Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02996-84

Combined Assessment Program Review of the Northern Arizona VA Health Care System Prescott, Arizona

February 10, 2011

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CT	computed tomography
ED	emergency department
EOC	environment of care
facility	Northern Arizona VA Health Care System
FTE	full-time employee equivalents
FY	fiscal year
ISO	information security officer
JC	Joint Commission
MDRO	multidrug-resistant organisms
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
QM	quality management
SOPs	standard operating procedures
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Northern Arizona VA Health Care System, Prescott, AZ

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of November 29, 2010.

Review Results: The review covered six activities. We made no recommendations in the following activity:

- Physician Credentialing and Privileging

Recommendations: We made recommendations in the following five activities:

Quality Management: Strengthen processes to ensure that the review of the major organ systems is completed prior to sedation.

Environment of Care: Ensure that only sharps items are disposed of in sharps containers. Complete and document annual N95 respirator fit testing.

Coordination of Care: Ensure that staff document advance care planning discussion using approved progress note titles and that written discharge instructions address the patient's activity level.

Management of Test Results: Ensure diagnostic clinicians consistently document the time and the means by which critical test results are communicated to ordering providers. Require ordering providers to document patient notification and treatment actions in response to critical results. Periodically monitor the process of communicating pathology test results to providers and patients.

Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to patients infected or colonized with multidrug-resistant organisms and their families and document it.

Comments

The Veterans Integrated Service Network and Interim Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through November 29, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Northern Arizona VA Health Care System, Prescott, Arizona,* Report No. 08-02986-67,

February 5, 2009). The facility had corrected all prior findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 326 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results

Review Activities With Recommendations

QM

The purpose of this review was to determine whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following area that needed improvement.

Moderate Sedation. VHA requires that a pre-sedation assessment, which includes a review of the major organ systems, is performed prior to administration of moderate sedation.[1] We reviewed the medical records of 10 patients who underwent moderate sedation and found that 3 (30 percent) had no documented evidence of pre-sedation assessments of the heart and lungs.

Recommendation

1. We recommended that processes be strengthened to ensure that the review of the major organ systems is completed prior to sedation.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the medical (4A), intensive care (4B), and CLC inpatient units; the domiciliary; the outpatient surgery (2A) and endoscopy suites; the laboratory and imaging

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

departments (CT scan, general radiology, nuclear medicine, and ultrasound); the primary care and dental clinics; and the ED. The facility maintained a generally clean and safe environment. In the CLC-1 unit, we found two expired multi-dose medication vials. Managers immediately removed the expired medications. Therefore, we did not make a recommendation for this finding. However, we identified the following conditions that needed improvement.

Waste Disposal. Local policies and state regulations define infectious (bio-hazardous) waste and sharps waste. According to recent facility guidelines on disposal of bio-hazardous waste, due to the high cost of sharps waste disposal, only certain medical sharps items (for example, contaminated needles, syringes, and scalpel blades) are to be disposed of in sharps containers. We found that sharps containers in several locations (2A, 4A, 4B, the primary care clinic, and radiology) contained non-medical sharps waste (such as urinals, empty intravenous bottles, and paper wrappers). These items should have been disposed of as regular waste.

N95 Respirator Fit Testing. For facilities using N95 respirators, OSHA standards require designated staff to be fit tested and trained annually for respirator use. We reviewed 32 designated employees' training records and determined that 7 (22 percent) employees had not received the required annual fit testing.

Recommendations

2. We recommended that only sharps items be disposed of in sharps containers.

3. We recommended that annual N95 respirator fit testing be completed and documented.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We found a consistent notification and screening process for advance directives. However, we noted that local policy did not identify the staff responsible for notifying and screening patients for advance directives. While we were onsite, managers agreed to update the local policy. Therefore, we did not make a recommendation for

this finding. We identified the following areas that needed improvement.

Advance Care Planning Progress Note Titles. VHA requires that staff use specific progress note titles when documenting advance care planning discussions with patients.[2] We reviewed advance care planning documentation for 10 patients and determined that the facility did not use the required progress note titles in any of the medical records.

Discharge Instructions. VHA requires the facility to provide discharge instructions to patients regarding medications, diet, activity level, and follow-up appointments.[3] We reviewed documentation for 10 discharged patients and found that only 7 (70 percent) of the medical records addressed activity levels in the discharge instructions.

Recommendations

4. We recommended that staff document patient advance care planning discussions using approved progress note titles.

5. We recommended that discharge instructions address the patient's activity level.

Management of Test Results

The purpose of this review was to follow up on a previous evaluation that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[4]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following areas that needed improvement.

Documentation of Ordering Provider Notification. VHA requires that diagnostic (laboratory, radiology, and pathology) clinicians document in the medical record the time and means or method of critical test result communication and the name of the ordering provider contacted.[5] We reviewed the medical records of 29 patients who had critical results. We found that diagnostic clinicians documented the time the ordering provider was notified in

[2] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[4] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.
[5] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

only 20 (69 percent) records and the means of communication in only 15 (52 percent) records.

Documentation of Treatment Actions. VHA requires ordering providers to document in the medical record patient notification and treatment actions in response to critical test results.[6] We reviewed the medical records of 29 patients who had critical results and found documented evidence of patient notification and follow-up actions in only 25 (86 percent) of the records.

Monitoring Results Communication. VHA requires facilities to monitor the effectiveness of communication of results to providers and patients.[7] We determined that radiology and the laboratory had established effective processes for monitoring communication of radiology and laboratory results to ordering providers. However, we did not find a similar process in anatomic pathology. Also, we did not find evidence that communication of pathology test results to patients was periodically monitored.

Recommendations

6. We recommended that diagnostic clinicians consistently document the time of notification and the means by which critical results were communicated to ordering providers.

7. We recommended that ordering providers document patient notification and treatment actions in response to critical results.

8. We recommended that the process of communicating pathology test results to providers and patients be monitored periodically for effectiveness.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected the medicine and CLC inpatient units and interviewed three employees. We identified no deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

[6] VHA Directive 2009-019.
[7] VHA Directive 2009-019.

Patient/Family Education. The JC requires that patients infected or colonized[8] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of personal protective equipment. We reviewed 10 medical records and found that 6 (60 percent) of the records did not have documented evidence of MDRO education.

Recommendation

9. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and that the education be documented.

Review Activity Without Recommendations

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

Comments

The VISN and Interim Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 11–17, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

[8] Colonization is the presence of bacteria in the body without causing clinical infection.

Facility Profile[9]		
Type of Organization	Primary and secondary health care system	
Complexity Level	3	
VISN	18	
CBOCs	Anthem, AZ Cottonwood, AZ Bellemont, AZ Kingman, AZ Lake Havasu, AZ	
Veteran Population in Catchment Area	66,900	
Type and Number of Total Operating Beds: • **Hospital**	25	
• **CLC/Nursing Home Care Unit**	85	
• **Domiciliary**	120	
Medical School Affiliation(s)	Western Medical, Phoenix, AZ	
• **Number of Residents**	2	
	FY 2010 (through July 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$136.6	$129.9
Total Medical Care FTE	855.4	828.2
Workload:		
• **Number of Station Level Unique Patients**	23,263	23,837
• **Inpatient Days of Care:**		
o **Acute Care**	6,507	8,226
o **CLC/Nursing Home Care Unit**	22,180	24,864
o **Domiciliary**	30,895	37,071
Hospital Discharges		
o **Acute Care**	1,387	1,593
o **CLC/Nursing Home Care Unit**	24	296
o **Domiciliary**	321	382
Total Average Daily Census (including all bed types)	196.0	192.2
Cumulative Occupancy Rate (including all bed types)	85.4%	85.2%
Outpatient Visits	232,971	259,025

[9] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
Medication Management			
1. Track open action items until resolved.	Tracking system for open items was developed and implemented.	Y	N
2. Consistently include QM/performance improvement data in provider profiles for consideration at reprivileging.	Ongoing Professional Practice Evaluation plans have been developed and implemented and maintained in provider profiles for reprivileging.	Y	N
EOC			
3. Ensure the ISO participates in EOC rounds.	ISO attendance is tracked.	Y	N
4. Display suicide prevention posters and brochures in highly visible areas.	Suicide prevention posters and brochures are posted throughout the facility.	Y	N
5. Properly maintain storage areas, and secure sharp instruments.	Supplies, including sharp instruments, are in locked storage areas.	Y	N
6. Conduct more frequent ED EOC rounds, and address identified deficiencies.	EOC checklists have been developed for the ED, routine inspections are conducted by ED staff, and any deficiencies are corrected.	Y	N

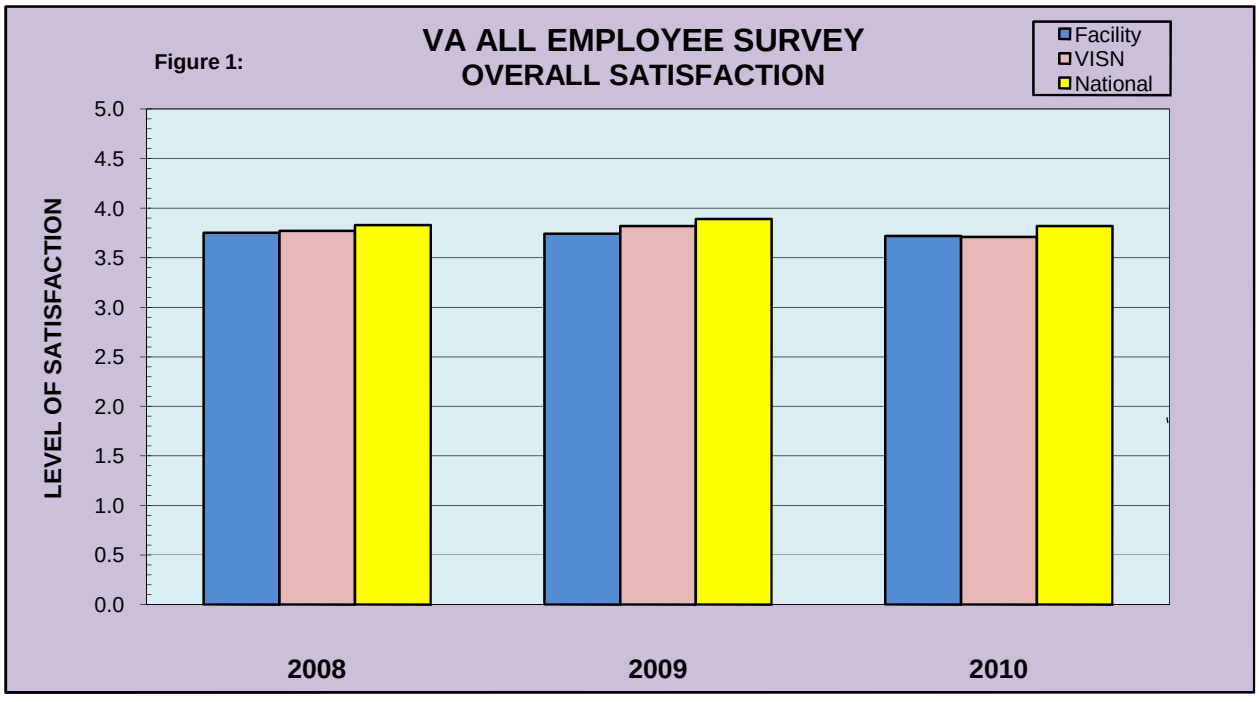
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 1	Inpatient Score Quarter 1	Inpatient Score Quarter 1	Inpatient Score Quarter 1	Inpatient Score Quarter 1
Facility	61.8	69.8	72.2	48.3	56.6	50.9
VISN	65.0	63.3	64.2	52.2	52.7	53.1
VHA	63.3	63.9	64.5	54.7	55.2	54.8

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[10] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	12.14	12.94	14.96	0	20.2	15.4
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[10] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 24, 2011

From: Director, VISN 18 (10N18)

Subject: **CAP Review of the Northern Arizona VA Health Care System, Prescott, AZ**

To: Director, Los Angeles Healthcare Inspections Division (54LA)

Director, Management Review Service (VHA CO 10B5 Staff)

1. I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program Review of the Northern Arizona VA Health Care System (NAVAHCS).

2. If you have additional questions or concerns, please contact Sally Compton, VISN 18 Executive Assistant to the Network Director, at (602) 222-2699.

(original signed by:)
Susan P. Bowers

Interim Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 21, 2011

From: Interim Director, Northern Arizona VA Health Care System (649/00)

Subject: **CAP Review of the Northern Arizona VA Health Care System, Prescott, AZ**

To: Director, Los Angeles Healthcare Inspections Division (54LA)

Network Director, VISN 18 (10N18)

1. I have reviewed and concur with the findings and recommendations in the draft report of the Office of the Inspector General Combined Assessment Program Review conducted the week of November 29, 2010.

2. Corrective action plans have been established with target completion dates, as detailed in the attached report.

(original signed by:)
Wendy J. Hepker, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the review of the major organ systems is completed prior to sedation.

Concur.

Target date for completion: February 1, 2011

Planned Action: To ensure completion of pre-sedation assessments and review of the major organ systems prior to sedation, the following actions are being taken. A Standard Operating Procedure, *History and Physical Examinations for Patients Receiving an Invasive Procedure*, has been completed and reviewed with clinicians performing invasive procedures with moderate sedation. A CPRS template, Pre-Moderate Sedation Note, has been developed to include all required pre-sedation assessment elements. The Invasive Procedure Committee will add the required pre-sedation elements to the data collection and tracking process and a sample of 10 records/month or 100% if the number of procedures is less than 10/month will be reviewed until a benchmark of 90% is achieved. After three months of achieving the benchmark, review of the pre-sedation elements will continue quarterly for one year. The Invasive Procedures Committee will report the outliers and action plan to the Medical Executive Board.

Recommendation 2. We recommended that only sharps items be disposed of in sharps containers.

Concur.

Target date for completion: March 15, 2011

Planned Action: To ensure staff knowledge and compliance with appropriate use of sharps containers, the following actions are being taken. A reference listing of items that are appropriate for sharps containers will be created and distributed. Assessment of compliance with appropriate use of sharps containers will be completed and documented during Environment of Care (EOC) Rounds. Findings will be reported to the EOC Board monthly until a benchmark of 90% is achieved for each unit. Once a unit achieves the benchmark, quarterly assessments will be performed.

Recommendation 3. We recommended that annual N95 respirator fit testing be completed and documented.

Concur.

Target date for completion: March 1, 2011

Planned Action: To ensure the completion and documentation of annual N95 fit testing and training for designated staff, the following actions are being taken. A listing of employees with overdue fit testing was distributed to their supervisors on January 12 and 13, 2011. A weekly audit of overdue fit testing will be performed by the Employee Health Practitioner beginning January 24, 2011 with monthly reporting to the EOC Board until a benchmark of 100% is achieved. Once benchmark is achieved, monthly audits will be performed for three months and if benchmarks continue to be maintained, audit frequency will be reduced to quarterly. A listing of employees due for fit testing will be distributed to Service Line Managers at the first of each month. An addendum to Health Care System Memorandum 138-39, *Respirator Program for Employees*, will be published defining clear expectations for compliance with fit testing and consequences of not completing fit testing, as required.

Recommendation 4. We recommended that staff document patient advance care planning discussions using approved progress note titles.

Concur.

Target date for completion: March 31, 2011

Planned Action: To ensure compliance with the use of approved progress note titles when documenting patient advance care planning discussions, the following actions are being taken. The Computerized Patient Record System (CPRS) documentation tools were updated to reflect the requirements of VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*. CPRS note titles have been amended and will be communicated to appropriate staff and training scheduled to be completed and fully implemented by Social Work, Acute Care Nursing, and Geriatric and Extended Care (GEC) Nursing by February 28, 2011. This documentation element will be added to monthly chart audits conducted by Acute Care and GEC Service Line Managers using a sample of 10 records/month or 100% if the number of admissions is less than 10/month for each Service Line. The data will be reported monthly to the Medical Records Committee and the Quality and Performance Board until a benchmark of 90% is achieved. After three months of achieving the benchmark, review and reporting of the data will continue quarterly for one year.

Recommendation 5. We recommended that discharge instructions address the patient's activity level.

Concur.

Target date for completion: March 31, 2011

Planned Action: To ensure patient discharge instructions include the patient's activity level, the following actions are being taken. Activity level instructions were added to the Nursing Discharge Note CPRS template and will be communicated to appropriate staff and training scheduled to be completed and fully implemented by Acute Care Nursing and GEC Nursing staff at discharge by January 31, 2011. This documentation element will be added to monthly chart audits conducted by Acute Care and GEC Service Line Managers using a sample of 10 records/month or 100% if the number of discharges is less than 10/month for each Service Line. After three months of achieving a 90% benchmark, review and reporting of documentation of patient activity level as an element of discharge instructions will continue quarterly for one year. The data will be reported quarterly to the Medical Records Committee and the Quality and Performance Board.

Recommendation 6. We recommended that diagnostic clinicians consistently document the time of notification and the means by which critical results were communicated to ordering providers.

Concur.

Target date for completion: March 1, 2011

Planned Action: To ensure that diagnostic clinicians consistently document the time of notification and the means by which critical results were communicated to ordering providers, the following actions are being taken. The Medical Center Policy, *Communication of Patient Test Results*, will be revised to include all aspects of notification of test results to include means or method of communication as well as documentation of date, time, and name of contacted provider. The revised policy will be communicated to appropriate staff and training scheduled to be completed and fully implemented by diagnostic clinicians by March 1, 2011. These documentation elements will be monitored and reported to the Medical Executive Board by monthly chart audits conducted by the Specialty Care Service Line Manager using a sample of 10 records/month or 100% if the number of notifications is less than 10/month, until a benchmark of 90% is achieved. After three months of achieving the benchmark, review and reporting of the documentation elements will continue quarterly for one year.

Recommendation 7. We recommended that ordering providers document patient notification and treatment actions in response to critical results.

Concur.

Target date for completion: April 10, 2011

Planned Action: To ensure that ordering providers document patient notification and treatment actions in response to critical results, the following actions are being taken. The ordering provider will document the acknowledgement of the receipt of the critical result, the medical provider's assessment, plan, and patient notification in CPRS. The elements of documentation/template will be communicated to/training completed and fully implemented by the ordering providers by April 10, 2011. The documentation elements will be monitored and reported to the Medical Executive Board using monthly chart audits conducted by the Primary Care and Specialty Service Line Managers using a sample of 10 records/month or 100% by each Service Line if the number of critical results is less than 10/month until a benchmark of 90% is achieved. After three months of achieving the benchmark, review and reporting of the documentation elements will continue quarterly for one year.

Recommendation 8. We recommended that the process of communicating pathology test results to providers and patients be monitored periodically for effectiveness.

Concur.

Target date for completion: April 1, 2011

Planned Action: To ensure the process of communicating pathology test results to providers and patients are monitored for effectiveness, the following actions are being taken. The process of communicating pathology test results to providers and patients will be monitored by the Specialty Service Line Manager and reported to the Medical Executive Board using a sample of 10 records/month or 100% if the number of pathology test results is less than 10/month until a benchmark of 90% is achieved. After three months of achieving the benchmark, review and reporting of the documentation elements will continue quarterly for one year.

Recommendation 9. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and that the education be documented.

Concur.

Target date for completion: March 1, 2011

Planned Action: To ensure that patients infected or colonized with MDRO and their families receive education on infection prevention strategies and that this education is documented, the following actions are being taken. A patient/family education template will be designed by the MDRO Prevention Coordinator to document the education provided to patients infected or colonized with MDRO and their families on infection prevention strategies. The elements of documentation/template will be communicated to the nurse managers on each unit by February 14, 2011. Training will be completed and the education template fully implemented by Acute Care and GEC Nursing staff by March 1, 2011. Completion of the template will be monitored by monthly chart audits using a sample of 10 records/month or 100% if the number of newly infected/colonized patients is less than 10/month until a benchmark of 90% is achieved. The results will be

reported monthly to the Medical Records Committee with outliers and action plan reported to the Quality & Performance Board. After three months of achieving the benchmark, review and reporting will continue quarterly for one year.

OIG Contact and Staff Acknowledgments

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