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http://dx.doi.org/10.1016/j.jaad.2017.06.025

Assessment of dermatology clinic resources at safety-net hospitals: Results from a national survey

To the Editor: Resources available to outpatient dermatology clinics at safety-net hospitals, which provide high proportions of uncompensated care to indigent patients, have not been well characterized. The goal of this study was to identify resource deficiencies in these clinics with the intent to optimize dermatologic care for the underserved.

A 42-question cross-sectional survey designed on Research Electronic Data Capture assessed the staffing, patient volume, appointment wait times, and medical services offered at outpatient dermatology clinics in safety-net hospitals affiliated with dermatology residency programs in the United States. Surveys were sent via e-mail to the chiefs of the outpatient dermatology clinics of 50 safety-net hospitals. Safety-net hospital statuses were based on institutions' Disproportionate Share Hospital patient percentage being in the top decile nationally, as defined in earlier studies.[1]

The survey had a 62% completion rate. Supplemental Table I (available at http://www.jaad.org) summarized the characteristics of the 31 responding clinics. Each half-day outpatient dermatology clinic had a median of 48 (interquartile range [IQR] 30-60) patients scheduled. The median no-show rate for these scheduled appointments was 30% (IQR 24.25%-35%). The median wait time until the third next-available appointment for a new and follow-up patient was 45 (IQR 30-90) days and 30 (IQR 16.5-55) days, respectively (Table I). Each half-day dermatology clinic had a median of 3 (IQR 1.75-4) providers per nurse, and 2 (IQR 2-4) providers per medical assistant (Table II). Most clinics offered select dermatology subspecialty services (eg, dermatopathology and pediatric dermatology) and treatments (eg, phototherapy and patch testing) (Supplemental Fig 1; available at http://www.jaad.org).

Table I. Statistics for appointments at outpatient dermatology clinics at safety-net hospitals

Category	N	Median	IQR
Patients scheduled per half-day clinic, n	25	48	30-60
No-show for patient appointments, %	28	30	24.3-35
Wait time till third next-available appointment for new patient, days	25	45	30-90
Wait time till third next-available appointment for follow-up, d	23	30	16.5-55
Patient commute time, min	12	35	27.5-60
Wait time from the moment a patient arrives for an appointment until the end of the appointment, min	23	48	30-60

IQR, Interquartile range.

Table II. Staffing at safety-net dermatology outpatient clinics

Category	N	Median	IQR
Half-day outpatient dermatology clinics per week	28	6.5	4-10
Attending physicians per half-day clinic without residents	14	2	1-2
Patients seen by 1 attending physician in a half-day clinic without residents	12	11.5	9-18.5
Attending physicians per half-day clinic with residents	31	2	1-2
Patients seen in a half-day clinic with residents	29	23	15.8-35
Residents per half-day clinic	31	4	3-5
Patients seen by residents per half-day clinic	30	8	7-9
Midlevel providers per half-day clinic	15	1	0.5-1
Patients seen by midlevel providers per half-day clinic	12	7.5	6-10.5
Nurses per half-day clinic	25	2	1-2
Providers per nurse	20	3	1.8-4
Medical assistants per half-day clinic	24	2	2-3
Providers per medical assistant	21	2	2-4
Clinic rooms per provider	29	2	2-4

IQR, Interquartile range.

The 30% no-show rate is similar to nonattendance rates among patients with state-supported insurance (26%).[2] High no-show rates in the safety-net outpatient dermatology clinics, which can be due to transportation constraints and inability to take leave from work, can result in increased wait times for appointment availability. Our survey revealed a mean wait time of 45 days for a new patient visit, compared with 29.1 days according to the 2014 American Academy of Dermatology Practice Survey, which compiled data from practicing dermatologists across the United States.[3] Extended wait times can be compounded by understaffing issues. Although

optimal staffing for outpatient dermatology clinics is not known, staffing ratios reported by safety-net dermatology clinics are less than ideal, as providers outnumber support staff. Hiring additional nursing staff can help improve clinic productivity and reduce wait times. For example, the increase from 1 nurse per provider to 2 nurses led to a 30% increase in completed visits at 1 university hospital dermatology clinic.[4] In the outpatient dermatology clinic at Parkland Health and Hospital System in Dallas, Texas, the hiring of an additional nurse resulted in a 31% decrease in wait times.[5]

Our survey of safety-net dermatology clinics revealed that they have long wait times for appointment availability, high no-show rates, and are understaffed in regards to medical assistants and nurses. Limitations included small sample size, urban location of all surveyed clinics, and lack of standardized definition of safety-net hospital. The need to characterize gaps in dermatologic care for underserved populations is crucial to allow for improved allocation of the limited financial resources at safety-net hospitals.

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Funding sources: None.

Disclosure: Dr Albrecht is directly employed by Cook County Health and Hospital Systems, and Dr McLellan is directly employed by Jacobi Medical Center.

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http://dx.doi.org/10.1016/j.jaad.2017.06.026

Oral tofacitinib monotherapy in Korean patients with refractory moderate-to-severe alopecia areata: A case series

To the Editor: Recent reports document successful treatment of alopecia areata (AA) with tofacitinib.[1-5] However, long-term data using tofacitinib monotherapy is still sparse, and we are unaware of the quality of treatment in persons of Asian decent. We report the results of extended tofacitinib monotherapy in adult Korean patients with moderate-to-severe AA.

After obtaining approval by the institutional review board, we retrospectively reviewed a prospective database having 32 patients with >30% hair loss who had undergone ≥4 months of treatment (Table I). Most (29, 90.6%) patients were refractory to previous treatments, which included oral steroid and cyclosporine. Alopecia severity had been recorded using the Severity of Alopecia Tool (SALT). $SALT_{50}$ and $SALT_{90}$ were defined by 50% and 90% regrowth, respectively.

Twenty-four patients (75.0%) exhibited >5% hair regrowth: 6 with 5%-50% regrowth (median duration and median total dose of tofacitinib; 7 months and 1960 mg, respectively); 9 with 50%-90% regrowth (9 months and 1820 mg, respectively); and 9 with >90% regrowth (10 months and 2240 mg, respectively). Eight patients showed no response (median duration and median total dose of tofacitinib; 6 months and 2240 mg, respectively). Eighteen patients (56.3%) achieved $SALT_{50}$ at a median of 3 (range 2-10) months, and 9 patients (28.1%) acquired $SALT_{90}$ at a median of 6 (range 4-11) months. All of them achieved $SALT_{50}$ or $SALT_{90}$ on a 5-mg twice daily regimen. In 6 patients, the dose was increased (up to 20 mg/day), which accelerated hair regrowth but did not result in $SALT_{50}$ during the follow-up period. Two of 18 $SALT_{50}$ achievers (11.1%) deteriorated after the initial response but