Delivering equitable care for disabled patients.

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Figure 1. Workflow of visiting dermatologist.

* Dermatological equipment includes scalpel blades, handles, double edged razor blades, dermal punches, scissors, forceps, suture kits, gauze pads, specimen containers, aluminum chloride, Vaseline, and band aids

** Informed consent obtained same day for urgent procedures
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An estimated 1% of the general population is living with an intellectual disability (ID), with 0.6% living with severe ID. The prevalence of skin conditions amongst the ID population is 10-14% greater compared to the general population, thus access to high-quality dermatological care is clear. Unfortunately, most medical students and residents do not receive formal training regarding unique adaptations required when caring for patients with ID. Some students even reported developing negative perceptions towards patients with disabilities. Compounded by the socioeconomic inequalities and high demand for dermatologists, high quality dermatological care is not always achieved for patients with disabilities. Patient immobility, poor eyesight, behavioral and emotional lability, and polypharmacy all pose as diagnostic and management challenges. When a dermatology consult is required, patient transport, behavior, triggers, and communication all need be considered. Thus, to address quality of care, management, and economic issues in our group home for the intellectually disabled, we provided dermatological care through a regularly scheduled visiting dermatologist.

Previous articles have highlighted the benefits of dermatological visits to nursing homes 3-4 times a year, we similarly report that visiting dermatology visits 4-5 times a year have also proven to be effective in a group home setting. We found many patient triggers can be avoided this way as patients need not travel to unfamiliar places and can be cared for and comforted in their familiar environments. Group homes are routinely equipped with basic medical equipment, therefore creating an agreement regarding covering costs and storing of dermatological equipment was not an issue. Additionally, as the nursing staff has become more familiar with our visiting dermatologist, they have been able to assist with biopsies and are familiar with post-care instructions for biopsies and cryotherapy treatments.

There is also a socioeconomic benefit as each patient does not need to be transported to the outside office individually reducing operating costs and staffing issues. These issues have especially been prevalent during the COVID-19 pandemic and rising costs our economy currently is facing. Our facility and patients are very fortunate to have an experienced dermatologist visiting bi-monthly whom spends 90 to 120 minutes seeing a total of 8-10 patients previously identified by the nursing facility amongst a population of approximately 75 patients (Figure 1). While we acknowledge that there is a shortage of dermatologists, we would like to emphasize that brevity,
infrequency of visits, and schedule flexibility. The most frequent conditions treated by our visiting dermatologist include atopic dermatitis, factitious dermatitis, irritant dermatitis, intertrigo, and identification of pre-cancerous or cancerous lesions. Additionally, the group home physician may also be present and shared decision can be made more effectively without any delays to initiating treatment. This allows for improved quality of care and patient management.

Lastly, we would like to urge teaching facilities to try to create more inclusive patient populations in clinical scenarios to break down the stigma and negative perceptions towards patients with ID. Afterall, it is our duty and privilege to provide equitable care for all our patients.
References


Agreement between dermatologist office/hospital is made.

Dermatological equipment is obtained and properly stored. *

Nursing staff identify patient(s), prepare a list of patient names and room numbers, and provide a brief history regarding area(s) of concern.

Documentation/clean up is performed by nursing facility and dermatologist.

Group home physician approves patient list.

A nurse accompanies dermatologist to pre-identified patients with group home physician available either in person or immediately by phone.

Dermatologist arrives with liquid nitrogen and dermatoscope.

Informed consent is obtained for patients who require procedures including cryotherapy to be performed at next visit. **