Assessing Inpatient Dermatology Availability in Virginia

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PRACTICE **POINTS**

- Dermatologists should interface with hospitals more frequently to offer consultations within the inpatient setting to improve diagnosis, reduce hospital stays, and reduce costs to all parties.
- Health systems and dermatologists should collaborate to reduce disparities and increase access to care by increasing consultative services (eg, via telemedicine).

To the Editor:

It is known that dermatologist evaluation of skin conditions in hospitalized patients confers enhanced diagnostic accuracy, timely and appropriate treatment, and an overall reduction in readmissions compared to assessments by nondermatology hospitalists.[1] Dermatology consultations have been shown to alter diagnoses in up to 50% of cases and lead to changes in management in nearly 75% of cases, even for prevalent dermatologic conditions such as drug rashes, cellulitis, and stasis dermatitis.[1,2] Previous studies have observed a multiday reduction in length of hospital stay, a 10-fold reduction in readmission rate, and lower 30-day mortality, all leading to a reduction in patient morbidity and costs to both the patient and the health care system.[3,4] Despite these benefits, there has been a decrease in the number of dermatologists providing inpatient services and a reduction in medical centers offering dermatology consultations over the past several years.[5] To better appreciate current trends of declining dermatology inpatient and consultative services within our region, we evaluated the availability of dermatology care at hospitals across Virginia.

A simple telephone survey was conducted across community hospitals in Virginia wherein medical staff administrators were asked to provide details regarding their dermatology staffing. The following figures were collected: number of dermatologists on staff, number of dermatologists with consulting privileges, number of affiliated dermatologists, and number of advanced-practice dermatology providers. Follow-up calls were carried out to elaborate on how dermatologists (when available) were integrated into inpatient care workflow and made accessible to hospitalists and emergency medicine departments. Academic centers, military hospitals, and specialty hospitals were excluded from the survey.

To better appreciate the relationships between hospital and population characteristics and the availability of dermatology care, publicly available data were collected on hospital bed counts and regional population density for each facility.[6-9] Spearman rank correlation analyses were conducted in Microsoft Excel to evaluate the association between the number of dermatologists on staff, number of consulting dermatologists, staffed inpatient beds, and population size.

Sixty-four hospitals—more than 70% of the 90 eligible community hospitals— responded to the survey between May and August 2024 and were included in the study. On-staff dermatologists were present at 8 (12.5%) of the hospitals surveyed; of these, 4 (50.0%) hospitals had between 1 and 5 dermatologists, 3 (37.5%) had between 6 and 10 dermatologists, and 1 (12.5%) had between 11 and 15 dermatologists. An additional 4 (6.3%) hospitals provided consultative dermatology services from outside dermatology clinics. Urban hospitals accounted for 9 of 12 (75%) hospitals offering in-house dermatology services, either through on-staff physicians or consultations with clinic-based providers.

Based on Spearman rank correlation analysis, there was a positive correlation between the number of dermatologists on staff and the number of staffed hospital beds

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(r=0.61; P<.001). Similarly, there was a positive correlation between the number of dermatologists on staff and the population density of the affiliated region (r=0.58; P<.001). Finally, there was a positive correlation between the number of dermatologists on staff and the number of available consulting dermatologists (r=0.89; P<.001).

At facilities with only consultative dermatology services accessible, there often was no formal dermatology team or department present. Rather, the hospitals relied on a loosely affiliated network of dermatology providers or navigated inpatient dermatology needs almost exclusively via internal medicine hospitalists or emergency medicine physicians. When available, dermatology support from dermatology physicians often was provided through teledermatology platforms. Although teledermatology has a large role in increasing access to care within underserved areas, its reliance on images and secondhand case descriptions can limit the provider's ability to perform a comprehensive examination and assessment. Moreover, it was noted that few hospital representatives could offer clarity on how dermatologists were integrated into the inpatient setting. It remained unclear whether dermatologists were practically accessible to the inpatient care teams in a structured manner.

The uneven distribution and limited availability of dermatology inpatient care in Virginia reflect national trends and underscore ongoing access issues for patients. Without intentional intervention, these trends are expected to continue, contributing to a glaring gap in hospital services as well as to patient morbidity and mortality. The correlation data obtained in our study further qualify these disparities. The positive correlations between dermatologist availability and hospital size and population density suggest that larger, more urban facilities are more likely to offer inpatient dermatology care, whether through staffing or consultation. This relationship is not unexpected, given the greater financial resources and specialist networks available to facilities with large patient volumes. This suggests that dermatology care is shaped by institutional capacity and geographic leverage rather than clinical need, reinforcing existing disparities.

Importantly, it should be noted that the data may overestimate the true availability of dermatologists to these patients. As revealed via follow-up survey calls, respondent facilities that provided dermatology via consultative services often did not have a defined structure for integrating this care into the inpatient workflow. In some instances, dermatologists were technically affiliated with the hospital but had varying levels of practical interaction with the hospital providers and their patients. Administrative staff's differing awareness regarding dermatology interaction with the hospital facility may reveal systemic underutilization and opportunities to improve coordination to achieve the greatest benefit from dermatology services. These observations are further informed by the scope of our study, which focused specifically on community hospitals. The exclusion of academic and military institutions—and the tendency of these to exist in more densely populated areas—may have limited how broadly our findings reflect nationwide dermatology access by omitting more established dermatology departments and specialty care. As a result, regional variations in predominant facility type should be considered when interpreting the implications of these results beyond Virginia's community hospital system.

In response to access limitations and differences in availability, facilities are turning to integrated teledermatology as a valuable tool to expand the reach of specialist care, particularly in rural or resource-limited settings. This modality acts as an important step toward improving equity in care by beginning to bridge geographic gaps; however, along with these logistical advantages, teledermatology also confers diagnostic limitations and clinical trade-offs that should be thoughtfully considered. Our findings highlight the need to expand access in a way that integrates technological advances with in-person care to build a sustainable and effective path forward without compromising the quality of care patients receive. We present these outcomes to emphasize the importance of increasing dermatology involvement in the care of hospitalized patients, which is a promising strategy to improve patient outcomes and reduce existing disparities in Virginia and nationwide.

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