286 Dermatology visits account for a majority of dermatologic diagnoses: A representative sample of U.S. outpatient visits

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Given their prevalence, skin diseases are an important public health issue. In 2013, over 25% of the US population was impacted by dermatologic diseases, resulting in $75 billion in direct healthcare costs. Through 2010, non-dermatologists diagnosed a majority of skin diseases in outpatient settings. We sought to assess whether this was still the case in 2016 and determine the most common dermatologic diagnoses seen in dermatology and non-dermatology practices. We assessed visits in the 2016 National Ambulatory Medical Care Survey, an annual representative survey of visits to U.S. outpatient physicians. We analyzed all diagnosis codes reported at visits with dermatologists and non-dermatologists to determine the most common dermatologic diagnoses. Observed visits were weighted to obtain a nationally representative estimate of all visits in the U.S. There were an estimated 49.9 million visits to dermatologists with 17.7 million visits to non-dermatologists, with 106 million dermatology diagnoses. The top 5 diagnoses for dermatologists were actinic keratosis, seborrheic keratosis, acne vulgaris, unspecified melanocytic nevi, and unspecified external cause. The top 5 dermatology diagnoses for non-dermatologists were unspecified dermatitis, rash and other nonspecific skin eruption, unspecified viral infection, unspecified toxic dermatitis, and unspecified chalazion. Seborrheic keratosis, malignant neoplasms of the skin, melanin hyperpigmentation, melanocytic nevi, and actinic keratosis were the most commonly referred diagnoses to dermatologists. In 2016, dermatologists diagnosed a majority (50.2%) of skin diseases in the outpatient setting. The skin conditions most commonly seen by non-dermatologists differ from those seen by dermatologists. These differences as well as the top diagnostic referrals can be used as a foundation for tailoring dermatology training for non-dermatologists.

288 Characterizing risk factors for hospitalization for psoriasis patients

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Psoriasis is a chronic autoimmune disease with a large economic impact. The objective of this retrospective study was to characterize patients who are hospitalized for psoriasis, and differentiate features for patients with a single hospitalization from those who are hospitalized multiple times during the study period. Hospitalized psoriasis patients were identified from an inpatient database at a single academic institution. Differences between psoriasis patients with one hospitalization and those with multiple hospitalizations were characterized, as were differences between patients who were hospitalized primarily for psoriasis and those who were admitted primarily for other reasons. Patients hospitalized 10 times had 290 hospitalizations with a mean Charlson comorbidity score (1.9 vs. 3.4, P < 0.05), shorter hospitalizations (0.4 days vs. 3.1 days, P < 0.05) and a lower death rate (0% vs. 4.7%, P < 0.05) than those hospitalized for other reasons. Patients with a primary discharge diagnosis of psoriasis also had a trend toward lower average income by zip code, though this value was not statistically significant. Our findings affirm the importance of regular dermatologic care for psoriasis patients in preventing hospitalizations. Dermatologists should be aware of the risk factors for hospitalization for psoriasis patients and work to mitigate them, as well as encourage patients to seek dermatologic care.

289 A retrospective study of cellulitis outcomes in Ohio hospitals with or without access to dermatology residency programs

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A retrospective study of cellulitis outcomes in Ohio hospitals with or without access to dermatology residency programs

March 29, 2020 - The University of Cincinnati College of Medicine, Cincinnati, Ohio, United States

Medicare costs from 2011-2017, common diagnosis related groups (DRG)s, inpatient discharges per bed size from 2011-2017 have been reported in Ohio hospitals with and without dermatology residency programs, with 368 WSS reported from 2015-2019 there were 368 WSS reported from 178 licensed facilities, excluding private offices. Dermatology accounted for 9 (2%) of the 368 cases, 8 of which were wrong-site and one wrong-side. Of the 9 procedures, 2 were biopsies, 4 excisions, 2 Mohs and 1 curetage. Five involved the head with 1 each from the chest/thorax, upper extremity, and spine and 1 was unspecified. Root causes of WSS identified by both the JC and PSA were accuracy and verification issues in procedure scheduling, failure to follow the three-part Universal Protocol and organizational safety culture issues. Additional strategies for dermatology include accurate biopsy site identification utilizing high-quality scanning and close-up photographs and specific and consistent anatomic designations. In conclusion WSS data may not reflect their absolute frequency. Health care facilities should conduct additional analysis of their existing procedures to minimize the occurrence of WSS.