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Expediting patient appointments with dermatology rapid access clinics

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Abstract

Background: Lengthy wait times for dermatology appointments in the U.S. limit care access. The **University of Pennsylvania's Department of** Dermatology has established an urgent care clinic (UCC) and an intermediate care clinic (ICC) to expedite appointments for higher acuity patients. **Objective: To describe our rapid access clinics'** operations, referral patterns, and distributions of diagnoses.

Methods: We performed a retrospective review of dermatology consult order and appointment data for UCC, ICC, and routine care to determine the number of orders, consult appointments, and follow-up appointments; appointment wait times; and frequencies of diagnoses in referring provider and consult appointments. Press Ganey patient satisfaction ratings were also analyzed.

Results: The median (interquartile range) wait times for UCC, ICC, and routine care, appointments were 3 (1-8) days, 36 (15-64) days, and 45 (12-97) days, respectively (P<0.001). The proportion of referrals originating from subspecialists varied among UCC (47.6%), ICC (20.2%) and routine care (15.8%), (P<0.001). Distributions of diagnoses differed among UCC, ICC, and routine care. Ratings for most satisfaction metrics were similar across clinic settings.

Conclusions: Dermatology rapid access clinics within an academic medical center can reduce wait times for higher acuity patients while maintaining patient satisfaction.

Keywords: triage, urgent care, access to care, appointment wait times, academic medical centers

Introduction

Lengthy wait times for dermatology appointments in the United States limit access to care. Wait times for new patient appointments vary by practice setting and geographic region but often exceed 45 days [1-3], even for patients with urgent problems such as changing moles [4]. These significant wait times result from excess demand for dermatology care relative to supply and from suboptimal resource allocation, such as unplanned appointment scheduling [5]. Strategies to improve care access include utilizing teledermatology [6-8], employing non-physician providers [9-11], and triaging patients [12-15].

To expedite appointments for higher acuity patients, the Department of Dermatology at the University of Pennsylvania established rapid access clinics: an urgent care clinic (UCC) in 2009 and an intermediate care clinic (ICC) in 2013.

The criteria for a UCC appointment include the following high-risk features: immunocompromised status, acute skin condition, vesicular or blistering eruption, suspected severe drug reaction, or suspicious mole. In addition, UCC appointments are scheduled if the referring provider would have otherwise sent the patient to the emergency department (ED). ICC appointments do not have

specified criteria and are scheduled for patients not meeting UCC criteria if the referring provider believes their condition warrants an expedited evaluation for some other reason. Patients referred to UCC or ICC are intended to be seen within 2-4 days or 2-8 weeks, respectively.

In the current iteration, the point-of-care provider (non-dermatologist in an outpatient or ED setting) evaluating a patient assesses their level of concern and acuity and places an order into the institutional electronic health record (Epic/PennChart) for either UCC, ICC, or routine/next available appointment. All UCC orders are routed to a pool of dermatology RNs who review the information, confirm the case meets eligibility criteria, and send the order to a scheduler who contacts the patient. Once an appointment is made, both the patient and referring physician are notified. Referrals for patients who do not meet the specified criteria for UCC are scheduled in alternative appointment slots outside of UCC, either into ICC slots, existing cancellation/no-show slots, or routine new patient slots, and the referring provider is notified. ICC orders are handled similarly, with review conducted by a CRNP (VR). The "routine" option is designed to serve as a referral tool for primary care doctors who intend to convey to their patients that a dermatology appointment should be made but is not an acute need. This generic referral option generates printed instructions for patients to call our department and schedule an appointment on their own. Only new patients are scheduled through this triage system. Referrals for established patients within our dermatology practice do not flow through this triage system.

UCC is staffed by the Hospital of the University of Pennsylvania inpatient consult attending (MR, RGM, or KTS) and the consult service senior dermatology resident prior to the start of afternoon inpatient consult rounds. ICC is staffed by a dermatology attending and 1-2 dermatology-trained CRNPs. Each clinic occurs 2-3 times weekly depending on provider availability. UCC has 3-4 reserved slots, whereas ICC generally has 10-14 slots, depending on the level of acuity of the cases being scheduled and staffing availability. After their UCC or ICC consultations, patients requiring follow-up

appointments are scheduled with other providers within the department to establish continuity of care.

A prior study of our institution's urgent care clinic determined that referring providers were highly satisfied with the care provided at the clinic, believed that patients received timely appoint-ments, and felt that use of the clinic avoided unnecessary trips to the ED [15]. Herein, we describe our rapid access clinic operations, referral patterns, and distributions of diagnoses.

Methods

Study design

We performed a retrospective review of dermatology consult orders for UCC, ICC, and routine care at our primary outpatient facility (the Perelman Center for Advanced Medicine) from February 26, 2013 to June 30, 2017. We determined the number of consult orders, consult appointments, and follow-up appointments; frequencies of referring specialties; and frequencies of diagnoses at the referring provider appointments and consult appointments. A single appointment could have multiple diagnoses, and all diagnoses were reported as International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. Data reports were generated through Epic software (Epic Systems Corporation, Verona, Wisconsin). Patient satisfaction ratings were obtained using aggregated Press Ganey reports over the same time period.

Exclusion criteria

If multiple consult orders were submitted before a consult appointment occurred, all but the most recent order were excluded from the analysis because the most recent order was assumed to be the one that prompted the scheduling of the consult appointment. In addition, consult orders lacking urgency levels were excluded. Cancelled or no-show consult appointments or follow-up appointments were excluded. Finally, consult appointments occurring greater than 12 months after the consult order, and follow-up appointments occurring greater than 12 months after the consult appointment were excluded from the analysis

Table 1. *Dermatology consult orders, February 2013 - June 2017.*

Order Urgency	2013	2014	2015	2016	2017	Total (%)
UCC	497	630	750	947	431	3,255 (8.6)
ICC	1,554	2,233	2,907	3,292	1,622	11,608 (30.8)
Routine	1,960	4,736	6,603	6,459	3,132	22,890 (60.6)
Overall	4,011	7,599	10,260	10,698	5,185	37,753

UCC, Urgent care clinic.
ICC, Intermediate care clinic.

because these appointments were presumed to have been scheduled for an unrelated dermatologic issue.

Statistical methods
Descriptive statistics were used to summarize findings among UCC, ICC, and routine care consultations and Press Ganey patient satisfaction metrics for UCC patients, ICC patients, and patients overall. Categorical (completion of consult appointments, completion of follow-up appoint-ments, and subspecialist referrals) and continuous (wait times) variables were compared among groups using non-parametric testing (chi-squared test and Kruskal-Wallis test, respectively). Subspecialist referrals were defined as those from any specialty other than internal medicine, family medicine, pediatrics, adolescent medicine, or geriatrics. The Kruskal-Wallis assumption of same distribution of wait times was visually verified. All analyses were conducted using Stata (College Station, TX: StataCorp LLC).

Ethical approval
This study was approved by the University of Pennsylvania Institutional Review Board.

Results:
Consult orders, consult appointments, and times to appointment
Between February 26, 2013 and June 30, 2017, 37,753 consult orders were submitted (Table 1), including 3,255 (8.6%) for UCC, 11,608 (30.8%) for ICC, and 22,890 (60.6%) for routine care. Referral volume increased steadily in all settings during the first 2 years of implementation before stabilizing

The overall median (interquartile range) wait time between consult orders and consult appointments was 31 (7-75) days (Table 2). This interval varied widely with order urgency: 3 (1-8) days for UCC, 36 (15-64) days for ICC, and 45 (12-97) days for routine care (P<0.001).

Overall, 36.0% (95% confidence interval [CI]: 35.6%-36.5%) of patients receiving a referral scheduled and completed a consult appointment. This proportion differed by order urgency: 64.9% (95% CI: 63.2%-66.5%) for UCC, 39.9% (95% CI: 39.0%-40.8%) for ICC, and 30.0% (95% CI: 29.4%-30.6%) for routine care (P<0.001). Of patients completing a consult appointment, 42.4% (95% CI: 41.6%-43.2%) also later completed a follow-up appointment; this percentage was higher for patients referred to UCC (48.9% [95% CI: 46.8%-51.1%]) than for those referred to ICC (39.8% [95% CI: 38.4%-41.3%]) or routine care (42.1% [95% CI: 41.0%-43.3%]), (P<0.001).

Patients rated UCC (96.9%) higher than ICC (77.2%) and routine care (83.6%) in terms of the ability to obtain a desired appointment. All other Press Ganey satisfaction ratings were similarly high for UCC patients, ICC patients, and patients overall, for both overall and access-related metrics, including ease of appointment scheduling and office hours.

Referring specialties
Within UCC, ICC, and routine care, the majority of consults originated from internal medicine/family medicine (80.1% overall [95% CI: 79.7%-80.5%]), (Table 3). The likelihood of a subspecialist referral differed significantly by order urgency, with 47.6% (95% CI: 45.9%-49.4%) of UCC orders, 20.2% (95% CI:

Table 2. *Dermatology consult orders, completed consult and follow-up appointments, wait times, and satisfaction ratings.*

	UCC	ICC	Routine	Overall
Consult Orders	3,255	11,608	22,890	37,753
Consult Appointments	2,111	4,634	6,860	13,605
% Orders Leading to Consult Appointments (95% CI)	64.9 (63.2-66.5)	39.9 (39.0-40.8)	30.0 (29.4-30.6)	36.0 (35.6-36.5)
Follow-up Appointments	1,033	1,846	2,891	5,770
% Consult Appointments Leading to Follow-up Appointments (95% CI)	48.9 (46.8-51.1)	39.8 (38.4-41.3)	42.1 (41.0-43.3)	42.4 (41.6-43.2)
Wait Times from Consult Orders to Consult Appointments (d)				
Median (IQR)	3 (1-8)	36 (15-64)	45 (12-97)	31 (7-75)
Mean (SD)	9.3 (22.0)	50.8 (53.2)	65.0 (67.8)	51.5 (61.0)
Satisfaction Ratings, Mean (SD)				
Overall	94.1 (6.6)	87.9 (14.2)	N/A	92.7 (10.1)
Access	91.7 (9.1)	85.4 (16.0)	N/A	89.3 (14.5)
Ability to get desired appointment	96.9 (8.5)	77.2 (28.4)	N/A	83.6 (25.4)
Convenience of office hours	87.5 (12.9)	86.0 (20.0)	N/A	88.9 (17.1)
Ease of scheduling appointments	88.3 (16.0)	82.1 (24.2)	N/A	88.5 (19.9)

CI, confidence interval.; IQR, interquartile range.; UCC, Urgent care clinic. ICC, Intermediate care clinic.

19.5%-21.0%) of ICC orders, and 15.8% (95% CI: 15.3%-16.2%) of routine care orders originating from a subspecialist (P<0.001).

Diagnoses
The most common cutaneous diagnoses in appointments resulting in referrals to UCC were rash/nonspecific skin eruption (30.7%), unspecified disorder of skin (6.6%), and unspecified dermatitis (3.5%), whereas in appointments resulting in referrals to routine care, the most common cutaneous diagnoses were unspecified disorder of skin (11.5%), melanocytic nevi (10.7%), and rash/nonspecific eruption (10.0%), Table 4. The distribution of diagnoses in appointments resulting in referrals to ICC resembled that in appointments resulting in referrals to routine care.

In UCC appointments, the most common diagnoses established by the dermatology provider were rash/nonspecific eruption (17.3%), unspecified neoplasm (14.4%), and unspecified dermatitis (9.3%), whereas the most prevalent diagnoses in routine care appointments were unspecified neoplasm (19.5%), seborrheic keratosis (12.2%), and melanocytic nevi (10.8%), Table 5. Again, the

distribution of diagnoses in ICC appointments resembled that in routine care appointments.

Discussion
Our findings indicate that a dermatology urgent care clinic within a large, tertiary academic medical center can reduce wait times for patients while maintaining patient satisfaction. Moreover, these patients more frequently attend consult and follow-up appointments and exhibit different distributions of diagnoses.

In an ideal triage system, wait times are inversely correlated with acuity. In our model, multiple tiers of care urgency improved access so that patients were more likely to receive dermatology care with the requisite degree of timeliness. The relative median wait times observed in UCC, ICC, and routine care reflect the objectives of this three-tiered model.

There are multiple potential explanations for the sizable percentage of patients not scheduling and completing their consult appointments. First, conditions may resolve on their own, thus eliminating the reason for the appointment. Second, patients may seek dermatology care outside our

Table 3. *Most common referring specialties.*

Rank	UCC		ICC		Routine		Overall	
	Diagnosis	%	Diagnosis	%	Diagnosis	%	Diagnosis	%
1	Internal Medicine and Family Medicine	49.2	Internal Medicine and Family Medicine	76.9	Internal Medicine and Family Medicine	81.4	Internal Medicine and Family Medicine	77.3
2	Hematology/Oncology	15.3	Rheumatology	4.0	Gastroenterology	3.8	Gastroenterology	3.3
3	Rheumatology	5.0	Gastroenterology	2.6	Rheumatology	1.8	Hematology/Oncology	2.9
4	Infectious Disease	3.9	Geriatrics	2.5	OB/GYN	1.6	Rheumatology	2.7
5	OB/GYN	3.8	Hematology/Oncology	2.4	Nephrology	1.4	OB/GYN	1.8
6	Geriatrics	2.8	Infectious Disease	2.2	Hematology/Oncology	1.4	Geriatrics	1.7
7	Gastroenterology	2.6	Nephrology	1.5	Neurology	1.4	Nephrology	1.5
8	Cardiology	2.3	OB/GYN	1.4	Adolescent Medicine	1.3	Infectious Disease	1.4
9	Nephrology	2.2	Pulmonology	1.1	Geriatrics	1.0	Neurology	1.3
10	Neurology	2.1	Allergy and Immunology	1.1	Allergy and Immunology	0.8	Allergy and Immunology	0.9

UCC, Urgent care clinic.
ICC, Intermediate care clinic

institution. These events are more likely to occur for less urgent conditions, which explains the large variation in the likelihood of completing consult appointments among patients referred to UCC, ICC, and routine care. Third, routine care appointments must be scheduled by patients themselves rather than triage staff. This additional step on the part of patients may have reduced appointment adherence. The higher likelihood of UCC patients scheduling and attending a follow-up appointment relative to ICC and routine care patients presumably reflects a greater need for follow-up care for patients with more serious skin conditions.

In terms of obtaining a desired appointment, UCC patients were more satisfied than patients overall, who in turn were slightly more satisfied than ICC patients. These differences may reflect the order of median wait times for these three groups (3, 31, and 36 days, respectively). For all other satisfaction metrics, however, our findings suggest that institutions can achieve high ratings in urgent and non-urgent settings simultaneously.

The greater proportion of subspecialist referrals to UCC relative to routine care likely resulted from a more medically complex patient base. As UCC was designed to accommodate patients with acute skin conditions, particularly in immunosuppressed hosts, it is not surprising that referrals to this clinic often originated from subspecialty clinics. Specifically, the high frequency of hematology/oncology, rheumatology, and infectious disease referrals may reflect the medical urgency that often stems from the immunocompromised state or infection in patients undergoing treatment by clinicians in these specialties.

The diagnoses of rash/nonspecific eruption, unspecified dermatitis, and contact dermatitis were greatly overrepresented in UCC relative to routine care consult appointments. In contrast, the diagnoses of melanocytic nevi and seborrheic keratosis were substantially less common in UCC relative to routine care. These findings suggest that patients referred to UCC are often sent for inflammatory skin conditions rather than lesion-related questions, reflecting the type of diagnoses that require acute evaluation in medically complex or immunosuppressed patients. Likewise, it is expected that benign and more easily recognizable

Table 4. *Most common diagnoses at referring provider appointments.*

Rank	UCC		ICC		Routine		Overall	
	Diagnosis	%	Diagnosis	%	Diagnosis	%	Diagnosis	%
1	R21 Rash and other nonspecific skin eruption	30.7	Z00.00 Encntr for general adult medical exam w/o abnormal findings	21.0	Z00.00 Encntr for general adult medical exam w/o abnormal findings	25.4	Z00.00 Encntr for general adult medical exam w/o abnormal findings	22.1
2	I10 Essential (primary) hypertension	8.2	I10 Essential (primary) hypertension	20.2	I10 Essential (primary) hypertension	17.5	I10 Essential (primary) hypertension	17.6
3	L98.9 Disorder of the skin and subcutaneous tissue, unspecified	6.6	Z23 Encounter for immunization	16.0	Z23 Encounter for immunization	15.3	Z23 Encounter for immunization	14.7
4	Z23 Encounter for immunization	5.3	R21 Rash and other nonspecific skin eruption	13.2	L98.9 Disorder of the skin and subcutaneous tissue, unspecified	11.5	R21 Rash and other nonspecific skin eruption	12.8
5	L30.9 Dermatitis, unspecified	3.5	L98.9 Disorder of the skin and subcutaneous tissue, unspecified	10.9	D22.9 Melanocytic nevi, unspecified	10.7	L98.9 Disorder of the skin and subcutaneous tissue, unspecified	10.9
6	Z00.00 Encntr for general adult medical exam w/o abnormal findings	3.0	D22.9 Melanocytic nevi, unspecified	10.4	R21 Rash and other nonspecific skin eruption	10.0	D22.9 Melanocytic nevi, unspecified	9.9
7	E11.9 Type 2 diabetes mellitus without complications	2.9	E11.9 Type 2 diabetes mellitus without complications	5.5	E78.5 Hyperlipidemia, unspecified	5.6	E78.5 Hyperlipidemia, unspecified	5.0
8	L29.9 Pruritus, unspecified	2.4	E78.2 Mixed hyperlipidemia	5.0	E78.2 Mixed hyperlipidemia	5.2	E11.9 Type 2 diabetes mellitus without complications	4.8
9	D22.9 Melanocytic nevi, unspecified	2.2	E78.5 Hyperlipidemia, unspecified	4.9	Z13.220 Encounter for screening for lipoid disorders	4.8	E78.2 Mixed hyperlipidemia	4.8
10	B20 Human immunodeficiency virus [HIV] disease	2.2	Z13.220 Encounter for screening for lipoid disorders	4.4	E11.9 Type 2 diabetes mellitus without complications	4.7	Z13.220 Encounter for screening for lipoid disorders	4.3

ICC, Intermediate care clinic.

lesions such as seborrheic keratoses would appear less frequently in UCC relative to routine care. The distribution of dermatologic diagnoses has been shown to vary with triage urgency [16] and inflammatory skin diseases and skin infections have been established as common pathologies in other dermatology urgent care settings [17, 18].

Our study has several limitations. First, our findings may not be generalizable to other institutions owing to the single-institution design. In particular, it may not be practical for institutions with smaller patient volumes or fewer providers to establish a similar system; institutions with limited electronic referral capability may have difficulty minimizing administrative burden on the part of the referring provider and triage staff. Second, it requires skilled staff to sort through the volume of orders, confirm the level of acuity and triage appropriately, and contact and schedule patients. Maintaining designated open provider slots to accommodate these acute referrals may be a challenge. Third, the available data did not permit determination of how

frequently the triage team modified the urgency submitted by the referring provider. A portion of the referrals to UCC or ICC are typically rerouted to each other or to routine care. However, an analysis of a dermatology urgent access clinic at another institution determined that the majority of referrals were appropriate [12]. In our triage system, we generally defer to the judgment of the point-of-care provider placing the order to determine how quickly the patient should be seen. Fourth, the exclusion criteria, while necessary to obtain the most representative description of our institution's experience, may have excluded a small number of consult orders that were legitimately placed multiple times before a consult appointment occurred, or were delayed for times exceeding 12 months,

although the authors believe this is very unlikely. Consequently, the actual wait times in these cases may be longer than calculated.

Conclusion

In conclusion, our study suggests that dermatology rapid access clinics can facilitate access to care for patients requiring urgent appointments. To promote evidence-based triage, additional research should determine the significance of various clinical predictors in triaging dermatology patients, including the reason for referral, comorbidities, and the referring specialty. Finally, future studies should evaluate the impact of these clinics on patient outcomes and determine the optimal allocation of resources between routine care and urgent care settings to maximize population health.

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Table 5. *Most common diagnoses at consult appointments*

Rank	UCC (%)		ICC (%)		Routine (%)		Overall (%)	
	Diagnosis	%	Diagnosis	%	Diagnosis	%	Diagnosis	%
1	R21 Rash and other nonspecific skin eruption	17.3	D48.5 Neoplasm of uncertain behavior of skin	19.7	D48.5 Neoplasm of uncertain behavior of skin	19.5	D48.5 Neoplasm of uncertain behavior of skin	18.8
2	D48.5 Neoplasm of uncertain behavior of skin	14.4	L82.1 Other seborrheic keratosis	13.0	L82.1 Other seborrheic keratosis	12.2	L82.1 Other seborrheic keratosis	11.3
3	L30.9 Dermatitis, unspecified	9.3	D22.9 Melanocytic nevi, unspecified	9.8	D22.9 Melanocytic nevi, unspecified	10.8	D22.9 Melanocytic nevi, unspecified	9.2
4	L25.9 Unspecified contact dermatitis, unspecified cause	6.5	I78.1 Nevus, non-neoplastic	7.1	D23.9 Other benign neoplasm of skin, unspecified	10.7	D23.9 Other benign neoplasm of skin, unspecified	8.2
5	L82.1 Other seborrheic keratosis	4.8	L57.0 Actinic keratosis	7.0	I78.1 Nevus, non-neoplastic	8.0	R21 Rash and other nonspecific skin eruption	6.9
6	L29.9 Pruritus, unspecified	3.4	D23.9 Other benign neoplasm of skin, unspecified	7.0	L57.0 Actinic keratosis	7.7	I78.1 Nevus, non-neoplastic	6.9
7	L57.0 Actinic keratosis	2.9	L21.9 Seborrheic dermatitis, unspecified	5.3	L57.8 Oth skin changes due to chr expsr to nonionizing radiation	6.3	L57.0 Actinic keratosis	6.7
8	D23.9 Other benign neoplasm of skin, unspecified	2.7	R21 Rash and other nonspecific skin eruption	5.2	L81.4 Other melanin hyperpigmentation	5.8	L30.9 Dermatitis, unspecified	5.9
9	D22.9 Melanocytic nevi, unspecified	2.7	L70.8 Other acne	5.0	L70.8 Other acne	5.6	L57.8 Oth skin changes due to chr expsr to nonionizing radiation	4.8
10	I78.1 Nevus, non-neoplastic	2.6	L30.9 Dermatitis, unspecified	4.9	L30.9 Dermatitis, unspecified	5.5	L70.8 Other acne	4.8

UCC, Urgent care clinic.
ICC, Intermediate care clinic.