foreFRONT AND CENTER

Q2 NEWSLETTER | SPECIAL EDITION

President's Message: So Much to Celebrate

By: Betsy Wernli, MD, FAAD

As another quarter comes to a close, I am reminded of our many blessings. One year ago we were in a state of confusion, fear, a complete unknown of what the future held. As I stand in a new world with so much hope, I feel more blessed than ever. Our Forefront Family has stood the test of time, and flourished despite the obstacles placed in front of us. We welcomed so many new colleagues, stayed open for our patients, and maintained a healthy and secure work environment for our staff. More than that, we topped off this month with a record number of visits, which says to me more than ever we are doing things the right way: our patients trust us, our patients need us, and we can give them the care they deserve.

So much to celebrate. Add to it all the fact that all of the Forefront Family was able to get together in May at the American Club in Kohler, WI for our Spring Retreat. We spent a wonderful weekend earning CME and experiencing our unmatched collegiality; I feel more motivated and renewed than ever! The retreat weekend focused on leadership and prepared us to lead our clinics in a new way, not only bettering our relationship with our staff, but also improving our work environment in creative ways. And of course, we elected our new physician Board of Directors, the leaders of our practice. Last but not least, we spent some much-needed time at the spa and outdoors!

This issue of Forefront & Center captures some of our retreat excitement, and also focuses on what we do best: treating patients! I hope you enjoy the amazing articles submitted by some amazing Forefront folks, and that they inspire you to begin Leading the Pack in 2021.

Sincerely,

Dr. Betsy Wernli

In This Issue:

Coding Corner: Tips & Tricks to Optimize your Communication

By: Molly Moye, MD, FAAD, FACMS

Most of us are becoming more comfortable with the 2021 Evaluation and Management coding changes. **Here are some tips to aid you in seamless documentation and code selection.**

Document Problem Complexity

Establish some code words with your medical assistants so that they know whether to select "stable chronic illness" vs "chronic illness with exacerbation." This distinction will make a difference in whether the problem portion of your medical decision-making is low or moderate. Even if your staff selects "stable chronic illness" as the problem complexity and "worsening" as the status in EMA, it will render LOW medical decision making. Working on this with your staff will decrease the number of charts you have to override to bill correctly.

Independent Historians

When the input of an independent historian is required for a visit based on patient characteristics such as developmental stage or dementia, it qualifies as LOW in the data element of MDM. When outside records are reviewed and/or lab tests are ordered/reviewed, the need for an independent historian can bump the data element up to MODERATE. Teach your medical staff to document the need for an independent historian in EMA under the CC/HPI section of the system. Please note that the use of a translator does not count as an independent historian as they are merely repeating the patient's words.

Prescription Drug Management

In the past, we educated that if a prescription was not written, it did not counts as prescription drug management. The AMA has clarified that all of the following count as prescription drug management as long as they are accompanied by appropriate documentation in the medical record: writing a new prescription, discontinuing a prescription, reviewing/continuing/modifying a current prescription, and deciding NOT to prescribe a certain medication that may not be in the patient's best interest due to side effects or medication interactions.

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The Extra Mile: Emotional Intelligence in Physician Leadership

By: Giacomo Maggiolino, MD, FAAD

Emotional Intelligence (EI), as defined as the ability "to be aware of, control, and express one's emotions, and to handle interpersonal relationships judiciously and empathetically", appears to be **key to effective physician leadership.**

01
EI is widely recommended as a way of developing physician leadership at an executive level.

02
Wide-ranging strategies have been proposed to develop physician leadership and EI.

03
Medical professional desire EI training since a body of evidence supports its benefits.

In fact, a recent review article found 83 articles addressing the theme that EI is a key component of medical leader development. Overall 3 overarching themes emerged from this systemic review of the literature: 1) EI is widely recommended as a way of developing physician leadership at an executive level in institutions throughout medicine; 2) Wide-ranging strategies have been proposed to develop physician leadership and EI, and 3) Medical professionals desire EI training since a body of evidence supports its benefits.

In healthcare, where we work in such an emotionally demanding environment, physicians along with PAs/NPs need to have a solid understanding of how our emotions and actions affect the people around us. The better we can relate to and work with others, the more adept we will be in connecting with both patients and staff to understand their needs, in acknowledging and managing various situations, and in leading our teams to provide comprehensive outstanding care.

> "Physician leaders who are able to exhibit high degrees of emotional intelligence (EI), particularly in how they manage their own emotions and react to the emotions of others, **demonstrate better clinical outcomes, greater professional satisfaction, increased empathy, and improved teamwork within health care organizations."**
>
> Ted A. James, MD, MHCM | Harvard Medical School

By improving our relationship and interactions with our staff and our patients, physician leaders can leverage emotional intelligence to create meaningful and lasting outcomes. Like nearly any other skill, our emotional intelligence can improve with continuous practice.

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The American psychologist, Daniel Goleman, developed an EI framework based on 4 components defined as follows:

Self-Awareness

The ability to know your emotions, strengths, weaknesses, drives and goals.

Social Awareness

Empathy; identifying with and understanding the desires, needs and perspectives of others.

Self-Management

The ability to stay calm when emotions are running high; adaptability.

Relationship Management

Social skills; managing relationships and resolving conflict to move people in a desired direction.

Harvard Medical Professor, Ted A. James, MD, MHCM, suggests using mindfulness as an important starting point to developing your EI:

Self-Reflect

Learn to pause and reflect on how you are feeling, especially in stressful or tense situations. This provides space to perceive and understand your emotional responses.

Acknowledge

By simply acknowledging your feelings and naming them, you can start to understand the drivers of your behavior. This exercise leads to greater self-awareness and ultimately greater freedom to choose how to best respond, rather than being controlled by impulse.

Control

Over time you begin to notice your triggers and learn to control them.

Practice

Practicing mindfulness and meditation can improve your ability to comprehend your own emotions, as well as the emotions of those around you, and strengthen your capacity to manage yourself and others.

Resources:

1. What Makes a Leader? Daniel Goleman, Harvard Business Review, Jan 2004
2. Primal Leadership: The Hidden Driver of Great Performance. Daniel Goleman, Richard E. Boyatzis, Annie McKee, Harvard Business Review, Dec 2001.
3. Laura Janine Mintz and James K. Stoller (2014). A Systematic Review of Physician Leadership and Emotional Intelligence. Journal of Graduate Medical Education: March 2014, Vol. 6, No. 1, pp. 21-31
4. "Emotional Intelligence – why it can matter more than IQ", Daniel Goleman, Bantam Books, 1995.
5. https://www.precheck.com/staff/antique-nguyen

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Clinical Corner: Pregnancy Associated Dermatoses

By: Ashley Dietrich, MD, FAAD

Case Study

34-yo G3P2 female currently 9 weeks gestation developed a very pruritic rash on the abdomen and trunk which quickly spread to chest, arms, upper legs over the past 2 weeks. Spares face and acral areas. She notes few blisters on the hips with itching of umbilicus, but rash not present there. Not painful. No new striae. No prior similar eruptions with previous 2 pregnancies or dermatology history. The use of triamcinolone is mildly helpful. The patient otherwise feels well. Pregnancy is uncomplicated at this point. No new oral medications, travel history, or known exposures. No other household members are affected.

Diagnostic Considerations

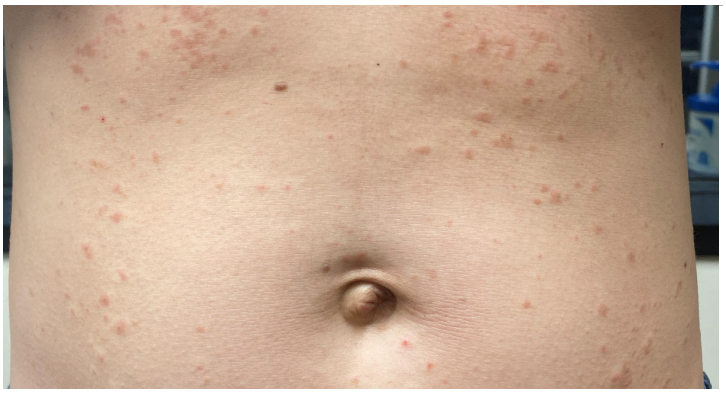
In addition to common acute rashes presenting to our clinics, we must also consider a few eruptions specific to pregnant patients as there may be complications to the pregnancy, harm to newborn, and treatment complications.

Exam

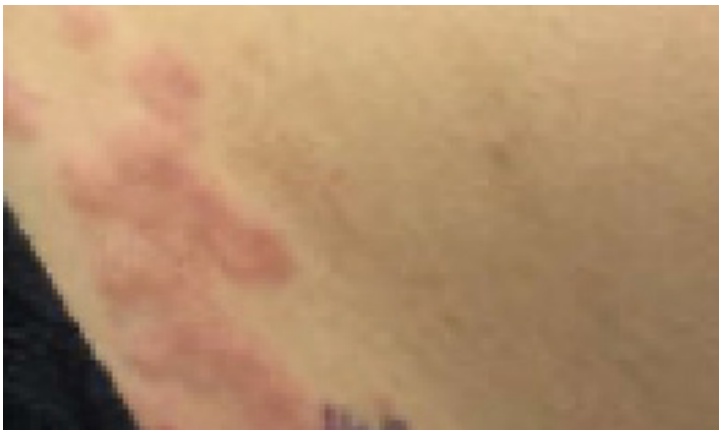
Remarkable for erythematous to pink papules and microvesicles, some coalescing into plaques overlying the abdomen, hips, lower back, chest, and less scattered lesions on upper arms and thighs. Not overtly within striae or umbilicus. Primarily without significant scaling. Some urticarial in appearance with the evidence of excoriation. Spares face, acral surfaces.

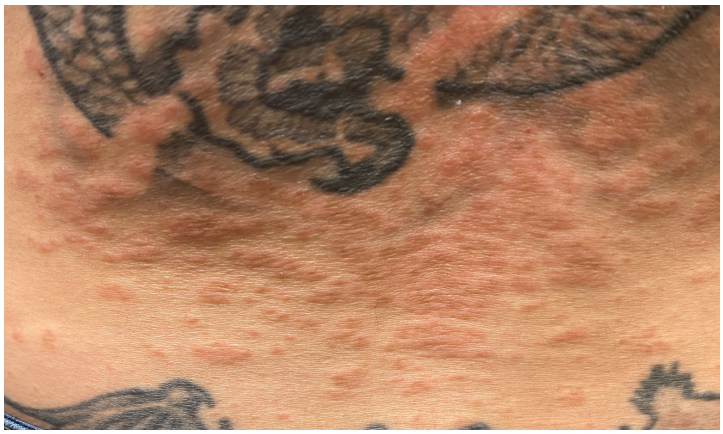
Next Steps

Routine labs including an IgE level were negative. A lesional biopsy for H&E was remarkable for subepidermal blisters with eosinophilic and neutrophilic infiltrate. At this visit, a perilesional punch biopsy for



Fun Fact: My distinguished attending, Dr. Luis Diaz, at UNC was involved in the discovery of this antibody and its relationship to autoimmune blistering disease.





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direct immunofluorescence (DIF) was negative. Given the concern for gestational pemphigoid, the patient was sent to an outside lab for serum indirect immunofluorescence (IIF) which was subsequently positive for ELISA IgG BP 180 antibodies.

Diagnosis

Gestational pemphigoid, aka pemphigoid gestationis, herpes gestationis (misnomer- unrelated to herpes virus), or bullous pemphigoid in a pregnancy.

Treatment

Given lack of response to triamcinolone, I increased strength to clobetasol and added pulse prednisone in conjunction with the patient's OB. We aimed to time prednisone courses around her gestational diabetes test (week 24). She is now considered a high-risk pregnancy and monitored closely by her OB.

Discussion

Gestational pemphigoid is a rare, but important "can't miss diagnosis" in pregnant patients as it carries a risk of prematurity, fetal growth restriction, graves disease postpartum, and the possibility of transient blistering of the newborn. While most symptom onset is between the second and third trimesters and often involves the umbilicus, the remaining clinical features, H&E, and IIF of our patient's case correlate best with this diagnosis. My patient has responded well to steroids thus far. Hopefully, she will not have the typical flare at delivery or any above complications. There may be a risk of recurrence with a future pregnancy, menstruation, and OCPs.

The differential eruptions of pregnancy include atopic eruption of pregnancy (AEP), Polymorphic eruption of pregnancy (PEP aka PUPPP), and Intrahepatic cholestasis of pregnancy.

AEP is the most common pregnancy-associated dermatosis typically arising in the first trimester with pruritis, eczematous lesions, and papules NOT in striae. Often serum IgE may be elevated. This poses no harm to the mother or fetus and is typically managed symptomatically until birth.

PEP is the next most common eruption of pregnancy presenting in the third trimester as striae begin to form and become more numerous. Often these pruritic urticarial-like papules start within striae but spare the umbilicus. There is no risk to mother or fetus and is typically managed symptomatically until birth.

Intrahepatic cholestasis of pregnancy often does NOT have a primary eruption, but rather only secondary lesions such as excoriations, prurigo nodules, and/or jaundice involving the extremities. There is a typical elevation of total serum bile acid levels and poses a risk of stillbirth if not caught early and treated with ursodeoxycholic acid. Importantly, only gestational pemphigoid should have positive immunofluorescence (DIF or IIF).

Clinical Note

Thank you to Drs. Wernli and Negrete as well as our administration staff and my core nursing staff for helping me locate the correct test from an outside lab. As our Forefront lab currently does not perform IIF testing, one may order the following from a local "ARUP" laboratory (ours was affiliated with Aurora) when concerned for autoimmune blistering disease: (90021): Serum for Pemphigoid Antibody Panel as semi-quantitative indirect fluorescence antibody (IFA)/ Semi-quantitative enzyme/linked immunosorbent assay.

Resources:
Bolognia, J., Jorizzo, J. and Schaffer, J., 2017. Dermatology. [Philadelphia]: Elsevier Saunders.

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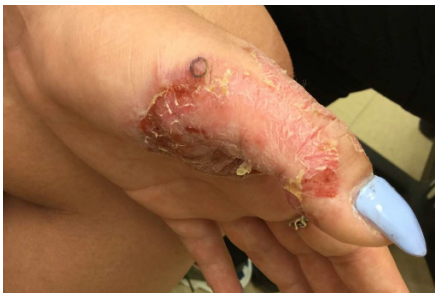
Under the Scope: Interesting Rashes

By: Kelli Hutchens, MD, MBA, FCAP

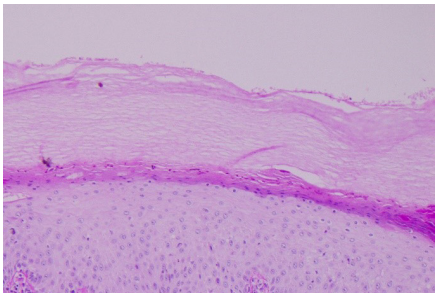
2021 is off to a great start. We're already into the second quarter and we've been seeing so many of your interesting patient samples under the scope. Thank you!

As I reflect on our year of leadership and leading the pack theme it reminded me of our quintessential leading rashes and some fun examples I have seen lately.

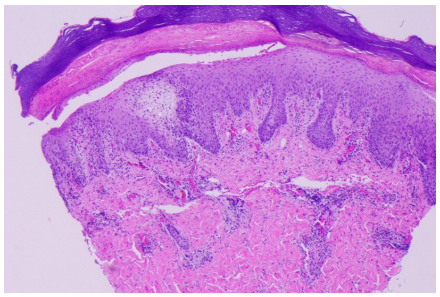
Resources:
Biopsies performed by Drs. Elizabeth Galler and Bebe Edmonds.



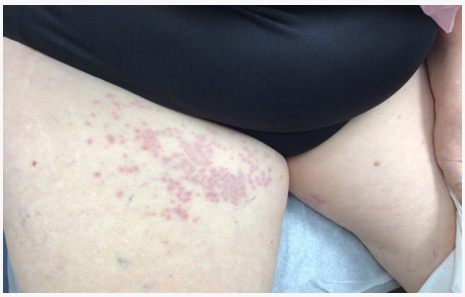
Clinical photo: This scale is leading its way all over this patient's thumb and heading up the palm and wrist.



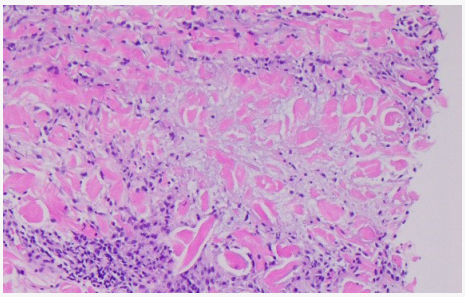
PAS stain at 400x highlights fungal hyphae sandwiched in the corneal layer.



H&E (100x). Sections show hyper parakeratosis overlying epidermal acanthosis with focal edema between keratinocytes. There is a moderate amount of perivascular and interstitial dermal inflammation mostly composed of lymphocytes with scattered eosinophils. The clinical photo and histology support allergic contact but the PAS stain nails the diagnosis of Tinea.



Clinical photo: This patient has small erythematous papules coalescing into a plaque. The small papules appear to be leading the spread distally and down this patient's right leg.



Under the scope this augmenated plaque is diagnostic of granuloma annulare. H&E at 200x shows a perivascular lymphocytic infiltrate with interstitial histiocytes. The histiocytes are surrounding areas of dermal mucin deposition. Interestingly, I personally observe that often times the varied clinical presentations of granuloma annulare tends to correspond with slight variations in the histology. I find raised annular plaques tend to have more well defined palisaded granuloma formation with a continuum to the pure interstitial form which is both clinical and histologically more diffuse.

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Forefront Flask Award: Most Interesting Rash

By: Doug Hansen, MD

Cutaneous Crohn's Disease Presenting as Linear Inguinal Ulcerations

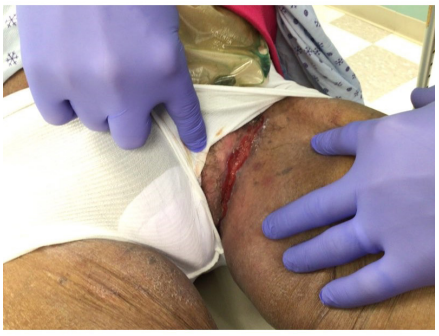
Clinical Summary

This 85 yo female presented with a one-year history of bilateral linear inguinal ulcerations. The patient has a history of rectovaginal fistula and had a partial colectomy a few years ago (the reason for the colectomy is not entirely clear and the pathology report is not immediately available for review). The initial clinical considerations were pyoderma gangrenosum and hidradenitis suppurativa.

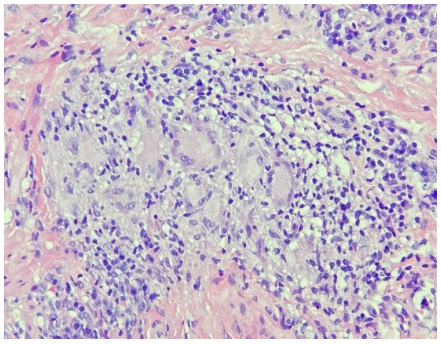
The biopsy revealed ulceration and dense dermal chronic inflammation, including scattered foci of non-caseating granulomata. Special stains for fungal, mycobacterial, and fungal organisms are negative; immunohistochemical staining for T. pallidum is negative.

Brief Discussion

The combination of deep linear ulcerations in the groin, combined with the presence of non-caseating granulomatous inflammation on biopsy, raises the question of vulvo-perineal ("metastatic") Crohn's disease. This entity can present in the setting of gastrointestinal Crohn's disease, or without any previous history of inflammatory bowel disease. A definitive diagnosis requires close clinical and pathologic correlation, as well as the exclusion of infectious agents as a cause of inflammation.



Deep linear ulceration left groin



High power image, demonstrating a focus of Non-caseating granulomatous inflammation, including multinucleate histiocytic giant cells.

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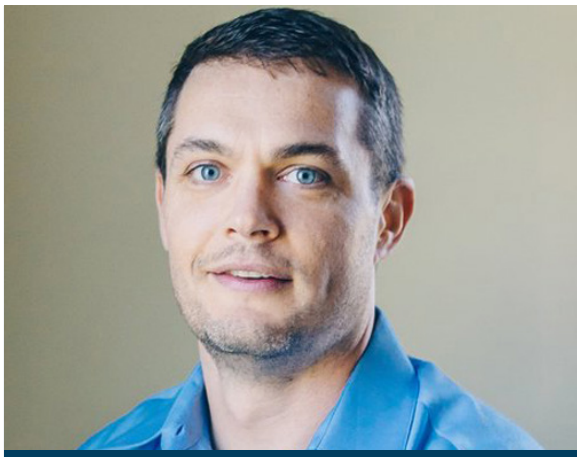

Winner of the Q1 Forefront Flask Award for Most Interesting Rash

Kamal Chantal, PA-C
Lynchburg, VA

Kamal is based in Virginia at RidgeView Dermatology, a Forefront Dermatology practice, where he has practiced since 2017. Kamal has a background in orthopedic/spine surgery before his career in dermatology. He is happily married to his wife Alexis who also practices at Forefront. They have 2 children and enjoy cooking, gardening, and horseback riding as a family.

Diversity in Dermatology: Effective Leadership

By: Nadia Sundlass, MD, FAAD

Throughout the disaster that was 2020, I was one of the lucky ones—I suddenly found myself with spare time. With COVID-19 inspiring lockdowns around the country, my planned trips to Colorado and Napa Valley, which I had been eagerly anticipating, were abruptly canceled. Even local activities became scarce as Pennsylvania imposed lockdowns. I was able to take advantage of the extra spare time and finally dive into leadership books that were recommended by friends I admire. A few books in, I realized they shared a common theme: to be an effective leader, you must legitimately care about your team members and their successes. A simple concept, yet one that is often forgotten, even in the care-taking profession of medicine.

I must admit, I was initially guilty of dismissing this as a lesson I didn't need to learn. I am a doctor after all. Of course, I care about people! However, over the past year, I've realized this is not true. I have come to appreciate the importance of relationships, and how quickly they can break down. Racial conflict, the pandemic, the 2020 election, all of which magnified our nation's polarization, have clearly demonstrated how easy it is to dismiss the experiences of those we disagree with—to see people as the other, as the enemy, and thus fail to empathize and connect with them on a productive level. Experiencing these events through the lens of the leadership books I was reading, I realized that I—a caring doctor of all people—was also guilty of dehumanizing those I disagreed with. How had this happened? Was it in spite of my medical training, or possibly because of it?

As was astutely observed in The House of God, the classic satire of medical training, the stereotypical way we are trained to survive in medicine is through dehumanizing others. Following "laws" such as "GOMERs (Get Out of My ER) go to ground" and "The only good admission is a dead admission" is described as the only way to mitigate the stresses of our profession. While this is meant to be tongue-in-cheek, medical training is undeniably stressful and does teach us to dehumanize our patients and our colleagues. We are trained to ignore our patients' humanity in order to carry out our work objectively. Being good at our jobs requires us to act in ways that would not be considered compassionate outside of a physician, PA, NP—patient relationship. Productive detachment is what allows us to calmly deconstruct and reconstruct faces with a scalpel and to inform patients they have life-threatening melanomas. But it is that same detachment and lack of empathy that leads us to reduce learners and support staff to tears, refer to colleagues by unprofessional names, and disparage other medical specialties for consulting us for inane reasons like "bilateral cellulitis." At its worst, this dehumanization can lead to atrocities like the Nazi experiments

> "To be an effective leader, you must legitimately care about your team members and their successes."

on concentration camp prisoners and women of color being operated on without anesthesia to develop surgical and obstetric techniques. Clearly, detachment in medicine is a double-edged sword. In the context of medical decision-making, it is a crucial skill that allows us to perform beneficial, but unpleasant, tasks without flinching.

However, in our role as leaders in the office and the community, it can be a major barrier to healthy and respectful relationships, can impede successful teamwork, and perpetuate harm.

Effective leaders must be able to monitor and modulate their attitudes towards members of their team. They need to employ empathy and real connection in order to prevent dehumanization from crippling their team and derailing their mission. It is easiest to dehumanize a person with whom you do not share similar life experiences. While we cannot change our pasts, one way to mitigate this is to intentionally develop connections with individuals with diverse backgrounds and viewpoints. At the level of a medical office, effective leadership requires treating the experiences and contributions of all staff as valuable, rather than minimizing the concerns of some employees in favor of others. The past year has highlighted the diversity of opinions, politics, and socioeconomics that are inevitably a part of our workplaces. This diversity should ideally be used to foster creative, resilient workplaces, and not used to sort people into in-groups and out-groups within our offices. As I learned from my Covid-quarantine leadership books: people respond very positively when their leaders genuinely care about them. So this is our challenge—self-reflection and self-awareness to recognize and stop ourselves from dismissing, devaluing, and dehumanizing others, even when they differ in opinion, appearance, or background from us.

> "We have an opportunity as physicians and leaders to shape potential conflicts into a constructive rather than destructive process."

It is comforting to find consensus within our own little bubbles, but to succeed as a larger organization, a comfortable consensus is not good enough. We have an opportunity as physicians and leaders to shape potential conflicts into a constructive rather than destructive process. Unfortunately, the interpersonal detachment we learn through medical training is not a productive trait in this regard. It is our responsibility to reflect and determine when is the appropriate time to detach, and when it is time to connect. As leaders, we cannot dehumanize our team. We must actively work to empathize and acknowledge the value that each team member brings to the organization regardless of our differences and to actively seek out diverse voices when they are not at the table to achieve lasting success. This is not something I'm good at yet. So when I'm backsliding, please say something!

Resources:

1. Washington, H. Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present. Doubleday, 2007.
2. Carnegie, D. How to Win Friends and Influence People. Simon and Schuster, 1936.
3. Patterson, K, et al. Crucial Conversations: Tools for Talking when Stakes are High 2nd ed.. McGraw-Hill Professional Publishing, 2011.
4. Maxwell, JC. The 21 Irrefutable Laws of Leadership. Harpers Collins, 2007.
5. Brown, B. Dare to Lead: Brave Work, Tough Conversations, Whole Hearts. Random House, 2018.
6. Sinek, S. Start with Why: How Great Leaders Inspire Everyone to Take Action. Portfolio, 2009.

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keeping up with the Kids

Keeping up with the Kids: Head and Neck Dermatitis

By: Sapna Vaghani, MD, FAAD

To keep up with the kids, you have to keep up with the literature! This quarter I am sharing with you a few interesting articles from recent issues of Pediatric Dermatology.

Background/Objectives

First, let's take a look at head and neck dermatitis. This is a clinical variant of atopic dermatitis that typically presents in adolescence or adulthood and targets more seborrheic areas of the face (forehead, eyelids, perioral region) and body, particularly the neck and upper trunk. It has been suggested that Malassezia may play a role in the pathogenesis however the jury is still out on this; some studies describe higher carriage rates of Malassezia in patients with severe atopic dermatitis and others show no difference. A recent review at the University of Bologna of 31 patients with head and neck dermatitis (17 with "adolescent-onset," 14 with "adult-onset") was performed. The adolescent group had a history of atopic dermatitis but presented differently; 60% exclusively had head and neck involvement compared to just 14% in the adult-onset group ($p<.05$). Dermatitis in the adult-onset patients was associated with concomitant widespread eczema with flexural involvement of the extremities, trunk, nipples, or hands ($p < 0.05$). Both groups, however, had a positive response to topical therapy in combination with itraconazole (100mg qD x 1 month, then 100mg qweek x 1 month). 11 of 31 patients (88% of adolescents and 57% of adults) had complete clearance.

Methods/Results

Interestingly, a recently published case series from the University of Pennsylvania & Children's Hospital of Philadelphia also highlights the possibility of a connection between Malassezia and head and neck dermatitis. In this case, the patients were on dupilumab for atopic dermatitis. While the most common adverse reactions of this medication in both adults and adolescents have been injection site reactions and conjunctivitis, several studies have reported the acute worsening or new onset of head and facial erythema and pruritus in adults (in up to 10% by some estimates)

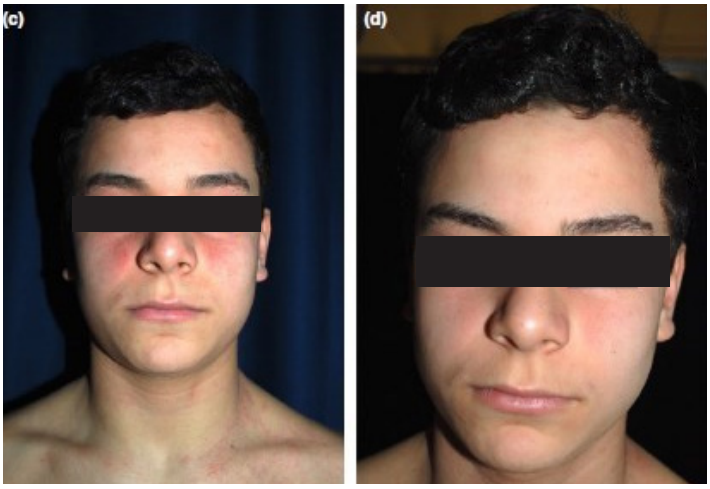

Figure 1 (C) Before treatment. (D) After 100 mg daily oral itraconazole and twice-daily pimecrolimus 1% cream for one month.

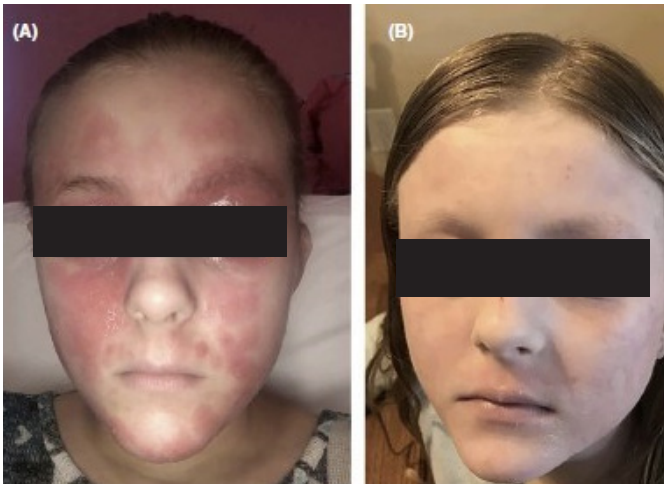

Figure 2 (A) Before treatment with fluconazole. (B) After 150 mg oral fluconazole daily for five days.

and more recently, in children. The first study dedicated to dupilumab-associated head and neck dermatitis in the pediatric population reported the incidence may be much higher in children with 7/24 (29%) of study patients developing it. In addition, the incidence increased with age, with rates of 17%, 27%, and 43% in those ≤ 10 years, 11-15 years, and 16-18 years respectively (P = .63).

While the pathophysiology of this head and neck dermatitis is not fully understood, the majority of proposed mechanisms focus on how IL-4 receptor blockade with dupilumab may shift the immune response to a helper T-cell subtype 1 (Th1)–activated response. This may subsequently unmask or cause allergic contact dermatitis, rosacea, psoriasis, or a Malassezia-related skin reaction like seborrheic dermatitis. Another potential explanation is that dupilumab shifts the immune response to primarily Th1- and Th17-activated pathways, thereby promoting Demodex proliferation and unmasking rosacea. In one retrospective study of 94 patients, about 6% experienced a rosacea-like folliculitis after initiating therapy with dupilumab, and biopsy and confocal microscopy revealed folliculitis and increased Demodex mites compared to controls.

Conclusions

This case series describes five adolescents who developed new-onset or worsening head and neck dermatitis after dupilumab therapy for atopic dermatitis. One of the patients had a shave biopsy, which was notable for spongiotic and psoriasiform dermatitis. All five improved after oral therapy with fluconazole, and just one patient needed to be retreated after the first course. This series suggests that Malassezia may be a contributing factor in the pathogenesis or that antifungal therapy may be an effective anti-inflammatory agent. The case series is limited by a small sample size however suggests that treatment with an oral antifungal agent may be helpful for an adolescent patient with head and neck dermatitis in the setting of dupilumab therapy as long as there are no contraindications. This series also found that topical antifungals may be less efficacious.

Resources:

1. de Wijs LEM, Nguyen NT, Kunkeler ACM, Nijsten T, Damman J, Hijnen DJ. Clinical and histopathological characterization of paradoxical head and neck erythema in patients with atopic dermatitis treated with dupilumab: a case series. Br J Dermatol. 2019;183(4):745-749
2. Muzumdar S, Zubkov M, Waldman R, DeWane ME, Wu R, GrantKels JM. Characterizing dupilumab facial redness in children and adolescents: a single-institution retrospective chart review. J Am Acad Dermatol. 2020;83(5):1520-1521.
3. Head and neck dermatitis, a subtype of atopic dermatitis induced by Malassezia spp: Clinical aspects and treatment outcomes in adolescent and adult patients. Alba Guglielmo MD | Andrea Sechi MD | Annalisa Patrizi MD |Carlotta Gurioli MD, PhD | Iria Neri MD
4. New-onset head and neck dermatitis in adolescent patients after dupilumab therapy for atopic dermatitis Christina E. Bax BA1 | Michele C. Khurana MD1,2 | James R. Treat MD1,2 |
5. Leslie Castelo-Soccio MD, PhD1,2 | Adam I. Rubin MD1,2,3,4 | Patrick J. McMahon MD1,2

Forefront Forum: Activities During Spring Retreat Weekend

By: Patti Reilly, Executive Administrative Assistant

The Spring Retreat is held every year on a weekend in May for all our Forefront physicians, PAs, and NPs at the American Club in Kohler, WI. Saturday morning was reserved for Forefront's Spring Retreat meeting, at which our physicians, PAs, and NPs earned CME credits. Saturday afternoon was open for Forefront attendees and their guests to have leisure time.

The American Club in Kohler, WI has so much to offer for organized activities and there was plenty for attendees to do on their own too, including:

The Shops at Woodlake, Bold Cycling, Yoga on the Lake, The Swing Studio, or Sports Core whose amenities include, indoor tennis courts, a swimming pool, lap pool, and all the latest exercise equipment. Attendees could also take a stroll through the village of Kohler or hike some of their beautiful trails. The possibilities were endless, click here to learn more about the activities available in Kohler.

Kohler Waters Spa

The Kohler Waters Spa is probably the most popular activity at every Spring Retreat. Spa sessions at the Kohler Waters Spa left guests feeling relaxed and revived!

Golf Courses

The American Club is well known for its beautiful and challenging golf courses. Four of which were designed by Pete Dye and are all on the list of the top 100 courses in the United States.

Sporting Clays

A favorite among many attendees is The River Wildlife facility—a beautiful wooded area that offers Sporting Clays or Five Stand under the instruction of their shooting range professionals.

Cooking Class

Retreat attendees who enjoy cooking participated in demos presented by a super talented American Club Chef. Participants got to sample the creation too!

Aromatherapy

Growing in popularity is The American Club's Aromatherapy Class. Retreat attendees created custom body care products to enjoy at home.

Wine Tasting

For those who enjoy wine and learning about it—the wine and cheese tasting sessions held on Saturday afternoon was where you wanted to be. The activity was led by The American Club's Sommelier.

Charter Fishing

Kohler, WI is located a few miles from the West coast of Lake Michigan and retreat attendees had the opportunity for charter fishing on the Great Lake. Whether it was their first time or if they were already an avid fisher, this was truly an amazing experience.

Reception

To wrap up a perfect day—the Saturday night reception held at the Kohler Design Center was a chance to network with peers and meet the new physicians, PAs, and NPs that have joined the Forefront family since our last retreat. And yes, those are Kohler plumbing fixtures in the picture—another industry Kohler is known for!

Photos courtesy of Kohler Co.

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President & Editor
Betsy Wernli, MD, FAAD

I have a busy practice in Manitowoc, WI. I completed my undergraduate at the University of Oklahoma where I stayed for medical school and completed residency at Iowa. I have three boys, four if you count my husband, and enjoy all things sports. I am obsessed with Peloton®, and love serving my Forefront physicians. I am always available by cell or email.

Molly Moye, MD, FAAD, FACMS

Molly is a fellowship-trained Mohs surgeon who practices in Elizabethtown and Louisville, KY. Her professional areas of interest are skin cancer detection and treatment, Mohs surgery, and performing cosmetic treatments including, Botox®. Molly finds it very rewarding to follow patients over time and see improvements in their quality of life as their skin conditions are treated.

Giacomo Maggiolino, MD, FAAD

Giacomo graduated from the University of Notre Dame, attended medical school at the University of Illinois in Chicago, and completed his residency at Cook County in Chicago. He now practices in Pleasant Prairie and Grafton, WI. He is kept busy at home with four young children but he also enjoys traveling and cooking—especially making homemade pasta and Italian dishes. Giacomo is Forefront's Public Relations Chairperson.

Ashley Dietrich, MD, FAAD

Ashley practices in Wauwatosa, WI, just outside Milwaukee. She completed her undergrad at Marquette University and then medical school just down the road at the Medical College of Wisconsin with her husband, Peter. She traveled south to a warmer climate to complete residency at the University of North Carolina, Chapel Hill. She enjoys being back in Wisconsin with Peter who is completing his urology residency at MCW as well as building a busy medical, procedural, and cosmetic practice. She enjoys golf, tennis, pickleball, Wisconsin sports, and wine tasting.

Kelli Hutchens, MD, MBA, FCAP

Kelli practices Dermatopathology in Manitowoc, WI. Kelli has a special interest in healthcare quality management practices and serves as the Medical Director for our pathology lab. She is passionate about the lab, providing support to all of the Forefront physicians and PAs/NPs and their patients. Kelli and her husband have three busy children, and she spends her free time at sporting events or traveling to Irish Dance competitions. She has dreams of one day having time to go on a bike tour of Italy with her husband and learning basic carpentry.

Doug Hansen, MD

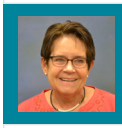
Doug completed his residency and immunohistochemistry fellowship at the University of Washington and his dermatopathology fellowship at the AFIP. His favorite thing is when the histopathology fits exactly with the clinical presentation. He also really likes skiing, hole-in-the-wall restaurants, and unexpected first-class upgrades. He is married with 3 teenagers and an attention-demanding Cavapoo puppy. Dr. Doug Hansen is our newest Dermpath joining us on March 1, 2021.

Nadia Sundlass, MD, FAAD

Nadia practices in Pittsburgh, PA and Wexford, PA. Originally from Green Bay, WI, she completed her dermatology residency at the University of Pittsburgh Medical Center following the MD/PhD program at the University of Wisconsin-Madison. She enjoys eating delicious food, playing the piano, traveling, and spending time with her husband Tom, and her dog and cat, Harry and Hermione. She is a member of the Diversity Committee.

Sapna Vaghani, MD, FAAD

Sapna is a pediatric dermatologist working in the suburbs of Chicago. She completed her undergraduate work at Northwestern University, followed by medical school at MCP Hahnemann (now Drexel) in Philadelphia. She came back to Northwestern to complete her residencies in pediatrics, dermatology, and finally, a fellowship in pediatric dermatology. Sapna's free time is spent with her husband and two girls. They love to cook, eat, do arts and crafts, and travel!



Executive Administrative Assistant
Patti Reilly

Patti has lived in Manitowoc, WI all her life. She joined Dermatology Associates of Wisconsin (DAW) in July 2010 and held the position of Executive Administrative Assistant. The first retreat that Patti planned had 12 physician, PA, and NP attendees, compared to the current spring retreat, which had over 300 physician, PA, and NP attendees. Patti enjoys that no two days at work are ever the same—especially when you have to keep up with Dr. Wernli! But that is what keeps it interesting and challenging. In her free time, Patti enjoys fishing, golfing, bowling, and relaxing with friends and family.

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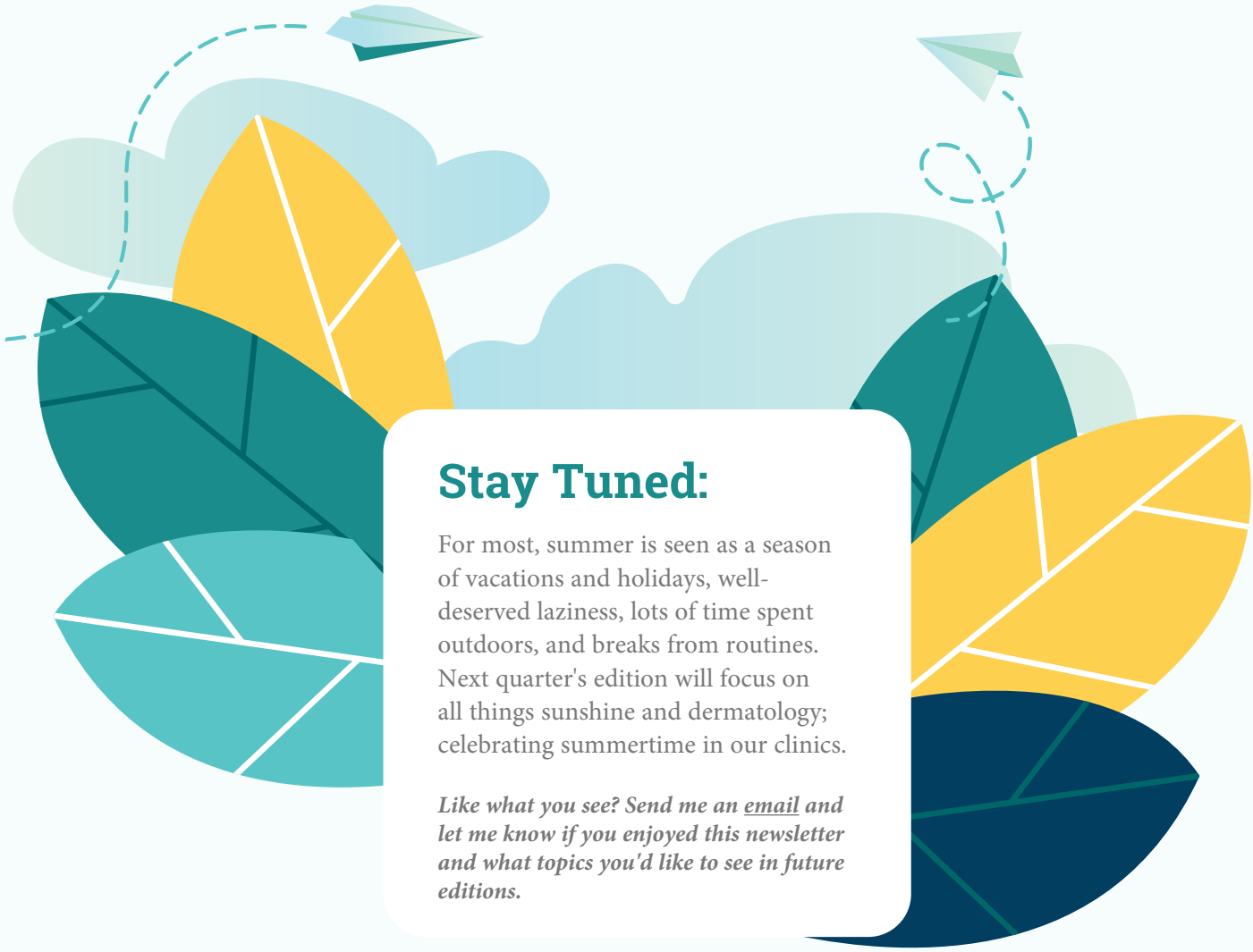

Stay Tuned:

For most, summer is seen as a season of vacations and holidays, well-deserved laziness, lots of time spent outdoors, and breaks from routines. Next quarter's edition will focus on all things sunshine and dermatology; celebrating summertime in our clinics.

Like what you see? Send me an email and let me know if you enjoyed this newsletter and what topics you'd like to see in future editions.

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