

Approaching the dermatologic care of people experiencing unsheltered homelessness through a volunteer street dermatology model



To the Editor: Although contemporary health care delivery models aim to tackle health care disparities, the most vulnerable patient populations continue to suffer from reduced access to care. A street-based approach presents a framework for clinical outreach to this truly underserved population that bears a disproportionate burden of disease.¹ Patients who would otherwise be unable to attend structured, charitable clinics can instead be evaluated in their own setting and on their own terms. Such “house-calls for the homeless” can bridge notable gaps in care, especially for essential yet difficult to access services like dermatology.²

The distinction between sheltered and unsheltered populations is not often made in medical literature, as previous studies involving people experiencing homelessness utilize shelter-based co-

orts.³ In the absence of reliable shelter, people experiencing unsheltered homelessness (PEUH) are exposed to conditions that increase their risk of suboptimal dermatologic health leading to cellulitis and osteomyelitis.⁴ Street Dermatology is a model to provide direct dermatologic care for PEUH living near sidewalks, encampments, and overpasses. Many of these patients live in squalid conditions with both food and medical insecurity, and lack the means to coordinate formal health care visits.

After registering with the state health department, ethical approval was obtained by the University of Miami Institutional Review Board (IRB) in conjunction with established volunteer street medicine providers.

PEUH encountered face-to-face were offered basic medical care by a team of providers supervised by a physician. Although board-certified dermatologists were invited to participate in the outreach, most initial dermatologic input was provided via store-and-forward telemedicine (Fig 1). Skin conditions

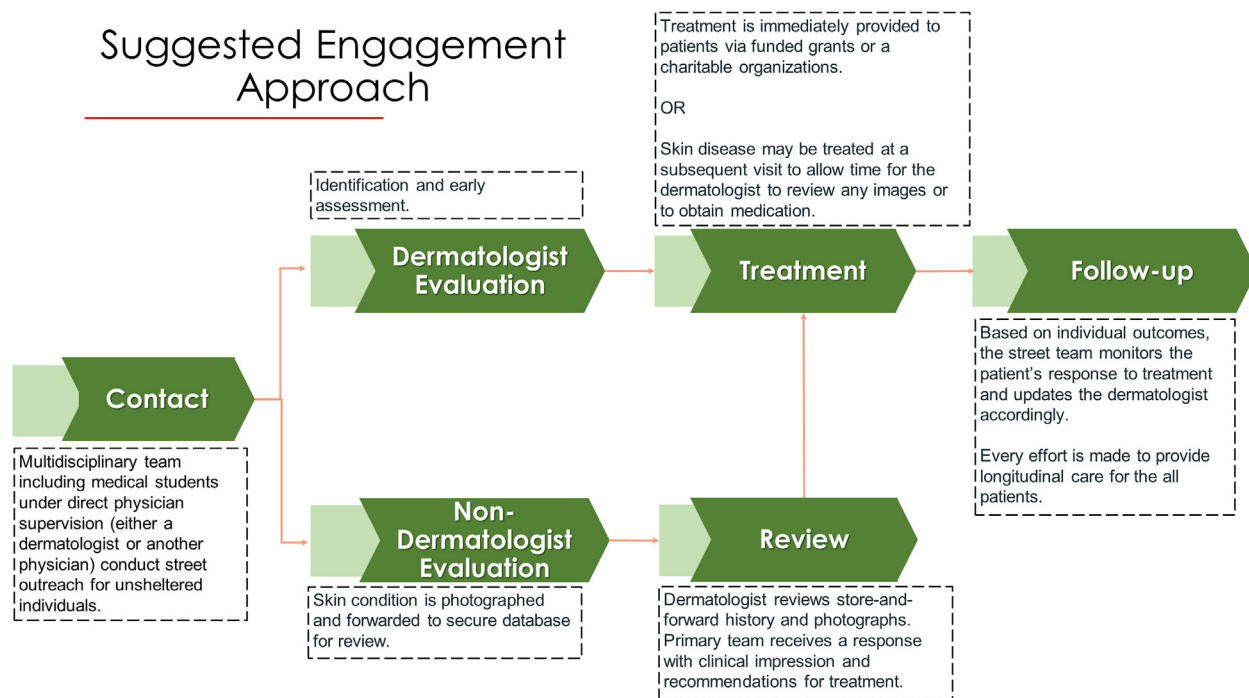


Fig 1. Flow diagram of Street Dermatology structure and function from initial patient contact to follow-up.

Table I. Dermatologic conditions encountered over a 6-month period

Type of condition	Number of diagnoses (% of total)
Inflammatory	30 (24.0)
Acne	4 (3.2)
Pseudofolliculitis barbae	1 (0.8)
Dermatitis	20 (16.0)
Contact	5 (4.0)
Chronic dermatitis/Lichen simplex chronicus	8 (6.4)
Photodermatitis	2 (1.6)
Venous	3 (2.4)
Unspecified	2 (1.6)
Psoriasis	2 (1.6)
Seborrheic dermatitis	2 (1.6)
Lichen planus	1 (0.8)
Infectious	35 (28.0)
Tinea cruris	1 (0.8)
Tinea pedis	10 (8.0)
Tinea manuum	1 (0.8)
Onychomycosis	10 (8.0)
Verruca vulgaris	4 (3.2)
Erosio interdigitalis blastomycetica	5 (4.0)
Pityriasis versicolor	1 (0.8)
Scabies	3 (2.4)
Ulcerations/erosions/wounds	16 (12.8)
Erosions and wounds	11 (8.8)
Burn	2 (1.6)
Post-trauma scars	3 (2.4)
Nail disorders	6 (4.8)
Paronychia	2 (1.6)
Micronychia	1 (0.8)
Leukonychia	1 (0.8)
Beau's lines	1 (0.8)
Clubbing	1 (0.8)
Pruritus	10 (8.0)
Prurigo nodularis	1 (0.8)
Cutaneous neoplasm or UV damage	13 (10.4)
Seborrheic keratosis	6 (4.8)
Actinic keratosis	3 (2.4)
Solar lentigo	2 (1.6)
Idiopathic guttate hypomelanosis	1 (0.8)
Melanoma	1 (0.8)
Miscellaneous	10 (8.0)
Arthropod assault	4 (3.2)
Acrochordon	1 (0.8)
Corns	1 (0.8)
Ichthyosis vulgaris	1 (0.8)
Xerosis	2 (1.6)
Terra firma-forme dermatosis	1 (0.8)
Unspecified, requiring dermatology evaluation	5 (4.0)
Total	125 (100)

were documented among 160 PEUH encountered in Miami-Dade County from January to June 2022. A total of 125 dermatologic diagnoses (Table I) were made. We reviewed patient history, clinical presentation, and recommended treatment weekly. There was a wide distribution of dermatologic disease noted, with infectious (28.0%, $n = 35$), inflammatory (24.0%, $n = 30$), ulcers/erosion/wounds (12.8%, $n = 16$), UV-induced/neoplastic disorders (10.4%, $n = 13$), and pruritus (7.2%, $n = 9$) being prevalent. Patients received treatment and education about their condition including preventative measures. Patient information was stored on a secure, custom REDCap medical record.

Life-changing diagnoses were also made. For roughly 15 years, one patient had a slow growing, quarter-sized hyperpigmented lesion on his cheek. During street evaluation, the characteristics of his lesion raised concern for melanoma. He was immediately connected to our dermatology service where he received biopsies which confirmed the diagnosis of melanoma at a depth of 1 mm. Subsequently, surgery was coordinated. In this way, PEUH could now be connected to reliable, specialized care.

This model's reproducibility varies on a regional basis but can be adopted by a multidisciplinary team of medical providers, educators, and social workers.⁵ Notable drawbacks include unpredictability of follow-up care due to the inherently informal structure of our evaluations. Funding is dependent on charitable contributions and first-line treatments may be unavailable. Such outreach works for patients whose condition does not warrant urgent medical care but still requires timely management. Street Dermatology demonstrates the vital role our specialty can play in the care in one of the most underserved populations.

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Conflicts of interest

None disclosed.

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