RESEARCH LETTER

Rapid Access Clinic Expedites Patient Connection with Dermatologic Services and Improves Productivity

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Access to dermatologic care, especially for urgent complaints, poses an ongoing challenge. To address long scheduling wait times and acute dermatologic complaints, institutions have sought innovative solutions to patient access problems.[1-5] To improve access at the University of Alabama at Birmingham, a twice weekly Rapid Access Clinic (RAC) was implemented in 2017 where up to 60 patients are scheduled on Tuesday. On Fridays, 40 patients were scheduled for the first month with 50 scheduled the subsequent months. These clinics are staffed by 6 dermatology residents plus 2 attendings. Referrals are not required. Most appointments are scheduled within 2 weeks. This clinic has been in place for around one year and we continue to see a similar number of patients. Visits are intended to be limited to a single dermatologic complaint, and patients are informed of this policy.

A retrospective review was conducted for all RAC patients seen over a 4-month period (9/1/2017-12/31/2017). Twenty-seven clinics with 1018 visits were reviewed for demographics, diagnosis, and follow-up recommendations (Table 1). The average patient age was 51.5 (range 5-100), 60.1% were female, and 89.7% were new patients. Despite our intent to limit visits to 1 complaint, most patients had several complains addressed. Seventy eight new cutaneous malignancies were diagnosed, including six melanomas (Table 1).

RAC implementation reduced appointment wait times considerably. Our department's scheduling wait times before RAC were 96 and 87 days for new and return patients, respectively (Table 2). After 10 months of RAC, the wait times were 35 and 32 days for

Table 1: Characterizing patient population, patient diagnoses, and follow-up recommendations from RAC.

Patient Demographics (n=1018)	**Mean (± SD) or n (%)**
Age	51.5 (+/- 18.6)
Female gender	612 (60.1%)
New patient	913 (89.7%)
Return patient with new complaint	49 (4.8%)
Total Eruptions Diagnosed	712 (47.9%)
Total Neoplasms Diagnosed	784 (52.1%)
Follow-up required	611 (60.0%)
Biopsy results	**Number of patients (total number detected)**
BCC	39 (45)
SCC SCC in situ	19 (23) 3 (3)
Melanoma	5 (6)
Adenocarcinoma	1 (1)

new, and returns. The no-show rate for RAC was 17.3%.

Implementation of the biweekly RAC model resulted in dramatic departmental productivity enhancement (Table 2). The average RAC encounter generated approximately 55% more wRVUs on average than non-RAC clinic visits due to a high proportion of new patients and procedures performed in RAC vs non-RAC clinic. By replacing one regular clinic with a RAC, one faculty member noted an increase of over 1000 wRVUs in a 5-month period. The change in wRVUs could not be assessed for the other RAC attending as they joined the department around the time RAC was implemented. The most frequently used billing codes in RAC were for skin biopsies, followed closely by destruction of benign lesions (Table 2). RAC significantly augmented our procedural referrals. RAC resulted in 116 procedural referrals, including 54 distinct lesions referred for Mohs surgery (Table 2).

Table 2: Identifying patient services and assessing productivity gains associated with RAC.

Productivity Measures	**Metrics**
Difference in RAC vs non-RAC wRVUS (%) per encounter	+55%
Change in wait times for new patients	61 days shorter
Change in wait times for return patients	55 days shorter
No-show rate (% of RAC appointments)	17.3%
Procedural referrals	**Number of patients (total number of lesions to treat)**
Excision	54 (58)
MMS	43 (54)
Laser treatment	4 (4)
Total	101 (116)

Table 2: Continued.

Procedure code	**% of patients (n)**
Skin biopsy (11100)	14.7 (150)
Destruction of benign lesions (17110)	12.3 (125)
Destruction of 1st premalignant lesion (17000)	10.2 (104)
Destruction of premalignant lesions 2-14 (17003)	7.0 (71)
Distinct procedural services (59 modifier)	4.6 (47)
Injection 1-7 lesions (11900)	2.2 (22)
Acne surgery (10040)	1.1 (11)

Implementing the RAC model helped us achieve our goals of shortening wait times, enhancing department revenue, and diagnosing more cutaneous malignancies, especially melanomas. Limitations of this study include its retrospective nature and short time frame. The RAC was implemented at a large tertiary care academic center staffed by a sizeable department with a broad referral base, thus results may not be generalizable to all clinic settings. Improving access to dermatologic care is complex; however, the RAC model accomplishes this goal for patients with acute complaints. Future studies are needed to assess the flexibility of implementing this model in different practice settings.

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