



# CMS 2012 Tri-Regional PACE CONFERENCE

Programs of All-Inclusive Care for the Elderly

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## TRANSCRIPT

### Fall Prevention

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Good afternoon, everybody. And I – as everyone says, with the lights shining in my eyes, I can't really see you, but if I have the sense anyone's sleeping, I – I promise you I will puff into the microphone, people. Hopefully I won't clear my throat too much, though.

Among the numerous misrepresentations on my resume, was allegation of a proficiency in Microsoft PowerPoint, and so I apologize to you, I've rendered my notes in Word only. So I guess I do realize, also, from the point of view of the evaluation, not having any visual materials, I'm basically dead man walking here.

That said, I'll get going. I'll start with my perspective on fall prevention. I work out of the CMS regional office in Boston, that's Regional Office One. That's six New England states. Excuse me. And I am a physical therapist, so I guess it just occurred to me to – to – to jump up and down like the donkey in Shrek and say, pick me, pick me when it came to volunteering for this component of the – of the conference.

Just to get started with the presentation, why do we look at fall prevention? It's, maybe, a firm grasp of the obvious that I have here. We need to keep our participants safe, obviously, but there's a huge cost. Approximately 16,000 a year over the age of 65 die as the result of falls. Another 1.8 million people are admitted to ERs. The cost of all this is about \$19 billion in the year 2000. In the year 2020, it's projected to be about \$45 billion. So when we talk about, you know, the solvency of Medicare down the road, you know, it's things like this that we really need to look at to – to try to make some meaningful improvements. And – and again, you know, regardless of the dollars and cents, we're just ethically bound to keep our people safe.

But I do acknowledge also what was said in – in the previous presentation, and I'm intrigued by that and I kind of salute the courage of it, which is to say that the PACE model is such that the risks that we allow our – our members, our participants, is such that it's heightened because of the philosophy, which is to say to keep them at the highest level possible out of the nursing home.

I'd also doff my hat to Kimberly Woodley when she posed that sort of a trick question to us and said, you know, raise your hands all of you who are involved in quality. To my mind, you know when I was on the other side of the clipboard so to speak. I go into PACE organizations and, you know, perform the audits,

but when I was on the private sector side of things I kind of thought that QA was essentially a paper compliance exercise. But, you know, I was just kind of operating under my physical therapy silo, but – but really, when you think about it, and I – as I hope these presentations – the culmination of these presentations – does impress on us all, QA really is everything. I mean, there was a mention earlier about evidence-based medicine, and you can't really even think of that unless you look at QA. So I think that just in terms of the holistic health of your PACE organization, you know, it's very important to – to conduct QA in a meaningful way. Not in a paperwork compliance way, but to really think, what are we doing, what is wrong, are we identifying things that are wrong, and are we taking effective measures to correct those – those problems, those dysfunctions.

One advantage of not having this all prepared so early was that – sorry, I just puffed – is that I was able to respond to some of the other presentations that have – have – have gone over the conference, and I've sort of adapted my – my discussion to some of what I've heard. And I'm going to structure it along Peggy Kosherzenko's basically medical algorithm, which is to say we'll be looking at definitions and then just in terms of what we do as clinicians, we'll look at assessments, care plan development, care plan implementation and reassessment.

So the first thing we really ought to discuss here, and I think that probably as a whole in the conference, maybe needed even a little more discussion, is definitions, certainly in the context of quality assurance, definitions are really vital. I mean it – it's your starting point. And if you can't agree on a common definition, it's – it's a huge data integrity issue. As one example, let's look at incidents of pressure sores. If you're – if you have staff that are just looking at any kind of skin lesion and just categorizing it as a pressure sore, that's a huge data integrity problem. What – what about stasis ulcers? You're whole treatment approach might be misguided if you're not even defining something properly. If something is the result of tissue maceration instead of pressure, you may be, again, treating it completely wrong, and the breakdown in care may not be because of failure to implement pressure relieving devices but to actually – to correct toilet of the – of that region.

So it's very important to – to have things defined. Unfortunately, neither the PACE manual nor the regulations define falls in a – in a very workable way. And so, I would suggest that – that you – however you do it, you do come up with some definitions that – that you all can agree on. What makes it problematic, though, is that with PACE you are dealing with providers in different venues. So, for instance, how you define a fall may be somewhat different from how the nursing home defines a fall, or another nursing home. So it's – it is a huge challenge for you to coordinate that communication and that – that – to – to speak that common language. That said, I would suggest that you – you consider the long-term care definition that is communicated by means of the MDS, the minimum data set. In the Resident Assessment Instrument Manual, a fall is defined as follows: It's unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. So, for instance, if someone were to push another resident and that resident fell, that would not be considered a fall. And that's, I think, worth – worth noting. It would be an accident or an incident for sure, but not a fall as we define it. And again, I hope that just kind of gives you a sense of why it is important to – to make these definitions very explicit, very narrow, or broad, whichever you think is right.

An episode where a resident lost his or her balance and would have fallen if not for staff intervention is considered a fall. That is also, maybe not the most intuitive idea. But so, if someone were, you know, losing – losing their balance and would have fallen, but didn't, the MDS considers that a fall. And the idea, again, is to – to put them in the assessment/treatment pipeline. And at least, you know, to give

that participant consideration for care, because, obviously, there's – there's some dysfunctions at work there.

A fall without an injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.

So that's the MBS definition. You know, whether you use that or not, you know, that's up for you to decide. I would say this, though. To the extent that long-term care facilities are – are bound by that definition, it may behoove you to give that one some careful consideration.

There's a best practice definition from Healthcare Association of New Jersey which I came upon. And it's similar to this. It's very broad. But, again, I'm kind of reading these just to – to stimulate your thinking as much as anything. A fall is an occurrence characterized by the failure to maintain an appropriate lying, sitting or standing position and an individual's abrupt, undesirable – undesired relocation to the ground. The definition of a fall extends to the following factors: an episode in which a resident has lost his or her balance and would have fallen were it not for staff intervention – similar to the MDS. The presence or absence of a resultant injury, a fall without injury is a fall, again like the MDS. And the distance to a lower – the next lower surface, for instance, the floor, does not determine the incidence of a fall. So even if they were in a low-lying bed and just kind of rolled onto the floor, according to this definition, that would be a fall.

I've developed my own definition that occurred to me while I was frantically trying to put this outline together, and that is the following: A fall is the outcome of a battle between the individual and gravity in which gravity is the victor. And that – that may sound a little glib and maybe not very useful, but – but the point I'm trying to make in my definition is the participant is – is losing, function has lost a battle, has lost the battle in – in – existing in the functional world. And that's what you need to take into your assessment in the development of a care plan.

That said; let's look at the whole – whole notion of risk identification. And this is – this is probably a topic that we can go on all day about, and there's just such a overwhelming soup – sorry, there's that "P" again. I'll say salad instead of soup. Of risks that – that play into loss of functional mobility and the risk for falls. And I think Dr. Zioncheck is going to be touching on that. And incidentally, when I was informed that I would be co-presenting with Dr. Zioncheck, I saw that his first name, it said "R" Zioncheck. And I was so hoping that his first name was Ryan, because then it would be Ryan Zioncheck, and I thought that sounded very cool. Alas, it was Roger, so I'm a little disappointed about that. Anyhow, here's what I want to get at with this, and I think this is a very important point. That when you do an assessment and you're – you're trying to identify risk, let me – let me just convey an anecdote to you that I – I think was a really a – a great revelation to me. I was a long-term care surveyor before getting into PACE. And I was looking at the medical record, and I flipped to the – the section that said assessments. And so I got to fall risk and I saw one, and I was like, hmm, and another, and I was like – I was irked. I was very irked. And the reason that I was irked was because I was not seeing scores for anything. There were no scores, so I – I finally asked the person who conducted the assessment, where's the score? How – how do you know what's going on here? The answer they gave me just floored me – no pun intended. They said to me that they don't score because a score in a sense is very meaningless. It doesn't really highlight the risk factors that are at hand here. And that, I thought, was hugely meaningful. So, for someone to say, oh, his Tinetti is a 19, that tells me nothing. It just – it says, okay, maybe they have a fall risk, but why do they have a fall risk? It's like wound care, too. You have a Braden scale, and people say, oh, well, they're low risk, so let's not worry about it. They're not at risk

for skin breakdown. But what if one of the factors that – that folds into that score is not care planned for and it's – it's something that results in skin breakdown. Then – then they're getting a pressure ulcer because this one risk that they did have was not spoken to. So don't – don't assess – or don't care plan on the basis of the score. I mean a score if your point of entry. If you're identifying a risk on the basis of a score, that's fine, so you know that – but it – that tells you that you need further investigation.

That said, you know, something like Tinetti, it gives you a nice qualitative analysis, structured qualitative analysis of a participant's gait and balance deficits. And it takes about ten minutes to perform. A much more expeditious method would be the – the timed up and go test. It's simply asking the participant to get up out of a chair, walk ten feet, turn around and go. And there's a very, apparently, strong correlation between fall risk and the inability to do that, up out of a chair and ten feet and turn around within 30 seconds. More recent studies would suggest that even 14 seconds, when we – when we eliminate people who have had strokes and stuff, so that's, again, just a point of entry. You don't – you don't just say, okay, they're – they're at risk and that's it. You – you want to say, okay, why are they at risk and then problem solve from that.

So with respect to care plan development, I would just say you need to be very participant specific. For instance, when you're looking at transfers. The whole approach to the participant may have a bearing on the – the safety or the success in that endeavor. If someone's on a Hoyer lift, you may have completely different reactions from one participant to – to the next. So just to say to a – an aide, who's – who's learning how to use a Hoyer lift – okay, you do this first, you do this second, you do this third, is not really the complete picture, and it could really be a disaster if the – the response of the participant is resistive and causes a fall or an accident as a result of fear. So, you know, you need to fold those things into, you know, your communications to your staff about how to approach these things.

In terms of care plan implementation, I'm not really here as a physical therapist to tell you what things to do, not in specific terms. Interestingly, though, when I first started thinking about this presentation last month, published in the *New England Journal of Medicine* was a study about the effectiveness of tai chi in fall prevention in the elderly. And that really does seem to be a very effective intervention. So when you think about them having Bingo as an activity, it may behoove you to actually staff some – some tai chi instructors and do that instead. And again, you know, it's probably cost effective, too, given the fact that like a hip – hip fracture, the surgery for which is close to forty - \$40,000, I think at this point.

In terms of my own biases, I think that any kind of sensory motor integration is really the way to go. You want to do closed kinetic chain types of exercises. So if you see the therapy staff just with people sitting in their wheelchair and just doing little calf raises, like that, that's really not satisfactory as far as I'm concerned. On the other hand, you know, batting the balloon could be kind of an interesting thing. The Wii, the new Wii programs are really very effective in – in doing dynamic balance types of activities. In terms of reassessment, what I really want to mention here is noncompliance. And this is something I've observed when – when we do audit and we go out and look at the interdisciplinary team and we're hearing reporting back that Mrs. Jones, oh, well, you know, she continues to wear her high heels, she's not heeding our recommendation to wear orthopedic shoes. And people, as often as not, seem to just throw up their hands and say oh well, she's non-compliant. You know, that's really not acceptable. We can't just say, well, we've developed this plan of care and they're not doing it and that's it. So, I mean, what can you do in that situation? Well, maybe what you have to do, and this is kind of going back to the previous presentation, is just, you know, if you can't beat 'em, join 'em, and so then you're going to try to maximize their stability while they're using their heels. If that's the real world situation. You

know, not on paper, not oh, high heels are bad, orthopedic shoes are good, so we're going to say that's the care plan, that's not the reality. The reality is that the participant is wearing heels and so you really have to speak to that noncompliance and make an effort to, you know, optimize the participant's safety in spite of the noncompliance and document that.

Someone refuses to use an assistive device, and maybe they're at home and they're wall walking. And we're saying oh, that's not cool, you shouldn't wall walk, you should use your walker, use your cane. Well, if they're not doing it, then maybe you accept the fact that they're wall walking and just remove stuff that's, you know, patently unstable and try to just make the environment a little better.

Same thing with throw rugs. And let me just relate this while I'm on the subject of throw rugs. I was showering at the hotel this morning, and I think at some point, maybe when I was like shampooing my hair, someone must have entered the bathroom. I say this because when I was done I opened the – the curtain, and the shower mat, towel, the, you know, the towel on the floor, wasn't – it was no longer beside the tub, it was in the middle of the bathroom. And so I was faced with a choice getting out of the tub, and sure enough, I decided, well, I'm going to just reach with my foot very far out to try to connect with the shower towel – thing – the result of which was a split that would be the envy of any exotic dancer that you've ever seen. Actually just a joke, but – I mean the towel was in the middle of the thing, but I didn't actually do that. But, again, something like throw rugs, you know, I know in my own house when my mom was ill, she had all these throw rugs, and, you know, obviously, you know, you want to remove those to maximize safety, minimize environmental hazards, and she just wouldn't have it, so what do you do? So in this case we – we tried to Velcro them down, and, again, a lot of care planning is not so much dealing with compliance as much as noncompliance and then, you know, making the adaptations based on – on the reality of the situation.

I think Peggy mentioned earlier the importance of implementation being done timely. So many root cause analyses that I've been on the phone with back in – involve people who are, you know, in a new living environment, you know, whether it's assisted living or whatever, and, you know, they get up and they have no idea where they are, and they fall as a result. So maybe it would be a good idea for you to have a – an inventory of night lights in your buildings and make sure that those are furnished to your participants, you know, when – when they're going to a new place. I know myself, just last night, at one point I awoke and I was on the ledge outside my window 14 stories high, and it was pretty terrifying. So anyhow, that's pretty much it in terms of my part of it. I – again, I'm sorry about not having a PowerPoint, mostly because I had a nice visual pun for you, which is to say this was fall prevention, I was going to show you a picture of my daughters on the beach in Aruba, and I was going to say, well next up is winter prevention, but, alas, we'll just have to go with the description.

So, I'm done with mine. Oh, just two websites that you might look at would include the Centers for Disease Control, [cdc.gov](http://cdc.gov), and then you can navigate to fall prevention, or an organization called Fall Prevention Center for Excellence. The website is [stopfalls.org](http://stopfalls.org). Thank you.

Thanks, Dick. Thanks, everyone, for hanging in there to 4:00 on the last day. I got invited here to talk about non-evidenced based medicine and share my opinion, so it's a very rare event at a scientific meeting, but I have no data to share at this point in time about what we do with the falls, or post-fall analysis, but I was invited to share my – my thoughts. So soon we will have data to actually have some evidence based medicine.

What we do at Senior Life, I'm the medical director. We have five centers throughout the state, different counties, five separate fall teams. And through a lot of coaxing and encouraging, we're trying to shift some of the energy and the input from sort of fall risk assessment to, you know, what can we do to actually prevent a fall. So, you know, what I tell my teams is that I fully expect them to know ahead of time when Mrs. Smith is going to fall. And everyone looks at me like I'm crazy, but I think if you start with that premise, that's really the only way you're going to prevent the fall if you know ahead of time. So I think there are some things that we're missing in general, taking traditional medical approaches that we're – we're leaving a lot of things on the table.

So the way I look at falls, I look at it as a continuum of just the change in function, so delirium is just another form of fall. So all of, you know, a lot of – if you look at your hospitalizations, people go to the hospital because they're leaning to the left or they have a low-grade temperature or they have a UTI or supposed UTI. And that's, you know, blamed on a lot of these things. So what I'm suggesting is kind of a different way of looking at members, more in a functional light that all these things in my mind are kind of continuations of the same thing. So what I mean by function is we do a post-fall analysis and we're looking at things like the nurse goes out and looks in the ears. Why look in the ears? Well, we're looking for wax, we're looking for sinus congestion. We're training our nurses to interpret what a normal tympanic membrane looks like, what a bulging tympanic membrane looks like, and the theory is that these things contribute to falls. So a lot of this is based on my own clinical experience, so I'm trying to get data to actually show that this does make a difference.

Another big area that we're looking at is checking orthostatic blood pressures. I think a lot of us do that already. Looking at medicines. For the first year I was there, we were looking at medicines, we were looking at medicines, we were looking at medicines. You know. Nothing was – no one knew what to do about it, so polypharmacy I think is a huge issues. We have managed to lower our overall number of meds. I think we're down to an average of less than eight. I think we have a ways to go. Another thing that we're doing is post-fall analysis, actually calculating an anticholinergic load. So the theory there is that, you know, these anticholinergic meds contribute somehow to the central nervous system and a fall.

So those are the two things that we're looking at. We have the Pharm D actually review the meds after the second fall within 30 days. So it's kind of a follow up. A lot of the – a lot of the docs, a lot of the teams just don't know where to go. Or they – or it's sitting right there in front of them. When I'm – I'm looking at the meds, it's pretty apparent to me that somebody getting Ditropan and Aricept all in the same – the same course of treatment is like a prescription for disaster. I see that being used even – even in PACE programs. So it's a pretty good example. So we look at ears, we look at blood pressures, we look at blood sugars. We don't necessarily do a blood sugar on everybody. We do ask the question is this possibly related to low blood sugar, yes or no, leave it up to the nurse to decide do they need a, you know finger stick blood sugar or not. Most importantly, based – the basis of this talk really is the bowel and bladder assessment. It's my personal view that a lot of these declines in function, why Mrs. Smith fell today and not yesterday, has nothing to do with her chronic illnesses, it has more to do with her day-to-day functional milieu, if you will. She had wax in her ears? Well, she didn't fall yesterday, but she's congested today and now she can't – can't manage. Or that she's – has fecal loading, for lack of a better term. That is extremely common. And so Fred mentioned there's two types of geriatricians, there's the UTI docs and then there's the other docs. I'm the third type whose sort of obsessed with the bowels, that I do – I do think that this – we're leaving this on the table is just huge from a functional standpoint. When you're noticing a decline in your – in your residents, you know, you have to get used to doing a different assessment. So the assessment I do is actually just ask, you know, what is the

normal bowel pattern, bowel and bladder pattern of your – of your members. What I tell the nurses is that they're responsible for knowing, not only the bowel and bladder pattern, eating pattern, waking patterns. Just like if you had a two-year-old child, you would – you know their – their patterns. You know when they're getting sick, things change. So in order to prevent things, to know two days before they fall. I do think that in a lot of these cases, when I'm reviewing the case it's like, wow, how did we miss that? How did we miss it? It's right there in front of us. So, looking at patterns. So training your staff, from the van drivers, to the MEs, to the nurses, to actually when you're – when they're doing their assessments, to look at somebody from a functional standpoint. It's more important to ask the question, did you sleep last night, did you move your bowels, any change in your bladder pattern. That's way more important than, you know, bowel sounds, or pressing all four quadrants. You know, that – that doesn't lead to anywhere.

So, you know, there's this functional assessment we're trying to do. Also looking at post – post-void – there's the "P" sound – the post-void residuals, particularly in men. I would – I would argue that since we have 50% plus of incontinence in our members that, you know, everyone deserves at least one post-void residual at a workup of urinary incontinence. But, for men, any time that they're sick, or any time they're, you know, the typical somebody wants to get a urine – you, know, a urine culture, I think it's way more important, put your hands on the abdomen. Ask the question, you know, are you going once a day every day? So I get pushed back all the time. That's not practical, you know, 30 years I haven't gone like that. I'm just saying is to have a goal where everyone is going once a day every day, your members are going – that's the key to quality of life. These people are going to do better. You're going to keep them out of the hospital. You're going to prevent falls.

Okay. Same thing with, you know, look in the ears. Wax. Sinus congestion. These are treatable things. So people laugh at me but we have a – a thing we're trying to get installed that on Fridays we call it Ears and Rears Fridays. So – so you can imagine, yeah, selling that one. And – and – and really, the whole purpose here is, you know, our members fall at home. Typically on the weekend. Typically at night. Typically alone. So if there is any way that we can prevent something, it's going to be Friday. So if what I'm saying has any validity, there are small little things that we can do that will have a huge impact, and that's – that's kind of the general oversight of what we're – what we're trying to do.

I did think it was interesting to listen to the lawyer yesterday talk about how his job got started, and, you know, the failure of care. Four out of those seven examples I would relate to being full of stool, okay? Impacted feces. Excessive falls. Dehydration. Malnutrition. Residents lying in their own waste. I'm personally very frustrated at seeing our members go to the hospital. Everyone comes back with the same diagnosis, dehydration, UTI, right lower lobe pneumonia. Is anybody putting this together? Right lower lobe pneumonia? How do you get right lower lobe pneumonia? You aspirate. Why'd you aspirate? Whose asking that question? No one. Right? If you're – if you're full of stool, where's the food going? Okay. It goes into your right lower lobe. You're not eating? Why aren't you eating? You're dehydrating? Why are you dehydrating? This is so common, and no one's looking at it. Millions of dollars are being spent.

So, in my past life, you know, I've done a lot of hospice and nursing home care, so I know the sounds, you know, pretty bizarre for somebody to get up here and talk like this, but I – I – I took the hit on this one and I'm – I'm willing to stand up here and say this is a real problem. We are collecting data. For a short period of time we're going to try to get flat plates on probably the first hundred falls, and just see, okay, you know, is it 50% of these have, you know, this is a significant factor or not. I think that will be an interesting study. I did want to leave some time, we have a few minutes left for discussion, or

somebody to throw tomatoes or something, but anybody want – anything to add? Agree? Disagree? Barking up the wrong tree? Donna?

Thank you very much. I was just going to see what you thought about the – the woman incontinence, our issue is ladies running to the toilet, it's not really the mean running to the toilet, and the fact that they love their Ditropan because they don't run to the toilet as fast, so, you know, it's really a Catch 22 in trying to get people to stop the Ditropan, because that's where the accidents are happening. So, great question. What's a side effect of Ditropan? Dry mouth. Right? Dry mouth. Constipation. So what I see everyday – I'm not saying Ditropan's a bad drug – but what I – what I – what I try to tell the teams is if you're going to use this – these types of medicines, you have to quantify them. Right? I'm having five episodes of incontinence now, and, you know, if you're still at five, it's not working, right, you stop the medicine. That never happens. Why? Because no one starts with, like, you know - that's an easy one. What I would say for – the most important thing you can do for urinary incontinence is check the bowels. No question. You can vastly improve urinary incontinence by checking the bowels. Now what do I mean by that? My teams are always saying, oh, yeah, yeah, we asked them, they're moving their bowels. That's not what I'm talking about. I'm talking about actually developing a, you know, questions and a physical exam, and I'm telling my staff to get flat plat – do the physical exam and actually get a flat plate of the abdomen. Correlate your findings, your physical findings, with that x-ray. Now after about five of these x-rays, most people are experts. It's not, you know, it's not rocket science. It's like, you know, you're using this part of your hand to palpate the abdomen. You're not using your fingers. You're using this part of your hand, and you're rolling it over – it's just like, you know, you feel like you're making bread, you know, you can outline the colon. If you can outline the colon, you're in trouble, okay. Especially the ascending colon. So the theory is that in incontinence you have a closed space. Your bladder and your bowel are in the same space. If your bowel is full, what's going to happen to your bladder? It's either, you know, changing the neck, you know, your bladder drops. It's irritating the bladder. It's exacerbating the incontinence. So, I would say that, you know, the first step would be to – to do, you know, a good bowel assessment before you start these medicines, and realize that they can also, you know, worsen by their anticholinergic side effects as well.

Anybody else?

Well as part \INAUDIBLE\ we can certainly support, you know, what he's saying. And, again, I know the data isn't quite there yet, but, you know, as a team we're seeing that when these people are falling, and we're doing these assessments, and we're getting the flat plates, they, a high percentage of the time, they are, in fact, full of stool, for lack of a better word. So, you know, it is, I think, initially when he came to our team and had these thoughts and these, you know, we do – we do tease him. You know, we make jokes about it as well, but we've really seen that, you know, it is, in fact, you know, a major cause of what's happening, so, you know, we're just trying to get the buy in from our team so we can get, you know, the data collected and get what we need to – to really support what he's saying.

And – and if you go back just to the mission of what we do, right, we're – we're saying we're focusing on quality of life is what we do, right? Well, how do you define quality of life? Right? Has anybody actually – I ask the teams that all the time. And everyone's going on about autonomy and this and that, and \INAUDIBLE\ at the end of the day, good life to me is quality of life is I slept well last night. I had a good meal. And a few other physiological functions that everything's working, right? That's good quality of life. So, you know, I – I think we're, you know, this is really – I think this is, you know, basic, basic stuff that we're – you know, it's not in any textbook. You know, radiologists don't read stool on an x-ray, so,



you know, if you're going to do x-rays, get the film yourself. Look at it, right? It's not rocket science. So. And I think there was another question.

This is – it was – I thought it was a very refreshing discussion. So – and frank – so I have to say it's really appreciated. In our fall analysis, we've noticed that a lot of the falls were related to cardiovascular drugs and diseases, but then the prevalence is high, so – have you made that connection as well?

Yeah, I think it goes back to the sort of fall risk assessment. You know, all of our members are at high risk. You know why – I don't need a Tinetti score. All of our members have cardiovascular – so what I'm saying is, okay, why are they doing good nine days out of ten and on the tenth day they fall. Why did they fall today? Why did they have this event today? So I think if you ask that question, if you have cardiovascular disease that just means – no one likes this analogy, but I do. You know, the – this – you know, life is sort of like a path, it gets narrower and narrower, right. So you collect all these chronic illnesses, and by doing that, you know, your path just gets narrower and narrower, and it's harder to, you know, maintain your balance, right? So having cardiovascular disease is just, you know, it's another one of those things. What's going to make you – you know that path narrow acutely, right, you're going to fall. So what I'm saying, I'm looking for things that – that are reversible, okay, cause instead of just throwing up the hands, you know, what's going to make that cardiovascular disease state worse, that, you know, frail state? Some of these things. You know, if I get sinus congestion, I wouldn't be up here talking, right? I just couldn't do it. Let alone if I had, you know, the narrow path, I'd be down. So these are reversible things

Another thing that I think is rarer that – that I think is often missed is gallbladder disease. Not common, but, you know, presenting symptoms in our population, they're leaning to the left, not looking well, falls. Anybody else?

**\INAUDIBLE\** again. One final thought. Nobody mentioned Vitamin D. I think we'd be remiss if we didn't do it. There's hard evidence for that. We spent probably between five and \$10,000 to prove that there's a high prevalence of deficiency and insufficiency of Vitamin D and in our 220 PACE members – participants, I'm sorry – so basically we routinely give everybody 2,000 units a day, or 1,000, depending upon the physician's preference, and everybody we – everybody in our program now has a level to at least 30.

So we – thanks, Fred. Absolutely critical. I think that's low-hanging fruit, you know, Vitamin D. And how you treat that, you know, there's different ways. We – we use 50,000 units a month as our preferred drug.

Okay, so, the hope is that, you know, we're going to have – if anybody wants to help with a study doing this, we're going to collect data, so we'll have at least incidences of, right? We won't have proof that, you know, if we have, you know, 50% of these the x-ray shows this, I don't think you can call that proof, but I – I think if you just think about these things and you start to do them in your own practice, you will see, it's pretty remarkable how sick somebody can look and, you know, and all their problems. And just one more plug. Common thing. Chest x-ray. Everyone loves chest x-rays almost as much as they love getting urine cultures. You know, the most common thing you see in a chest x-ray is this bilateral lower lobe whatever, right? Infiltrate atelectasis. And my question to the team would be, well what – what gives you atelectasis? You know, what collapses your lower lungs? Anybody want to take a guess at that one? Right. Okay, simple, right? No one ever looks at it. And forget, if you go to the hospital, you

can get 59 CAT scans and everything else, no one's going to, you know, check your abdomen. So, that's all I have to say. Thanks, everybody.