Quick tips for the QMs: keys to success

Caralyn Davis, BA, Staff Writer

The quality measures (QMs) are an integral part of facility life, with the potential to influence survey and the public perception of facility quality (i.e., whether residents step foot in the door). In the near future, QMs also could be data drivers for pay-for-performance programs, as well as facility quality assurance and performance improvement (QAPI) plans. So providers need to understand their QMs and proactively address any issues that they identify. Here are some tips for doing that:

Learn the numerator criteria.

The QMs sometimes seem mysterious, but in fact CMS has provided a definitional roadmap via the measure specifications in the MDS 3.0 Quality Measures User’s Manual (v8.0). Providers have to take the time to sit down with the most current version of the manual, says Carol Hill, RN, MSN, RAC-Tag, C-NE, president of Hill Educational Services in Warrior, AL.

“Knowing where the measures actually come from will enable providers to analyze their measures so they can appropriately target quality improvement (QI) activities.”

While the MDS items that impact exclusions and covariates are important, “your first area of focus for MDS coding should be the criteria for the numerators,” she suggests. “The numerator is the core of each measure, but providers sometimes don’t understand what it entails.”

Understand what assessments are in play.

“Once providers understand what MDS criteria make up each measure, they need to learn which MDS assessments CMS looked at to identify whether those criteria were met,” says Hill. “With the MDS 2.0 QMs, only a few assessment types were reviewed, and residents typically dropped off the QM reports once six months had passed since they met the criteria. Now, a variety of different assessments are used for the measures.”

Finding the sweet spot: diabetes management in LTC

The prevalence of diabetes is increasing in America, including among older adults in long-term care facilities. As little as two years ago, almost 27% of nursing home residents fulfilled the diagnostic criteria for diabetes, most with type 2 (Travis, Buchanan, Wang, & Kim, 2004; Resnick, Heineman, Stone, & Shorr, 2004). That number has continued to climb, with recent estimates from the CDC showing a possible 165% increase in diabetes diagnosis by 2050 (Boyle et al., 2001).

Established treatment guidelines for the management of diabetes remain the same in LTC patients as in the general population; however, clinical priorities and strategies may need to be modified and glycemic goals should be balanced against quality of life. It’s important for caregivers to adopt a protocol-driven, team-based, individualized approach to care, because many patients in LTC facilities have diabetes-related complications and comorbidities that require individualized care plans and treatment strategies. Approximately 69% of LTC residents suffer from more than one chronic condition in addition to diabetes, including depression, delirium, vision loss, hypertension, kidney failure, or heart disease (Mayfield, Deb, & Potter, 1995).

The financial impact on society as well as on the individual is staggering. The American Diabetes Association (2013) estimates that in the United States alone, the total cost associated with diagnosed cases of diabetes is $176 billion, with an additional $69 billion in lost productivity. This brings the total cost to a $246 billion impact on the U.S. economy. With adjustments made for age and gender differences within the population, average medical expenses for persons with diabetes were 2.3 times higher than expenditures would be in the absence of diabetes. That’s not surprising when you consider that a hospital stay following a heart attack can cost $31,000; a year of dialysis can be $81,000; and amputation surgery (which diabetics are 15 times more likely to receive)
Further, some measures use what is called a look-back scan, which examines all assessments within the current episode. When QMs use a look-back scan, “some results could linger for up to 130 days for short-stay QMs and for close to a year for long-stay QMs,” says Hill. “For example, the long-stay QM Percent of Residents Experiencing One or More Falls with Major Injury (No13.01) uses a look-back scan. Consequently, a fall with major injury potentially can continue to show up on a facility’s QM reports many months after the incident occurred.”

Review Facility-Level QM Report weekly.

At a minimum, facilities should print the three QM reports used by traditional surveyors—the Facility Characteristics Report, the Facility-Level QM Report, and the Resident-Level QM Report—monthly as part of their QI activities, says Hill. Note: To learn how to access and interpret these and other reports, see Section 11, “MDS 3.0 QM Reports,” in the CASPER Reporting User’s Guide for MDS Providers.

However, since most facilities transmit weekly, the best practice is to print the Facility-Level QM Report weekly, suggests Hill. “The information on this report is updated weekly, usually on Mondays, so I encourage facilities to run the report every week to see how the previous week’s MDS submissions impacted it. This will limit surprises and ensure you address potential issues as close to real time as possible.”

Target MDS coding before QI.

Each QM is displayed as a facility percentage and as state and national percentile comparison ratings. QMs will flag for traditional surveyors when a facility is at or above the national 75th percentile. “When you have high measures, it’s easy to become overwhelmed thinking ‘Where do I start?’” notes Hill.

However, MDS coding is always the place to start, says Hill. “You have to audit to determine if your MDS coding for the high measure is accurate. If your MDS coding is accurate, then you can examine facility systems related to that QM and institute or adjust QI as appropriate.”

Start with the Five Star QMs.

The Five Star QM ratings on Nursing Home Compare get a lot of public attention, but sometimes providers aren’t up to speed on them, says Sarah Riggin, RN, C-NE, RAC-MT, an MDS nurse consultant with Forth Smith, AR-based Nursing Consultants. “Some facilities aren’t even checking their Five Star ratings, and they don’t realize that, just as the QM calculations have changed, the way the Five Star ratings are calculated has changed since the transition to MDS 3.0.”

The Five Star QM ratings are based on nine of the 18 QMs publicly reported on Nursing Home Compare. These include seven long-stay measures and two short-stay measures. Providers can learn exactly how the ratings are calculated by reviewing the July 2012 Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users’ Guide.

Providers can get an advance look at their Five Star ratings by accessing the Five Star provider preview reports, which are typically generated in CASPER on the third Thursday of each month. Notices about the preview reports and details about the availability of the Five Star help line are posted in CASPER and on the QIES Technical Support Office Nursing Home Provider Information page. The QMs on Nursing Home Compare are then updated quarterly. (Note: Due to the federal government shutdown, the October quarterly update will occur in November.) CMS has created a step-by-step instruction guide to help providers access their data on Nursing Home Compare, as well as their provider preview reports.

The Five Star QM rating “is such an easy way to grade yourself that it’s a great starting point for facilities to get a handle on their QMs,” says Riggin. “When my team enters a facility, we like to gain some momentum by starting with the Five Star QMs where we can make an immediate impact. Then we’ll work our way backward to the other QMs.”

Review the Missing Assessment report routinely.

While many providers spent the summer perusing their Missing Assessment reports to help clean up missing discharge assessments by Sept. 30 as mandated by S&C memo S&C-13-56, “it’s important to continue to review this report going forward to ensure that the QMs are a clear reflection of the facility’s patients,” says Riggin. “Most facilities transmit weekly now, so we encourage them to run the Missing Assessment report preferably weekly but at least monthly.”

Often providers don’t understand that submitting assessments out of sequence can result in missing assessments, says Riggin. Here’s an example: A facility can result in missing assessments, says Riggin. Here’s an example: A facility doesn’t combine a discharge assessment and a 5-day PPS MDS but uses the same assessment reference date for both assessments. The MDS nurse completes the discharge MDS and submits it. However, the MDS nurse was waiting for some information for the 5-day MDS, so she completes and submits the 5-day MDS after the discharge assessment.

“In this type of situation, you will have a missing discharge assessment because your assessments are out of sequence.”

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Pay attention to the antipsychotic QMs.

The National Partnership to Improve Dementia Care is still working to reach its past-due national goal of reducing antipsychotic drug use in long-stay nursing home residents by 15 percent. While CMS announced this summer that at least 11 states have already met or exceeded the 15 percent target, nationally antipsychotic drug use among long-stay residents has dropped only 9.1 percent, according to first-quarter 2013 data.

Consequently, it’s no surprise that the measure Percent of Long-Stay Residents Who Received an Antipsychotic Medication (N031.02), as well as measure Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication (N011.01), is receiving a lot of attention right now, says Riggin. “We have facilities in three states, and the physicians we work with are targeting the antipsychotic QMs because they are getting pushback from physician organizations and CMS. In addition, surveyors in our states also are gearing up for a big push to survey facilities that haven’t achieved any meaningful reductions toward the target. So the antipsychotic QMs are a big focus for us right now—and should be for all providers.”

There is no quick fix for reducing antipsychotic drug use, notes Riggin. “Often, providers try to get a simple doctor’s diagnosis of schizophrenia, Tourette’s syndrome, or Huntington’s disease so that patients will be excluded from the long-stay QM. While you do want to make sure you have accurate diagnoses so that residents are appropriately excluded, the practice of readjusting diagnoses alone isn’t going to fix the underlying problem. You have to drill down to what the real problem is and look at the root cause: Why are they on this medication? Is there a better solution? And if there isn’t, you need to have documentation of the process you used to determine that.”

Need help setting up systems for antipsychotic drug use? Review the advance copy of the surveyor interpretive guidance on dementia care and antipsychotic drug reduction in survey and-certification memo 13-NH, which updated Appendix PP of the State Operations Manual at F309 (quality of care) and F329 (unnecessary drugs). Another option is to view three CMS-produced surveyor training videos focused on dementia care and the reduction of antipsychotic medication use or to visit the Dementia Care page at Advancing Excellence in America’s Nursing Homes.

CASPERS reports help you navigate the QMs

Section 11, “MDS 3.0 QM Reports,” of the CASPER Reporting User’s Guide for MDS Providers gives providers insights into how to access and interpret four CASPER reports that can help them understand their quality measures (QMs) and drive related quality improvement activities. Here are some excerpted report descriptions:

• The MDS 3.0 Facility Characteristics Report identifies potential areas for further emphasis or review as part of a survey or a facility’s quality assurance and improvement processes. It provides facility demographic information and includes comparison state and national percentages for a specified timeframe. By comparing the facility percentages with the state numerators and denominators, you can determine whether the facility’s demographic characteristics differ from the norm.

• For each QM, the MDS 3.0 Facility Level Quality Measure Report shows the facility percentage and how the facility compares with other facilities in their state and in the nation. This report helps facilities identify possible areas for further emphasis in facility quality improvement activities or investigation during the survey process.

The MDS 3.0 Facility Level Quality Measure Report displays QM

The practice of readjusting diagnoses alone isn’t going to fix the underlying problem...Is there a better solution?
can be $40,000. These costs can often be avoided with proper detection and interventions that include diet, activity, or medications and that carry a significantly lower price tag.

Nursing facility staff are responsible for providing quality medical management for their diabetic residents, regardless of which type of diabetes they have. Last year in one three-month period, 16 skilled nursing facilities were cited at the immediate jeopardy level for failure to adequately monitor and manage their residents’ diabetes. Four of these residents died. Numerous other facilities were cited at lower levels for errors in diabetes management. Diabetes-related issues identified by state surveyors conducting chart review resulted in citations under a variety of categories. The following most commonly identified areas include examples:

• **Missed blood glucose monitoring.** A resident’s admission orders were entered incorrectly into the electronic record, and he missed receiving 44 blood glucose checks over a period of 12 days. He was transferred to the emergency room with ketoacidosis and a blood sugar of 1719. The 24-hour chart checks designed to confirm that the admission orders were correctly entered had not been done.

• **Blood sugar checked too soon before administration of insulin.** A resident’s blood glucose level was checked for sliding-scale insulin 1.25 hours before administration.

• **Administration of incorrect units of insulin.** Review of the medication administration records for several residents who received sliding-scale insulin revealed the following errors: Resident #1 received 6 units instead of 4, Resident #2 received 10 units instead of the ordered 8 units, and Resident #3 received 2 units when she should not have received any.

• **Insulin administered to wrong resident.** A non-diabetic resident became lethargic and could not eat his breakfast. When CNAs could not arouse him for care, a glucose check revealed a blood sugar of 40. Upon transfer to the hospital, his blood-sugar level was 26. Lab tests suggested insulin administration had occurred.

• **Missed doses of insulin.** During med pass observation at 5 p.m., a resident’s blood sugar registered >500 on the glucometer. The nurse administered 12 units of regular insulin per the sliding scale, but failed to administer the ordered 20 units of long-acting insulin. The resident stated he had not received his morning long-acting insulin either.

• **Insulin administered to residents with no intake.** A new admission with diabetes had standing orders for insulin twice daily and for tube feedings as his only source of nourishment. The insulin was begun on the day of admission. The tube feeding was not started until the formula arrived late on the second day.

• **Physician not notified.** A physician was not notified of a resident’s glucometer results that consistently ran above the range of the insulin coverage.

• **Lack of proper cleaning of glucometers between residents.** Between multiple resident uses the glucometer was wiped with an alcohol wipe, not cleaned with an appropriate solution per manufacturer instructions.

This review of common diabetes management challenges and pitfalls is presented to highlight areas for quality improvement monitoring. It is critical that nursing personnel obtain the latest information about diabetes and apply that knowledge to competently meet their diabetic residents’ needs.

In observance of National Diabetes Awareness Month, we invite you to visit www.aanac.org to view our new Diabetes Solution Page, a one-stop shop for articles and information, podcasts and videos, and interactive tools and resources from a variety of partners, including the Centers for Disease Control and Prevention, the American Diabetes Association, and others. An infographic outlining the severity and scope of diabetes in America and in long-term care is also available this month for you to download and share with friends and colleagues.

In addition, we invite you to join editor in chief of DiabetesInControl.com, David Joffe, BSPharm, CDE, FACA, for a one-hour webinar that identifies and explores the institutional, staff, resident, and medication-related factors that contribute to the complexity of delivering diabetes care in LTC. AANAC members pay only $39 for this critical clinical information, supported by an unrestricted education grant from Avanir Pharmaceuticals.

**REFERENCES**


DEAR AANAC MEMBERS:

On behalf of the Board of Directors, I want to thank everyone who participated in our nominating process. Our nominees represent the best and brightest in terms of knowledge, skills and commitment to the issues that affect long-term care. Because the candidates were so well qualified, selecting among them was a daunting task.

The Nominations Committee reviewed everyone who was nominated to identify those with the knowledge, experience and skills to fill a Board position. After this initial screening, candidates were interviewed and evaluated according to the criteria established by the Board to strengthen the Board of Directors. As a result of these deliberations, the top nominees were recommended by the Nominations Committee to the Board of Directors for approval. The Board of Directors is pleased to announce the following slate of candidates for your consideration:

**Susan Duong, BSN, RN, PHN, NHA, RAC-CT, C-NE**
RAI Director
Cedar Crest Nursing and Rehabilitation Center
Santa Clara, CA

**Gail Harris, RN, BSN, RAC-CT, C-NE**
Regional Nurse Consultant
Preferred Care Partners Management Group
Valley Mills, TX

Following your review of the slate, if no alternative candidates are put forth through a petition process, these candidates will be approved and seated on July 1, 2014. If you wish to nominate an alternate candidate by petition, the process is as follows: you may nominate a candidate by petition of 2.5% of the membership (367 members); should you wish to engage in this process, the petition must be submitted to the AANAC office by January 7, 2014. If you have questions about this process, do not hesitate to contact me at rminnema@aanac.org.

Sincerely,

*Ruth Minnema, RN, MA, C-NE, RAC-CT*
Chair, Board of Directors
Q + A

Is being impatient with a resident abuse?
During our yearly abuse in-service this question came up: If you do an abuse allegation investigation for a complaint such as a staff being impatient with the resident due to being slow to complete a task, giving meds in hot cereal instead of pudding, complaining about staffing in front of the patient, etc., and “willful” abuse or neglect cannot be substantiated but the staff’s conduct was improper, what would the disciplinary action be? Is this grounds for termination as far as CMS is concerned or would other disciplinary action be appropriate?

Your facility must be able to demonstrate its actions met the requirement of regulations in protecting all residents.

F323 Abuse defines verbal abuse as “the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families within their hearing distance, regardless of their age, ability to comprehend, or disability.” Mental abuse includes humiliation. Was a resident humiliated or subjected to disparaging or derogatory language during these events? If so, verbal or mental abuse may have occurred.

F326 Staff Treatment of Residents requires that certain components be included in the facility’s policies and procedures. They follow, with comments about your concerns:

1. SCREENING Was the employee screened properly when hired? Review the personnel record to verify this. If concerns are identified, address them. If there is evidence of a systemic problem with screenings, this is the time to make corrections.

2. TRAINING It is great that your annual training brought about discussion of these concerns, but were they initially reported in a timely manner and acted upon then? Is there proof upon hire and annually that this employee received training and demonstrated understanding? Does new employee orientation include adequate training about abuse/neglect/mistreatment? If someone is not exhibiting the expected behavior, is the person reeducated at that time? Are there mechanisms in place to ensure that absolutely every employee receives abuse prevention, identification, and reporting education? Have families, residents, and staff been provided information on how to report concerns? If any of the answers are “No,” they should be corrected.

3. PREVENTION This component of F326 asks if supervision is provided to “identify inappropriate behaviors, such as using derogatory language, rough handling, and ignoring residents while providing care....” There is also an expectation for assessment, care planning, and monitoring of resident with needs and behaviors which might lead to conflict or neglect, so care plan updates may be needed and communicated to appropriate staff.

4. IDENTIFICATION Did staff understand their responsibility to identify and report their observations immediately? If not, provide additional training for them.

5. INVESTIGATION Was your investigation thorough? Were the incidents reported to the administrator in a timely manner? If not, create an improvement plan.

6. PROTECTION During the investigation, how were all residents protected from this individual to ensure the problem behaviors were not repeated? If nothing was done, develop a plan for next time and educate the team about it.

7. REPORTING/RESPONSE In your discussion you state that the investigation did not substantiate a finding of abuse, so you would not need to report it; however, the facility still has responsibility to respond to the behaviors of the individual with education, or with education combined with documented discipline depending on the details of the employee’s actions and performance history. Periodic reevaluation of the individual’s behavior and performance is a must to prevent recurrence. The behavior must be addressed, because it may rise to the level of abuse next time if left unchecked. Your facility must be able to demonstrate its actions met the requirement of regulations in protecting all residents. As follow-up to your investigation, document the additional actions you are taking to ensure your facility is totally in compliance with these regulatory requirements. Use your facility disciplinary protocols to guide the decision of whether this employee should be terminated or retained with clear expectations for improvement and a plan for monitoring.

Betty Frandsen, RN, NHA, MHA, C-NE
(bfrandsen@aanac.org)

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Please help me with this ADL coding dilemma?

After reading the newsletter that was posted yesterday on AANAC homepage I am still confused regarding the steps for coding based on the article,” ADL algorithm takes back seat” and the question on page 4 regarding ADL coding dilemma. The scenario from the question states that total assist occurred 4 times and limited assist occurred 6 times. Based on the article on page 1, I would code limited assist since this meets the requirement of Step 1. I do not understand how the question on page 4 states the correct coding would be extensive. Any clarification would be helpful. Thanks.

What needs to be considered here is both the definition of the rules of three AND the definition of extensive assist.

On Page G-4 of the RAI manual

Code 3, extensive assistance: if resident performed part of the activity over the last 7 days and help of the following type(s) was provided three or more times:

• Weight-bearing support provided three or more times OR
• Full staff performance of activity three or more times during part but not all of the last 7 days.

I have italicized the item that causes the scenario in the LTC leader to be extensive. Total assist is full staff performance this occurred four times in the LTC leader scenario but not all of the times therefore the correct coding is extensive. This meets the second rule of three.

Jennifer LaBay, RN, RAC-MT, (jlabay@hcldri.com)

The main purpose of the new rule for hospitals is that they are to make a determination about admission status sooner than they potentially have been. The goal is to reduce the number of observation days and lengthy stays where the resident is not admitted.

If a resident has three midnights in the hospital in any combination of observation and admitted status, can we cover them on Medicare?

I was asked today about a new rule that became effective for the hospitals starting in Oct. If a resident was in the hospital on observation for 2 days and then admitted for 1 day the resident qualifies for med A. Is this correct? I had heard some talk about it some months ago but nothing since.

The main purpose of the new rule for hospitals is that they are to make a determination about admission status sooner than they potentially have been. The goal is to reduce the number of observation days and lengthy stays where the resident is not admitted. Unfortunately, the new hospital rule does not impact the rules for Skilled Nursing Facilities related to the 3-Day qualifying stay. We still have to make sure that the resident had 3 qualifying consecutive inpatient midnights in the hospital before that technical requirement is met to access the Medicare A benefit (Managed Care can waive this requirement).

Judi Kulus, NHA, RN, MAT, RAC-MT, C-NE (jkulus@aanac.org)

Our nursing home is under new ownership. Do we have to do all new admission and Medicare assessments over again?

My facility is being sold. Just found out we are getting a new NPI number. Does this fact alone mean that we have to complete discharge assessments, then an entry followed by an admission assessment? Does it also mean all PPS assessment schedules start over? My building is one of 15 sold from the same corporation. Eleven of us are getting new NPI numbers.

This is from page 2-5 of the RAI Manual. If you are getting a new provider number, the new owner is not assuming the assets and liabilities of the previous owner. That means you will need to be re-certified as a new facility by the state survey agency. Please confirm all this with your corporate folks before you go to all this work (in my experience the water gets pretty muddy in cases like this), but if it is true that you are getting a new provider number, then what is listed below is how to proceed.

The previous owner would complete a Discharge assessment—return not anticipated, thus code A0310F=10, A2000= date of ownership change, and A2100=02 for those residents who will remain in the facility.

• The new owner would complete an Admission assessment and Entry tracking record for all residents, thus code A0310F=01, A1600= date of ownership change, A1700=1 (admission), and A1800=02.

• Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See information above regarding newly certified nursing homes.

Judy Wilhide Brandt, RN, C-NE, RAC-MT (judy.wilhide@judywilhide.com)
The population of the United States continues to age. According to the Administration on Aging (2011), the number of older adults over the age of 65 was 39.6 million in 2009. This figure represents 12.9% of the United States population. This number is expected to grow, especially with the aging of the baby boomers, the largest segment of the population world-wide. By the year 2030 the older adult (those over the age of 65) population is expected to reach 72.1 million or 19% of the United States population.

The aging population requires nurses to be educated in Geriatrics in order to provide evidence-based care to the aging population. The ability to care for an aging population requires nurses to be educated in the care of the older adult in a variety of settings including acute care, long term care, and home care. Health care curriculums are anticipated to include basic geriatric information as part of required curriculum. However, the need for specialized education in Geriatrics will climb with the aging of the population, especially given that most health care workers care for older adults across the health care continuum.

Healthcare curriculums are anticipated to include basic geriatric information as part of required curriculum. However, the need for specialized education in Geriatrics will climb with the aging of the population, especially given that most health care workers care for older adults across the health care continuum. There will be a greater need for specialized geriatric curriculum, continuing education programs in geriatrics, and specialized programs in geriatrics as well as specialized credentialing (Center for Health Workforce Studies, 2006). The Joint Commission (2010) has called for reform including the need for nurses to become better educated to meet the needs of the aging population.

The National Gerontological Nursing Association (NGNA, 2012) recommends that all registered nurses be required to take continuing education in geriatrics for licensing. According to the NGNA, nurses who received specialized education in geriatrics provide improved care to older adults. This is essential given that the care of older adults “represents 50% of hospital days, 60% of all ambulatory adult primary care visits, 70% of home care visits, and 85% of skilled care facilities residents” (p. 2). This specialized training is essential for the registered nurse in order to understand and recognize the physiological, psychological and cognitive, sociological, and unusual elements associated with the aging process. This training is also in keeping with the expectations and goals of the Patient Protection and Affordable Care Act to improve the health care for all Americans.

Based on these trends, Regis University has responded with a Gerontology Certificate Program to meet the educational needs of Registered Nurses across the United States with a minimum of an Associate Degree in Nursing. The Gerontology Certificate Program will begin online in January, 2014, and will focus on the older adult and the issues associated with this aging population. This certificate will build a foundation of understanding of normal changes in aging as well as changes that are not normal. Health promotion and the development of a therapeutic relationships will also be essential. With the increase in chronic disease and illness, this certificate program will place an emphasis on acute and chronic disease management. Emphasis will also be placed on patient advocacy and management across the aging population continuum of care.

The course content for the four courses is based on the following criteria:

- Course content is based on the American Association of Colleges of Nursing (2008) basic Geriatric education in The Essentials of Baccalaureate Education for Professional Nursing Practice.
- Course content is based on the American Association of College of Nursing (2010) Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults.

This training is also in keeping with the expectations and goals of the Patient Protection and Affordable Care Act to improve the health care for all Americans.

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