



# Building a Modern Dermatology Department



How blending the best of private practice and academic medicine works for this pediatric dermatologist.

**WITH ANDREW C. KRAKOWSKI, MD**

**>>** As the founding chair of a new dermatology department and residency in dermatology program at St. Luke's University Health Network in Bethlehem, PA, Andrew C. Krakowski, MD understands first-hand both the challenges and benefits of designing a program from the ground up. Ahead, he shares his journey in helping to open a new dermatology department and how he used what he learned throughout his career in pediatric dermatology to design a department that blends the best of academic and private practice.

## When you first started in pediatric dermatology, what did you imagine your career and practice would look like?

**Andrew C. Krakowski, MD:** My father, Frank, was a geriatrician who was able to help a great number of elderly patients through many a tough time in the sunset of their lives. I witnessed that growing up and loved it. I was amazed that you could find your way in the world by helping other people. But I found that I had more interest in focusing on the sunrise—to me a child's world is so full of promise and optimism, you've got a full life ahead of you and a chance to change the world. So I always knew I wanted to work with children. I draw strength and energy from it.

Before becoming a pediatric dermatologist, I completed a full pediatrics residency at Johns Hopkins. Working in Baltimore and treating patients without a lot of resources, I saw the positive impact I could have helping pediatric patients with skin conditions and knew I couldn't do anything else. It took two years, but eventually I was accepted into a residency program in dermatology at the University of California Medical Center San Diego.

While interviewing for residency, I remember being asked what I wanted my future pediatric dermatology practice to look like. I distinctly remember being chastised by an interviewer for being too honest about wanting to go into private practice and not being 100 percent committed to

going into academic medicine. They were tough words to hear, but it turned out that I was ultimately the only member of my graduating class to take a career within an academic medical center. And the irony is when I finally got to the academic medical center, it seemed like we spent a lot of our time trying to claw back time for academics, anyway.

To me, the line between what is "academic" and what is "private practice" has always been blurred. There are master clinicians and researchers in the private practice sector who have found novel ways to partner with academic medical centers. And many working academic physicians now consult with and advise many companies and industry groups. I've come to realize that there's a tremendous amount of flexibility in the system and you don't need to make your career fit someone else's expectations.

I worked in an academic medical center for the early start of my career, which launched me and turned me into the dermatologist I am today. After working several years in the private sector, including in the world of private equity dermatology, I am back in an academic medical center. In my new role at St. Luke's University Health Network, the microscope is not focused on how many publications you crank out per year; rather, the spotlight is on clinical outcomes and patient satisfaction, which for me is a perfect blend of private practice and academic medicine because it forces you to do both equally well.

A new academic practice model tries to create a "concierge" academic medical practice with the efficiency of private practice and the outcomes-driven focus of an academic medical center. Clinical outcomes matter. Patient satisfaction matters. Then everything else falls into place.

## thebottomline

**Tell us about your current position and what your practice actually looks like today.**

**Dr. Krakowski:** I see a mix of patients, but my focus is pediatric dermatology. As the only pediatric dermatologist in the Lehigh Valley, PA, with more than two million people served by the health system, there are many children who need the services of a sub-specialist. My clinical schedule is about 50 percent children. One of the goals that I had when I set out to create the pediatric dermatology clinic at St. Luke's was to first identify the needs of the community and then come up with a plan to meet them. St. Luke's partnered me with a clinical administrator, someone with the business acumen to help bring my strategic vision to reality. From my experience in private practice in Conshohocken and Bryn Mawr, PA, I knew I was drawing patients from more than an hour and half away, so I was aware that there was a great need in the community for a pediatric dermatology clinic and wanted to come up with a way to serve that region effectively.

One of the first specific things that St. Luke's allowed me to do was to create minimum appointment times of 30 minutes for every new pediatric patient, and up to 45 minutes for patients with difficult conditions like eczema or certain genodermatoses. In private practice, if I spent 45 minutes with a patient, the rest of the day's schedule would be completely messed up and unmanageable. But the time spent educating pediatric patients and their families is so important. As a pediatric dermatologist, you're championing these children and adolescents and you can't cut corners. Families come to you in their greatest time of need, asking you for help. For me—and St. Luke's agreed!—the typical 10-minute dermatology visit was not going to meet our patients' needs. You're not going to get a family who comes in with, for example, a baby with newly diagnosed epidermolysis bullosa, to any worthwhile level of comfort or understanding in 10 minutes. Instead, you need to be able to get through your part and, critically, leave time for questions or even just silent reflection.

Next, we started by hand-picking a clinical dermatology staff with the right demeanor for the pediatric environment. You have to come every day with a white kid-glove approach and be prepared for the potential screaming, the crying, the nervousness, and know how to calm a child who's having a procedure. Even something as simple as freezing a wart can be tough both on the patient and the staff. Young patients yelling at them because they don't want you to do something that ultimately is trying to help them—that takes its toll. But with the right crew, you can turn that into a positive experience for the child and the family. And that makes all the difference.

My clinical team even helped customize a room designated solely for pediatric patients. The room itself looks different—



**Dr. Krakowski with his dad, Frank, and a medical student.**

with kid-friendly paper for the exam beds, bright, primary-colored signage, kid-friendly distraction tools like iPads, etc. And we made sure that the procedure rooms were designed to accommodate parents so that they are able to be present physically if they want. We don't force them to remain in the room during a procedure, but if they elect to be there, we wanted to have room for parents to sit down and watch the process, knowing that we're taking the best possible care of their children.

Overall, we try to make our patients' experience within the health system as easy as possible. For example, we have recently structured a number of shared clinics with rheumatology, plastic surgery, and oncology. For our difficult patients who require comprehensive multi-specialty management, we will bring the patient into one exam room and have the specialists together to help coordinate care for the individual patient. The patient leaves with more efficient and better delivered clinical service and fewer copays and less time away from their personal lives.

**What did you learn from establishing a private pediatric dermatology practice and your time in academic dermatology that you were able to use to help you build this new dermatology department?**

**Dr. Krakowski:** What we've tried to create is a "concierge" academic medical practice with the efficiency of private practice and the outcomes-driven focus of an academic medical center. Clinical outcomes matter. Patient satisfaction matters. Then everything else falls into place.

This is not only about taking patients with the best insurance—we accept all insurances in the area—it's about creating a clinic that meets our community's needs.

We've started by experimenting with novel ways to improve the flow of the dermatology practice itself. Working

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with my clinical administrator partner, I painted a vision of what happens in an emergency room setting. The patient is brought back to one room and from that point forward, everything typically happens in that room. The patient is not being shuffled down the hall to have an EKG done or being forced to leave the room with their robe half open in the back to get their weight checked and vital signs entered. For me, having been a dermatology patient myself, this is a model I wanted to follow, so that is what we built.

Once the overall model was outlined, it was easy to find other opportunities to create efficiencies that not only helped the bottom-line but also made better sense for the patients. In my old practices, we had a front office person who checked patients in, a medical assistant who took vitals and walked patients to their rooms, and then a back-office staff member to check out patients. At St. Luke's, we've created an entirely new designation of staff member, a “dermatology clinical assistant,” who brings our patients directly back to a single exam room and owns the patient from start to finish. This staff member is expertly trained to handle front-office responsibilities. They can take calls, they can check patients in, they can take copays, and register patients right into our EMR. And it's all done in the privacy of the exam room. Then, the dermatology clinical assistant transitions his or her role into that of a medical assistant to take whatever data he or she is allowed to input for the physician and then alert the physician that the patient is ready to be seen. Once the physician enters the room, that dermatology clinical assistant again transforms into a medical scribe who enters the encounter data. This allows the physician to focus on the patient instead of looking at a computer. I literally don't touch a computer in the exam room because my highly-trained dermatology clinical assistants are able to take what I'm saying and transcribe it directly into the electronic medical record.

Likewise, in academic practice, I found there was always a concern that the right patient forms were being delivered to the correct patient. You did not want to risk a HIPAA violation. With a shared printer that's 75 feet away from where the patient is and everything feeding to that single printer, there was always a chance that you could hand someone the wrong patient instructions or print out. Borrowing from private practice experience, we instead

put a printer and label maker in each room, and the computer in that patient room only connects to that specific printer. Now, we can print out patient instructions and review them one last time with the families, ensuring the correct order of medications, side effects to watch out for, or whatever. This increases our speed and efficiency, helps prevent safety errors, and, ultimately, allows our clinical dermatology staff to really own that room and the individual patient being seen within it.

One obstacle we did not anticipate was having to “retrofit” our unique clinic flow to our electronic medical record's input protocols. We use Epic and, originally, there was a mismatch, to say the least. Working with St. Luke's IT department and the clinical administration, we were able to customize the flow of data input into the system to better mirror what our dermatology encounter actually looks like—we have basically created an Epic version of an EMR specifically geared to how a dermatologist would want to enter the data. Consequently, I don't touch a computer in the room, and my notes are typically 90 percent finished at the end of a patient visit. At the end of the day, I click through my notes to check and update them, and within a half an hour I am on my way. In essence, we have managed to create a customized system with the data storage capabilities that Epic offers, so that we still have that data available for clinical research and for larger patient quality improvement and patient safety projects.

Overall, the entire process has been a pretty cool way to merge the feeling of a boutique private dermatology practice with the advantages of working at a large medical center.

### **You started in academics, then practiced in the private sector, and now you're back in an academic setting? What led you back?**

**Dr. Krakowski:** I missed the collegiality. I missed being surrounded by smart people who want to be collaborative. I would make a medical-based pun in my private practice office, and no one else understood what the joke was. I wished I could keep one foot in private practice and one foot in a traditional academic center and happened to see that there was a chance to start a new dermatology residency. You don't get to do that very often. So the chance to start a new training program and to create a sort of

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boutique feel in terms of how we train our future dermatologists with these principles in mind—to show them that there is a “merged” world between private and academic practice that I believe works better than either or. I also wanted to teach future dermatologists that you can approach your career from a number of different perspectives and still manage to find personal and professional happiness. Burnout is not an unavoidable consequence of practicing medicine. That made the headfirst plunge worth the risk, because I believe this is the future of our profession.

**Is a career in pediatric dermatology still viable? Would you recommend it? How do you see the sub-specialty evolving?**

**Dr. Krakowski:** I highly recommend it for the right person. It's not for everyone, but as long as there are premies, newborns, infants, toddlers, children, preteens, and adolescents, there will be a need for specialized care of their skin because children must be approached quite differently. The presentation of dermatological conditions may be different in kids. The environment treats their skin differently. The products made for their skin may be formulated differently. Consequently, the subspecialty has to exist, and it will continue to thrive. And I know the people doing it—my pediatric dermatology colleagues—are happy to provide that service to the public and our adult dermatology colleagues. I think it's more than viable.

One nice thing about my new job with my blended patient population is that I can see my patients throughout their entire lives. I'm not just at a children's hospital where I have to say goodbye after a certain age; I can continue with my patients' care throughout their lives. The idea that if you're a pediatric dermatologist—all you do is pediatrics and pediatric skin—I believe that is going to have to evolve. With the era of biologics that has been ushered in, the promise of immunotherapy, the potential to modify at the molecular level a genetic condition that was once thought incurable, we are going to have to open the lid to our silo, climb out, and join the larger medical community to collaborate and take the best care of our patients. I think we're going to see that the sharp demarcation of “only pediatric dermatologist” will eventually soften. The horizons will expand, and those artificial designations will fall. Eventually, we'll grow more connected in our approach to the lifelong care for our patients, and our knowledge and skill sets will have to evolve to keep up with all these new strategies. ■

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