet those requirements as they exist today; learn more at www.aad.org/dataderm. We’ve also created a wealth of advice about how to succeed in reporting in the MACRA section of the AADA Practice Management Center at www.aad.org/MACRA.

We also know that prior authorization requests are a real pain point for members, chewing up hours of their time as well as that of their staff. In the old days we might have offered some generic advice about how to successfully write a prior auth letter. Today we’ve developed a letter generator that creates a letter you can print or download and send to the insurance company. Each letter includes evidence to support your choice of a particular medication for a particular patient. Use the letter generator at www.aad.org/priorauth.

Finally, we know the business environment is changing. We could have asked our new Emerging Practice Models Committee to publish a 70-page white paper about dermatologists’ practice options; few would read it and fewer would find it useful. Instead, we’ve created a library of resources to help you assess your options, including Dermatology World articles, interactive tools, and case studies about different potential practice models. Find these resources at www.aad.org/practicecenter.

Your Academy has been working for you all year, getting ready for what may feel like the first day in a new school for some of you. I hope you’ll take advantage of all of our hard work to make yours a little easier. dw

Academy seeks assistant secretary-treasurer nominees

Applications and nominations are now being solicited for the position of assistant secretary-treasurer for the American Academy of Dermatology and AAD Association. The term begins March 2019. Marta J. Van Beek, MD, MPH, is the current Assistant Secretary-Treasurer.

Members interested in serving the Academy in this position should have significant administrative and financial management experience. The position of assistant secretary-treasurer requires a considerable time commitment. Applicants must be able to serve for six years: three years as assistant secretary-treasurer and three additional years as secretary-treasurer.

To learn more about the position and apply, visit www.aad.org/AST. Applications are due Jan. 5, 2018. Questions may be directed to Cyndi Del Boccio in the AAD Executive Office at (847) 240-1041 or cdelboccio@aad.org.
OBITUARIES

BY JERRY GRAFF, MD

The Academy recently learned with sorrow of the passing of the following members of the dermatologic community.

JAMES K. ATON JR, MD, of Atlanta, Jan. 20, 2017 in St. Petersburg, Fla., at age 83; trained in dermatology at Univ. of Maryland, he was a career military dermatologist serving as Chief in various military hospitals including at 95th Evac. Hospital, Da Nang, Vietnam and 14 years at Eisenhower Army Medical Center, Ft. Gordon, Ga.; retired in 1988 and became a Staff Physician in derm at Eisenhower and other institutions in Georgia as well as teaching at Med College of Georgia; awarded Legion of Merit before retiring from the Army; active in Episcopal Church and was well-known stamp collector and member of Stamp Club of Augusta, Ga.

CLAY S. BAKER, MD, of Pocatello, Idaho, Apr. 19, 2017 at age 46; trained in derm at Southern Illinois Univ.

JAMES M. BARR JR., MD, of Lawrenceburg, Ky., Aug. 27, 2016 at age 74; after training in derm at Univ. of Louisville, had a private practice in Frankfort, Ky., for 34 years; enjoyed spending time on his 48-acre property as well as books, camping, swimming, scuba diving, and ballroom dancing; was a strict vegetarian for over 40 years and loved animals so much that he dedicated his property to the conservation of wildlife.

JEROME W. BUZAS, MD, of Reading, Pa., Dec. 18, 2016 at age 69; trained in derm at Univ. of Maryland.

DAVID A. BYRNE, MD, of Bloomington, Ind., June 15, 2017 at age 79; a first for this column: Dr. Byrne, at his wife’s behest, wrote his own obituary! Some excerpts: began working career in aerospace engineering; moved on to real estate sales — “I found I was the worst salesman who ever lived.” decided to study medicine and ultimately trained in derm and dermatopathology at Univ. of Missouri Medical Center; practiced dermpath in Bloomington for 40+ years; relished “the endlessly fascinating study and application of human biology. Good luck had I, despite occasional errors of intellect or character needing to be overcome or forgiven. With my apologies to Strunk and White — Margery will never ask me to write another obituary.”

TIMOTHY K. CHARTIER, MD, of Farmington, Conn., May 26, 2017 at age 51; overcame financial obstacles early in life to graduate Magna Cum Laude and A.O.A. from, respectively, college and med school; trained in derm at Harvard Combined Res. Program and in Mohs at Mass. Eye and Ear; established private practice in Farmington and performed thousands of Mohs and dermsurg procedures; impressed his patients with his “kind demeanor, comforting personality, and his immense knowledge of dermatology;” served as an officer in several Connecticut dermatology and medical societies and was Assoc. Clinical Professor at Yale as a volunteer teaching derm surgery to residents; loved playing racquetball and competed in tournaments in the Northeast; loved music, playing the guitar and ukulele; a family scholarship in his honor will fulfill his wish to “give a bright, young, determined individual the means to afford higher education.”

SMITH H. GIBSON, MD, of Edgewood, Ky., Feb. 28, 2017 at age 94 on his 71st wedding anniversary; trained in derm at Mayo Clinic and practiced in Covington, Ky. for 48 years; served as past president of Kentucky and Cincinnati Derm Societies and Grant County Med Society; volunteer faculty at Univ. of Cincinnati derm dept.; led their Archives Journal Club for 30 years; member of founding committee to organize the Mayo O’Leary Society in 2004; won Excellence in Teaching awards twice and was designated Clinical Prof. Emeritus at Univ. of Cincinnati; winner of Lifetime Achievement Award there; honored for patient care by Kentucky legislature; enjoyed classical music, antiques, and travel.

FRANKLIN M. GLICKMAN, MD, of Roslyn Heights, N.Y. and Boynton Beach, Fla., March 10, 2017 at age 87; trained in derm at Bronx VA Hosp.; practiced dermatology in Brooklyn, N.Y. before obtaining a masters degree in health care admin. from NYU and becoming Chair of Graduate Med Education at Wyckoff Heights Hosp., in Brooklyn; received Humanitarian Award there in 1973; wrote two textbooks and five novels; wrote poetry and music and played piano and harpsichord which he built; served in many leadership positions in civic, medical and, specifically, in dermatological organizations.

CONTINUED ON PAGE 64
PAUL MCKENNA, MD, of Pacific Palisades, Calif., Apr. 13, 2016 at age 81; born in Northern Ireland; after med school graduation, served two years as missionary doctor in Nigeria; trained in derm at Mass. General Hosp. plus a fellowship at Univ. of Southern California; practiced in L.A. for 36 years specializing in hair transplantation; never turned any patient away for lack of ability to pay and volunteered his services for many in need.

PHILIP F. MURRAY, MD, of Newport News, Va., Dec. 22, 2016 at age 95; trained in derm at Univ. of Buffalo, N.Y. and practiced in Hampton, Va; lecturer in derm at Med College of Virginia in Richmond and asst. prof. of derm at Eastern VA Med School; after retirement became interested in complementary medicine and taught “Approaches to Better Health” at a local university Lifelong Learning Society; helped establish Peninsula Peace Education Center and joined Physicians for Social Responsibility; loved music and played piano even in last weeks of life.

PERRY LEE RASHLEIGH, MD, of Mystic, Conn., May 9, 2017 at age 83; trained in dermatology at Univ. of Colorado Anschutz Med Campus.

JACK G. ROBBINS, MD, of Durham, N.C., Nov. 6, 2011 at age 87; trained in dermatology at Duke Univ. Med Center and practiced in Durham; was on faculty at Duke; served in the U.S. Army during World War II and in the Air Force in the Korean Conflict.

L. THOMAS ROZUM, MD, of Oshkosh, Wis., Aug. 27, 2015 at age 73; trained in derm at Univ. of Wisconsin and had a private practice for 27 years; then worked part time at a community health network in Berlin, Wis.; his many interests and joys included travel, astronomy, music (opera), art, and humor.

RAMON RUIZ-MALDONADO, MD, of Mexico City, Mexico, Apr. 5, 2017 at age 80; trained in dermatology at Univ. Clinic in Vienna, Austria.

JAMES L. Secrest, MD, of Mansfield, Ohio, Mar. 7, 2017 at age 94; played football at Univ. of Rochester and was inducted into their first Sports Hall of Fame class of 1992; served in U.S. Army in World War II and volunteered for first MASH unit 8055 in Korea; trained in derm at Univ. Hospitals, Cleveland and practiced in Mansfield 37 years; avid golfer who enjoyed sports and travel and was known for his sense of humor.

EDWARD M SHAPIRO, MD, of Houston, Aug. 23, 2015 at age 90; trained in dermatology at Henry Ford Hospital.

STUART C. SMITH, MD, of Tallahassee, Fla., Nov. 23, 2016 at age 93; trained in derm at Univ. of Virginia Med Center and was first dermatologist to practice in the Florida panhandle; was active in civic organizations and helped found the Peace Garden in Tallahassee; loved gardening and became a rose judge, bridge, classical piano, and wine collecting.

JERRY H. STEPHENS, MD, of Houston, Aug. 20, 2015 at age 86; trained in derm at Baylor College of Med and practiced privately, then with Kelsey-Seybold Clinic until retiring at 76; major non-medical interest was in orchids and became an Emeritus Judge with Amer. Orchid Soc.

WILLIAM J. (JERRY) WHITEHEAD, MD, of Oakland, Tenn., Dec. 14, 2015 at age 80; trained in derm at San Antonio Uniformed Svcs. Hlth. Edu. Cons.; practiced for 40+ years in Germantown, Tenn.; was a member of many local and national medical and derm societies and was a past president of the Memphis Dermatological Society.

Obituaries are published in Dermatology World after information is submitted to the AAD. Information on member obituaries should be submitted in writing to Member Resource Center, AAD Member Services Dept., P.O. Box 4014, Schaumburg, IL 60168-4014, via fax at (847) 330-1090, or via email at mrc@aad.org. Jerry Graff, MD, assembles additional information for each obituary on behalf of DW.
AAD Board approves updated BCC, SCC guidelines

The Board of Directors of the American Academy of Dermatology approved new guidelines of care for the management of basal cell carcinoma and guidelines of care for the management of cutaneous squamous cell carcinoma at its July 29 meeting. The two new guidelines will be submitted to the *Journal of the American Academy of Dermatology* for publication and will be available at [www.aad.org/guidelines](http://www.aad.org/guidelines).

The Board also approved the 2016 audit report, the results of which will be published in the November issue of *Dermatology World*.

During the meeting, the Board heard about the Academy’s growing social media efforts. The Academy has three primary audiences for its social media. Posts directed to the public are shared using the handle @AADskin, with more than 100,000 combined followers on Facebook, Twitter, YouTube, and Pinterest. The Academy’s member social media channels, all named @AADMember, can be followed on Facebook, Twitter, and Instagram. A third channel, @JAADJournals, keeps readers of the *Journal of the American Academy of Dermatology* and *JAAD Case Reports* informed about the latest new studies.

Finally, the Board elected Linda Stein Gold, MD, to a two-year term on the Executive Committee.

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**AAD Social Media**

Follow the AAD on social media at @AADMember on Facebook, Twitter, and Instagram.

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**A very cool leap in skin cancer prevention.**

If you watch *Shark Tank*, you may remember the *tutublue* story. When actress Sarah Buxton was diagnosed with skin cancer, her dermatologist gave her a choice: put away the surfboard and paddleboard, or find a way to protect herself from head to toe.

The result... *tutublue* - a first of its kind one-piece beach suit made with UPF 50 tested fabric that blocks 97% of the sun’s harmful UVA & UVB rays. Ideal for any outdoor activity.

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Right now through SPZ’s Patient Loyalty Program you can offer your patients a 15% savings on all *tutublue* orders. Call Sun Protection Zone for brochures with your unique discount code today. To enhance this offer, we also have special discounts exclusively for your office staff on all *tutublue* merchandise. To take advantage of this offer, call us at: 714-895-3615.

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WORCESTER, MASSACHUSETTS

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CENTRAL NEW JERSEY

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BE/BC dermatologist needed for general and cosmetic dermatology practice in NYC. 2-3 days per week. Friendly staff, flexible working hours, competitive salary. Forward CV to contact@212skin.com

LONG ISLAND/NYC
FT/PT BC/BE derm needed to join as associate. Excellent opportunity to join busy plastic surgery practice. Forward CV to mweissler@gmail.com.

KNOXVILLE, TENNESSEE
The price is (not) right

BY EMILY MARGOSIAN, CONTENT SPECIALIST

How much does dermatologic care cost? According to recent reports, not even physicians themselves may know. A recent JAMA study found that dermatology providers, including all practitioner types (MD, DO, NP, PA), consistently underestimated the cost of commonly prescribed dermatologic medications, although they fared better in accurately predicting the cost of common dermatologic procedures (2017; Apr 74(1):609-617).

The authors note that as ongoing health care reform continues to move in a direction that emphasizes the importance of high-value care, significant expected-to-actual cost discrepancies can have a chilling effect on patient adherence and result in inferior clinical outcomes, whereas the ability of physicians to properly communicate costs to patients may enhance medical-decision making, improve adherence and outcomes, and potentially reduce overall health care expenditures.

See the graphic below for a breakdown of provider accuracy rates regarding dermatology drug and procedure costs.

Dermatology provider knowledge of drug and procedure costs

- **Drug Estimates**
  - **52%** absolute error
  - **449** underestimates
  - **101** overestimates

- **Procedure Estimates**
  - **34%** absolute error
  - **140** underestimates
  - **107** overestimates
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