

DataDerm Update



Joining can do a lot for your practice and patients.

BY VISHAL ANIL PATEL, MD

>> I recently interviewed Marta Jane Van Beek, MD, MPH, the C. William Hanke associate professor of dermatologic surgery and director of the division of dermatologic surgery and cutaneous oncology within the department of dermatology at the University of Iowa Carver College of Medicine in Iowa City, IA, and Stefan C. Weiss, MD, managing director of dermatology at OM1 in Boston, MA, to discuss the latest insights into real-world dermatology from DataDerm, the American Academy of Dermatology's (AAD) clinical data registry. OM1 helps optimize and link the data from DataDerm. The AAD launched DataDerm in 2016 to help members improve the quality of care they provide, optimize practice efficiency, facilitate research, and demonstrate their value to payers.



Marta Jane Van Beek, MD, MPH



Stefan Weiss, MD

Dr. Patel: What should dermatologists know about DataDerm?

Marta Jane Van Beek, MD, MPH: DataDerm is a registry tailor-made for dermatologists. There are multiple reasons to join. If a practice chooses to report its Merit-based Incentive Payment System (MIPS) quality measures through DataDerm, it will have access to a dashboard that allows them to see how they are doing compared to all dermatologists participating in the registry. However, even if a practice reports its MIPS measures through another entity, DataDerm participation is still important for the specialty. Collectively, the data from DataDerm is used to improve our advocacy efforts for physicians and patients, identify opportunities for better treatments, and develop educational strategies for continuing education. For all of these reasons, members who participate in DataDerm are helping the specialty move forward and prove its value in the house of medicine.

Dr. Patel: How is DataDerm being used to identify disparities in dermatologic care?

Dr. Van Beek: For the first time, DataDerm is allowing us to see how real-world dermatology is practiced across the country. We know that dermatologists are treating severe

diseases and making patients better. With the AAD-OM1 partnership, we can link our data with other datasets to subsegment populations by defined characteristics—race, ethnicity, education, and other social determinants of health. While access to care accounts for the largest disparities in dermatologic care, we can now fully understand how care delivery differs among patients with access to care.

Dr. Patel: What has the data revealed so far?

Stefan Weiss, MD: Utilization of biologics versus methotrexate in psoriasis was similar in White and non-White patients, and two of the greatest drivers of therapeutic determination were income and education.

Dr. Van Beek: This likely accounts for different types of insurance and out-of-pocket costs for patients. Among atopic dermatitis patients, Black patients [accessed] dermatologic care with more severe diseases compared to White or Asian patients. This indicates an opportunity to intervene earlier to minimize the suffering of these patients. Understanding therapeutic utilization and impact across different population groups augments the knowledge collected in clinical trials. The majority of efficacy and safety data are derived from clinical trials. When clinical trials are not representative of the diversity of the population, the data collected cannot be attributed to underrepresented populations. Real-world dermatology data can complement that picture by highlighting the efficacy and safety of patient types who otherwise were not included in the clinical trial. This can be particularly useful for understanding efficacy and long-term safety.

Dr. Patel: What other issues will the data help define and address?

Dr. Weiss: Safety and efficacy can only be discussed in relation to the clinical trial population over the long term. Real-world dermatology data offers a more complete picture of the patient population impacted. Furthermore, safety and efficacy can then be subsegmented by social drivers, including race, ethnicity, [sex], income, and education.

Dr. Van Beek: Additionally, if we can identify patients who present with more severe disease or identify patterns where

patients were forced to switch to medications that didn't help their disease, we can take that data to legislators and insurance companies to advocate for improved access to important medications.

Dr. Patel: How does DataDerm help doctors with reimbursement issues?

Dr. Van Beek: DataDerm data has already been used to advocate for fair reimbursement for physicians. We can identify multiple trends where the payment system is flawed and cannot keep pace with the cost of providing care. This data is especially important as the AAD is advocating for inflationary adjustments to the Medicare payment system. ■

Vishal Anil Patel, MD, is the director of cutaneous oncology at GW Cancer Center, the director of dermatologic surgery at GW department of dermatology, and an associate professor of dermatology and medicine/oncology at George Washington University School of Medicine & Health Sciences in Washington, DC. He served as interim editor while Mark D. Kaufmann, MD, completed his term as president of the AAD. Dr. Kaufmann will return in May 2023, and he and Dr. Patel will serve as coeditors for "Digital Practice."

DataDerm is open and available to all dermatologists through the AAD.

For additional information, please contact at dataderm@aad.org