Dermatology Immediate Care: A Game Changer for the Health Care System?

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PRACTICE **POINTS**

- Emergency departments and most immediate care (IC) centers often lack prompt access to board-certified dermatologists.
- A dermatology urgent care/IC model may shorten wait times, improve access for vulnerable patients and pediatric populations, and reduce unnecessary hospital admissions and costs.
- Increased access to dermatology benefits other specialties by enabling multidisciplinary care leading to faster diagnosis and treatment.
- A staged referral-first dermatology IC pilot with defined staffing and triage rules is a practical path to demonstrate value and scale the service.

Emergency departments (EDs) and immediate care (IC) centers frequently lack timely access to board-certified dermatologists, contributing to delays, misdiagnoses, and unnecessary treatments. Multiple studies show dermatology consultation often changes diagnosis and management and improves short-term clinical outcomes. Implementing a dermatology urgent care/IC model (initially referral-based with defined staffing blocks and triage rules) could reduce ED visits, shorten wait times, improve access for vulnerable patients and pediatric populations, and prevent interruptions in specialty therapies such as oncology and transplant care.

Emergency departments (EDs) and immediate care (IC) facilities often do not have prompt dermatologic care available for triage and treatment. Many EDs do not have staff dermatologists on call, instead relying on input from other specialists or quick outpatient dermatology appointments. It can be challenging to obtain a prompt appointment with a board-certified dermatologist, which is preferred for complex cases such as severe drug reactions or infection. In the United States, there are few well-established IC centers equipped to address dermatologic needs. The orthopedic specialty has modeled a concept that has led to the establishment of orthopedic urgent care/IC in many larger institutions,[1] and many private practice clinics serve their communities as well. We present a rationale for why a similar IC concept for dermatology would be beneficial, particularly within a large institution or health system.

Dermatology Consultation Changes Disease Management

There is diagnostic and therapeutic utility in dermatology evaluation. In a prospective study of 591 patients who were either hospitalized or evaluated in an ED/urgent care setting, treatment was changed in more than 60% of cases when dermatology consultation was utilized.[2] In another prospective review of 691 cases on an inpatient service, dermatology consultation resulted in treatment changes more than 80% of the time.[3]

Cellulitis has been a particularly well-studied diagnosis. Dermatologists often change the diagnosis of cellulitis in the hospital setting and reduce antibiotic exposure. In a prospective cohort study of 116 patients, 33.6% had their diagnosis of cellulitis changed to pseudocellulitis following evaluation by the dermatologist; of 34 patients who had started antibiotic therapy, 82.4% were recommended to discontinue the treatment, and all 39 patients with pseudocellulitis had a proven stable clinical course at 1-month follow-up.[4] In another trial, 175 patients with presumed cellulitis were given standard management (provided by the medicine inpatient team) either alone or with the addition of dermatology consultation. Duration of antibiotic treatment (including intravenous therapy) was reduced when dermatology was consulted. Two weeks after discharge, patients who had dermatology consultations demonstrated greater clinical improvement.[5]

Improving ED and IC Access to Dermatology

Emergency department and IC teams across the United States work tirelessly to meet the demands of patients presenting with medically urgent conditions. In a study examining 861 ED cases, dermatology made up only 9.5% of specialist consultations, and in the opinion of the on-call dermatology resident, 51.0% (439/861) of cases warranted ED-level care.[6]

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Data from the 2021 National Hospital Ambulatory Medical Care Survey showed that the mean wait time to see a physician, nurse, or physician assistant in an ED was 37.5 minutes, but wait times could range from less than 15 minutes to more than 6 hours.[7] According to a study of 35,849 ED visits at nonfederal hospitals in the United States, only 47.7% of EDs admitted more than 90% of their patients within 6 hours.[8] Moreover, perceived wait times in the ED have been shown to greatly impact patient satisfaction. Two predictors of perceived wait time include appropriate assessment of emergency level and the feeling of being forgotten.[9] In a study of 2377 ED visits with primary dermatologic diagnoses, only 5.5% led to admission.[10] This suggests many patients who come to the ED for dermatologic needs do not require inpatient hospital care. In these cases, patients with primary dermatologic concerns may experience longer ED wait times, as higher acuity or emergency cases take precedence. Studies also have shown that more vulnerable populations are utilizing ED visits most for primary dermatologic concerns.[10,11] This includes individuals of lower income and/or those with Medicaid/Medicare or those without insurance.[11] Predictors of high ED use for dermatologic concerns include prior frequent use of the ED (for nondermatologic concerns) instead of outpatient care, income below the poverty level, and lack of insurance; older individuals (>65 years) also were found to use the ED more frequently for dermatologic concerns when compared to younger individuals.[10]

Importantly, there is a great need for urgent dermatology consultation for pediatric patients. A single-institution study showed that over a 36-month period, there were 347 pediatric dermatology consultations from the pediatric ED mostly for children aged 0 days to 5 years; nearly half of these consultations required outpatient clinic follow-up.[12] However, dermatology outpatient follow-up can be difficult to obtain, especially for vulnerable groups. In a study of 611 dermatology clinics, patients with Medicaid were shown to have longer wait times and less success in obtaining dermatology appointments compared to those with Medicare or private insurance.[13] Only about 30% of private dermatology practices accept Medicaid patients, likely pushing these patients toward utilization of emergency services for dermatologic concerns.[13,14]

There is a clear role for a dermatology IC in our health care system, and the concept already has been identified and trialed in several institutions. At Oregon Health and Science University (Portland, Oregon), a retrospective chart review of patients with diagnoses of Morgellons disease and neurotic excoriations seen in dermatology urgent care between 2018 and 2020 showed an 88% decrease in annual rates of health care visits and a 77% decrease in ED visits after dermatology services were engaged compared to before the opening of the dermatology urgent care.[15] Another study showed that uninsured or self-pay patients were more than 14 times more likely to access dermatology urgent care than to schedule a routine clinic appointment, suggesting that there is a barrier to making outpatient dermatologic appointments for uninsured patients. An urgent access model may facilitate the ability of underinsured patients to access care.[16]

Improving Dermatology Access for Other Specialties

Needs for dermatologic care are encountered in many other specialties. Having direct access to immediate dermatologic treatment is best for patients and may avoid inpatient care and trips to the ED for consultation access. Ideally, a dermatology IC would allow direct care to be provided alongside the oncology outpatient team. New immunologic therapies (cytotoxic T-lymphocyte–associated protein 4 and programmed cell death protein 1/programmed death-ligand 1 treatments) can cause dermatologic reactions in more than 40% of patients.[17] Paraneoplastic syndromes can manifest with cutaneous symptoms, as can acute graft-vs-host-disease.[18] In a study at Memorial Sloan Kettering (New York, New York) analyzing 426 same-day outpatient dermatology consultations, 17% of patients experienced interruptions in their cancer therapy, but 83% responded quickly to dermatologic treatment and resumed oncologic therapy—19% of them at a reduced dose.[19] This is an important demonstration of prompt dermatologic consultation in an outpatient setting reducing interruptions to anticancer therapy. The heterogeneity of the cutaneous reactions seen from oncologic and immunomodulatory medications is profound, with more than 140 different types of skin-specific reactions.[20]

Solid-organ transplant recipients also could benefit from urgent access to dermatology services. These patients are at a much higher risk for skin cancers, and a study showed that those who receive referrals to dermatology are seen sooner after transplantation (5.6 years) than those who self-refer (7.2 years). Importantly, annual skin cancer screenings are recommended to begin 1 year after transplantation.[21]

Direct access to dermatology care could benefit patients with complicated rheumatologic conditions who present with skin findings; for example, patients with lupus erythematosus or dermatomyositis can have a spectrum of disease ranging from skin-predominant to systemic manifestations. Identification and treatment of such diseases require collaboration between dermatologists and rheumatologists.[22] Likewise, a study of a joint rheumatology-dermatology clinic for psoriatic arthritis showed that a multidisciplinary approach to management leads to decreased time for patients to obtain proper rheumatologic and dermatologic examination and a faster time to diagnosis; however, such multidisciplinary clinic models and approaches to care often are found only at large university-based hospitals.[23] In a patient population for whom time to diagnosis is crucial to avoid permanent changes such as joint destruction, a dermatology IC could fill this role in community hospitals and clinics. A dermatology IC also can serve patients with specific diagnoses who would benefit from more direct access to care; for example, in 2017 there were 131,430 ED visits for hidradenitis suppurativa (HS) in the United States. While HS is not uncommon, it usually is underdiagnosed because

it can be challenging to differentiate from an uncomplicated abscess. Emergency department visits often are utilized for first-time presentations as well as flares of HS. In these situations, ED doctors can provide palliative treatment, but prompt referrals to dermatologists should be made for disease management to decrease recurrence.[24]

Final Thoughts

A huge caveat to the dermatology urgent care system is determining what is deemed "urgent." We propose starting with a referral-based system only from other physicians (including IC and urgent care) rather than having patients walk in directly. Ideally, as support and staff increases, the availability can increase as well. In our institution, we suggested half-day clinics staffed by varying physicians, with compensation models similar to an ED or IC physician rather than by productivity. Each group considering this kind of addition to patient care will need to assess these points in building an IC for dermatology. The University of Pennsylvania's (Philadelphia, Pennsylvania) system of rapid-access clinics to facilitate access to care for patients requiring urgent appointments may function as a model for future similar clinics.[25] Creating a specialized IC/urgent care is not a novel concept. Orthopedic urgent care centers have increased greatly in the past decade, reducing ED burden for musculoskeletal complaints. In a study evaluating the utility of orthopedic urgent care settings, time to see an orthopedic specialist and cost were both greatly reduced with this system.[1] The same has been shown in same-day access ophthalmology clinics, which are organized similarly to an urgent care.[26]

In 2021, there were 107.4 million treat-and-release visits to the ED in the United States for a total cost of $80.3 billion.[27] This emphasizes the need to consider care models that not only provide excellent clinical care and treat the most acute diagnoses promptly and accurately but also reduce overall costs. While this may be convoluted for other specialties given the difficulty of having patients self-triage, dermatologic concerns are similar to orthopedic concerns for the patient to decipher the etiology of the concern. As in orthopedics, a dermatology IC could function similarly, increasing access, decreasing ED and IC wait times, saving overall health care spending, and allowing underserved and publicly insured individuals to have improved, prompt care.

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