United States General Accounting Office

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Report to the Chairman, Committee on Veterans' Affairs, U.S. Senate

December 1991

# VA HEALTH CARE

# Compliance With Joint Commission Accreditation Requirements Is Improving

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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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December 13, 1991

The Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

In April 1990 the Joint Commission on Accreditation of Healthcare Organizations[1] told the Department of Veterans Affairs (VA) that VA medical centers performed significantly worse than non-VA hospitals in accreditation surveys conducted from 1987 to 1989. These surveys also showed that medical centers failed many key quality assurance elements more often than their non-VA counterparts. VA argued that the findings were due to a lack of documentation and did not mean that the quality of care provided in VA medical centers was poor. On June 1, 1990, you requested that we examine VA medical centers' compliance with the standards of the Joint Commission, how medical centers' compliance compares with that of non-VA hospitals, and VA's current and past quality assurance efforts.

As agreed with your office, this report discusses (1) VA medical centers' compliance with Joint Commission standards in 1990 compared with their compliance in 1989 and that of non-VA hospitals for both periods and (2) VA central and regional office oversight activities to assure medical centers implement quality assurance requirements. (See app. I for our scope and methodology.)

## Background

VA operates 159 medical centers throughout the United States, each of which it expects to seek and maintain accreditation by the Joint Commission. The Commission has been accrediting VA medical centers since 1953. In addition, it surveys each center once every 3 years. In 1988, the Commission began conducting multihospital surveys of VA medical centers in given regions of the country.[2] Under this approach, a region's medical centers are surveyed on a consecutive basis by the same core team of surveyors. The goals of this effort are to achieve consistency between surveys and facilitate comparisons among medical centers.

[1]The Joint Commission is a private, nonprofit organization that conducts surveys at various health care organizations that voluntarily seek accreditation. It accomplishes its mission through setting standards, conducting survey evaluations, accrediting health care organizations, and conducting educational activities.

[2]Before 1988, the Commission surveyed VA's medical centers whenever their accreditation was due to expire, without regard for the centers' locations.

Joint Commission accreditation surveys evaluate the administrative structure and processes hospitals have to (1) deliver care, (2) monitor the quality of that care, and (3) evaluate the results of their monitoring activities. Commission surveys are not intended to measure or assess the quality of health care or the outcomes of care hospitals are delivering. In July 1989, the Commission revised its accreditation guidelines for hospitals. The standards that form the basis for accreditation, however, did not change. The revised guidelines placed greater emphasis on the activities conducted by hospitals to monitor and evaluate the quality of care they are providing.[3]

Surveyors spend 3 to 5 days in a hospital assessing compliance with Joint Commission standards through review of documentation provided by the hospital's staff, observation of on-site activities, and assessment of the staff's explanations of how their activities meet the standards. Using guidelines from the Commission, surveyors rank each hospital's compliance with the standards on a scale from 1 to 5. A score of 1 represents substantial compliance; 2, significant compliance; 3, partial compliance; 4, minimal compliance; and 5, no compliance. Surveyors submit their reports to Commission headquarters, where the reports are reviewed, analyzed, and given an accreditation decision grid score based on predetermined formulas that weight the significance of individual standards comprising a Commission element.[4]

Depending on the seriousness of the problems identified, medical centers that do not meet Commission standards can be denied accreditation, given a conditional accreditation, or given accreditation with Type I recommendations for corrective action.[5] Accreditation can be denied if any condition exists that poses a threat to public or patient safety or if medical centers fail to correct Type I recommendations after two follow-up surveys.

[3]Specifically, departments, such as the nursing service and the medical staff, determine the important aspects of care they will monitor (based on the specific kinds of patients and conditions they treat), identify indicators or measurable variables to monitor those aspects, establish thresholds at which care provided will be evaluated, and review the care provided to see if a problem exists.

[4]In addition to standard scores, hospitals receive element scores. Elements are not scored directly by surveyors, but are based on algorithms that combine the standard scores. Element scores form the basis for both the overall compliance score and the accreditation decision.

[5]Virtually all accredited hospitals receive Type I recommendations, which result from noncompliance scores on standards and/or elements that the Commission designates as key factors in its accreditation decision. Whether fully or conditionally accredited, organizations must remedy any Type I recommendations within time periods specified by the Commission.

The Joint Commission awards conditional accreditation when a hospital is not in substantial compliance with the standards, but is capable of resolving those problems in a timely manner. Conditionally accredited centers must develop a plan of correction; receive Commission approval for it; and implement the plan, thus correcting compliance problems. The Commission conducts a follow-up survey within 6 months of when it approved the plan of correction. During this survey, the Commission reevaluates the original Type I recommendations and decides whether to accredit the organization. Commission surveys are the only external, solely quality-assurance-related reviews that VA medical centers receive on a recurring basis.[6]

## Results in Brief

VA medical centers surveyed by the Commission in calendar year 1990 performed substantially better than those surveyed in 1989. In addition, their overall compliance scores were close to those received by non-VA hospitals in 1990. Also, on many key quality assurance elements that comprise the overall scores, VA medical centers showed substantial improvement over compliance scores received by centers in 1989.[7] This was a direct result of intensive efforts by the VA central office, regional offices, and individual medical centers to assure that medical centers are following Commission requirements and properly documenting their quality assurance activities.

## Principal Findings

### VA Has Quality Assurance Mechanisms in Place to Help Medical Centers Comply With Joint Commission Requirements

VA regulations require that each medical center continually monitor specific critical areas that affect the quality of care the center is providing. These monitoring efforts include reviews in such areas as medical records, surgical cases, infection control, mortality and morbidity, and patient incidents (e.g., medication errors, falls, suicides, and assaults). (See app. II for an outline of the elements of VA's quality assurance program). The VA regulations are supplemented by Joint Commission standards that each center must meet to receive accreditation (see app. III for a listing of areas covered under Commission surveys). Both VA and

[6]Until 1989, when the program was terminated, VA periodically reviewed quality assurance programs at its medical centers through the Systematic External Review Program conducted by VA regional office personnel.

[7]Although we did not obtain 1991 survey data, a Commission official informed us that VA's compliance scores are continuing to improve.

the Commission have specific guidelines for the kinds of documentation necessary to show compliance.

VA's quality assurance system is the responsibility of the Chief Medical Director, who heads the Veterans Health Administration (VHA). VHA, through the Associate Chief Medical Director for Quality Management, develops systemwide quality-assurance-related policies, procedures, and requirements, and guides VA regional offices and medical centers on how to meet them. This includes guidance on how to meet, identify, or interpret Joint Commission standards. However, the Associate position was either vacant or held in an acting capacity from April 1988 to August 1990, and, during this period, regional offices and medical centers received limited guidance.

Each VA regional office has a quality assurance manager responsible for monitoring medical centers' programs. The regions' quality assurance personnel are expected to assist medical centers in meeting both VA regulations and Commission standards. With respect to Commission surveys, the assistance can take the form of monitoring activities, such as mock surveys, site visits, and examination of credentials files. Regional office personnel know the criteria that their medical centers will be measured by and when a Commission survey will be conducted. Part of the regions' job is to assure that medical centers (1) comply with the standards and (2) have the required documentation to prove a track record of compliance.

At individual medical centers, the quality assurance coordinator is responsible for assuring that they meet VA and Joint Commission regulations and standards. However, the efforts of other clinical service staff also are necessary to achieve hospitalwide compliance. For example, quality assurance staff depend heavily on the medical, nursing, and engineering staffs to implement most VA regulations and conduct monitoring and evaluation activities that meet Commission standards. But if medical personnel do not meet their quality assurance responsibilities, the quality assurance manager cannot achieve compliance with VA regulations or Commission standards.

## VA Medical Centers Were Not Equally Prepared for Joint Commission Surveys in 1989

From July to December 1989, the compliance scores given to medical centers by the Joint Commission varied widely among VA regions. This was primarily because some VA regions and medical centers did a better job of preparing for these surveys than others. Medical centers that received low scores generally could not provide surveyors with sufficient documentation to show compliance with applicable standards. As a result, 11 medical centers received conditional accreditation, and several received fairly low compliance scores. In addition, VA's overall average compliance score was significantly lower than that received by our sample of non-VA hospitals.

The average compliance score received by the non-VA hospitals in our sample—surveyed between July and December 1989—was 78. VA's average medical center score during this period was 70. Of the 56 VA medical centers surveyed nationwide by the Commission during this period, only 11 had compliance scores above 78, and 8 of these are in one VA region. Conversely, 11 centers (10 from one region) received a conditional accreditation from the Commission. Appendix IV provides the specific scores received by each center in both 1989 and 1990.

The way medical centers prepared for accreditation surveys was inconsistent among VA's regional offices. In the Western Region, for example, the regional office made minimal efforts to prepare centers for their surveys. Ten of the 24 medical centers surveyed in the region from July to December 1989 received a conditional accreditation from the Commission. The region's overall average compliance score in 1989 (62) was the lowest of any in VA. Unlike the Western region, the two other VA regions where centers were surveyed in 1989 prepared their medical centers by conducting site visits and hiring consultants to visit the centers, conduct mock surveys, and identify areas needing improvement. The former Southeastern region's average compliance score of 82 exceeded that of the non-VA hospitals surveyed during this period, while the Midwestern region's average was 73.

Table 1 shows, by region, the range of scores received by medical centers surveyed in 1989.

**Table 1: VA Medical Centers' Compliance Scores on Joint Commission Accreditation Surveys** (July 1-Dec. 31, 1989)

| | Centers in range, by region | | |
|---|---|---|---|
| **Range of Scores** | **Great Lakes** | **Southwestern** | **Western** |
| 50-59 | 0 | 0 | 12 |
| 60-69 | 5 | 1 | 5 |
| 70-79 | 14 | 3 | 7 |
| 80-89 | 2 | 6 | 0 |
| 90+ | 0 | 1 | 0 |

As we noted earlier in this report, VA said that the problems cited by the Joint Commission represented a lack of documentation and did not reflect the quality of care its medical centers were providing. However, without such documentation there is no evidence that appropriate procedures were being followed or that the facilities have the capability to provide quality care. Further, adequate documentation of problems, incidents, or complications over time allows medical center management to identify trends in patient care, opportunities for improvement, and the effectiveness of actions taken to address problems.

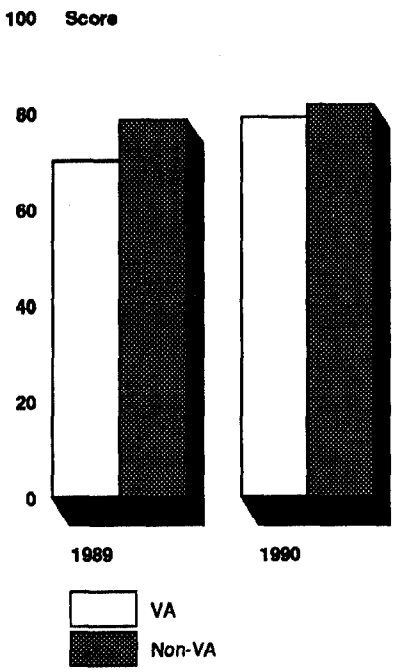
## VA's Compliance With Joint Commission Standards Is Improving

VA's compliance with Joint Commission standards improved substantially in 1990. VA's average compliance score of 79 for the 49 medical centers surveyed is close to the average compliance score of 82 received by the 200 non-VA hospitals included in our survey sample. Furthermore, unlike the situation that occurred in 1989, none of the centers surveyed received a conditional accreditation. This improvement is primarily due to the extensive educational and compliance efforts made by all organizational entities in VA to improve medical centers' performance on Commission surveys.

In 1990, VA's central office conducted national training programs and satellite video conferences to address specific parts of the Joint Commission survey. VA's regional offices and medical centers made extensive use of professional consulting services to evaluate quality assurance programs and conduct mock surveys. In addition, individual medical centers conducted training programs targeted at specific compliance problems.

Figure 1 shows the improvement VA medical centers made between 1989 and 1990 and compares the performance of VA and non-VA hospitals.

**Figure 1: VA and Non-VA Average Overall Compliance Scores** (1989-90)




Note: The average compliance score is a simplified and balanced overview of a hospital's performance. A score of 100 is the best possible score and equates to substantial compliance with all Joint Commission standards.

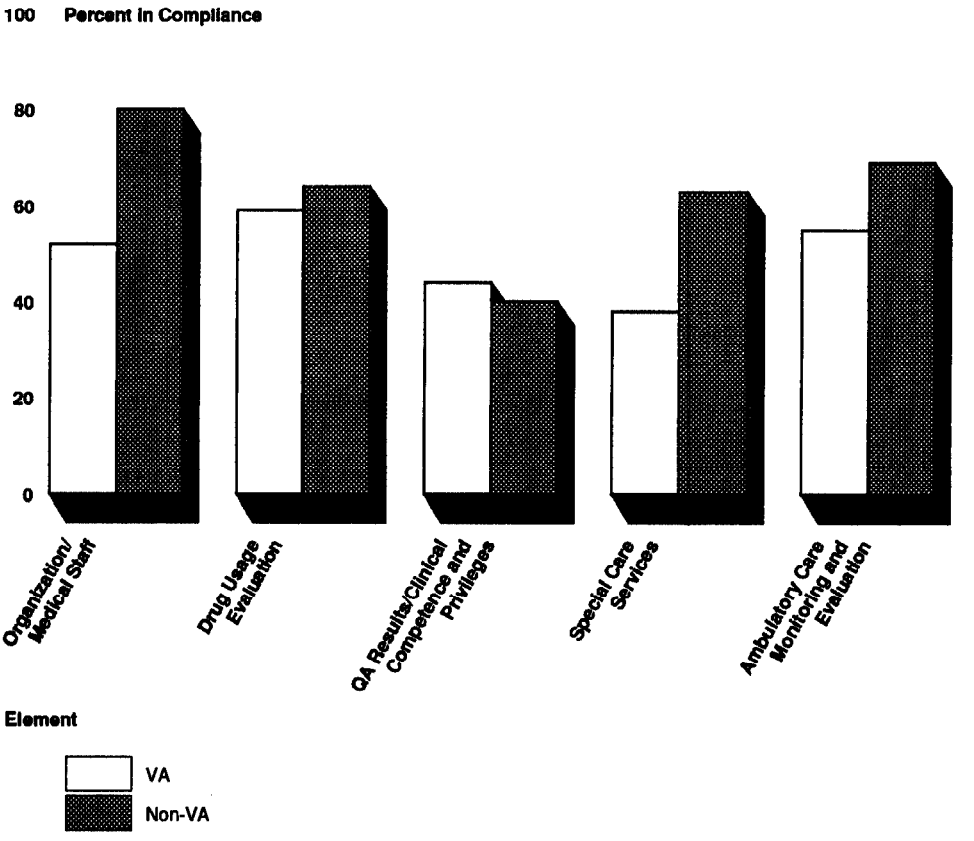
The most notable improvement in VA occurred in the Western Region where the average compliance score was 86 (compared to 62 in 1989). VA's former Southwestern region, which had begun preparing for its surveys 18 months before they were scheduled and kept appraised of all current survey requirements, also did well in 1990. Through extensive use of training, seminars, consulting services, and site visits by regional staff, the Southwestern region's centers were well prepared for the Commission surveys, receiving an average compliance score of 81.

Despite improvements in their compliance scores, VA medical centers still score significantly lower than non-VA hospitals in certain elements that comprise the overall score. These elements include blood usage review, surgical case review, and surgical and anesthesia services. To achieve high element scores, a hospital must be in significant or substantial compliance with Commission standards. To do this, a hospital must be able to document a 12- to 36-month record of compliance. Shorter periods of documentation will result in ratings of partial, minimal, or no compliance. Because many VA medical centers got a late start in documenting

their quality assurance efforts, several are still behind the non-VA hospitals' compliance rates on individual elements.

Figure 2 compares the percentage of VA and non-VA hospitals surveyed in 1989 and 1990 that are in significant or substantial compliance with selected Joint Commission elements.[8] As shown, VA is improving but has a way to go before its scores are comparable to the non-VA hospitals surveyed.

**Figure 2: VA and Non-VA Rates of Compliance** (1990)




## Conclusions

VA has sufficient quality assurance mechanisms in place to assure positive performance in Joint Commission surveys if medical centers follow them. However, effective implementation of quality assurance systems requires the active, coordinated involvement of VA's central office,

[8]See app. V for a more complete comparison of rates of compliance on 15 other elements.

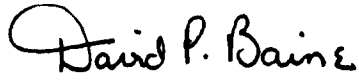
regional offices, and medical centers. VA's experience from 1989 to 1990 proves that when this involvement occurs and each unit assists in the preparation for Commission surveys, relatively high compliance scores can be achieved. Ideally, however, VA medical centers should be engaged in continuous quality improvement and should not need extensive preparation for a Joint Commission survey.

## Agency Comments

In a November 1, 1991, letter, the Secretary of Veterans Affairs stated that this report recognizes the significant strides VA has made in improving compliance with Joint Commission standards. The Secretary attributed this improvement to VA's regional staff commitment to meeting the Commission's requirements, Commission survey readiness training for VA physicians, and implementation of the principles of continuous quality management.

We are sending copies of this report to the Secretary of Veterans Affairs and interested congressional committees. We will also make copies available to others upon request. If you have any questions about this report, please call me at (202) 275-6207. Other major contributors are listed in appendix VI.

Sincerely yours,



David P. Baine
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**Abbreviations**

| | |
|---|---|
| VA | Department of Veterans Affairs |
| VHA | Veterans Health Administration |

# Scope and Methodology

For this review, the Joint Commission on Accreditation of Healthcare Organizations provided us with survey results for (1) the 105 VA medical centers surveyed between July 1, 1989, and December 31, 1990, and (2) a random sample of 346 non-VA hospitals surveyed during the same period. We selected the sample of non-VA hospitals from American Hospital Association data. In addition, we assured that these hospitals were comparable with VA medical centers in terms of survey year, affiliation with a medical school, and hospital size (number of beds). Before providing us with survey data, the Joint Commission removed the hospitals' names and all other identifying characteristics.[1]

We compared the survey data on the basis of overall compliance scores, as well as scores on specific elements that comprise the survey. In order to conduct a more in-depth analysis, we focused on (1) 14 elements that a Joint Commission official stated were most critical to delivering quality care; (2) 5 elements for which the difference in rates of compliance were the greatest in the Commission's April 1990 report to VA (organization of the medical staff, surgical case review, physical rehabilitation services, special care services, and special treatment procedures); and (3) 1 additional element (using quality assurance results to determine clinical competence and privileges) about which VA expressed concern because agency policy appeared to conflict with Commission standards. Although we controlled for size, affiliation, location, and survey year, only location and survey year (VA's Western region 1989 surveys) were associated with lower scores.

We interviewed officials and reviewed records at VA's central office, its four regional offices, and the Joint Commission. At VA's central office, we interviewed officials responsible for developing policies and guidance related to meeting, identifying, and interpreting Commission standards. We visited each of VA's four regional offices to discuss oversight activities with regional quality assurance, clinical services, and fire and safety protection staff. We also reviewed regionally developed quality assurance guidance, files, and records and discussed them with officials responsible for their development and implementation.

At the Joint Commission, we reviewed the 105 VA medical centers' survey reports to determine the reasons surveyors cited them for noncompliance on those elements. We also interviewed Commission officials

[1]The Commission treats all the information it obtains during its accreditation survey process as confidential between it and the surveyed hospital. As a result, we agreed with the Commission's request that non-VA hospital names be removed.

to discuss their policies, standards, and views regarding VA's compliance with quality assurance standards.

We performed our work in accordance with generally accepted government auditing standards between July 1990 and July 1991.

# Areas in Which VA Medical Centers Conduct Quality Assurance Evaluations

**Continuous Monitoring:**

- Medical records review
- Surgical case (tissue) review
- Blood services review
- Therapeutic agents and pharmacy review
- Laboratory review
- Radiology and nuclear medicine review
- Psychiatric program review
- Commitment usage analysis
- Restraint and seclusion usage analysis
- Infection control review
- Surgical and anesthetic complications review
- Autopsy review
- Mortality and morbidity review
- Review of rejected applications
- Patient incident review

**Patient Injury Control:**

- Quality assurance investigations

**Utilization Review**

**Credentialing and Privileging**

**Problem Focused Health Care Evaluation Studies**

**Occurrence Screening**

# Areas in Which the Joint Commission Evaluates a Hospital for Accreditation Purposes

| | |
|---|---|
| Medical Staff | Appointment/reappointment<br>Clinical privileges<br>Organization<br>Special treatment procedures |
| Medical Staff Monitoring Functions | Medical staff/departmental monitoring and evaluation<br>Drug review<br>Blood review<br>Medical record review<br>Pharmacy and therapeutics review<br>Surgical case review |
| Hospitalwide Monitoring Functions | Infection control<br>Utilization review<br>Risk management |
| Nursing Services | Nursing process<br>Licensure<br>Direction and staffing<br>Monitoring and evaluation |
| Quality Assurance Programs | Governing body/management support<br>Written plan<br>Quality assurance results a determinant of clinical competence/privileges |
| Medical Records | Delinquency<br>Medical record services |
| Patient Services/ Monitoring and Evaluation | Dietetic services<br>Diagnostic radiology services<br>Emergency services<br>Nuclear medicine<br>Pathology and medical laboratory services<br>Pharmaceutical services<br>Radiation oncology services<br>Rehabilitation services<br>Respiratory care<br>Social work service<br>Special care units<br>Surgery and anesthesia services |

| | |
|---|---|
| Governance and Administration | Governance<br>Management/administration |
| Plant, Technology, and Safety Management | Life safety<br>Safety management<br>Equipment management<br>Utilities management |
| Laboratory | Proficiency testing<br>Quality control<br>Administrative procedures<br>Safety<br>Professional staff |
| Alcohol and Other Drug Dependencies | Objectives/scope of the program<br>Treatment planning process<br>Monitoring and evaluation |
| Ambulatory Health Care | Provision of service/monitoring and evaluation<br>Record content/continuity |

# Joint Commission Survey Scores Received by VA Medical Centers Surveyed From July 1, 1989, to December 31, 1990

| Medical center | Actual grid score |
|---|---|
| **Eastern region, 1990** | |
| Richmond, Virginia | 86 |
| Hampton, Virginia | 84 |
| Butler, Pennsylvania | 81 |
| Salem, Virginia | 81 |
| Altoona, Pennsylvania | 81 |
| Fort Howard, Maryland | 78 |
| Clarksburg, West Virginia | 78 |
| Wilkes-Barre, Pennsylvania | 78 |
| Beckley, West Virginia | 77 |
| Pittsburgh, Pennsylvania | 75[a] |
| Martinsburg, West Virginia | 75 |
| Philadelphia, Pennsylvania | 75 |
| Washington, D.C. | 73 |
| Lebanon, Pennsylvania | 72 |
| East Orange, New Jersey | 72 |
| Pittsburgh, Pennsylvania | 72[b] |
| Wilmington, Delaware | 72 |
| Perry Point, Maryland | 71 |
| Erie, Pennsylvania | 71 |
| Coatesville, Pennsylvania | 69 |
| Baltimore, Maryland | 69 |
| Huntington, West Virginia | 69 |
| Lyons, New Jersey | 66 |
| **Average** | **75** |
| **Central region, 1989** | |
| Iowa City, Iowa | 84 |
| Lexington, Kentucky | 84 |
| Fargo, North Dakota | 79 |
| Lincoln, Nebraska | 77 |
| Grand Island, Nebraska | 75 |
| Marion, Illinois | 75 |
| Des Moines, Iowa | 74 |
| St. Louis, Missouri | 73 |
| Kansas City, Missouri | 73 |
| Fort Meade, South Dakota | 73 |
| Hot Springs, South Dakota | 72 |
| Columbia, Missouri | 72 |
| Leavenworth, Kansas | 71 |

(continued)

| Medical center | Actual grid score |
|---|---|
| Topeka, Kansas | 71 |
| Knoxville, Iowa | 70 |
| Poplar Bluff, Missouri | 70 |
| Omaha, Nebraska | 70 |
| Minneapolis, Minnesota | 69 |
| St. Cloud, Minnesota | 68 |
| Louisville, Kentucky | 68 |
| Wichita, Kansas | 65 |
| Sioux Falls, South Dakota | 64 |
| **Average** | **73** |
| **Southern region, 1989** | |
| Montgomery, Alabama | 90 |
| Memphis, Tennessee | 88 |
| Biloxi, Mississippi | 87 |
| Columbia, South Carolina | 84 |
| Nashville, Tennessee | 83 |
| Jackson, Mississippi | 82 |
| Tuscaloosa, Alabama | 80 |
| Tuskegee, Alabama | 79 |
| Birmingham, Alabama | 74 |
| Murfreesboro, Tennessee | 69 |
| **Average** | **82** |
| **Southern region, 1990** | |
| Dallas, Texas | 91 |
| Houston, Texas | 91 |
| Little Rock, Arkansas | 89 |
| Fayetteville, Arkansas | 89 |
| Temple, Texas | 88 |
| Amarillo, Texas | 87 |
| Oklahoma City, Oklahoma | 87 |
| Big Spring, Texas | 86 |
| Marlin, Texas | 85 |
| Kerrville, Texas | 85 |
| Bonham, Texas | 83 |
| Muskogee, Oklahoma | 82 |
| Alexandria, Louisiana | 81 |
| New Orleans, Louisiana | 80 |
| Shreveport, Louisiana | 79 |
| Fayetteville, North Carolina | 79 |

(continued)

| Medical center | Actual grid score |
|---|---|
| San Antonio, Texas | 79 |
| Waco, Texas | 78 |
| Mountain Home, Tennessee | 70 |
| Asheville, North Carolina | 70 |
| Salisbury, North Carolina | 68 |
| Durham, North Carolina | 63 |
| **Average** | **81** |
| **Western region, 1989** | |
| Miles City, Montana | 77 |
| Sheridan, Wyoming | 76 |
| Salt Lake City, Utah | 76 |
| Grand Junction, Colorado | 75 |
| Denver, Colorado | 72 |
| Cheyenne, Wyoming | 72 |
| Fort Harrison, Montana | 71 |
| Fort Lyon, Colorado | 68 |
| Los Angeles, California | 65 |
| Long Beach, California | 61 |
| Seattle, Washington | 61 |
| Walla Walla, Washington | 60 |
| Spokane, Washington | 59 |
| Martinez, California | 59 |
| San Francisco, California | 59 |
| Roseburg, Oregon | 58 |
| Portland, Oregon | 57 |
| Boise, Idaho | 55 |
| Sepulveda, California | 54 |
| Fresno, California | 53 |
| Tacoma, Washington | 52 |
| Palo Alto, California | 52 |
| Livermore, California | 51 |
| Reno, Nevada | 50 |
| **Average** | **62** |

(continued)

| Medical center | Actual grid score |
|---|---|
| **Western region, 1990** | |
| Tucson, Arizona | 92 |
| Albuquerque, New Mexico | 87 |
| Phoenix, Arizona | 83 |
| Prescott, Arizona | 83 |
| **Average** | **86** |

[a]Highland Drive.

[b]University Drive.

# Comparison of VA and Non-VA Hospital Compliance Against Selected Joint Commission Elements (1990)

| | Percent in compliance | |
|---|---|---|
| **Element** | **VA** | **Non-VA** |
| Surgical case review | 26 | 50 |
| Monitoring and evaluation-medical staff | 43 | 60 |
| Respiratory care services | 70 | 91 |
| Special treatment procedures | 77 | 85 |
| Rehabilitation services | 81 | 77 |
| Surgery and anesthesia services | 55 | 72 |
| Safety management | 36 | 31 |
| Blood usage review | 54 | 75 |
| Emergency services | 71 | 86 |
| Alcohol and drug treatment planning | 49 | 44 |
| Alcohol and drug monitoring and evaluation | 83 | 60 |
| Life safety (inpatient) | 35 | 37 |
| Equipment management (inpatient) | 62 | 74 |
| Utilities management (inpatient) | 52 | 65 |

# Major Contributors to This Report

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