

The Impact of Variable Levels of Admittance to Precaution for Children with Atopic Dermatitis is being studied

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Abstract

Medicaid covers an estimated 50% of children in the United States. Some of these patients are illiterate about health and have limited access to medications and specialty care. These factors influence treatment adherence in paediatric patients suffering from atopic dermatitis (AD), the most common inflammatory skin disease in children. This study examines and compares treatment patterns and healthcare resource utilisation (HCRU) among large cohorts of Medicaid and commercially insured children with Alzheimer's disease. A small number of children were examined by a dermatologist or an allergy/immunology specialist. There were several significant differences between commercially and Medicaid-insured children with AD. Disparities found for Medicaid-insured children included: fewer received specialist care, higher emergency department and urgent care centre utilisation, a higher proportion had asthma and non-atopic morbidities, high-potency topical corticosteroids and calcineurin inhibitors were less frequently prescribed, and antihistamine prescriptions were more than three times higher, despite similar rates of comorbid asthma and allergies among antihistamine users. Treatment patterns also differed significantly across physician specialties.

Keywords: Atopic dermatitis • Atopic eczema • Medicaid • Access to care • Emergency department reliance

Introduction

Medicaid covers an estimated 50% of children in the United States. Access to care for Medicaid patients is a persistent issue in the United States (US). Several studies have found that Medicaid patients are less likely to have outpatient access to specialty providers. A variety of factors contribute to the shortage of specialists accepting Medicaid patients, including unfavourable fee-for-service reimbursement, longer payment wait times, and higher clinic non-attendance rates. Skin disease is very common in children, accounting for up to 30% of all paediatric primary care visits. The most common inflammatory skin disease in children is atopic dermatitis (AD), a chronic inflammatory skin disease characterised by eczematous lesions and intense pruritus. In the United States, the estimated prevalence among children under the age of 18 is around 11-13%. Up to one-third of these patients are estimated to have moderate-to-severe disease, as well as a higher risk of atopic and non-atopic morbidities when compared to children who do not have AD. The impact of Alzheimer's disease is significant, particularly among children with moderate-to-severe disease and their caregivers. Chronic sleep disruption caused by persistent pruritus has a significant impact on daily functioning, quality of life (QoL), and psychosocial health. AD in children is also linked to lower academic performance, difficulties forming social relationships and participating in sports, as well as higher rates of anxiety, depression, and even suicidal ideation [1].

Literature Review

The following criteria were used to identify paediatric patients with Alzheimer's disease: 1 medical claim with a diagnosis of Alzheimer's disease

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(International Classification of Diseases, Ninth Revision [ICD-9] code 691.8; ICD-10 codes L20.x), less than 18 years of age on the first observed AD diagnosis (defined as the index date), and continuous health plan eligibility 6 months pre-index date (baseline period; up to 6 months for infants 1 year old). Patients with an autoimmune condition who were diagnosed during the baseline period or on the index date were excluded. This criterion was used to help exclude the use of potentially beneficial treatments for conditions other than Alzheimer's disease. The observation period lasted from the index date to the present. The end of continuous health plan eligibility or the end of data availability, whichever came first. Age, gender, type of healthcare provider seen on the index date, and AD-related comorbidities assessed during the 6-month baseline period and on the index date were among the baseline characteristics [2].

The number of prescriptions per year considered, the proportion of patients with 1 combination therapy (overlap 3 months between 2 distinct AD treatments), and the proportion of patients with 1 prescription filled for the selected AD medications among patients with at least one treatment for AD during their observation period were all factors considered (treated patients). TCS, TCI, antihistamines (topical and oral; sedating and non-sedating), montelukast sodium, SCS, immunosuppressants (azathioprine, cyclosporine A, methotrexate, mycophenolate mofetil, interferon gamma), intravenous immunoglobulin (IVIG), and phototherapy were among the medications assumed to be prescribed to treat AD. Although topical and oral antibiotics are frequently used, they were not included because, while they are prescribed for infected AD, they are also used for a variety of unrelated, common childhood infections. At the end of our available data, we were unable to evaluate the use of crisaborole, which was approved in December 2016 [3].

Similarly, dupilumab was not included in the list of selected AD treatments because it had not yet been approved for AD in adolescents during the time period studied. There were also significant differences in antihistamine prescribing patterns across provider types. Patients who saw a non-specialist provider (other providers) on the index date were the most likely to receive systemic antihistamines, with more than half of these patients receiving them. There were also differences in the proportion of sedating antihistamines prescribed. Sedating antihistamines were prescribed in 72.9% of patients who saw a dermatologist on the index date, compared to around 50% of those who saw other types of providers. The majority of commercially insured patients who were prescribed systemic antihistamines received sedating antihistamines, with up to 80% of patients seeing a dermatologist on the index date receiving sedating antihistamines.

This study aimed to compare real-world patterns of care, medications prescribed, and HCRU between two large cohorts of children with AD covered by Medicaid and Commercial insurance plans using administrative healthcare claims data. Access to medical care, particularly subspecialty care, for paediatric patients is a well-known but understudied issue. For broad therapeutic areas, most publications have relied on surveys of either providers or caregivers. Few studies have focused on differences in treatment patterns of paediatric patients with Alzheimer's disease observed across different providers. This study provides a unique portrait of AD care patterns derived from large samples of Medicaid and commercially insured children. Furthermore, treatment and HCRU analyses Stratified by provider type, the data reveal more about the nature of potential healthcare disparities [4].

Discussion

The majority of Medicaid patients were seen by other types of providers (68.9% vs. 22.9% Commercial), primarily PCPs, nurse practitioners, and acute care providers, all of whom approach AD treatment in different ways. Patients who saw a dermatologist on their index visit were the most likely to receive high-potency TCS and TCI. This finding suggests that dermatologists are more comfortable using higher potency agents because they are more familiar with the principles of topical treatment and the low risk of side effects when these medications are used as directed. Overall, children with Medicaid were less likely to be prescribed high-potency TCS, SC, and TCI. Lower TCI utilisation among Medicaid patients could be attributed to formulary constraints and dermatologists, the provider type most commonly prescribing TCI, have more limited access. This large administrative healthcare claims analysis was hampered by a few limitations.

One issue is the nonspecific use of the term "eczema," which refers to a broader group of dermatoses that includes AD as well as a wide range of other ICD diagnostic codes. Only AD-specific ICD codes were used to identify relevant patients in order to limit our cohort to those with AD and exclude those with other types of eczema. We also ran sensitivity analyses on a larger cohort with a broader range of eczema-related diagnostic codes, and the results were similar. Another limitation is the failure to include patients with Alzheimer's disease who did not seek treatment for their symptoms, potentially skewing the study sample toward patients with more severe disease. Finally, race results were unavailable. Commercial patients (only available to Medicaid patients) are thus excluded. A growing body of evidence suggests that there are differences among various racial groups of Alzheimer's disease patients, including greater severity in Black and Hispanic patients. As a result, some of the differences observed between Medicaid and Commercial patients could be attributed to differences in race distribution among patients in the two samples [5].

Conclusion

According to the findings of this claims data analysis comparing two large paediatric AD cohorts, Medicaid- and commercially insured children, a

minority of patients were seen by a specialist. Non-specialist providers saw a significantly higher proportion of Medicaid patients than specialists, with dermatologists seeing the lowest proportion. As a result, it was not surprising that Medicaid patients had a higher reliance on ED and urgent care centres, particularly for AD-related care, with a rate of ED visits more than twice as high for Medicaid patients compared to Commercial patients, highlighting the importance of access barriers to outpatient and specialist care. Finally, antihistamines were more than three times more commonly prescribed to Medicaid patients. There are currently no well-established standards of care or pediatric-specific guidelines that clinicians accept. Alzheimer's disease and treatment approaches differ greatly across physician specialties. Disparities in access to specialty care amplify these variations, exacerbating the unmet treatment needs of children with AD. To treat this chronic condition, a more consistent and coordinated approach is required. Long-term disease control has the potential to reduce the direct burden of AD as well as the risk of developing atopic and non-atopic comorbidities, which may help reduce healthcare resource utilisation in this patient population.

Acknowledgement

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Conflict of Interest

None.

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