Cutting edge medicine - Innovation - Treatment - Solutions - Advances - Cure

ALACHUA COUNTY MEDICAL SOCIETY

House Calls

WINTER 2022

Hospital Medicine

The role of the Hospitalist and how this team of doctors works to improve healthcare outcomes.

Retirement is the pursuit of a *lifetime*

Take the next step in your retirement planning.

The demand for new residences at Oak Hammock is at an all-time high. That's why it's imperative to secure your space on the Oak Hammock waitlist today.

By making a thoughtful decision now, you'll be better positioned for the future.

- Fully refundable deposit of just $1,500
- No risk to you with easy cancellation policy
- Invitations to exclusive lectures, presentations and social events
- Regular monthly updates to keep you aware of community happenings

Our community is located at 5100 SW 25th Blvd. in beautiful Gainesville, Florida.

Download your waitlist application at **OakHammock.org/waitlist** or call us for more information at **352.415.2775.**

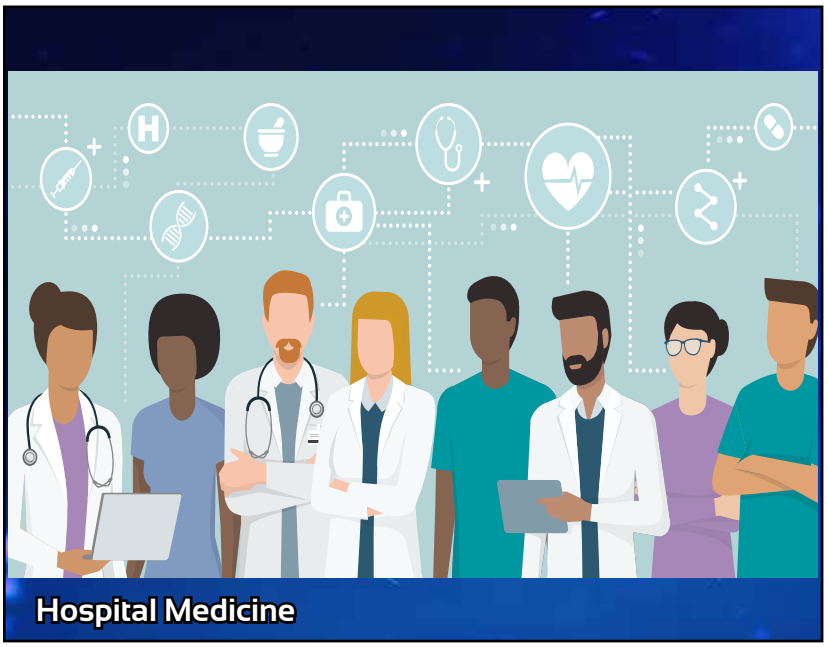
Oak Hammock
at the University of Florida®

CONTENTS

Recurring Columns

Featured Articles

Our Medical Community



CONTRIBUTING AUTHORS

Steve Figg, MD

NFRMC Internal Medicine

Dr. Steven C. Figg is an Internist in Gainesville, Florida and is affiliated with North Florida Regional Medical Center. He received his medical degree from University of Maryland School of Medicine and completed his Residency at the University of Florida in Internal Medicine. He has been practicing for more than 20 years.

Carl Dragstedt, DO

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 medical degree from Nova Southeastern University. He then completed an Internship and Residency in Internal Medicine, and Fellowships in Cardiovascular Diseases and Interventional Cardiology at the University of Florida.

Nila Radhakrishnan, MD

Chief, UF Health Hospital Medicine

Nila Radhakrishnan, MD, is an Associate Professor of Medicine at the University of Florida in Gainesville, Florida and serves as the Chief of the Division of Hospital Medicine. She received her Medical Degree from the University of Miami, followed by her Residency in Internal Medicine.

Kiran Lukose, MD

UF Health Hospital Medicine

Dr. Lukose, MD, is a Clinical Assistant Professor and Care One Clinic Director for the Division of Hospital Medicine at the University of Florida. His academic interests include care for vulnerable patient populations and integrated care models. He is an avid promoter of interprofessional education to integrate a multidiscipline approach in patient care.

Sheri Kittleson, MD

UF Health Palliative Care

Dr. Sheri Kittelson, MD, FAAFP serves as Division Chief for the UF Health Palliative Care Program. She graduated from the University of Colorado where she completed her Medical Degree, and Palliative Care Fellowship. She completed a Residency in Family Medicine at the University of Florida. She is board-certified in both Family Medicine and Palliative Care. Her mission at UF Health is to improve the care delivered to patients and families with life-limiting illness, and to advance research in palliative care.

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. He founded Gainesville Family Physicians, enjoying 20 years in Private Practice. He served as a Hospitalist and Chief Medical Officer at NFRMC. Dr. Medley is a Past President of the ACMS and of the Florida Academy of Family Physicians. Currently retired and volunteering at Haven Hospice, he has served as Executive Editor of *House Calls* for the past 23 years, and has authored over 101 editorials and articles for this publication.

Irfan Nasir, MD

NFRMC Hospital Internal Medicine

Irfan Nasir, MD, graduated from Rawalpindi Medical College, Pakistan, followed by Residency at UF Health Community Health and Family Medicine. He served as a Hospitalist at UF Health from 2007 to 2018, and Chief of Hospital Medicine at UF health Shands Hospital from 2013-2018. He is currently a Hospitalist and Partner with Hospital Internal Medicine at NFRMC. Dr. Nasir lives in Gainesville with his wife and daughter and is an avid fan of cricket and traveling.

Paige Barker, MD

UF Health Internal Medicine

Paige Barker, MD, is an Assistant Professor at UF Health Internal Medicine, Palliative Care. She received her Medical Degree from the University of Florida and Residency in Internal Medicine at the Beth Israel Deaconess Medical Center at Harvard University. She completed a Fellowship in Hospice and Palliative Medicine at New York University. Dr. Barker serves as the outpatient palliative care medical director in the third-year medical student ambulatory clerkship.

CONTRIBUTING AUTHORS

Thomas Zavelson, MD

Retired Pediatrician

Dr. Thomas Zavelson is a Retired Pediatrician and Clinical Professor of Pediatrics at the University of Florida College of Medicine. He was a founding Partner with the Pediatric Associates of Gainesville; and Chairman of the North Florida Regional Medical Center Department of Pediatrics. He received his Medical Degree from Duke University, followed by his Residency in Pediatrics at the University of Florida. He currently serves as a Board Member for the Florida School for the Deaf and Blind.

Raed Al Yacoub, MD

UF Health Hospital Medicine

Raed Al Yacoub, MD, is an assistant professor within the Department of Internal Medicine at the University of Florida. He received his Medical Degree from University of Jordan and completed his Internal Medicine Residency and Hospice and Palliative Care Fellowship at the Jacobs School of Medicine and Biomedical Sciences (University at Buffalo) in New York.

Brenda Krygowski, MD

UF Health Palliative Care

Dr. Krygowski is with the UF Health Palliative Care Program, Inpatient Palliative Care team. She received her Medical Degree from the University of Buffalo and her Residency in Family Medicine at Eastern Virginia Medical School at Portsmouth. She is dual board-certified in Family Medicine and Hospice and Palliative Medicine.

Dan Griffin, BS, CSCS

Owner, Sweat Life Fitness

Dan Griffin received his degree in Exercise Sport Science with a specialization in Fitness & Wellness from the University of Florida. He is certified through the National Strength & Conditioning Association as a Certified Strength & Conditioning Specialist. He is the owner of Sweat Life Fitness in Gainesville, Florida, a fitness studio dedicated to educating, motivating and inspiring its clients to become their all-time best.

Peter Calabrese, MD

Hospital Medicine

Dr. Calabreses received his Medical Degree from the University of Illinois Medical School, and later completed his Residency there in Internal Medicine. He ran an Internal Medicine Private Practice in Chicago before moving to Gainesville to practice Internal Medicine at Alachua General Hospital and North Florida Regional Medical Center. He is now retired and enjoys time with family and friends and is looking forward to the birth of his first grandchild.

Leslye Pennypacker , MD

UF Health Palliative Care

Dr. Pennypacker is board-certified in Internal Medicine and Geriatrics, with secondary board certification in Hospice and Palliative Care. She completed Medical School at Yale School of Medicine in Connecticut, and an Internal Medicine Residency and Geriatrics Fellowship at the University of Colorado, followed by ten years on faculty at the Medical University of South Carolina.

Janelis Gonzalez, MD

UF Health Internal Medicine

Dr. Gonzalez completed medical school at Florida International University. She is currently a Resident at the University of Florida, Internal Medicine GME program and serves as Ambulatory Chief Resident during the 2021-2022 academic year. Outside of medicine, Janelis enjoys spending time with her dog, Maggie, and her significant other as well as baking, jigsaw puzzling, and running.

Margaret Lo, MD

UF Health Internal Medicine

Margaret Lo, MD, is a Professor for the division of General Internal Medicine and a physician at UF Health Internal Medicine – Medical Plaza. She earned her Medical Degree from the State University of New York Upstate Medical University and completed a residency in Internal Medicine at the University of Florida.

The Beginning of the End... or the End of the Beginning?

Thoughts on the COVID-19 Pandemic

Carl Dragstedt, DO, ACMS President

As the world approaches the 2nd anniversary of the arrival of the novel respiratory virus SARS-CoV-2, the infectious agent responsible for the global COVID-19 pandemic, we continue to be bombarded with salvos of so-called "good news" and "bad news" in an ongoing and continual basis.

It was nearly a year ago that the first mRNA vaccines to prevent the morbidity and mortality associated with COVID-19 became available. (I was fortunate to receive my first jab on December 22, 2021, at which time less than 1 million doses had been administered in the US.) Through a truly global effort, to date nearly 55% of the world's population has received at least 1 dose of a COVID-19 vaccine, with over 8 billion total doses having been administered. Despite these numbers, a staggering statistic should rightfully temper our enthusiasm: a mere 6.2% of people in low-income countries have received at least one dose (ourworldindata.org/covid-vaccinations). While the reasons for such stark discrepancies can be dissected and debated, as physicians with a commitment to public and global health, this reality should elicit a sense of moral repugnance and resolve to call for efforts designed to promote global health equity.

Dr. Dragsgtedt receiving his first Covid-19 vaccine.

This past summer, many of us in clinical practice experienced first-hand the tsunami of infections and deaths related to the Delta variant of SARS-CoV-2. Nearly all of those who were hospitalized with moderate or severe disease and succumbed to death were unvaccinated, despite the tragic truth that vaccines had been widely available and free to the general population in the United States since the spring. We do not have to dust off our microbiology textbooks from medical school to understand the dynamics: a susceptible (unvaccinated) population of potential hosts became unwitting prey to a more virulent and aggressive genetic variant of the original wild-type viral strain. Hopefully, as the population at large has either vaccine-mediated or natural immunity, additional scenes such as the Delta summer will be less likely.

But wait...there's more! As of this writing, the Omicron strain, with its numerous genetic variations, has already been detected in many states. Will this variant wreak similar despair as Delta? Is this variant more virulent or contagious than prior variants, including Delta? Will vaccination or natural immunity from prior infection be effective in mitigating morbidity and mortality? Is this latest named variant cause for concern or just the latest boogeyman to emerge from the pandemic? The medical community hopes to have

Continued on Page 5

Continued from Page 4

answers to these questions soon, as winter months are upon us. At this juncture, however, there is no evidence that currently available vaccines are ineffective or prone to so-called "immune escape".

This brings me to a story which highlights our role as physicians, even nearly 2 years into the pandemic. A few weeks ago, I counseled a cardiac patient (I'll call him Mr. Brightside) on the importance of being vaccinated. He told me he'd promised his daughter (a vaccine conspiracy theorist) he would not. I advised Mr. Brightside that his prior CABG and lower extremity amputation from peripheral arterial disease put him in a "high risk" pool for adverse outcomes from COVID-19.

Over the past several months, I've had patients storm out of my clinic, use profanities, and become red in the face at the mere mention of COVID-19 vaccination. Yet after nearly a year of recommending the high-risk unvaccinated to get their jab, my first patient agreed to get vaccinated.

In spite of what seems like a never-ending barrage of pandemic news, information, disinformation wars, skepticism, and burnout, as physicians we should never give up or lose sight of our duty and calling to be beacons of truth and counsel to our patients. You never know when the light bulb will turn on!

From the Desk of the EVP

A Variant of Concern

Jackie Owens, Executive Vice President

In the days that have lapsed since the omicron variant was discovered in South Africa, scientists are struggling to verify the threat it poses to the world. Currently classified as a "variant of concern" by the World Health Organization and the Centers for Disease Control and Prevention, it's rate of transmission, severity, recurrence, and resistance to vaccines are yet to be determined. As of this print date, omicron is already confirmed to exist in more than 20 countries and 18 states in the U.S. Based on the rise in Covid-19 cases and on sequencing data in South Africa, scientists estimate that omicron can infect 3 – 6 times as many people as Delta, over the same time-period, and are waiting to see if the South Africa pattern is repeated in other countries to determine the complexity of the immunological landscape.

What We Know about Omicron - Infection and Spread (CDC)

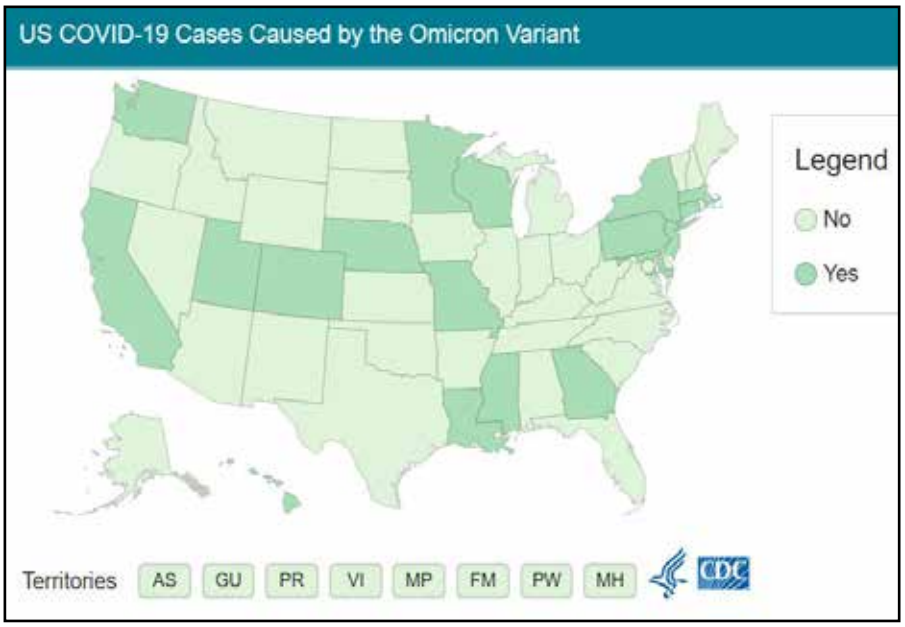
- How easily does Omicron spread? The Omicron variant likely will spread more easily than the original SARS-CoV-2 virus and how easily Omicron spreads compared to Delta remains unknown. CDC expects that anyone with Omicron infection can spread the virus to others, even if they are vaccinated or don't have symptoms.
- Will Omicron cause more severe illness? More data are needed to know if Omicron infections, and especially reinfections and breakthrough infections in people who are fully vaccinated, cause more severe illness or death than infection with other variants.
- Will vaccines work against Omicron? Current vaccines are expected to protect against severe illness, hospitalizations, and deaths due to infection with the Omicron variant. However, breakthrough infections in people who are fully vaccinated are likely to occur. With other variants, like Delta, vaccines have remained effective at preventing severe illness, hospitalizations, and death. The recent emergence of Omicron further emphasizes the importance of vaccination and boosters.
- Will treatments work against Omicron? Scientists are working to determine how well existing treatments for COVID-19 work. Based on the changed genetic make-up of Omicron, some treatments are likely to remain effective while others may be less effective.

The ACMS is recommending the continued observance of the CDC Guidelines including:

1. Everyone ages 5 and older can get vaccinated against COVID-19.
2. People who are fully vaccinated can resume many activities they did before the pandemic. However, people should wear a mask indoors in public if they are in an area of substantial or high transmission.
3. Get a booster vaccine.

We will continue to report science based data on the Covid-19 virus as it becomes available.

References available upon request.



The Rise of the Hospitalist

An Interview with Steve Figg, MD

By: Scott Medley, MD

[EDITOR: I have known Dr. Steve Figg for over 20 years. He has served as a Hospitalist at North Florida Regional Medical Center (NFR) for all of those years. He considers himself the "scheduling and coordinating guy" for his 35-doctor Hospitalist group. Many consider him to be the consummate Hospitalist. I have admired him professionally for many years. And I came to know him more personally as he served expertly as my Attending Physician when I was hospitalized for nine days at NFR early in 2018 with severe Influenza A pneumonia. His care was outstanding. Dr Figg graciously agreed to sit down with us for this interview.]

Editor: (Dr. Scott Medley) Your training was in General Internal Medicine – Did you ever consider going into a subspecialty?
Dr Figg: I never really considered the financial and lifestyle implications of doing a subspecialty. Maybe I should have. But I didn't want to give up practicing all facets of Internal Medicine. I think I may have become bored if I had subspecialized.

Editor: When did you decide to become a Hospitalist? Was the specialty even available then?
Dr Figg: I was offered a position as a Hospitalist here at NFR. The program was pretty well-established by then under the leadership of Drs. Chuck Wilson and John Nelson. As my Residency was ending, I remember our Chief Resident telling us, "You can't just do Hospital Medicine". And my colleagues and I looked at each other and grinned.

Editor: When I was practicing at Alachua General Hospital (AGH) and North Florida Regional Medical Center (NFR) in the 80's, there were only about 2 hospitalists. Now there are about 35 in your group at NFRMC, and even more than that at Shands – UF. What happened?
Dr Figg: I believe that several things happened. The volume of admissions was increasing. It became very difficult for an office-based physician to keep up with an outpatient and inpatient practice. The convenience of having someone admit your patients was great. Now the breadth of knowledge needed to practice both in- and outpatient medicine has remarkably expanded. Some docs can do both, but it's very difficult--- I respect them.

Editor: Is one advantage of your Hospitalist Practice that you have some blocks of time off, not just weekends?
Dr Figg: Yes, that is one advantage. I can take one or two weeks off without worrying much about overhead, following up on labs/imaging studies, etc., like an office Doc needs to. The tradeoff is I must work a fair number of weekends; that interferes with my family time,--but I try to make it work the best I can.

Editor: Isn't it a big challenge coordinating the schedules of the 30-some physicians in your group:
Dr Figg: Yes, it is certainly a challenge coordinating schedules, making sure that we have everything covered and that our docs get the time off they desire, etc. The key here is the flexibility of our group members. They all work very well with me and with each other.

Editor: About how often are you "on call"?
Dr Figg: Our "call" is not straightforward. When we're working a block of days, we may be "on call" 2 days out of 3. Our call is doing a 3-hour shift in the ER that day, admitting sick people. When we are "on call", we may be at the hospital from 7:30 AM, and be there as late as 7:30 PM. The COVID pandemic has not stretched those times, but it has stretched the number of days we each work per month as the hospital has needed "more hands on deck".

Editor: You have the excellent reputation of being the "go –to-guy" to get patients taken care of even when you're not "on call" – how do you manage that?
Dr Figg: I simply try to be available, and I can almost always answer phone calls from colleagues. I consider it an honor to get that phone call from a colleague. The system can be difficult to navigate, so I try to make it "one-stop-shopping" and smooth the way for the patient. I was told by the late Dr. Bruce Brient that the 3 "A's" of a successful consultant are affability, availability, and ability. It's funny but true.

Editor: Before the COVID pandemic-and we'll indeed get to that – with what diagnoses were you and your group mostly dealing?

Continued on Page 8

Continued from Page 7

Dr Figg: We were probably dealing mostly with the "Big Three" – congestive heart failure, pneumonia/COPD, and strokes/CVAs. Unfortunately, we were also seeing a steady rise in drug overdoses. But we also see a huge variety of diseases-another facet I enjoy about this practice.

Editor: One of the most important facets of your job is to provide continuity of care – making sure the patient's Primary Care doctor receives the information to continue the care of the patient as an outpatient. How do you accomplish that?
Dr Figg: You're correct – continuity of care is an important part of our practice. The hospital has a mandate to inform the Primary Physician of a patient's admission and to send a Discharge Summary to that Doc. The hospital is actually quite good at that. They understand the importance of continuity of care. We try to do our best with that.

Editor: For about what per cent of inpatients at NFRMC does your group provide care?
Dr Figg: We have about 20 docs working at any time, seeing about 20 patients each, so that's about 400 patients most days – about 85% of the inpatients at any given time.

Editor: How do you and your group interact with the Hospital Administration?
Dr Figg: We have an excellent relationship with the Hospital Administration. We communicate with them regularly – which is the key to that relationship. We try to work together.

Editor: We have covered COVID in our last several issues of HOUSE CALLS. Now for the inevitable question – how has the COVID pandemic impacted your practice?
Dr Figg: The impact from COVID has been phenomenal. For a while, the Hospital was overflowing. Our group was seeing almost all of the COVID patients – many of whom were very ill. It certainly stretched the resources of our group, making all our jobs more stressful. The "trickle-down effect" was very impactful...it put a strain on our phlebotomists, radiology procedures, operating schedules, and everything else. But the worst part, Scott, and you've heard this before, is that much of the suffering and many of the deaths could have been preventable with vaccines. Caring for a previously healthy 40-year-old unvaccinated patient now on a ventilator and dying is very sad and very frustrating. At the peak of the Pandemic, you could count on about half your admissions being, "Here is another unvaccinated hypoxic person with diffuse pulmonary infiltrates for you."

Editor: What are the best and worst aspects of your practice?
Dr Figg: One of the best aspects is the "rapid turnaround". We can very often cure the patient with the acute disease and send them home. That can be very satisfying. Unlike the outpatient docs, we don't have to contend with a patient's chronic problems for years. Probably the worst aspect is dealing with all of the "self-inflicted" diseases – COPD, obesity, alcoholism, illicit drug use, and now unvaccinated COVID. If people took better care of themselves, I'd probably be out of work!

Editor: What do you see as the future of the Hospitalist Movement?
Dr Figg: We've come a long way. I think the term "Hospitalist" wasn't coined until about 2001. I'm not smart enough to see the future, but I think the trend will grow. One can now earn a special certification as a Hospitalist from the ABIM (American Board of Internal Medicine). Soon you may be writing about "The Rise of the INTENSIVIST" – as those specialists now provide most of the care for patients in the ICUs. And they've been a wonderful addition to NFR.

Editor: Would you like to close with any good news?
Dr Figg: Yes. I have seen a steady improvement in the availability and efficiency of our Hospice consultants. They are there when we need them and they do a great job. They offer a tremendous service to our patients.

Editor: Anything else you'd like to add?
Dr Figg: I'd like to say that I'm very fortunate to enjoy my work. I never "trudge into work". Every day is a new challenge. I'd also like to thank a couple of people. Dr. Craig Kitchens was a terrific early mentor---extremely knowledgeable, an excellent teacher, and very funny. Also thank you to Dr. Chuck Wilson – one of the early Fathers of the Hospitalist Movement – he started in 1987 – and is still working here today. Chuck helped give me a start to this career that I enjoy so much.

Editor: Thank you very much!
Dr Figg: Thank you!

HIIT Your Goals! How Principles of High Intensity Interval Training Can Boost Your Career Productivity

Nila Radhakrishnan,MD, UF Health Hospital Medicine and
Dan Griffin, BS, CSCS, Sweat Life Fitness

Nila Radhakrishnan, MD

Dan Griffin, BS, CSCS

The daily juggle:

There are never-ending career and personal demands that all of us face and process daily. A career in healthcare means there is always an urgent issue that cannot wait and there must be dedicated focus on the patient care issue in front of us. We are all juggling multiple inboxes such as email, patient messages, staff messages and communications. Beyond these urgent daily matters, many of us have additional career goals. Maybe you always wanted to read a leadership book to help you prepare to lead a project which could position you for a leadership position. Perhaps you want to write a patient case report to help you with academic scholarly output. Perhaps you have wanted to write a book. Most people are trying to juggle family needs, raising children, household chores and social obligations. The pandemic has also shown us that now, more than ever, we all need to prioritize self-care such as sleep, health, nutrition, and exercise. There are only 24 hours in a day, so how can everything get fit in?

Where oh where is the time?

If we are able to invest time into things that would help us to meet long-term personal and professional goals, the payoffs are often significant in terms of career and personal progression and satisfaction. The challenge is that these important tasks can feel overwhelming and nebulous since they take time, and we are always responding to the urgent tasks in front of us. Typically, the long-term professional and stretch goals get continuously put "on the back burner" since there is not an urgent deadline. How can we make time to move the tasks forward that will give us the most returns in terms of productivity and professional development, while still fulfilling personal and professional demands in a timely manner?

High Intensity Interval Training (HIIT)

What is HIIT? As the name suggests, it is a training module that involves short periods or intervals of intense work followed by intervals of rest/recovery (see below for an example of a typical HIIT workout).

HIIT has become very popular in exercise and training environments due its efficiency; the ability to accomplish a lot of work in a short amount of time. This shorter time frame makes tasks seem more manageable and not so overwhelming. It is much easier to schedule 20-minute intervals in your schedule than to block off 3 straight hours. And, once you get going and create positive momentum, your progress builds and compounds and your results are amazing!

The most important aspect of HIIT is the intensity; that's what makes it effective. To get the most out of a HIIT session you must be "dialed in" and focused on your goal and not allow distractions to sidetrack you. Intensity is relative to the individual – an advanced athlete's intervals are going to look a lot different than a beginner's, but that is the beauty of HIIT, you can customize the intervals to your own ability level, skill set, schedule or goal/task.

Finally, when developing a HIIT workout or applying the principles to other tasks in your life, your intervals need to be realistic and sustainable; otherwise, you will not stick to them.

Example HIIT workout
Work interval: 20 seconds
Rest interval: 10 seconds
8-minute HIIT workout:
20s: Squats
10s: Rest
20s: Push-ups
10s: Rest
20s: Lunges
10s: Rest
20s: Mountain Climbers
10s: Rest
Repeat above four times for a total of 8 minutes.

Continued on Page 10

Continued from Page 9

Intervals of Focus

There are examples of using intervals to achieve productivity. Francesco Cirillo created the "Pomodoro technique" in the 1990s (1) . Pomodoro is the Italian word for tomato and he named this technique named after a kitchen timer shaped like a tomato. He described intervals of "focused work time" for 25 minutes followed by 5 minutes of dedicated rest. During the 25 minute work interval, the focus must be on the task and nothing else. During the "work" time, there can be no checking email, scrolling social media, or responding to calls. During the structured rest time, it is encouraged to do something refreshing like walking around, deep breathing, or anything else. Then it is back to the 25 minutes of work. The advantage of the Pomodoro technique is that it allows for focused work time in small aliquots which helps with making progress and overcoming procrastination. It is easier to find 25 minutes than a large block of time. 25 minutes of mindfulness can achieve more than one hour of interrupted work.

Let us take an example of how to use principles of interval training to move a high-yield task forward such as moving forward a personal project. This can seem overwhelming to start and finish. Without a strict deadline, this can also be easy to procrastinate since there is inevitably something seemingly more urgent that will hijack our attention. We all are very busy, and we have short attention spans. We think we must wait until all conditions are perfect to start a project. When will the day come when we have hours blocked, we have the perfect quiet environment, we have all our ideas assembled, we are caught up on everything and we can complete our project? The problem is for most people, this day never comes, and the task is never started, much less finished. How many of us have a task we have been procrastinating? How many of us have a task that we have procrastinated for over a year since we never find that "perfect day" to complete it? Principles of interval training can help us here.

"Ready, fire, aim."

For exercise, as for most things in life, getting started is the key. Rarely is there a perfect time, when all the stars align, and a message is sent from the heavens indicating that now is the ideal time. You simply must make up your mind and take the first step. Even if everything isn't perfect. Even if you are not ready. Even if it is uncomfortable. Throughout my twenty years as a strength & conditioning coach I have had the pleasure of working with thousands of clients – professional athletes, doctors, teachers, kids and everyone in between – and I have noticed there are two factors that determine success more than any others: making the commitment to get started and then remaining consistent. It's that simple.

By employing short, small, achievable intervals, the principles of HIIT make getting started easier and consistency more likely. You will see greater results from working out consistently for 30 minutes 4 days per week than you will from working out 1 day per week for 2 hours; and you are more likely to stick with it.

High Intensity Interval Training principles can help us to overcome procrastination and increase our productivity for our professional goals. By focusing on a short, intense interval, we can block out a reasonable amount of time, like 20-30 minutes, with the goal to intensely move a task forward without having the fear and pressure to complete it. This can help overcome the inertia and unconscious procrastination that can come with tackling a big, important task. Many small intervals, done regularly and with focus will lead to the completion of the task. It is surprising how much can be achieved by just starting. Often the 25 minutes of dedicated work will lead to another 25 minutes and then another. Just as a runner may struggle for the first 10 minutes of a run but then gets into a pace and feels good enough to keep going, just the act of starting to take forward action can help to overcome the mental inertia to take on a lofty goal.

How to pick the intervals?

In Exercise training we consider a few things, namely: the task/goal of the individual, their ability level and their schedule/outside demands. All of these factors play a role in choosing the appropriate intervals. For example, an untrained and sedentary 50-year-old may begin with a work to rest ratio of 1:3, meaning their rest/recovery interval will be three times that of their work interval. Whereas a more advanced exerciser may have a work to rest ratio of 3:1, meaning their rest/recovery interval will only be one-third of their work time. Likewise, the activity plays a role in determining the intervals. Maximal strength-based movements require more rest time as to allow for appropriate muscle recovery and cardiovascular based movements typically do not require as much recovery time. So, look at your task and determine what the best approach is, and, most importantly, choose intervals that are realistic and sustainable and will lead to long term consistency. Be sure to reassess your goals and

adjust your action plan on a regular basis. Now get out there and attack your goals with purpose and passion!

For productivity, different types of tasks can require different types of "work" intervals. In our current environment of "sound bites" and multi-tasking, focused work takes practice to "get into shape." For career productivity, after some practice with intervals, you will get a sense of which tasks require each type of interval. Let's take the example of documentation. We know there has been much observation about how much time is spent on documentation in the Electronic Medical Record. Focused interval work can help to tackle charting and help physicians to finish this task at work rather than spending nights and weekends completing charts. For a follow-up inpatient progress note, setting a timer for 5 minutes of productive, focused time without distraction can lead to the note being completed and with fewer interruptions. It is also likely going to be a much more accurate note. Most all inputs, including calls, can wait 5 minutes. A complex note may take more than 5 minutes and by setting intervals, a physician can add an additional interval if needed.

The payoffs from increased professional productivity and career development are significant.

As Brian Tracy says "Rule: It is the quality of time at work that counts and the quantity of time at home that matters."(2) Certainly, we have all regularly put in additional hours when absolutely needed. However, when long, unproductive hours are the norm, this can lead to burnout and unhappiness. When we are not able to move forward our strategic priorities we can feel "stuck" and not moving towards our purpose. What if instead, we saw that day-by-day we were moving closer to our goals? Using intervals to move forward strategic priorities can help us move towards our purpose. Using intervals to help us with our daily mundane tasks can open up time for our loved ones and hobbies

Bonus tips for success:

Removing "decision-fatigue" is a key way to help overcome procrastination and anxiety over a task. This is why morning exercisers lay out their exercise clothes, water bottle and shoes the night before. Similarly, before a "productivity interval" to take advantage of the "work time" it is helpful to have all of your tools set up, such a lap-top, "favorite" a needed webpage (but not be tempted to surf) and keep a timer. It is equally important to "turn off" as many inputs as possible, such as notifications and emails. The key is not to allow the preparation to take on a life of its own and also to avoid delaying the task if the perfect preparation is not completed. Whether it is for physical fitness or career productivity Nike's slogan of "Just Do It" applies.

References available upon request.

Academic Article	**25 minutes: 5 minutes**	**Break down the various parts of the writing into aliquots and work on an aliquot in each interval**
Inpatient Progress Note	**5 minutes: 3 minutes (to answer pages or urgent calls)**	**During the 5 minutes focus on the task**
On-line CME course or board practice questions	**30 minutes: 5 minutes**	**Break-down a 2-hour course to complete over 4 blocks**
Writing a book	**20 minutes: 5 minutes with a longer break every 3 rounds**	**Scheduled daily or every other day**
Reading a book on leadership	**15 minutes: 3 minutes**	**Read a little each day**

Random Ramblings of a Family Medicine Hospitalist

Irfan Nasir, MD
NFRMC Hospitalist

The term "Hospitalist" was mentioned and thus popularized in a NEJM article in 1996 by Dr. Waechter and Dr. Goldman. There is some merit to the argument that the term "Hospitalists" originated at North Florida Regional Medical center in Gainesville. I have the pleasure of working with one of the originators of Hospital Medicine in my current group, Dr. Charles Wilson.

Speaking casually with hospitalist colleagues across the US, there is some debate as to where the actual practice started, but I choose to stick to the above narrative since it provides me bragging rights of being part of the sentinel group.

I started as a hospitalist in 2007 after graduating from a Family Medicine residency, which was quite robust in its inpatient training. Our residents worked and rounded in a community hospital where Family Medicine was the only residency, thus making us the only residents rotating in the hospital. Alongside our residency, there was a group of physicians who would manage their own patients. They were called "CSI" - short for "community service for inpatients." This was the Hospitalist group for Alachua General Hospital. I thought to myself – what a cool concept and what a catchy name. After popularization of the CSI series on TV, the group changed its name to CIS – "Community inpatient service", understandably not wanting to be dubbed crime scene investigation as physicians.

During residency, I gravitated toward hospital medicine, partly due to how much happier I was in the hospital. I had colleagues in residency who dreaded their hospital rotations, and I couldn't figure out why.
After graduating, I joined the hospitalist group that I admired and suddenly, my mentors became my colleagues. This decision was not without the guilt of abandoning Primary Care in my own selfish pursuits. However, the adrenaline rush of closing the anion gap in DKA, or correcting the respiratory acidosis in a COPD exacerbation with BiPAP was catnip of the highest order for me. The 10-15 minute slot per patient in the residency clinic setting left me unsatisfied with my work - primarily since the residency clinic was often comprised of clinically challenging patients with multiple medical and psycho-social issues.

Hospital Medicine was dominated in numbers by Internal Medicine trained physicians when I started my career, and this still holds true to some extent. There are still exclusive Internal Medicine Hospitalist groups around, but that situation seems to be decreasing. Being a Family Medicine graduate gave me some valuable advantages. I felt more comfortable treating younger patients and pregnancy or post-partum complications. Assisting deliveries at a small community hospital and at a university hospital setting certainly instilled a level of confidence I would have otherwise lacked.

Spurred on by demand, the movement for family medicine trained hospitalists has gained considerable traction. In the 2007-2008 Society of Hospital Medicine Annual Survey, 3.7% of U.S. hospitalists claimed family medicine training. That number increased to 6.9% of physicians who answered the SHM membership data report in 2010.

A Medscape Hospitalist Lifestyle, Happiness & Burnout Report from 2019 estimated 17% of hospitalists were trained in family medicine. In the latest State of Hospital Medicine Report published in 2020, 38.6% of hospital medicine groups containing family medicine-trained physicians were part of a university, medical school, or faculty practice; 79.6% did not have academic status; 83.8% were at a non-teaching hospital; 60.7% were in a group in a non-teaching service at a teaching hospital; and 52.8% were in a group at a combination teaching/non-teaching service at a teaching hospital.

The hospital medicine schedule brings, along with it, unique challenges. Hospitalists who work 7-day on and 7-day off schedule do struggle with having to turn on and turn off their medical brains. While working during their stretch on, family life tends to

Continued on Page 13

Continued from Page 12

take a back seat during the 7 days off. The schedule certainly allows time to wind down and continue hobbies that you would otherwise abandon if working a traditional schedule.

Being in hospital medicine for 14 years, I have heard the term " burnout" being thrown around as if it was going out of fashion. I was partly in charge of hiring for a group of 50 physicians at a university hospital medicine group. I interviewed many candidates for hospital medicine who came in swearing their allegiance to the field of hospital medicine. A lot of the same "devotees" would enter hospital medicine with remarkable zeal and fervor and shortly thereafter apply for sub-specialty fellowship in the same year. A lot of these same folks would claim burnout as the reason for leaving hospital medicine. A small subset of physicians joined hospital medicine with the dreams of "easy money", to soon realize that you have to earn every penny as a hospitalist.
Burnout is real but we need to make sure we do not diminish the importance of the word with insincerity, or dare I say, stupidity of signing up for the wrong job.

That being said, the prospects of burnout in hospital medicine exist just as in other medical fields. The prospects of acute decompensation of patients remain all day. The arrival of a patient's family at all times of the day and difficult goals of care discussions add to the burden. The relationship with emergency room physicians and consultants plays a major part in how you are able to handle the rigors of daily work and rounding. Hospital administration also plays a huge part in the morale of the hospital workforce, but especially hospitalists. The implementation of quality metrics sometimes impedes the workflow of an inpatient rounder, no matter how noble the reasoning behind it. Hospitalists fight through their days with the above, internalizing all the stress unknowingly. On a daily basis, I am sure I make more than a few decisions that alter patient's lives in measurable ways. The decision of placing a patient on an anticoagulant or a "Gtube placement," although usually shared decisions with patients and families, leave you burdened by the end of the day

Much has been said and written about COVID-19 recently, but emergency room, ICU and hospital medicine has been at the forefront of caring for the sickest patients during this horrible pandemic. We saw quite a few of our consultant colleagues providing inpatient care through iPads - some even getting hilariously upset at the prospects of having to see patients with COVID-19. But I digress, lest I get myself in to undue trouble.

It remains important to uncouple yourself from work to a certain degree. Take care of yourself, your family and loved ones - all common-sense measures that are valid for all professions.

The field of hospital medicine is alive, well, and thriving. The continued inclusion of family medicine-trained physicians with ever increasing numbers is quite welcome. I feel hospital medicine will continue to grow in all its beautiful, diverse forms including academic university hospital groups, multi-specialty groups, large national hospitalist groups, rural hospital medicine groups and smaller private groups, each serving its unique needs. I have seen Neuro-Hospitalists, Psychiatry-Hospitalists, Nephro-Hospitalists and even heard rumblings of Surgical-Hospitalists (unsure about that one though) a few years back spurning from the Hospitalist model.

I can remember around 2005 when I was quite a "green" hospitalist, an established primary physician at a smaller rural hospital counselled me to leave hospital medicine as he felt this was a dying "fad". He chuckled at the prospects of someone working this job long-term. I'm glad I didn't pay heed to his advice since I recently found out he joined a multi-specialty hospitalist group 2 years after rendering his unsolicited wisdom, and I remain a Hospital Medicine "Lifer",

I am excited about the future and evolution of the field that has provided me with a unique opportunity to earn my livelihood while enjoying the ability to help people in their unhealthiest moments in the Hospital.

Upcoming ACMS CMEs:

January 11, 2022
Domestic Violence
2 hr CME

Register at acms.net or
email acmsassist@acms.net

MCMS
INSURANCE
TRUST

See What's NEW in 2022!

~Dental & Vision~

Effective March 1, 2022, the ACMS Health Insurance Co-op is excited to announce that new, large group dental & vision benefits are available to you and your employees!

Guardian®

Dental

- **Extensive provider network**
- **2 plan options**
  (Up to $2,500 annual max benefit)
- **Orthodontia Benefit**
  (for children up to age 26)
- **No waiting periods**
  (including orthodontia)

Vision

- **National provider network with VSP**
- **Affordable co-pays**
- **Expanded coverage limits**
- **Annual exam, frames, and lenses or contacts**

Be on the lookout for benefit details, rates, and more in your 2022 renewal packet!

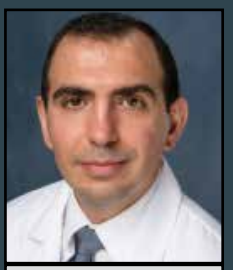
For more information regarding this opportunity, please email:

Ocala.GBS.TrustBenefits@AJG.com

Building a Palliative Care Service Using Hospitalists

Sheri Kittelson, MD; Al Yacoub, MD; Paige Barker, MD; Brenda Krygowski, MD; Leslye Pennypacker, MD; Janelis Gonzalez, MD; Nila Radhakrishnan, MD; and Margaret Lo, MD


Dr. Kittelson


Dr. Yacoub


Dr. Barker


Dr. Krygowski


Dr. Pennypacker


Dr. Gonzalez


Dr. Radhakrishnan


Dr. Lo

Fifteen years ago, I started my professional career at the University of Florida (UF) as a resident, then a Hospitalist, and most recently as founder and chief of the Palliative Care (PC) program. During my time in Hospital Medicine, I gained a solid foundation of clinical experience and a deep understanding of population health within hospital systems. I saw the sickest of patients nearing the end-of-life experience, multiple transitions in different health care settings, fragmented care, preventable readmissions, increasing demands on family caregivers, and unnecessary patient suffering often stemming from poor communication and a lack of adequate symptom management, psychosocial/spiritual support, and advance care planning.

Stepping back from the patient, I examined the situation and felt a calling to leadership to improve care at the system level. While doing more research on this topic, the same concerns were being recognized nationally as a health care crisis, worsened by the aging baby boomer population, contributing to soaring health care costs despite mediocre quality outcomes. The Institute of Medicine published Dying in America, calling on health care leaders across the U.S. to improve the quality of care and honor individual preferences near the end of life. (1) The State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals provides an analysis of whether seriously ill patients in the U.S. are receiving equitable access to palliative care services in hospitals. Unfortunately, Florida - the third most populated state with a large elderly population - fell in the bottom third nationally with a "C" grade for its poor performance in end-of-life care. (2) UF was in the bottom 20% of academic hospitals, without a palliative care program.

In response to the national health care movement, members of the UF Health Care workforce strategically planned a system and community-wide initiative to raise awareness about advance directives. The primary goal of the "Who Will Speak For You?" campaign was to encourage every Alachua County adult to consider, communicate, and document their end-of-life medical preferences in an advance directive. Knowing my passion for end-of-life care and interest in system-based quality improvement, I was asked to serve as the physician Hospitalist leader on the organizing committee. The committee's work spanned years and included dozens of team members from different disciplines including medicine, nursing, social work, chaplaincy, legal, ethics, informatics, and community members. The program was a tremendous success, raising our system's advance directive rate from 9% to 30% and received national recognition. The program laid the foundation for my knowledge and passion for dedicating my career to palliative care.

After serving on the Advance Directive Committee, I developed a strategic plan to train experienced Hospitalists and recruit and hire a multidisciplinary team to build a palliative care division from the ground up. During the 2015 academic year, I went back into residency to receive formal palliative care fellowship training at The University of Colorado, a robust and established program. Through this training, I received a valuable perspective that I brought back to UF. Upon my return, I became Chief of the eleventh Division in the Department of Medicine, filling a critical role for the institution. Our team created both an adult and pediatric inpatient interdisciplinary consult service.

Continued on Page 16

Continued from Page 15

We also established two outpatient clinics embedded in the cancer center and a heart failure clinic serving thousands of patients and families since creation. Our efforts improved access to care across the region and across the continuum of services from hospital to clinic and from the time of diagnosis to death. It is a privilege and honor to serve the sickest and most vulnerable patients and advocate for their needs. Our interdisciplinary team includes board certified physicians, advanced practice providers, social workers, chaplains, psychologists, and ethicists. The team serves to better anticipate and address patient and caregiver needs to help prevent and relieve suffering. We also help clarify goals of care, which often changes utilization patterns, improving both quality and efficiency across the entire health system to serve all patients better.

Around the country, communities like ours are feeling the barrage of the COVID-19 pandemic. Our team helps guide patients and their families through this challenging health care pandemic that most of us have not experienced in our lifetime. The PC team has been called upon to provide symptomatic relief of distressing symptoms, including shortness of breath, and help support patients, families, and health care teams who are suddenly forced to make complex decisions about life and death. Unfortunately, at times we are called on to deliver news that someone's loved one is not going to survive. Further challenging the situation is that these difficult conversations have had to occur over noisy oxygen delivery devices, behind N95 masks, sometimes through iPad interrupters, or worse, by phone with families who are not allowed to visit their loved ones. Our heart goes out to patients who have had to die in isolation from their loved ones. Even our use of "No One Dies Alone" (NODA) volunteers has been limited due to infection control risks. We have built careers around the idea that people should find peace, meaning, and connection in their final days. (3) The teams have struggled to creatively meet those end-of-life goals with this disease. We are grateful to our hospice colleagues for supporting patients and families with COVID to die in more peaceful environments by allowing safe visitation at end of life in care centers in addition to providing much needed support to patients who want to die at home. Additionally, we hope to support hard working colleagues through the risks to their health, families, and the emotional toll from overstrained resources, difficult conversations, and sometimes death. Dr. Gray, palliative care physician, states, "We dig deep into our reserves of patience and compassion to remind ourselves of the trusted privilege we each have to serve the sickest patients." (3) We add locally that our compassion applies to both vaccinated and unvaccinated patients.

Beyond COVID, we continue to focus on our discipline and advancing goals outside our hospital and community. Our institution, and others in the South, have historically been engrained in the more traditional fee-for-service model, which favors volume over value. This payment model is insufficient to support high quality interdisciplinary palliative care. Value-based payment models provide financial incentives for providers to improve care quality and control costs at the population level through investment in high-value services like palliative care that have demonstrated the ability to do both. The American Academy of Hospice and Palliative Medicine (AAHPM) engages in public policy advocacy to advance the field, promote the interests of palliative care and hospice patients, and support the health professionals who care for them. The needs of patients and their families throughout the care continuum guide AAHPM's policy agenda. Recent priorities include: 1) developing a well-trained workforce, 2) preserving and expanding timely access to hospice and palliative care in all clinical settings through emerging technologies, and 3) seeking sustainable reimbursement for inter-professional time spent delivering high-value services aligned with patient and family goals.

Palliative care is still a relatively new discipline. The State of Florida has no formal palliative care governing body to advocate for services, often falling behind other states. However, for the past three years, a group of over thirty organizations have worked together as a Steering Committee to form the foundation of the Florida Palliative Care Coalition. (4) The inaugural summit was held this year, marking an important date for the third largest state home to one of the largest elderly populations in the country. The Coalition aims to be the one voice and focal point for advancing palliative care in our state. The Coalition's mission is to support and inspire the acceleration of solutions that promote a better quality of life for Floridians living with serious, chronic, or advanced illness through research, education, advocacy, and access to holistic healthcare. The goal is to create a multi-year action plan that addresses the areas of focus needed to improve access to palliative care, including quality, public policy, consumer awareness, education, and workforce development. Through the FPCC, a workgroup on education set forth to advance education for providers, patients, and their families, and payers. "An estimated 71% of U.S. adults reported having never heard of palliative care, despite its documented benefits." (5) Community-

Continued on Page 17

Continued from Page 16

and population-based interventions are necessary to raise awareness and inform the public about palliative care. Education and information most often come from one's medical provider. Training palliative care providers requires defining primary (the care all medical providers can provide) vs. specialty trained providers and the role of each. Primary palliative care includes basic management of pain and symptoms, basic discussions about prognosis, goals of treatment, suffering, code status, and referral to specialty palliative care when needed. Standardized medical education is needed for all physicians and advanced practice providers. Requirements for multidisciplinary specialty level palliative care are outlined on the Center to Advance Palliative Care website https://www.capc.org/jobs/palliative-care-certification/.

Although PC is encouraged by the Association of American Medical Colleges, the only mandate from the Liaison Committee on Medical Education to U.S. medical schools is that end-of-life care be included in medical school curricula. Many medical schools, like UF, have voluntary educational threads spanning four years of medical education to include rotation time with the palliative care service. Students' educational topics include: defining PC, communication including delivery of bad news, symptom management, ethics, and law. In July 2021, the Accreditation Council for Graduate Medical Education (ACGME) will require all Internal Medicine Residents to receive palliative care training. ACGME has not specified the specific duration, learning objectives, or Milestone competencies for residents. (6) It also remains unclear how and when this requirement will be expanded to other medical specialties such as surgery and pediatrics.

Palliative care is a relatively new medical specialty. More must be done to ensure an adequate and competent palliative care workforce is available to provide comprehensive symptom management, intensive communication, and a level of coordination of care that addresses the episodic and long-term nature of serious, chronic illness. Advancing education on a national level is imperative to address the shortages systematically. Please visit the American Academy of Hospice and Palliative Medicine (AAHPM) to support HR 1339/S 641, the Palliative Care and Hospice Education and Training Act (PCHETA) to create educational centers, expand physician training, provide workforce development, and support academic career awards and career incentive awards. (7).

References available upon request.

House Calls Magazine

Winter 2022

Advertising in *House Calls* does not imply approval or endorsement by the Alachua County Medical Society. All advertising is subject to acceptance by the Board of Directors.
Send all advertising submissions to:

Alachua County Medical Society, 235 SW 2nd Avenue, Gainesville, FL 32601.
Ph: (352) 376-0715;
Fax: (352) 376-0811;
www.acms.net.

House Calls is a quarterly publication of the Alachua County Medical Society, Inc., Gainesville, Florida.

Who Is or Isn't an MVP?
An Approach to Multi-Visit Patients

Kiran Lukose, MD
UF Hospital Medicine

Background

Multi-Visit Patients, or super-utilizer patients, are a unique patient population who have high health care utilization and cost in our system. An analysis by the Agency for Healthcare Research and Quality shows that the sickest 5% of U.S. patients account for over half of U.S. health care costs. Formal analysis has revealed that this population carries a significant burden of medical illness. A large proportion of these patients suffer from mental illness and substance abuse. Studies have also shown that super-utilizers have higher mortality and poor health outcomes.

A multidisciplinary approach has been used in different programs across the U.S. for tackling this problem. Although programs differ in their structure and mechanisms of service delivery, most offer discharge follow up, mental health and substance abuse treatment, pain management, primary care linkage, pharmacist-assisted medication reconciliation, housing and frequent face-to-face encounters. Institutions may choose from a variety of tool-based standards or use their own definitions. However, using super-utilizer criteria that are poorly aligned with the population being served can result in misallocation of resources and diminished effects of interventions. To be most effective, health care institutions must understand which criteria are available and most relevant to their specific patient populations. The usual processes are not sufficient to provide health equity for super-utilizers.

Social determinants of health, or SDOH, are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health functioning and quality-of-life outcomes and risks. SDOH can be grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. SDOH have a major impact on people's health, well-being and quality of life. About one in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider and they may not be able to afford the health care services and medications they need. When their health is not well taken care of, they get chronically ill and the chances of them being a super-utilizer becomes high.

An integrated practice unit

At UF Health, a large academic health center based in rural North Central Florida, we are dedicated to serving the community and providing health equity through high-quality care. An improvement project was launched to understand the needs of our frequent visitors and preliminary data showed that frequent visitors, defined as 4 or more ED visits in a 6 month period represent 6% of the population but account for 23% of emergency room visits and 20% of total costs. At UF, Multi-Visit Patients) account for 12% of the total discharges and 41% of total readmissions. Additionally, data showed that the Multi-Visit Patients' readmission rates are as high as 49%, compared with the general readmission rate of around 10%.

To address this issue, a pilot project was launched and 2,485 patients were identified for having more than four ED visits in a six-month period. An ambulatory ICU model named "Care One" was created with a physician, pharmacist, social worker, RN, psychologist and an addiction-medicine specialist. Our goal of this Integrated Practice Unit is to reduce the overuse of the ER, improve coordination of care and quality of care, and eventually transition patients to a local primary care physician. These patients were referred to the clinic for intervention and we looked at the number of ED visits six months prior to the Care One appointment and the number of ED visits six months after the Care One clinic appointment as our

Continued on Page 19

outcome measures. We serve two discrete populations. The primary target population is patients with greater than four ED visits in six months. For this population our clinic acts as a safety net, trying to catch them before they get so sick that they need the ED. The secondary population we serve are post-discharge patients who are medically complex Multi-Visit Patients. Our goal is to have patients seen as soon as they are discharged, get them established with the appropriate subspecialty clinics and later transition them to their primary care physicians. We serve as a bridge for these patients who have challenges navigating the health system.

Medical complexity and coordination of care

Our analysis shows that we encounter four common scenarios:

1) Patients who have high medical complexity with limited health literacy who require more time for education and coordination of subspecialty visits
2) Patients who need help with Coordination of care and assistance to navigate the complex health-care system
3) Patients who need pain management and addiction-medicine interventions
4) Patients who need further investigative tests such as labs and imaging.

After three years, pilot study data showed us that for those patients seen at Care One, there was a decrease in ED visits by 4.5 visits (11%), hospital admissions were down by 3 (23%), and there was a decrease of 13 days in subsequent hospital days (23%).

UF Health has two major robust and active committees in our institution. Our Emergency Department looks at the patients who are frequent visitors to the ED. The In-patient MVP (IP MVP) committee looks at the frequently admitted patients in real time.

For the IP MVP committee, Dr. Kiran Lukose, the Care One medical director, serves as the physician champion. We pick the highest utilizers from the list and discuss the case in a multidisciplinary approach. Since at any given time we have more than 100 MVPs admitted, it is not practical to reach to all of them in real time and discuss the cases due to limited resources. Currently, the IP MVP committee only focuses on patients admitted under two services as a pilot project, and our goal is to expand further as we develop more robust systems.

Awareness of the existence of multi-visit populations and their needs is the key. When we pulled our data at first, it was eye-opening to see that we have more than 100 MVPs admitted at UF Health at any given time. To identify needs in real time, the MVP committee members gets a daily list of MVP patients who are currently admitted. Dedicated social workers then interview these patients in real time. It takes several hours and multiple visits to secure the patients' trust and get to the core of their problems.
Collaboration is the key in taking care of this patient population and we are integrating professional students from various disciplines into the practice of the Care One clinic.

We have pharmacy students, dental students, social work interns, occupational therapy students, mental health counselor students, medical students and medical residents rotate in the clinic. Since we do not follow the traditional 15-minute or 30-minute appointment structure, students do not have time constraints and can interact with the patients. Involvement of students are well-received and appreciated by the patients.

Super-utilizer patients need a multidisciplinary approach in their management. This approach has shown to empower the patient to be able to decrease their reliance on the emergency department and the hospital. Patients can then rely more on their primary care doctors and community resources. Limited health literacy is a major issue for these patients, so we ensure that instructions are given in layman's terms and a teach-back method is used to determine whether the patient understands the plan. Our work on Multi-Visit Patients points out clearly that they are not the problem. The fragmented health care system that they are unable to navigate is the problem. The Care One clinic continues to track patient outcomes as well as educational outcomes as we provide high-quality medical care to this patient population to achieve better health equity in our community.

References available upon request.

ACMS HAPPENINGS

Celebrating & Remembering Colleagues

Haven Hospice

October 26, 2021

L to R Haven Hospice Staff: Vicky Robertson, Event Coordinator; Pauline Taylor, President; Shirley Codada, MD, CMO; and Marty Franklin, CFO.

L to R: Faye Medley and Scott Medley, MD.

L to R: Marlaine Van Arnam and Florence Van Arnam.

L to R: Noara Londono; Diane Chapman; John Dryfuss, MD; Peggy Dryfuss and Jack Londono, MD.

HAPPENINGS ACMS

Celebrating & Remembering Colleagues

Haven Hospice

October 26, 2021

L to R: Phil Parr, MD; Scott Medley,MD; Carol Liquori; and Gordon Finlayson, MD.

L to R: Justine Vaughen Fry, MD and Faye Medley.

L to R: Rogers Bartley, MD and Roy Chapman, MD

L to R: Signe Clayton and Paul Clayton, MD

In Memoriam

Burton "Burt" V. Silverstein, MD

(1945 - 2021)

Burt Silverstein, MD passed away on Thursday November 4, 2021. The cause of death was metastatic pancreatic cancer. Dr. Silverstein was born May 7, 1945, in Brooklyn, NY. He received his Medical Degree from the University of Pennsylvania. His four year residency in internal medicine, also at the University of Pennsylvania, was interrupted after two years when he was called upon to serve in the medical corps of the U.S. Air Force in Guam during the Vietnam war. His children were both born in Guam. After completing his military duty as a major, he returned to Philadelphia to complete his residency. He then moved with his family to North Carolina, where he completed a cardiology fellowship at Duke University and became a board certified cardiologist. In 1978 he moved to Gainesville, where he practiced as a cardiologist, first with Cardiology Associates of Gainesville and then with the Cardiovascular Institute, until his retirement in 2021. Burt loved traveling, and visited all 7 continents. He is survived by his wife Janet Silverstein, sons Craig and Todd Silverstein, sister Zelda McBride, and three grandchildren.

Howard W. Ramsey, MD

(October 2021)

Dr. Ramsey established the first cath lab at the Gainesville VA Hospital and performed all of the invasive cardiology procedures at Shands and the VA hospital as he was the only trained invasive cardiologist on faculty. In 1972, Dr. Ramsey moved his practice to NFRMC where he established the NFRMC cath lab, invasive cardiology and the Nuclear Cardiology program. His community cath lab model became the standard for high quality programs and he was asked to help open community hospital cath labs all over Florida and Georgia. He received his Medical Degree from the University of Florida. He was a founding member of Interventional Cardiologists of Gainesville, later merging to become The Cardiac and Vascular Institute. Dr. Ramsey represented the very ideals of cardiovascular medicine with a legacy of over 30 providers, 180+ employees and a hospital that provides cardiovascular care to tens of thousands of patients in our community every year.

William M. Murphy, MD

(August 2021)

Dr. William Murphy, age 78, passed away after a prolonged battle with cancer. Born in Des Moines, IA, he was educated at Drake University and Harvard Medical School, served in the U.S. Navy, and held faculty positions/professorships at the University of Tennessee, Baptist Memorial Hospital Memphis, and Tulane Medical Center before coming to the University of Florida in 1994. A widower for many years, he is survived by daughters Jamar Kroll (Scott) of Boston, MA and Shawn Pendergrass (Joe) of Knoxville, TN, as well as three grandchildren – Mary Elizabeth, Sally, and William Pendergrass.

Dr. Murphy was an internationally known pathologist with expertise in diseases of the urogenital system. A lover of history and travel, Dr. Murphy was a voracious reader and could discuss with authority issues affecting almost any time period, including current events. He traveled all over the world and visited more than 60 countries. He enjoyed hosting guests and visiting colleagues and friends across the globe.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, October 5, 2021

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, October 5, 2021, virtually on Zoom.com.

Approval of Minutes: The minutes of the September 7, 2021 Board Meeting were reviewed by the Board. Dr. Ryan moved approval of the minutes, seconded by Dr. Levy, motion carried.

Treasurer's Report: At Dr. Bruggeman's request, Ms. Owens presented the financial report.

Alachua County Medical Society, Inc. – a 501(c)6:
This will be a rebuilding year for the ACMS, as the pandemic has changed both the business parameters and our membership base. We are pursuing several Strategic Initiatives including:
• Increasing Membership
• Hosting In-person Events
• Integrating New Technology
• Improving Virtual Opportunities for Members
• Increasing Non-dues Revenue
• Reducing Expenses
•Strengthening Strategic Partnerships with Other Organizations
• Expanding our Geographical Boundaries

Membership Dues are down slightly from last year, however, they are expected to increase in the next few months based on verbal commitments from various physicians and university departments. Publication Income increased due to Directory Ad sales with anticipated increases in House Calls ad sales as well. We have recently closed long-term contracts for advertising in House Calls that will result in a net profit for the publication. Publication Expense has declined due to a reduction in the number of printed issues (conversion to electronic format). All other expenses being relatively inline, these declines resulted in a net loss of $3K for the two-month period under review.

Alachua County Medical Society Foundation, Inc. - a 501(c)3:
ACMSF had total Grant Income of $17.5K for the 2 month period, with total Grant Disbursements of $2.5K. Total Current Assets (grant funds and endowments) are $115.6K with Total Assets of $166K.

We have been approved for a FAFCC Grant in the 2021-22 cycle for $75K as follows:

Personnel Costs:	$55,276
Operational Costs:	$ 4,000
Programmatic Costs:	$15,000
Conference Award:	$ 500
CMR Licensing Award:	$ 224
Total Grant:	$75,000

Dr. Bruggeman motioned approval of the Treasurer's Report, seconded by Dr. Ryan, and carried by the Board.

President's Report: Dr. Dragstedt discussed the Strategic Initiatives with the group and asked the EVP to create a flyer that could be circulated amongst the hospital groups to encourage new membership. Drs. Riggs and Balamucki volunteered to circulate that information to UF and NFRMC, respectively. Dr. Dragstedt announced that we are accepting nominations for the Board position formerly held by Dr. Andreoni and for two NFRMC Board Liaisons. Dr. Ryan recommended the EVP contact Dr. Robyn Hoelle and Keith Molinari for the NFRMC nominations.

EVP Report: Ms. Owens reported that a Board member had asked if the ACMS had a response to the hiring of Dr. Joseph Ladapo as Florida Surgeon General. The Board discussed the idea and asked the EVP to look into any statements that have been made by the FMA and other Medical Societies around the state and report back at the next meeting. Dr. Dragstedt emphasized that we will continue to provide scientifically based medical advice in keeping with our primary mission.

The ACMS Poster Symposium is scheduled for October 28, 2021, virtually. All members are encouraged to attend. Drs. Ryan, Levy, Tyndall-Smith, Bruggeman and Dragstedt volunteered to be Judges for the event.

The Robb House roof replacement should be complete by the end of October.

There being no further business to discuss, the meeting was adjourned.

A Note from our **Editor**

Service Call - The Bad Old Days

By Scott Medley, MD

[Editors Note: editing all and authoring some of this issue of House Calls brought back a lot of memories for me – not all of them good. I know that other physicians had similar experiences, so I decided to recall some of those experiences from myself as a retired Family Physician, from Dr. Pete Calabrese as a retired Internist, and from Dr. Tom Zavelson as a retired Pediatrician. Following is a brief summary of some of our memories of those much different times, about 40 years ago:]

Scott Medley, MD:

When I established my Family Practice in Gainesville in the early 80's, there was no such thing as a "Hospitalist." In fact, when it came to providing medical care for hospital inpatients, it was "every man (or woman) for himself." This system applied not only to one's own patients, but also to "unassigned community patients" who didn't have their own doctor, "but just showed up in the Emergency Room" often unannounced and usually very sick. Members of the general medical staff rotated this dreaded "Service Call," usually about once per month. When a doc was on "Service Call" he or she "took all comers" – regardless of numbers or severity or type of illness.

I remember one of the worst days I was on Service Call, I had about 12 admission – all day and all night – with all manners of illness – a "GI Bleeder"; a "heart attack"; a severe pneumonia; a "stroke", a cocaine overdose; and many more. I had to provide care for all these patients until they died (not uncommon) or were discharged, no matter how it impacted my full office practice and my own private practice admissions. Obviously, I got no sleep during this 24 hour period. No, it was not the best way to practice medicine – neither for the patients or the physicians. Thank goodness we now have Hospitalists and Intensivists and "Service Call" is a thing of the past.

Pete Calabrese, MD:

I started general Internal Medicine private practice in the Chicago area in 1987. At that time young ambitious doctors would solicit service call from established physicians and pay a nominal fee for the privilege. When I moved to Gainesville in 1990 starting my Internal Medicine practice all over again, service call was how I built some of my patient population. I could get all I could handle for free. Established physicians would solicit me to take their service call. I took a lot of it. It was stressful. Sleep deprivation was usually involved. The most difficult was a weekend service call as this also included call for the "call group" covering usually around 6 or 7 other physicians and their hospitalized patients and any of their weekend admissions. I remember an exhausting Saturday service call trying to finish rounding on about 25 inpatients when a 43-year-old diabetic woman was admitted through service call to my service. She was comatose with diabetic ketoacidosis. I had no past medical history. No family members were available. It was a very busy Saturday with 5 or 6 additional service call admissions. This woman coded, full cardiopulmonary arrest. I did not leave her bedside for over three hours. I did not think she would survive. Fortunately for me, but more fortunately for her, Dr Jim Wynne was on call and helped me stabilize the patient. For the record Jim did not leave the ICU bedside for over 5 hours and heroically saved her life.

I will start on Medicare Health Insurance next February as I turn 65 and I promise you, I DO NOT MISS SERVICE CALL!

Continued on Page 25

Continued from Page 24

Tom Zavelson, MD:

I vividly remember the day, after my first year in private practice and complaining to my Dad about all of the many things that were descending upon me at the same time he said, "Tom, just remember that you can't have your butt in two places at the same time." When you're at the ballpark, you have to follow the fly ball and concentrate on bringing it in; then when you get to the dugout you can think about and address your next at bat. You can't do two things at the same time. And boy was he right. "Prioritize, son."

For those of us in the medical profession, the past 50 years have indeed been the substance of a nine-inning game that seemed never to end. For the longest time, though we tried our best, we struggled to get off first base and each inning seemed to last an eternity. The doctor ranks were way too thin; we had the infielders but desperately needed additional outfielders, bat boys, club-house helpers and more ground crew. Instead, what we were faced with were more umpires, faster balls and increasingly more restless fans. There were way too few teams and we seemed to always be facing the same ones. There was a Draft but it took too many of us out of the Game and never a draft to expand our rosters. The Physicians League had plenty of owners, but hardly any expansion clubs. We needed more players and we needed them STAT. There were way too many days that all we wanted was to get off of the field, run to the dugout and sit our exhausted butts on the bench. And to make it worse, our cleats seemed to always be stuck in the mud.

It was a routine night in November, 1975, when I was called back to Alachua General Hospital (AGH) at 0345 hours for the second time that night to evaluate a 3-month-old little girl with a temperature of 102.5; my first trip was at 2230 hours to attend an emergency C-Section. Prior to this latter trip there were, of course, at least 4-5 patient-related phone calls from concerned parents that I needed to deal with. Then there was the next day to face. After morning rounds beginning at 0630, I examined 2 or 3 newborns, talked to the parents, did a "Circ." or two, rounded on my three in-patients on the 7th floor, restarted a blown IV, and finally arrived at my office by 0830 - not having enough time to grab a Big Biscuit from Skeeters. By 1:00 Cindy - my only nurse - was still upright and alert and Jackie, - my only other employee - was checking a patient using her trusty Pegboard. With phone-to-ear while talking to parents, she tried her best not to be frustrated by the other two phone lines blinking away. By 7:00 that evening, I was finally able to lock the back door, drive back to AGH, round on my inpatients and examine 1 or 2 more newborns. And that was a really good day- no calls to come in for an emergency C-Section or to come to the ER for a sick kid or an admission. As they now say: "Copy and Paste" for many months and years to come.

This was the first inning of what was to be a very long game with days repeating themselves, pitch after pitch. After leaving my faculty position at UF Dept. of Pediatrics, I was in my 18th month of a "private" pediatric practice. At that time I was "on call" every day and night (now referred as 24/7, a term we were not familiar with) for my own outpatients, the delivery room, my inpatients and, by hospital rules, on the Emergency room rotational call schedule.

Fortunately, I was a young and physically healthy doctor in an aging Medical world, getting used to hardly ever seeing my own two children awake nor my wife with open eyes and in a vertical state.

At that time, we Docs accepted this as just the sacrifices that we needed to make in order to fulfill our "calling" and had absolutely no idea that eventually changing times would allow us to begin to experience a more controlled and controllable life.

In those days there were a couple of former semi-retired general surgeons who were the first line of defense in the ER. They did a great job with most adults but the kids, gynecological, psychiatric and orthopedic patients usually prompted calls to the "specialists" who were exhausted, frustrated and very much unaware where their butts would land next.

Finally, after nearly 10 years, an opus of rapidly changing events allowed us to realize that we might finally be able to get off of First Base and move onto later innings. Enter: well trained and experienced ER Docs, Anesthesiologists who were no longer afraid to touch newborns, nurses who eventually perfected techniques for starting IVs and drawing blood, Docs like Jim Wynne who was always there to help us manage ICU patients and the ever-increasing numbers of specialists in renal, pulmonology, ENT, Neurology, Radiology. Orthopedics, and Ophthalmology just to name a few. Enter: Stat Flight bringing inpatients unknown to us from places that we didn't know existed. Enter: beepers that stopped beeping but sent

Continued on Page 25

Continued from Page 25

you voice messages and frustration because you could not find a phone in order to discover what the message was about. Enter: permanently-mounted car phones, "suitcase" battery phones (bulky but usually worked), followed by ones that you could carry around on your belt like those slide rules from college days.... you know the rest of that story. Enter: HMO's and a need to hire more employees for the growing amount of "paperwork", growing numbers of lawyers who did not look favorably on our ranks, a new hospital on the other side of town and a developing cadre of those who wanted to own and better control us. Nevertheless we were still in the game, the player numbers were increasing, the uniforms starting to look different and the innings beginning moving along, but still no Seventh Inning Stretch!

Slow Forward (the Fast Forward button had yet to be invented) to the development of ICUs of all sizes and shapes with skilled Docs that managed them "24-7." There were soon enough players in the ER to handle the influx of ER patients - thus making ER Call much more manageable and somewhat less stressfull. Enter: programs like Pediatrics After Hours followed by an ever-increasing number of hospital and private "Doc in the Boxes" all of which added their share of relief and ultimately a degree of improved patient care. The 8th Inning was approaching but the need to put our butts in two places, though not at the same time (office and hospital) still very much slowed the game, added more anxiety and, in the end, made for less effective in-patient care.

And Finally, ... Enter: the Hospitalists, again differing sizes and shapes. What a difference. The Game had now really begun to change. As we now enter the top of the 9th inning, we can finally find time to trot off the field, remove our dirty cleats and place our butts on the bench. Let's just hope that it will be a long time before the score will dictate that we will have to go into extra innings.

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

Are you caring for someone with dementia?



Savvy CAREGIVER

Savvy Caregiver Training is an educational program designed for caregivers who assist family members with Alzheimer's or any other form of dementia

Course Objectives

Participants will learn:

- Signs of dementia
- To recognize a persons losses and abilities
- Self-care strategies
- Effective ways to manage common behaviors
- How to connect with local resources

Classes offered throughout the year **online** and in various **locations throughout our service area**

For more information or to view our current class schedule, contact us or visit our website

agingresources.org/savvy-caregiver-training | savvy@agingresources.org
Elder Options hotline: 800-262-2243

ELDER OPTIONS

Department of ELDER AFFAIRS STATE OF FLORIDA

Savvy Caregiver is offered by Elder Options with support from the Florida Department of Elder Affairs

Florida HEALTH
Alachua County

EXTENDED HOURS CLINIC

FLORIDA DEPARTMENT OF HEALTH IN ALACUHA COUNTY

Monday-Friday; 5pm-7pm
Saturday and Sunday; 10am-3pm

Closed on state observed holidays

Primary Care

Follow-up/Sick Visits
Blood Pressure Checks
Medication Refills
Vaccinations
PPD placement & reads

Pediatrics

Follow-up/Sick Visits
Vaccinations

Family Planning

Birth Control
Reproductive Health Visits
Pregnancy Tests

Communicable Diseases

STD Screening
STD Treatments
COVID-19 Testing

Accepting New Clients!

Call for more information regarding eligibility and to make an appointment

224 SE 24th ST, Gainesville, FL - alachua.floridahealth.gov - (352)334-7910

Alachua County Medical Society
235 SW 2nd Avenue • Gainesville, FL 32601-6256

CHANGE SERVICE REQUESTED