

A pilot program for community dermatologists working with primary care residents to provide dermatology consults to a regional hospital

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Abstract

With the high demand and limited supply of dermatologists, the majority dedicate their time primarily to outpatient practice. A number of obstacles to inpatient dermatology consults have been described, as well as the essential benefits for some of the sickest patients. Dermatology residency programs partially relieve this need, however with the transition to a single Graduate Medical Education accreditation system and many previously American Osteopathic Association-accredited dermatology programs ceasing to train residents after 2020, it is prudent to recruit additional possible consultants. One possible solution is to involve non-dermatology residents as part of the consult service team. We report on our experience of piloting such a program, for community dermatologists providing consults to a regional hospital utilizing family medicine and internal medicine residents.

Keywords: consult; inpatient; telemedicine; HIPAA

While many individuals with skin disease are able to be adequately managed in the outpatient setting, a valuable role exists for dermatologists in the care of hospitalized patients. Dermatologist involvement improves inpatient care, results in a change in definitive diagnosis and treatment in a majority of cases, and provides educational opportunities to primary inpatient teams [1, 2]. Many barriers have been identified for dermatologists seeing hospitalized patients, including institutional bureaucracy, time constraints, and poor reimbursement [3, 4]. Dermatology residents play an important role in

assisting with hospital consultations, however with the transition to a single Graduate Medical Education accreditation system and many previously American Osteopathic Association-accredited dermatology programs ceasing to train residents after 2020, these obstacles will only become more relevant in the upcoming years. One possible solution is to involve non-dermatology residents as part of the consult service team. We report on our experience of piloting such a program, for community dermatologists providing consults to a regional hospital utilizing family medicine (FM) and internal medicine (IM) residents, and explore the benefits, logistics, and lessons learned.

This pilot program involves dermatologists and dermatology residents from four community dermatology practices that have been participating in a consult service to a regional hospital for over 20 years. Due to experiencing the aforementioned consultation difficulties, it was decided to involve FM and IM residents in the call schedule. Each July, all participants receive a copy of the consult service expectations and workflow (Appendix 1). Once a consult is received, the dermatologist has the option to complete it alone or with the assistance of a resident within 12 hours. Both FM and IM residents at this hospital are required to rotate through dermatology and participation in consults while on that service is now an expectation. If no resident is rotating on dermatology at the time of a consult, it is assigned to the FM or IM resident on-call. If a dermatology resident is on service at the hospital that month, he or she is also expected to be part of the consult teamwork. Upon initial resident evaluation, a consult

note is written and communication takes place with the dermatologist to decide the appropriate next steps and whether the patient should be seen by the dermatologist in the hospital or as an outpatient after discharge. If an inpatient visit is warranted, the dermatologist should join the resident at the bedside for further evaluation. Follow-up with the dermatologist should be recommended and coordinated as appropriate.

The collaboration between the dermatologists and residents was established to provide benefits to the dermatologists, residents, and patients. It saves time for the dermatologist and allows them to continue to maintain staff privileges and a good working relationship with the hospital. The residents are provided with educational opportunities to enhance their dermatology knowledge and skills. In particular, with a field as visually involved as dermatology, personally observing and examining the patient can enhance their ability to describe, evaluate, recognize, and manage dermatological conditions. This is especially important for primary care physicians who are commonly involved in the decision of when to consult dermatology. The majority of inpatient dermatology consults come from the IM service, so improving physician comfort level with dermatology can help to minimize unnecessary consults and save time and resources [5]. Patients benefit from dermatology consultations by improved inpatient care, decreased readmission rates and hospital length of stay, and follow-up coordination [1].

Challenges that have arisen since the implementation of this program include logistics with scheduling, communication, and assigning roles. Ideally, the resident receiving the consult will be at or near the hospital that day and can go see the patient at their convenience. In reality, they are often at other sites and are unable to get to the patient until evening hours when they have completed their own obligations. Ultimately, the dermatologist and resident must decide the most feasible person to see the patient that day. Communication, collaboration, and respect are key to the success of this teamwork.

Health Insurance Portability and Accountability Act (HIPAA)-compliant technology is a valuable asset to this collaborative model. Many options exist for this

technology, but this regional hospital chooses to use hospital-provided secure phones or an HIPAA-compliant smartphone instant messaging mobile application to securely exchange patient information and photographs. This greatly assists with establishing urgency and can minimize unnecessary trips to the hospital by the dermatologist. However, training and onboarding of all consult service team members with the technology can be logistically difficult, and communicating solely through this means does not allow the dermatologist to personally lay hands on the patient. Effective communication through technology alone also relies on the resident's ability to appropriately describe patient exam findings utilizing descriptive morphology terminology.

Another challenge involves billing for the consultation. For example, if only the FM or IM resident sees the patient, with or without their service attending, does the primary care physician or the dermatologist bill for the visit? One could argue that because it is a dermatology consult and the resident communicated with the dermatologist, the dermatologist could potentially bill, though it would essentially be an enhanced telemedicine consultation since there was not face-to-face time. In this pilot program, it was decided that the attending physician who personally sees the patient bills for the service. Regardless of the attending that ultimately cares for the patient, the patient still benefits from the communication between the resident and dermatologist.

The expansion of the dermatology consult service team to include FM and IM residents highlights the benefits and challenges to dermatology hospital consultations. The partnership is time-saving for dermatologists, educational for residents, and improves the care patients receive. Effective communication, clear expectations, established protocols for scheduling and billing, and respect for all participants are necessary for success. When it would not otherwise be feasible to have an inpatient dermatology consult service, hospitals should consider this strategy as a possible way to fulfill this need. There are certainly logistical challenges to implementing and growing a successful, inpatient dermatology consult service with non-dermatology residents, but the rewards are valuable.

APPENDIX: Dermatology Consult Service with Primary Care**I. Educational Purpose**

The primary care physician should be competent to evaluate and treat patients with a dermatologic disease process, triage the urgency of evaluation, and understand when a referral to a dermatologic specialist is appropriate. Furthermore, the house-staff should learn the basic and proper nomenclature identifying cutaneous lesions. They should also be adept at identifying distribution of lesions and generating a differential and treatment paradigm. The dermatologist may improve their skills in teaching to primary care physicians through more frequent case-based interaction.

II. Expectations of residents:

1. See the patient within 12 hours of when the consult was placed.
2. Perform an initial evaluation and assessment and triage the urgency of the visit.
3. Write up consult note and place it in the chart at the time of visit.
4. Fill out consent form and place in chart prior to taking digital photographs.
5. Text the dermatologist on-call utilizing HIPAA-compliant technology*
 - a. Summary of the patient's dermatologic history and physical exam findings.
 - b. Photograph of the cutaneous lesion(s) when applicable.
6. Discuss with the dermatologist whether the patient should be seen as an inpatient or outpatient, and collaborate to formulate an assessment and plan.
7. Perform biopsies when indicated.
8. Subsequent Visits (Day 2+)

- a. Review new results, interim history, and examine patient.
 - b. Discuss any new or modified impressions/recommendations with the primary house staff and attending physician in person (preferred) or by telephone.
 - c. Document daily progress note in chart.
9. Display professionalism by timely dictation or writing of notes, communication with referring physicians and associated medical professionals.
 10. When an unusual case is encountered, perform a literature search on the case and report results to the dermatology attending and on rounds.

III. Expectations of dermatology attendings:

1. See patient alone or contact the resident on-call for this service:
 - a. Internal medicine months: page (xxx)xxx-xxxx.
 - b. Family medicine months: page (xxx)-xxx-xxxx.
2. The following information should be communicated to the resident:
 - a. Patient name, date of birth, and room number, brief history and clinical question for the consulting service, and preferred contact information.
3. Collaborate with the resident to determine a plan:
 - a. If inpatient dermatology management is warranted, determine who will round (the dermatologist or the attending of the resident's service).
 - b. The attending that sees the patient bills for the visit.
 - c. One option, based on conversations and information from the resident, is to see the patient as an outpatient (i.e. not a critical case and/or problem

might be better addressed in office rather than hospital bedside).

4. Display professionalism by being reachable by HIPAA-compliant technology and responding in a timely manner.

5. Create an atmosphere to foster an evidence-based approach to consult recommendations, teach to the resident's training level, and collaborate with the resident in a collegial manner.

IV. Consult Service Director- Here to help!

a. (Attending name): If there are questions or concerns, please feel free to call/text at (xxx)-xxx-xxxx.

References

1. Milani-Nejad N, Zhang M, Kaffenberger BH. Association of dermatology consultations with patient care outcomes in hospitalized patients with inflammatory skin diseases. *JAMA Dermatol.* 2017;153(3):E1-E6. [PMID:28296992].
2. Connolly DM, Silverstein DI. Dermatology consultations in a tertiary care hospital: A retrospective study of 243 cases. *Dermatol Online J.* 2015;21(8). [PMID:26437155].
3. Helms AE, Helms SE, Brodell RT. Hospital consultations: time to address an unmet need? *J Am Acad Dermatol.* 2009;60(2):308-311. [PMID:19150273].
4. Fox LP, Cotliar J, Hughey L, Kroshinsky D, Shinkai K. Hospitalist dermatology. *J Am Acad Dermatol.* 2009;61(1):153-154. [PMID:19539858].
5. Connolly DM, Silverstein DI. Dermatology consultations in a tertiary care hospital: A retrospective study of 243 cases. *Dermatol Online J.* 2015;21(8). [PMID:26437155].