Contents
1. Executive Summary ................................................................................................................................... 2
2. Quality Committees.................................................................................................................................. 4
   2.1 Infection Prevention and Control Committee ..................................................................................... 4
   2.2 Pharmacy and Therapeutics Committee ............................................................................................. 8
   2.3 Safety Committee ................................................................................................................................ 9
   2.4 Medicine Committee ............................................................................................................................ 11
3. Goals.......................................................................................................................................................... 13
   3.1 Quality: Provide high quality health services to empower and promote the physical, mental and social health of the GT community ........................................................................................................... 13
      3.1.1 Improve the management of patients with elevated blood pressure .............................................. 13
      3.1.2 Improve treatment of patients with latent TB ............................................................................. 14
3.2 Access: Provide students timely access to a broad range of health care services, reduce barriers to access, and provide faculty/staff access to strategically chosen services .............................................................................. 16
   3.2.1 Integrate care coordinators into psychiatry care delivery model .................................................... 16
   3.2.2 Improve the outpatient therapy referral process ............................................................................. 17
   3.2.3 Implement depression screening ....................................................................................................... 19
   3.2.4 Increase LiveHealth Online kiosk registrations ............................................................................ 20
   3.2.5 Reduce wait time to first appointment ............................................................................................ 21
   3.2.6 Increase the number receiving the flu vaccine .................................................................................. 22
   3.2.7 Expand specialty services based on referral patterns ..................................................................... 23
3.3 Healthcare Delivery: Optimize health care delivery processes to ensure quality, safety, and efficiency and to reduce health disparities ........................................................................................................... 24
   3.3.1 Improve access to data outcomes ...................................................................................................... 24
   3.3.2 Enhance the efficiency of delivery-of-care process ......................................................................... 25
3.4. Financial-Manage financial resources to optimize delivery of care while controlling the costs of care.................................................................................................................................................................. 26
   3.4.1 Improve the margin on pharmacy pricing .......................................................................................... 26
3.5. Workplace Experience .............................................................................................................................. 27
   3.5.1 Strengthen employee relations among all employees ....................................................................... 27
   3.5.2 Assist employees with identifying to achieve goals and job opportunities .................................... 28
4. Risk Management ....................................................................................................................................... 29
5. Peer Review ................................................................................................................................................. 33
6. After Hours Care ......................................................................................................................................... 34
7. Quality Improvement .................................................................................................................................. 36
   7.1 Allergy Patient Compliance Study ....................................................................................................... 36
   7.2 Improved Same Day Access to appointments ....................................................................................... 37
8. Quality Assurance ........................................................................................................................................ 40
   8.1 Prescribing Events ................................................................................................................................. 40
   8.2 Urinary Tract Isolates .............................................................................................................................. 43
   8.3 Laboratory Monthly Turnaround Time (TAT) report .......................................................................... 46
   8.4 Test Not Performed ............................................................................................................................... 47
   8.5 Laboratory Monthly Turnaround Time (CBC-TAT) report .................................................................. 48
   8.6 Unacceptable PT Error .......................................................................................................................... 49
   8.7 Hematology -Hematocrit (Hem-5D) (%) Abbott Cell-Dyn Ruby ............................................................ 50
   8.8 Radiology Turnaround Times ................................................................................................................ 53
   8.9 Overread External Misses ..................................................................................................................... 54
10. Benchmarking ........................................................................................................................................... 55
11. Psychiatry Wait Times ............................................................................................................................... 58
Executive Summary

Stamps Health Services is committed to the principles of providing high quality care, ensuring access to care, delivering care in an efficient manner, stewarding our financial resources in a responsible manner, and providing a workplace environment that supports the personal wellbeing and growth of our employees. This report describes many of our efforts in the past year to achieve these goals through our Quality Program.

Our Quality Committees are a major component of our Quality Program. Our Quality committees include the Quality Committee, the Medicine Committee, The Infection Prevention and Control Committee, the Pharmacy and Therapeutics Committee, and the Safety Committee. The Infection Prevention and Control Committee changed leadership this year. Dr. Pickens stepped down as chair after many years of outstanding leadership. Dr. Stephen Holbrook has assumed leadership of the committee. The committee conducted our annual urine culture study, which gives guidance to our providers regarding our community’s most common urine pathogens and resistance patterns. Culture of surfaces within Stamps showed one positive culture that was addressed with enhanced cleaning. Compliance with reporting of Reportable Diseases remains high, with 100% of cases reported, most without needing a reminder to the provider. The 2017-2018 flu season showed a significant increase in students presenting with flu symptoms during the month of February 2018, consistent with the national influenza season. The Pharmacy and Therapeutics Committee continued to update the formulary on a regular basis. The Prescribing Events Quality Assurance study showed the rate of prescribing errors is low, but did not meet our goal. An area of improvement was identified regarding providers updating changes to prescriptions in the EMR. The Safety Committee continued its work to ensure a safe environment for patients and staff. Falls and fainting remain the most common causes of workplace injury. One needle stick injury occurred; factors contributing to this were investigated and steps were taken to remediate the possible contributing factors. The Medicine Committee continued its study of management of elevated blood pressure readings in the clinic. Data analysis shows there is still room for improvement for addressing and following up on elevated BP readings. The committee also continued to address the response to positive answers to the suicide question on the Depression Screen. We found many positive responses were being overlooked initially. A new Alert has been set up in Medicat so that when a patient responds to the suicide question positively, an alert will pop up when the chart is accessed. With the assistance of IT staff this alert is now operational and its effect on addressing positive responses will be monitored. Peer review shows that compliance with checking allergies and medications remains high and compliance with checking vital signs after fluid administration remains at 100%.

Stamps Health Services had several quality goals. We achieved our goals for treatment of latent TB, average wait time to first assessment for new psychiatry patients, initiation of depression screening in Primary Care and Women’s clinics, increasing the number of students seen by the nutritionists, and increasing the number of faculty/staff/students receiving flu shots. We made progress in cultivating a culture of mutual respect and support for all employees, offering professional development opportunities, improving our margin on pharmacy pricing, improving access to data outcomes, improving the outpatient referral process to community provides in psychiatry, improving patient compliance with allergy shot schedules, and management of elevated BP measurements.

Our Risk Management program identified an increase in incidents in 2018 compared to 2017, from 7 to 16. Pharmacy had a higher number of incidents than other locations in the building. The most commonly reported incident involved an injury to staff. Two of the sixteen incidents had a risk assessment score indicating significant risk.
Peer Review activities continued in 2018. For Primary Care providers peer review occurred in the context of quality studies, particularly with regard to management of elevated BP readings. In Women’s Clinic and Psychiatry Clinic, provider peer review occurred in the form of chart reviews. For Nursing and medical assistants, peer review looked at compliance with documentation of vital signs after IV fluids and documentation of medications and allergies.

Stamps Health Services provides a nurse advice line for students to access for after-hours care. In 2018 we had a 9% decrease in the number of calls compared to 2017. The majority of calls are for medical issues. 99% of calls related to a medical issue were followed up within 2 business days after the call.

A Quality Improvement project to improve Same Day access to appointments implemented in the Fall 2018 semester resulted in a 38% decrease in the number of walk in patients seeking care. This reduction in walk in patients has continued into the Spring 2019 semester.

Quality Assurance activities including continuation of the monitoring of Prescribing Error events, monitoring of antibiotic resistance rates in isolates of urinary tract pathogens, laboratory turnaround times, and radiology turnaround times.

Stamps Health Services participated in a Benchmarking study through AAAHC/ACHA. SHS scored above the mean for medication allergy documentation and tobacco screening. We scored below the mean for documentation of influenza documentation. We also scored below the mean for depression screening; however, the data set studied was for a time period before we implemented our depression screening protocol. On a repeat study our own data suggests we would score above the mean for this item for a time period after implementation of depression screening.

One area of significant improvement that occurred in 2018 was a reduction in time to first contact with a psychiatrist. A change in the workflow for appointment with a psychiatrist, so that a student saw both the care coordinator and the psychiatrist on their first visit reduced the time to first contact with a psychiatrist from 16.8 days to 9.1 days.

Respectfully submitted,
Benjamin Holton, MD
Senior Director
Chair, Quality Committee
2. Quality Committees

2.1 Infection Prevention and Control Committee

Members
- Stephen Holbrook MD -Chair
- Steven Terry - Vice-Chair/Physician Assistant
- Berdia Brunson- Medical Assistant
- Helen Ukoh- Diagnostics Manager
- Huei Chu –Medical Assistant
- Denise Fair - RN

Brief Description of Committee
- The Infection Prevention and Control Committee shall oversee the program for surveillance, prevention and control of infection at Stamps Health Services.

Committee Goals
- Oversee the program for surveillance, prevention and control of infection.
- Define epidemiological important issues and approve the type/scope of surveillance and investigation activities.
- Recommend actions to prevent or control infections based on analysis of surveillance and investigation activities.
- Review Infection Control policies and procedures annually.
- Recommend Institute surveillance, prevention and/or control studies as deemed necessary.
- Increase and maintain the interest of employees in infection prevention and control issues.

Results
- Monitoring of notifiable diseases insured that all notifiable diseases were reported as required by law. (117 chlamydia, 15 gonorrhea, 3 mumps suspects (2 tested positive), 1 HIV, 1 Syphilis 1 chickenpox, and 3 dog bites.
- 36 of 37 surveillance cultures obtained in various locations in the building were negative. 1 positive for Pseudomonas and Acinetobacter species. The practice of obtaining surveillance cultures reinforces the need for constant sanitation.
- Incidences of Strep and influenza infections were monitored so that staff could be informed of developing trends.
- Annual urine culture study was performed. Results were shared with providers to promote appropriate antibiotic use.
- The annual review of committee charter and policies was completed.

Metrics:
- Reportable Disease Reporting- Goal: 100%
  Results: Reportable disease reporting continues to improve. Actual reporting was 94% and 100% after provider reminder. Although the goal was met, there is still inconsistent reporting, without a reminder, from providers. Providers will be reminded to report as per state law.
Other Communicable Diseases

- For 2018 the percentage of sore throat cases due to Strep seen at Stamps remained fairly stable in the 5-10% range. This is the range that is expected in populations of the age of patients seen at Stamps. Also as expected, the incidence of flu cases peaked in the winter months and was minimal in the warmer months. Cultures positive for herpes simplex were stable during the year at a low level. The number of cases of chlamydia and gonorrhea diagnosed at Stamps was relatively unchanged when compared to 2017. There were 3 cases of mumps, 1 case of Syphilis and 1 case of chickenpox.
- **Bacterial Surveillance**
  - Goal: No Positive Cultures
    - *Results:* A total of 40 surveillance cultures across different areas of Stamps. There was one positive culture for Pseudomonas and Acinetobacter species in the Travel, Immunization and Allergy department. Staff was alerted and cleaning procedures reinforced.
2.2 Pharmacy and Therapeutics Committee

Members
- Nina Thoman PharmD- Chair
- Paula Gaffney RN
- Benjamin Holton MD
- Angelo Galante MD
- Marjan Kirkland NP
- Barrie Fogg LPN
- Cindy Naiver CMA(AAMA), CPC
- Kimberly Bell, MSM, CNM
- Steven Terry, PA-C
- Marjan Kirkland, FNP-C
- John Scuder- Director, Health Operations

Brief Description of Committee
- The P&T Committee reviews and updates the formulary list each quarter so that it includes safe and effective drugs approved by the Food and Drug Administration (FDA). They also review each therapeutic class of drugs on a yearly basis, to ensure that the formulary continues to provide a representative sample of the medications available for a condition. Medication coverage criteria is updated and reviewed to reflect current standards of practice. The Committee serves both an advisory and an educational role within Health Services to assist in formulating policies and developing educational programs on all matters relating to the evaluation, selection, and use of pharmacological products.

Goals
- Review and update the formulary on an annual basis.
- Review data collected for quality initiatives (Prescribing & Dispensing Event Data).
- Educate staff members on quality event data and make recommendations to prevent future events.
- Serve as the Drug Utilization Review Board (DUR).

Results
- 2018 Formulary as updated and approved.
- Cycle 13 data:
  - Dispensing events 0%, goal 100%
  - Prescribing events 0.46%, goal <0.4%
  - EHR upload 67%, goal 100%
- Medicat messaging, email reminders and individual provider education is used to remind providers to update the EHR. The committee will evaluate additional actions to meet goal.
- Reviewed and updated committee charter.

Metrics: This committee does not report metrics.
2.3 **Safety Committee**

**Members**
- Vacant - Safety Officer (Chair)
- Cassandra Arnold - Customer Svc Rep II (Vice-Chair)
- Jacqueline Parks - Medical Assistant
- Tabarrion Stoves - Radiology Coordinator
- Theron Stancil – Assistant Director, Health Systems
- Sherika Henderson - Medical Assistant
- Rachel Brown – Clinical Case Manager
- Abigail Nicolas – Clinical Case Manager
- Helen Gosby - Practice Coordinator

**Brief Description of Committee**
- The Safety Committee is to evaluate, promote and develop policies and procedures that promote safety awareness, safe practices and the maintenance of safe facilities and equipment.

**Goals**
- Increase and maintain the interest of employees in health and safety issues.
- Annually evaluate and update workplace safety program.
- Participate and report on safety related Institute initiatives.
- Promptly review all safety-related incidents, injuries, and accidents.
- Ensure compliance with federal and state health and safety standards.

**Results**
- The Safety Committee has helped maintain a safe environment for our patients as well as staff by reviewing and monitoring current safety procedures and equipment.
- Reviewed 9 incident reports with safety related events.

**Metrics**
- **Fire Drill**
  - Goal: 1 fire drill per quarter (only two drills were performed due delays in the fire marshal office and resignation of Facility Manager.)
  - *Results:* Average evacuation time was 1:50 minutes. This is within the 2 minute threshold. Continue to monitor.
Workplace Injuries

- Goal: 100% of workplace injuries reported.

<table>
<thead>
<tr>
<th>Month</th>
<th>Incident Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>Staff slipped and fell to floor hitting her right arm.</td>
</tr>
<tr>
<td>Feb</td>
<td>Patient fainted while watching a procedure</td>
</tr>
<tr>
<td>Mar</td>
<td>Staff member sustained a superficial laceration during a procedure, Fire Drill conducted</td>
</tr>
<tr>
<td>Apr</td>
<td>Staff member sustained a superficial laceration, provider fell while suturing, staff member hit on forehead with lid</td>
</tr>
<tr>
<td>May</td>
<td>No incidents</td>
</tr>
<tr>
<td>Jun</td>
<td>No incidents</td>
</tr>
<tr>
<td>Jul</td>
<td>Staff member slipped on water on floor, Fire Drill conducted</td>
</tr>
<tr>
<td>Aug</td>
<td>No incidents</td>
</tr>
<tr>
<td>Sep</td>
<td>Staff member slipped on water dripping from ceiling</td>
</tr>
<tr>
<td>Oct</td>
<td>Patient fainted during blood draw, patient fainted after flu shot</td>
</tr>
<tr>
<td>Nov</td>
<td>No incidents</td>
</tr>
<tr>
<td>Dec</td>
<td>Staff member stuck with needle</td>
</tr>
</tbody>
</table>
2.4 **Medicine Committee**

**Members**
- Emily Richardson, MD- Chair
- Benjamin Holton MD
- Diane Heath MD
- Debbie Spillers-Nursing Mgr.
- Steven Terry- PA
- Keisha Runnels-Medical Assistant
- John Scuderi-Director, Health Operations
- Shan Baker –Women’s Health Mgr.
- Shannon Croft MD-Lead Psychiatrist
- Julie Powell, FNP
- Melanie Thomas, RN
- Gina Talbot MD

**Brief Description of Committee**
- The committee’s goal is to foster an environment that promotes the advancement, promotion, retention, and vitality of the medical staff and ensure the standard of medical care is met.

**Goals**
- Perform PEER review activities.
- Review and monitor the standard of medical care.
- Review clinical policies and procedures.
- Review and monitor the efficiency and effectiveness of clinical operations.

**Results**
- Repeat data analysis after initial intervention shows continued opportunity for improvement.
- Ongoing monitoring of positive screens for suicidal ideation; changes to mental health intake.
- Refrigerator installed in Women’s Clinic for vaccine storage.
- Ongoing discussion re: GT/city management of E-scooters and possible safety initiatives.
Metrics
- Review of Allergies and Current Medications by Medical Assistant
  - Goal: 100% Women's Health and Primary Care
    - Results: 96%. Continue to monitor.

<table>
<thead>
<tr>
<th>NARRATIVE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-April</td>
<td>1 missing allergy review from W Health. Data as of 05/25/18 from W Health and Primary Care only</td>
</tr>
<tr>
<td>Aug-Dec</td>
<td>1 missing allergy/med review from W Health. Data as of 01/28/19 from Primary Care and W Health</td>
</tr>
</tbody>
</table>

4.5.2 Review of Vital Signs - IV Fluid Administration by RN/LPN
Goal: 100% Women's Health and Primary Care
Results: 100%. Continue to monitor.
3. Goals

3.1 Quality—Provide high quality health services to empower and promote the physical, mental, and social health of the GT community.

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3.1.1 Improve the management of patients with elevated blood pressure.

**Responsible Person(s):** Benjamin Holton MD  
**Measurement 1:** Percentage of patients identified to have high blood pressure who achieve control of blood pressure.  
**Benchmark 1:** Achieve BP<140/90 in 80% of identified patients

**Action Plan/Project:**
- Review Medica data, access current medical standard for achieving goal, educate staff. The plan will be patient specific but will include but not limited to medications, medication compliance, lifestyle changes (exercise, diet), follow-up appointments, and accountability through peer review.

**Semi-Annual Progress #1 (Jul-Dec):**
- As a Quality Study SHS decided to look at how well we identify and follow up on patients who have an elevated blood pressure when measured during a primary care clinic visit. Initial data collection occurred during fall semester 2017. 100 charts on patients with a BP reading above 140 systolic or above 90 diastolic were reviewed. 35% of those patients had a BP less than 140/90 on a subsequent visit. Those that did not have a documented BP less than 140/90 either had no further visits where a blood pressure was taken or they had subsequent visits and BP readings were still elevated. Our goal is to achieve a BP<140/90 in 80% of identified patients. Corrective actions will be taken during spring semester 2018 with repeat measurement of data in June 2018.

**End of Year Progress (total fiscal year):**
- Data collection at the end of FY 18 included a review of 48 patient charts. A BP of <140/90 was achieved in 46% of patients. This does not meet our goal, but is an improvement from baseline date where the percent achieving a BP<140/90 was 35%. A significant number of patients did not have a subsequent visit to determine if BP improved. The 54% of patients who did not achieve BP<140/90 did not necessarily have continued high blood pressure, we just don't have data about whether subsequent blood pressure readings had come down to the normal range. Since the benchmark was not met and there is a need to collect better data, the department has decided to continue this objective in FY19 with action plans to improve upon these results.

**Final Action Plan Status:** Completed-Forwarded to Next Year
3.1.2 Improve treatment of patients with latent TB.

**Responsible Person(s):** Benjamin Holton MD  
**Measurement 1:** Completion of treatment for latent TB.  
**Benchmark 1:** 90% of patient who start treatment for latent TB will complete treatment

**Action Plan/Project:**
- Monitor compliance with treatment regime by active tracking of patients, with follow up phone calls by staff for patients missing appointments.

**Semi-Annual Progress #1 (Jul-Dec):**
- Individuals with latent TB have had exposure to TB, have the bacteria in their body, but show no manifestations of disease. They cannot spread TB to others. Treatment of latent TB reduces the number of individuals who convert from latent TB to active TB. According to the CDC, national rates of completion of treatment of latent TB are in the range of 40-50%. The rate of completion of treatment of latent TB at Stamps at the beginning of this study was 48%, consistent with national rates. Between 6/1/17 and 12/1/17, 19 students initiated treatment for latent TB. 10 students have completed treatment (completion rate of 52.6%). An additional 8 students are still in the process of treatment. The completion rate, if you assume all of those currently in treatment complete treatment, will be 94.7%. Our goal is 90% of patients initiating treatment complete treatment. We are on track to meet this goal if those currently in their course of treatment complete treatment.

**End of Year Progress (total fiscal year):**
- For the time period 7/2017-6/2018, 22 students initiated treatment for latent TB. As of 6/15/18, 21 student have completed treatment, for a completion rate of 95%, which exceeds our goal of 90%. 100% of student taking 12 weeks of directly observed therapy completed treatment, 100% of students taking Rifampin for 4 months completed treatment, 80% of students taking 9 months of INH have completed treatment.

**Final Action Plan Status:** Completed-Discontinued
3.1.3 Improve the patient compliance with allergy shot schedules.

**Responsible Person(s):** Benjamin Holton, Debbie Spillers  
**Measurement 1:** Percentage of students compliant with their allergy shot schedule.  
**Benchmark 1:** 80% of patients receiving allergy shots will have missed <3 scheduled shots.

**Action Plan/Project:**
- Patient compliance will be enforced via education re: expectations prior to initiation of shots, reinforcement of expectations if appointment missed; suspension of administration of allergy shots if exceed three missed appointments

**Semi-Annual Progress #1 (Jul-Dec):**
- 70% of students were compliant with their allergy shot schedule. This is an improvement from 2017 (56%) Out of 77 allergy patients, 23 missed/no showed for appointments more than 3 times in the fall semester. Data so far is suggesting that patients who remain noncompliant are the ones that have been non-compliant through their treatment course. Newer patients that have completed the paperwork have been slightly more compliant but all orders from allergists across the board have problems with sending clear and concise orders. As a result, allergy personnel will have patient resign the Patient Allergy Agreement and reinforce through education the importance of maintaining allergy injection schedule. Once we begin this then we are hoping to increase compliance to schedules. If not, the patient will be sent back to allergist for injections.

**Actions taken include:**
- Revamped some of the policies governing the administration of allergy injections.
- Decrease time allotment by nursing staff in managing paperwork/problems associated with allergy injections.
- All new patients have signed and completed the new Allergy agreement that instructs them on importance of adhering to prescribed schedule.
- Incident log created to document problems with allergist office in receiving and clarifying orders/incorrect orders sent.

**End of Year Progress (total fiscal year):**
- Analyzing data after spring break to determine if reeducation and new policies have improved compliance rates among patients.

**Final Action Plan Status:** Completed-Discontinued
3.2 Access - Provide students timely access to a broad range of health care services, reduce barriers to access, and provide faculty/staff access to strategically chosen services.

3.2.1 Integrate care coordinators into psychiatry care delivery model.

**Responsible Person(s):** Shannon Croft (scroft3), John Scuderi (jscuderi3)

**Measurement 1:** Time to first assessment by psychiatry personnel

**Benchmark 1:** The average wait time to first assessment for new patients is <10 days

**Action Plan/Project:**
- Care givers and psychiatrists will be organized into teams. First assessments will now be done by care coordinators, with scheduling arranged to maximize their availability. This is a reworking of patient flow designed to decrease wait times. Wait times to first assessment will be monitored and care coordinators schedules will be adjusted as needed to keep wait times low.

**Semi-Annual Progress #1 (Jul-Dec):**
- There were 207 new patients during the reporting period. The average wait time for new patients is 7.1 days to first appointment with a care coordinator. This meets the benchmark for this objective.

**End of Year Progress (total fiscal year):**
- During FY 2018, Stamps Psychiatry saw a total of 498 new patients. The average wait time for the patient's initial contact to the clinic for their initial consultation was 7.1 business days. The average wait time over the course of the year from the initial consultation to the new patient appointment with a psychiatrist was 20 business days. The average wait time from the initial contact to the new patient appointment with a psychiatrist was 27.1 days.

**Final Action Plan Status:** Completed - Forwarded to Next Year
3.2.2 Improve the outpatient therapy referral process to transition patient through the continuum of care using community providers.

Responsible Person(s): Shannon Croft MD
Measurement 1: Percent of referred patients who established care with outside provider
Benchmark 1: 75% of patients referred will complete referral

Action Plan/Project:
- Hire a third care coordinator. - Referral tool used (in conjunction with the counseling center) is currently being upgraded for improved navigation and utility for case managers.

Semi-Annual Progress #1 (Jul-Dec):
- The clinical care coordinators worked with 496 new or existing psychiatric students for referrals for therapy. 117 students declined services or were ambivalent about services, reducing the total patients served to 379. Overall, the care coordinators connected 283 students with therapy in the community and 96 students continue to be actively seeking therapy.

- A chart review of 25 randomly selected patients from July – December 2017 suggested that 44% of patients (11 out of 25 patients) were not connected to therapy 1-2 months following the psychiatrist’s recommendations. Only 66% (i.e., 14 patients) were connected.

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Connected to therapy</th>
<th>Actively seeking therapy (contacted therapists)</th>
<th>Ambivalent / Declined Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw total</td>
<td>283</td>
<td>96</td>
<td>117</td>
<td>496</td>
</tr>
<tr>
<td>Percentage</td>
<td>57.06%</td>
<td>19.35%</td>
<td>23.59%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentages excl. referral declines</td>
<td>74.67%</td>
<td>25.33%</td>
<td>--</td>
<td>379</td>
</tr>
</tbody>
</table>

New Changes:
- During this period, instead of breaking down the students into four groups (connected to therapy, actively seeking therapy, ambivalent/unconnected, and declined services), we modified it to three groups to better reflect the clinical care coordinator’s interactions with students. We combined the unconnected/ambivalent students with the students who declined services due to the similarities in the interactions that the care coordinators had with them. This group of students were provided referrals by the care coordinators however, since receiving referrals, they have either not followed up with the care coordinator, not responded to multiple follow up contacts, or declined the referrals when they did follow up with a care coordinator.

End of Year Progress (total fiscal year):
- The clinical care coordinators worked with 562 new or existing psychiatric students for referrals for therapy from July 2017 to June 2018. 158 students declined services or where ambivalent about services, reducing the total patients served to 404. Overall, the care coordinators connected 266 students with therapy in the community and 138 students continue to be actively seeking therapy. A chart review of 25 randomly selected patients from July 2017 to June 2018 suggested that 44% of patients (11 out of 25 patients) were not connected to therapy 1-2 months following the psychiatrist’s recommendations. Only 66% (i.e., 14 patients) were connected.

Page 17 of 58
connected to therapy 1-2 months following the psychiatrist’s recommendations. 56% (i.e., 14 patients) were connected.

- Although the percentage per quarter of students that establish off campus therapy is typically around 50%, over the course of the year, many students were able to get connected to therapists, increasing our overall rate of success to about 66%, which means that we have partially met our goal. Since the work that the care coordinators complete with students is often on an ongoing basis, it is anticipated that many of the students that are actively seeking therapy at this time, will be connected by the next quarter.

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Connected to Therapy</th>
<th>Actively Seeking Therapy (contacted therapists)</th>
<th>Ambivalent/Declined Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw Total</td>
<td>266</td>
<td>138</td>
<td>158</td>
<td>562</td>
</tr>
<tr>
<td>Percentage</td>
<td>47.33%</td>
<td>24.56%</td>
<td>28.11%</td>
<td>100%</td>
</tr>
<tr>
<td>% excl. referral declines</td>
<td>65.84%</td>
<td>34.16%</td>
<td></td>
<td>204</td>
</tr>
</tbody>
</table>

**New Changes:**
- Over the course of the past year, Psychiatry hired a third clinical care coordinator, worked with the Counseling Center to develop a comprehensive referral database, screened all positive suicide screens from Primary Care and Women's Health, and revised the clinic's intake system so that both the clinical care coordinator and the psychiatrist evaluate the student in their first meeting.

**Final Action Plan Status:** Completed-Forwarded to Next Year
3.2.3 Implement Depression Screening of all patients in Primary Care and Women’s Clinics.

**Responsible Person(s):** Benjamin Holton MD, Debbie Spillers, Shannon Croft MD  
**Measurement 1:** Percentage of patients at SHS screened for depression  
**Benchmark 1:** 90% of all patients seen at SHS screened for depression

**Action Plan/Project:**  
- Incorporate required PHQ9 survey at self-check in.

**Semi-Annual Progress #1 (Jul-Dec):**  
- SHS decided to screen patients coming to Primary Care and Women’s Clinics for depression in accordance with the US Preventative Services Task Force recommendations. Our goal was initially set at 90% of all patients coming to Primary Care and Women’s Clinic receive screening. To date, 10,479 screenings have been done on 13,710 visits, for a rate of 76.4%. During implementation of Depression screening, we made a conscious decision to exclude visits within one week of a previous screening. This exclusion most likely accounts for the majority of visits that did not get screening. Since the screening process occurs when patients check in, it is unlikely that we are missing many students except those who have been purposefully excluded.

**End of Year Progress (total fiscal year):**  
- For the time period 8/21/17-6/29/18, 21,100 screenings were performed. The number of visits to primary care and women's clinic during this time was 26,947. 78% of patients visits had a depression screening completed. While this does not meet our initial stated goal of 90%, we made the decision during implementation to not re-screen patients who had had a screen in the past week. This exclusion of patients who had been screened within the past week most likely accounts for the reduced percentage. Overall, we feel this was a successful implementation of depression screening in primary care and women's clinic.

**Final Action Plan Status:** Completed-Discontinued
3.2.4 Increase LiveHealth Registrations

**Responsible Person(s):** John Scuderi  
**Measurement 1:** Number of individuals pre-registered with LiveHealth Online  
**Benchmark 1:** 600 pre-registrations

**Action Plan/Project:**
- Provide 5 registration opportunities in Healthy Space

**Semi-Annual Progress #1 (Jul-Dec):**
- There were 5 preregistration (Aug 4th, 18th, and Sept 14th, 15th, 22nd) events held resulting in 330 pre-registrations for the LiveHealth Kiosk. Pre-registration options (from home or office) were also communicated in the Daily Digest.

**End of Year Progress (total fiscal year):**
- No further action taken during the reporting period and the benchmark was not met (600 pre-registrations).
- At the close of FY 18, there were 5 preregistration (Aug 4th, 18th, and Sept 14th, 15th, 22nd) events held resulting in 330 pre-registrations for the LiveHealth Kiosk. Pre-registration options (from home or office) were also communicated in the Daily Digest.

<table>
<thead>
<tr>
<th>visits during the period 3/1/17 to 1/29/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tech Student GA7649</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>109 registrations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>visits during the period 3/1/17 to 1/29/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tech Student GA7649</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>109 registrations</td>
</tr>
</tbody>
</table>

**Final Action Plan Status:** Completed-Discontinued
3.2.5 Reduce wait time to first appointment and increase number of students seen by the dietitians.

**Responsible Person(s):** Amber Johnson, Leah Galante  
**Measurement 1:** Average time to first appointment  
**Benchmark 1:** Average time to first appointment < 10 days

**Action Plan/Project:**  
- Improve efficiency of scheduling process through active management of schedule by support personnel, referral process that designates urgency of referral, pilot of group sessions.

**Semi-Annual Progress #1 (Jul-Dec):**  
- Nutrition wait time data was collected for fall semester 2017. Data indicate that, while initial consult wait times in August (fall semester began Aug 21) were slightly over 8 days, they quickly increased to nearly 24 days for initial consults in December. Urgent appointment times increased from 5.5 days in August to 6.5 days in September. After this, wait times decreased to 3.5 days in December. Data files attached.

**End of Year Progress (total fiscal year):**  
- For the time period August 17-June 18, Average time to first visit was 15.99 days. For Fall Semester the average time to first visit was 18 days; for Spring Semester the average time to first visit was 12 days, and if you exclude the month of January from calculation for Spring Semester, the average time is 10 days. This reduction in time to first appointment between Fall and Spring semesters coincides with the transition of one of the dieticians from .5 FTE to full time. Total nutrition visits for FY18 was 841, for FY17 total visits were 762, for a 10% increase in total visits.

**Final Action Plan Status:** Completed-Discontinued
3.2.6 Increase the number of GT faculty, staff, and students receiving the flu vaccine.

**Responsible Person(s):** Benjamin Holton MD, Debbie Spillers, John Scuderi

**Measurement 1:** # of flu shots given by SHS

**Benchmark 1:** >4200 flu shots given

**Action Plan/Project:**
- Work with Greek Life and other student groups to offer flu shots, work with GSGA to identify opportunities to immunize graduate students, work with communications staff to improve notification of students.

**Semi-Annual Progress #1 (Jul-Dec):**
- Stamps scheduled flu clinics in October and November for students.
- Flu shots are also available for faculty and staff every Tuesday and Thursday in the Pharmacy.
- 3,574 flu shots have been administered. Flu shots will be available in January-March.

**End of Year Progress (total fiscal year):**
- For FY18, 4,476 flu shots were administered by Stamps Health Services. Of the 4,476 shots, 4,215 were given to students in the clinic (94%) and 261 were given to faculty/staff through the pharmacy (6%). The department met the FY 18 benchmark to administer 4200 flu shots. Of the 22,000 students who attend the Atlanta campus of Georgia Tech and approximately 8,000 employees, it is difficult to determine overall, how many students and employees received the flu vaccine. Students and employees have many options to receive flu shots elsewhere, off-campus. The objective, however is to continuously increase the number of flu shots administered through Stamps Health Services. That way, health officials are able to obtain a more concrete estimate of what percent of the GT campus community is complying with CDC recommendations for the flu vaccine.

**Final Action Plan Status:** Completed-Forwarded to Next Year
3.2.7 Expand specialty services based on referral patterns.

**Responsible Person(s):** Benjamin Holton MD  
**Measurement 1:** Identify top 2 reasons for referrals  
**Benchmark 1:** Go or no go decision for specialty services by 10/2017

**Action Plan/Project:**
- Examine referral patterns and conduct a cost-benefit analysis to determine if the addition of personnel and services related to the referral specialty areas would be viable as part of Health Services.

**Semi-Annual Progress #1 (Jul-Dec):**
- Although the top two referral areas are Dermatology (249 referrals) and Orthopedics (131 referrals), we have elected to defer any further action in light of the mental health task force recommendations. It is unknown at this point if we will consider any action on specialty referrals in the future.

**End of Year Progress (total fiscal year):**
- Expansion of specialty services is deferred at this time.

**Final Action Plan Status:** Completed-Discontinued
3.3 Healthcare Delivery-Optimize health care delivery processes to ensure quality, safety, and efficiency and to reduce health disparities.

3.3.1 Improve access to data outcomes to better evaluate and communicate the results of key performance indicators.

**Responsible Person(s):** John Scuderi  
**Measurement 1:** Dashboard buildout  
**Benchmark 1:** Completed dashboard

**Action Plan/Project:**
- Procure Tableau, train developer, and identify key clinical and business processes for dashboard.

**Semi-Annual Progress #1 (Jul-Dec):**
- Procured Tableau, train Assistant Director, Health Systems (February and March 2018), identify key clinical and business processes for dashboard. We have also developed a dashboard using excel.

**End of Year Progress (total fiscal year):**
- Our Assistant Director, Health Systems completed the following Tableau training courses.  
  Desktop I: Fundamentals – February 20-21, 2018  
  Desktop II: Intermediate – March 14-15, 2018  
  Visual Analytics – April 9-10, 2018  
  We are currently building key clinical and business processes for dashboard visualization.

**Final Action Plan Status:** Completed-Discontinued
3.3.2 Enhance the efficiency of delivery-of-care process.

**Responsible Person(s):** Benjamin Holton MD

**Measurement 1:** Length of Stay in clinic

**Benchmark 1:** Average Length of Stay <80 minutes

**Measurement 2:** Percentage of student checking out at end of care process

**Benchmark 2:** Percentage of student checking out >75%

**Action Plan/Project:**
- Adjust patient flow through the clinic to direct more patients toward the cashier at the end of the visit, identify key bottlenecks that lead to increased length of stay.

**Semi-Annual Progress #1 (Jul-Dec):**
- SHS set a goal for average length of stay for primary care visits to be less than 80 minutes, and to increase the number of student checking out to >75%. The longest time interval in a patient’s length of stay in the clinic is the time period from provider completing care to discharge from the system. This time interval represents time for care given by nurses after the provider has completed assessment, time in lab or x-ray, and/or time in the pharmacy. The length of this time interval is affected by whether students who do not go to lab/x-ray/pharmacy check out and get a discharge time. For July-December 2017 our average length of stay was 83.6 minutes, longer than our goal. The percentage of students checking out has declined to 41%, which may reflect a change in location of the check-out desk. Additional efforts will be required to meet goal.

**End of Year Progress (total fiscal year):**
- Average length of stay for primary care visits for the time period 7/2017-12/2017 (fall semester) was 83 minutes. Average LOS for the time period 1/2018-6/2018 was 86 minutes. The average LOS for January through March was 96 minutes, for April through June was 75 minutes. We did not meet our goal for Average LOS. Percentage of students who checked out is 38% for FY18 through May. For the time period January-May it was 34%. Our data indicate there is still work to be done to improve percentage of students checking out and consistency of data collection.

**Final Action Plan Status:** Not Completed - Discontinued
3.4. Financial-Manage financial resources to optimize delivery of care while controlling the costs of care.

3.4.1 Improve the margin on pharmacy pricing.

Responsible Person(s): John Scuderi, Nina Thoman
Measurement 1: Pharmacy pricing margin
Benchmark 1: 3% increase over FY17

Action Plan/Project:
- Evaluate pharmacy pricing methodology and make recommendation.

Semi-Annual Progress #1 (Jul-Dec):
- Due to the manner in which the prescription pricing was previously set, the pharmacy began to see a decrease in prescription profit from FY15 to FY17. This was mainly due to the fact that the cost of prescription medications has increased substantially over the last 5 years. Since the pharmacy pricing scale was set up based on quantity sold and not a percentage markup of drug cost, the pricing scale became extremely difficult to manage properly. Thus, we reviewed all prescriptions filled during FY17 for SHIP and cash paying patients without any insurance to determine the most sustainable pricing method which would allow the pharmacy to maintain a 20% profit on prescription medications without significantly shifting increased costs to our SHIP plan and patients without insurance. We presented three models as described below.
  - Multiplier of X% (same % whether brand or generic)
  - Multiplier of 25% for Brand and Varied for Generic
  - Fixed $ Increased based on current price scales
- Ultimately, Model 2 was better suited for our needs. This eliminated the issues the pharmacy staff was having micro managing the price scales based on quantity. It also eliminated drastic price increases to the SHIP plan and non-insurance paying patients while allowing the pharmacy to maintain a 20% profit.

End of Year Progress (total fiscal year): Goal met. No further changes made during the reporting period.

Final Action Plan Status: Completed-Discontinued
3.5 Workplace Experience- Enhance the workplace experience for Stamps employees to improve and better utilize their skill sets and promote positive interpersonal interactions.

3.5.1 Strengthen employee relations skills among staff to facilitate a culture of mutual respect and support for all employees.

Responsible Person(s): John Scuderi, Keysha Buchanan

Measurement 1: Workplace Experience Survey-Items #6-9 and 16-17 (Workplace Experience Category)

Benchmark 1: Workplace Experience Survey-Items #6-9 and 16-17 of the Workplace Experience Category will be >= 80% somewhat/strongly agree

Action Plan/Project:

- Plan 1: Require supervisors and employees to attend civil treatment training (discuss with facilitator to address supervisor response consistency).
- Plan 2: Request the Campus Services HRBP and the Stamps HR Manager conduct a refresher with supervisors and employees on selected GTHR and USG employee policies.

Semi-Annual Progress #1 (Jul-Dec):

- We will be offering civil treatment training for supervisors and staff in the Spring. Date/Time TBD

End of Year Progress (total fiscal year):

- No FY 18 data were available to determine whether or not the benchmark was met. The Department of Strategic Consulting that conducted the Workplace Experience Survey decided NOT to conduct the survey at the close of FY 18 to allow departments more time to implement their action plans. The additional time will also help the Administration and Finance units to determine if their action plans were effective at improving their survey results.
- Employees attended Civil Treatment Training during the week of Spring Break. 8-10 employees were unable to participate and will be scheduled in fall of 2018.
- LaTrese Ferguson is leading a book club with manager on Rebuilding Trust in the Workplace. Similar discussions of the book will be led by manager with those who report to them.
- A Morale Committee has been formed with several events being planned for employees.

Final Action Plan Status: Completed-Forwarded to Next Year
3.5.2 Assist employees with identifying needed skills, education and training to achieve their career goals and expanded access to job opportunities.

Responsible Person(s): John Scuderi, Keysha Buchanan

Measurement 1: Workplace Experience Survey-Items #2, 3, 4, & 5 (Talent Development)

Benchmark 1: Workplace Experience Survey-Items #2, 3, 4, & 5 in the Talent Development category will be >= 80% somewhat/strongly agree

Action Plan/Project:

- Plan 1: Offer TALEO training to interested employees to be informed of and identify GT position openings that match their skill sets, credentials and interests.
- Plan 2: Have supervisors and employees collaboratively complete a career goals template as part of their annual personnel evaluation. The template allows employees and supervisors to have
  - Employees self-assess their current status are pre-determined criteria
  - Supervisors assess the employee’s status on the same criteria
  - Employees and supervisors identify steps to help the employee achieve his/her career goal
  - Supervisors offer support and resources as available
- Plan 3: Increase financial resources to help employees obtain their continuing medical education (CMEs)

Semi-Annual Progress #1 (Jul-Dec):

- Waiting on HRBP to schedule TALEO training.
- Asking supervisors to help employees identify if they’re interested in career advancement, and if yes, identify their career goal, completes tool, discuss steps to achieve goal, provide any support or resources available to help employee, and provide periodic progress on personal career goal.
- Started discussion on how professional development dollars are allocated and looking at ways to offer additional funding.

End of Year Progress (total fiscal year):

- No FY 18 data were available to determine whether or not the benchmark was met. The Department of Strategic Consulting that conducted the Workplace Experience Survey decided NOT to conduct the survey at the close of FY 18 to allow departments more time to implement their action plans. The additional time will also help the Administration and Finance units to determine if their action plans were effective at improving their survey results.
- A Director’s Fund of Professional Development dollars has been agreed upon by the Governing Board. These funds will be distributed twice a year to assist employees to attend a conference. Employees must apply for the funds. Providers (physician, NP’s, PA’s) are not eligible for these funds. Career goals will continue to be discussed as part of the annual Performance Review Process. TALEO training has not yet occurred.

Final Action Plan Status: Completed-Discontinued
4. Risk Management

- The Risk Management Program uses a process-driven approach that enables Stamps to visualize, assess and manage significant risks that may adversely impact the attainment of key organizational objectives. The governing board is responsible for: (1) ensuring the development and ongoing success of the risk management program, (2) allocating resources to implement risk management programs and activities, (3) ensuring that, where practicable, employees receive training in risk management, and (4) the program is integrated through the quality improvement process.

- The table below is a review of our program components, areas of concern and actions.

<table>
<thead>
<tr>
<th>Program Component</th>
<th>Areas of Concern</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss control prevention, which consists of identifying potentially compensable</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>events, risk assessments, occurrence reporting and management of SHS policy and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>procedure manual.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensuring that risks to health and safety are eliminated or controlled when</td>
<td>None</td>
<td>No incidents reported</td>
</tr>
<tr>
<td>planning the design of new projects, purchasing new equipment; and prior to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>introducing construction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dismissed from care or refused care.</td>
<td>No issues to report</td>
<td>None</td>
</tr>
<tr>
<td>Impaired health care professionals.</td>
<td>No issues to report</td>
<td>None</td>
</tr>
<tr>
<td>Involve the Office of Legal Affairs at the Georgia Institute of Technology as</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of timely notification to the professional liability insurance</td>
<td>No issues to report</td>
<td>None</td>
</tr>
<tr>
<td>carrier when adverse or reportable events occur.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review and analysis of all adverse incidents and incident reports</td>
<td>No issues to report</td>
<td>Reviewed by Quality Committee and Governing Board.</td>
</tr>
<tr>
<td>Facilitation of Root Cause Analysis (RCA)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ensure linkage between Risk Management and Quality Improvement.</td>
<td>No issues to report</td>
<td>No issues to report</td>
</tr>
<tr>
<td>Periodic review of clinical records and clinical record policies.</td>
<td>Policies on three year cycle or as appropriate.</td>
<td>None</td>
</tr>
<tr>
<td>Education in risk management activities, including infection control and safety</td>
<td>No issues to report</td>
<td>We continue to evaluate our onboarding process and work with hiring managers.</td>
</tr>
<tr>
<td>policies and processes, is provided to all staff within 30 days of commencement</td>
<td></td>
<td></td>
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<tr>
<td>of employment, annually thereafter, and when there is an identified need.</td>
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</tbody>
</table>
Incident Management Review

- The governing board reviews all incident reports as they occur. Data from each incident report is recorded and used to evaluate trends and risk. Each incident is assigned a score according to the grid below. Scores range from 1 (most serious) to 5 (least serious or no action needed).

<table>
<thead>
<tr>
<th>SEVERITY CODE</th>
<th>PROBABILITY CODE</th>
<th>Frequent (A)</th>
<th>Likely (B)</th>
<th>Occasional (C)</th>
<th>Rarely (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Catastrophic</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Imminent and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>immediate danger</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>of death or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>permanent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>disability.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Critical</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Permanent partial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>disability,</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>temporary total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>disability.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Significant</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Hospitalized</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>minor injury,</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>reversible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>illness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Minor</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>First aid or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>minor medical</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>treatment.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>V</td>
<td>Negligible</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Results:**
- There were a total of 16 reported incidents in 2018 versus 7 incidents in 2017. The location of incidents was spread across multiple areas with pharmacy representing 25% of the reported incidents although all were non-critical in nature.

**Risk Management CY 2018 Incident Location**

- Each incident is reported by subtype. The most common reported incident involved an injury to staff. Incidents may be forwarded to a particular Quality Committee for review. For example, incidents regarding falls and injury are forwarded to the Safety Committee.
For each subtype, the event description is as follows:

- **Fall (37%)**
  - 3- Syncope
  - 1- Lost balance
  - 1- Slipped

- **Staff Injury (25%)**
  - 2- Superficial laceration
  - 1- Equipment related
  - 1- Sharps Injury

- **Medication (13%)**
  - 2- Verification of prescription
  - 1- Pharmacy refrigerator temps

- **Code Blue (13%)**
  - 2 occurrences

- **Care of Patients (13%)**
  - 1- Left against medical advice
  - 1- Vaccination

- A risk assessment score (RAS) is assigned to each incident. Of the 16 total reported incidents, 2 incidents were assigned as significant involving a staff injury. One involved a staff injury and the other was an AMA event involving GT police and Dean of Students office. Any RAS <5 is reviewed by the appropriate staff.
5. Peer Review

Peer Review is an essential part of the Quality Program at Stamps Health Services. It occurs in several formats, including chart review and quality studies. One quality study that has been ongoing relates to recognition of and addressing of elevated blood pressure readings. Providers are given feedback on their individual performance. Below are summary data from this study:

<table>
<thead>
<tr>
<th>Provider</th>
<th># patients</th>
<th>#repeated BP</th>
<th># addressed BP</th>
<th># F/U visit rec</th>
<th>#BP&lt;140/90 achieved</th>
<th># w/FU BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 2</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Provider 4</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provider 6</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Provider 8</td>
<td>18</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Provider 10</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Provider 1</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Provider 3</td>
<td>23</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Provider 5</td>
<td>13</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Provider 7</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Provider 9</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Provider 11</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

In future iterations of this study these data will be compared by provider to measure individual improvement in performance as well as overall clinic improvement.

Women’s clinic performed Peer Review on Providers in the form of chart reviews for Procedures and chart reviews on Clinic visits. Medical Assistants had peer review done in the form of chart reviews for review of allergies and medications.

In Psychiatry Clinic, chart reviews performed by peers were completed, assessing adequate documentation of allergies and medications, mental status exam, treatment plan, patient instructions and health education, assessment of risk of harm to self or others, potential substance abuse, client’s insight, motivation and involvement. Overall level of care was also assessed. These reviews demonstrate compliance with these documentation expectations. These chart reviews are kept by Helen Gosby, the practice manager in Psychiatry.

Another peer review activity in 2018 involved assessment of compliance with AAAHC standards for documentation of informed consent, performance of time out, and written discharge instructions for procedures done at Stamps. Initial data showed 90% of reviewed charts were compliant with documentation of informed consent, 68% were compliant with documentation of performance of a time out, and 65% were complaint with documentation of written discharge instructions. This review looked at procedures done in Primary Care clinic and Women’s Clinic. Peer review of compliance with checking Allergies and Medications and compliance with checking vital signs after IV fluid administration was done for the January to April time period in 2018. 99% of charts were compliant with checking medications and allergies. 100% of charts were compliant with checking vital signs after administration of IV fluids.
6. After Hours Care

- The nurse advice line was implemented in March 2016 as a quality initiative to provide students with an after-hours nurse advice line option. This option is available when calling Stamps main phone number. For 2018, 171 calls were received. This is a 9 percent decrease over 2017.

![Nurse Advice Line Calls Per Month](image)

- To better understand call patterns, we look at time of call, call type and age of caller. No anomalies were observed. Note: All calls since inception.

![Age of Caller](image)
• Calls are defined as medical or as other. Other includes general questions about Stamps, immunizations, insurance, appointments, and charges.

• All medical calls are reported to Stamps within 1-2 business days. The Senior Director contacts the caller within 2 business days to see if any further assistance can be provided. Note: All calls since inception.
7. Quality Improvement

Quality Project Name: 7.1 Allergy Patient Compliance Study
Project Owner: Debbie Spillers, RN
Start Date: 08/22/2017
End Date: 05/15/2018
Cycle: 1

---

PLAN

1. A statement of the purpose of the QI study that includes a description of the problem and an explanation of why it is significant to the organization. Improve compliance among allergy patients to their prescribed schedule of injections in order to reduce significant reactions, increase the efficacy of the treatment and decrease the need for additional written orders from allergists’ offices.

2. Identification of the measurable performance goal against which the organization will compare its current performance in the area of study.
   SHS measurable goals are as follows: (1) Decrease in number of allergy injection patients that miss 3 or more injection visits. (2) Decrease need for new written orders from allergists’ office and incidence of incorrect orders given from allergists’ offices.

---

DO

3. A description of the data that will be collected in order to determine the organization’s current performance (i.e., study methodology.)
   - Atlanta allergist vs out of area allergist
   - Non-compliant patients with difficult orders
   - Patients that miss more than 3 visits
   - Clarity of orders from allergists offices
   - Occurrence of systemic or increasingly significant local reactions.

---

STUDY

4. Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).
   The event results are as follows:
   Fall semester data shows the following:
   *Of 77 current allergy patients we still have 13 that are under the care of an allergist out of the Atlanta area and 11 that are out of state. These are patients that were receiving allergy injections prior to the new policies being enacted.
   *Non-compliance due to missed appointments (over 3 appointments)
     8 out of 24 --- out of Atlanta area and/or out of state
     3 out of 53 with Atlanta based allergist
   *Out of a total of 77 patients, only 17 have not had to have orders clarified for any reason. Even patients that do not miss appointments have unclear instructions and incomplete orders.
   *Still with multiple faxes to allergists’ offices to correct/clarity orders --- incident log created to document these occurrences.
   *Not a measureable increase in the number of systemic reactions
5. A comparison of the organization’s current performance in the area of study against the previously identified performance goal. No improvement as of this cycle, due to no corrective actions as of yet.

6. Implementation of corrective action(s) to resolve identified problem(s).
   Review and resign policy and procedure statements that address compliance with allergy injections schedules. No show messages sent consistently to patients that miss their appointments
   Declining administration of allergy injections to students who continue to be non-compliant with their injection schedules and returning them to the care of their allergist.

7. Re-measurement (a second round of data collection and analysis to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.
   Will perform cycle 2 over the summer.

8. Communication of the findings of the quality improvement activities.
   Results will be shared with applicable staff, governing board, quality committee, and medicine committee.
Quality Project Name: 7.2 Improved Same Day Access to appointments.
Project Owner: Benjamin Holton, MD
Start Date: October 1, 2018
End Date: December 31, 2018
Cycle: 1

PLAN

1. A statement of the purpose of the QI study that includes a description of the problem and an explanation of why it is significant to the organization.

Most visits to Primary Care Clinic at SHS are due to acute illness or injury. The proportion of students seeking care for management of chronic illness or injury is relatively small compared to a traditional primary care practice in a community setting. SHS has traditionally had an appointment based system for seeing patients, as opposed to a walk-in based system. The advantages of an appointment based system include reduced wait time once the patient arrives in the building and more evenly distributed patient encounters throughout the day instead of encounters bunched up at popular times for students to walk in, such as lunch time. A disadvantage of the appointment based system has been that students who are acutely ill or injured cannot find an available appointment for 1-3 days. As a result, a number of students would present as walk in patients and end up being seen by a nurse for triage.

2. Identification of the measurable performance goal against which the organization will compare its current performance in the area of study.

SHS measurable goals are as follows:
- Reduction of walk in patients by at least 25%
- Walk in patients are a surrogate measure of the need for same day appointments

DO

3. A description of the data that will be collected in order to determine the organization’s current performance (i.e., study methodology.)

- Number of walk in patients per day.
- Comments on the Monthly Customer Service Survey will also reviewed to see if there is a change in the number of comments about access to same day appointments. This data is more difficult to obtain, and the number of comments is not great at baseline

STUDY

4. Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).

The event results are as follows:
For the first six weeks of fall semester (8/20/18-9/28/18), a total of 409 walk in patients were seen for an average of 68 patients per week.

5. A comparison of the organization’s current performance in the area of study against the previously identified performance goal.

Since the goal of this study was a percent reduction in walk-in patients, no absolute benchmark was available against which to compare current performance.
6. Implementation of corrective action(s) to resolve identified problem(s).
   Approximately 20 percent of appointments were set up as same day appointments, becoming available online at 7am the day of the appointment.

7. Re-measurement (a second round of data collection and analysis to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.
   For the 10 weeks in the rest of fall semester (10/1/18-12/7/18) 422 walk in patients were seen, for an average of 42.2 per week. This is a reduction of 38% in the number of walk-in patients seen before and after implementation of the same day appointments. We achieved the goal of reducing walk in patients by at least 25%.

8. Communication of the findings of the quality improvement activities.
   Results of the study were shared with Quality Committee and Governing Board at their meetings and was shared with all SHS staff at an All-Staff meeting.
8. Quality Assurance

Quality Project Name: 8.1 Prescribing and Dispensing Events
Project Owner: Nina Thoman, Pharmacy Manager
Start Date: January, 2018
End Date: December, 2018
Cycle: 13

PLAN

1. A statement of the purpose of the QI study that includes a description of the problem and an explanation of why it is significant to the organization.

Prescription and dispensing events are commonly reported in the literature. SHS wanted to determine if our pharmacy experienced events and if yes, how did we perform against a peer pharmacy. The purpose of this study is as follows:

- To determine the prescription and dispensing event percentage.
- Prevent the potentially harmful consequences of prescription and dispensing events.
- Improve the efficiency and effectiveness of providers prescribing medications.
- Reduce SHS liability that can be associated with prescription and dispensing events.

2. Identification of the measurable performance goal against which the organization will compare its current performance in the area of study.

SHS measurable goals are as follows:
- Prescribing events = ≤0.30%
- Dispensing events = 0%
- Provider compliance on updating Rcopia within 2 business days = 100%

DO

3. A description of the data that will be collected in order to determine the organization’s current performance (i.e., study methodology.)

SHS prescription records will be reviewed and the prescription events counted as follows:

- Incorrect dosage or duration (Wrong/No strength, Wrong/No Qty)
- Incomplete Rx (Incomplete/Incorrect Sig, Wrong Drug, Wrong Patient)
- Other prescribing events (Wrong Formulation, No Signature/Wrong Provider)
- Drug/drug interaction (prescribed medication which affects the activity of another medication the patient is taking)
- Drug/allergy interaction (Allergy)
- Drug/disease contraindication (prescribed medication is contraindicated with the patient's other disease states or diagnosis.)
- Clinical Abuse/Misuse (medication is prescribed in an inappropriate manner in regards to indication or dose, or its use results in adverse social/personal results for the patient.)
- Therapeutic Duplication (two or more medications of the same type/category are unintentionally prescribed to treat a medical condition)
- The events listed above are then classified (in order of significance) and reported by percentage as follows:
  - **Type A** (Potentially serious to patient) - Wrong Patient, Wrong Drug, and Incomplete/Incorrect Sig, Drug-Drug Interaction, Allergy, Drug-Disease Contraindication, Therapeutic Duplication
  - **Type B** (“Major nuisance” Pharmacist must contact prescriber) - Wrong Formulation, Wrong/No Strength, Wrong/No Qty, No Signature/Wrong Provider, Clinical Abuse/Misuse
• **Type C** (“Minor nuisance” Pharmacist may dispense the prescription using professional judgment without contacting prescriber) – Wrong Pharmacy
• **Type D or Trivial** (Prescription does not conform to guidelines) – OTC escribed

### STUDY

1. **Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).**

The event results based on 20,260 newly prescribed SHS prescriptions are as follows:

<table>
<thead>
<tr>
<th></th>
<th>SHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Event Rate</td>
<td>0.36%</td>
</tr>
<tr>
<td>Dispensing Event Rate</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Based on the results, we expanded our review of prescribing events at SHS and classified them (in order of significance) as Type A, B, C, and D. The results are as follows: **Type A = 0.19% (38 events)**, **Type B = 0.17% (36 events)**, **Type C = 0.06% (13 events)**, and **Type D = 0.05% (10 events)**.

2. **A comparison of the organization’s current performance in the area of study against the previously identified performance goal.**

Prescribing Events- SHS is not at goal.
Dispensing Events- SHS is at goal.
Medicat/Rcopia Updated- SHS is not at goal (67% corrected).

### ACT

3. **Implementation of corrective action(s) to resolve identified problem(s).**

**Prescribing Events**- The occurrence of Type A events is predominately “Incomplete/Incorrect Sig” for Cycle 13. The pharmacist will continue to communicate with the head of each department any concerns regarding education/training of their staff. As the majority of the events are due to incomplete/incorrect sig, the heads of each department should reiterate with their providers to review the prescription in its entirety for accuracy one last time prior to “signing and sending.”

Our review of provider compliance on updating Rcopia within 2 business days found that 67% (73 correctable errors) were in compliance. The pharmacy currently Medicat messages the provider as a reminder to update the patient’s EHR. The pharmacy will continue to send these messages.

**Dispensing Events**- No deficiencies noted.

4. **Re-measurement (14th round of data collection and analysis to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.)**

We will perform cycle 14 (January 2019 - December 2019).

5. **Communication of the findings of the quality improvement activities.**

Results will be presented to the P&T Committee for review and additional guidance. The head of each department will also receive the data upon completed review by the P&T Committee.
3-year tending data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed prescriptions</td>
<td>2,858 newly prescribed SHS prescriptions</td>
<td>26,544 newly prescribed SHS prescriptions</td>
<td>27,027 newly prescribed SHS prescriptions</td>
</tr>
<tr>
<td>Prescribing Event Rate</td>
<td>0.48%</td>
<td>0.43%</td>
<td>0.46%</td>
</tr>
<tr>
<td>Dispensing Event Rate</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>
8.2 Urinary Tract Isolates
Helen Ukoh, Laboratory Manager

1. Providers use the antibiotic sensitivity data of urinary to pathogens to make evidence based decisions on selection of appropriate antibiotics to treat urinary tract infections in our population. Additionally, evaluating the percentage of patients treated with antibiotics who had negative cultures is instructive. Based on data obtained in the study, providers had a discussion of the appropriate use of antibiotics in patients with symptoms of urinary tract infections. Pathogen sensitivity has remained fairly stable during the study years. Providers should be diligent to monitor for increased rate of treatment failure requiring a change in antibiotics.

2. Note that the sensitivity of E. coli to TMP-SMX is 77% (same as in 2013.) It is recommended that when sensitivity of E. coli to TMP-SMX is less than 80%, other antibiotics be considered for first line treatment of uncomplicated UTI in females. 100% of the E. coli isolates were sensitive to nitrofurantoin.

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL # OF URINE</td>
<td>137</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>POS (those with susc. testing)</td>
<td>65(47%)</td>
<td>38(76%)</td>
<td>39(78%)</td>
<td>40(80%)</td>
<td>36(72%)</td>
<td>37(74%)</td>
</tr>
<tr>
<td>NEG or contaminants</td>
<td>72(53%)</td>
<td>12(24%)</td>
<td>11(22%)</td>
<td>10(20%)</td>
<td>14(28%)</td>
<td>13(26%)</td>
</tr>
<tr>
<td>Chlamydia T. RNA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ORGANISMS ISOLATED FROM POSITIVE URINE CULTURES**

<table>
<thead>
<tr>
<th>ORGANISM</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>E.coli</em></td>
<td>80%</td>
<td>76%</td>
<td>89.7%</td>
<td>72.5%</td>
<td>61.0%</td>
<td>62.2%</td>
</tr>
<tr>
<td><em>Staph. saprophyticus</em></td>
<td>9%</td>
<td>8%</td>
<td>5.1%</td>
<td>17.5%</td>
<td>14.0%</td>
<td>24.3%</td>
</tr>
<tr>
<td><em>Kleb. pneumoniae</em></td>
<td>3%</td>
<td>5%</td>
<td>2.6%</td>
<td>5.0%</td>
<td>8.3%</td>
<td>8.1%</td>
</tr>
<tr>
<td><em>Proteus mirabilis</em></td>
<td>3%</td>
<td>0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other*</td>
<td>5%</td>
<td>11%</td>
<td>2.6%</td>
<td>5.0%</td>
<td>13.9%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

*Includes: Enterobacter sp.; Citrobacter sp.; Staph. aureus; Coag neg Staph (not Staph. saprophyticus), Group B beta-hemolytic Streptococcus; Pseudomonas sp; etc.

*Notes for 2018 study: 69% of negative cultures reported as Contaminants - “Single or Multiple organisms present, each less than 10,000 cfu/ml” One sample positive for K.pneumoniae and Staph saprophyticus.
No E.coli (ESBL) isolate ed in 2015; 2017; 2018
Note: No P. mirabilis isolated in 2014; 2015; 2016; 2018
Note: No C. koseri isolated in 2014; 2015; 2016, 2017; 2018
8.3 Laboratory Monthly Turnaround Time (TAT) report
Helen Ukoh, Manager Diagnostic Services

Reference Laboratory
Goal: ≥ 98% of ordered test resulted within the established TAT.
Result: ≥ 98%
Variance Analysis:
January: Instrument problem at the Reference Lab for 4 days
December: Excessive delays in testing

![Reference Lab TAT 2018](chart)

### Reference Lab TAT 2018

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Compliance</td>
<td>94.6%</td>
<td>99.0%</td>
<td>99.0%</td>
<td>98.8%</td>
<td>99.3%</td>
<td>98.6%</td>
<td>99.3%</td>
<td>98.7%</td>
<td>97.8%</td>
<td>99.2%</td>
<td>99.2%</td>
</tr>
<tr>
<td>Total # of Test</td>
<td>2232</td>
<td>2010</td>
<td>1812</td>
<td>1646</td>
<td>1142</td>
<td>938</td>
<td>1051</td>
<td>2448</td>
<td>1886</td>
<td>2381</td>
<td>1786</td>
</tr>
</tbody>
</table>
8.4 Test Not Performed
Helen Ukoh, Manager Diagnostic Services

TEST NOT PERFORMED (TNP): due to hemolysis, wrong test, wrong sample, mislabeled, difficult stick, etc.
Goal: ≤ 1% of TNP for any reason
Result: Within goal

<table>
<thead>
<tr>
<th>TNP</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.1%</td>
<td>0.3%</td>
<td>0.4%</td>
<td></td>
</tr>
</tbody>
</table>
8.5 Laboratory Monthly Turnaround Time (CBC-TAT) report
Helen Ukoh, Manager Diagnostic Services

CBC
Goal: ≥ 98% of ordered test resulted within the established TAT.
Result: ≥ 98%

Variance Analysis:
August: Workload issues
October: Instrument problems
December: Delay in annual instrument maintenance

<table>
<thead>
<tr>
<th>Month</th>
<th>% Compliance</th>
<th>Total CBCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN</td>
<td>99.3%</td>
<td>148</td>
</tr>
<tr>
<td>FEB</td>
<td>99.5%</td>
<td>183</td>
</tr>
<tr>
<td>MAR</td>
<td>98.4%</td>
<td>192</td>
</tr>
<tr>
<td>APR</td>
<td>98.9%</td>
<td>183</td>
</tr>
<tr>
<td>MAY</td>
<td>98.2%</td>
<td>110</td>
</tr>
<tr>
<td>JUN</td>
<td>98.2%</td>
<td>110</td>
</tr>
<tr>
<td>JUL</td>
<td>100.0%</td>
<td>104</td>
</tr>
<tr>
<td>AUG</td>
<td>97.1%</td>
<td>140</td>
</tr>
<tr>
<td>SEP</td>
<td>100.0%</td>
<td>168</td>
</tr>
<tr>
<td>OCT</td>
<td>97.1%</td>
<td>205</td>
</tr>
<tr>
<td>NOV</td>
<td>98.4%</td>
<td>183</td>
</tr>
<tr>
<td>DEC</td>
<td>94.5%</td>
<td>109</td>
</tr>
</tbody>
</table>
8.6 Unacceptable PT Error
Helen Ukoh, Manager Diagnostic Services

Unacceptable proficiency testing error
Goal: ≤ 5 per year
Result: Within goal

No errors reported
8.7 Hematology -Hematocrit (Hem-5D) (%) Abbott Cell-Dyn Ruby
Helen Ukoh, Manager Diagnostic Services

Results: SHS Laboratory Proficiency Testing was within the acceptable range across all tests.

<table>
<thead>
<tr>
<th>SAMPLE ABT-06</th>
<th>Peer Group</th>
<th># Labs</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Uncertainty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abbott Cell-Dyn Ruby</td>
<td>206</td>
<td>42.7</td>
<td>1.1</td>
<td>40 - 46</td>
<td>0.1</td>
</tr>
</tbody>
</table>

![Graph showing Hematocrit results for SAMPLE ABT-06](image)

<table>
<thead>
<tr>
<th>SAMPLE ABT-07</th>
<th>Peer Group</th>
<th># Labs</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Uncertainty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abbott Cell-Dyn Ruby</td>
<td>208</td>
<td>31.8</td>
<td>0.9</td>
<td>29 - 34</td>
<td>0.08</td>
</tr>
</tbody>
</table>

![Graph showing Hematocrit results for SAMPLE ABT-07](image)

<table>
<thead>
<tr>
<th>SAMPLE ABT-08</th>
<th>Peer Group</th>
<th># Labs</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Uncertainty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Group</td>
<td># Labs</td>
<td>Mean</td>
<td>SD</td>
<td>Range</td>
<td>Uncertainty</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------</td>
<td>------</td>
<td>-----</td>
<td>-------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Abbott Cell-Dyn Ruby</td>
<td>208</td>
<td>21.1</td>
<td>0.6</td>
<td>19 - 23</td>
<td>0.05</td>
<td></td>
</tr>
</tbody>
</table>

### SAMPLE ABT-09

<table>
<thead>
<tr>
<th>Peer Group</th>
<th># Labs</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Uncertainty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott Cell-Dyn Ruby</td>
<td>208</td>
<td>21.2</td>
<td>0.6</td>
<td>19 - 23</td>
<td>0.05</td>
</tr>
<tr>
<td>Peer Group</td>
<td># Labs</td>
<td>Mean</td>
<td>SD</td>
<td>Range</td>
<td>Uncertainty</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------</td>
<td>------</td>
<td>-----</td>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>Abbott Cell-Dyn Ruby</td>
<td>207</td>
<td>42.8</td>
<td>1.1</td>
<td>40 - 46</td>
<td>0.1</td>
</tr>
</tbody>
</table>
8.8 Radiology Turnaround Times
Tabarrion Stoves Radiology Coordinator

Goal: 98%
Read within 24 hours = 98%

Results: All tests read after 24 hours are flagged and follow-up completed by the radiology coordinator. Since all radiology exams are read by a SHS board certified physician at the time of visit, there is very low risk or patient care implication.

February-March: The exams were read within 24hrs, but were not transcribed and pasted into our imaging reporting system.
April-June: Pacs/Ris system was down for server repair.
August: The exams were read within 24hrs, but were not transcribed and pasted into our imaging reporting system.
8.9 Overread External Misses
Tabarrion Stoves Radiology Coordinator

Goal: <5% of total over reads
Results: Within goal
Clincs were asked to review 25 randomly selected charts that included at least one primary care visit. Each chart was evaluated for documentation of:

- Medication and material allergies
- Influenza vaccination
- Screening for tobacco
- Screening for depression
Depression Screening
Mean Compliance = 40%
Georgia Institute of Technology = 0%

SD = .42.8%
Variance = 1836%
Percentiles:
25th = 0%
50th = 28%
75th = 92%

Influenza Documentation
Mean Compliance = 40%
Georgia Institute of Technology = 16%

SD = 33.5%
Variance = 1120%
Percentiles:
25th = 8%
50th = 36%
75th = 68%
Tobacco Screening
Mean Compliance = 85%
Georgia Institute of Technology = 100%

SD = 21.3%
Variance = 455%

Percentiles:
25th = 84%
50th = 92%
75th = 96%
11. Psychiatry Wait Times

- In the fall semester of the 2017-2018 academic year the Georgia Tech community suffered a significant trauma with the death of a student on campus. Access to mental health services became an issue in the aftermath of this event, and wait times for an appointment in the GT Counseling Center and in Stamps’ Psychiatry Clinic were identified by the community as issues to be addressed. Stamps initiated a PDSA with a measurable goals of 90% of patients will wait <10 days for first assessment. The original model involved the Care Coordinators and psychiatrists being organized into teams. First assessments will be done by care coordinators, with scheduling arranged to maximize their availability. Patient flow will be redesigned to a model where patient requests appointment with psychiatry clinic → appointment with care coordinator → appointment with psychiatrist.

- After review of the results from July 2017 to December 2017, additional reduction in wait time to see a psychiatrist was needed. A change in the workflow for appointment with a psychiatrist, so that a student saw both the care coordinator and the psychiatrist on their first visit reduced the time to first contact with a psychiatrist from 16.8 days to 9.1 days.