



DermWorld

A Publication of the American Academy of Dermatology | Association
Navigating Practice, Policy, and Patient Care

07.2021

Telemedicine in the time of COVID-19... and beyond

How a novel virus
disrupted and transformed
health care delivery.

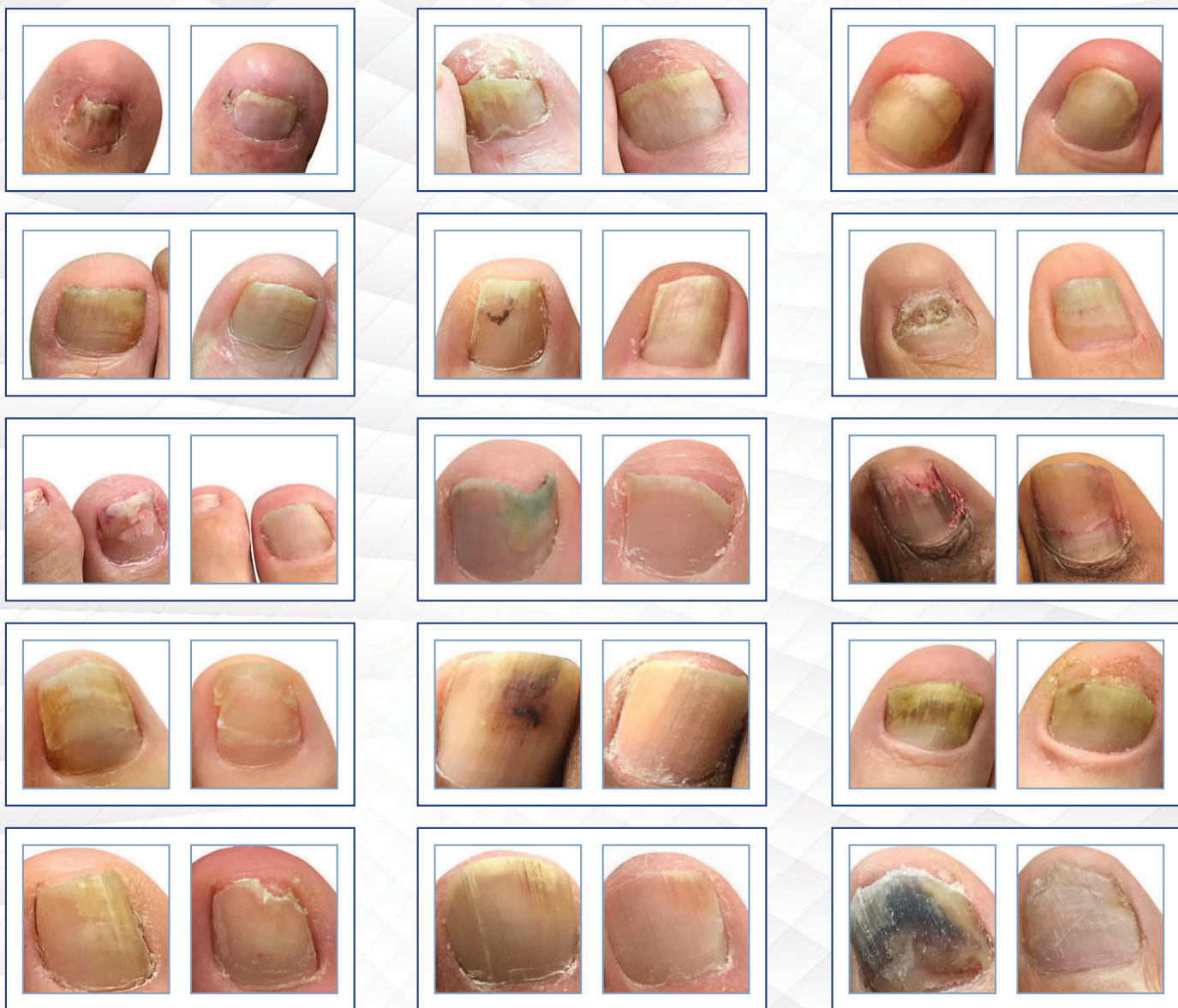


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from the editor



DermWorld

Being homeless.



It is truly hard for me to imagine, and yet every day I drive by a growing number of thrown-together blue tarps and tents that pass for homes. The comfort that my privilege affords me allows me to be irritated by the piles of trash accumulating around the scattered hovels and somehow ignore the fact that there are people living inside. Maybe, just maybe, it is easier to be angry, rather than horrified.

I don't know how to fix the homeless problem, but I have had the privilege of caring for people experiencing homelessness. As I tried to match treatments for their skin with realistic options, I realized how much we rely on simple assumptions in our daily care. We assume our patients can arrive on time for their appointments and that they can get to the pharmacy to fill their prescriptions. We assume that they will use the medications we prescribe, and we never question whether they have a safe place to keep their meds. We assume that their medications will be there from one day to the next. We presume our patients have running water to take their pills and wash their wounds. And we expect our patients to get better. Unfortunately, homelessness makes all these simple expectations very challenging and, in some case, impossible. Our feature about providing dermatologic care to homeless patients highlights some of the difficulties that may be experienced by those with unstable housing as they access our health care system — if they access it at all. This excellent article by Assistant Editor Emily Margosian highlights the work some of our fellow AAD members have done in their own communities caring for homeless patients. I think their stories will both inspire you and help you better care for your own patients who may be in the same situation, either now or in the future.

One of the silver linings of the COVID pandemic has to be the rapid adoption of telehealth. I recall being hesitant to embrace virtual visits a few years ago, and now I cannot imagine not having them as part of my patient care armamentarium. It has been an interesting learning experience finding out what we can and cannot do well through a video camera. The need for immediate widespread adoption of telehealth broke down many of the barriers that may have discouraged many of us from trying telemedicine, not the least of which is lower compensation than in-person visits. Without legislative intervention, once the public health emergency is declared over, these benefits will end. Read about the Academy's efforts to ensure that telemedicine remains a viable — and available — option for providing health care as we go forward.

At *DermWorld*, we love to look forward to the future, and in this edition, we look at changes in the world of clinical trials. Newer technologic advances offer novel opportunities and new ways to reach out and potentially increase participation in clinical trials. If done well, this may expand our research opportunities to persons and communities we might not otherwise reach, and hopefully enhance our knowledge base quicker and easier.

In addition to these outstanding feature articles, our staff writers and, of course, our Editorial Advisory Workgroup members have done a great job pulling together a variety of topics of interest in their columns this month. While I am sure many of you are spending time outdoors, celebrating life again sans mask, I encourage you to enjoy a little downtime! And, of course, read this month's *DermWorld*!

KATHRYN SCHWARZENBERGER, MD, PHYSICIAN EDITOR

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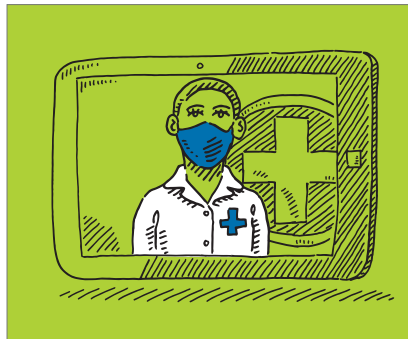
Weekly updates from the Academy. Look for it every Thursday!



Get the latest in the dermatologic literature with Dr. Warren Heymann.

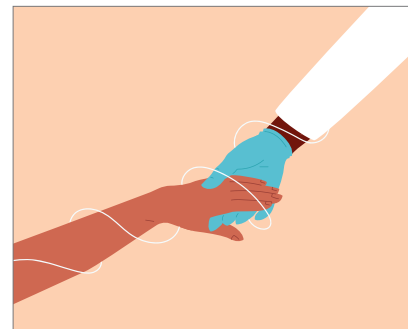


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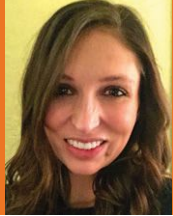
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What's hot?

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



Mallory
Abate, MD



Rosalie Elenitsas, MD

The FDA has approved the first treatment for progeria (Hutchinson-Gilford progeria syndrome). As we all know, progeria is a rare but devastating genetic syndrome that results in premature aging and death in affected patients. Disease results from abnormal accumulation of the structural protein, progerin. Although infants appear normal at birth, they quickly develop the classic clinical findings, which include a small face in relationship to head size, a small jaw, dark circles, and a beaked nose. Skin is very atrophic and appears prematurely aged. Prominent scalp veins are present. Children experience loss of body fat and body hair. Children with progeria die of atherosclerotic disease (including heart attack and stroke) at an average age of 14.5 years old. In November 2020, the FDA approved Zokinvy® (lonafarnib), an oral medication that inhibits the formation of progerin, for children 12 months of age and older with progeria. In a study of 62 children with progeria treated with lonafarnib, lifespan was increased up to 2.5 years. Prior to this approval, the only treatment for progeria was supportive care (www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-hutchinson-gilford-progeria-syndrome-and-some-progeroid-laminopathies).

Have you noticed an increasing trend that your pathology laboratory is using more immunohistochemical stains? You are not alone. The use of immunohistochemistry has been increasing with the development of newer and better stains. In dermatopathology, there are increasing trends in the use of these stains for melanocytic lesions. In an article from last year, Dinehart and colleagues studied the use of immunohistochemistry in the diagnosis of melanoma (*J Cutan Pathol.* 2020. 47: 446-50). In this report, they studied all biopsy-proven melanomas in an 18-month period from a single dermatology clinic. Of 356 melanomas, 228 (64%) utilized immunohistochemistry. Of these cases, 60% of melanomas from an academic institution employed stains, and 73% of those from a private laboratory. In a more recent paper from New Zealand, Chen and Hitchcock studied 1,230 cases of melanocytic lesions, benign and malignant, in their laboratory (*Am J Dermatopathol.* 2021. 00: 1-3). Three hundred (24.4%) of the cases utilized immunohistochemistry. This study was performed in a government-funded, not-for-profit laboratory, so there was no financial incentive for ordering more stains.

Why is there so much use of immunohistochemistry with melanocytic lesions? There are multiple explanations including: 1) In amelanotic melanocytic lesions, it is important to confirm the melanocytic lesion lineage using the stains. There is particular benefit in desmoplastic melanoma; 2) The stains assist in distinguishing between an atypical nevus, melanoma in situ, and invasive melanoma; 3) Immunohistochemical stains can assist in identifying lymphovascular invasion in malignant melanoma; 4) In some cases, stains can improve accuracy of margin assessment on melanoma excisions.

While we are seeing this increased utilization of immunohistochemistry in melanocytic lesions, I suspect there is also an increase in other types of cases such as cutaneous lymphoma. In many instances, **the stains improve our diagnostic capabilities and help guide therapy, but at the same time they add to the increasing cost of health care. The development of appropriate use criteria on stain utilization is likely in our future.**

More What's Hot!



Check out more
What's Hot
columns from
the DermWorld
Editorial Advisory
Workgroup at
www.aad.org/dw.



Sylvia Hsu, MD



Kenneth Katz, MD,
MSc, MSCE

Erythema multiforme (EM) is over-diagnosed. **Target-like papules and plaques may be present in morbilliform drug eruptions, leading to the misdiagnosis/over-diagnosis of EM.** Most published cases of drug-induced EM are actually not EM. Using the key words 'erythema multiforme,' a search of PubMed revealed 1,360 articles from 2010 to February 2016 (*Br J Dermatol.* 2015; 175(3): 650-651). In that list, 51 articles had 'drug' or the name of a specific drug and 'erythema multiforme' in their title. Access was obtained to 36 of these articles. Based on the photographs and clinical descriptions, and using the Bastuji-Garin clinical criteria, the reported cases were classified as (1) definite/probable EM (suggestive clinical photograph showing raised typical targets with acral distribution); (2) possible EM (atypical targets or unusual distribution); or (3) 'no case' (widespread eruption, no target lesions, strong suspicion of another diagnosis). Of the 36 papers (with 37 cases), the diagnosis was considered definite/probable EM in six cases (16%), possible EM in seven cases (19%), and 'no case' in 24 (65%). Alternative diagnoses in the 'no case' group included three cases of Stevens-Johnson syndrome, one case of Stevens-Johnson syndrome/toxic epidermal necrolysis overlap, nine cases of maculopapular eruptions due to a drug, and five cases of allergic contact dermatitis.

Concerning drug causality of the six cases of definite/probable EM, the relationship in each case was suggested based on only the time relationship between start of the culprit drug and EM. There were no *in vivo* or *in vitro* drug tests and no author mentioned the possibility of coincidence.

This study shows that confusion on the diagnosis of EM is rampant. Disseminated maculopapular drug eruptions can present with lesions resembling targets, which can mimic EM clinically and there may sometimes be some histopathologic similarities with EM. However, one should keep in mind that EM affects well under 10% of the body surface area; the median involvement of EM is 1% of the body surface area.

Ask dermatologists about vancomycin, and they likely will associate it with "Red Man Syndrome," a term first used in 1959 to describe histamine-mediated reactions, with prominent cutaneous manifestations, to vancomycin infusions. That term is problematic, according to authors of a Perspective in the *New England Journal of Medicine* (2021;14:1283-6).

Like the term "redskin" — the erstwhile mascot of the Washington Football Team — the term "Red Man" has racist connotations, the authors write, reflecting historical narratives pejorative to Native American and Indigenous people. And that's not all. Other concerns with the term include its use of white males as a reference group; its alignment with race-based medicine; and its contribution to under-recognition of cutaneous conditions in non-white populations.

This is not merely a semantic issue. A "Red Man Syndrome" diagnosis is more likely for male patients compared with female patients, according to studies, and for white patients compared with Black patients. Physicians likely would be comfortable treating patients with a "Red Man Syndrome" diagnosis with vancomycin, after pretreatment or with a slower infusion rate. But for patients who had "Red Man Syndrome," but were diagnosed with a less specific "allergic reaction" to vancomycin, physicians might instead choose an alternative, and likely second-line, antibiotic.

What is to be done? Jettison the term, the authors argue, as has been done with Nazi-associated medical eponyms. **The authors instead advocate for use of the non-racist, more clinically useful, and more easily documented term "infusion reaction" for non-immune-mediated drug reactions such as that associated with vancomycin. DW**

Behind the lens



DermWorld takes a look at training and research gaps that impact skin of color patients at www.aad.org/dw/monthly/2021/january/feature-behind-the-lens.



Acetophenone azine: 2021 allergen of the year

By Kathryn Schwarzenberger, MD

In this month's Clinical Applications column, Physician Editor Kathryn Schwarzenberger, MD, talks with Denis Sasseville, MD, and Nadia Raison-Peyron, MD, about their recent Dermatitis paper about the allergen of the year, 'Acetophenone azine.'



Dr. Schwarzenberger: Many of us who love allergic contact dermatitis eagerly await the announcement of the "Contact Allergen of the Year." The 2021 winner is acetophenone azine! I suspect many of our members will not be familiar with this. Can you explain what this is and where our patients may encounter it?

DRS. SASSEVILLE AND RAISON-PEYRON:

Acetophenone azine is a chemical that belongs to the ketazine family, members of which are used as industrial biocides and intermediates in organic chemistry. It was, however, recently identified as a potent sensitizer in a dozen or so cases of severe allergic contact dermatitis from protective shin guards and sports footwear. The culprit objects were padded with ethyl vinyl acetate (EVA) foam that gave strong positive reactions when patch tested. Given that acetophenone azine is not an ingredient in the synthesis of EVA, it is believed to be formed "in situ" through reactions taking place between other additives.



Dr. Schwarzenberger: Is this an allergy we are likely to be diagnosing? When should we suspect it and what other allergens could also be likely suspects?

DRS. SASSEVILLE AND RAISON-PEYRON:

Allergic contact dermatitis from acetophenone azine should be suspected in any patient, often a child, who presents with

dermatitis localized to areas in contact with sports or other equipment padded with EVA. The degree of suspicion is even greater if, when patch tested, the patient reacts positively to a fragment of the padding material but negatively to baseline, shoe, rubber, glues, and plastics series.



Dr. Schwarzenberger: Is acetophenone azine commercially available for patch testing? If not now, do we have any hope that it might be soon?

DRS. SASSEVILLE AND RAISON-PEYRON:

Unfortunately, acetophenone azine is not commercially available as an allergen for patch testing. It can be bought from suppliers of chemical products and mixed in petrolatum at a concentration of 0.1% for patch testing. We have suggested that it should be included in any patch testing shoe series.



Dr. Schwarzenberger: Do you have any tips for managing allergic contact dermatitis in patients in whom you suspect this allergy? Are there alternatives or other ways to avoid exposure?

DRS. SASSEVILLE AND RAISON-PEYRON:

Affected patients need to stop further exposure to the suspected objects and require proper treatment. The initial sensitization is mostly due to shin guards (large area of contact, thin skin, sweating, and friction),

Academy pamphlets



Check out the Academy's patient pamphlets on allergic contact dermatitis at <https://store.aad.org/products/46>.



with subsequent involvement of other body parts exposed to EVA-containing equipment (sport shoes, flip-flops, insoles, swimming goggles, bicycle saddles, etc.). Wearing long socks or layers of clothing under the shin guards may help preventing sensitization but will not afford adequate protection to an already sensitized individual. Patients should seek EVA-free shin guards or other equipment whose padding is made of urethane foam, felt, or silicone. Unfortunately, EVA is used extensively, and a study carried out by the French equivalent of the American FDA revealed that 14% of sampled footwear contained acetophenone azine. It is very likely that an unknown number of patients with foot or anterior leg dermatitis diagnosed as irritant contact dermatitis, or dyshidrosis, are in fact allergic to acetophenone azine.

Q **Dr. Schwarzenberger: How are new allergens like this usually discovered?**

DR. SASSEVILLE: Identification of new allergens initially requires correspondence with the manufacturer of the suspected object or product, to obtain full disclosure of its constituents, and ideally samples for patch testing. Unfortunately, this approach is often unsuccessful, as the industry is notoriously secretive about its manufacturing processes. This is when interactive collaboration between dermatology and chemistry plays a crucial role in the discovery of new sensitizers, as exemplified by the superb detec-

tive work carried out by Dr. Raison-Peyron and her co-workers. The techniques usually employed consist of gas or liquid chromatography coupled with mass spectrometry. These assays are time consuming and costly, and are not readily available or accessible outside of academic centers.

Q **Dr. Schwarzenberger: Who decides which allergen gets the august title of "Contact Allergen of the Year"? Any hints about possible future candidates we might look forward to seeing?**

DRS. SASSEVILLE AND RAISON-PEYRON: The decision to create a journal section titled "Allergen of the Year" was made by the Board of Directors of the American Contact Dermatitis Society (ACDS) more than 20 years ago. Dr. Don Belsito has been spearheading this initiative, and each year announces the winning entry at the annual meeting of the ACDS. For many years, this allergen was selected by the members of the North American Contact Dermatitis Group (NACDG). The selection is now made by a subcommittee of the ACDS, still headed by Dr. Belsito. Any member of the ACDS may submit suggestions of allergens deemed worthy of the title "Allergen of the Year." This allergen is often new or emergent, but "older" allergens (i.e., cobalt, formaldehyde, etc.) may be chosen because of changing prevalence, presence in new sources of exposure, etc. **DW**



Denis Sasseville, MD,
serves in the Division of Dermatology at McGill University Health Centre in Montreal, Quebec, Canada.



Nadia Raison-Peyron, MD,
serves in the Department of Dermatology at the University of Montpellier in Montpellier, France. Their paper appeared in *Dermatitis* at https://journals.lww.com/dermatitis/Fulltext/2021/01000/Acetophenone_Azine.3.aspx.

Dr. Sasseville receives royalties from UpToDate for a contribution unrelated to contact dermatitis. Dr. Raison-Peyron has no conflicts of interest to disclose.

Disclaimer: The views and opinions expressed in this article do not necessarily reflect those of DermWorld.



DermWorld



Don't miss this month's Insights!

In the latest commentaries, Dr. Heymann and the *DermWorld Insights & Inquiries* editorial board address topics including:

- Deep learning in dermatopathology
- Assessing the significance of a long-developed habit:
The role of LDH in dermatology
- Getting to the heart of neonatal lupus erythematosus
- Putting a finger on the diagnosis of Achenbach syndrome

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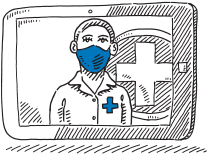
BY **ALLISON EVANS**, ASSISTANT MANAGING EDITOR

Since its beginnings in the late 1960s, telemedicine has been relegated to the periphery of the health care system. Rigid rules around patient location and eligible services, interstate licensure challenges, inconsistent reimbursement models, and other aspects of care have created substantial barriers to telehealth utilization. A novel virus, however, changed everything — and decades' worth of telemedicine policy advocacy was realized in a matter of weeks.

Shortly after most stay-at-home orders were put into place, CMS — under the 1135 waiver — broadened access to Medicare telemedicine services by removing the geographic and originating site restrictions, eliminating state-specific licensure requirements, and supporting payment parity so that physicians and other providers could be compensated for the care provided to Medicare patients regardless of patient and clinician location. Many states and private insurers followed CMS' lead.

“During the public health emergency, telemedicine has been able to bridge the gap and allow access to care to continue without putting patients and physicians at risk, all while saving personal protective equipment for in-person care when needed,” said Jules Lipoff, MD, immediate past chair of the Academy's Teledermatology Task Force and assistant professor of clinical dermatology at the University of Pennsylvania's Perelman School of Medicine.

However, while CMS has the authority to loosen telehealth restrictions during a public health emergency (PHE), without congressional action, these changes are not permanent. >>



Telemedicine in the time of COVID-19... and beyond

Pre-pandemic to public health emergency

“Prior to the pandemic or the public health emergency taking effect, you had to be in a provider’s office in a rural location in order to have reimbursable telehealth through the Medicare program. Therefore, telehealth utilization and reimbursement in Medicare was well below 1%,” said Kyle Zebley, director of public policy at the American Telemedicine Association.

Throughout the pandemic, telemedicine has made up a substantial number of claims for both Medicare and private payers. In early March 2020, more than 50% of Medicare medical encounters were telemedicine encounters. However, the flexibilities that have allowed providers to practice medicine this past year are temporary; they are tied to the declaration of a PHE, Zebley explained.

“There is an incredibly diverse and large body of evidence supporting that telemedicine, and teledermatology, specifically, can be quite effective and equivalent to in-person management, in many circumstances. It was frustrating that before the pandemic, we were not able to advance its use more,” said Dr. Lipoff, who has been an advocate of telemedicine for more than a decade. “Given the millions of patients who have tried telehealth and benefited from it during the pandemic, telemedicine’s importance is clear, and I believe Congress must act to extend and expand telehealth support permanently beyond the public health emergency,” he said.

“There is an incredibly diverse and large body of evidence supporting that telemedicine, and teledermatology, specifically, can be quite effective and equivalent to in-person management, in many circumstances.”



Forming ranks

On the frontlines of the pandemic, read about how dermatologists stand with their medical colleagues to help where most needed at www.aad.org/forming-ranks.

A changing landscape

Currently, 22 states have laws that specifically address telehealth reimbursement, up from 16 states in 2019. A portion of them — 14 states — now mandate true payment parity, up from 10 states two years ago. All but seven states now have some requirement on the books for how commercial insurers should cover and pay for telehealth.

Ultimately, telemedicine needs to be sustainable, said Cory Simpson, MD, PhD, deputy chair of the Academy’s Teledermatology Task Force and clinical instructor of dermatology at the University of Pennsylvania’s Perelman School of Medicine. “We’re expected to provide care for a patient; we’re still liable for it; and we’re dedicating the time and resources to it. There’s just no solid argument for why that shouldn’t be paid for as a normal physician

evaluation and management service if we are evaluating and managing a problem regardless of how it is accomplished.”

“The Academy supports fair reimbursement for telemedicine, and we want telemedicine services to go through the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) process, just like with in-person codes,” said Rachna Chaudhari, MPH, the Academy’s director of practice management. “We support patients accessing telehealth services across state lines if it allows access to a board-certified dermatologist who already has an existing relationship with that patient.”

One major gap in the PHE telehealth flexibilities, said Dr. Lipoff, is that CMS did not expand payment for store-and-forward telemedicine such as shared digital photograph visits. Since there isn’t payment parity for store-and-forward visits, there isn’t the same incentive to adopt the practice, despite the potentially dramatic gains in efficiency.

Nearly all states have lifted restrictions on patients' originating site — which would have required patients to be in a specific clinical setting for virtual visits to be covered. These restrictions prohibit accessing virtual care from home, for example, which became commonplace during the pandemic and made telehealth more accessible for patients. Now, Tennessee is the only state with originating site requirements, although lawmakers have loosened the requirements in a bill passed last year.

“One thing is clear: A doctor's time is a doctor's time, whether it's in person or virtual. When it comes to facility costs and brick and mortar costs, we understand telehealth doesn't have that physical infrastructure by nature,” Zebley said. “We also understand that it takes a strong level of investment to get the technology off the ground and to continue to innovate the technology, so you can't say that there are no costs involved behind the scenes. But we're not getting to the reimbursement issues if we don't first get past this geographic and originating site barrier,” he said.



AADA Telemedicine Toolkit

Access a wealth of teledermatology resources, including how to get started, coding, implementation, and more at www.aad.org/telederm-toolkit.

Teledermatology in practice

Many policymakers and practitioners assume that dermatology is perfect for telemedicine because it is such a visual specialty, said Joseph Kvedar, MD, professor of dermatology at Harvard Medical School and chair of the board of the American Telemedicine

5 considerations for patients when taking teledermatology-ready photos



Exposure

If indoors, use fluorescent daylight or full-spectrum bulbs. If the lighting is dim, consider using the flash in one of the images. If outdoors, use well-lit natural lighting. Avoid shadows and glare in the photos.



Focus

Focus photos by touching the object you want to highlight (e.g., lesion or rash) on the device screen before taking the photo. Use “macro” mode for close ups of a single lesion. Make sure photos are not blurry before submitting them to your dermatologist.



Orientation

Place the camera lens parallel to your skin. Do not angle it up or down. Be sure the lighting does not project the shadow of your device onto the skin.



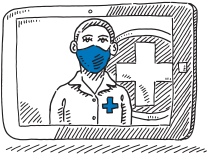
Background

Minimize other objects or patterns in the image background. Use a solid, neutral color wall or clean table for the background and remove “distractions,” like jewelry, clothing, makeup, etc.



Cropping

Take photos from several views, including close-up, medium, and wide-angle pictures. Make sure to show the entire area of skin around the lesion or rash. If it's hard to see, circle it, or draw an arrow pointing toward it with a marker. It may be helpful to place a ruler or coin next to the lesion so that the dermatologist can get an accurate sense of size.



Telemedicine in the time of COVID-19... and beyond

Association. Yet, as many dermatologists adopted the practice of telemedicine for the first time during the pandemic out of necessity, they realized that virtual care can indeed be optimized for effective management of many cutaneous conditions.

At the height of the pandemic, Dr. Lipoff was seeing about 80-90% of patients by telemedicine. “I think it’s going to settle down to somewhere like 15% moving forward, which is still way higher than we were doing pre-pandemic.”

“If you think about a patient who has a known condition like acne, psoriasis, or atopic dermatitis, who’s stable, but needs to check in and get medicines refilled, most physicians will likely agree that it can be done very efficiently through a telemedicine visit,” Dr. Simpson said. “If a melanoma patient wants to utilize telemedicine, that’s very different. You’d be less willing to take the risk if there’s a high chance that you could be missing something malignant in a virtual encounter.”

“Conditions like acne, psoriasis, eczema, and rashes can be handled reasonably well over the video visits,” said Sara Perkins, MD, assistant professor of dermatology at Yale School of Medicine’s department of dermatology, in the July 2020 issue of *DermWorld*. “Telemedicine has also been a useful tool to triage patients. At the height of the pandemic, we had to make difficult decisions about which patients to see right away and which to reschedule, particularly those patients with potential skin cancers,” she said.

Dr. Lipoff and his colleagues published a survey in *JAMA Dermatology* that affirmed some of the assumptions that had been made about dermatologists’ perceptions of teledermatology. The vast majority of dermatologists did not feel comfortable doing

a total body skin exam unless it’s in person, he said. In contrast, almost no dermatologists felt that acne needs to be treated in person (doi:10.1001/jamadermatol.2021.0195).

Video visits for isotretinoin management have been a huge success, said Elizabeth Jones, MD, assistant professor of dermatology at Thomas Jefferson University. “They have saved valuable time for pediatric and young adult patients and their parents as they balance extracurricular activities and school demands. Also, the current allowance of at-home pregnancy tests makes these visits much more convenient for female patients.”

Before the pandemic, only 14% of dermatologists had practiced teledermatology. A few months in, nearly 97% had used it. “While not shocking, this tells us that for the first time, most dermatologists are getting real experience with teledermatology, which will help us figure out what works and what doesn’t,” Dr. Lipoff explained.

A hybrid model

For the most part, practices have returned to seeing patients in person at near pre-pandemic levels, said Chaudhari. “Now, practices are incorporating telemedicine into the practice workflow so that physicians are seeing a mix of in-person and telemedicine patients during the day. It’s more integrated with the practice.”

An individual practice must consider the population it serves, the planned application of use (i.e., consultative, triage, direct care, or follow up), and reimbursement,” said Dr. Jones. “Creating a sustainable model at the outset is crucial to success.”

For a hybrid approach to be effective, dermatologists must have a plan for what conditions and types of patients they’re willing to see virtually, both for the comfort level of the

“Now, practices are incorporating telemedicine into the practice workflow so that physicians are seeing a mix of in-person and telemedicine patients during the day. It’s more integrated with the practice.”

practicing physician and allowing for efficient triaging by office staff, Dr. Kvedar said.

People have noted that there have been issues with both live-interactive and store-and-forward modalities, Dr. Perkins said. “One thing that has been discussed is this hybrid model where you have patients upload photos before their visit, as in the store-and-forward modality, and then you pair it with a live-interactive video.”

Because many teledermatology appointments rely on patient-generated images, it’s important that dermatologists figure out how they are going to accept those images or add them to charts, if not done via an electronic health record system, Dr. Kvedar said. “Our patients submit photos over the patient portal and then we have a nurse check the image quality before the appointment. While this is labor intensive, it actually saves quite a bit of time in the end.”

The *JAMA Dermatology* survey reported that 72% of respondents felt the hybrid model — that combines video and stored photographs — to be the most effective system, although 85% agreed that reimbursement for store-and-forward was too low, said Dr. Lipoff. “We want to make sure that all teledermatology services are adequately compensated, so that physicians can be empowered and able to use them,” Dr. Lipoff noted.

Will Congress carve a path forward?

“We have bipartisan champions on both sides of the aisle,” said Zebley. The House Committee on Energy and Commerce held a hearing on telehealth in March in which everyone agreed about the usefulness and clinical appropriateness of telemedicine.

There are a number of bills that would permanently lift the geographic and originating site barriers that are currently embedded in law — notably, the CONNECT for Health Act of 2021, of which the Academy has expressed its support. “The issue is that it’s very difficult for a standalone bill to pass, and Congress tends to

act on deadlines. The American Telemedicine Association is optimistic that whether it’s an extension of flexibilities or permanency, it’s hard to imagine that members of Congress, President Biden, and HHS Secretary Xavier Becerra would allow these flexibilities to lapse,” said Zebley.



AAD Teledermatology Position Statement

View the Academy’s recently updated Teledermatology Position Statement at www.aad.org/telederm-ps.

Looking to the future

“There is this narrative that people are very happy with the convenience and quality of telehealth and so we won’t go back to where we were pre-pandemic when there was little use of telehealth for patient visits. But that’s an emotional case we’re making, not an economic or legal one,” Dr. Kvedar said.

Indeed, according to the *JAMA Dermatology* survey, 70% of respondents believe teledermatology will continue after the pandemic, but only 58% said they intended to personally continue using it. While telehealth shows real promise in our health care system, there are still many concerns about supportive reimbursement, regulations, and technological innovation, Dr. Lipoff said.

Over the past year and a half, there has been more research published than ever before about telemedicine — and it’s critical that this research continues, noted Dr. Lipoff. “As policymakers consider permanently loosening regulatory restrictions, we should aim to establish a system that amplifies and leverages telemedicine where it can add the most value — by lowering overhead costs and improving access to care.” DW

Using emotional intelligence to guide payment discussions.

Knowing the right time and the right words to say during financial conversations can mean the difference between a patient moving forward with the dermatologic care they need or want.



A big part of the patient experience is emotional, especially when it comes to cost. One of the most important things your team can do is *look at the entire visit through the patient's eyes*. This can help ensure the patient feels heard by a staff who is trained and empowered to

positively impact not only the patient's outcome, but their financial experience as well.

Learning to look for and understand emotional cues can help your team interpret when a patient wants to move forward with a treatment plan but is hesitant about cost. It's all about knowing how to proactively listen, reframe their approach to the discussion, and respond with helpful options. If patients are uncertain how to fit out-of-pocket costs into their budget, offering promotional financing options can help them stay focused on their goals.

If cost is a concern, offering a financing option can help patients stay focused on their goals. For example, if a patient is hesitant when cost is discussed, your staff can share your physicians' qualifications and experience, what sets your practice apart, and offer patient financing options to help them move forward.



Showing you care builds rapport.

Patients often go online to learn more about specific treatments, potential cost and providers. To that end, make sure your web presence is friendly, easy to use and informative. And since the first call to your practice will greatly influence their first impression, look for ways to be reassuring, compassionate and emotionally supportive.

Building rapport is the first step. For example, when patients call, ask what prompted them to contact your practice? Do they want to be seen by the provider for a specific concern? Are they interested in a specific treatment or have a goal in mind but need to know their options? Responding with honest interest shows empathy and builds trust, which are essential for patients to follow through.

Look for emotional cues and respond appropriately.



The way your team interacts with patients has a powerful impact on the patient's overall experience. A tuned-in staff looks at each patient differently, and tends to pay attention to cues and body language. Encourage your team to notice how patients respond when they share additional details about a treatment plan and cost. Some patients may be reluctant to take the next step until a financing option is presented.

Learn how to respond effectively.

Your team, no matter their position, should be prepared to listen and respond to patient cues such as uneasy body language or a change in voice volume and tempo, which may signal a concern. Offering a financing option can help the patient stay focused on their goal. Here's when it helps to assure them you have payment options.



Help put cost into perspective.

For many patients, even a little uncertainty about

their financial responsibility for a treatment plan is enough to keep them from pursuing it. And yet, when patients know a financing option is available, that may be all they need to move ahead with the dermatologic care they need or want.

Presenting the CareCredit health, wellness and personal care credit card as a payment option to all your patients can help increase acceptance of your recommendations.

CareCredit provides a contactless way for patients to apply and pay your practice. They can use their mobile device to scan a custom QR code to learn about CareCredit, apply privately and, if approved, use it to move forward the same day.* They can also see if they're prequalified with no impact on their credit score.

Make it a whole team approach.

A team approach to the financial discussion can help everyone feel more comfortable, and a practice that learns together will be better prepared to educate patients. To help your team feel more comfortable during cost conversations, CareCredit offers resources for enrolled practices, including *"Preparing for Financial Discussions,"* a quick guide with insights and sample scripts.

Key takeaway.

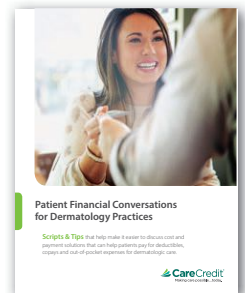
The key to a satisfying patient experience is to genuinely understand what each patient wants and how to respond effectively. This takes a dedicated staff who knows how to integrate details about your doctors' qualifications and experience and what sets your practice apart along with conversations about payment solutions. By focusing on each individual, your staff really can help create opportunities to help patients move forward confidently.

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CMS updates 2021 first and second quarter NCCI edits

By Tiffany E. McFarland, RHIT, Coding Analyst, Coding & Reimbursement

Academy coding staff address important coding topics each month in DermWorld Coding Consult. To read more Derm Coding Consult articles, visit www.aad.org/dcc.

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CMS has released the first and second quarter updates to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits: Version 27.0, which went into effect Jan. 1, 2021, and version 27.1, which went into effect April 1, 2021.

CMS National Correct Coding Initiative edits overview

The NCCI PTP code pair edits are designed to prevent improper payments when incorrect code combinations are reported together for Medicare Part B and most private payer covered services. The NCCI PTP table includes a list of correct code edits for physicians and non-physician clinicians (NPCs).

The table is comprised of a list of Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) code combinations that are mutually exclusive from one another. In other words, if one of those mutually exclusive codes are reported together on the same day by the same physician or NPC for the same patient, one of the services would be bundled into the primary procedure and denied payment.

2021 first and second quarter NCCI coding updates

The NCCI program undergoes continuous refinement. Medicare Administrative Contractors (MACs) implement the new versions effective

Jan. 1, April 1, July 1, and Oct. 1 of each year. While the first and second quarter of 2021 do not have dermatology-related updates or changes, it is important to understand the impact of these updates for the future.

It is vital to the revenue cycle to become familiar with the NCCI Edits to save time and resources for proper claim submission. When CPT code pairs are denied based on NCCI PTP edits, physicians or NPCs cannot balance bill Medicare or Medicaid beneficiaries as this qualifies as an example of incorrect coding practices.

Correct Coding Modifier Indicators (CCMI)

The table is formatted by columns that provide a clear and concise visualization of the code combinations that may or may not be reported together with the appropriate modifiers by a CCMI.

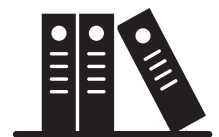
This indicator determines whether an NCCI-associated modifier will permit the code pair to bypass edits. A modifier indicator of a "0" means no modifiers associated with the NCCI may be used to bypass the edit(s), and a "1" means modifiers associated with NCCI may be used to bypass the edit(s) under specific circumstances. See the table below for additional details and examples. More information can be found at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.



CCMI	CCMI descriptor	Code combination example		Rationale	Resolve
		Column 1	Column 2		
0	An NCCI-associated modifier is not allowed and will not bypass the edit	11104	11102	CPT manual or CMS manual coding instructions	Codes with this CMMI cannot be paid for the same patient on the same DOS by the same physician or NPC. <i>Only one primary skin biopsy code can be reported on the same DOS. The punch biopsy is reported as primary code; report an add-on code for the tangential biopsy (e.g., 11103).</i>
1	An NCCI-associated modifier is allowed and will bypass the edit	11102	17000	Mutually exclusive procedures	<i>Edit can be bypassed and the column two code may be eligible for payment if an NCCI-associated modifier is appropriately appended to one of the codes.</i>
9	The use of NCCI-associated modifiers is not specified. This indicator is used for all code pairs that have a deletion date that is the same as the effective date	13100	13153	Misuse of column two code with column one code	This indicator was created so that no blank spaces would be in the indicator field. For example, the edit for code combination 13100 and 13153 went into effect on 05/06/2000 and was deleted on the same day making the edit obsolete.

Also, visit the AADA Coding Resource Center to find practical tips, tools, quizzes, and videos about common dermatologic coding issues at www.aad.org/coding. DW

Academy Coding Ultimate Pack



Achieve coding excellence and avoid costly errors with the Academy's Coding Ultimate Pack. Check it out at <https://store.aad.org/products/13560>.

Moving the needle: Medicare physician payment

By Victoria Houghton, Managing Editor

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

For several years, physicians have endured a 2% Medicare payment reduction as part of sequestration — a component of the 2011 Budget Control Act. However, given the impact of the COVID-19 public health emergency (PHE) on physician practices, Congress suspended the scheduled 2% across-the-board Medicare payment reduction through 2020.

However, by the fall of 2020, it was clear that the PHE would not be over by the end of the year, and that physician practices would need continued relief. In order to extend the moratorium on the 2% Medicare payment reductions, the American Academy of Dermatology Association (AADA) and Academy members jumped into action:

Advocacy priorities



Learn about the Academy's advocacy priorities and how to join efforts to protect your practice at www.aad.org/member/advocacy/priorities.





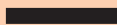
Want to get involved?



Want to learn more about building relationships with state legislators? Academy staff can help. Contact lalbany@aad.org and vpasko@aad.org to learn how you can make the most out of your conversations.



Community care



Considerations for dermatologists when
treating patients experiencing homelessness

BY **EMILY MARGOSIAN**, ASSISTANT EDITOR

Every January, the Department of Housing and Urban Development (HUD) conducts a point-in-time count across the country to gauge the rate of homelessness in the United States. In 2019, HUD identified over half a million (567,715) people in the U.S. living without shelter — marking the third straight year in which the number of people experiencing homelessness had increased.

While the negative economic impact of COVID-19 remains ongoing, the cause behind the country's rising rate of homelessness is both long-term and multifactorial, suggested University of California, San Francisco dermatologist Sarah Coates, MD. "I think foremost is housing unaffordability. That's the number one reason that people are unhoused; they just simply cannot afford housing at the cost that it is currently. We see that not just on the coasts, but in rural areas as well. Income inequality is also a big part. In this country it's hard to earn a living wage for many of our residents. When you combine that with the high cost of housing, it's challenging to make ends meet. Poor mental health, substance abuse, and inadequate health care infrastructure also play a role. That's definitely true of the population that we have here in San Francisco, for example, which is one of the largest unsheltered populations in the states." >>

Although many dermatologists may have limited experience working with unhoused patients, that may be a matter of perspective, according to Erin Amerson, MD, chief of dermatology at San Francisco General Hospital. “I think it’s important to understand that you as a dermatologist are probably caring for people who are experiencing homelessness and you don’t know it,” she explained. “There are different populations of people who manage to hide it. I’ve definitely seen patients who are old enough to be on Medicare, who are insured, and are able to show up for appointments, and you’d never know unless you ask.”

This month, *DermWorld* explores considerations for dermatologists when treating patients experiencing homelessness, including dermatologic conditions commonly seen in homeless populations, treatment challenges and solutions, how to inquire about housing status, and ways dermatologists can improve access to care in their local communities.

Common skin conditions in homeless populations

Dermatologic conditions are often prevalent among individuals experiencing homelessness due to exposure of the skin to the elements and often inadequate clothing and hygiene. Long-term exposure to cold can result in frostbite and pernio. In warm climates, individuals experiencing homelessness often present with severe sunburn, along with heightened rates and more severe cases of skin cancer. “We’ve observed that skin cancers appear to be a bit larger and more advanced at time of presentation,” said Jennifer Tan, MD, dermatology faculty member at Massachusetts General Hospital and the Boston Health Care for the Homeless Program. “We’ve had two patients in recent years who have died from metastatic basal cell carcinoma.”

Environmental exposure and long days standing can also result in wounds and trauma to the feet and lower extremities. “We see a lot of foot infections and tinea pedis,” said Dr. Coates. “We also see non-healing foot wounds, like ulcers. People get ulcers for various reasons, but they have a really hard time healing when they’re on their feet all day long.”

Many patients experiencing homelessness are more likely to have skin and soft tissue infections, often related to lack of access to bathing and hygiene

products. “We often see bacterial skin infections like cellulitis, impetigo, ecthyma, and abscesses. We also see that these infections are often associated with an underlying skin condition. For example, a traumatic wound or injury, venous stasis ulcers, or stasis dermatitis that has not been addressed,” said Aileen Chang, MD, assistant professor of dermatology at the University of California, San Francisco. “We also observe more ectoparasite diseases like scabies, body lice, and arthropod bites.”

An August 2020 *JAAD* study found that homeless patients also experience higher rates of “common” dermatologic diagnoses, such as acne, psoriasis, and eczema when compared to the general population, likely due lack of access to basic skin care products (<https://doi.org/10.1016/j.jaad.2019.09.078>).

According to John Browning, MD, assistant professor of pediatrics and dermatology at Baylor College of Medicine and the University of Texas Science Center at San Antonio, this reflects his own experience working with patients experiencing homelessness. “We certainly see plenty of atopic dermatitis, especially super-infected with staph or strep. We do see some acne too. You would think if you’re homeless, you might not really care about your acne, but we still see people with bad acne who come in and want it treated.”

Treatment challenges (and solutions) when caring for homeless patients

Access to care

Often, homeless patients may not know when or how to seek medical assistance, and both patients and physicians often struggle to navigate a system not engineered for their care. “Unfortunately, the way insurance is structured in our country makes it really hard for people to want to care for these patients,” said Dr. Coates. “I think we have to acknowledge that many dermatologists are in private practices and don’t accept Medicaid, and there are many states that did not expand Medicaid. So many people who are living in abject poverty don’t have access to basic health care and will never get to see a dermatologist.”

One potential avenue for broadening access is to bring dermatologic care directly to vulnerable patients. “We’re lucky, frankly, to live in San Francisco, where we have a really robust safety net

program. We work with our primary care doctors to try to help get someone in social services to help coordinate their care when we can. We also work closely with a street medicine team that goes out and meets people regularly to dispense medications,” said Dr. Amerson. “We also have a telederm program

with the street team where they can upload photos of patients to better meet people at the point of care.”

Dr. Tan agreed that working outside the traditional practice model has been an effective strategy. “I think one of the innovative aspects of our program is providing care directly to where

U.S. homelessness statistics

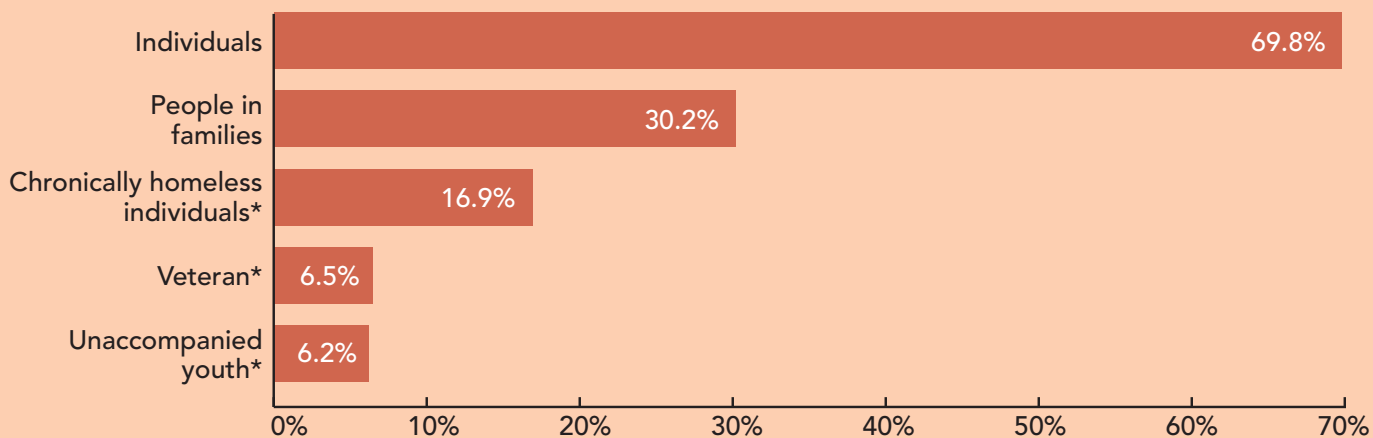


More than half a million people (567,715) experienced homelessness in 2019. That's **17 out of every 10,000 Americans**.

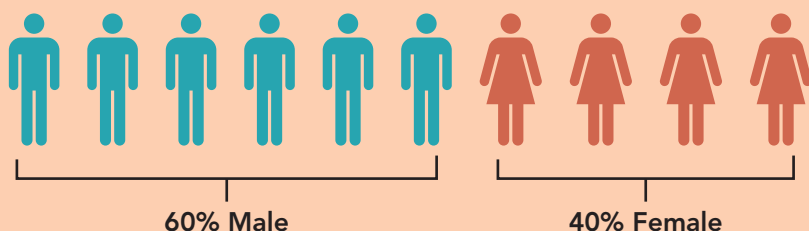


More than 200,000 Americans sleep outside or in other locations not meant for human habitation. Among individuals experiencing homelessness, **1 in 2 are unsheltered**.

People experiencing homelessness in 2019



Homelessness rates by gender in 2019



Homelessness is significantly defined by gender — **60% of all people experiencing homelessness are male**, and among individuals, **70% are men and unaccompanied male youth**.

Source: U.S. Department of Housing and Urban Development
*Subsets of individuals and families experiencing homelessness

patients are comfortable receiving it, which is usually in conjunction with their primary care clinic in homeless medicine, in a shelter-based clinic, or even on the streets. That way, our patients are not displaced and having to come meet us in our dermatology practices,” she said. “I think building trust in this particularly vulnerable population does take extra time. Many of our patients, in addition to the struggle of trying to find daily food and shelter, are also burdened by a history of either violence or abuse and have a general mistrust for the health care system. Bringing care directly to patients in an environment they’re comfortable with can really help.”

Follow-up care

Follow-up care can be particularly difficult when working with patients experiencing homelessness due to a variety of complicating factors. “We have experiences where we say, ‘lost to follow-up’ or ‘not adherent,’ but in reality, you have someone who’s lugging all their worldly belongings across the city every time they have to come to a clinic visit,” said Dr. Coates. “We live in a city that’s seven-by-seven miles — that’s a long distance to travel if you can’t afford bus fare. One thing we’ve been doing is trying to partner with more regional clinics. If there’s a clinic that’s only a block away from someone, they can go there instead and get in touch with us.”

Implementing designated ‘drop-in’ hours during which patients can show up without an appointment is another potential way to improve care continuity. “We’ve found it helpful to say, ‘Okay, we’d like to see you at this time, but recognize that may be challenging. We’re happy to see whenever you can make it during business hours,” said Dr. Chang.

Undiagnosed mental health issues may also complicate treatment and follow-up adherence. The mental health burden of U.S. adults experiencing homelessness is 46% — significantly higher compared to the 18.5% national average. “Our patients who are experiencing homelessness are a very heterogeneous group. There are certainly plenty

who are struggling with mental illness or substance use disorders, that make trying to come up with any kind of care plan challenging,” said Dr. Amerson.

“For scabies, we often learn in training that you should start with topical medicine. In reality, if someone doesn’t have access to privacy or a shower, asking them to put cream on from the neck down, twice, separated by a week is not going to fly.”

Dr. Browning and his colleagues have adopted a unique approach to treating skin cancer in the event that follow up may be unlikely or not possible for the patient. “If we see small basal cells or small squamous cell cancers, we try to do an electrodesiccation and curettage right away so that if the patient doesn’t follow up, we have done a decent first-round job of treating

it,” he explained. “If it’s a large one, or it’s a difficult location, obviously we can’t do that. We do have several Mohs surgeons who are really fantastic who have volunteered their time, and they’ll take off the difficult ones that need it for free.”

One tip Dr. Tan has found helpful in improving patient follow-up is to establish a plan before the patient leaves the clinic. “We’ll try to set up a time for them to come back within a week or two, especially if they have something like a suspected skin cancer, in the event that we might not be able to get in touch with them with biopsy results — their cell phone might be disconnected, or they might not be at the same shelter. Establishing a follow-up plan before patients leave the clinic has been really helpful, we’ve found.”

Achievable treatment plans

Due to limited access to refrigeration, clean clothes, or even privacy to apply topical treatments, dermatologists often must take a creative approach when developing treatment plans for their patients experiencing homelessness.

“Body lice and scabies are really common. Since some people may not have access to running water or clean clothes, one of the things we do in our general dermatology clinic at San Francisco General is keep donated clothing to give to people. You can treat someone for scabies, but if they don’t have any new clothes to wear it’s really hard for them to actually get rid of their infestation,” said Dr. Coates. “We often must consider the factors in a person’s environment

that are preventing them from being able to heal. These may be things that you and I may not think about if we are housed, but are a real struggle if you're not. For scabies, we often learn in training that you should start with topical medicine. In reality, if someone doesn't have access to privacy or a shower, asking them to put cream on from the neck down, twice, separated by a week is not going to fly. Instead, we can treat with oral ivermectin, and that has been much more successful in our experience. That's just one example of how we might modify our plan."

"One of the things that we've been trying to put into practice is minimizing reliance on topical therapy, specifically for persons experiencing homelessness who are unsheltered, which unfortunately is a significant population in San Francisco," agreed Dr. Chang. "Traditionally sometimes we may feel that someone who's experiencing homelessness should not get systemic therapy because we're worried about their ability to take that medicine regularly, or worried about side effects and monitoring. I think all those are still valid concerns, but I've been trying to push myself to really evaluate each patient as an individual and what their circumstances are."

Medication management

Medication management for patients experiencing homelessness can pose a number of logistical challenges. "Can they store their medications in a refrigerator? That's a huge problem for people who are taking biologic drugs, for example," said Dr. Coates. "One way we've addressed this issue is by partnering with local pharmacies to have them store the medication in their refrigerator, and then the patient can come pick it up and get their medication injected in-clinic."

Dermatologists working with homeless patients may also have to take extra time to ensure that medication is secure, and the patient understands how to use it. "When we give out medication, we're not necessarily writing a prescription; we're dispensing it to them. We have to label it and make sure we have their name on a medication bottle with the date," explained Dr. Browning. "We include the instructions spelled out and take a little bit of extra time to counsel them on how to take it, and any side effects that might occur, which is something we typically rely on the pharmacist to do in the United

States. We learned early on that if we just give them a sample bottle without a label or instructions, if they're in a shelter, the shelter will often confiscate it because they don't know if it's something they might be abusing or if it's really theirs."

Inquiring about housing status

While most physicians are not trained to inquire about housing status when taking a patient history, it can be a critical component of their care. "I want to underscore how important it is to ask these questions," said Dr. Amerson. "I can't tell you how many times I have known a patient for months or years and have been shocked to find out they're living in a car because I didn't ask. Regardless of what somebody looks like, you just never know, especially in this day and age."

Although important to screen for patients' housing status, it requires some nuance. Dr. Chang makes a point to give clinical context when she asks a patient about housing status to avoid offending or alienating them. "I really try to frame and explain why I'm asking the question, because it could seem out of the blue if you were to ask someone 'Where are you living these days?' with no context," she explained. "For example, when I see someone who I think has body lice, I might say something like, 'I see that you're really itchy and uncomfortable, particularly on your upper back, the sides of your body, and around your waist. Sometimes when I see that pattern, I think about body lice infestation. Typically, we see body lice infestation in people who have difficulty bathing or aren't housed. Are you experiencing that?'"

While physicians want to avoid making assumptions about a patient's housing status, some dermatologic conditions should prompt a conversation. "When you see things that we know to be associated, like ectoparasitic infestation or nutritional deficiency, that's your inroad to ask gently about housing status," said Dr. Coates.

How can dermatologists get involved?

While the visibility of homelessness may look different to dermatologists depending on where they live, there are several options for getting involved. Physicians can participate in free skin cancer screenings and dermatology clinics in their

local communities. Free care clinics are often the sole means by which unhoused patients can access specialty care such as dermatology. “I think free clinics are certainly something that most dermatologists can engage in. Many communities across the U.S. have free clinics, and a dermatologist who’s interested could ask if they could volunteer their time once a month, depending on the needs of the community, to provide services there,” said Dr. Chang.

Dermatologists in rural areas or locations that don’t have established free care clinics may also consider reaching out to medical respite centers that serve homeless patients. “Respite centers are inpatient facilities for patients who don’t meet criteria for hospital care, but who are too sick to be living on the streets. There are over 100 centers across the U.S., and they have really revolutionized homeless health care,” said Dr. Tan. “The National Health Care for the Homeless Council provides access to a directory of respite centers, which might be helpful for dermatologists who are having trouble identifying a location at which to volunteer.”



COVID-19 skin care and hygiene kits for the homeless

DermWorld spoke with Tufts University medical student Haya Raef, and Jennifer Tan, MD, at Massachusetts General Hospital, about their efforts to create COVID-19 skin care and hygiene kits for the homeless in the Boston and Portland, Maine areas. Read more at www.aad.org/dw/weekly/covid-19-skin-care-and-hygiene-kits-for-the-homeless.

Dermatologists can also leverage their access to basic skin care products to help improve the skin health of their local communities. “People experiencing homelessness have very limited access to over-the-counter supplies that are essential to the management of common skin diseases,” said Dr. Tan. “As dermatologists, we

are uniquely positioned because we have great ongoing relationships with the skin care industry.” In conjunction with the Boston Health Care for the Homeless Program, Dr. Tan and a team of

students and residents began distributing diagnosis-specific skin care kits to treat acne, eczema, and dry skin. “Many times, these supplies or sample-size products are things that we already have in our offices, that may have a limited time frame before they expire. Being able to mobilize these critical supplies to our patient

population has been very appreciated by patients and may be an interesting point of health care engagement.” Expanding on this model, over 1,000 hygiene kits were distributed during COVID-19.

While access to specialty care remains a major barrier for unhoused patients, incorporating education about their care into medical training curriculum may be another step forward toward systemic improvement, suggested Dr. Tan. “I think it’s important to teach trainees how to care for this population and am proud that the rotation is part of the curriculum for our residents,” she said. “It not only familiarizes trainees with homeless health care, but also teaches empathy and may inspire them to care for marginalized populations in the future, which I think is part of the solution to addressing disparities.”

Dr. Browning correlates his own interest in working with homeless patients back to his medical school days, an experience he says has shaped his philosophy as a physician. “My mentors taught me at a very young age that at the end of the day, my job was to provide medical care for people and not judge them for their circumstances. It made me very comfortable working with that population, feeling like I could talk to them and engage with them. They’re just regular people, who may be on the street for a variety of reasons, but at the end of the day, they still need care and help.” **DW**

“My mentors taught me at a very young age that at the end of the day, my job was to provide medical care for people and not judge them for their circumstances.”

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Virtual grand rounds

By Emily Margosian, Assistant Editor

DermWorld talks to Stephen Ostrowski, MD, PhD — dermatology instructor at Harvard Medical School and grand rounds course director for Massachusetts General Hospital’s Department of Dermatology — about the advantages and challenges of hosting virtual grand rounds.

The evolution of education

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Read more about how technology trends have shifted the learning landscape for physicians at www.aad.org/dw/monthly/2019/november/evolution-of-education.

Q **DERMWORLD:** What prompted your department to pivot to a virtual grand rounds format?

DR. OSTROWSKI: It was entirely due to the COVID shutdown. At first, we weren’t sure how long the shutdown was going to last. Once we realized it was going to be prolonged, we polled our faculty to see what they thought would work well virtually. We have always done our grand rounds series in person and really did not have any plans to switch to a virtual format. However, since we couldn’t have in-person gatherings, making the switch to virtual allowed us to restart our grand rounds series about four to six weeks after the first shutdown.

Q Have there been any growing pains or challenges from converting to a virtual series?

DR. OSTROWSKI: I think overall it went smoothly. We use the Zoom program, which is very user friendly. We have an institutional account that we use to set up the meetings; people can log on to other computers, and it is pretty point and click for them.

I host the meetings, so in the beginning I went through and did all the tutorials. They have a lot of good online resources, so you learn all the different functions: how to mute participants if they need to be muted or unmuted, how to monitor the chat screen, how to set up the meetings, and things like that. From a user standpoint, it’s been very straightforward for the participants. They just click the link, and it opens up automatically on their computer.

Q What has the reception been like?

DR. OSTROWSKI: I think attendance is

potentially a little bit higher, particularly for people who are off site. The Harvard dermatology residency training program is multi-site; there are multiple institutions involved, and ours is only one of the institutions. At Massachusetts General, we typically have two grand rounds per month, and the other sites (Brigham and Women’s, Beth Israel, and Lahey) also have monthly grand rounds. Geographically, they’re separate, so usually the faculty members from other programs don’t attend our grand rounds. Since going virtual, I think it’s a little bit easier for people from other sites to attend.

Q Have there been other advantages from moving to a virtual format?

DR. OSTROWSKI: I think that people appreciate the flexibility of it. Normally, the event is an entire morning, so if you’re not going to be on-site that day, you’d come down for the grand rounds. Now if people are doing other things, or if they have clinic afterwards, I think they like that they can just log in and out and do it virtually.

Q Has anything been lost in the transition from in-person to onscreen?

DR. OSTROWSKI: The component of grand rounds that’s case-based, where patients used to come into the clinic and you’d examine them, is obviously missing. As we’re finding clinically, a lot of what we do as dermatologists can’t be done 100% by telemedicine. You have to be able to physically see the patient to really do a proper dermatology examination. For the lectures, I think overall it works well, but sometimes it’s hard to gauge the level of engagement with the audience. With in-person there’s also the added benefit that when we invite speakers, you get to



meet people from outside institutions and network. We've tried to replicate that by planning our virtual visits as we would an in-person visit, which would typically involve individual meetings between our faculty members and the incoming speaker. We've continued that in the virtual format, although the personal connection is a bit lost.

Q How do you ensure patient privacy in a virtual format where others could potentially gain access?

DR. OSTROWSKI: We have a specific mailing list that it's sent to, and it is password protected. We also monitor to make sure that the people who are signing on are part of our program.

Q Does your department post recorded, non-confidential grand rounds for residents?

DR. OSTROWSKI: We've recorded some of them, and it does depend on whether there are any patient privacy concerns, for example whether the patients have been consented for a durable recording. A lot of the talks will include research, so we also take into consideration whether it includes unpublished data, and the comfort level of the speaker for a recording. However, we have recorded a few, mainly only for residents who are unable to attend the grand rounds.

Q Do you have a dedicated moderator for each virtual session?

DR. OSTROWSKI: It fluctuates a little bit. The first week of the month, the grand rounds features an invited outside speaker who comes and gives a lecture. Either I moderate those sessions, or one of the faculty members who helped

invite that speaker will moderate the session. In the third week of the month, we do a patient case-based grand rounds. That would be where we used to have the patients come into the clinic, and then all the physicians would examine the patients and go back and do the case conference. For those sessions, typically one of the residents will moderate with help from one of the attendings, and that format has continued virtually.

Q What are some strategies you use to encourage participation?

DR. OSTROWSKI: As with all virtual meetings, it can be hard to tell if you're engaging the audience or not. I think the invited speakers have done a really nice job. They will sometimes do poll questions, or things like that. We've also tried to incorporate poll questions when the residents do their case conference. A lot of times in person, you'd be polling the audience or asking people to raise their hands on what they think might be the best course of treatment for the patient presented. The residents have done a nice job replicating that virtually, and I think that feature of it is even better than you can do in person, because some people may be hesitant to raise their hand. With the virtual poll questions, you get a really great percentage of people responding to the question, and a nice visual of what all the responses are.

Q How do you prepare before a lecture to ensure there are no technical glitches?

DR. OSTROWSKI: Ironically, I'd say IT was probably a bigger issue in-person because we had physical equipment and would have instances where you'd show up and the computer or the projector wasn't working. The



Stephen Ostrowski, MD, PhD,

is an instructor in dermatology at Harvard Medical School, and grand rounds course director for Massachusetts General Hospital's Department of Dermatology.




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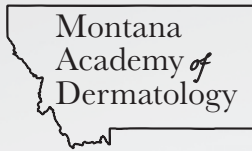
Zoom format has been pretty straightforward. Generally, when I am the host, I set up the meeting ahead of time and with the help of our department administrators send the email links. I usually log on about 15 minutes before, and then invite the speaker or the resident who's presenting that day, and they also log in around that time. We run through things together to make sure they can share their screen, and that their audio is coming through.

DR. OSTROWSKI: Ultimately, our department leadership committee will make a final decision on that, but I think that at least some component of it will be incorporated in the long term. For example, if an invited speaker was unable to make it in-person because of a weather problem, instead of having to cancel and reschedule, hosting virtually might allow us to still move forward with the event. We've also had the opportunity to invite international speakers for our grand rounds, which typically was very challenging before. **DW**

 **Do you think virtual grand rounds are here to stay?**



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Business associate agreements 101

By Daniel F. Shay, Esq.



Every month, DermWorld covers legal issues in “Legally Speaking.” This month’s author is a health care attorney at Alice G. Gosfield and Associates, P.C.

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The Health Insurance Portability and Accountability Act (HIPAA) of 1996 has been a fact of life for physicians for decades. Regulations for the Privacy Rule were first published in 2000, with the Security Rule being published in 2003, and additional modifications published over the years since then. In that time, many physician practices have grown familiar, even comfortable, with aspects of HIPAA and especially the Privacy Rule.

One aspect of the privacy rule — business associate agreements (BAA) — is a familiar term to most physicians, but they may not really understand what it means, when BAAs are necessary, or what a BAA must include. Understanding what BAAs are and how they function is essential because if the business associate breaches its agreement, it can create direct liability for the physician practice, as if it breached the law itself. In this article, we clarify and explain a few misconceptions and address what to look for when presented with a BAA.

When is a BAA needed?

A BAA is necessary when a physician practice (a ‘covered entity’ or CE under HIPAA) enters into a relationship with another business or individual (the “business associate, or BA) where the nature of the services provided by that business or individual *on behalf* of the CE requires or is likely to involve having access to the CE’s protected health information (PHI).

If a contractor is hired to perform services where disclosure of PHI is not limited or incidental, the contractor is a BA, and a BAA is necessary. Examples of these types of services include those provided by billing companies, document storage and retrieval providers, and EHR services. In each case, the services provided involve the disclosure and use of PHI as part of the duties and not merely as an incidental byproduct of the services. The question is whether the services performed on behalf of the CE involve the use or disclosure of PHI in the performance of the contractor’s duties.

Incidental access to PHI does not make someone a BA. For example, janitorial staff are not considered business associates. The types of potential disclosures of PHI that could arise from janitorial work (e.g., seeing PHI in trash cans or on desks) are incidental, occur as a byproduct of the janitorial duties, and could not be reasonably prevented. These disclosures are permitted under HIPAA.

A BAA is also not necessary when the service provider is under the CE’s direct control, in which case they are considered “workforce” under HIPAA, and no BAA is necessary. For example, if a dermatologist had a staffing agency provide front desk staff, the front desk staff would be considered “workforce” under HIPAA because they would be under the direct control of the dermatology practice. On the other hand, if the staffing agency also provided billing services, and those



services were rendered off site at the staffing agency's own office, then a BAA would be required; not for the services of the front desk staff, but for the services of the off-site billers.

A covered entity may also function as a BA for another covered entity. Because a BAA is only necessary when the services are provided on behalf of a CE, this can lead to some confusion as to whether a CE is acting in its own capacity on its own behalf or is functioning as a BA which will require a BAA.

For example, if a dermatology practice refers certain pathology slides to a laboratory, where the pathology lab will analyze the slides and submit claims in its own name for the analysis, such an arrangement would not require a BAA. The disclosure here would be treated as a disclosure between two covered entities for the purpose of treatment and payment; no BAA is necessary. On the other hand, if the dermatology practice hired the pathology lab to perform interpretations for it and the dermatology practice then submitted a claim for the lab services in its own name, the lab would be a BA. In the first instance, the lab is acting on its own behalf. In the second instance, the lab is performing services on behalf of the dermatology practice.

Required BAA elements and what to look for

Most BAAs look very similar, although there are often differences in their details. In large part, this is because the Privacy Rule requires certain core elements in a BAA. If you are reviewing a BAA, you should make sure it contains these elements, or have a knowledgeable attorney review the document.

The BAA must describe the permitted and required uses and disclosures of PHI by the BA, and those uses and/or disclosures may not exceed what the CE itself is permitted to do. The BA may use and disclose PHI for its own management and administration or may perform data aggregation services relating to the health care operations of the covered entity. Data aggregation itself is where data (which may include PHI) is combined and analyzed to determine common patterns. These data can have both clinical and commercial value for CEs and BAs alike.

Note that a BAA may state that the BA may perform data aggregation services, but those services must be related to the health care operations of the CE, not solely for the BA's benefit. For example, if an EHR vendor performed data aggregation on the PHI entered into the EHR by physicians, it would need to

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use that aggregated data for the CEs in some way (e.g., providing clinical decision-making tools that are developed from the aggregated data), rather than to simply use aggregated data for the vendor's own purposes (e.g., to sell to a pharmaceutical company).

The BAA must also specify that the BA will not use or further disclose the PHI other than as permitted under the BAA or as required by law. The BA must also use appropriate safeguards and comply with the Security Rule. It must report to the CE any uses or disclosure of information that the BA learns of, including breaches of unsecured PHI. This should be done as soon as possible, to permit the CE time to meet its own reporting requirements under HIPAA.

The BA must also require subcontractors that create, receive, maintain, or transmit PHI on behalf of the BA to agree to the same restrictions as the BA itself. In essence, this means the BA will pass the terms of the BAA on to its subcontractors.

The BA must make PHI available upon request from a patient and must make amendments and incorporate any amendments made by the CE. It must also provide an accounting of disclosures of the PHI upon request, meaning that it must keep track of such disclosures and provide that information to a patient when the patient requests. These duties are all time-sensitive. Under the HIPAA regulations, these

obligations must be performed between 30 and 60 days from the date of the patient's request, depending on the specific duty. As a result, most BAAs will involve shorter timeframes (e.g., 10-45 days) to allow the CE to meet its own requirements within the regulatory window. Be careful of the timeframes involved.

Other requirements include that a BA must make its internal practices, books, and records relating to use and disclosure of PHI available to the Secretary of Health and Human Services (or their designee), and that, upon termination, the BA must return and/or destroy all copies of PHI where feasible. If this is not feasible, then the BA must maintain the PHI until such time as it becomes feasible, under the terms of the BAA. In practice, this could mean that the BAA obligations will apply forever. For example, if the BA has incorporated PHI into a larger data set that merges the PHI of multiple CEs, it may not be able to remove individual pieces of PHI or destroy them.

Conclusion

The specific requirements and form of BAAs can be complex. While common elements are typical, determining whether and when a BAA is necessary, as well as whether the provisions of a BAA are adequate or required, can be daunting. Experienced health care counsel can help. **DW**

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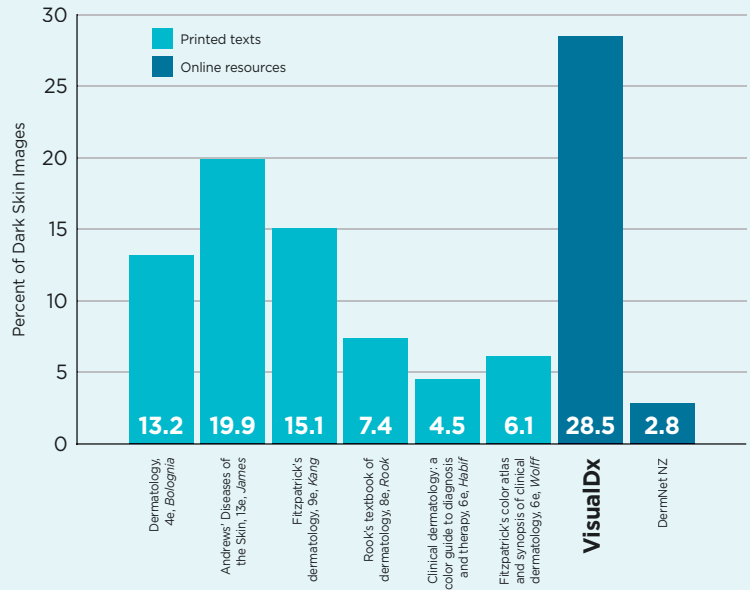
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JAAD (June 2020)¹: “VisualDx demonstrates pathology on dark skin in remarkably high proportion compared to other resources.”

Extent of illustration of dark skin in commonly used dermatologic learning resources for the 65 common dermatologic conditions included in this study.



1. Alvarado SM, Feng H. Representation of dark skin images of common dermatologic conditions in educational resources: a cross-sectional analysis. JAAD (2020). <https://doi.org/10.1016/j.jaad.2020.06.041>. Published June 10, 2020. Accessed June 18, 2020.

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A new frontier?

Experts discuss the role of technology in clinical trials and what the future may or may not hold for dermatology.





BY RUTH CAROL, CONTRIBUTING WRITER

The physical exam is at the heart of clinical trials in dermatology...or is it?

In the future, clinical trials in dermatology will likely be a hybrid of in-person and remote visits, noted Howard Sofen, MD, associate clinical professor of dermatology at Olive View-UCLA Medical Center. Many of the interim visits in select types of trials can be done virtually. >>

A new frontier?

Using either the telephone or computer, remote visits within dermatology trials are becoming more common, stated Andrew Blauvelt, MD, MBA, president of Oregon Medical Research Center. Moving to completely remote trials in dermatology, however, is unlikely because they often require physical exams as well as blood tests. For dermatology trials to go entirely remote, the FDA would have to change its assessment requirements, he added.

In general, clinical trials are expected to move significantly toward including more remote components in the next three to five years, said Orlaith Burke, PhD, Life Sciences innovation portfolio lead at Accenture. Just how fast this move occurs will depend on the need and preferences for participants to interact in person with the physician, she said. Digital devices and artificial intelligence (AI) are already being used to enhance patient recruitment and augment enrollment in clinical trials. Eventually, there is a future vision where trials could be done by algorithm, which could significantly reduce the time it takes to run a clinical trial — from years to hours — and some of these are developments being tested already, she added (see sidebar). For now, Dr. Sofen would be happy to move beyond faxed papers that need to be signed, dated, verified, and filed each time he draws a lab.

Hybrid model will fill a niche

While palpation of the skin and blood tests rule out moving to entirely remote trials, interim visits that don't require taking those measures can be done remotely, Dr. Blauvelt noted. Participants in a study for chronic urticaria, for example, could use an app or website to report the number of hives and/or how itchy the hives are as endpoints in a largely remote trial, Dr. Sofen said.

In theory, blood draws could be done by an office closer to the participant's home, or by a home health nurse, reducing the burden on those who must travel long distances to the study site. But in Dr. Sofen's experience, that option didn't work well. "It sounds

good but when it came down to it, it was a disaster," he said. Dr. Sofen participated in one trial that relied on visiting nurses to do the blood draws; the

primary outcome was the level of a medication in the patients' system. Different nurses went out each time, making it difficult to gauge the quality and consistency of the work being done, and some were unable to go to where some participants lived, creating scheduling issues. "As an investigator, leaving those details up to someone else leaves room for errors," he said.

"The more AI or automation can identify, access, and recruit diverse sample groups for trials, the better."

While Dr. Sofen is confident that his staff perform blood draws among other tasks correctly, signing off for other providers who he doesn't know was uncomfortable from an accountability perspective.

On the other hand, qualitative research, including quality of life surveys, patient in-takes, and symptom assessments, could all be done completely remote, Dr. Blauvelt said. Participants could record patient-reported outcomes measures electronically from their homes.

Real-time data capture

The emphasis on patient-reported outcomes measures in clinical trials within the past 10 years coupled with the growth in AI-enhanced wearable technology could enable participants to track and/or capture data electronically, Dr. Burke pointed out. Today, people use wearable technology to track exercise, heart rates, and sleep patterns as part of their daily routine. The Apple watch has been approved by the FDA as a Class II medical device capable of recording an electrocardiogram (ECG), detecting arrhythmias, and detecting falls, lending itself for possible use in some clinical trials, she said.

Capturing data in this manner could be beneficial for trials in some specialties. For example, collecting ECG and heart rate could be helpful in cardiology studies for primary or secondary endpoints, Dr. Sofen suggested. Patients could be sent a blood pressure device that sends the data electronically and could receive medications in the mail for a hypertension trial, Dr. Blauvelt said.

In dermatology, however, it's unlikely that collecting data this way would be helpful for primary outcomes, Dr. Sofen said. He was involved in a clinical trial collecting data to determine if wrist movement correlated with nighttime itching and insomnia. Technical difficulties made data collection problematic and the results did not correlate with the patient itching, which was the primary outcome, Dr. Sofen explained. These digital methods, however, may be beneficial to collect secondary outcomes or provide interesting adjunct data in dermatology trials, he added.

Virtual props

Although teledermatology has assumed a place in practice, especially during the COVID-19 pandemic, it has limited usefulness for playing a major role in clinical trials, Dr. Blauvelt said. Teledermatology enables the U.S. military to have a dermatologist in Maryland evaluate a rash of a soldier in Iraq, Dr. Sofen said. But that setup requires technical people on both ends to ensure connectivity and quality images. "In the real world, people don't know what to focus on," he said.

Digital devices vs. AI-enhanced technology

Digital devices and AI-enhanced technology may sound like futuristic jabber, but they refer to commonly used items.

Digital devices include:



desktop computers/
laptops/tablets



cell phones/
smartphones

AI refers to the use of computers to mimic human cognitive functions, such as the ability to acquire information, reason, generalize, draw conclusions, and learn from past experiences.

AI-enhanced technology include:



teledermatology



wearable devices



apps

The internet is a commonly used form of communication and information gathering. So are direct email, texting, and social media. All of the above are increasingly being used in clinical trials.

A new frontier?

It's nearly impossible to get the quality of video and/or photography needed to do a true evaluation, and then have it validated remotely, Dr. Sofen said. He participated in one virtual acne trial, which was

successful, but it was difficult to obtain consistent, high-quality photography for assessing skin lesions. The technology would have to improve to pick up skin differences on camera, Dr. Burke agreed.

Endgame: Trials by algorithm

The use of technology could revamp the future of clinical development and transform the trial process from nine years to mere hours, according to Accenture (www.accenture.com/_acnmedia/PDF-107/Accenture-The-Dock-Clinical-Trials-LifeSciences-Aug19.pdf). This would occur in three successive waves.

The first wave will take advantage of new technologies to collect patient data in real time, Burke said. Taking wearable technology to the next level, built-in sensors in clothing, phones, and household devices could collect data from patients, effortlessly and continuously. Placing these small, wireless, self-powered, passive sensors in the participant's body could increase the quality of the data being captured without impacting the user "wearing" them. Many of these tools are passive so the patient wouldn't be burdened to fill out and submit multiple forms, she said. Temporary digital tattoos, which are the next generation of skin patches, are currently being developed to measure ECGs, detect falls, and even release drugs. How the data are tracked and sent to ensure authenticity will need to be addressed, Burke added.

In the second wave, physicians and patients will have access to AI-enhanced digital agents that will be used to direct them to appropriate clinical trials based on patient data, she continued. The agent will then check whether the patient is eligible for any of the suggested trials and provide additional information. Once a patient provides their informed consent, the agent will finish the onboarding process.

This stage will require the standardization of all data collection and management across multiple systems. Paperless management systems will be needed to support the accurate collection of trial information, inclusion/exclusion criteria, and the patient's electronic health record data. As AI technologies mature, agents will be trained to do complex cognitive tasks, such as determining patient eligibility.

In the final wave, AI-enhanced technology will direct patients to appropriate trials, determine eligibility, offer informed consent, and onboard them, Burke said. Decentralized data repositories will securely manage the data obtained from either existing data of patients who are currently receiving treatment or patients who contribute their data based on their medical condition, characteristics, lifestyle, etc. Traditional clinical trials will be replaced with trials by algorithm. As an example, AI-enhanced technology could be used to identify a target for a new medication, run synthetic cohort analyses, capture patient variability within the cohort, model likely interactions of a drug in those patients, and predict the likely outcome of a trial, all based on the data, Burke said. Such simulations are currently in the early stages of use for clinical trial design. HumMod, an integrative physiological model, has been used to create a synthetic control arm by replicating the findings of clinical trials evaluating how different human organs, such as the liver or kidney, interact with different drugs, she explained. This brave new trial world could boost patient participation as well as reduce patient risk and trial costs.

Recruitment and enrollment

Digital devices and AI-enhanced technology could help cast a wider net for recruitment, Dr. Burke said. An estimated 86% of clinical trials fail to meet recruitment goals within their proposed timeframe, so any improvement would help. “The more AI or automation can identify, access, and recruit diverse sample groups for trials, the better,” she said. The caveat is that everyone must have access to baseline connectivity. “Assuming that access to baseline connectivity grows, so will the diversity of the patient population that can be accessed,” she added.

The pool of participants would grow, but only for individuals who are internet savvy, which is a fraction of the people out there, Dr. Sofen said. “Some people are very adept at logging into the internet, but the vast majority of the population either doesn’t have access to a computer or the ability to navigate the internet. They are lucky to have cell phones,” he added. The lack of quality internet access and optimal camera equipment complicates reaching potential candidates in rural areas as well.

In Dr. Blauvelt’s experience, social media advertising campaigns don’t increase enrollment in significant numbers. “They’re not very effective because the majority of people who express interest end up not being good candidates. It’s just a wider pool of people to wade through and reject,” he said.

“Virtual recruitment may sound good, but I’ve never found anything that replaces my sitting down and talking to a patient,” Dr. Sofen added.

Augmenting enrollment with automation could make the various steps more efficient and patient centric, Dr. Burke said. AI-enhanced technologies could help identify eligible patients, obtain informed consent, onboard them, and accurately collect trial information either from the patient or the patient’s electronic health record data. Informed consent could be simplified and accelerated by using an electronic consent platform, sometimes referred to as eConsent. “Core to the feasibility of digital control trials will be tenets around ownership of data, patient consent, and data security,” Dr. Burke emphasized. “The patient needs to know who has visibility of their

data, what they are consenting to, and who has access to their data. The data has to be secure.”

Crowdsourcing — an open call for voluntary assistance from a large group of individuals — could potentially be harnessed to increase the speed and efficiency of data collection for clinical trials. Crowdsourcing was helpful in gathering information about COVID-19, especially in the beginning of the pandemic when information was rapidly evolving. As an example, the COVID-19 Dermatology Registry was launched in March 2020. There are also registries focused on psoriasis, atopic dermatitis, hidradenitis suppurativa, and alopecia, among others. Dr. Sofen believes that crowdsourcing would be most helpful for long-term, large, population studies, but not for dermatology trials because they tend to be small. Most Phase II dermatology trials seek to recruit only 100 participants and Phase III trials seek 1,000 participants, he said. Crowdsourcing can be helpful with the caveat of the inherent bias in people who volunteer, Dr. Burke added.

In theory, remote trials would be less expensive. However, investigators may have to provide patients with technology, such as a smartphone, broadband, or even basic WiFi, Dr. Burke said. Trials could be cheaper if lab tests are performed in a reliable manner and medications are shipped to the participant’s home, Dr. Sofen said. But remote trials put more burden on the site staff to coordinate them. Investigators will need a data strategy to manage and clean the data to ensure they are collecting only the data they need.

Ultimately, patient preference will have a lot to do with the progress of remote trials. “There is a large hands-on personal component for patients participating in a clinical trial,” Dr. Sofen said. They need to have in-depth conversations with the physician and/or coordinator. The potential downside of remote trials is an increased risk of depersonalization as interactions increasingly occur via technology, Dr. Burke said. Technology cannot entirely replace the human interaction, support, trust, and care provided by visiting a physician’s office, she concluded. **DW**



Kenneth J. Tomecki, MD



Members beyond detection

‘Under the radar’ (i.e., ‘going unnoticed’ or ‘avoiding unnecessary attention’) — all phrases that define a few Academy members who simply ‘go about their business’ and more without fanfare, notoriety, or attendant accolades. They just simply do what they choose to do for the greater good, either for patients, family, friends, or their communities, sometimes doing so distantly. These folks deserve our quiet applause, our gratitude, our heartfelt thanks for all that they do. A few examples of members working and contributing under the radar:

Genette Okoye, professor and chair of dermatology at Howard University, served as the medical lead for Howard’s COVID-19 community testing initiative last year in an underserved neighborhood in northeast Washington, D.C. When the pandemic temporarily closed the Howard dermatology clinics, Dr. Okoye recruited staff and dermatology residents to establish a free community testing site, where residents had quick, easy, open access for COVID testing four days/week. Given that success, a second testing site opened in a nearby church, followed by an employee testing site at Howard, all of which followed her initial strides to provide testing for D.C. residents in an underserved area of the city. Amy Derick, Chicago-area dermatologist, collaborated with a nearby health system earlier this year

to provide COVID-19 vaccinations for more than 1,500 physicians in need. Louis Kuchnir, a Boston-area dermatologist, did likewise. Working with local school superintendents, he established a COVID-19 vaccination site at his office for eligible school nurses from eight local school districts in Grafton, Marlborough, and Waltham, Massachusetts.

Richard Huggins, a dermatologist at Henry Ford Health Systems, is the medical director of the largest local vitiligo support group in the country: V Strong Detroit. He founded the group and has missed only one meeting since 2009. He chairs the patient support programs for Global Vitiligo Foundation (GVF), and he recently created and oversees GVF Student Allies, a group of 20+ medical student volunteers across the country who assist and coordinate support group activities. Given that commitment, Dr. Huggins was named Man of Excellence in 2016 by local news media and honored twice as faculty humanitarian by Henry Ford dermatology residents.

Marc Inglesee, a Tallahassee dermatologist and former FSDDS president, is frequently the go-to person for interview and testimony at the state capitol whenever dermatology-related matters arise for consideration, debate, or commentary, when politicians and lawmakers need to hear from a dermatologist on legislation. When asked, Marc is invariably available for

Academy volunteerism opportunities



Check out AAD volunteerism opportunities at www.aad.org/member/career/volunteer.



commentary, testimony, or simply an opinion as resident derm advocate in Tallahassee. As such, he has regularly helped the specialty and his colleagues in Florida. Thanks, Marc.

Jun Lu is a dermatologist at UConn Health who recently began providing telemedicine/derm evaluations at York Correctional Facility for incarcerated women. She provides the service with Tara Hood, a nurse-clinician at the Connecticut Dept. of Corrections. “Our partnership fills a major need,” said Dr. Lu, providing “safe, convenient care in an accessible location,” especially important during COVID times. Both Dr. Lu and Ms. Hood were recognized by AAD last year as ‘patient care heroes.’

In the derm political arena, two individuals really deserve a round of applause: Kelley Pagliai Redbord and Bruce Brod. Kelley is a tireless advocate for health care reform, especially at the state level, primarily via the Academy GAHP Council and Congressional Policy Committee which she chairs. She is relentless, amazingly versed, and always willing to roll up her sleeves and tackle tough issues, which she has done for more than 10 years. Bruce is another dedicated and tireless advocate who practices what he preaches. He currently chairs the GAHP Council which orchestrates AADA responses to all federal and state legislative and regulatory issues that face the specialty. He has

been active in his state (Penn.) and testifies about scope of practice and tanning legislation at the state and federal levels on a regular basis. He is often the derm voice ‘on the Hill.’ Kelley and Bruce are the designated derm combatants in the D.C. arena.

Vinh Chung, dermatologist in Colorado Springs, has a truly remarkable story. Born in South Vietnam soon after the country fell, he and his family crossed the South China Sea. Dr. Chung and family ‘made their way’ to the states where he obtained a medical degree and a master’s degree in theology. His memoir, *Where the Wind Leads*, outlines his approach to work, exemplified by his manner and approach to life, specifically dermatology. He has touched many individuals (e.g., family, friends, employees, and especially patients), exhibiting joy and inspiration to many less fortunate. I learned about Dr Chung and his six tips for finding derm joy from Mark Kaufmann, current AAD president-elect.

Those are only a few individuals who have made a difference within the specialty, quietly, yet effectively, without fanfare or notoriety. They deserve our gratitude and applause. More to follow. Stay tuned.

Input for this column provided in part by Drs. Cheryl Burgess, Linda Stein-Gold, Andy Weinstein, Kelley Redbord, and Bruce Brod. DW

Become a mentor



Learn more about the Academy’s mentorship programs at www.aad.org/member/career/li/become.



What volunteer opportunities does the Academy offer members?

By Stacia Johnston, Member Communications Specialist

DermWorld digs into an issue that is affecting the specialty and discusses the Academy's key activities to address and advocate on the issue.

We know our members are busy managing their practices, taking care of patients, exploring networking and continuing education opportunities, and tending to family and social lives. While it can be hard to find time to volunteer, research indicates that volunteering reduces stress, combats depression, and, simply put, makes you happy.

Now that you're sold on volunteering, take a look at some of the ways you can get involved with the Academy's volunteer opportunities.


 **Academy councils, committees, and task forces**


Get involved in setting the strategic direction of the Academy by joining a council, committee, or task force. Submit your applications next April.

 **Academy Advisory Board**

The AB deliberates on members' proposed resolutions, and if approved, proposes them to the Academy's Board of Directors for consideration.

 **Camp Discovery***
Volunteer your time with the AAD's summer camp program and help children with skin diseases.

 **Mentorship program**
Use your expertise to guide the development of a young physician on issues related to clinical care, business, and more. You can even counsel medical students from minority backgrounds who are considering a career in dermatology.

 **Shade Structure Program**
Sponsor public schools and non-profit organizations in need of shade structures for outdoor locations that are not protected from the sun.

 **Skin Cancer Screening Program**
Conduct free skin cancer screenings in your community, joining those who have provided nearly three million screenings.

Be a part of the inspiring effort among dermatologists dedicated to helping patients, communities, and the specialty. Learn more about these volunteer opportunities and others at www.aad.org/member/career/volunteer. **DW**

**Due to COVID-19, Camp Discovery will be virtual for the summer 2021 sessions.*

Academy volunteerism opportunities



Learn more about AAD volunteer opportunities at www.aad.org/member/career/volunteer.



How can I get involved in the AADA's Virtual Legislative Conference?



Dermatology advocates, mark your calendar for this year's AADA Virtual Legislative Conference, which will take place Sept. 23-28.

Registration for the conference is open now! To learn more, visit www.aad.org/member/advocacy/leg-conference.

Like many others, in 2020 the AADA Legislative Conference converted to a fully virtual format to adapt to the needs of the COVID-19 era. Despite the transition from in-person to on-screen, last year's AADA Legislative Conference broke attendance records.

This year's virtual event will bring together dermatologists, dermatology residents, patient advocates, and practice administrators to advocate on top-priority issues affecting the specialty. 2021 attendees can expect:

- Education about health policy issues through webinars and on-demand videos.
- Networking with other physicians from their state.
- Opportunities to meet with their members of Congress via video call to discuss issues affecting dermatologists and their patients.

The AADA Virtual Legislative Conference is open to all U.S.-based Academy members. **DW**

Missed last year's event?



Get a recap of the AADA's record-breaking impact on Capitol Hill in 2020. Read more at www.aad.org/member/advocacy/leg-conference/2020-recap.



Looking for more answers?

Send your burning questions to *DermWorld's* Asked & Answered column at dweditor@aad.org, and keep an eye out for the answer in an upcoming issue of *DermWorld*!

Dermatology residency memories

By Arthur L. Norins, MD

DermWorld's First Person column offers Academy members the opportunity to share their personal reflections about how dermatology is changing and how they've adapted.

Got a story to tell?

.....



DermWorld's First Person column is the place to tell it. Share your personal reflections about how dermatology is changing and how you've adapted.
Email dweditor@aad.org.

The American Academy of Dermatology meeting was scheduled in Chicago the first week of December 1956. The meeting was held at the Palmer House Hotel located just inside the downtown Loop. Northwestern University Medical School was not far from the hotel. The University allowed the Academy to have dermatopathology teaching sessions at the Medical School site. The facilities were excellent, including the availability of microscopes. The Northwestern residents gathered and set up the microscopes. I was one of those residents.

Earlier that year, I was a pediatric resident at the University of Michigan. We were allowed to take a one-month elective; I choose dermatology. It was an excellent month that gave me a quick look at the field; I attended rounds and clinics. During those years we had military obligations. I had enrolled in the Berry Plan which allowed me to take my pediatric residency before active duty. After much thought, I made a big decision to switch my career to dermatology, and hoped the Army would approve. After getting approval from Dr. Curtis to start in the Michigan dermatology program, I wrote to the Army to get their approval; the answer came quickly: "NO; you will get orders to report for active duty in July." I finished my year in pediatrics and returned to my home in Chicago to await orders.

I had received my medical degree at Northwestern. There, I had taken a course in dermatology taught by Dr. Herbert Rattner, the dermatology program director. I told him of my interest

in dermatology and asked if I could follow the residents around for the weeks before the Army called. During the second week of observing, I received a letter from the Army: "We are pleased to allow you to take a three-year residency in dermatology before active duty." Dr. Rattner was very kind and let me officially join the Northwestern residency program.

The next couple of months were busy. Department meetings were exciting. Northwestern had no full-time faculty; but it did have a large clinical faculty that would come to help in the clinics. There were many excellent practitioners and willing teachers. There was a monthly department meeting. The room was always packed. Cases were discussed. Dr. Rattner was the editor of the *AMA's Journal of Dermatology and Syphilology*. He would present many of the papers that had been submitted for publishing. At that time, it was the only dermatology journal. Each paper would get discussion from the group. That kept the department members about six months ahead of publication.

There was excitement in their talk of the upcoming Academy meeting. Northwestern was about a fifteen-minute bus ride from the Palmer House. It was convenient to have the dermatopathology meetings there in that the microscopes did not have to be transported to the hotel. Many of our faculty would be participating in courses and giving lectures at the meeting. All the residents were able to attend.

Dr. Rattner explained that there were many reasons for having a December meeting in

Chicago each year. There was not much flying back then; most members came by train. A central location was desirable. The time, several weeks before Christmas, seemed strange. It proved to be excellent because of generally low patient office visits that made it conducive for most members to leave their practice. A high percentage of members who came actually spent their time in the meetings. The first winter storm of the year helped. Back then, most members were male; they were often joined by their wives. The wives were attracted to Marshall Fields, a large, well-known upscale department store just one block from the hotel. Much of their Christmas shopping took place then.

Most important, the meeting was valuable because of content; there were many small and specific topic breakout sessions as well as larger sessions devoted to current advancements. The Academy was proud that such a large percentage of the members throughout the country came to the meeting and actually attended the sessions. It was the envy of other medical societies. In later years in my residency, Dr. Rattner invited me and my wife to join him and his wife at the dinner dance that was a social highlight of the meeting. During the evening, the orchestra would play songs from the different states; the members from those states would stand, give a whoop, and wave their handkerchiefs. Importantly, the Academy was known to allow residents to attend the meeting and all the teaching sessions. Most programs allowed their

senior year residents to attend. This created a solid bond between the Academy and future dermatologists. It was years later when the Academy voted to have the meeting at a different site, the Americana Hotel in Miami.

Those were the years when “preceptorships” were allowed in a resident’s third year. One would spend half of their time in the clinics at a university and the other half in one of the faculty member’s personal office. It was an honor to be invited into a preceptorship. One got to see what office practice was like. Dr. Rattner got approval from the Board for me to have my preceptorship start in his office in my second year. His office was on Michigan Avenue across the street from the Chicago Art Institute. When morning clinic at the university was over, I took the bus to the office. If there was a little time before office hours, I would spend it in the Art Institute. That was the best way to take in a wonderful museum — just one room at a time, not rushed — enjoying the artwork for 30 minutes. Then go across the street to the office. (Especially good, since the museum visit back then was free.) Next time, I got to visit another room, of a different period, and discover another artist.

Dr. Norins currently resides in Cupertino, California. Continue reading more of his dermatology residency memories at www.aad.org/dw/monthly/2021/july/first-person. DW

Read more



Continue reading more of Dr. Norins’s dermatology residency memories at www.aad.org/dw/monthly/2021/july/first-person.

AAD Board selects Keyvan Nouri, MD, MBA, FAAD, as next assistant secretary-treasurer



Keyvan Nouri, MD,
MBA, FAAD

The Board of Directors of the American Academy of Dermatology held its first-ever hybrid meeting on May 15, with many members of the Board gathering in person for the first time since the start of the COVID-19 pandemic.

At that meeting, the Board selected Keyvan Nouri, MD, MBA, FAAD, as the Academy's next assistant secretary-treasurer. He will succeed Daniel D. Bennett, MD, FAAD, for a three-year term that will begin at the conclusion of the March 2022 Annual Meeting. (Dr. Bennett will become secretary-treasurer at that time.) Dr. Nouri is Louis C. Skinner, Jr., MD Endowed Chair of Dermatology, Richard Helfman Professor of Dermatologic Surgery, chair of the University of Miami Medical Group, and director of Mohs, dermatologic, and laser surgery and director of surgical training for the University of Miami department of dermatology. He completed his dermatology residency at the University of Miami followed by Mohs/Dermatologic surgery fellowship at New York University. Dr. Nouri has published 12 well-known textbooks in dermatology/dermatologic surgery, currently serves as editor-in-chief of *Lasers in Medical Science*, and is a member of the AAD's Advanced Leadership Forum Workgroup, having previously served on the Education and Volunteers Abroad Committee and World Congress Fund Review Task Force.

The Board approved "Measuring Improvement in Psoriasis and Dermatitis: The Development of Pruritus Clinical Quality Measures" for publication in *JAAD*, which is a step toward making two pruritus quality measures available for use by more clinicians within the MIPS program.

The Board updated an administrative regulation to ensure that the two candidates the Board of Directors and Advisory Board consider each year to represent them at the Nominating Committee will not work for the same institution or practice. All administrative regulations are available online at www.aad.org/Forms/Policies/ar.aspx.

The Board approved an updated, five-part professionalism and ethics pledge; members can learn more and take the pledge at <https://account.aad.org/EthicsPledge>.

The Board also approved an Advisory Board resolution that requires the use of video conferencing software for Academy Council, Committee, and Task Force conference calls.

The AAD Association Board of Directors approved an Advisory Board resolution that opposes restriction by pharmacists and insurance carriers of off-label prescribing of medications.

Before you register...



Please note that Maritz Global Events is the official AAD Housing Provider. You should only make your housing reservations through the AAD Meeting website. Need more information? Visit www.aad.org/dw/monthly/2019/october/asked-and-answered-academy-legitimate.

Register for the 2021 AAD Summer Meeting

Join the Academy in Tampa, Aug. 5-8, for the 2021 AAD Summer Meeting. Gain insight into the latest clinical information, practice trends, new techniques, and emerging products. Learn more about registration and housing and visit www.aad.org/member/meetings for program updates.





Submit nominations!

The Academy is seeking nominations of qualified members to be considered for officers, directors, and nominating committee member representatives in the 2022 AAD election.

View reference materials, and submit nominations and letters of support at www.aad.org/aadnominations.

For more information, send an email to callfornominations@aad.org or contact Joan Tenut at (847) 240-1046.

REQUIREMENTS

 <h4>President-elect</h4> <ul style="list-style-type: none"> • Must have served one year on Board of Directors • Fellow in good standing • Three-year commitment • Divestment required • Term begins close of 2023 Annual Meeting <p>2022 AAD election activities</p> <ul style="list-style-type: none"> • Pre-election interview • Five (5) minute videotape speech which mirrors live speech during Annual Business Meeting • Officer Town Hall event • Post-election interview with successful candidate 	 <h4>Vice President-elect</h4> <ul style="list-style-type: none"> • Must have served one year on Board of Directors • Fellow in good standing • Two-year commitment • No divestment required • Term begins close of 2023 Annual Meeting <p>2022 AAD election activities</p> <ul style="list-style-type: none"> • One-minute videotape statement • Officer Town Hall event • Post-election interview with successful candidate
 <h4>Board of Directors</h4> <ul style="list-style-type: none"> • Four-year commitment • Fellow in good standing • No divestment required • Terms begins close of 2023 Annual Meeting <p>2022 AAD election activities</p> <p>Forty-five second videotape statement</p>	 <h4>Nominating Committee Member Rep.</h4> <ul style="list-style-type: none"> • Two-year commitment • Must be from West Region • Term begins close of 2022 AAD Election <p>2022 AAD election activities</p> <p>Thirty second videotape statement</p>

Nominating Committee

Mark Lebowhl, MD, FAAD, Chair
 Craig N. Burkhart, MD, MPH, FAAD
 Brett M. Coldiron, MD, FAAD
 George W. Elgart, MD, FAAD

Molly A. Hinshaw, MD, FAAD
 Julie A. Hodge, MD, MPH, FAAD
 Sara Moghaddam, MD, FAAD

UNAUTHORIZED MEMBER ACTIVITIES

No member of the American Academy of Dermatology shall directly contact any member of the Nominating Committee regarding nominees under consideration. Any lobbying of committee members **may eliminate** the nominee from consideration by the Nominating Committee.

No nominee, slated nor write-in candidate(s), may engage in any campaign activities prior to the official announcement of the slate of candidates on March 1, 2022. Both slated and write-in candidates should discourage others from campaigning on their behalf prior to the slate announcement. Violation of this rule **may result in disqualification** of the candidate.

PRESIDENT-ELECT AND VICE PRESIDENT-ELECT CANDIDATES MUST AGREE TO ABIDE BY THE FOLLOWING EXCERPT FROM THE RESTRICTIONS ON AAD/A OFFICERS AND JAAD EDITORS

The president, president-elect, vice president, secretary-treasurer and assistant secretary-treasurer shall not serve in a leadership position (officer) or on the executive committee of another national dermatology professional society,¹ or dermatologic disease focused organizations² as such simultaneous service may pose significant conflicts of interest for such AAD/A officers. The president, president-elect, vice president, secretary-treasurer and assistant secretary-treasurer should not be precluded from serving on charitable or non-profit organizations not related to dermatology.³

The directors shall not have the same prohibitions as the president.

¹ Such organizations include, without limitation, the American Osteopathic College of Dermatology, American Society for Dermatologic Surgery, American Society of Dermatopathology, American Society of Mohs Surgery, Medical Dermatology Society, Society for Investigative Dermatology, Society for Pediatric Dermatology, Women's Dermatologic Society, American Board of Dermatology, American College of Mohs Surgery and the American Dermatological Association. The Board of Directors may modify this list from time to time.

² Including, for example, the Coalition of Skin Diseases and the National Psoriasis Foundation.

³ Including, for example, the American Heart Association, American Red Cross, United Way, Humane Society of the US, and Salvation Army.

PRESIDENT-ELECT CANDIDATES MUST AGREE TO ABIDE BY THE FOLLOWING EXCERPT FROM THE ADMINISTRATIVE REGULATION ON CODE FOR INTERACTIONS WITH COMPANIES

1.4. No Key Society Leader, defined for purposes of this Code as the Presidential-level of a Society's membership organization (e.g., the President, President-Elect, and Immediate Past President as applicable) may have Direct Financial Relationships with Companies during his or her term of service.

Direct Financial Relationship⁹: A Direct Financial Relationship is a relationship held by an individual that results in wages, consulting fees, honoraria, or other compensation (in cash, in stock options, or in kind), whether paid to the individual or to another entity at the direction of the individual, for the individual's services or expertise. As used in this Code, the term Direct Financial Relationship does not mean stock ownership or intellectual property licensing arrangements.

¹¹ **Definition:** A Direct Financial Relationship is a compensated relationship held by an individual that should generate an IRS Form W-2, 1099 or equivalent income report. Key Society Leaders (including the President, President-Elect, Immediate Past President, the Secretary-Treasurer, Assistant Secretary-Treasurer, the chief executive officer of a Society's membership organization, and the Editor(s)-in-Chief of Society Journal(s)) may provide uncompensated service to for-profit health care products companies ("Companies") and accept reasonable travel reimbursement in connection with those services. Key Society Leaders may accept research support as long as grant money is paid to the institution (e.g., academic medical center) or practice where the research is conducted, not to the individual. Exception may be made in certain circumstances for provision of consultant or investigator expertise related to protocol development and/or safety monitoring or any other consulting work related to one's own past, current or potential research studies as long as the activities are not related to marketing or promotional efforts. In this event, the Secretary-Treasurer must be provided with background information and approval must be provided in advance for an exception to the policy. In these circumstances, compensation to the individual may not exceed \$10,000/company/year. Verifying 1099 forms must be submitted to the Secretary-Treasurer when received. **This exception may not be applied to the President, who shall remain free from any and all direct financial relationships during his/her term of office.**



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SALES INFORMATION

UPCOMING DEADLINES FOR 2021 ISSUES:

- September August 5
- October September 2
- November October 7
- December November 4

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Medicine approaches gender parity; falls short of racial and ethnic diversity

By Emily Margosian, Assistant Editor

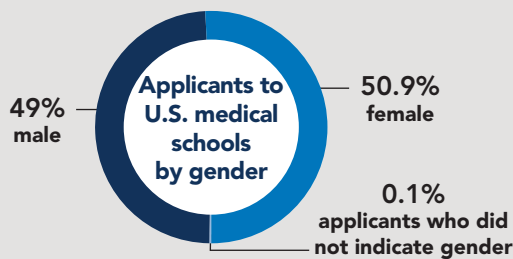
Every three years, the Association of American Medical Colleges (AAMC) releases a statistical report in combination with data from the American Medical Association (AMA) on diversity in medical education and the physician workforce in the United States. According to the most recent report, diversity among medical school applicants, matriculants, and graduates has continued to grow. However, gains in diversity were not shared by all groups.

AAMC data also indicated that medical school faculty continues to be predominantly white (63.9%) and male (58.6%), particularly so at the professor and associate professor ranks, and there remains persistent underrepresentation of racial and ethnic minority groups and women in medical school faculty positions. Like faculty demographics, most active physicians are white (56.2%) and male (64.1%). However, according to AAMC data, among the youngest cohort of active physicians (34 years of age and younger), women outnumbered men in most racial and ethnic groups.

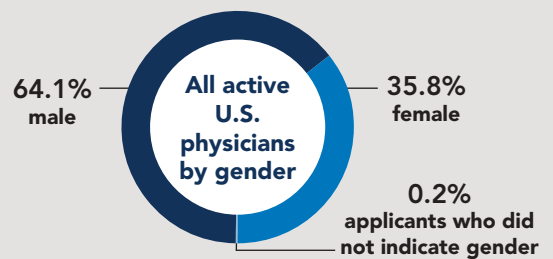
See the graphic below for an expanded breakdown of the current race and gender demographic trends in undergraduate medical education and the physician workforce. **DW**

U.S. diversity in medicine: 2018 – 2019

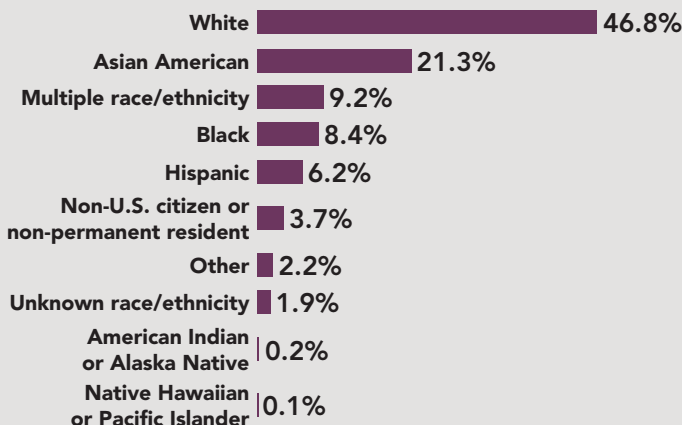
Undergraduate medical education



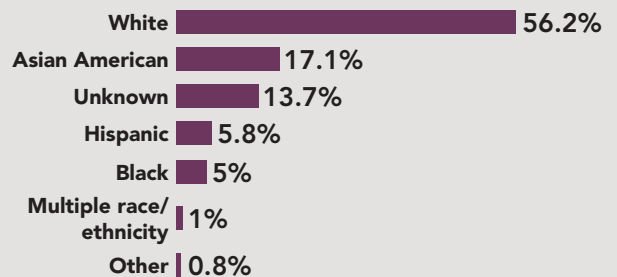
U.S. physician workforce



Applicants to U.S. medical schools by race/ethnicity



All active U.S. physicians by race/ethnicity



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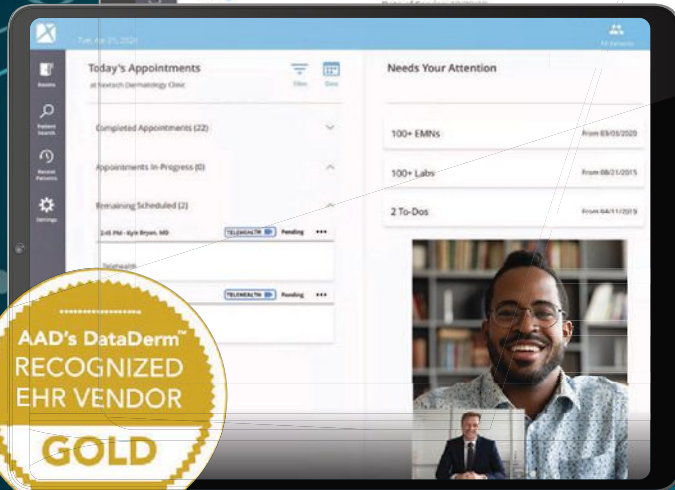
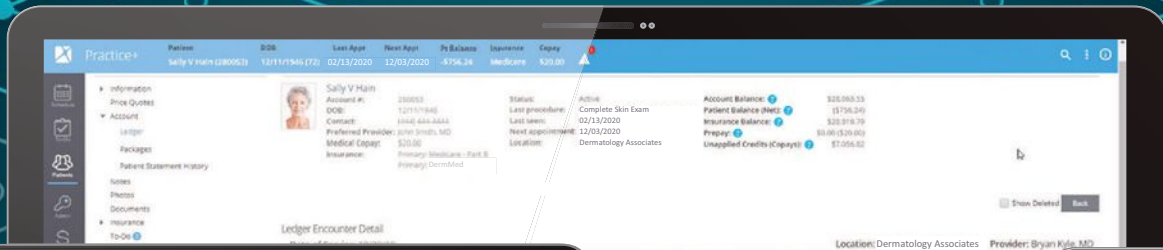
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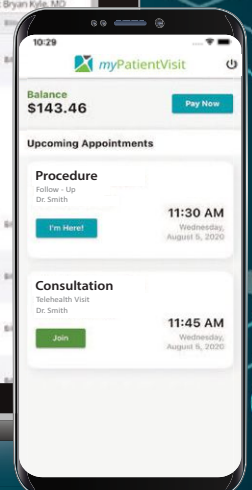
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9002	\$1,000.00			Active	
9003	\$100.00			Active	
123	Patient	\$211.87	\$200.00	\$0.00	-\$86.62
123	Patient	\$196.84	\$200.00	\$0.00	-\$196.66
123	Patient	\$183.49	\$200.00	\$0.00	-\$196.51
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