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Navigating Practice, Policy, and Patient Care



FILLING *the* MEDICINE CABINET

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Don't miss this edition of *Dermatology World*.



Summer is almost over and, hopefully, you are taking a little time for yourselves and family before the long days start getting shorter. However, I encourage you to spend a few minutes with us, as our staff and writers have pulled together some fabulous articles that may help optimize the business side of your practice.

Do you have a practice manager? If not, should you have one? Our feature article may help you decide. A good practice manager today fulfills many diverse roles and can be a key element in the functional and financial success

of your practice, whether you are in solo practice, an organization, or even academic practice. Learn about qualities of a good manager and make sure the one you hire is the right fit for your practice.

Malpractice is a topic we all hate to think about; however, it is best addressed proactively. Remember your Mom's old saying about "an ounce of prevention..." As always, Mom was right, even if she wasn't talking specifically about malpractice insurance. Malpractice insurance is here to protect you and your assets. Make sure you understand your policy and that you have adequate coverage for your needs. Are you leaving your practice and, if so, do you need tail coverage? If you don't know — or if you don't even know what this is — I recommend reading Ruth Carol's very informative article, which includes a very clear, yet detailed description of the different facets of malpractice insurance. Also make sure to consider the other insurance needs of your practice, including liability coverage. Your carrier may offer risk management services, including educational opportunities about a variety of related topics, including cybersecurity and HIPAA compliance. See what your insurance carrier has to offer.

In the spirit of "being prepared," you may also want to read what Cliff Lober has to say about advance directives. As dermatologists, we have not traditionally been in the position of helping our patients make these important decisions. However, it is important that all of us who provide care ensure that our patient's care wishes are known and that we follow them to our best extent. And, since all of us at some point will be a patient, we may wish to ensure that we have addressed these issues personally.

We wrap up this edition with a great article highlighting the wonderful advances in the understanding and management of atopic dermatitis. In the past 10+ years, biologics have revolutionized the management of psoriasis. Now atopic dermatitis is in the spotlight. Several new and exciting treatments are in use, including the IL-13/IL-4 inhibitor dupilumab, and other novel treatments are in the pipeline. I am personally excited about Janus kinase inhibitors, which I have already been using to treat eczema — in my dog. Oclacitinib, a JAK inhibitor, was approved by the FDA for management of canine atopic dermatitis in 2013. My old dog, Sunshine, has itched for several years (no doubt in part due to his cat allergy), so we recently started him on therapy. I'm happy to say his itching has improved and we have been able to retire his "cone of shame." We still, however, have the cat...

KATHRYN SCHWARZENBERGER, MD, PHYSICIAN EDITOR

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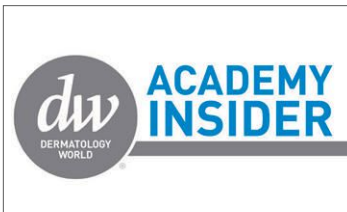
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Q If you're running late, how long does your staff wait before giving patients in the waiting room an update?

“ I try not to wait until patients are in the waiting room to let them know I am running late. As soon as I am 20 minutes behind, my staff are instructed to call/text patients and let them know that they can get here 20 minutes later. Patients greatly appreciate this, even if they are already en route. ”

– Ellen Gendler, MD, New York

“ 15 minutes. ”

– Malini Fowler, MD, San Antonio

“ I do my best to stay on time and rarely get more than 15 minutes behind. However, if we are more than 30 minutes behind my front desk lets patients know that we are running a little behind due to emergencies. Most patients are very understanding and do not mind. 95% of the time we are right on schedule. ”

– Asma Ahmed, DO, Toms River, N.J.

“ We use Nextech EMR, which can tell the patient care team when a patient is ready to room. If we are running behind, our patient entry and patient care team will give constant real-time updates via walkie-talkie if there are any delays. It is a bit difficult to gauge how far 'behind' we are at any given time, since we are constantly moving and can often catch up with the way our templates are set up. Our goal is to stay on time for every patient. However, they often show up at the time of their appointment and still have paperwork that they did not fill out online. So even a perfect schedule can end up with delays. ”

– Carolyn Jacob, MD, Chicago



Next month's question

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

How much sick leave do you give your staff?

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.



Edward W. Cowen, MD, MHSc



Deepti Gupta, MD

The first human retrovirus, identified in 1980, was not HIV, but human T-cell lymphotropic virus-1 (HTLV-1). It was reported in a patient with cutaneous T-cell lymphoma by Robert Gallo (who would co-discover HIV 3 years later) (*Proc Natl Acad Sci USA*. 1980;77[12]:7415-7419). **HTLV-1 infection may cause a myelopathy/spastic paraparesis syndrome or lead to adult T-cell leukemia/lymphoma (ATLL) with skin involvement resembling mycosis fungoides.** And, similar to mycosis fungoides, ATLL can present with a smoldering or chronic variant characterized by patch and plaque disease or by acute leukemic involvement with lymphadenopathy, organomegaly, and hypercalcemia.

Although only a fraction of individuals infected with HTLV-1 infection develop ATLL (3-5%), seropositivity in endemic areas (Japanese, Caribbean, Aboriginal Australian populations) ranges from 10-45%. As with HIV, the virus is spread via sexual contact, mother-to-child transmission, and exposure to contaminated blood, suggesting that prevention strategies employed in the HIV/AIDS epidemic could control the spread of HTLV-1 in endemic areas.

In a May 10 open letter, Gallo and 59 other leading researchers and patient advocates called on the World Health Organization to undertake a global campaign against HTLV-1 using strategies proven to reduce the risk of transmission of HIV and hepatitis B and C virus (<http://gvn.org/who>). For instance, universal antenatal screening for HTLV-1 is mandated in Japan (the only country doing so), and has reduced the rate of mother to child transmission in that country from 20% to 2.5% (*Lancet*. 2018 May 12;391[10133]:1893-1894). In the interim, dermatologists should remain vigilant regarding the possibility of HTLV-1 infection in patients with CTCL from endemic areas or with other risk factors such as IV drug use.

Biotin has become a popular dietary supplement recommended by dermatologists, both in the U.S. and abroad, to improve disorders of the skin, hair, and nails. Deficiency of biotin can lead to alopecia, dermatitis, and neuromuscular dysfunction. However, the data is limited on biotin supplementation to treat dermatologic conditions, especially in patients with normal biotin levels.

The Food and Drug Administration (FDA) issued a recent warning that consumption of biotin may lead to falsely elevated or diminished laboratory test results. A biotin-streptavidin based immunoassay is required for many examinations. A clinical trial in healthy adults taking 10mg of biotin per day for 7 days resulted in falsely diminished levels of thyroid stimulating hormone, parathyroid hormone, and N-terminal pro-brain natriuretic peptide, and falsely elevated free triiodothyronine. Misdiagnosis of Graves disease has been reported in euthyroid children and adults on biotin. Troponin levels have also been reported to be falsely diminished leading to one reported case of death.

Biotin supplementation should be discussed with patients and the lab should be notified if a test was done while a patient was taking biotin.

Based on biotin pharmacokinetic data it is recommended that adults taking biotin 10mg/day wait 8 hours prior to labs being drawn, those taking 100-300mg/day wait 3 days, and children taking 2-15mg/kg/day of biotin wait 1 week (*J Am Acad Dermatol*. 2018; 78:1236-8).

Dermatology and infectious diseases



Read more about dermatologists' role in the global treatment of HIV in *Dermatology World* at www.aad.org/dw/monthly/2016/december/staying-the-course.



Corey Hartman, MD



Michel McDonald, MD

Harmful chemicals in black hair care products may affect health. A recent study found that hair care products used primarily by black women in the U.S. contain a variety of chemicals that have been linked to asthma, hormone disruptions, and even cancer (*Environ Res.* 2018 Apr 24. pii: S0013-9351(18)30151-8. doi: 10.1016/j.envres.2018.03.030. [Epub ahead of print]).

An analysis of 18 commonly used hair cosmetics such as relaxers (which chemically straighten hair), root stimulators, and anti-frizz products detected 66 chemicals with potentially toxic effects. The majority of such compounds were not mentioned on the products' ingredient labels, researchers say. Eight in 10 of the products studied contained parabens and phthalates, which are known endocrine disruptors — substances that disturb the body's hormone balance. Regular exposure to phthalates can cause early puberty and preterm births. The researchers also detected nonylphenol, a compound associated with obesity and a higher risk of breast cancer, in 30% of the hair treatments. These substances are mostly used as preservatives or plasticizers to create the products' creamy consistency. Five of the compounds studied had the highest concentrations in products aimed at children, and the largest variety of chemicals was often present in products marketed for everyday use.

One problem the researchers identified was incorrect labeling. Some of the substances were not mentioned on the product packaging at all whereas others were referred to by vague terms such as "fragrances." Black women are more likely than white or Hispanic women to suffer from hormonal diseases that are exacerbated by substances that disrupt hormonal balance. A 2016 study showed black women in the U.S. have higher concentrations of such chemicals in their bodies than do women from other ethnicities.

Maintaining patient comfort and minimizing pain when performing multiple stages of Mohs surgery can sometimes be challenging. The use of 0.5% bupivacaine with 1:200,000 epinephrine as an adjuvant to 1% lidocaine with 1:100,000 epinephrine is useful in prolonging anesthesia in Mohs micrographic surgery (MMS) (*Dermatol Surg.* 2018;44:607-610). In a randomized trial of 51 patients undergoing MMS, all patients received 2.5ml of lidocaine with 1:100,000 epinephrine prior to the procedure. At the end of Stage 1, the first group of patients received 2.5ml of 0.5% bupivacaine with 1:200,000 epinephrine and a second group received 2.5ml of 1% lidocaine with 1:100,000 epinephrine. With a mean time of 76 minutes to retest, zero of the 20 patients given bupivacaine had a positive response to pain stimuli, and seven of the 25 patients receiving only lidocaine had a positive response to pain stimuli. While this study has limitations, **bupivacaine does appear to be useful as an adjuvant anesthetic to decrease patient discomfort.**

Drug shortage resources



Stay up to speed on the latest news regarding drug shortages at www.aad.org/advocacy/drug-pricing-and-availability/dermatologic-drug-shortages.



**Christopher
Messana, DO, JD**



Christen Mowad, MD

A pain in the leg... hip, knee, arm...



Read more about managing contact and irritant dermatitis with metal implants and prosthetics in *Dermatology World* at www.aad.org/dw/monthly/2017/october/a-pain-in-the-leg.

Earlobe keloids are a common and challenging problem. Many treatment options exist, including silicone gel/sheeting, intralesional steroid injection, surgical excision, excision followed by adjuvant radiotherapy, and injection of bleomycin, mitomycin, and imiquimod. While no uniformly effective treatment exists for keloids, surgical excision in combination with intralesional steroid injection is often effective. However, evidence-based treatment protocols for this approach are lacking.

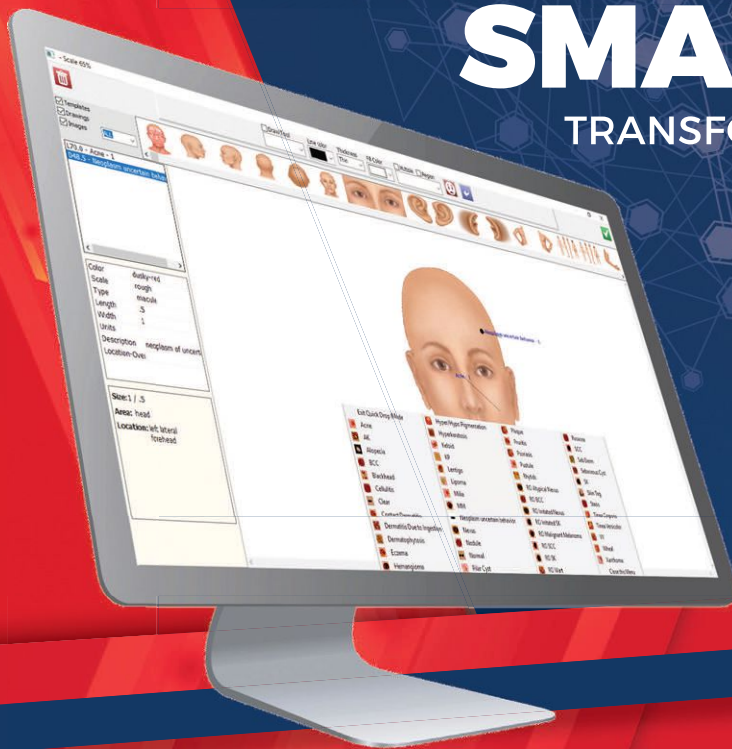
A multispecialty retrospective review was published in the June 2018 issue of *Dermatologic Surgery* and demonstrated that **surgical excision followed by serial injection along the suture line of intralesional triamcinolone acetonide 40 mg/mL at the time of surgical excision and at postoperative weeks 1, 2, 4, 6, 10, and 14 statistically minimizes the risk of earlobe keloid recurrence** (*Derm Surg.* 2018; 44(6):865-9). In patients that received serial intralesional steroid injection following surgical excision, the recurrence rate was 26.2%. Interestingly, the authors found that after six injections the recurrence rate increased, perhaps, because these are the most challenging refractory cases.

The authors highlight the importance of postoperative treatment planning prior to surgery to maximize patients' compliance with a serial injection treatment plan.

Allergic contact dermatitis is a common cause of dermatitis in the United States. The system standard for diagnosing allergic contact dermatitis is patch testing, which allows for accurate diagnosis of the allergens that are causative in the dermatitis. The identification and subsequent avoidance of the causative allergens results in clearance of the dermatitis. The FDA-approved allergen series of 36 allergens has a reported detection rate of 66%. Testing beyond a screening series increases the ability to detect relevant allergens in the patient's environment. Supplemental allergens are needed to better evaluate and diagnose a patient's allergens. Although screening series are sometimes a reasonable way to begin the evaluation of a patient suspected of allergic contact dermatitis, **comprehensive patch testing is often required to adequately assess patients, identify their allergens, and help resolve their dermatitis** (*Dermatitis.* 29(3): 107-111). A patient's history, physical exam, occupational, avocational, and personal care product exposure history is integral in selecting the additional allergens to test with. Patch testing is an effective way to evaluate and treat allergic contact dermatitis and expanded testing is most beneficial. This can dramatically improve the quality of life of the patients we treat. Providers who are familiar with the allergens, the process, and the allergen education and available resources are key to the success of this tool. *dw*

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Key components of evaluation and management: Medical decision making

BY ALEXANDER MILLER, MD



Alexander Miller, MD, addresses important coding and documentation questions each month in Cracking the Code. Dr. Miller, who is in private practice in Yorba Linda, California, represents the American Academy of Dermatology on the AMA-CPT® Advisory Committee.

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Medical decision making (MDM) is the third key component of evaluation and management (E/M) that is used for defining levels of service. It is also more challenging to quantify than the first two: history and physical examination. Medical decision making is stratified in the Current Procedural Terminology® (CPT®) manual into four categories: straightforward, low complexity, moderate complexity, and high complexity.

The degree of complexity is determined by three elements:

- Number of diagnoses considered or management options
- Amount and/or complexity of data to be reviewed, including medical records and diagnostic tests
- Risk of significant complications, morbidity, and/or mortality; comorbidities, only if these significantly increase medical decision making complexity

To qualify for a specific level of medical decision making, components of at least two elements must meet or surpass the criteria listed for that level of service. See Table 1, below.

Table 1

Type of decision making	Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of significant complications, morbidity and/or mortality
Straight-forward	Minimal	Minimal or none	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

CPT does not explicitly define the meanings of the various strata of complexity, such as “minimal,” “limited,” etc. It is up to the individual practitioner, biller, or coder to figure this out and integrate it into determining a proper level of E/M service. Attempts at quantifying decision making by assigning numerical values to various chart data sets are aimed at bringing objectivity to the process. The Centers for Medicare and Medicaid Services (CMS) provides greater detail in a Medicare Learning Network (MLN) publication dated August 2017, accessible at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf. These criteria are likely to be used by Medicare auditors ferreting out chart data to determine a level of medical decision making.

Below is an abridged version of CMS criteria for each of the three decision making components.

Number of diagnoses and/or management options include:

- Number and types of problems dealt with during the visit
 - Decision making for problems you (or another dermatologist in your practice) previously diagnosed may be simpler than for specified but not precisely diagnosed problems
- Complexity in establishing a diagnosis
 - Requiring an opinion from another health care professional may indicate greater complexity
- Types of management decisions made
 - Improving/resolving problems are judged to be less complex than those worsening or failing to improve



One should document pertinent diagnoses/management options, including:

- Assessment/diagnosis
- Improvement, stability, or resolution of a problem; may document whether expectations for treatment results are met
- Include differential diagnoses when pertinent
- Describe management components, including patient instructions, medication risks/benefits

Risk of complications, morbidity, mortality

- Risk is determined for each of the following categories:
 - Presenting problem
 - Recommended diagnostic procedures
 - Treatment options
- Risk is assessed between the existing encounter and the next anticipated patient encounter
- Level of risk (minimal, low, moderate, high) is determined by the highest risk level within any one of the above three categories

Document the following:

- Comorbidities/associated diseases that increase risk of complications, morbidity, mortality
- Type of diagnostic or surgical procedure scheduled as a consequence of the E/M evaluation
- Any procedure done during the course of the E/M
- Urgent referral for diagnostic or surgical procedure

Table 2 provides a stratification of risk and includes some dermatology-specific examples.

Table 2: Risk Table

Level of Risk	Presenting Problem(s)	Diagnostic Procedure Example	Management Options Example
Minimal	<ul style="list-style-type: none"> • One self-limited or minor problem (e.g., tinea corporis) 	<ul style="list-style-type: none"> • KOH wet mount 	<ul style="list-style-type: none"> • Topical therapy • Systemic therapy
Low	<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness • Acute uncomplicated illness or injury 	<ul style="list-style-type: none"> • Skin biopsy 	<ul style="list-style-type: none"> • OTC treatment • Minor surgery with no risk factors
Moderate	<ul style="list-style-type: none"> • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic diseases • Undiagnosed new problem with uncertain prognosis (e.g., cutaneous/subcutaneous mass) • Acute illness with systemic symptoms • Acute complicated injury 	<ul style="list-style-type: none"> • Incisional biopsy 	<ul style="list-style-type: none"> • Minor surgery with identified risk factors • Elective major surgery with no identified risk factors • Prescription drug management
High	<ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g., toxic epidermal necrolysis, DRESS, SLE exacerbation) • Abrupt change in neurologic status 		<ul style="list-style-type: none"> • Elective major surgery with identified risk factors • Drug therapy requiring intensive monitoring for toxicity

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The third component of MDM, amount and complexity of data to be reviewed, is rarely crucial to determining MDM levels in dermatology. However, there are instances where extensive laboratory/pathology reports review or detailed examination of outside chart material is done. In such situations this component of MDM may be relevant. In most cases diagnoses and management options and the risk of significant complications, morbidity, and/or mortality categories will be used for determining MDM. Only two of the three components of MDM must be graded to establish an MDM level. So, scoring low on the data review category is typically not relevant.

The CPT describes an additional, useful component for determining E/M levels: Nature of Presenting Problem. This is a reason for an encounter that is classified as minimal, self-limited or minor, low severity, moderate severity, and high severity. The exact descriptions of each encounter category are found in the Evaluation and Management (E/M) Services Guidelines section of the CPT.

What if greater than 50% of a patient visit is spent on face-to-face counseling and/or coordination of care rather than history, examination, and MDM? Then, time will determine a level of E/M service.

For time-based services one should document the following:

- Counseling and/or coordination of care encompassed greater than 50% of face-to-face encounter time
- Total length of time of encounter
- The counseling and/or coordination of care provided

Next month's Cracking the Code will bring the key components of E/M together to illustrate various encounter scenarios and their corresponding E/M levels. *dw*

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IMPORTANT SAFETY INFORMATION

Warnings and Precautions

Topical corticosteroids, including IMPOYZ Cream can cause reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency. This may occur during treatment or after withdrawal of treatment. This may require that patients be evaluated periodically for evidence of HPA axis suppression. Factors that predispose to HPA axis suppression include, use of high-potency steroids, large treatment surface areas, prolonged use, use of occlusive dressings, altered skin barrier, liver failure, and young age. If HPA axis suppression occurs, gradually withdraw the drug, reduce frequency of application, or substitute with a less potent corticosteroid. If signs and symptoms of withdrawal occur, systemic corticosteroids may be required. Recovery of HPA axis function is generally prompt and complete upon discontinuation of topical corticosteroids. Although rare, systemic effects of topical corticosteroids may manifest as Cushing's syndrome, hyperglycemia, and glucosuria. Pediatric patients may be more susceptible to systemic toxicity because of their larger skin surface to body mass ratios. **Local Adverse Reactions with Topical Corticosteroids** - Local adverse reactions from topical corticosteroids may be more likely to occur with occlusion, prolonged use, or use of higher potency corticosteroids. Some local adverse reactions may be irreversible. **Concomitant Skin Infections** - Use an appropriate antimicrobial agent if a skin infection is present or develops. If appropriate, discontinue use of IMPOYZ Cream. **Allergic Contact Dermatitis** - Allergic contact dermatitis with corticosteroids is usually diagnosed by observing failure to heal rather than noting a clinical exacerbation.

Adverse Events - The adverse reaction that occurred in at least 1% of subjects treated with IMPOYZ Cream and at a higher incidence than in subjects treated with vehicle cream was application site discoloration (2% versus 1%). Less common local adverse events occurring in < 1% of subjects treated with IMPOYZ Cream were application site atrophy, telangiectasia and rash.

impoyz™

(clobetasol propionate)
Cream, 0.025%

Please see Brief Summary of Prescribing Information on the following page.

1. Impoyz Cream full Prescribing Information.

CLB1214 4/18

This Brief Summary does not include all the information needed to use IMPOYZ safely and correctly. See full Prescribing Information.

IMPOYZ (clobetasol propionate) Cream, 0.025%, for topical use

INDICATIONS AND USAGE

IMPOYZ Cream 0.025% is indicated for the treatment of moderate to severe plaque psoriasis in patients 18 years of age and older.

DOSAGE AND ADMINISTRATION

Apply a thin layer of IMPOYZ Cream to the affected skin areas twice daily and rub in gently and completely. Use IMPOYZ Cream for up to 2 consecutive weeks of treatment. Treatment beyond 2 consecutive weeks is not recommended, and the total dosage should not exceed 50 g per week because of the potential for the drug to suppress the hypothalamic-pituitary-adrenal (HPA) axis [see Warnings and Precautions (5.1)]. Discontinue IMPOYZ Cream when control is achieved. Do not use if atrophy is present at the treatment site. Do not bandage, cover, or wrap the treated skin area unless directed by a physician. Avoid use on the face, scalp, axilla, groin, or other intertriginous areas. IMPOYZ Cream is for topical use only. It is not for oral, ophthalmic, or intravaginal use. Wash hands after each application.

DOSAGE FORMS AND STRENGTHS

Cream, 0.025%: each gram contains 0.25 mg of clobetasol propionate in a white to off-white cream base.

CONTRAINDICATIONS. None

WARNINGS AND PRECAUTIONS

Effects on the Endocrine System: IMPOYZ Cream can cause reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency. This may occur during treatment or after withdrawal of treatment. Because of the potential for systemic absorption, use of topical corticosteroids, including IMPOYZ Cream, may require that patients be evaluated periodically for evidence of HPA axis suppression.

Factors that predispose a patient to HPA axis suppression include the use of high-potency steroids, large treatment surface areas, prolonged use, use of occlusive dressings, altered skin barrier, liver failure, and young age.

Evaluation for HPA axis suppression may be done by using the adrenocorticotropic hormone (ACTH) stimulation test. In a trial evaluating the effects of IMPOYZ Cream on the HPA axis, subjects with plaque psoriasis applied IMPOYZ Cream twice daily to at least 20% of involved Body Surface Area (BSA) for 15 days. Abnormal ACTH stimulation tests suggestive of HPA axis suppression were seen in 3 of 24 (12.5%) subjects on IMPOYZ Cream [see Clinical Pharmacology (12.2)]. In another trial to evaluate the effects of IMPOYZ Cream on the HPA axis, subjects with moderate to severe plaque psoriasis applied IMPOYZ Cream twice daily to at least 25% of involved BSA for 28 consecutive days. Abnormal ACTH stimulation test suggestive of HPA axis suppression was seen in 8 of 26 (30.8%) of subjects on IMPOYZ Cream. If HPA axis suppression is documented, gradually withdraw the drug, reduce the frequency of application, or substitute with a less potent corticosteroid. If signs and symptoms of steroid withdrawal occur, supplemental systemic corticosteroids may be required. Recovery of HPA axis function is generally prompt and complete upon discontinuation of topical corticosteroids. Systemic effects of topical corticosteroids may also manifest as Cushing's syndrome, hyperglycemia, and glucosuria. These complications are rare and generally occur after prolonged exposure to larger than recommended doses, particularly with high-potency topical corticosteroids. Use of more than one corticosteroid-containing product at the same time may increase the total systemic exposure to topical corticosteroids. Minimize the unwanted risks from endocrine effects by mitigating risk factors favoring increased systemic bioavailability and by using the product as recommended [see Dosage and Administration (2)]. Pediatric patients may be more susceptible to systemic toxicity because of their larger skin surface to body mass ratios [see Use in Specific Populations (8.4)].

Local Adverse Reactions with Topical Corticosteroids

Local adverse reactions from topical corticosteroids may include atrophy, striae, telangiectasias, burning, itching, irritation, dryness, folliculitis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, secondary infection, and miliaria. These may be more likely to occur with occlusive use, prolonged use, or use of higher potency corticosteroids, including IMPOYZ Cream. Some local adverse reactions may be irreversible.

Concomitant Skin Infections: Use an appropriate antimicrobial agent if a skin infection is present or develops. If a favorable response does not occur promptly, discontinue use of IMPOYZ Cream until the infection has been adequately treated. **Allergic Contact Dermatitis:** Allergic contact dermatitis with corticosteroids is usually diagnosed by observing failure to heal rather than noting a clinical exacerbation. Such an observation should be corroborated with appropriate diagnostic patch testing. If irritation develops, discontinue the topical corticosteroid and institute appropriate therapy.

ADVERSE REACTIONS

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. IMPOYZ Cream was evaluated in two randomized, multicenter, prospective, vehicle-controlled clinical trials in subjects with moderate to severe plaque psoriasis. Subjects applied IMPOYZ Cream or vehicle cream twice daily for 14 days. A total of 354 subjects applied IMPOYZ Cream and 178 subjects applied vehicle. The adverse reaction that occurred in at least 1% of subjects treated with IMPOYZ Cream and at a higher incidence than in subjects treated with vehicle cream was application site discoloration (2% versus 1%). Less common local adverse events occurring in < 1% of subjects treated with IMPOYZ Cream were application site atrophy, telangiectasia and rash.

Postmarketing Experience

The following adverse reactions have been identified during post-approval use of clobetasol propionate: striae, irritation, dryness, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, secondary infection, hypertrichosis, and miliaria. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

USE IN SPECIFIC POPULATIONS

Pregnancy: Risk Summary There are no available data on IMPOYZ Cream in pregnant women to inform a drug-associated risk for adverse developmental outcomes. Published data report a significantly increased risk of low birthweight with the use of greater than 300 grams of potent or very potent topical corticosteroid during a pregnancy. Advise pregnant women of the potential risk to a fetus and to use IMPOYZ Cream on the smallest area of skin and for the shortest duration possible (see Data). In animal reproduction studies, increased malformations, such as cleft palate and skeletal abnormalities, were observed after subcutaneous administration of clobetasol propionate to pregnant mice and rabbits. No comparisons of animal exposure with human exposure are provided due to minimal systemic exposure noted after topical administration of IMPOYZ Cream [see Clinical Pharmacology (12.3)]. The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Data

Human Data

Multiple observational studies found no significant associations between maternal use of topical corticosteroids of any potency and congenital malformations, preterm delivery, or fetal mortality. However, when the dispensed amount of potent or very potent topical corticosteroid exceeded 300 g during the entire pregnancy, use was associated with an increase in low birth weight infants [adjusted RR, 7.74 (95% CI, 1.49–40.11)]. In addition, a small cohort study, in which 28 sub-Saharan women using potent topical corticosteroids (27/28 used clobetasol propionate 0.05%) for skin lightening during pregnancy, noted a higher incidence of low birth weight infants in the exposed group. The majority of exposed subjects treated large areas of the body (a mean quantity of 60 g/month (range, 12–170g) over long periods of time.

Animal Data

In an embryo fetal development study in mice, subcutaneous administration of clobetasol propionate resulted in fetotoxicity at the highest dose tested (1 mg/kg) and malformations at the lowest dose tested (0.03 mg/kg). Malformations seen included cleft palate and skeletal abnormalities. In an embryofetal development study in rabbits, subcutaneous administration of clobetasol propionate resulted in malformations at doses of 0.003 and 0.01 mg/kg. Malformations seen included cleft palate, cranioschisis, and other skeletal abnormalities.

Lactation: Risk Summary There is no information regarding the presence of clobetasol propionate in breast milk or its effects on the breastfed infant or on milk production. Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical administration of clobetasol propionate could result in sufficient systemic absorption to produce detectable quantities in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for IMPOYZ Cream and any potential adverse effects on the breastfed infant from IMPOYZ Cream or from the underlying maternal condition. **Clinical Considerations:** To minimize potential exposure to the breastfed infant via breast milk, use IMPOYZ Cream on the smallest area of skin and for the shortest duration possible while breastfeeding. Advise breastfeeding women not to apply IMPOYZ Cream directly to the nipple and areola to avoid direct infant exposure.

Pediatric Use: The safety and effectiveness of IMPOYZ Cream in patients younger than 18 years of age have not been established; therefore, use in children younger than 18 years is not recommended. Because of a higher ratio of skin surface area to body mass, pediatric patients are at a greater risk than adults of systemic toxicity, including HPA axis suppression, when treated with topical drugs [see Warnings and Precautions (5.1)]. Rare systemic toxicities such as Cushing's syndrome, linear growth retardation, delayed weight gain, and intracranial hypertension have been reported in pediatric patients, especially those with prolonged exposure to large doses of high potency topical corticosteroids. Local adverse reactions including striae and skin atrophy have also been reported with use of topical corticosteroids in pediatric patients. Avoid use of IMPOYZ Cream in the treatment of diaper dermatitis.

Geriatric Use: Clinical studies of IMPOYZ Cream did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience with topical corticosteroids has not identified differences in responses between the elderly and younger patients. **NONCLINICAL TOXICOLOGY** **Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term animal studies have not been performed to evaluate the carcinogenic potential of clobetasol propionate cream. In a 13-week repeat dose toxicity study in rats, topical administration of clobetasol propionate cream, 0.001, 0.005 and 0.025 % at corresponding doses of 0.004, 0.02 and 0.1 mg/kg/day resulted in corticosteroid class-related systemic effects such as reductions in body weight gain, reductions in total leukocytes and individual white cells, decrease in weight of adrenals, thymus, spleen, liver and lung. Histologically, there were decreased hematopoiesis in the bone marrow, thymic atrophy and mast cell infiltration of the mesenteric lymph nodes. All these effects were indicative of severe immune suppression consistent with long-term exposure to corticosteroids. A no observable adverse effect level (NOAEL) was determined to be clobetasol propionate cream, 0.001% (0.004 mg/kg/day) in male rats while a NOAEL could not be determined in females. The clinical relevance of the findings in animals to humans is not clear, but sustained glucocorticoid-related immune suppression may increase the risk of infection and possibly the risk of carcinogenesis. Clobetasol propionate was not mutagenic in three different test systems: the Ames test, the *Saccharomyces cerevisiae* gene conversion assay, and the *E. coli* B WP2 fluctuation test. Fertility studies conducted in the rat following subcutaneous administration of clobetasol propionate at dosage levels up to 0.05 mg/kg/day revealed that females exhibited an increase in the number of resorbed embryos and a decrease in the number of living fetuses at the highest dose.

Manufactured by DPT Laboratories Ltd. San Antonio, TX 78215 For Encore Dermatology, Inc. Scottsdale, AZ 85254

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2018 update: Maintenance of Certification

STATE NEWS ROUNDUP

BY VICTORIA PASKO, MANAGER, STATE POLICY

Linking maintenance of certification (MOC) to licensure has been a hot-button issue for several states in the last couple of years. Currently, no state requires MOC for licensure and none have made any attempts to link the two. However, states are getting out ahead of the issue. Oklahoma passed the first law that prohibits linking MOC to licensure, and Arizona, Georgia, Kentucky, Maine, Maryland, Missouri, Tennessee, and Texas passed laws in 2016 and 2017 to the same effect. Georgia, Oklahoma, and Texas also prohibit linking MOC to hospital privileges and reimbursement. This year, 17 states are addressing the issue as well.

California

Bill #: SB 487

Overview: The award or maintenance of hospital and/or clinical privileges shall not be contingent on participation in MOC.

Status: Referred to the Senate Committees on Business, Professions, and Economic Development and Health

Florida

Bill #: HB 81, SB 628

Overview: The Florida Board of Medicine, the Department of Health, health care facilities, or insurers may not require MOC or osteopathic continuing certification or recertification as a condition of licensure, reimbursement, or admitting privileges for a physician who practices medicine and has achieved initial board certification in a specialty or subspecialty.

Status: Both bills withdrawn from consideration

Indiana

Bill #: SB 208

Overview: Prohibits a hospital from denying hospital staff or admitting privileges to a physician based solely on the physician's decision to not participate in MOC. Specifies that medical licensing statutes do not require a licensed physician to hold or maintain a board

certification in a medical specialty area in order to practice. Prohibits an accident and sickness insurer from denying a physician the right to enter into a reimbursement agreement with the insurer, denying a physician reimbursement for a covered service, or setting reimbursement for services provided by a physician at a lower rate, based solely on the physician's decision to not participate in MOC. Prohibits a health maintenance organization (HMO) from preventing a physician from entering into a participating provider contract with the HMO, denying a physician reimbursement for a covered service, or setting reimbursement for services provided by a physician at a lower rate, based solely on the physician's decision to not participate in MOC.

Status: Passed Senate; died in House Committee on Public Health

Iowa

Bill #: HF 2010

Overview: Prohibits the state, hospitals in the state, employers, and insurers from requiring physicians to participate in MOC or osteopathic continuous certification program in order to maintain a license, admitting privileges, malpractice insurance, or employment, or to receive reimbursement.

Status: Died in Human Resources Committee

Maryland

Bill #: HB 857

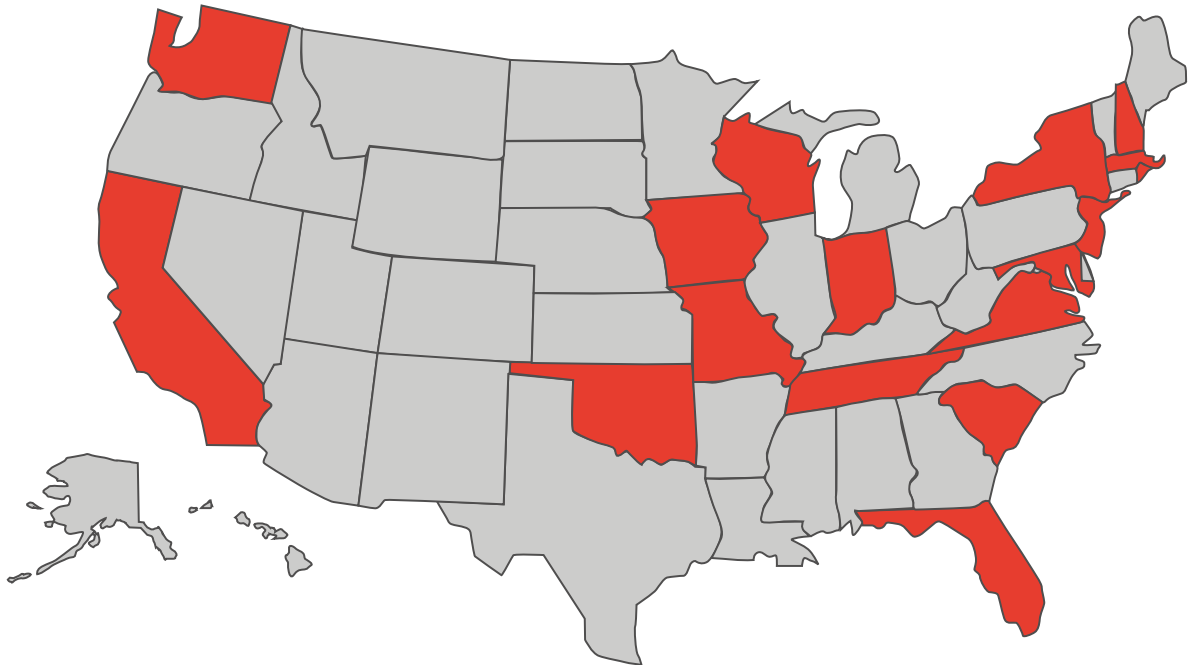
Overview: An entity granting physician privileges may use active certification of a physician by a specialty certification board as criteria to determine physician privileges, but may not require specialty certification by a particular specialty certification board as a prerequisite for the granting of physician privileges. Physician privileges include: Reimbursement, employment, hospital admitting privileges, or malpractice coverage.

Status: Failed in the Committee on Health and Government Operations

State policy



Learn more about the Academy's state policy work — and what's happening in your state — at www.aad.org/advocacy/state-policy.



KEY:

 Legislation under consideration

Massachusetts

Bill #: H 2446

Overview: Physicians shall not be required to secure MOC as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital.

Status: Heard in the Joint Committee on Public Health

Missouri

Bill #: HB 2355

Overview: No hospital, health care facility, or institution or program owned, operated, or licensed by the state shall discriminate against any physician based on the physician's MOC status. Any health carrier or hospital in the state shall accept any continuing medical education or recertification provided by the National Board of Physicians and Surgeons (NBPAS) as MOC.

Status: Died

New Hampshire

Bill #: HB 1769

Overview: Would prohibit linking MOC to state licensure, and prohibit health benefit plan issuers from differentiating between physicians based on a physician's MOC with regard to paying/reimbursing the physician, or directly or indirectly contracting with the physician to provide services to enrollees.

However, health plan issuers may differentiate only if certification or accreditation by a national certifying or accrediting organization of an entity is a requirement of physicians seeking staff privileges or credentialing at the health care facility where the managed care plan contracts for patient care and no alternative health care facility is also under contract by the managed care plan without such requirement where the physician in question has staff privileges or credentials and could reasonably provide similar services. Additionally, any health facility licensed in the state,



hospitals owned or operated by the state, and other programs that directly or indirectly receive state financial assistance, may not differentiate between physicians based on a physician's MOC. There are exceptions, such as if the facility is a medical school, an academic medical center, or other site that is involved in the training of residents; the physician is making an initial application to the medical staff; the entity's designation under law or certification or accreditation by a national certifying or accrediting organization is contingent on the entity requiring a specific MOC by physicians seeking staff privileges or credentialing at the entity, and the differentiation is limited to those physicians whose MOC is required. Further, these entities may differentiate if the voting physician members of the entity's organized medical staff vote to authorize the differentiation and that vote is recommended to and approved by the entity's governing body.

Status: Passed House; referred to interim study in Senate

New Jersey

Bill #: S 2141

Overview: Provides that nothing in current law, regulation, or requirement of the State Board of Medical Examiners is to be construed to require a licensed physician who is in compliance with the biennial registration requirements to secure MOC as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital in the state.

Status: Referred to Senate Health, Human Services, and Senior Citizens Committee

New York

Bill #: A 4194/ S 7357A

Overview: A governing body of a hospital may not refuse to act upon an application or to deny or withhold staff membership or professional privileges of a physician who was previously board certified and

who has not maintained such certification, solely because the physician is not board certified. Further, a health care plan may not refuse to approve an application from a physician, who was previously board certified and who has not maintained certification, to participate in the in-network portion of the health care plan's network solely because the physician is not board certified.

Status: A 4194 referred to Assembly Health Committee; S 7357A referred to Senate Health Committee

Oklahoma

Bill #: HB 3231

Overview: Hospitals and health plans shall not discriminate — on the basis of education — against eligible physicians who have graduated from medical schools and postdoctoral programs approved by either the American Osteopathic Association or the Accreditation Council for Graduate Medical Education, or been awarded board eligibility or board certification by specialty boards recognized by either the American Osteopathic Association or the American Board of Medical Specialties, irrespective of recertification status or participation in Osteopathic Continuing Certification or MOC.

Status: Passed Public Health Committee; died upon adjournment

Rhode Island

Bill #: HB 7964/SB 2408; HB 7571; HB 7572

Overview:

HB 7964/SB 2408: Prohibits the Board of Medical Licensure and Discipline from requiring a physician applicant or physician licensee to maintain a national or regional certification that is not otherwise specifically required before it issues a license or license renewal. No facility licensed in Rhode Island shall deny a physician a hospital's staff or admitting privileges based solely on the physician's decision not to participate in MOC. Health care insurers are also prohibited

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from denying reimbursement to, or preventing a physician from, participating in any of the insurer's provider networks based solely on a physician's decision not to participate in MOC.

HB 7571 and HB 7572 prohibit the Board from requiring any form of specialty medical board certification, specialty examination, or MOC as a licensure requirement to practice medicine in Rhode Island.

Status: HB 7964/SB 2408: Considered in House Health, Education, and Welfare and Senate Health and Human Services Committee. HB 7571/HB 7572: Heard in the House Health, Education, and Welfare Committee.

South Carolina

Bill #: H 4116

Overview: No provision of the state's Medical Practice Act may be construed to require a physician to secure MOC as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital or federally qualified health center.

Status: Enacted; went into effect May 18, 2018

Tennessee

Bill #: SB 1824/HB 1927

Overview: No physician licensed in the state shall be denied staff privileges or employment by a facility licensed under the same chapter based solely on the physician's decision to not participate in any form of maintenance of licensure or MOC, including requiring any form of maintenance of licensure tied to MOC. Further, a health insurance entity shall not deny reimbursement to, or prevent a physician from, participating in any of the insurance entity's provider networks based solely on a physician's decision to not participate in MOC, including basing a physician's network participation on any form of maintenance of licensure tied to MOC.

Status: Enacted; went into effect July 1, 2018

Virginia

Bill #: HB 157

Overview: Prohibits the board from requiring participation in any MOC or osteopathic continuous certification program or obtaining or maintaining any national or regional certification as a condition of licensure to practice medicine in the Commonwealth. Also prohibits hospitals and other entities from requiring MOC or osteopathic continuous certification as a condition of granting or continuing staff membership or professional privileges to a licensed physician, and further prohibits insurers from requiring MOC or osteopathic continuous certification as a condition of participation or reimbursement for a physician.

Status: Died

Washington

Bill #: HB 2257

Overview: Physicians or osteopathic physicians and surgeons would not be required to participate in MOC as a condition of licensure or license renewal. Physicians would be allowed to fulfill license-renewal requirements through satisfactory participation in a recognized MOC program.

Advocacy: The American Academy of Dermatology Association sent a letter of support

Status: Enacted; went into effect June 7, 2018

Wisconsin

Bill #: AB 936

Overview: No physician would have been required to secure MOC as a prerequisite for reimbursement from a third party or as a condition for hospital staff privileges. Would not allow MOC requirement for renewal of a license to practice medicine and surgery.

Status: Died *dw*



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Is dermatology on the right path for diversity?

BY KATHRYN SCHWARZENBERGER, MD

In this month's Acta Eruditorum column, Physician Editor Kathryn Schwarzenberger, MD, talks with Henry W. Lim, MD, and E. Nikki Pritchett, MD, MPH, about their recent Journal of the American Academy of Dermatology article, "Diversity in Dermatology: Roadmap for Improvement."

Diversity in dermatology



Read more about the history of African Americans in medicine and the diversity challenges that remain in *Dermatology World* at www.aad.org/dw/monthly/2018/february/paving-the-way.

Q **Dr. Schwarzenberger: Dr. Lim, you identified diversity in dermatology as a key area of focus during your recent AAD presidency. Thank you for championing this critically important issue. We appreciate the outstanding work you and your colleagues have done in this area, which is beautifully detailed in your recent JAAD publication. How did you become so passionate about the topic?**

Dr. Lim: It is because of my own life experience. I grew up in Indonesia, went to college in Canada, attended medical school and did residency in New York. I have practiced in New York City, San Diego, and now in Detroit. The diversity of culture and individuals that I have been exposed to in my life journey gives me a great appreciation of the importance and the strength of diversity in health care, which leads us to deliver excellent care to our patients.

Q **Dr. Schwarzenberger: Does dermatology have a diversity problem and, if so, what are possible ramifications that may result from this?**

Dr. Lim: I approach this issue as an opportunity for improvement. Among all specialties, dermatology currently ranks second to last in the percentage of those who are underrepresented in medicine (UIM). It is well recognized that diversity in the physician workforce improves outcomes not only for minorities but for all patients. In addition, multiple studies have shown that UIM physicians

are more likely to practice in areas where health care disparities exist.

Q **Dr. Schwarzenberger: What is the AAD doing to help rectify the problem?**

Dr. Lim: The Academy organized the President's Conference on Diversity in Dermatology, held Aug. 5, 2017. Participants included leaders of Association of Professors of Dermatology, Society for Investigative Dermatology, Skin of Color Society, and American Dermatological Association. For the first time, AAD, along with APD, SID, and SOCS, participated in the National Student Medical Association annual meeting in March 2018. The Academy has also formed an intersociety workgroup (AAD, APD, SID, and SOCS), working with the Diversity Task Force, to continue to address this topic; a Diversity Champions retreat is currently being planned. The AAD Diversity Task Force, under the leadership of Amit Pandya, MD, has facilitated outreach effort to college and medical students to generate their interest in medicine as a profession, and dermatology as a specialty.

Q **Dr. Schwarzenberger: It appears that most of the efforts described are centered in the academic world. Since most of our members work in non-academic settings, is there anything they can do to help increase diversity in dermatology?**



Dr. Pritchett: Dermatologists in nonacademic settings can be instrumental in addressing two key factors that contribute to decreased diversity in dermatology: Lack of exposure and the narrow pipeline from elementary to medical school. Dermatologists can mentor students either formally through programs offered by the AAD or other dermatology societies, or informally by allowing interested students to shadow them in clinic. They can also participate in school career days or other community-based activities in order to increase awareness of dermatology as a specialty. Finally, they can discuss what it's like to be a doctor and their reasons for choosing dermatology with their younger patients, which may spark their interest.

Q Dr. Schwarzenberger: How will we know when we are there? Does the AAD have specific goals in mind that we hope to achieve?

Dr. Lim: This is going to be a multi-year effort. The action items suggested by the Diversity Conference of increasing the pipeline of UIM students applying to medical school, increasing the exposure and level of interest of UIM medical students in dermatology, and increasing the number of UIM students recruited into dermatology residency programs will require sustained effort by all of us to succeed. An early metric that can be assessed would be the number of UIM applicants to dermatology, and the number of UIM in dermatology residency programs.

Q Dr. Schwarzenberger: Your efforts so far have focused primarily on racial and ethnic diversity in the specialty; however, there are other real and potential disparities in dermatology (LGBT, rural vs. urban, etc.) that may impact our workforce and, as a result, the care that we provide our patients. Can you comment on any of these and share any relevant AAD activities?

Dr. Pritchett: There are multiple underrepresented groups that deserve culturally competent care and an understanding of their specific dermatologic issues. As mentioned, one group is LGBT. The AAD has formed an Expert Resource Group for Lesbian, Gay, Bisexual, and Transgender/Sexual and Gender Minority (LGBT/SGM) Health. This group promotes research, advocates policies that enhance health, and encourages professional development of dermatologists caring for LGBT/SGM communities. Additionally, there have been LGBT health-related sessions at Annual and Summer scientific AAD meetings and the online Basic Dermatology Curriculum is being revised to include more LGBT health-related content.

Dr. Lim: In the selection of candidates for Board of Directors, effort is made to achieve a balance among candidates from different geographic areas, gender, academic/private practice, etc. The Scientific Assembly Committee also makes a strong effort in promoting younger members to participate as speakers. *dw*



Dr. Lim is the former president of the AAD and chair emeritus of the Henry Ford Hospital department of dermatology.



Dr. Pritchett is a dermatologist at Henry Ford Hospital.

Their article appeared in the *Journal of the American Academy of Dermatology*.
doi: 10.1016/j.jaad.2018.04.003.

Advance directives, living wills, and durable power of attorney

BY CLIFFORD WARREN LOBER, MD, JD



Every month, Dermatology World covers legal issues in Legally Speaking. Clifford Warren Lober, MD, JD, presents legal dilemmas in dermatology every other month. He is a dermatologist in practice in Florida and a partner in the law firm Lober, Brown, and Lober.

Suggested topics



If you have any suggestions for topics to be discussed in this column, please email them to loberc@gmail.com.

See the February 2013 issue of *Dermatology World* for disclaimers.



Carli: Bryan, one of the quality measures available in the Merit-based Incentive Payment Program (MIPS) requires us to ask our patients if they have an advance care plan or surrogate decision maker. What is the difference between an advance care plan, living will, durable power of attorney, or advance directive? This is really confusing.



Bryan: An advance directive, in the broadest sense, is an instruction (directive) or set of instructions made in advance of an anticipated event. A medical advance directive describes for your physician and family what medical treatments or procedures you wish to be pursued in the event you are unable to communicate your wishes in the future, such as should you become unconscious, terminally ill, or legally incompetent to make decisions. Advance directives include living wills, a durable power of attorney, do-not-resuscitate orders, organ or tissue donation requests, and physician orders for life sustaining treatment (POLST).

Carli: What is a living will?

Bryan: A living will is a formal legal document that specifies the actions that should or should not be taken if you are unable to make medical decisions for yourself because of incapacity. It describes the circumstances under which you would or would not want therapeutic or palliative treatments such as oral or intravenous feeding, fluids, antibiotics, pain medication, dialysis, cardiac resuscitation, etc., to be given or withheld. A patient may, for example,

decide to discontinue aggressive treatments but continue palliative care such as pain medication and fluids.

Carli: Are there any other things that might be in a living will?

Bryan: Yes. You may, for example, wish to indicate whether you want your kidneys, other organs, or body to be donated in the event of your death. Make sure your state does not require a separate donation form.

Carli: Does a living will have to be in writing?

Bryan: Most states require a living will to be written and witnessed by one or two people who are not relatives or treating medical personnel, and notarized. Some states, however, recognize oral living wills. To avoid confusion, I recommend that a living will be put in writing and that you check the specific requirements of your state regarding witnesses and notarization.

Carli: When does a living will become effective?

Bryan: In most states two physicians must certify that you are in a terminal state and/or do not have the capacity to make medical decisions.

Carli: What if I change my mind?

Bryan: You can revoke or modify a living will at any time and for any reason, as long as you are legally competent. Some states only recognize living wills for a limited number of years and, if you live in one of those states, you need to periodically renew your living will.



Key points

1 Advance directives include living wills, a durable power of attorney, do-not-resuscitate orders, organ or tissue donation requests, and physician orders for life sustaining treatment (POLST).

2 A living will is a formal legal document that specifies circumstances and actions that should be taken if one is unable to make medical decisions for themselves because of incapacity. It describes the situations under which one would want therapeutic or palliative treatments to be given or withheld.

3 A health care power of attorney identifies the specific individual or individuals to whom you wish to give the right to make medical decisions for you in the event you are unable to do so.

4 A physician order for life-sustaining treatment, also called a provider or medical order for life-sustaining treatment, is a document that is written by your physician. It does not replace your living will or power of attorney, but rather is a set of instructions that ensures that the wishes expressed in those documents are followed.

5 Several states have statutory forms that are required for a living will, durable power of attorney, or other advance directive to be legally sufficient.

Carli: Isn't a living will the same as a durable power of attorney?

Bryan: Absolutely not. Whereas a living will specifies the actions that should or should not be taken if you are unable to make medical decisions, a health care power of attorney identifies who will make decisions for you in the event you are incapacitated. A living will and a durable power of attorney, therefore, both function to fulfill a patient's wishes.

Carli: Is a health care proxy the same as a health care surrogate?

Bryan: Yes. Depending upon the laws in your state, a health care proxy may be called a surrogate, agent, advocate, or attorney-in-fact.

Carli: Does a power of attorney have to be in writing?

Bryan: States almost uniformly require a power of attorney to be in writing, witnessed, and notarized. Some states also require the individual to whom the power of attorney is given (called the proxy) to sign the statement as well.

Carli: How should someone decide to whom he or she should give a durable power of attorney?

Bryan: They should select someone who clearly understands what therapeutic and palliative treatments they would want as well as the circumstances under which these treatments should be given or withheld. People usually chose their spouse or another close relative. It is also a good idea to select an alternate proxy should the individual to whom you give power of attorney be unavailable.

Carli: Is a durable power of attorney the same as a physician order for life sustaining treatment?

Bryan: No. A physician order for life-sustaining treatment, also called a provider

order for life-sustaining treatment, is a document written on a form that is filled out by your physician. It does not replace your living will, but rather contains instructions that ensure that the wishes expressed in that document are followed. It is usually posted on or near your bed where hospital personnel can easily find it. Like a living will, it contains instructions concerning the use of feeding tubes, antibiotics, resuscitation, etc.

Carli: Where can someone get the forms for a living will and durable power of attorney?

Bryan: Hospitals by law offer the appropriate forms to patients who are admitted if they have not already executed a living will or durable power of attorney. Alternatively, the forms can be obtained from your attorney, state department of health, or state medical organization. Some states merge the two forms into one so that you can name your health care proxy as well as execute your living will.

Carli: Is there anything else I should do?

Bryan: Yes. You should keep the original documents and provide your health care proxy, local hospital, and your physician with copies. You should also review the documents annually to determine if you wish to make any changes.

Carli: What are the "Five Wishes"?

Bryan: The "Five Wishes" is an advance directive document offered by the non-profit group Aging with Dignity. It contains both a living will and a designation of a health care proxy, as well as sections that allow one to describe other personal matters (such as how he or she wishes to be remembered). Available on the internet, it has been used by over 20 million people and is legally sufficient in 42 states. In the eight other states, it can be appended to the required statutory forms.

Carli: Thanks, Bryan! *dw*



Hiring high-quality clinical and non-clinical staff

BY FAIZA WASIF, MPH

Each month Dermatology World tackles issues “in practice” for dermatologists. This month Faiza Wasif, MPH, the Academy’s practice management manager, offers tips on an area she commonly receives questions about from members.

Every aspect of a physician practice is important to delivering the highest quality of care to patients — and this includes both the clinical and non-clinical staff that work alongside you. These individuals make up the “care team” that ensures the patient’s entire experience is welcoming, seamless, and effective. Therefore, it is important that you hire staff who are competent and compassionate. Follow these best practices to hire high-quality clinical and non-clinical staff.

When you are ready to start looking for candidates:

- **Determine need:** Deciding how many and what mix of staff to have in your office is one of the most difficult decisions a practice makes. Consider the type of practice you have (e.g., solo, group), the size of the practice, the number of patients seen, and how many claims are processed in a week.
- **Draft the job description:** Formulate a concise and thorough job description including a job title, summary of responsibilities, and required and desired qualifications.
 - **Clinical positions:** Be sure to require proper licensing or certification depending on the nature of the job; outline specific clinical responsibilities in accordance with their level of training; and emphasize the importance of the patient-clinician relationship.

➤ **Non-clinical positions:** Outline the minimum education/qualifications needed and identify specific characteristics and skills needed to succeed on the job.

- **Plan to advertise:** Advertising a position online is the most common method for recruitment. The Academy offers a job-posting site for clinical positions through AADCareerCompass; practices also hire for general positions through indeed.com or linkedin.com. There are also numerous staffing agencies that can help recruit top talent.

After you have attracted some potential candidates:

- **Review resumes:** When reviewing resumes watch for typos, grammatical errors, gaps in employment, and/or false information. Work with an outside agency to verify the applicant’s education and be sure to check references. Remember to review the resumes in accordance with the nature of the job — clinical or non-clinical.
- **Conduct phone interviews:** This is a great screening tool to further narrow down your pool of candidates. You can learn why the applicant is interested in the job; what their salary preference is; their strengths and weakness; and if they are willing to work flexible hours. You can even perform this as a video interview to get a better sense of the applicant.

Looking for clinical staff?

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AADCareerCompass
Powered by Health eCareers

List your available position with AADCareerCompass at www.healthcareers.com/aad.



- **Set up an in-person interview:** Be prepared with a standard list of questions relevant to the position but also let the interview flow and generate questions throughout the conversation. Never ask questions regarding age, sex, race, national origin, religion, health or disabilities, military service, or conviction records due to federal and state employment laws.
- **Verify employment:** Once candidates are further narrowed down, verify their employment history and speak with their references. Make sure you speak with at least three references who either worked with the individual in the past or serve as professional acquaintances.

When you have identified your ideal candidate:

- **Make the offer:** Offering a position can be done through verbal or non-verbal means. All offer letters should include salary information, work hours, job title, supervisor's name, benefits, a brief synopsis of orientation, and a statement about whether the offer is at-will or a contract. Most offers are also conditional on an interim period, typically 90 days.
 - o **Clinical position:** Clinical staff — such as physicians — are typically hired on a contract basis. Be sure to carefully draft

the provisions of the contract including salary compensation, benefits, schedule/call expectations, terms and termination provisions, and any state-specific restrictive covenants. It is wise to have this drafted and/or reviewed by an attorney.

- o **Non-clinical position:** These positions are typically at-will in which an employee can be dismissed by an employer for any reason (that is, without having to establish “just cause” for termination), and without warning, as long as the reason is not illegal (e.g., firing because of the employee's race or religion). A contract is not typically required for these positions.

Once the ideal candidate has reviewed and accepted the offer letter or signed the contract, it is time to welcome them on board! Remember, taking the time to plan for, recruit, and hire the most qualified staff who best fit your practice environment will help to ensure optimal patient care and high practice efficiency. Continue to assess your new employees on a regular basis to make sure they are fitting your practice culture and receiving the training they need to be successful.

To learn more and access numerous templates for recruiting, hiring, and training staff be sure to purchase the comprehensive *Dermatology Employment and Procedures Pack*: <https://store.aad.org/products/10159>. *dw*

Employment manual



Access numerous templates for recruiting, hiring, and training staff. Purchase the comprehensive *Dermatology Employment and Procedures Pack* at <https://store.aad.org/products/10159>.



Dermatologist on the run

BY EMILY MARGOSIAN, ASSISTANT EDITOR

Each month, Dermatology World addresses issues “in practice” for dermatologists. This month Dermatology World talked to Douglas Naversen, MD, about how his office builds staff morale through group exercise.



“I wanted to parlay what I know about running into a fun way to motivate our staff.”

- Douglas Naversen, MD

Casting call



Do you know a dermatologist with a unique hobby or pastime? Are you one yourself?

Email your suggestion to **dweditor@aad.org**. You could be featured in a future issue of *Dermatology World*.

It takes major motivation to complete a single marathon. Douglas Naversen, MD, has run 25.

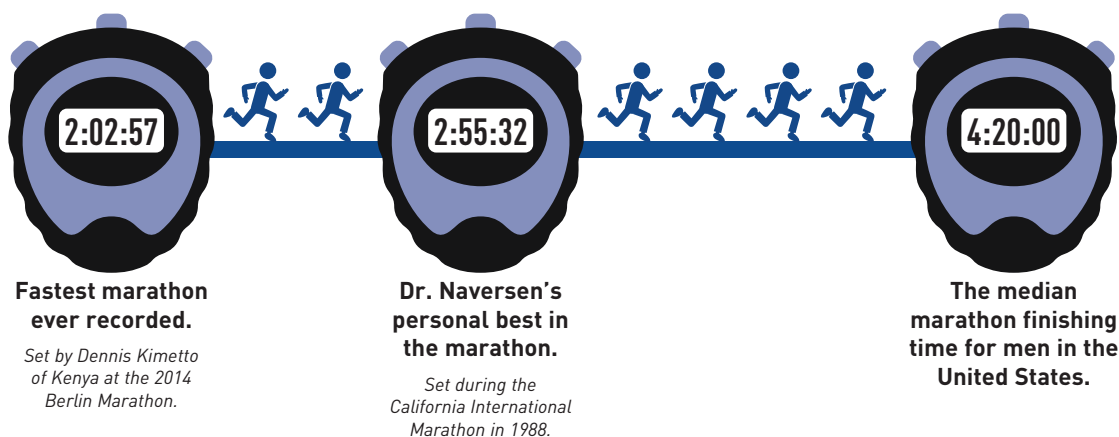
“My personal record is two hours, fifty-five minutes, and thirty-two seconds, which I set at age 40. It qualified me for the Boston Marathon,” says Dr. Naversen, who is in private practice at Dermatology & Laser Associates in Medford, Oregon. “We take our running seriously in southern Oregon. I’m a Buckeye; I was born and raised in Ohio, and I think maybe that’s one of the reasons why I moved here, since Oregon is known as a running state.” As a longtime personal passion for Dr. Naversen (who once ran at least a mile every day for seven years), running has unsurprisingly worked its way into his professional life as a dermatologist as well.

Every April for the past six years, staff from Dr. Naversen’s practice have hit the trail to compete in the annual Pear Blossom Run. (Medford is home to Harry and David’s pear orchards.) With the option to either run or walk their choice of a five-kilometer or 10-mile course, all participating staff members have their entry fee covered by the practice. “I wanted to parlay what I know about running into a fun way to motivate our staff,”

explains Dr. Naversen. “Office morale can be tough with hirings, firings, difficult patients, skin cancer, itchy rashes, and the like. The Pear is a great way for our staff to bond, and as we’re office-based, also gives us an opportunity to stay in shape and collectively shed some pounds.”

The race has grown in popularity among Dr. Naversen’s staff over the years. He estimates last spring 13 members of his office participated; this year there were around 20. The bump may be the result of a little friendly competition between coworkers, however. “The winner — the staff member who’s the fastest — gets a special trophy, so they have bragging rights for the whole year,” he explains. “One member of our staff has won it for the last three or four years, so we always speculate about who’s going to knock her off her pedestal. We post the results in our break room, so everyone can see how each other did.”

The race has also sparked conversations among patients as well, and helped raise the practice’s profile within the local community. “We take a group photo just before the start of the race, and the photos are posted prominently in each of our



three dermatology suites for public viewing,” says Dr. Naversen. “Every year our practice also donates \$2000 to the Pear Blossom Scholarship Fund, and I get to present the scholarships to the high school seniors between the 5K and 10 mile. I like to say I get to meet the kids before they become famous.”


Dr. Naversen encourages other dermatologists to look into local races as a potential team bonding activity — regardless of skill level. “I’m sure your area has a fun run, whether it’s a 5K or a 10K. I encourage you and your staff to get fired up, trim your figures, and do some bonding with your crew.” *dw*



Dr. Naversen and members of his staff at this year's Pear Blossom Run.



Douglas Naversen, MD,
is a dermatologist in private practice in Medford, Oregon.



FILLING *the* MEDICINE CABINET

Dupilumab and crisaborole have
changed atopic dermatitis treatment —
and now more new drugs are on the way

BY **VICTORIA HOUGHTON**, MANAGING EDITOR

Ten years ago, Emma Guttman-Yassky, MD, PhD, was knocking on doors in an attempt to garner interest from pharmaceutical companies in atopic dermatitis research. “I really tried to convince these companies to go for atopic dermatitis, but no company wanted to hear about it,” said Dr. Guttman, professor and vice chair, department of dermatology, and the director of the Center for Excellence in Eczema and the Laboratory for Inflammatory Skin Diseases at the Icahn School of Medicine at Mount Sinai in New York. Although roughly 15 to 20% of children and 4 to 7% of adults suffer from atopic dermatitis worldwide, at the time all eyes were on the psoriasis space, said Dr. Guttman.

Today, things are different. “Now many of these companies gradually became interested in atopic dermatitis.” Dr. Guttman likens the atopic dermatitis story to several aspects of the psoriasis narrative. “Similar to psoriasis, atopic dermatitis is an immune-driven disease and can be targeted using immune-based targeted therapies.” However, “atopic dermatitis is a more heterogeneous disease with different phenotypes and we are starting to learn that there may be no one-size-fits-all approach to treating the condition.”

Dermatology World talks with experts about where things stand with medicine’s understanding of the pathogenesis of atopic dermatitis and how this understanding is shaping the development of potential treatment options for this heterogeneous condition. >>



Therapeutic wins

Merely two years ago, the treatment options for atopic dermatitis patients were fairly limited. “The only U.S. FDA-approved systemic therapy was prednisone,” said Robert Sidbury, MD, MPH, co-chair of the National Eczema Association Scientific Advisory Committee and division chief of dermatology at Seattle Children’s Hospital. “If you ask a room of dermatologists what their least-favorite drug for atopic dermatitis is, it would be the prednisone.”

Enter: crisaborole (Eucrisa) and dupilumab (Dupixent). The FDA approved crisaborole — a topical PDE-4 inhibitor — and dupilumab — an IL-13 and IL-4 inhibitor — in December 2016 and March 2017, respectively. Now that physicians and their patients have had time to test these newly approved drugs in real life, how are they faring?

Crisaborole

“With crisaborole, the efficacy is modest,” said Eric Simpson MD, MCR, professor of dermatology at Oregon Health and Science University School of Medicine. “However, it does provide a nice option for a non-steroidal approach.” Lisa Beck, MD, Deans professor of dermatology and medicine at the University of Rochester Medical Center, agrees and adds, “There is the occasional person with very good response to crisaborole, but I think this is unfortunately a pretty rare event. I must say I’ve been disappointed in its clinical efficacy.”

Additionally, Dr. Beck notes that a number of patients have reported burning and itching. “I was not originally counseling patients about this side effect because the phase 3 trials reported this side effect in only 4.4% of patients.” Despite Dr. Beck’s counsel, she still finds that many patients do not want a refill because they’re not willing to tolerate the side effects for what they perceive as a pretty minimal benefit, this is particularly true for pediatric patients — as the topical is approved for children as young as two.

Dr. Sidbury also finds that the cost of the medication can be a deterrent. “The original price I heard quoted was \$600 for a 60 gram tube and that’s not accessible for anyone really for chronic use. However, the manufacturer

has been very good at trying to use coupons and various strategies to make that more accessible,” said Dr. Sidbury.

Dupilumab

Conversely, for many patients with moderate-to-severe atopic dermatitis, dupilumab has been a game changer. “About 80 to 90% of our patients are finding that this drug is very beneficial to them,” said Dr. Beck. “It’s not at

all uncommon that we hear from a subset of these patients that it’s life-altering therapy.” According to Dr. Beck, for many of these patients the itch relief is significant and is often noted within a week or two of starting treatment. “The relief is very clearly noteworthy and leads to significant elevation in patients’ mood. The improvement in the appearance of skin lesions tends to lag behind the itch reduction, but patients are very patient as their biggest complaint

is the itch.”

Not everyone has a dramatic response to dupilumab, however, says Dr. Beck. Additionally, a number of patients report eye-related side effects. “We’ve seen a whole range of eye complaints: dry eyes, itchy eyes, and sometimes swelling of the eyelids.” However, Dr. Beck finds that the side effects are minimized when she counsels patients about proper eye care prior to initiating treatment.

In addition to ocular side effects, Dr. Beck notes that getting access to dupilumab has been challenging at times. “Dupilumab has been somewhat difficult to get prior authorization approval. However, like all new expensive biologics, it gets easier with time as insurances clarify their criteria for drug approval.”

Logical biologics?

With the success of dupilumab, is there really a need to develop new treatments in this space? For Brian Kim, MD, MTR, co-director of the Center for the Study of Itch and assistant professor of dermatology at Washington University School of Medicine in St. Louis, the answer is a definitive ‘yes.’ “This is a very sophisticated immune pathway. You have these cytokines that block inflammation and these cytokines that block itch. They’re all in the same family and I think a lot of those cytokines are very promising. Dupilumab is not the end of it. In my mind, I think it’s actually the beginning of it.”

“Dupilumab is not the end of it. In my mind, I think it’s actually the beginning of it.”

Lebrikizumab and tralokinumab – IL-13

Despite the widespread success of dupilumab, much research is being devoted to understanding the significance of dupilumab's IL-4 inhibition. Researchers have been inadvertently singling it out by studying IL-13 inhibitors lebrikizumab and tralokinumab. Additionally, "It's always nice to have options because of the heterogeneity of the disease and because there will be patients who don't respond to dupilumab or get adequate response," said Dr. Simpson. "IL-13 blockers tralokinumab and lebrikizumab: Those are pretty safe bets that they should have some activity."

So far, a phase 2 study of lebrikizumab indicated that 125 mg taken every four weeks with topical corticosteroids resulted in a significant reduction in Eczema Area and Severity Index (EASI) scores and was well tolerated in adults with moderate-to-severe atopic dermatitis (*J Am Acad Dermatol.* 2018 May;78(5):863-871.e11). Similarly, a phase 2b dose-ranging efficacy and safety study of tralokinumab in adults with moderate-to-severe atopic dermatitis found that 300 mg every two weeks over 12 weeks significantly improved the Scoring of Atopic Dermatitis (SCORAD), Dermatology Life Quality Index, pruritus numeric rating scale, and EASI 50 scores, with an acceptable safety profile (*J Am Acad Dermatol.* 2017 June; 76(6), Suppl 1: AB20). While these biologics look promising, Dr. Simpson remains cautiously optimistic. "Whether they will provide benefit or work in patients who fail dupilumab, we'll just have to look at the phase 3 data."

Nemolizumab – IL-31

For atopic dermatitis patients with a more intense component of itch, nemolizumab could be an option, said Dr. Beck. "Anti-IL-31 targets the cytokine that we think is a potential pruritogen. It's an itch-inducing mediator." Results of a study published in the *New England Journal of Medicine* showed lightning-fast improvements in itch with a 60% reduction in pruritus visual-analogue scale scores as early as four weeks into the trial (2017; 376:826-835). A subsequent 52-week study showed additional gradual improvement in the pruritus visual-analogue score (<https://doi.org/10.1016/j.jaci.2018.03.018>).

Atopic dermatitis: Treating pediatric patients

The influx of interest in developing treatments for atopic dermatitis is welcomed news for the population of adults with atopic dermatitis. However, there are 10 to 20% of children worldwide who suffer from atopic dermatitis. For these younger patients, crisaborole was approved for use in patients as young as two years old. However, "Most people will say that there's been more stinging at the application site than was expected," said Robert Sidbury, MD, MPH, co-chair of the National Eczema Association Scientific Advisory Committee and division chief of dermatology at Seattle Children's Hospital. "That's been a bit of a barrier to its use particularly for pediatrics. If something stings, the parent may not get another shot at the tube." Given the reports of stinging and burning at the application site, where does dupilumab stand in the pediatric space?

Fortunately, "Testing for dupilumab in younger patients is underway," said Dr. Sidbury. "Currently, there is a subset for patients six months to six years, and a subset for six to 11 years." So far, Dr. Sidbury says the trials look promising. Additionally, "The other interesting thing is, in the pediatric phase 2 dupilumab data from Europe, there was no conjunctivitis signal."

While the dupilumab trials are ongoing, Dr. Sidbury argues that it's becoming increasingly obvious that nipping atopic dermatitis in the bud with younger patients — before the spread of the atopic march — is essential, as it can potentially help patients beyond the condition's cutaneous symptoms. "The other area that's been pretty busy in atopic dermatitis is associated comorbidities." Indeed, there have been reports of comorbidities from rhinitis and asthma to cardiovascular disease and ADHD. "There are probably 20 other associations within the last five years that are less clearly causal and are worth watching." Yet, given the increased interest in atopic dermatitis research, Dr. Sidbury is enthusiastic about the future treatment options for pediatric patients. "I know what we have now versus what we've had in the past. The approvals that we've seen in the last year and the massive pipeline of other potential treatments, makes me very excited about the situation."



When it comes to EASI scores, however, nemolizumab doesn't compare to dupilumab, says Dr. Beck. "What was a big concern was that the improvement in EASI appeared to be more modest than what we've been seeing with dupilumab."

GBR 830 – OX40

Although its name doesn't end in 'mab,' GBR 830 — an OX40 inhibitor — is another biologic that is piquing some interest as a potential treatment for atopic dermatitis. OX40 is a co-stimulatory immune receptor on the T cells. When overactive it contributes to an increased severity of autoimmune disease and promotes inflammation.

"OX40 antagonism is another treatment approach that is being studied and it seems to be successful in preliminary studies," said Dr. Guttman. The results of a 12-week, phase 2a double-blind, placebo-controlled study were presented at the 2018 AAD Annual Meeting, indicating that 17 out of 23 patients who received intravenous infusions of GBR 830 on days one and 29 saw clinical improvements in EASI scores. The most common side effect was headache. In April, Glenmark Pharmaceuticals announced plans for a phase 2b trial of GBR 830.

Fezakinumab – IL-22

For atopic dermatitis patients with epidermal hyperplasia, IL-22 blockade looks increasingly promising, says Dr. Guttman, as IL-22 promotes epidermal hyperplasia and inhibits skin barrier function. Dr. Guttman, et al performed a randomized, double-blind, placebo-controlled trial with intravenous fezakinumab monotherapy every two weeks for 10 weeks, with follow-up until 20 weeks. The decline in SCORAD scores from baseline at 12 weeks was significantly stronger in the patients treated with fezakinumab and the most common reported side effect was upper respiratory tract

infections (*J Am Acad Dermatol*. 2018 May; 78(5): 872-81. e6).

Although the paper acknowledges limitations such as a narrow sample size and no EASI or pruritus numerical rate scale assessments, Dr. Guttman is intrigued. "IL-22 shows promise in a subset of patients and will be interesting to follow."

Yet for Dr. Beck, with all of these biologics, the question remains: How can you improve upon dupilumab? "I think it will be interesting to see how these drugs develop. However, I think that the question for any new drug is: How do you distinguish yourself from dupilumab? How do you look safer or more effective?"

JAKpot?

For some patients, the answer to the question

about how to improve upon dupilumab is simple: Stop the injections. "The potential benefit of JAK inhibition is that patients can have an oral therapy," said Dr. Simpson. Additionally, "It's a slightly broader blockade of inflammatory mediators, so it can maybe handle the heterogeneity of the disease." Additionally, Dr. Guttman adds, "You can stop and restart whenever you want. We need to remember that that's something we cannot do with biologics."

The excitement around JAK inhibitors has permeated throughout the house of medicine as well. "You have people who are very interested in these pathways for a lot of other indications and a lot of other disease states. There's a new potential indication for JAK inhibitors in many realms — alopecia areata, vitiligo, and also in rheumatology," said Dr. Kim. "I think excitement begets excitement."

Baricitinib – JAK1/2

Baricitinib, an oral selective JAK1 and JAK2 inhibitor, modulates pro-inflammatory cytokine signaling, and has achieved some promising results in atopic dermatitis

"By studying this disease, we've actually been able to learn more about other chronic itch disorders. There's much more to come beyond atopic dermatitis as a result of this investment in research. This is just a starting point for us."

trials. In a recent phase 2, randomized, double-blind, placebo-controlled study, patients on 2 or 4 mg of baricitinib for 16 weeks saw improvements in EASI 50 scores, as well improved pruritus and sleep loss (*J Am Acad Dermatol.* 2018 Feb 1. pii: S0190-9622(18)30129-4).

However, the researchers acknowledged that patients were given a topical corticosteroid for four weeks prior to the study, and therefore longer studies evaluating baricitinib as a monotherapy are warranted. Currently, a phase 3 study is underway and is expected to be completed by the end of 2018.

Upadacitinib (ABT-494) - JAK1 inhibitor:

Similarly, JAK1 inhibitor upadacitinib also appears to be meeting its primary endpoints. At the 2018 AAD Annual Meeting, researchers presented results from a Phase 2b study evaluating upadacitinib in various once-daily doses for 16 weeks. The average percentage improvement from baseline in EASI scores ranged from 39, 62, and 74% for 7.5, 15, and 30 mg respectively by week 16. Additionally, the average percent change from baseline in the Pruritus Numerical Rating Scale was 40, 48, and 69% for 7.5, 15, and 30 mg respectively by week 16. The most common side effects were upper respiratory tract infections, acne, and atopic dermatitis worsening.

JAK/SYK - ASN002

Dr. Guttman is also intrigued by a dark horse that has recently entered the realm of potential JAK inhibitors for atopic dermatitis: ASN002. "This is a JAK/SYK inhibitor that shows promise." The theory behind this oral JAK/SYK inhibitor is that it reduces the cytokine production and signaling involved in the Th2 and Th22 cytokine pathways.

At the 2018 AAD Annual Meeting, researchers presented results from a recent clinical proof of concept study indicating that ASN002 met its efficacy and safety endpoints. After four weeks of treatment, nearly all patients on either 40 or 80 mg once-daily doses achieved a 50% improvement in EASI 50 scores by week four. Additionally, patients reported a marked reduction in itch

per the Numeric Rating Scale after four weeks. "Larger and longer studies are needed to show long-term disease control and safety over time," said Dr. Guttman in a press release, "but this is very exciting news so far." A phase 2b study is currently underway and is expected to be completed in July 2019.

Despite these intriguing study results with acceptable safety profiles, Dr. Beck remains cautious

about the potential side effects of long-term use. "The oral JAK inhibitors appear to have pretty remarkable clinical improvement. The next step is to find the right dose that offers the best benefit but minimizes the side effects. Patients don't like having to undergo regular drug monitoring for side effects and this is a drug category where I suspect it will be very unlikely that they will get approved without some requirements for routine blood monitoring."

Overall, while these drugs are still in the development stages, Dr. Kim is delighted by the progress that has been made with atopic dermatitis treatments. "I think that in the future we're going to see more personalized treatments in atopic dermatitis, where we can say, 'You're going to do well on dupilumab' or 'you have more itch-predominant atopic dermatitis so you're going to do better on nemolizumab.'" Dr. Kim is also optimistic about the domino effect this research will have on other aspects of dermatology. "By studying this disease, we've actually been able to learn more about other chronic itch disorders. There's much more to come beyond atopic dermatitis as a result of this investment in research. This is just a starting point for us." *dw*

"I think that the question for any new drug is: How do you distinguish yourself from dupilumab? How do you look safer or more effective?"



Check out the New and Emerging Therapies for Atopic Dermatitis Roundtable video from JAAD at <http://olc.aad.org/diweb/catalog/launch/package/3/eid/2209349>.



HOW *to* HIRE *a* GREAT PRACTICE MANAGER

Finding the right fit for your practice

BY EMILY MARGOSIAN, ASSISTANT EDITOR

Behind the scenes, who keeps your practice running? According to the 2017 AAD Practice Profile Survey, 64% of dermatology practices currently employ a practice manager. Against the backdrop of an aging population with growing health care needs, combined with evolving patient and regulatory criteria regarding quality of care, demand for the role is expected to increase by more than 20% over the next decade according to the U.S. Bureau of Labor Statistics.

As true jacks-of-all-trades, practice managers wear many hats to meet the needs of the modern dermatology office — encompassing finance, billing, marketing, operations management, human resources, quality reporting, and patient-centered customer service. “You put all that into a cauldron, and then you’ve got one of the more complex industries in the country to navigate through,” says Tony Davis, CPA (inactive), president of the Association of Dermatology Administrators and Managers (ADAM), and executive director of Dermatology Specialists, PA, in Minneapolis. “Doing all that without a practice manager is likely very difficult for a physician who’s trying to do the very best they can to give timely and quality care to the patient. No matter the style of practice you’re in, regulatory and compliance-related concerns are hitting you throughout the day. So there are a wide range of reasons why having someone to help man the ship would be valuable to a provider.”

This month, dermatologists and practice managers discuss:

- What makes a good practice manager
- How to find the right fit for your practice >>



HOW to HIRE a GREAT PRACTICE MANAGER

What makes a good practice manager?

At the end of the day, a practice manager's primary goal is to keep the office running smoothly. Although each individual's day-to-day responsibilities often depend on the size and type of practice in which they work, there are some core skills an outstanding practice manager should have in their toolkit. They are:

Regulatory expertise

In recent years, practice managers have shouldered increased responsibility for helping practices navigate a wide array of federal regulations in order to remain in compliance. "From Meaningful Use and PQRS, to now MIPS and MACRA — that whole alphabet soup of reimbursement models — it can be very complicated," says Davis. "Even with EHR doing some of the work for you, there still needs to be an adjudication of human involvement in that to make sure that we are doing the right things to meet some of those quality requirements that the government has placed before us."

"MIPs is significant," agrees Nichole Holoman, MHA, director of operations at MacInnis Dermatology. "It's on my mind every day. As the super user for our EHR, I have to go in on the back end, and configure our software to meet our needs, as well as monitor our MIPS data. We're always checking weekly, sometimes daily, which is labor intensive, although I feel it's more manageable now that we've upgraded our EHR."

Practice managers also aid physicians on other aspects of practice relating to compliance, including patient care and safety, as well as malpractice concerns. "Doctors have a responsibility to stay up to date on the medical side of things: what's the latest and greatest," says Davis. "That all can be a challenge, without even including the regulatory side of things, which sometimes feels as if it changes week-to-week. That's where we are able to step in."

Business savvy

From overseeing coding, billing, and collections to managing payroll and keeping an eye on overhead costs, a good practice manager should also feel comfortable taking charge of the business end of operating a medical practice. "There's a whole industry around just how the revenue cycle of a dermatology practice works. So there's an intense knowledge that's required around that,"

says Davis. "Finance is my thing. Making sure there are good controls in place for appropriate tracking and recording of transactions that have been going on, and producing financial statements and management reports. Tracking how the practice is performing. There are a myriad of components that go into how a health care organization runs."

Colleen MacInnis, MD, dermatologist and practice owner of MacInnis Dermatology, attests that Holoman plays a central role in keeping

her practice's financial operations afloat. "She's in charge of making sure everyone gets paid; she's in charge of making sure that everyone we owe money to gets paid. Essentially making sure that we run on a day-to-day basis."

Beyond finance, a good practice manager should play an important role in managing patient care and ensuring that the patient experience is positive during every phase of an office visit. Davis emphasizes that this level of oversight is key, particularly as reimbursement trends toward value-based payment. "We can help address day-to-day patient concerns. The completion of the visit goes beyond the patient just being in the clinic and then walking out the door," he explains. "Often times the problems we run into are when the ball gets dropped somewhere along the way, which causes an issue with the patient, and then in turn it also causes an issue with the physician. A good practice manager can think through the full transaction of health care delivery and make sure you've got good solid folks at each point of care along the way."

"A good practice manager can think through the full transaction of health care delivery and make sure you've got good solid folks at each point of care along the way."

Human resources

What takes up most of a practice manager's time? "Human resources, 100%," says Holoman. Between hiring, firing, training, and supervising clinical and non-clinical staff, "People always have questions about their time off, or their pay, or have conflicts you need to mediate," she says. Practice managers assuming the role of HR within a practice should also be knowledgeable regarding employment law, conducting performance reviews, and compensation analyses. "As the practice has grown, we now have three locations, two dermatologists, two physician assistants, and probably 26 or 27 employees. She's in charge of all of the staff," says Dr. MacInnis. "We have managers under her for the front office, for the medical staff themselves, and for billing, which we do in-house. Each of those leaders report to her."

IT 101

While noting that most larger practices outsource their IT (his included), Davis emphasizes that a good practice manager should be armed with a basic level of tech savvy to troubleshoot everyday hiccups. "Having an internal IT structure is paramount. If the computers go down, it seems like the clinic's frozen," he says. "I think it's awfully hard not to have some sort of IT expertise at your fingertips, someone to troubleshoot on a daily basis who knows if the EHR or practice management system isn't working, or what to do if your credit card machine is down. It's good to have someone close at hand who knows enough to be 'dangerous' in that sense."

Dr. MacInnis confirms how helpful this in-house technical support can be. "We have fully implemented an EHR and Nichole is really literate in all of the electronic medical record keeping systems. All the things you have to do to bring them on, and to switch from one to another. You name it, we do it. We're really an involved practice, and want to keep everything as in-house and under our control as possible," she explains.

Finding the right fit

As every dermatology practice is different, how can physicians find the right practice manager

Practice manager checklist

- ☒ Entering quality measures and overseeing compliance
- ☒ Managing accounts payable
- ☒ Overseeing billing and coding
- ☒ Ordering medical and office supplies
- ☒ Overseeing business operations, keeping overhead low
- ☒ Managing marketing, PR, social media efforts
- ☒ Scheduling clinical and non-clinical staff
- ☒ Supervising non-clinical staff
- ☒ Managing payroll



HOW to HIRE a GREAT PRACTICE MANAGER

to meet their specific needs? Despite the varying demands of different practice models, there are some core criteria dermatologists can follow when looking to fill the role:

Shared vision

All three sources identified shared values as the primary factor contributing to a successful physician-practice manager working relationship.

“First and foremost, do they fit the culture of the organization? Do they understand the vision that the owners, that the physicians want?” asks Davis. “I think you have to start there and understand that — and you have to believe it — because you won’t be effective in your role if you don’t believe in the vision of where the doctors want to take the practice.”

Dr. MacInnis agrees. “We’ve been together a long time now, so we really understand each other and where we’re going. Times might be hard, things might be tough, but my team knows if they stick with me and with this practice, we’re going to do right by people, and I think that’s been really important as far as retaining my best staff.” Holoman agrees, noting that an ideal practice manager should be, “Somebody who truly believes and buys into your organizational mission, vision, values, and culture.”

Prioritize communication

Not everyone is a people person, but a good practice manager must have exemplary communication skills to succeed, says Dr. MacInnis. “Everything else can be learned, but if you cannot deal with people, then you’re not going to be able to be an effective office manager. You can learn all the EHRs, how to bill, and all those other things, but you cannot learn how to deal with people. We’ve made people the core of our practice, and that’s how we’ve been successful.”

Often mediating between patients, medical staff, office employees, and insurers, practice

managers should be experts at navigating between grit and graciousness, according to Holoman.

“Something that’s really resonated with me as a key characteristic of a practice manager is to be ruthless with your time, but gracious with people. You have to be strong enough to set the rules, while remaining empathetic. I’ve experienced managers who go on power trips, and they don’t last long. I’ve seen people get so emotional, unable to find balance and they just can’t handle

it. I’ve seen people just be extremely harsh with their staff. A manager without emotional intelligence exhibiting these behaviors, will just not work out in the long run.”

Don’t pigeonhole based on credentials

While there are an array of certifications and higher education available to current and aspiring practice managers, dermatologists shouldn’t make them prerequisites to considering

a candidate, says Davis. “I don’t think we’re at that point where those sort of certifications are required to do an effective job. In my experience of almost 25 years, there’s a wealth of experienced managers out there who learned on the job. Some of the best administrators and office managers that I’ve seen came from internal growth movement from front desk through the revenue cycle up through administration.”

While Davis and Holoman themselves bring outside education to their roles, Davis maintains that experience tends to be the best bellwether of someone’s performance as a practice manager. “You don’t need to be a CPA; you don’t need to be an MBA of any kind. Those things are helpful, but I also think that folks who have learned through the coding department, or through the clinical side of things — whether they be CMAs, LPNs, RNs even — can be extraordinarily good managers of practices.”

Consider management vs. medical experience

What makes for a better practice manager: a background in management or medicine? Sources are split. “I’m a CPA by trade, so I came out of

“Something that’s really resonated with me as a key characteristic of a practice manager is to be ruthless with your time, but gracious with people.”

a public accounting firm that dealt with a lot of physician practices, and I learned my craft by living in boardrooms of doctors' offices and helping them with their financial budgeting and financial statement preparation," says Davis.

Holoman's path to practice management took a different route. "When I came to Florida 11 years ago, I worked for a very big dermatology practice, and on my very first day of work, Nichole was my medical assistant," recalls Dr. MacInnis. After that initial meeting, Dr. MacInnis eventually left to establish her own private practice, with Holoman electing to join. "Dermatology is my second career. I started as a dermatologist when I was 40. Before that I was actually a farm animal veterinarian," says Dr. MacInnis. "Nichole is a very bright person, and medical assisting was never her goal either. She knew she would grow, and when I met her I knew she would grow too. So I've just been supportive of her, and made sure to make time for her to do whatever training she needed. Last year she finished her master's in health administration. She did night classes while continuing to be my office manager, and I've supported her in that growth all this time."

Holoman cites her background as a medical assistant as a key part of her success as a practice manager. "I feel that having a background and experience within a medical organization, as a nurse or a medical assistant or working your way through the ranks, really gives you a good foundation and focus on patient-centered care," she says. "That's what the future of medicine in dermatology is gearing toward — we're being judged by the patient now more than ever. I think it's really important to have somebody who's worked in the different roles within a medical office, with the capacity to learn, and has an inside perspective, rather than just a business degree."

However, Holoman acknowledges that a certain level of business expertise is eventually needed in order to do the job. "As far as running the business side of the practice itself, there can be a lot of gaps if you don't have a mentor to show you the ropes of what a budget is or to help you with the revenue cycle, per se. If you have gaps in your knowledge that come from a mentor or education, you could be at a loss. I personally went back to school to get my master's in health administration, because I thought I was missing knowledge in some areas that could push the organization to the next level."

Then and now: The evolution of practice management

While in the past dermatologists may have cast a wider net when looking to hire a practice manager, as the rigors of the health care landscape have heightened, so too have the demands of the position. "It is now becoming a younger person's specialty," says Dr. MacInnis. "When I first opened my practice, I brought on two older people in the role — who have both since retired — and they had a lot of trouble. One struggled with the EHR, and the second had a strong background in IT, but couldn't do the other stuff very well. Nichole has really taken on every facet of the job, and has been able to tackle all the new requirements with less stress."

Davis agrees that while in the past, dermatologists may have filled a practice manager's role by hiring, "a receptionist or an office manager who initially just maybe did some payroll, might have done the supply ordering, and did a bit of everything," he adds that "a lot of dermatology now requires a specialty or expertise in managing those parts of a practice."

Professional standards regarding the hiring of a spouse or family member as a practice manager are also changing. "ADAM was actually founded by the spouses of dermatologists, who would go along to the AAD Annual Meeting," explains Davis. "However, for all the complexities that have arisen from when health care was simpler to now, there's just this desire to take it out of the family environment because of the level of expertise that's needed to execute a lot of the management functions of the job," says Davis. "That's not meant to be any sort of disparaging comment around spouses running practices. I think there is some team component to that which can work quite well. It just depends on the level of education and understanding that spouse might have around health care management — they may be strong in one area and need help in other areas."

However, despite any changes to the rigor and complexity of the job, according to Davis, "that's what makes it interesting, what makes it fun, but also very challenging too." *dw*



Experts offer tips on getting the most
out of malpractice insurance

BY RUTH CAROL, CONTRIBUTING WRITER

You may not be paying for your medical malpractice insurance, but that doesn't mean you shouldn't know who the policy is with, what the policy covers, and how it works.

Medical malpractice insurance protects physicians and other licensed health care professionals from liability associated with wrongful practices resulting in bodily injury, medical expenses, and property damage as well as the cost of defending lawsuits related to such claims, according to the National Association of Insurance Commissioners.

At a minimum, the medical malpractice insurance policy should cover professional services, stated health care attorney Vasilios "Bill" Kalogredis, chair of the health law department at Lamb McErlane, PC, in Philadelphia. Because the type of services and procedures dermatologists provide can vary, it's important that they specify which ones they offer when filling out the policy application. For example, does the dermatologist provide medical dermatology only, medical and surgical dermatology, Mohs micrographic surgery, dermatopathology, and/or cosmetics? Does the dermatologist have a subspecialty? What about teledermatology and locum tenens? "That will dictate what the premium cost is, what they are covering, and what the risk is," he said. If an employer, such as a hospital, is paying the policy, many times it will cover only the work the physician does for that organization, Kalogredis added. >>



Usually the physicians in a group are covered by the same insurer, said Crystal R. Brown, senior vice president of underwriting for The Doctors Company, the nation's largest physician-owned medical malpractice insurer. The same insurer will typically cover mid-level providers, such as physician assistants (PAs) and nurse practitioners, as well as the entity/ies. Often, physicians and mid-level providers will have the option for individual or shared limits, she said.

Non-licensed individuals, such as medical assistants, may be covered under either the professional or general liability policy, said Daniel F. Shay, attorney with Alice G. Gosfield & Associates, P.C. in Philadelphia. Aestheticians may be able to purchase relatively inexpensive society-sponsored coverage, Kalogredis added. It's important to remember that the physician typically supervises these individuals and therefore is liable for their actions. That's why it's important to list the number of non-physician providers and even aestheticians working in the practice or group and make sure everyone has the appropriate coverage, he said.

In addition to providing insurance coverage for providers and employees, consider getting it for the business entity (e.g., corporation, partnership, or limited liability company). "If the doctor gets sued, the entity is likely to get sued," Kalogredis said. "You want to protect the entity as well."

Generally speaking, malpractice insurance does not cover illegal acts, intentional violation of laws and/or regulations, and sexual misconduct. Including falsified information on the insurance application will void the policy.

Claims-made versus occurrence policies

There are two types of malpractice insurance policies: claims-made and occurrence. It's important to understand the difference because a claim may be filed years after an incident takes place and it may or may not be covered, depending on the type of policy.

A claims-made policy only provides coverage for incidents that occur if the policy is in effect both when the incident took place and when a lawsuit is filed. If

a physician with a claims-made policy paid for 2016 is sued in 2018, that incident would not be covered. The claim would have to have been made in 2016 for it to be covered under the claims-made policy, Kalogredis explained. Very often, a physician stays with the same carrier and so the claims-made policy coverage is uninterrupted.

However, if the physician changes carriers, moves for a new job, or retires, he or she will need to purchase extended or "tail" coverage. Tail coverage, which is purchased from the existing carrier, extends coverage for a specified amount of time after a policy ends. Tail

coverage is sometimes written into a claims-made policy. If not, it can be purchased. Another form of extended coverage is "nose" coverage for claims that arise from incidents that occurred under a previous terminated policy but first reported under the current policy. Nose coverage is typically purchased from the new carrier; sometimes it is incorporated into the new policy. It's important to have continued malpractice

coverage during times of transition for incidents that may have occurred in past years.

An occurrence policy is similar to what most people have on their houses and cars. It provides coverage for incidents that occur during the life of the policy, regardless of when the claim is made, and even after the policy has been canceled. If a physician with an occurrence policy for calendar year 2016 gets sued in 2018 for an incident that occurred in 2016, the physician will be covered, Kalogredis said. The only time a dermatologist would need tail coverage with an occurrence policy is if the carrier goes out of business, Shay noted.

The other difference between the two types of policies is cost. A claims-made policy is less expensive the first year. As it matures, which typically takes five years, the premium rises because it is covering more years. But in times of transition the physician will need to buy extended coverage. Depending on how many years the dermatologist is in practice, tail coverage in many cases is five figures, Kalogredis said. An occurrence policy is more expensive upfront, but it is more comprehensive and doesn't require extended coverage. Fewer carriers offer occurrence policies

"If the doctor gets sued, the entity is likely to get sued... You want to protect the entity as well."

because most physicians are interested in claims-made policies, Shay said, so the former may be harder to find.

When deciding between the two types of policies, Brown recommended considering the benefits of claims-made versus occurrence coverage; the number and quality of carriers that offer claims-made or occurrence coverage; what happens if the dermatologist decides to leave the group, practice, or territory; and the cost of the policy over time. "Dermatologists should make sure that their employment contract clearly outlines who is responsible for securing medical professional liability coverage, nose, tail, and any endorsements or other enhancements needed when they negotiate their employment agreement," she added.

The group that Chad Prather, MD, is part of purchased a claims-made policy because it was more affordable in the beginning and it allowed them to tailor the coverage to include the tail. "It's my understanding that a claims-made policy and occurrence policy is essentially going to be the same price over time," said Dr. Prather, who practices in Baton Rouge and Lafayette, Louisiana. "We felt like the claims-made policy with tail coverage would give us the same type of coverage as an occurrence policy." Stan N. Tolkachjov, MD, who practices in a group in Birmingham, Alabama, also has a claims-made policy, but the physicians have to purchase tail coverage if they leave the practice.

Coverage limits

Coverage limits refer to the maximum dollar amount the insurance carrier will cover in losses. There is the per-occurrence amount, which is paid out for a specific incident, and there is the aggregate, which is the amount that is paid out in total for the year. Some states have a minimum requirement for coverage limits, so be prepared to comply with that. In states with patient compensation funds and meaningful tort reform those limits will likely be lower. A common amount for coverage limits is \$1 million per-occurrence and \$3 million in the aggregate.

When Dr. Prather first started in a small private practice, the group had \$100,000 per-occurrence and \$300,000 in the aggregate coverage limits. Now that there are five dermatologists and two PAs in five locations, including two in Texas, they moved to \$1 million per-occurrence and \$3 million in the aggregate. Louisiana is one of a handful of states that has a state



An umbrella policy for medical malpractice or personal liability?

An umbrella policy is over and above the basic insurance, Kalogredis explained. "If you have \$1 million per occurrence and \$3 million in aggregate coverage for medical malpractice and the same for personal liability, and you want more than that," he said, "you purchase an umbrella policy to provide incremental coverage."

There are pros and cons to doing this for the malpractice insurance versus personal liability coverage. "If an individual is personally liable and the insurance limits don't cover the claim, then the doctor will be individually liable for the difference," Kalogredis explained. For example, if the patient sues the doctor for \$2 million and the physician has \$1 million per occurrence coverage, that leaves \$1 million not covered by insurance. The patient can go after the doctor's personal assets. In essence, an umbrella policy covers if the judgment against the doctor exceeds the coverage they have with basic insurance. It's wise to speak with local counsel about the best way to protect assets in your state, Kalogredis said, as the rules vary from one jurisdiction to another. (To learn more about this, look for next month's Money Matters column.)

"The idea of personal liability and umbrella coverages is to cover your exposure and protect your limits," Brown said. "Weigh your net worth and your exposure. It is worth protecting your business and your personal assets."



compensation fund. “As long as you participate in the state compensation fund and your claims are qualified, our state limits payouts to \$100,000 per-occurrence and \$300,000 in the aggregate,” he said, “but we go with the higher coverage just to be on the safe side.”

Dermatologists should consider their severity for risk and exposure based on type of procedures, type of incidents/claims, frequency versus severity of claims, legal climate, and covering their own assets as well as their practice’s assets, Brown said. “You have to strike your own balance keeping these factors in mind. You do not want to have inadequate coverage, but you also do not want to be over insured and become a target due to having more insurance than other defendants,” she added.

Other factors to consider

Consent-to-settle clause. Sometimes, carriers prefer to settle a lawsuit, even if it lacks merit, because defending it might cost more money than it does to settle. If the malpractice policy does not have a consent-to-settle clause, the carrier can settle a claim against the physician’s wishes, even if he/she is blameless. Having a consent-to-settle clause prevents the company from settling a case without the dermatologist’s consent, Kalogredis said. That’s important because any settlement made on a physician’s behalf must be reported to the National Practitioner Data Bank. This, in turn, can affect the physician’s insurance status, hospital privileges, and participation in a managed care group. “A consent-to-settle clause is something dermatologists would want to have in their medical malpractice policy,” he said. “In fact, some doctors pick insurance companies because of that.”

Both Drs. Tolkachjov and Prather have a consent-to-settle clause in their policies. It was important for Dr. Tolkachjov’s practice to select a carrier that has a strong track record of defending their physicians in court and a reputation for not being quick to settle.

Be sure to avoid a “hammer clause,” which can impose some extra penalties to compel a physician to settle a claim, Brown warned. For example, if the

physician chooses to go to trial instead of settling as recommended by the carrier, and the trial results in a higher award amount than the settlement would have been, the physician may be required to pay the difference.

Claims trigger. A claims trigger can be either incident driven or written demand. An incident-sensitive policy recognizes incidents reported whereas a written-demand policy only recognizes written demands for money, Brown explained. In the latter case, the carrier will not recognize an incident until it is turned into a written demand. Most

medical malpractice policies have incident-sensitive claims triggers, she added.

It’s important that the dermatologist understands what constitutes an incident and their obligation to report it, Kalogredis said. For example, if a patient complains about something, but doesn’t make a formal complaint, is that enough to trigger a claim for coverage? Does the physician have to notify the insurance company that there might be a claim? If the physician doesn’t report a potential claim, can the carrier deny coverage?

Dr. Tolkachjov must notify the insurance company immediately upon the notice of an incident or claim. “If something occurs that could potentially be a lawsuit, the providers and managers would discuss it and likely err on the side of caution and give that information to the carrier,” he said. Similarly, Dr. Prather’s policy has an incident-driven claims trigger. “It could be a verbal report, but there’s also a reporting form that gathers the details,” he said. “Our insurance company invites us to call and verbally report an incident. They are helpful about gathering information prior to a formal report being filed or a suit being filed,” Dr. Prather added.

Defense costs responsibilities. Defense costs include attorneys’ fees and court costs. Some malpractice policies do not pay for defense costs or cap

“A consent-to-settle clause is something dermatologists would want to have in their medical malpractice policy. In fact, some doctors pick insurance companies because of that.”





the amount the carrier will pay. If the policy limits the amount it will pay, be sure the limit is high enough to cover defense costs in addition to a settlement or judgment amount. Ask if defense costs are in addition to the primary limits of insurance or a part of the limit of liability, Brown said. "Policies with defense costs in addition to the limit of liability have additional monies

for defense costs that do not erode the limit of liability. Read your policy carefully," she added.

Both Drs. Tolkachjov's and Prather's policies cover defense cost responsibilities. "They're paid by the insurance company and they are unlimited," Dr. Prather said. "The policy states that the defense costs are outside the limits of liability." Because the policy

What to ask the insurance carrier

"Dermatologists should know about the carrier as well as the coverage," Brown said. She offered the following key questions that dermatologists should ask the insurance carrier:

-  Does the carrier specialize in medical professional liability?
-  How long has the company been in business?
-  What is the carrier's market share, member count, or number of policy holders, and total gross written premium?
-  What is the carrier's asset size, surplus, and ratings from A.M. Best, Fitch, and Standard & Poor's?
-  What services does the carrier provide to its members or policy holders? What value-added services does it offer for patient safety? What claims services does it offer and what is the process for reporting an incident or a claim?
-  How does this carrier differentiate itself from their competitors?
-  What is covered in the policy and what is excluded? How does this compare to other carriers?
-  Is this a claims-made policy? Am I covered for my prior acts?
-  Is the claims trigger incident sensitive or written demand?
-  Does this policy offer consent to settle? If so, is there a hammer clause?
-  Are defense costs in addition to the limit of liability of the primary policy or do they erode the limit of liability?
-  Is my entity covered under this policy as well as any mid-level employees?
-  Are all employees, contracted workers, and volunteers covered under this policy? Does this policy afford coverage for any locum tenens?
-  Am I covered for my work on committees acting on behalf of the named insured (e.g., credentialing, peer review, and medical ethics)?
-  Does the policy provide coverage for any Good Samaritan acts?
-  What are the terms of the extended reporting coverage if I choose to leave the practice, die, or retire? Are there any other benefits afforded to me when I leave the practice, die, or retire?



includes some limits for medical defense, the practice purchased supplemental insurance for that.

Deductibles. Many malpractice policies do not require a deductible. But some do offer it as an option that enables a physician to obtain a discount on the premium. An indemnity-only deductible requires the physician to pay it only in the event of an indemnity judgment. An indemnity and defense deductible must be paid as soon as expenses are incurred defending the claim, whether or not an indemnity payment is made. When deciding whether to get a deductible, dermatologists will have to balance the discount received versus the exposure, Brown noted. Some policies will pay the deductible and seek reimbursement. Read your policy carefully, she added.

Neither Drs. Tolkachjov's nor Prather's policy has a deductible.

Risk management services. Risk management services include, for example, the use of consent forms/checklists and patient safety protocols in the form of in-service training and/or on-demand webinars. "Whether risk management services are required or offered will vary depending on the marketplace, the carrier, and the loss experience of the physician," Brown said. Some carriers offer premium discounts if the practice/group participates in these services designed to decrease claims and improve patient care. "If you can get a discount on your rate by doing these activities and it might help make you a little bit safer from a malpractice perspective, why not do them, unless it's going to be a major impediment to implement them in your practice," Shay added.

Both Drs. Tolkachjov's and Prather's carriers offer risk management services eligible for premium discounts. For Dr. Tolkachjov's group, these services include complimentary risk assessments, consent forms, and checklists offered through educational seminars and on-demand webinars with an added bonus of continuing medical education credits. Sometimes the insurance company sends a representative and an attorney to the office to address the entire staff. "They are helpful because we discuss current issues and they provide good examples on a case basis of situations that can occur and how to help prevent them from happening," he said. In Dr. Prather's case, many of the services are provided through online education. "Our physicians tend to

find the training very helpful," he said. Recent courses addressed medical documentation, social media, and patient engagement.

Other offerings. Dermatologists may want to consider purchasing separate insurance coverage for other types of liability that are associated with running a medical practice, said Brown, who gave the following examples.

- **Cyber liability** provides first-party and third-party coverage for bodily injury directly caused by a data security breach, coverage for civil regulatory fines and penalties, post event mitigation, coverage for identity monitoring/medical record restoration/credit monitoring, coverage for notification/monitoring on a number of notified individuals, contingent business interruption as well as extra expense, and comprehensive cybercrime coverage including funds transfer fraud and social engineering.
- **Regulatory liability** from billing errors and omissions. Coverage includes attorney fees, external auditor and medical expert costs associated with defending these claims as well as fines and penalties and damages.
- **Directors and officers liability**, which covers officers and director of a corporation or managing partners in a partnership, protects from liabilities related to operating and managing a business.
- **Employment practices liability** protects against claims for such employee allegations as wrongful termination, wage and hour disputes, discrimination, harassment, or retaliation. These could be covered under the medical malpractice policy or general liability policy, Kalogredis added.

Approximately seven years ago, Dr. Prather's group purchased supplemental insurance for cyber liability because they believed the risk has the potential to shut down the practice. Dr. Tolkachjov's practice has supplemental coverage for cyber attacks, privacy breaches, and regulatory audits.

"It's important to understand what kind of medical malpractice coverage is being provided under your policy," Kalogredis concluded. "It's important to read the policy or hire someone you trust to read it, so that you get the coverage you need." *dw*



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BY SUZANNE OLBRICHT, MD



We live and work within a broad, intertwined community

It's August, which means summer vacations, cook-outs, and sunscreen sunscreen sunscreen. While the dog days of summer can be a great time to relax and catch up on the year's top beach reads, it can also bring disruptive and devastating weather events to many parts of the country.

Nearly a year has passed since Harvey, Irma, and Maria touched ground, yet the destruction of these storms still affects the daily lives of many people. Some estimates indicate that the 2017 Atlantic hurricane season was the most expensive season on record — with an estimated \$200 billion in damages. While the devastation that these storms inflicted is heartbreaking, I have been comforted by the fact that so many of my colleagues were willing to step up and help.

The Academy's Board of Directors initiated several programs to assist in hurricane relief efforts. The Academy's fund-matching donation program allowed Academy staff and members to donate funds that were distributed to the American Red Cross, United Way, and local food banks, sites identified by our members who live in these communities. For every donation made via the Academy, the Academy matched these funds, up to \$100,000. In total, 299 members and staff donated \$89,319 and together we contributed \$150,911 to the relief efforts. Additionally, for AAD members who were affected by the hurricanes, the Academy offered assistance in the form of low-interest loans for AAD-member licensed dermatologists and dermatology graduate members who sustained physical damage not covered by insurance.

The hurricane relief efforts represent a fraction of the philanthropic activities that we undertake in our communities together. Your Academy has initiated a number of essential programs and services that improve lives in the United States and around the world and garner respect for the specialty

and the Academy. You will recognize programs such as the SPOT Skin Cancer™ program, Camp Discovery, shade structure grants, and international scholarship programs. We have a longstanding involvement in the Indian Health Service in Chinle, Arizona, supporting third-year residents to go there and see patients for a week as well as offering teledermatology consultations between visits. This year, you can also pay it forward by supporting the Academy's Resident Education Grant, which earmarks funds to ensure that residents get off to a great start in their careers by helping them attend the Annual Meeting. There are many ways you can show your support for these programs and others that improve patient care and strengthen our specialty. The opportunities to give back abound. Learn more about the many different ways your charitable giving can help the Academy in its efforts to promote healthy skin and healthy lives at www.aad.org/support-aad.

The old adage says that charity begins at home. To me home is our big, broad, intertwined communities where dermatologists banded together can make a difference in the lives of fellow human beings. We can and do make the effort to assist when we can. I know that if the 2018 hurricane season attempts to outdo the destruction of the 2017 season, our specialty will be standing ready to assist. Thank you for all of your support. *dw*

Aspire



To read more stories about members of the dermatology community who are dedicating themselves professionally and personally to advancing skin health, check out the latest issue of the Academy's *Aspire* magazine at www.aad.org/members/publications/aspire.

AAD Cares



To get the latest news on Academy volunteer and philanthropy activities and programs, subscribe to the 'AAD Cares' section of the Academy's new *DW Academy Insider* e-newsletter. Visit www.aad.org/account/communication/ and select 'AAD Cares' under *Dermatology World Academy Insider*.



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Deadline for Academy Election nominations is Oct. 1

Submit nominations

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To view reference materials and/or submit nominations, visit **www.aad.org/aadnominations** or email **callfornominations@aad.org**.

Submit applications

.....



Eligibility criteria and online submission information are available at **www.aad.org/members/awards/young-investigator-awards**.

Submit nominations and letters of recommendation for the 2019 Academy Election by Oct. 1 for Officers, Directors, and Nominating Committee Member Representatives (East Region).

To view reference materials and/or submit nominations, visit **www.aad.org/aadnominations**, or email **callfornominations@aad.org**. Nominations may also be mailed to:

Attn: Chair, Nominating Committee
American Academy of Dermatology
P.O. Box 1968
Des Plaines, IL 60017-1968

Contact Joan Tenut at **Callfornominations@aad.org** or call **(847) 240-1046**. – JOAN TENUT

Applicants sought for research excellence award for young dermatology investigators

Each year the Academy recognizes outstanding basic, translational, and clinical research by young dermatology investigators through the AAD Young Investigator Awards. The purpose of the award is to acknowledge significant research advances in the science and practice of dermatology by those beginning their research careers who are likely to become established, independently funded investigators in dermatology.

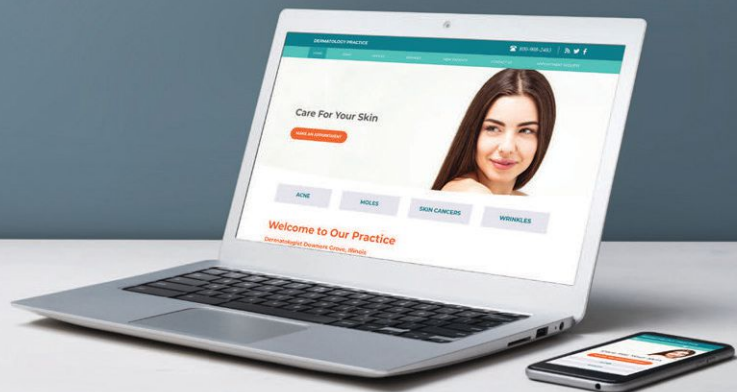
For 2019, the Academy is offering a basic/translational research award track and a clinical research award track. Up to two basic/translational researchers and one clinical researcher will be selected as the recipients of the 2019 awards. Each recipient will receive a \$6,000 prize. The award selection panel will evaluate submissions for originality of the research concept, soundness of the research design, quality and clarity of the narrative research description, perceived value of the research to dermatology, quality, and strength of publications, and an overall assessment of the applicant's potential.

Applications for the 2019 awards are being accepted until Sept. 30, 2018. Eligibility criteria and online submission information are available at **www.aad.org/members/awards/young-investigator-awards**. For more information, contact Allen McMillen at **amcmillen@aad.org**. – ALLEN MCMILLEN

These awards are made possible in part by a contribution from Helen Gruber in memory of her husband, Murray Gruber.

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Leadership Programs



For more information on applying for Academy leadership programs, visit

www.aad.org/LeadershipForum

www.aad.org/ADLP

or

www.aad.org/AdvancedLF

Apply today for Academy leadership programs

In order to encourage dermatologists to take leadership roles in their specialty going forward, the Academy is seeking applicants for three leadership programs in 2019.

Leadership Forum

The 2019 Leadership Forum will bring together aspiring leaders in dermatology with experienced mentors to enhance their communication and leadership skills. The event will take place May 30-June 2 at the Eaglewood Resort near Chicago. Aspiring leaders will engage in an interactive program with colleagues and Academy leadership, and will learn critical competencies for physician leaders, including self-assessment and leveraging innate skills. It is open to dermatologists in both private-sector practice and academic settings. The Academy will provide travel and lodging expenses, as well as on-site meals for the Leadership Forum. Applications will be open June 15 through Oct. 1, 2018. For more information on the 2019 Leadership Forum, visit **www.aad.org/LeadershipForum**.

Academic Dermatology Leadership Program

The Academic Dermatology Leadership Program is facilitated by the Academy to provide physicians in academic settings the resources to meet the unique challenges of life in academia. A total of 18 Academy members will be chosen to participate in this highly selective program, which includes informative sessions at both the annual and summer AAD meetings, participation in the 2019 Leadership Forum, and opportunities to connect with an experienced mentor. This program requires a year-long commitment of between five and eight hours per month in addition to the on-site sessions. Applications will be open from June 15 through Oct. 1, 2018. For more information on the Academic Dermatology Leadership Program, visit **www.aad.org/ADLP**.

Advanced Leadership Forum

The Academy also offers an Advanced Leadership Forum designed for mid-career level dermatologists. The event will take place May 30-June 2 at the Eaglewood Resort near Chicago, in conjunction with the Leadership Forum. Applications are open to all dermatologists, especially those with a particular interest in developing leadership skills that are transferrable to both practice and advocacy settings. Eligibility requirements include the member being 10 years out of residency training or six years past Leadership Forum attendance. Applications will be open from June 15 through Oct. 1, 2018. For more information on the Advanced Leadership Forum visit **www.aad.org/AdvancedLF**. — JAIME LEWEN

Save the date: 2019 World Congress of Dermatology



The 24th World Congress of Dermatology will be held in Milan, Italy, **June 10-15, 2019**.

For more information, visit **www.wcd2019milan.org**.

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Calculating cosmetics

BY EMILY MARGOSIAN, ASSISTANT EDITOR

2017 was a busy year for dermatologists. According to survey data from the American Society for Dermatologic Surgery (ASDS), last year dermatologists performed nearly **12 million** procedures overall. While skin cancer treatments ranked as the single most-performed dermatologic procedure at **3.5 million**, cosmetic procedures cumulatively accounted for over **8 million** of dermatology's total procedures performed for the year — a 19% increase from 2016. While injectable and laser-based treatments that counteract signs of aging remain in demand, body sculpting procedures have begun to creep upward in popularity among dermatology patients. For more on 2017's top cosmetic procedures performed by dermatologists, see the graphic below. *dw*



#1

**Laser,
light, and
energy-based
devices**

3.2 million
procedures performed



#2

**Neuro-
modulators**

2.1 million
procedures performed



#3

**Soft-
tissue fillers**

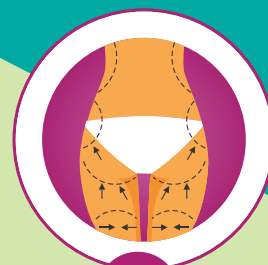
1.6 million
procedures performed



#4

**Chemical
peels**

485,000
procedures performed



#5

**Body
sculpting
treatments**

434,000
procedures performed

2017's top cosmetic treatments



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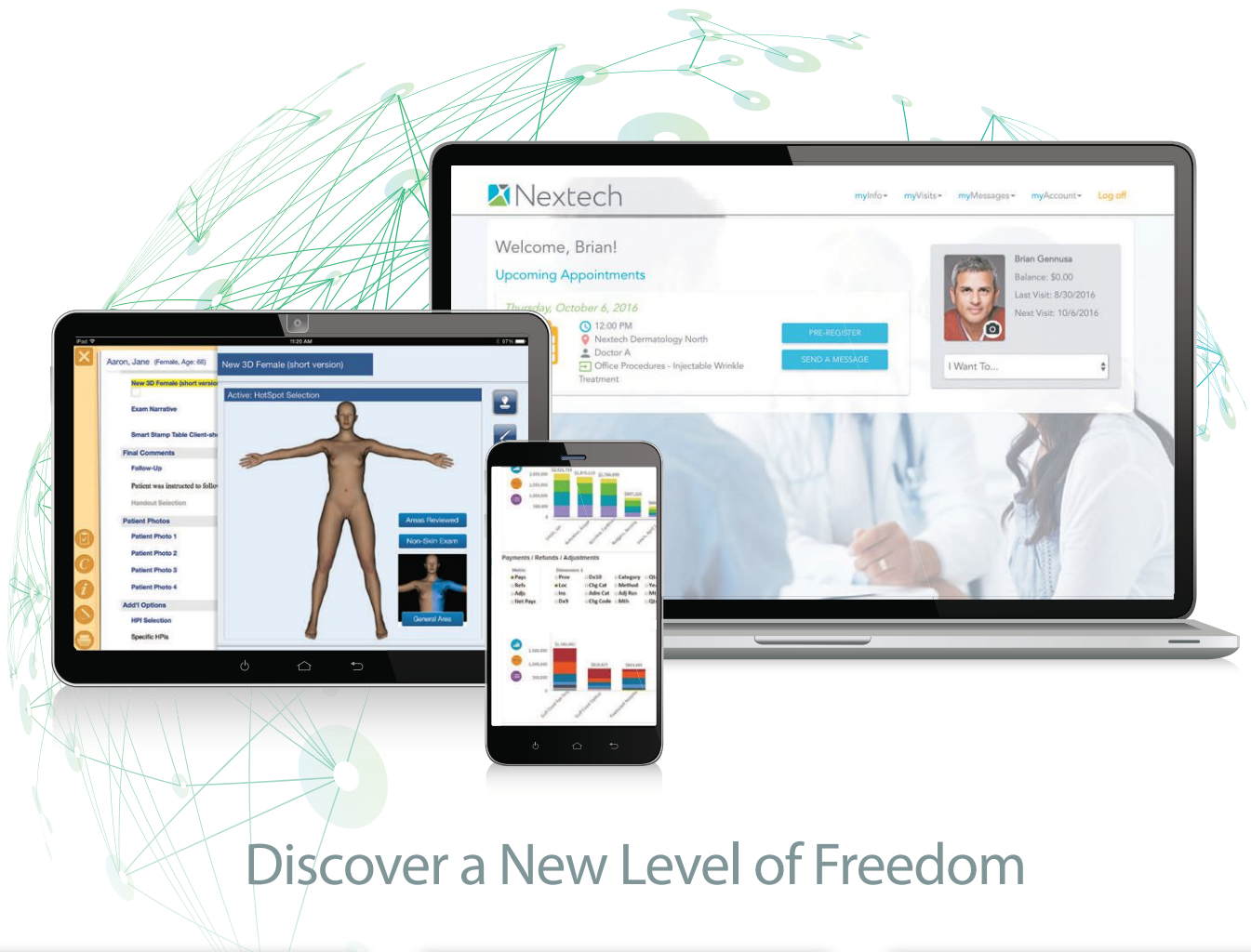
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