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ALACHUA COUNTY MEDICAL SOCIETY

House Calls

FALL 2021

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We Exceeded Our Goal - $21,650!

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Thanks to YOU we've raised $21,650 to replace the roof and related repairs at the Robb House! Construction has started this month and we'll keep you posted on the progress.

CONTRIBUTING AUTHORS

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SIMEDHealth Primary Care

Born in Germany, Dr. Floegel graduated from Humboldt University School of Medicine in Berlin. Following a year as a House Officer in the United Kingdom, she moved to Tallahassee, Florida for her Family Medicine residency with Florida State University. She arrived in Gainesville in 2006 and completed her Geriatric Fellowship with the University of Florida. Dr. Floegel is certified in Family Medicine and Geriatric Medicine. Antje provides outpatient Family Medicine, Primary Care, and Geriatric services with SIMEDHealth.

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Lake City VA, Cardiology

Dr. Dragstedt is a Cardiologist with the North Florida/South Georgia VA Medical Center in Lake City, Florida. He received his degree in Osteopathic Medicine from Nova Southeastern University, completing an Internship and Residency in Internal Medicine at the University of Florida. Dr. Dragstedt stayed on at UF to complete Fellowships in Cardiovascular Diseases and Interventional Cardiology. He is board certified in Internal Medicine, Cardiovascular Diseases, and Interventional Cardiology.

Bobby Slaton, MD
Gainesville Internal Medicine

Robert C. Slaton, MD, is the senior member of Gainesville Internal Medicine Physicians. A native of West Palm Beach, FL., he received his Medical Degree from the University of Florida, followed by an Internship and Residency in Internal Medicine. Dr. Slaton also completed a Fellowship at UF in Endocrinology. After serving two years in the United Sates Army, he returned to private practice where he joined the Gainesville Medical Group, Andrews and Associates. In 2003 he joined Gainesville Internal Medicine Physicians. He specializes in Endocrinology (particularly the primary care of diabetes) and Geriatrics.

Scott Medley, MD
Retired Family Physician

After graduating from the University of Kentucky College of Medicine, Dr. Medley served in the U.S. Army, completing his Residency in Family Medicine and attaining the rank of Major. He later established Gainesville Family Physicians, enjoying 20 years in Private Practice. He then served as a Hospitalist and Chief Medical Officer at NFRMC. He is a Past President of the ACMS and of the Florida Academy of Family Physicians. Dr. Medley was awarded the Gainesville Sun Community Service Award in 1987 and was Florida Family Physician of the Year in 1992. He currently is retired and volunteers at Haven Hospice. Dr. Medley has served as Executive Editor of House Calls for the past 23 years, and has authored over 100 editorials and articles for this publication.

Geraldine S. Bichier, MD
Haven Hospice

Geraldine Bichier, MD currently serves as the Associate Medical Director of the Haven Medical Group. Prior to joining the Haven Medical Group in 2008, Dr. Bichier served as Assistant Medical Director at the Center for Clinical Trials Research at the University of Florida. She received her Medical Degree from the University of Wales in the United Kingdom. Dr. Bichier completed a Fellowship in Nephrology at the University of Florida, and her Residency in Internal Medicine at the University of California San Diego Medical Center while serving patients at the Valley Nephrology Medical Group in Fresno, California.

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ALACHUA COUNTY MEDICAL SOCIETY

Thanks

Matthew F. Ryan, MD, PhD

For his outstanding leadership as ACMS President, 2019-2021

ACMS is pleased to announce Officers for 2021-22

President
Carl Dragstedt, DO

Dr. Dragstedt is a Cardiologist at the North Florida/South Georgia Veterans Affairs Medical Center in Lake City, Florida. He was raised in the Boston area and attended Bates College in Lewiston, Maine. He graduated from Nova Southeastern University College of Osteopathic Medicine in 2004, completing his Internship, Residency and Chief Residency in Internal medicine at the University of Florida. He stayed on at UF to complete Fellowships in Cardiovascular Diseases and Interventional Cardiology. Dr. Dragstedt is board certified in Internal Medicine, Cardiovascular Diseases, and Interventional Cardiology. He is a recent graduate of the FMA Physician Leadership Academy and is the ACMS Delegate Liason to the FMA. Married with two children, he enjoys spending time with his family, attending his children's activities, and traveling.

Vice President
Christopher Balamucki, MD

Dr. Christopher Balamucki is a Radiation Oncologist at the NFRMC Cancer Center. He received an undergaduate degree in Chemical Engineering, with a double minor in Chemistry and Biology from Virginia Tech. He received his Medical Degree from the Wake Forest University School of Medicine, completing an internship with Wake Forest's Baptist Medical Center, followed by his Residency in Radiation Oncology at the University of Florida. Dr. Balamucki is experienced in treating a wide range of cancers and has published his work related to head & neck, skin and GI cancers in addition to trigeminal neuralgia treated with Gamma Knife Stereotactic Radiosurgery. He is a member of the American Society for Therapeutic Radiology and Oncology (ASTRO).

Secretary/Treasurer
Brittany Bruggeman, MD

Dr. Bruggeman is an Assistant Professor of Pediatric Endocrinology at the University of Florida. She joined the faculty after completing her fellowship, residency, medical school, and undergraduate training at the University of Florida, graduating summa cum laude from the Medical Honors Program- go Gators! She is board certified in Pediatrics and is a leader in patient advocacy and policy within the American Academy of Pediatrics and American Diabetes Association. Her current pursuits include the clinical care of pediatric diabetes and endocrine patients and research exploring the natural history and pathophysiology of exocrine dysfunction within type 1 diabetes.

Please Welcome our incoming Officers!

Meet the New President

An Interview with Carl Dragstedt, DO, ACMS President

By Jackie Owens, ACMS Executive Vice President

JO: Thank you for joining us, Dr. Dragstedt, and please tell us about yourself. Where were you born and what brought you to Gainesville?

CD: I was born in Wiesbaden, Germany to a military family. I spent nearly all of my formative years in the Boston area, before relocating to Florida to attend Medical School, Residency, and a Cardiology Fellowship. After learning all that Gainesville has to offer, it was an easy decision for my wife and I to remain here and call Gainesville home!

JO: What prompted you to pursue medicine and specialize in Cardiology?

CD: I was raised by my mother, who was an O.R. nurse, and had a burgeoning curiosity in medicine from the time I was young. It was not until I had graduated from college that I decided to pursue medical school. Though I concentrated in the liberal arts, I felt that medicine offered a perfect union of my passions for both humanities and biological science. I would credit my decision to pursue Cardiology to two mentors I had the privilege of working with during my internship year at the University of Florida, Drs. Dick Conti and Carl Pepine. They cultivated my appreciation and curiosity in Cardiology at an early phase of my post-graduate training.

JO: What do you like best about being a physician?

CD: At risk of sounding cliché, as physicians we regularly find ourselves at the crossroads and intersections of peoples' lives. We are truly privileged to meet, listen to, and counsel our patients within the larger rubric of their cultural and socioeconomic identities. No other profession offers quite the diversity of encounters we are so fortunate to experience every day, irrespective of our practice environment. Lastly, perhaps more in the past 18 months than ever before, society at-large continues to look to the medical profession as pillars of information, veracity, and clarity. I see our role as physicians in this context as irrefutable in our calling to serve.

JO: Since your installation as President in May, you and the ACMS Board have successfully influenced local discussions regarding public healthcare and the current pandemic. What are your additional goals for the ACMS during your tenure as President: 2021-2023?

CD: My hope is that our Society will continue to engage in the important matters and discussions that we face. The Covid-19 pandemic has dominated virtually every facet of both our personal and professional lives over the past 18 months. I am hopeful that as we continue to emerge from the pandemic that we continue to provide wise counsel to those seeking the broad expertise of many in our membership.

At a more local level, I would love to see more young physicians from across our medical centers and private clinics become more involved in the ACMS and the Florida Medical Association, particularly at the Annual Convention and House of Delegates. Please reach out to me if you'd like to become involved!

JO: You have been a strong voice for physicians in the ACMS and at the Florida Medical Association for several years. We appreciate your service. Why is supporting organized medicine on the local level important to you?

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Meet the New President

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CD: Being involved in the ACMS for nearly a decade, I realize that engagement in our county medical societies is the foundation to understanding how national or regulatory policy is or is not working locally. It also affords a direct opportunity to become involved at the state level through the Florida Medical Association (shameless plug #2!), where our collective voices as the largest organized body of physicians in the state can greatly inform and influence the legislative processes in Tallahassee.

JO: Collectively, physicians can make a difference in the medical industry. What do you feel are the greatest challenges facing medicine today?

CD: The Covid-19 pandemic has resulted in unimaginable and, often, unnecessary suffering for those who've suffered with the disease. The immeasurable toll the pandemic has wrought on those among us who deliver care and console the bereaved has highlighted the paramount importance of physician self-care and wellness. I feel it's crucial for those in hospital leadership and seats of political power to hear our voices on these kinds of issues. I also believe it is essential that, as physicians, our unique and qualified education and training continues to be valued by the various stakeholders in healthcare, including patients, administrators, 3rd party payors, and legislators. Physicians will and should always be the first person that individuals, organizations, or institutions look to for expert guidance on matters pertaining to healthcare and public policy.

JO: We are most fortunate that you and your family decided to settle down here. I understand your wife is a Pediatric Dentist at Grins & Giggles, Pediatric Dentistry. Please tell our readers more about your family.

CD: I just celebrated my 20th anniversary! My wife, Alissa, is a pediatric dentist and avid equestrian. My children, Quinten (15) and Alivia (14) are both in high school.

JO: Congratulations on your Anniversiary! Between the two of you, your schedules must be hectic. How do you spend your free time – hobbies and interests?

CD: When we find time for it, I love travel, winter skiing, exercising, mountain biking, live music, dabbling in playing various instruments, and all things Gator sports! I recently acquired my great-grandfather's banjo, and while I'm curious to learn, I won't promise any serenades!

JO: Although I'm certain you're a talented musician, we appreciate your reluctance concerning the banjo serenade.

Thank you for joining us and we look forward to your tenure as President!

CD: Thank you! I'm looking forward to the next two years as well.

The Dragstedt family vacationing in Mykonos, Greece pre-pandemic 2019.

In The News – Promising New Drugs for Alzheimer's Disease

Jackie Owens, Executive Vice President, ACMS
with Scott Medley, MD, Executive Editor, *House Calls*

Physicians caring for patients and their families with Alzheimer's disease (AD) have been continuously frustrated that there are no drugs to effectively slow the progress of this devastating disease. Just recently, two new drugs have entered the scene. In April, 2021, Family Practice News (FPN) [1] reported that "Novel Alzheimer's Drug Slows Cognitive Decline In Trial". "Results from a phase 2 placebo-controlled trial of the investigational antiamyloid drug DONANEMAB show that the novel agent met the primary outcome of slowing cognitive decline in patients with early symptomatic AD". "Findings showed that the use of Donanemab resulted in a better composite score for cognition and for the ability to perform activities of daily living (ADL's) than placebo at 76 weeks." The FPN article is full of complicated statistical analyses. But the treated group showed a reduction in amyloid plaque level on PET scans and slowed cognitive decline.

"In a statement, Maria Carrillo, PhD., Chief Science Officer for the Alzheimer's Association, said 'the organization is encouraged by this promising data'. It is the first phase 2 AD trial to show positive results on a primary outcome measure related to memory and thinking...more work needs to be done on this experimental drug therapy."

"Howard Fillit, MD, neuroscientist and founding executive director and chief science officer of the AD Drug Discovery Foundation, said the study showed 'the pharmacology works' and that 'the drug did what it was supposed to do' in terms of removing A-beta plaque. It also gave us a signal that in a relatively small phase 2 study that there might be a mild cognitive benefit. Basically, it was a positive study that needs to be followed by another, much larger study to get us to really see the benefit."

Then, on June 8, 2021, the following headline from The Associated Press: "FDA Approves New Alzheimer's Drug". [2] Again, this was very exciting news, but it was not without controversy. This is the first new drug for AD in 20 years. The FDA Advisory Committee stated the drug is "reasonably likely" to benefit AD patients. "It can likely treat underlying disease rather than just manage symptoms like anxiety and insomnia." The drug ADUCANUMAB, marketed as "ADUHELM" has the ability "to reduce harmful clumps of plaque in the brain" and is expected to help slow dementia.

Some independent advisors, however, say that the drug has not been shown to help slow disease and that there are "residual uncertainties" surrounding the drug. AD attacks areas of the brain needed for reasoning, memory, communication, and basic activities of daily living (ADL's).

Six million people in the U.S. have AD, and there are many more cases globally. With worldwide aging of the population, the incidence of AD is expected to grow exponentially.

To this point there are no effective drugs to slow the progression of AD. That is why this news is so exciting. There are dozens of failed drugs for AD. Will these two be different? We can only hope!

References available upon request.

Dr. Bobby Slaton: Coming Up On 50 Years In Private Practice

Robert Slaton, MD Gainesville Internal Medicine
Interview by Scott Medley, MD

[Editor's Note: I have known Dr. Bobby Slaton for over 30 years. (He prefers to be called "Bobby" rather than "Robert" or "Bob"). After maintaining a very busy and hugely successful Private Practice for almost 50 years, Dr. Slaton is considered to be one of the icons of Medicine in Gainesville. He is the consummate personal physician, having numerous patients for whom he has provided care for decades. He is the Senior Partner in Gainesville Internal Medicine Physicians (GIMP), a group of ten internists. Dr. Slaton was so gracious as to sit down with us recently to reflect on his almost 50 years in Private Practice]

Editor (Dr. Scott Medley): Have you really been in practice for almost 50 years? You must have started when you were about ten years old:

Dr. Slaton: Actually, I entered Practice just after I completed my tour in the U. S. Army in 1976. We were celebrating the Country's bicentennial.

Editor: We'll get into some specifics later, but in general, what was your practice like, then and now?

Dr. Slaton: Of course, I was very busy at first, seeing mostly younger and middle-aged patients every 15 minutes. My Practice has evolved into mostly Geriatrics now, as my patients have aged. I'm now "about 95% Medicare" and I'm taking fewer new patients.

Editor: You were in on the "ground floor" of the establishment of North Florida Regional Medical Center (NFR). I know you've seen some changes there.

Dr. Slaton: The hospital has certainly grown and changed. Seems like there is always major construction going on. I have worked well with all their Administrators. The Hospital provides excellent care. I'm proud to have been one of the founding physicians.

Editor: How have you dealt with the "computerization" of Medicine and the onslaught of the Electronic Medical Record? Be honest, now and be nice...

Dr. Slaton: Actually, I have adapted quite well to the EMR. We here at GIMP were "computerized" early on. I've kind of developed my own "hybrid system" which works well for me. (At this point, Dr. Slaton looked up on his Smartphone the records of a patient he had last seen in 2006.) "See what I mean?" he says.

Editor: You seem to have a very close relationship with your patients. Please tell us about that.

Dr. Slaton: To me, being a Physician is all about the relationships with your patients. It means everything. I have some patients for whom I have provided care for over 40 years. My precious time with them is much more than a "Doctor's Visit".

Editor: I understand that you have several patients who are 100 years old?

Dr. Slaton: Yes I have at least five. They are a joy to take care of. Many of them still have "beautiful brains and witty minds". (There is a photo in Dr. Slaton's office given to him by a patient which features a family of five generations of women ages "about a hundred and two to two years old").

Editor: I've heard you speak passionately about "transitional care". Can you tell us what that is?

Dr. Slaton: Transitional Care is maintaining consistency in a patient's care. It's "connecting all the dots" from a patient's pre-admission, through their Hospital stay, and after their discharge. It is frustrating to sometimes see the detachment of a Hospitalized patient from their primary care doc. It's very difficult to maintain an office practice and provide complete care for one's hospitalized patient. I attempt to at least be aware when one of my patients is hospitalized and to make "continuity and social rounds" on them. I try to make sure the reason for their hospitalization is fully addressed. Patients need a strong medical advocate to make sure their problems are taken care of and

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that they understand their medications, discharge instructions, etc.

Editor: I know you are now teaching Resident Physicians. You must be a great Role Model for them. What are some of the main messages you are attempting to impart to them?

Dr. Slaton: As you know, unfortunately primary care is now unpopular as a specialty. I'm a recruiter for primary care. I try to show the Residents the satisfaction in continuity of care and transitional care and in building relationships.

Editor: You have subspecialty training in Endocrinology and Geriatrics. Have you practiced those specialties much, or has your practice been mostly General Internal Medicine?

Dr. Slaton: You asked earlier about changes I've witnessed in Medicine. One of the greatest changes has been in the monitoring and treatment of Diabetes. (At this point Dr. Slaton slid a small device across his upper arm revealing his blood sugar.) You see, I'm a diabetic and that is how I now monitor my blood sugar...no more "pricking fingers". There also has been an explosion in the number of drugs to treat diabetes. Our outcomes are much better.

Editor: Here's the inevitable question. How has the COVID-19 pandemic affected your practice? You have always seemed to me to be the epitome of the "person-to-person", " hands-on" physician. What have the "distance visits" been like for you?

Dr. Slaton: Well, we almost had to "shut down" for a while. But no one was turned away. I did a few telehealth visits, but mostly I continued person-to-person visits. That's what I'm all about.

Editor: Are most of your patients accepting COVID vaccinations? Are you encountering much "vaccine hesitancy"?

Dr. Slaton: No, most of my patients are now vaccinated. My older patients are eager to get the vaccine.

Editor: What do you see as the next big challenge in Medicine?

Dr. Slaton: One word: communication. We have all these computer devices and gimmicks, but it still comes down to communication between the physician and the patient. Again, sometimes the patient needs a "medical advocate", often a family member, to be sure the patient understands their diagnosis and treatment.

Editor: How much longer will you practice? Any "sneak-preview" timelines for us?

Dr. Slaton: Right now, I almost feel like I am "emotionally retired". I do pretty much what I want when I want. I hope to practice as long as my health holds out—possibly to age 80 or older. The Practice of Medicine is more than a job—it's a way of life.

Editor: Anything else you'd like to add?

Dr. Slaton: I hope to "hang in there" because of the long-term fantastic relationships with so many patients. I am also disturbed and fascinated by the development and progression of Dementia in my numerous elderly patients. Picking up on the earliest signs of dementia and then accompanying that patient's journey until they end up in hospice care is sadly interesting. I just wish we had better drugs for Dementia.

Editor: Thank you so much for your time and for your insights, Dr. Slaton.

Dr. Slaton: Thank you!

L to R: Scott Medley, MD; Bobby Slaton , MD; and Zhao Han, MD, Dr. Slaton's Newest Associate.

Pain in the Elderly: Assessment and Challenges

Anje-Mareike Floegel, MD
SIMEDHealth Primary Care

In my primary care clinic, I often encounter elderly patients that are quietly enduring pain on a daily basis. They often perceive pain as an age-related condition, as a normal, even essential, part of life.

They make excuses for their pain, deny they are in pain, they do not want to bother their family members or do not want to be a nuisance to them. "It's not that bad. I can manage . . ."

These elderly patients often fear further testing with the involved costs and potential for incidental findings; "What is the copay for the MRI?" or "I am afraid they will find cancer on my scan."

Caretakers, and physicians too, often view pain as inevitable part of the aging process; simply believing chronic pain is quite common in older adults. A study funded by the National Institutes of Health (NIH) found that more than half of the older adults surveyed reported having bothersome pain in the last month, and three quarters of them reported having pain in more than one location. About 30% of the elderly population suffers chronic pain lasting three to six months or more than expected. Nursing home patients may have a prevalence as high as 45-80%.

Some studies have found an age-related increase in the prevalence of pain with older age predicting a more likely onset of, and failure to recover from, chronic pain. But many studies have failed a direct relationship between age and pain. Typically, older patients are more likely to report pain in multiple locations, and elderly women are more likely than elderly men to report pain.

Multiple factors pose barriers to effective treatment of pain in the elderly. Such include patient-related factors and factors related to medical professionals, to medications and interventions. Patient-related factors include fears, misconceptions, personal factors and comorbidities.

Common patient fears include being labeled as weak, or becoming addicted to prescription medication. "I am not going to that pain clinic." Patients may have concerns about non-treatable conditions, or that treatment will mask disease progression. They may have fears of adverse effects from medications. Comorbidities like depression, dementia or altered cognition, speech and hearing impairment, or physical impairment are also barriers for adequate care and treatment of pain in the elderly. Personal factors like cultural and religious beliefs, comfort with a health care setting and practitioner, ambulatory status, accessibility, dependency on others for transportation, insurance coverage, social support are all playing a role as well.

Medical professional related factors include time constraints in office settings, lack of multidisciplinary approach or lack of communication, denials and authorizations for insurance coverage for procedures or medications and elaborate documentation requirements.

Polypharmacy, complex dosage regimens, adverse effects or interactions with medications or interventions, and complex medication packaging are other common barriers to effective geriatric pain management.

Treatment of pain in the elderly is further challenging by the fact that 75% of people 65 and older have two or more chronic conditions such as heart disease, diabetes, chronic lung disease, or arthritis. A person over 65 years of age, takes on average approximately nine or more medications per day, this increases the risk of adverse reactions from drug-to-drug interactions. The adverse reaction risk is also higher in elderly patients due to physiologic changes in the body that come with age.

Decreases in gastric secretion and motility of the gastrointestinal tract may inhibit the absorption of nutrients and alter the absorption of some drugs. Body composition most often changes with age. These changes include increases in body fat and

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decreases in lean body mass, total body water, and serum albumin and these may impact the distribution of medications. Circulating albumin and other proteins bind many different drugs, for instance nonsteroidal anti-inflammatory drugs (NSAIDs) and tricyclic antidepressants (TCAs). Therefore, more unbound drug may be available for activity, toxicity and drug-to-drug interactions. The volume of distribution and half-life of lipophilic drugs is often increased in the elderly. Plasma concentrations of hydrophilic and highly protein-bound acid drugs may be increased as well.

Hepatic volume and blood flow decline with age, which can lead to reductions of drug metabolism. Age associated progressive nephrosclerosis and decreased renal flow can lead to decreased glomerular filtration rate (GFR) and subsequently increased serum concentration of renal metabolized drugs and their metabolites. Concurrent cirrhosis, chronic liver disease, or chronic kidney disease impact drug metabolism to a greater extent. The decline in hepatic and renal function may lead to increased risk of adverse events and drug-to-drug interactions due to elevated drug or metabolite concentration. Slowed gastrointestinal motility may increase the risk of constipation. Decreases in the elasticity of the lung and increased chest wall rigidity can lead to reductions in respiratory ability, and thereby increasing the risk of respiratory depression. Elderly patients have a higher risk of falls and are more susceptible to the cognitive and sedative effects of many pain medications.

Many people believe pain sensitivity decreases with age. In some cases, older adults may have a higher pain threshold and higher pain tolerance, perhaps due to decrease in the number of peripheral nociceptive neurons and changes in conduction properties of primary nociceptive afferents. Other mechanisms proposed for increased pain and pain sensitivity in the elderly, due to physiologic changes like a decrease in neurotransmitters such as GABA, serotonin, noradrenaline, and acetylcholine, and reduced endogenous analgesic responses.

The most common causes of pain in the aging population are musculoskeletal disorders like degenerative spine and arthritic conditions with joint pain, stiffness and muscle rigidity. Other significant causes include neuralgia, neuropathic pain, ischemic pain, pain due to recent injuries, pressure sores, leg ulcers, skin tears, and pain due to cancer as well as its treatment.
Chronic pain can decrease function, create fear of movement, decrease the ability to focus and sleep and to cope with common stressors of life and thereby increase the incidence of depression. Pain may worsen other chronic diseases requiring ongoing management, like hypertension, heart disease and diabetes. Pain can decrease one's quality of life.

A comprehensive assessment of the elderly patient is essential to make one or more diagnoses before outlining a treatment plan. This includes evaluation of the functional status of the elderly (gait, balance, visual and auditory acuity), the ability to perform daily activities, screening for cognitive impairment, depression and substance abuse, review of comorbidities, determination of the degree of independence and their need for caregivers and overall quality of life.

Finding the time to accomplish this in a typical primary care setting can be quite difficult in the context of managing many other health conditions and problems older patients may have.

Because of the complexity of pain in geriatric patients, a multidisciplinary approach in which physicians, physical therapists, behavioral health clinicians, and others collaborate, is ideal. Some older patients will not admit to experiencing pain, but instead to the presence of an ache or discomfort or a burning sensation. Each history should inquire about the timing of the pain (total length, time of the day when better or worse), quality of the pain, severity or intensity of the pain. A wide range of assessment tools, numeric rating scales or verbal descriptor scales can be used for the elderly. Unidimensional pain scales are often used in context of a busy clinic encounter as they assess pain intensity only. Examples are Verbal Pain Descriptor (none, mild, moderate, severe), numerical rating scales (0-10), the Visual Analogue Scale, the Paine Thermometer and the Faces Pain Scale. These can also be used in patients with mild to moderate cognitive impairment. Multidimensional pain scales can capture the multidimensional aspects of pain, including its impact on function. Examples of such scales include the Brief Pain Inventory, Geriatric Measure and the McGill Pain Questionnaire in its long or, more practical for the use in the clinic setting, short form.

Despite the high prevalence of pain in the elderly, pain is often under-diagnosed, and under-treated, particularly in those who have severe dementia due to the difficulty in communicating their experience

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of pain due to major cognitive or linguistic impairments.

Assessment of pain in older patients with cognitive impairment often requires a triangulated approach which includes self-report, caregiver report and direct observation. The self-reports of elderly patients with cognitive impairments are often influenced by pain at the moment, rather than past or recent pain. Types of behavior suggesting underlying pain include facial expressions (grimacing, frowning, clenched teeth), vocalizations (noisy breathing, gasps), changes in activity patterns (eating, sleeping, restlessness), changes in mental status (irritability, aggression, confusion), body movements (guarding, bracing, rocking, rubbing the affected area), and interpersonal interactions (disruptive, aggressive, social withdrawal). Bodily changes suggesting pain are raised temperature, pulse and blood pressure, perspiring, flushing or looking pale.

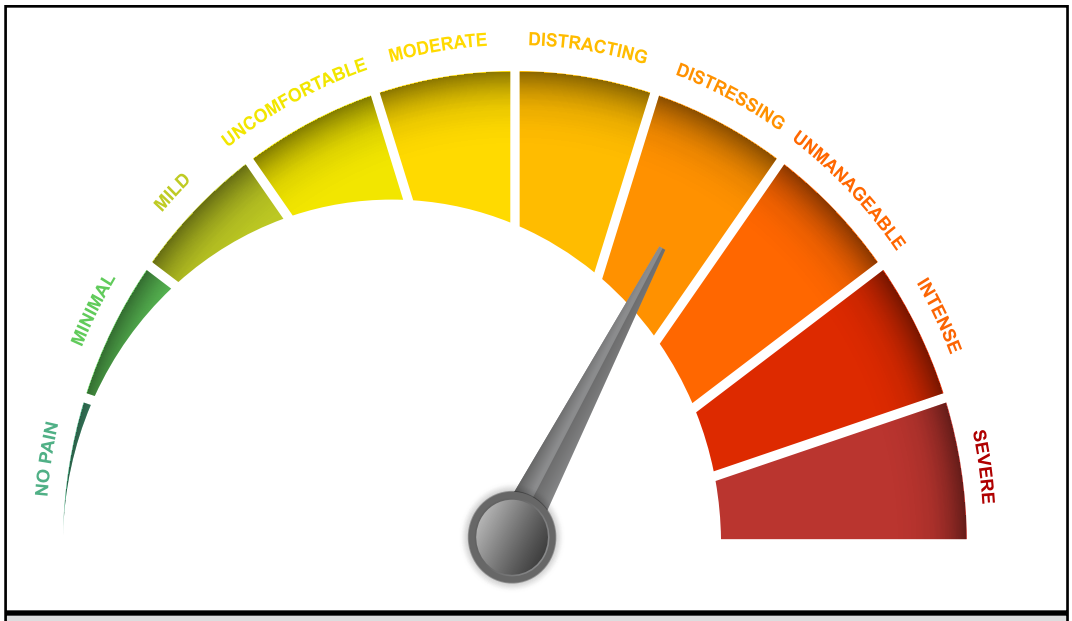
A physical examination, assessing previous consultations, workups and imaging studies and interpreting further laboratory and diagnostic studies complete the assessment prior to formulating a treatment plan.

Goals of treatment should be modulated pain, the ability to perform valued activities, regained independence, improved function, and improved quality of life. Goals should be realistic, as not all pain could be eliminated, and not all conditions are curable.

Non-pharmaceutical approaches are often lower in cost with minimal side effects. These include physical and occupational therapy, acupuncture, chiropractic therapy, massage therapy, myofascial release techniques as well as cognitive behavioral therapy, hypnosis, mindfulness and meditation.

Traditional recommendations, such as exercise, stretching, balance training may be unfeasible for elderly patients that have physical limitations. Many elderly patients may be too fragile to undergo traditional manipulation and massage therapy. Physical therapy and even yoga may be too strenuous. Physical rehabilitation including the use of assistive devices and in-home-modifications can help to stabilize the underlying condition causing pain, while preventing secondary injuries. This promotes independence with adaptation to a condition or disability.

Interventional modalities include localized procedures such as joint and trigger point injections and orthopaedic surgeries. Modern interventional pain management embraces various injection procedures including nerve blocks, epidural and spinal injections, and kyphoplasty. Other advanced minimally invasive procedures such as radiofrequency nerve ablations, lumbar decompressions and spinal cord stimulation can be beneficial in select patients.



Pain Scale: Various levels of pain are indicated on the above Pain Scale, from minimal to severe.

Pharmaceutical approaches include a long list of medications. Non-opioids are preferred over opioid medications and used primarily for nociceptive pain (mechanical low back pain, post-op pain, injuries, trauma, arthritis).

The American Geriatrics Society considers Acetaminophen as the initial treatment of mild, persistent pain because of its effectiveness and safety profile. Acetaminophen lacks inflammatory activity so its effects may be limited in long-term treatment of

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inflammatory conditions.

Non-steroidal anti-inflammatory drugs (NSAIDs) should be started at low doses and used briefly. They should be used with caution because of the risk of gastrointestinal bleeding (nonselective NSAIDs), chance of further reducing kidney function, and possibly worsening heart failure.

Antidepressants can improve chronic neuropathic pain (post-herpetic neuralgia, neuropathic back pain, polyneuropathy, trigeminal neuralgia, migraines). Unfortunately all antidepressants have increased side effect potential in the elderly. Common side effects of tricyclic antidepressants (TCAs) in the elderly are sedation, cognitive dysfunction, anticholinergic effects and orthostatic hypotension. Selective noradrenaline reuptake inhibitors (SNRIs) can increase blood pressure and cause arrhythmias. Selective serotonin reuptake inhibitors (SSRIs) have a more favorable side effect profile in the elderly.

Anticonvulsants may be effective for neuropathic pain, but their use is often limited due to the side effects of somnolence, dizziness, fatigue and weight gain. Multiple drug-to-drug interactions are known concerns.

Most muscle relaxants should be avoided in the elderly patient because of excessive sedation and potential risk of falls.

Topical or transdermal applications can be useful to treat neuropathic and localized, nociceptive pain with a low incidence of side effects.

Opioid analgesics can be considered in the geriatric patient for the treatment of moderate to severe pain which is impairing function and lowering their quality of life. However, the elderly are more sensitive to the effects of opioids due to physiologic age-related changes, and comorbid medical conditions and their treatments. Other things to consider in whether to use opioid analgesics in the elderly include prior or current substance abuse, their ability to manage the prescriptions responsibly by themselves or with the help of a caretaker, polypharmacy, and the potential for side effects. Common side effects of opioids in the elderly include prolonged sedation, cognitive and psychomotor impairment, hallucinations, nightmares, constipation, nausea and respiratory depression causing or worsening issues like sleep apnea and sleep-disordered breathing. Opioids may also precipitate or worsen depression. The functioning of the hypothalamic-pituitary-adrenal axis can be affected by opioids, potentially leading to increased prolactin levels and decreased levels of sex hormones.

Patients often think prescription analgesic, particularly opioids, are highly addictive and therefore commonly decline to take them. This stereotype is often shared by their family and friends. Although opioid medications can cause physiologic dependence, research shows this is rare in elderly patients treated with them. Furthermore, studies have shown that older age is actually associated with decreased risk of prescription analgesic medication abuse and misuse.

As medicinal use of cannabinoids has been legalized now, more elderly patients are seeking advice regarding prescriptions, availability, use and benefits. Some studies have shown marked reduction in pain and better safety profile compared to opioids. However, the safety of long-term cannabinoid therapy is not established. Their common side effects include euphoria, psychosis, sedation, dizziness, change in cognition, tachycardia, and postural hypotension.

General advice in prescribing any analgesic prescription is to prescribe a trial of a scheduled medication , to use a step wise approach (WHO step ladder approach), "start slow and go slow," while being aware of possible under treatment. While monitoring the patient continue to balance the risks and benefits of the treatments, and continue to be alert to herbal and dietary supplements taken by the elderly patient as they may be prone to drug-to-supplement interaction. Patients who do not respond well to one medication may respond well to another.

Pain in the elderly is a specialized illness. The assessment and treatment of pain in the aging adult poses many challenges. We have many treatment modalities to use including pharmacotherapy, psychosocial treatment, physical rehabilitation, and interventional modalities. Combining the non-pharmaceutical with pharmaceutical approaches may not completely eliminate pain, but can result in a substantial improvement of pain. While such a multidisciplinary team approach geared toward lessening pain, improving function and independence and overall quality of life in the elder is extraordinarily complex, it is equally rewarding.

References upon request

Allowing Death

Geraldine Bichier, MD
Haven Hospice

A young woman is dying. She is comatose and has not had anything to eat or drink for several days. What is she waiting for? As I watch her from the doorway, her estranged teenage son is led in and sits beside her. Incredibly she rises up and envelops him in her arms. What do you call that? Forgiveness? Closure? A miracle? She dies a few hours later. It is events like this that are humbling and make me realize that we as doctors know so little about dying.

As I look back over several decades of being a physician I realize that until coming to work at Haven I had rarely seen a dying person die. I remember three instances. A 16-year-old with cystic fibrosis, an elderly woman after a massive stroke, and one of my continuity patients with end-stage COPD. Each of these deaths was made possible at the insistence of family or of the patient themselves. We don't let people die. We interfere, we treat, we resuscitate. We are trained to keep people alive. We are not trained to allow a natural process to take over, intervening only to relieve suffering. But this is what I do now. The provision of hospice services allows a natural process to play out. It does not hasten or cause death. Many studies have shown this. Morphine does not kill people. Diseases do. Perhaps age does as well (we wear out). Hospice care allows dying people to die.

Hospice is a curious beast. The concept may have been created by Dame Cicely Saunders, but what we have here was created by Medicare. If ever there was an argument for government -health care it would be the Hospice Medicare Benefit. Full of regulations, bureaucracy, irritating rules, yes. But so wonderful and humane. We provide compassionate, effective and incredible care for dying people, whether in their homes or in our care centers. Nurses, care aides, social workers, chaplains and physicians all working as a team to provide the best death possible. You need to be humble as the physician because, believe me, you are on the bottom rung of care providers as far as the patients and families are concerned.

Although many people assume that the care center is where people go to die, most of those we care for die in their home or a facility. It is incredible to me how families manage this. People do not usually die suddenly in their sleep or within a few minutes. It is a process over several days to weeks for most and it takes a lot of difficult, exhausting work. We would prefer it be a process over months, but too many people come to us late. Maybe because their provider didn't recognize what was happening or because the people themselves could not acknowledge it. There are lots of reasons. So for most people, dying at home means a lot of work for families and we are there to support, educate and help them achieve their goal. Very rarely we can provide continuous nursing care for a day or two, but the majority of times the bulk of work is done by family and friends. It is a 24/7 job, often giving medications and nursing care every few hours. Dying is not pretty and can be very traumatic for the patient and family unless we help them intervene with medications. Dying often involves a lot of agitation and restlessness which can be confusing and exhausting to deal with. There is urine, feces, sweat, blood, mucus – all these bodily fluids that have to be cleaned away by family members who are not trained to do this. And then there is morphine - a scary word for a lot of people. And all these medical decisions that have to be made by an overwhelmed, grieving family. When to give? Did it work? Should I have used lorazepam instead? Often difficult decisions for us, but unbelievably difficult for a lay person. Our nurses will visit once a week, more frequently during the last few days. Our CNA's often visit several times a week. Then there is further attention from social workers and chaplains, addressing the existential and psychosocial aspect of death and loss. However, after the visits there is just the family left to carry on. I would like to think that they feel supported, listened to and part of the team, not alone. We have nurses and providers available 24 hours a day to give advice and help by phone. And there is always a nurse available if an additional visit is needed for problems that cannot be solved by telephone. Still, I am always in awe of how family and friends get this done. In the facilities a lot of the work is done by facility staff, but hospice is there to support in exactly the same way as for home patients.

Sometimes symptoms are just too difficult to manage at home or in a facility. Or a family/patient may not

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want to die at home because of the presence of children or lingering memories of a dead body. These people are usually transferred to the care center. Many of you will have visited one of our units. If not, I urge you to. If we know a person is likely to need the care center at some time we also encourage them or their families to visit ahead of time so that it is not such an alien place. For many, coming to the care center equates to 'the end', and although this is not always the case, the transfer is made even more emotional and dreaded because of this thought. The care centers are not hospitals. They are calm and quiet and full of smiles, respect, love and compassion. Each room has a beautiful view, a private bathroom and a sleeper sofa for family. We have a chef who can conjure up virtually anything at any time (dying being a bit like pregnancy). It is a place of celebration and remembrance with a beautiful non-denominational chapel that houses a glorious locally-made stained glass window. There are oaks and fountains, koi ponds and bluebirds outside.

Perhaps the greatest clinical challenge we face during the dying process is terminal delirium. Many people, whatever they die from, will experience this to some degree. And for some, especially the young and those with dementia at baseline, it is extreme. Instead of physical restraints, as in the hospital, we use a calm environment and medication. Sometimes a lot. Whatever symptom we are addressing with medication, we always start with the lowest dose and titrate upwards, monitoring the effect. Unfortunately, we cannot always achieve what many wish for – a non-distressed conversational person. Sometimes the unintended happens, resulting in someone who is somnolent but peaceful and pain-free. This 'secondary unintended effect' is different from palliative sedation, also an ethically accepted intervention, where sedation itself is used as a therapeutic tool for refractory distress when other efforts have failed. The fact that good symptom management sometimes comes with decreased awareness is one of the hardest things we have to explain and help families through. Sometimes we have to help other providers through it, too. The management of dying is often not as we would wish but it is what it is, and allowing death to occur with minimization of suffering is the goal.

Why do any of us do what we do? I recently had a resident shadow me at the care center. He admitted that he didn't like sick people. He's going to be an orthopaedic surgeon and replace joints. It's good to know yourself. When I was ten-years-old I wanted to be a doctor and saw myself sitting on people's beds, holding their hands. 'Ministering to the sick', just like our family doctor at the time. It's what I do now. I visit people in their homes and hear their stories, share a tiny piece of their lives. I have cared for a man who danced with Marilyn Monroe, someone who filmed Elvis on the Ed Sullivan Show, a man with a pet monkey, a 107-year-old woman (think of what changes she has seen), a couple at the end of nearly 80 years of marriage, a Tuskegee Airman. If I need to take two hours to address a concern, or offer comfort I can. There is no 10-minute clinic time slot. We recently cared for a young man with near total-body burns that came to the care center traumatized from two years of inadequate pain control and dehumanization. He and his mother had many weeks of laughter and joy, pain free, before he died. Several years ago we moved a Native American with cancer from a three-bedded room in a nursing home to the care center to better manage his pain and were able to give him the death outdoors that he wanted. We provided a haven for an 18-month-old dying of congenital CMV and her parents, who were being criticized by their small community for allowing a child to die.

It is so immediately gratifying and I am given this feeling of worth. The satisfaction of actually helping at a time of such distress. Many people really open up at this time and share thoughts, fears and experiences. I really use every minute of my training and experience. What a life.

Upcoming ACMS Programs:

September 14, 2021
Nicole Iovine, MD, PhD
COVID Update - 1 hr CME

October 12, 2021
Prescribing Controlled Substances
2 hr CME

November 16, 2021
Prevention of Medical Errors
2 hr CME

January 11, 2022
Domestic Violence
2 hr CME

MCMS, Inc. Insurance Trust

The Health Insurance Trust serving the Alachua County Medical Society

Created by Physicians, for Physicians and their Staff

Program History

Background: The Medical Society Insurance Trust was established in Marion County over 40 years ago.

Purpose: Created by physician employers in the private practice of medicine as a way to provide comprehensive medical coverage to their employees and families.

Growth: Since that time, the program has expanded to 12 total counties state-wide and continues to offer affordable insurance solutions to independent physician practices.

Sustainability: The program is governed by a Board of Trustees, made up of local leadership and decision makers, to manage risk and ensure long term program success.

Program Advantages

Plan Variety: Groups can offer up to 11 different health plans through Florida Blue.

Rate Stability: Using a funding strategy called Minimum Premium, the Trust functions under one, state-wide program in an effort to further stabilize healthcare costs for both the practice and the employees.

Large Group Benefits: Joining MCMS, Inc. Insurance Trust allows small groups access to large group benefits and rates.

Statewide Reserves: The Minimum Premium funding structure is designed to protect the over $5 million reserve balance for the program's continued success. As statewide plan performance improves, premium holidays can provide additional rate relief!

For a Proposal of Insurance, please email:

Kristy Rowland at **Ocala.GBS.TrustBenefits@AJG.com**

For more information regarding the MCMS, Inc. Insurance Trust, Alachua County Associate Members, visit:

www.TrustACMS.com

Gallagher

Insurance | Risk Management | Consulting

MCMS INSURANCE TRUST

Florida Blue

HAPPENINGS

ACMS

Residency Relief

TopGolf at Ben Hill Griffin Stadium

April 24, 2021

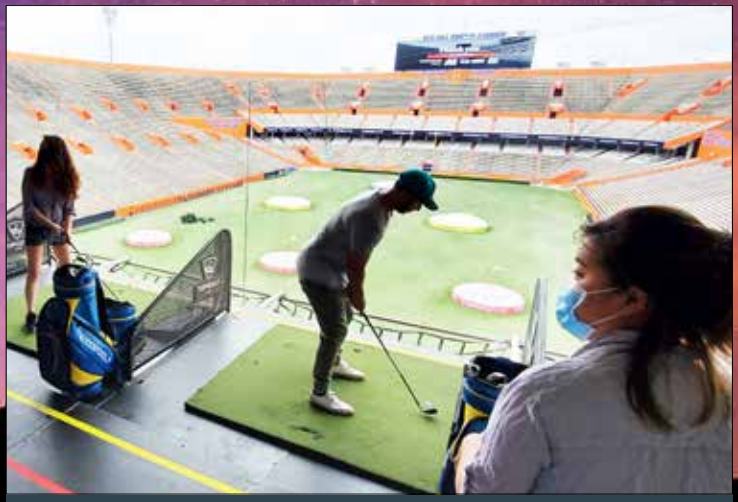
(all participants were vaccinated)

L to R: Karen LaLonde; James Neshewat, JD, Partner and Financial Advisor with St. Johns Asset Management; and Insley Edgar. Thanks to you all for sponsoring such a wonderful event!

Residents practicing their swing.

Mediclal Residents enjoying lunch on the stadium terrace.

Dr. Matt Ryan, ACMS President (center), with Residents at Top Golf.



Center: Alex Toirac, MD teeing up at the stadium.

HAPPENINGS

ACMS

A Hole In One!

Residency Relief

Top Golf at Ben Hill Griffin Stadium

April 24, 2021

Our Residency Relief Group on the Touchdown Terrace after a day of golf. Thanks again to St. Johns Asset Management for sponsoring this much needed break for the Residents.

HAPPENINGS ACMS

ACMS Annual Meeting & Installation of Officers
May 18, 2021.

Attending the ACMS Annual Meeting and Installation of Officers virtually this year. Thanks to everyone for joining us! Hopefully, we'll return to in-person meetings soon.

Charles Riggs, MD, Holding Matthew Ryan, MD, PhD Recognition Plaque for his Dedication and Service to the Alachua County Medical Society. Thank you Matt!

HAPPENINGS

ACMS

Keira Grace Foundation - Share the Cure

June 5, 2021, UF Hilton

(all participants were vaccinated)

L to R: Ellery Altshuler, MD; Valentina Fandino; Erica Braschi; Patti Locascio; Eileen Lauzardo, MD; Michael Lauzardo, MD; Sally Scott; Steve Gregg; Olga Mas, MD; and Patrick Bizub.

L to R: Manuel Marichal; Leah Locascio; Ryan Lauzardo; and Logan Locascio Dancing the Wobble at the after party.

Keira Grace Foundation - Share the Cure

June 5, 2021, UF Hilton

The Lauzardo Family L to R: Michael Lauzardo, MD; Eileen Lauzardo, MD; Sophia Lauzardo; and Ryan Lauzardo.

Faye Medley and Scott Medley, MD.

L to R: Ryan Lauzardo; Emmett Kendall; Tyler McNamee; Bailey Davis; Lexi Scammacca; and Rowan Cassarly.

L to R: Chris Doering, Judd Davis and Michael Lauzardo, MD

In Memoriam

Bruce Brient, MD

(August1939 – June 2021)

Dr. Brient grew up in Kansas City, MO. He completed Medical school at the University of Kansas and was the first medical student west of the Mississippi accepted into the Duke University Surgery Residency program. He finished his residency at the University of Illinois. Dr. Brient was an associate Professor at Shands Teaching Hospital before starting his own surgery practice in 1981. He built a successful practice at what was then Alachua General Hospital and later joined the Surgical Group of Gainesville at North Florida Regional Medical Center. He was one of a kind, and he loved his job and his patients so much that he continued operating until he was 80. Dr. Brient is survived by his wife C. J, first wife Carol Brient, his three children Paul Brient, Scott Brient, Carrie DeFoe, and eight grandchildren.

Frank Carrera, III, MD

(1932 - March 2021)

Dr. Carrera graduated from Emory University medical school and, after serving his country as a Captain in the U.S. Air Force 858th Medical Group (SAC), he returned to his medical training in Psychiatry at the University of Florida at Gainesville. He served as a Professor of Adult and Child Psychiatry at the University Of Florida School Of Medicine for 25 years. After retiring from academia, he worked as a consultant for Devereux Behavioral Health. He is survived by his children, Elizabeth, Frank, David, 4 grandchildren, and 3 great-Grandchildren.

James V. Freeman, Jr., MD

(November 1936 – May 2021)

Dr. Freeman received his Doctorate of Medicine at the University of Tennessee. After serving his country as a medical officer in the Navy, he returned to his home state of Florida to complete a neurosurgery residency at UF Shands Hospital in Gainesville, where he served as Chief Resident. Dr. Freeman opened one of the first community neurosurgery practices in Gainesville in 1970 and provided care to patients for nearly 30 years. His first wife, Eloise B. Freeman, preceded him in death. He is survived by his second wife, Patsy Johnson Freeman; his three children, two stepchildren, and many grandchildren and great-grandchildren.

Phillip P. Toskes, MD

(January 1940 - May 2021

Dr. Toskes earned his MD from the University of Maryland, graduating with honors in 1965. He served as major in the U.S. Army from 1970-1973. Following his service, Dr. Toskes chose to start his long career at the University of Florida, eventually becoming a fully tenured professor at the Medical school. In addition to being a beloved professor, Dr. Toskes was a world-renowned Gastroenterologist recognized for his passion for pancreatitis. He held numerous positions with the NIH, Veterans Hospital, as well as at the University of Florida. He served as head of the Gastroenterology/Hepatology and Nutrition Department, and later on became the Chief of Medicine at the University Of Florida Department Of Internal Medicine. He is Survived by his wife Patricia, three children, Tammy Toskes, Tracy Toskes-Konopka, Steven Toskes and six grandchildren.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, March 9, 2021

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, March 9, 2021, virtually on Zoom.com.

Introduction of New Student Board Member: Riley Bohan was introduced as the new UF Medical Student Representative to the Board and welcomed by all present.

Treasurer's Report: Ms. Owens reported that Membership Dues continue to decline due to Covid-19 related budgetary cuts. This decline has been offset by Grants and reductions to expenses in Events, Publications, and Payroll, resulting in a net gain of $13.3K for the seven months under review. The ACMSF has received Grant Income of $48K, with total disbursements of $5.9K. Total Current Assets (grant funds) are $73K with Total Assets of $123K. Dr. Levy motioned approval of the Treasurer's Report, seconded by Dr. Barash, and carried by the Board.

President's Report: Dr. Ryan stated that he would like the ACMS to start meeting in person again, as soon as CDC guidelines indicate it is safe to do so. He also mentioned that we are accepting nominations for the ACMS Awards and requested volunteers for the Awards Committee.

EVP Report: Ms. Owens reported that the Robb House will be fumigated for termites this month and that the building will be closed for a few days. She requested permission from the Board to pursue additional bids to replace the roof of the building and have the work performed this summer. The roofing project was approved to proceed with bids by Dr. Levy, seconded by Dr. Gillette, and approved by the Board. The "Residency Relief" program to be held at TopGolf at UF Ben Hill Griffin Stadium on April 24th will accommodate 100 people, 64 of which may golf. This event will be sponsored by St. Johns Asset Management and will be socially distanced and will include lunch, and social time, followed by golf.

NFRMC has requested that we move the Research Poster Symposium to the Fall as they would like to be able to hold it in person. Dr. Balamucki motioned approval of the date change, seconded by Dr. Carter, and carried by the Board.

The Board requested that the April meeting include a presentation on the state of the Covid pandemic, and when we might safely be able to gather again in person. Ms. Owens agreed to contact the names recommended and invite one of them to present. Various locations were recommended for the Annual Meeting and Awards Program. Ms. Owens agreed to look into the options.

Alachua County Medical Society - Board of Directors Meeting Minutes, April 6, 2021

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, April 6, 2021, virtually on Zoom.com.

Treasurer's Report: Ms. Owens reported that Membership Dues continue to decline due to Covid-19 related budgetary cuts. This decline has been offset by Grants and reductions to expenses in Events, Operations, Publications, and Payroll, resulting in a net gain of $7.9K for the eight months under review. The ACMSF has received Grant Income of $48K, with total disbursements of $5.9K. Total Current Assets (grant funds) are $73K with Total Assets of $123K. Dr. Rosenberg motioned approval of the Treasurer's Report, seconded by Dr. Balamucki, and carried by the Board.

President's Report: Dr. Ryan made a request for nominations for the incoming ACMS Secretary/Treasurer, noting that we would vote on the position at the May Board meeting. He also announced that the Annual Awards Committee would be meeting this month to review the applications for the ACMS Awards. The Board discussed the possibility of meeting in person and when it might be safe to do so. Dr. Michael Lauzardo will be addressing this issue at our April Monthly Meeting and will give guidance on Covid-19 safety protocols.

EVP Report: Ms. Owens announced a Call for Delegates for the annual FMA meeting in Orlando on July 31st this summer. She also discussed the progress of the Robb House improvements. The "Residency Relief" program to be held at TopGolf at UF Ben Hill Griffin Stadium on April 24th will accommodate up to 100 people, 64 of which may golf. This event is sponsored by St. Johns Asset Management and will be socially distanced.

A Note from our **Editor**

Falls In The Elderly — Outpatient and Inpatient

By Scott Medley, MD

OUTPATIENT FALLS

She was a wonderful person—"the salt of the earth," as we used to say. She helped my mother—a single parent—raise my older brother, my younger sister, and me. In fact, we lived with her in her small house in her small town in Southeastern Kentucky—Appalachia. She was my maternal grandmother Scott, and we called her "Scott Scott." In her early 90's her mental status was fine and she was quite active—until she fell and fractured her hip. Amazingly, she recovered from that fracture and was able to ambulate and to resume her favorite role—cooking delicious meals for our large family. But then she fell again and fractured her other hip. That was the beginning of the end for her. After the second fracture she never fully recovered and died at age 98.

Table 1

Risk Factors for Falls in the Elderly

- Poor Vision
- Poor Balance
- Medication Side Effects
- Deconditioning
- General Weakness
- Poor Footwear - "Flip-flops", "Crocs", Etc
- Vitamin D Deficiency

One of her daughters—my mother—was also a Saintly Lady. She did a marvelous job raising her three children on limited means. At age 90, she was active, had early dementia, but lived alone in a home she had occupied for most of the previous 70 years. Then she fell and fractured her hip. Again, this changed everything---again this fall was the beginning of the end for her. After her hip surgery she was never quite the same. She was never able to return to the home she loved, and after several years in Rehab facilities, she died at age 95.

Unfortunately, these true stories are quite typical. Every year, millions of people over age 65 fall. In fact, more than one out of four elderly people experience a fall with injury. And falling once doubles the chance of falling again [1] 684,000 people die from falls every year, and many more survive but are left with a permanent disability. Fall death rates are 64 deaths per 100,000 older adults. And fall death rates are increasing—30% from 2009 to 2018. According to the CDC, 1 out of 5 serious injuries are from falls. [2] 3 million people per year are treated in ER's for falls and 800,000 per year are hospitalized due to a fall, usually due to a head injury or hip fracture. 95% of hip fractures are caused by falling. Falls are the most common cause of traumatic brain injury (TBI). In 2015, the total medical costs for falls exceeded $50B, 75% paid for by Medicare or Medicaid. (For some risk factors for falls, see Tale 1.)

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INPATIENT FALLS

I am honored to serve as the "required Community Member" on the Patient Safety Committee (PSC) at North Florida Regional Medical Center (NFR). This Committee serves numerous functions, But one of the main goals of this group is to monitor patient falls in the hospital and to find ways to prevent those falls. It is obvious that members of this Committee are dedicated, enthusiastic, and passionate about their mission. There are national standards on fall rates set by the Joint Commission and the hospital must meet these standards. As part of background for this article, I met with several members of the PSC. (see photo).
Members of the PSC reminded me that their ultimate goal is to completely eliminate falls in the hospital. The PSC is constantly striving to recruit the entire hospital staff to help eliminate falls. 100% of the staff receive falls risk education. The process begins on admission to the hospital. The patient's fall risk is assessed and a "fall risk bundle" is instituted. Patients at risk for falls receive bright yellow wrist bands, non-slip socks, and alarms on their beds, indicating when a patient tries to get out of bed without assistance.

But the message to the Hospital Staff is that everyone, including the patient's family and visitors, is at risk for a fall. Patients are reassessed after they receive anesthesia or undergo a significant change in medication. Staff is

Table 2

Measures to Prevent Falls in the Home:

- Dispense of "Throw Rugs" and Clear Walkways
- Place "Grab Bars" in the Bathroom
- Use "non-Skid" Footwear
- Place Railings on Both Sides of Stairs
- Eliminate Steps Where Possible
- Use Brighter Lights

- Use Ambulatory Assist Devices
  - -Canes
  - -Crutches
  - -Walkers
  - -Wheelchairs

For a current and exhaustive review of mobility assist devices, see American Family Physician - June 15, 2021.(3)

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Falls in the Elderly-Outpatient And Inpatient

Continued from Page 25

educated that "everything is different from home" for the patient in the hospital. Elderly patients, especially, need to become familiar with their new hospital surroundings. Well-placed posters remind patients "Call, don't fall" and go on to state "Please call, you're not bothering us!" Some factors that make patients at-risk for falls are listed in Table I.

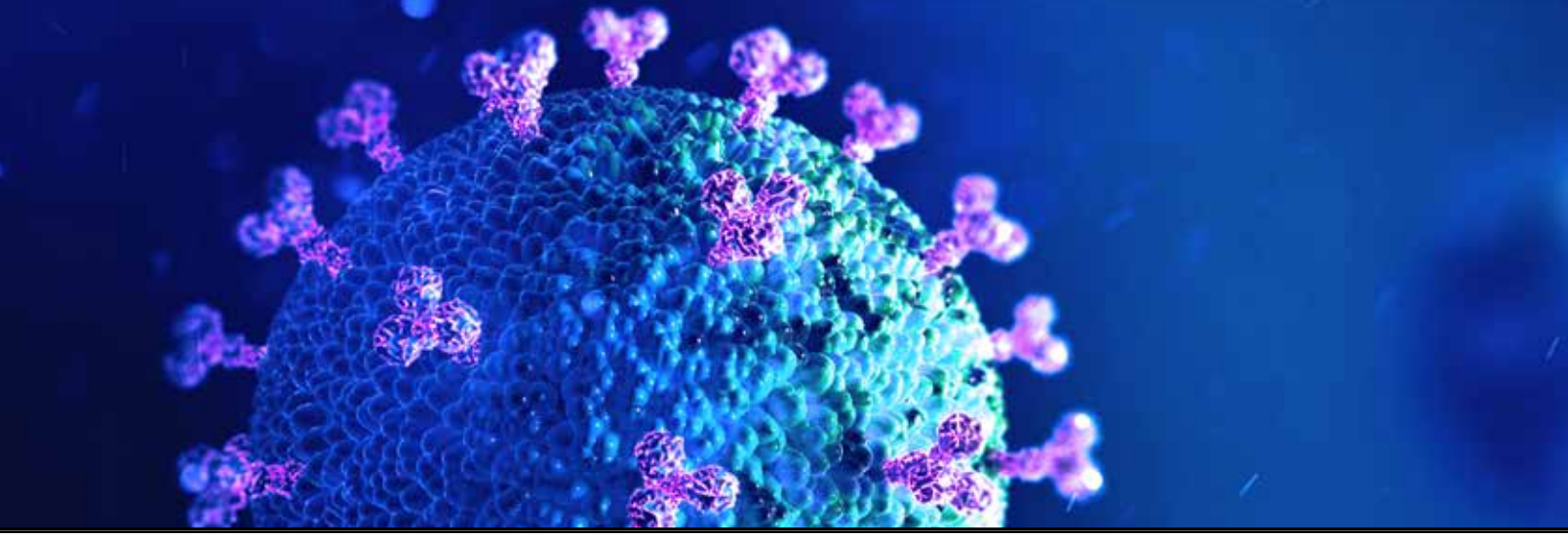
The hospital welcomes "medical advocates" – usually family or friends – to remain with the patient in the hospital. PSC members reminded me that this situation has been especially difficult during the Covid Pandemic, which necessitated stricter restrictions on visitors.

Finally, when the patient is ready for discharge, another fall assessment must be done to determine the patient's safety at home. (See Table 2) The patient's medications list must be reconciled and the need for Durable Medical Equipment ("DME's") is established and fulfilled.

Hopefully, dedicated groups like PSC's will continue to work to eliminate or prevent falls in the inpatient setting. And the number of falls in the outpatient setting will also improve, prolonging the lives of our precious parents and grandparents.

References Available On Request

Some members of the Patient Safety Committee at NFRMC: L to R: Scott Medley, MD, community member; Alicia Swanson, RN, ANCO; Chip Overstreet, PT, Director of Rehab; and Rebecca Weseman, Director of Patient Safety.



COVID-19 Testing and Vaccination Updates

Florida Department of Health - Alachua County

- **COVID-19 Testing** is by appointment only for those who are experiencing symptoms (fever, chills, cough, shortness of breath, fatigue, body aches, headache, new loss of taste or smell, sore throat, congestion, nausea, vomiting, diarrhea), and are available at the Alachua County Health Department's East Gainesville location (224 S.E. 24th Street, Gainesville) from 7 a.m. to 6:30 p.m., all week, including Saturday and Sunday.

- **COVID-19 Vaccinations** are available on a walk-in basis Monday through Friday from 11 a.m. to 7 p.m., and Saturday and Sunday from 7 a.m. to 7 p.m. COVID-19 vaccination appointments are available by calling 352-334-7910.

"Getting a free COVID-19 vaccination prevents expensive and painful hospitalizations," stated Paul Myers, Administrator of the Alachua County Health Department. "Getting vaccinated protects yourself, family, friends, and those you come into contact with."

Due to high demand, COVID-19 testing at the Alachua County Health Department is by appointment only and exclusively for those who are ill. If you have symptoms of COVID-19 and want to be tested, please call 352-334-8810 to make an appointment.

If you need a COVID-19 test for travel purposes, please call the Alachua County Health Department's Foreign Travel appointment line at 352-334-7910.
For more information, visit http://www.alachua.floridahealth.gov/.

Please Note: This Event has been postposned until March 2022 due to the Covid resurgence.

Join Us for a Great Party with a Purpose!!!

#StopChildrensCancer

Event Information

Valet Parking Open Bar Hors d'oeuvres Amazing Buffet Dessert Bar
Beverage Bar Silent Auction Live Auction Glitz & Glamour
Music & Dancing with The Malones & Orlando Transit Authority Horns

Sponsorships, Corporate Tables & Tickets

Signature ~ $10,000

Corporate Tables:4 | Tickets: 32 | Recognized in All Promotions | Program Full Page Ad

Gold ~ $4,250

Corporate Tables: 2 | Tickets: 16 | Recognized 5 Times in Promotions | Program 3/4 Page Ad

Silver ~ $2,000

Corporate Table: 1 | Tickets: 8 | Recognized 3 Times in Promotions | Program 1/2 Page Ad

Bronze ~ $1,000

Corporate Table: ½ | Tickets: 4 | Recognized 1 Time in Promotions | Program 1/4 Page Ad

All Sponsorships Receive: VIP Valet Parking, Preferred Table Location & Placement, Fantasy Event Promotions (Advertising, Sponsor Level Signage, Website & Social-Media) VIP Invitation to Breakfast Tour with Dr. Bill Slayton, Division of Hematology & Oncology Department of Pediatrics at UF Health.

Corporate Table (8 tickets) ~ $1,600	Single Tickets ~ $200

Thank You for Being Part of the 33rd Annual Fantasy Event Ruby Jubilee!!!
Visit ~ www.StopChildrensCancer.org Call ~ (352) 377-2622 ~ We are happy to assist you!

The Millennium Center

1,646± SF

Sale Price:
$294,900

Lease Price:
$23.50/SF Gross

FOR SALE/LEASE

4340 W. Newberry Road, Suite 204; Gainesville, FL 32607

1,646± SF of prime office space For Sale or For Lease in the Millennium Center building. The Millennium Center is conveniently located at the corner of NW 43rd Street and W. Newberry Road - - one of the main east-west corridors in Gainesville with an average daily traffic count of 35,500 vehicles. Suite 204 is easily accessed via lobby elevators. This space is currently divided into two separate office spaces that could be combined into one large office space. In its current configuration, the first office space consists of a waiting area, an area for the receptionist with extensive room for storage, two private offices, breakroom, restroom and a telecommunications closet. The second space consists of a very large, open workspace, one private office, breakroom, storage room and restroom. The Millennium Center has ample parking for customers and has a bright, large common lobby with electronic directories. It is also convenient to shopping, banking, restaurants, public transportation and is only one mile from both I-75 and the University of Florida. There are limitless possibilities for this space to meet your business needs.

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