The OAR Advocate

Ohio Association of Rheumatology

June 2010

A Newsletter for Rheumatologists in the State of Ohio

About *The OAR Advocate*

Welcome to *The OAR Advocate*, the publication of the Ohio Association of Rheumatology (OAR). Published semiannually, its aims are: (1) to inform our members of news, events and trends in Ohio and nationally relevant to the practice of rheumatology; (2) to opine on issues that impact the practice of rheumatology; and, (3) to entertain our membership. In broadly defining our goals, we do not have a predetermined concept of what *The OAR Advocate* should be; rather, we seek your input and want it to be your publication. In that spirit, as editor I invite you to contribute articles, opinion pieces, stories about your practice, or even brief, informative cases. Please see the May 2009 *OAR Advocate* on our website for details about how to submit your contributions.

Gary M. Kammer, M.D., editor

Why You Should Attend the Fifth Annual OAR Meeting!

by Gary M. Kammer, M. D.

In my first president's blog in February entitled "Looking Back…Looking Forward", I reported that our Fourth Annual OAR Meeting was a smashing success (President's blog, www.ohiorheumatology.org). If you were there, I am certain you would heartily agree. And, we hope you will join us again this year. If not, we invite you to join us at rustic Cherry Valley Lodge in Newark, Ohio, bring your spouse or significant other and the family, and enjoy leisure, learning and socializing with your colleagues from around the state.

Here is an advance peek at an outstanding line-up of speakers and topics. The morning session will leisurely start at 7 AM with a continental breakfast and time to peruse vendors' booths. The morning's theme is advocacy. Dave Racer, noted author and speaker on health care reform, will give the keynote address "What's Next? Health Care Reform and Your Practice Future". His talk will highlight the growth of politically driven health care, how it created an entitlement mentality, the specifics of the Affordable Care Act of 2010, and how it may be possible over time to reduce federal authority over individual health care decisions and the private practice of medicine.

Our second esteemed speaker is Jane Orient, M. D., executive director of the American Association of Physicians and Surgeons and a general internist in private practice in Tucson, AZ. She has written and spoken extensively on health care reform, most recently "Is Medicare Voluntary" in the Summer 2010 issue of that society's journal. She will speak on "Medicare Hits the Iceberg: Implications for Patients and Physicians". Her talk will emphasize the fiscal realities of Medicare, the government reactions of price controls, fraud prosecutions, and options for physicians under Federal law. In particular, she intends to focus on the implications of the "Patient Protection and Affordable Care Act" for Medicare.

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SAVE the DATE

OAR Annual Meeting

September 24 and 25, 2010

Newark, Ohio

www.cherryvalleylodge.com

Why You Should Attend
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Our third speaker is someone we're well acquainted with at OAR: Jeff Smith. Mr. Smith, an attorney at the Ohio State Medical Association, has addressed our meetings on previous occasions, and returns at the request of our membership. His talks are terse and to the point, but pragmatic and entertaining. He will present an overview of pending and current health care reform legislation in Ohio.

Lunch will include a brief business meeting that will update you regarding our current Board appointments, our finances, our progress over the past year on several projects, and the many challenges that face our organization.

Following lunch, the afternoon session will focus on clinical rheumatology. The goal that we have set for our four highly esteemed speakers is to emphasize new research and how it impacts on diagnosis and therapy of rheumatic diseases. Our topics and speakers include: Idiopathic Inflammatory Myopathies, Chester Oddis, M. D., professor of medicine, University of Pittsburgh School of Medicine; Disease Activity Markers in Rheumatology Practice, David R. Mandel, M. D., private practice, Mayfield Heights and Chardon, OH; The Medical Therapies for Osteoarthritis—Where We Are Now and Where We Must Go, Charles J. Malemud, Ph. D., professor of medicine, Case Western Reserve University School of Medicine; and, Biologic Agents: Where Is the Field Going, What's In the Pipeline and New Mechanisms of Actions, Larry Moreland, M. D., professor of medicine and chief of rheumatology, University of Pittsburgh School of Medicine.

We invite you to join us!

Gary M. Kammer, M. D. is the current president of OAR, chair of the Agenda Committee for the Annual Meeting, and a practicing rheumatologist in suburban Cleveland.

The Electronic Health Record and Meaningful Use: What Does it Mean?

by David Bacha M.D.

As medical practices struggle to find ways to fund the implementation of an electronic health record (EHR), an awareness of how the government plans to provide monies is essential. The American Recovery and Investment Act of 2009 includes an EHR Incentive Program that could provide up to $44,000 to an eligible Medicare or Medicaid provider who is using an electronic health record. The essence of the incentive is simple---pick a certified system, install the certified system and use it in a meaningful way. However, the definition of meaningful use is not so clear, and the rules have not been finalized yet.

Currently, it is projected that the requirements for meaningful use will change over time and occur in three stages. Stage 1 is set to begin in 2011, and requires capturing health information in a coded format, tracking key clinical conditions, communicating for care coordination and beginning to report quality and public health information. By 2013, stage 2 will necessitate expansion into areas of disease management, medication management, patient access to their health information, quality measurements and bidirectional communication with public health agencies. Stage 3 begins in 2015 and focuses on achieving improvements in safety, quality and efficiency.

The degree to which the Centers for Medicare and Medicaid Services' (CMS) objectives and measures need to be met is still in the process of being defined; however, the final criteria are projected to be available later this summer. In order for an eligible provider to maximize the incentives received, he or she need to meet stage 1 criteria by 2012, but can begin to receive payments in 2011 if "meaningful use" is accomplished. In addition, penalties for not using an EHR in a meaningful way will begin in 2015. Ultimately, for those who are utilizing an EHR or contemplating implementing one, an understanding of the criteria that define meaningful use and the timeline involved will be critical in order to qualify for funds from the incentive program.

David Bacha, M. D. is a practicing rheumatologist in Akron.

Who we are . . .

Gary M. Kammer, M. D. (Willoughby, Ohio), president;

Robert Haladay, M. D. (Sandusky, Ohio), vice-president;

Terrence Foley, M. D. (Willoughby, Ohio), secretary-treasurer.

OAR Board members are:
Ed Herzig, M. D. (Fairfield, Ohio) and **William Treuhaft, M. D.** (Toledo, Ohio).

Meetings

We hold regular meetings, usually monthly, that can be easily accessed from your office or home by teleconferencing. We announce these meetings one month in advance in our meeting minutes that are posted on our website, and we remind you with an e-mail announcing the agenda. Lasting about an hour, these meetings discuss works in progress and introduce new business. We welcome your input, so please plan to join the meetings. The teleconference phone number is 1-888-557-8511; pass code is 8455129.

Practicing Rheumatology

by Gary M. Kammer, M.D.

I would venture that most rheumatologists decided to specialize in rheumatic and musculoskeletal diseases for three reasons. First, these disorders are intellectually fascinating. Can you think of a discipline in medicine with such a diverse array of disorders? Recall that there are more than 100 causes of arthritis! This panoply spans all of the major body systems. Complex cellular and humoral immune mechanisms exist to defend us from infectious agents. "Our" diseases surreptitiously turn non-antigenic proteins into autoantigens that evade detection while simultaneously creating havoc by turning the immune system on its head, causing autoimmunity that co-opts normal immune mechanisms and wreaks unconstrained tissue injury. Since my entré into rheumatology in 1975, science has discovered a bewildering array of complex mechanisms that mediate autoimmune diseases: immune complexes; antigen presentation; the complement cascade; autoantibodies; HLA-A,B,C, D, etc; T, B, NK, NKT, and dendritic cells (and their subpopulations); cytokines and chemokines and their receptors; necrosis and apoptosis; and, cell signaling. And, this doesn't include the vast knowledge base of biochemistry, molecular genetics and the human genome, to name a few. You're probably thinking of many other examples I left out. And, we're still only on the 20 yard line.

Second, most internists and family docs don't really understand these disorders. To them, they are a bewildering and seemingly endless list of esoteric diseases. Like you, however, I wanted to understand, diagnose, and treat these diseases. And, I knew that rheumatology was highly likely to remain a small, niche discipline throughout my career and that rheumatologists would be sought out by other docs and patients alike. In contrast to the science, however, two things haven't changed an iota since the '70s: rheumatologists are still the last specialist to be consulted when a complex case is being evaluated and we're still getting many consults for a +ANA.

But, the third reason was, for me, the most compelling: patient care. My mother had aggressive and painful erosive osteoarthritis of the hands that left her unable to paint, crochet or even cook at times. Her physician in the '60s was paralyzed with indecision due to lack of knowledge and treatment. I knew that an aging population would put enormous pressure on the federal government and private agencies like the Arthritis Foundation to ramp up research in order to come up with new therapies. And, I wanted to be on the forefront of that progress. Once the technology was in place to pry open the secrets of the immune system, discoveries of lymphocyte subsets, cytokines and cytokine receptors have led, in the past decade, to biologic agents aimed at these cells and their cytokines/receptors. No one would now argue that, despite potential serious adverse effects, these agents have revolutionized the therapy of rheumatoid arthritis, psoriatic arthritis and spondyloarthropathy.

OAR Newsletter

In this issue of The Advocate, we have focused on the practice of rheumatology. Four of our members have addressed three vital subjects in rheumatology today. David Mandel, M. D, (Mayfield Heights and Chardon, OH) president emeritus of OAR and a Board member, has written on his experience with disease activity markers in practice. This essay will presage a talk that he will present at our upcoming 5th Annual OAR meeting in September. (You won't want to miss this discussion of RAPID 3, RAPID 5 and much more.) Next, David Bacha, M. D. (Akron) presents a brief essay on the Electronic Medical Record (EMR), a hot topic these days. Reading his piece prompted me to go to several websites to update my understanding of the federal regs now in place that mandate EMRs within the next few years. And, Bill Treuhaft, M. D. (OAR Board member) and Ed Goldberger, M. D. (both of Toledo) present a pithy and hard-pressing essay critiquing use of consultants in the hospital by hospitalists. This timely piece deserves further comment.

Hospitalists and Consultants

Drs. Treuhaft and Goldberger's theme is that the consultation system in hospitals between hospitalists and specialists is dysfunctional. Not so long ago, when internists and family docs admitted their own patients to the hospital, they were the captains of the team: they were in charge of their patient's assessment and treatment. Because they had cared for their patients in the office and intimately knew and understood their medical disorders, these captains knew what specialists to call when their patients were admitted for an acute illness that required a particular specialist(s). If their patient had been under the care of a cardiologist, endocrinologist or rheumatologist, for example, those specialists or their on-call associates were consulted. The consulting physician usually posed a specific question for the specialist to address.

Treuhaft and Goldberger put their finger on the tender point when they state that the hospitalist today "serves as little more than an H & P service, followed by a triage function to recruit consultants, who do the actual work of providing the care". In other words, hospitalists function more like goalies to keep the ball in play rather than like captains of the medical teams. Moreover, Treuhaft and Goldberger astutely point out that consultants often arrive to do the consultation before hospitalists have even seen the patient! "We have been consulted by hospitalists even before they have evaluated the patient; they base their consult request on information they get by phone from the ER physician or the community-based PCP."

Even more concerning is the emerging trend that patients are often repeatedly re-admitted for recurrent medical problems to different hospitalist teams and repeat assessments are performed with comparable or identical results. Again, Treuhaft and Goldberger opine:

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"Sometimes this is one of a string of admissions of the same patient, but who gets readmitted to a different hospitalist service each time (whichever one is on-call or taking admissions for that shift), resulting in a different attending doctor, perhaps different consultants, and fragmented, inefficient, and more expensive care." Again, one would ask: Who's the team captain or who's calling the shots? Has the hospitalist reviewed the previous hospital admission(s) now easily accessible via the EMR?

Treuhaft and Goldberger offer their own prescription to deal with this thorny issue. They gently decline to see the patient until the hospitalist has finished his/her evaluation. Importantly, they take the time to speak to the hospitalist to decipher the reason for the consultation. To this, I would add the following steps now being taken in our office to determine whether or not a consultation is appropriate. Yes, it is reasonable and necessary to establish that a consultation is indeed indicated. Use of unnecessary consultations drives up the cost of care, and utilizes specialists' time that could be better spent seeing patients in need. Our practice is currently considering implementing the following stepwise procedure:

Step 1.
Is this a new patient to our practice or an established patient? If this is an established patient, is the medical problem for which we are being consulted a new one or the existing medical problem(s) for which we are already treating the patient?

Step 2.
What is the specific question the consulting physician is asking us to address? If the patient is new to our practice, the hospitalist or admitting physician must have performed the admitting history and physical examination, determined a specific problem is present or at least have developed a differential diagnosis with which they need assistance. We do not accept diagnoses such as "weakness", "patient cannot walk", "high ESR" or "back pain". We expect that the attending physician should have evaluated the patient to a point that they have a tentative or working diagnosis. If that is not tenable, then we speak with the admitting physician to determine if this is an appropriate consultation. Often, we find we can provide sufficient assistance and education by telephone so that a consultation is unnecessary.

If this is an established patient whom we follow but who is hospitalized for an unrelated medical problem and there is no change in the rheumatic disorder, we politely decline to see the patient and recommend that the patient follow-up with us in the office after discharge.

Step 3.
When in doubt, our practice's on-call physician always speaks with the attending physician. Our goal is to alleviate the problem of inappropriate consultations that Treuhaft and Goldberger describe, However, I believe that part of the onus for unnecessary consultations should be placed on the hospital administration. In my institution, the medical staff bylaws detail how the consultation process is to be carried out. When flawed judgments repeatedly lead to unnecessary or inappropriate consultations, we would pursue step 4 by discussing the matter with the senior medical officer of the hospital. We would seek his advice and, if necessary, ask that he step in. Whether or not these four steps will resolve these problems remains to be seen. But, since this is not just a rheumatology issue but is truly a systemic problem that all other specialists are grappling with, the final step would be to bring it to the floor of a medical staff meeting for discussion.

Gary M. Kammer, M. D. is the current president of OAR, co-editor of this issue of The Advocate, and a practicing rheumatologist in suburban Cleveland.

OAR Mission

From its inception in 2003, OAR has been a non-profit, 501 C3 organization composed of rheumatologists dedicated to the advancement of quality arthritis and musculoskeletal health care for all persons in the State of Ohio.

Our mission is to:

- Advocate and protect patient access to all appropriate treatments for rheumatic diseases,
- Establish and maintain clinical guidelines defining appropriate treatment of arthritis and rheumatic diseases,
- Nurture the interest and development of medical students and trainees in the field of rheumatology,
- Augment and support other organizations involved in arthritis care in order to enhance the quality of rheumatology services for all patients.

Quantitative Measures in a Rheumatology Practice: It's Time to Use One

by David R. Mandel, M.D.

We as rheumatologists measure and monitor diseases quite differently than other chronic illnesses like hypertension, diabetes and asthma.

During the past 20 years we have come to understand that there is no perfect gold standard test that monitors disease activity in our diverse group of patients with various rheumatic diseases.

The many old and new laboratory tests are not as sensitive or specific as we would like.

X-rays often lag behind the changes in disease and do not adequately reflect the structural damage that has occurred. Ultrasound and MRI may provide a more precise image. However, their cost and access can be a problem.

What we as clinicians are looking for is a reliable, easy, validated and relatively inexpensive tool that can aid us in monitoring disease activity.

Disease activity measurements fill this role quite well and can also be used to assist in changing and monitoring patient treatment. There have been numerous studies that show excellent correlation between disease activity measurements predicting high and low clinical disease activity.

Today there are many quantitative measurements for us to use in daily practice. Examples include the Health Assessment Questionnaire (HAQ) or Rapid Assessment of Patient Index Data (RAPID), which are primarily patient driven. The HAQ is now almost 30 years old. There are 20 activities of daily living with four levels of response to describe each activity: without any difficulty (0); with some difficulty (1); with much difficulty (2) and unable to do (3). These activities are then classified into 8 categories of 2 or 3 each.

The HAQ disability score is the mean of the highest of 0-3 scores in each of the 8 categories. The modified HAQ (MHAQ) was developed later and can be scored in much less time and is more patient friendly.

The Disease Activity Score (DAS-28) includes 28 tender and 28 swollen joint count, a sed rate ESR or CRP and a patient global estimate. The scoring, however, does require a calculator based on its formula.

The Clinical Disease Activity Index or CDAI involves 28 tender and swollen joints and a physician global estimate. It is much simpler to calculate than the DAS.

In a report by Dr. Ted Pincus of a large group of practicing rheumatologists when queried about how often they did a formal tender and swollen joint examination almost 45% rarely performed these regularly at patient visits.

We in the rheumatology community need to show our patients and ourselves that we are the primary physicians who understand and examine the musculoskeletal system and evaluate the joint regularly and report these findings with each patient visit. It has been estimated that the average time to perform a HAQ is about five minutes. Compared to scoring, a DAS takes about 2 minutes and a RAPID 3 about 5 seconds.

Numerous studies have validated that each of these quantitative measurement tools is more precise and accurate in evaluating patient disease activity than our current methods, i.e. laboratory or x-ray.

During the past 12 years I have incorporated patient assessment tools into my daily practice and have used the RAPID 3 routinely on all patients. This can be adapted to patients who have osteoporosis and fibromyalgia as well.

We review the results with patients, discuss the findings and compare previous results. These help to direct the examination and enrich the patient interaction. Often issues that might not have been addressed are discussed. The patient also sees that his or her care is better directed to a target with these tools being one of the more important goals of treatment.

The use of quantitative measurement reinforces the physical examination which we perform and improves on our clinical judgment and assessment. The consequences of this practice are a more objective and focused level of patient care that enhances treatment.

As we have all seen in recent years, third party payers are continually reviewing our care of patients. By providing these objective written questionnaires, along with our progress notes, we can be educating payers about the standard of care that rheumatologists provide to patients with musculoskeletal disease and how this is different and more comprehensive than what is rendered by other health care providers.

In summary, the use of quantitative measures not only offers invaluable information about the patient, it also provides significant prediction regarding outcomes in patients who have inflammatory arthritis regarding functional status, work disability and cost. All of these issues provide important information regarding the status of our patients and help direct and guide towards better patient care.

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David R. Mandel, M. D. is president-emeritus of OAR, a Board member, and practicing rheumatologist in suburban Cleveland, Ohio..

Modern Medicine

William Treuhaft, M. D. and Ed Goldberger, M.D.

When we were younger, our doctors seemed to know everything and be able to do almost anything. Whether he (it was almost always a "he" in those days) was a general practitioner or a pediatrician, or later an internist, he usually came up with an appropriate diagnosis and treatment plan. Maybe we were just lucky enough not to be very ill then, but we'd get better and life would go on. Marcus Welby, M. D. pulled us through again.

Nowadays, that type of one-doctor-knows-everything person probably doesn't exist, and it probably isn't such a bad thing. Medicine has gotten extraordinarily complicated. We know much more about disease and treatment. Even if one individual could have such a comprehensive data base, healthcare delivery has become so complex what with insurance issues, hospital systems, regulations and all, that it would be nearly impossible for one person to do it all.

But it now seems like today's PCPs often know less about the conditions of patients we help care for than they did a few years ago. Many PCPs no longer attend at the hospitals; they relegate that task to hospitalists, who, more often than not, have never seen the patient before. The hospitalists then request assistance from consultants, including us, to help with management. Now it's true that outcomes research and length of stay data show improvement with this new practice paradigm, but something has been lost in the transition. When the patient is discharged back home to the care of the PCP, that doctor may have only a limited view of all that went on during the hospital admission.

Our experience is that often the hospitalist serves as little more than an H & P service, followed by a triage function to recruit consultants, who do the actual work of providing the care. We have been consulted by hospitalists even before they have evaluated the patient; they base their consult request on information they get by phone from the ER physician or the community-based PCP who refers the patient in.

Sometimes this is one of a string of admissions of the same patient, but who gets readmitted to a different hospitalist service each time (whichever one is on-call or taking admissions for that shift), resulting in a different attending doctor, perhaps different consultants, and fragmented, inefficient, and more expensive care. And, if the patient happens to have a rheumatic disease as well, we often get asked to see that patient even if the reason for admission has nothing to do with the rheumatic diagnosis, the disease is inactive, or the patient sees another rheumatologist who doesn't come to that hospital!

Some of us will argue that these are all good reasons for us, as rheumatologists, to function as PCPs for our own rheumatic disease patients, given the current environment. But this just brings us back to the dilemma mentioned above: we don't know everything and can't do everything. Although, given our field, we're probably more up to date with topics in general medicine than many, that doesn't necessarily mean we can or should practice general medicine. Many of us do rheumatology because we find the area so fascinating that we want to devote all our time to it alone. Some practice in a geographic area where there isn't enough rheumatology manpower (or womanpower) to fulfill the demand and, as a result, they're as busy as they can be already, without additional burden. Some simply don't want to be on-call at 3 AM for a non-rheumatologic telephone call from a patient. Then, too, many of us who rely on referrals from other primary physicians don't want to irritate them by taking over a patient's care completely; that's a quick way to strangle one's practice.

So what is the best approach for us? In Northwest Ohio, we provide consultations at six of the seven acute-care hospitals and, usually, we're happy to do so. But sometimes, if it appears that the consultation request is inappropriate or unnecessary, we decline. There was the time we were asked to reconsult --for the fourth time-- on a patient we know well with severe RA who'd recently had a MRSA abscess which required I & D and long term antibiotics. The reason for the consult was the same each time: When can she go back on her arthritis medications, including Remicade? The answer was the same each time as well, and was documented in her previous chart, which the new-to-her hospitalist hadn't reviewed very carefully. We called the doctor and reiterated our previous recommendations and saved time and money in the process. At times, if it's obvious that the hospitalist hasn't even yet seen or evaluated the patient, we decline the consult request by saying we'll hold off seeing the patient until the workup is further along and it becomes more evident that our input is needed. We were once asked to see a patient for arthritis of the ankle, which turned out to be a distal tibial fracture; the referring doctor hadn't even requested an Xray!

Proponents of the electronic medical record tell us that, when we all have access to one unified chart, healthcare will become more seamless. We'd like to believe that, but it assumes that we all have the time and inclination to familiarize ourselves with volumes of data, which takes time and for which we wouldn't be reimbursed. These are problems that will grow larger in the future and will have to be addressed. Solving them should start with us. What's your approach?

William Treuhaft, M. D. and Ed Goldberger, M. D. are practicing rheumatologists in Toledo, OH.

How OAR Works

We accomplish our mission by developing and implementing achievable goals. In 2003, OAR recognized that the administration of office-based therapies by all specialists was being targeted for reform by Congress in a bill entitled HR 1622 Quality Cancer Care Preservation Act. This bill contained language regarding reimbursement policies for the use of biological agents. In response to this Act and the recognition that burdensome future regulations would follow, OAR authored a pivotal position paper recommending, among several items, the renaming of the bill to include non-oncologists who administer biologic agents as well as recommendations on reimbursements. OAR stated: "The administration of biologics, as well as the follow-up and maintenance care, is complicated in a variety of conditions such as Rheumatoid Arthritis and Crohn's disease. There should be equal, fair, and comprehensive reimbursement at a higher level for patients receiving biologic therapy for all specialties that use biologics."

In addition to position papers, we frequently correspond with our elected officials in the Ohio legislature and in Congress. Shortly after the Ohio Revised Code Title LVII Chapter 5751 Commercial Activity Tax (CAT) was implemented in 2005, OAR learned that this bill provides an exclusion for the gross receipts attributable to the administration of infusible chemo-therapeutic, biologic and therapeutic agents and supporting drugs for patients with cancer. OAR recognized that this law carved out an unfair exclusion for oncologists while including all other physicians who administer biologic agents in their offices, including rheumatologists. In an effort to level the playing field, former OAR president David R. Mandel, M. D. (Chardon, OH) wrote to tax commissioner William Wilkins in February 2006 advising him of this inequity in the law and asking for redress. Dr. Mandel wrote: "The Ohio Association of Rheumatology believes it is imperative that the Ohio Department of Taxation amend the CAT Law immediately to correct this inequity. Specifically, we recommend that the Ohio Revised Code 5751.01 (S) (2) (v) be amended to drop the last two words "with cancer" from this paragraph. This would allow the exclusion of gross receipts to extend to any physician who administers chemotherapeutic, bio-logics or therapeutic medications in his office." Although this thorny issue has not yet been resolved by the Legislature, OAR continues to meet with Ohio legislators and to communicate our concern.

These are among many examples of the work OAR continues to pursue on behalf of Ohio rheumatologists.

OAR Membership Form

Those interested in OAR membership, please complete the form below and return with your $50 annual membership fee.

Name: ____________________

Title: ____________________ MD/DO: ____________________

Address: ____________________

City/State: ____________________

Zip: ____________________ Phone: ____________________

Email: ____________________

Return your OAR membership form to:

Ohio Association of Rheumatology
36100 Euclid Avenue #170
Willoughby, OH 44094

If you have any questions regarding the Ohio Association of Rheumatology, please contact Gary Kammer, M.D. at gmkammer@hotmail.com or Michelle Pohl at michelle.pohl@lhs.net.