Stamps Health Services
2019 Annual Quality Report

Completed by:
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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.

One major component of the Stamps Health Services Quality program is our quality committees, including the Quality Committee which oversees all quality related activities, and its subcommittees which are the Infection Control and Prevention Committee, the Medicine Committee, and the Pharmacy and Therapeutics Committee. The Infection Control and Prevention Committee oversaw quality assurance activities including compliance with reporting of mandatory notifiable diseases, surveillance cultures throughout the SHS building, annual urine culture study, and latent TB treatment compliance. One clinical result of such activities was learning that SHS achieved better treatment success with a 4-month course of Rifampin than with other regimens. The Pharmacy and Therapeutics Committee continued to review and update the SHS formulary each quarter. It also continued to monitor Prescribing Error Events. Type A and Type B prescribing error rates remain below 0.5%. The Medicine Committee continued its Elevated Blood Pressure quality study, oversaw implementation of a pop-up alert Medicat for a positive suicide screen that reduced the likelihood that a positive response would be overlooked, and evaluated the implementation of administration of Gardisil vaccine in Women’s Clinic, with a small increase in number of vaccines given as a result.

Stamps Health Services submitted several goals to Campus Services. Notably, SHS did achieve a reduction in the time between a new psychiatry patient’s initial contact with SHS and their first appointment with a psychiatrist. SHS also achieved its goal of increasing the number of GT faculty, staff and students who received a flu vaccination, with 5585 flu shots administered, exceeding our goal of 4500. SHS also achieved an improvement in compliance with utilizing two patient identifiers to identify patients.

SHS saw a reduction of incidents reported through its Risk Management Program. Medication error was the most common incident identified through the Risk Management program (5 events). As part of the program each incident was analyzed and steps take to prevent recurrence. No significant harm was identified.

Monitoring of Nurse Advice Line calls continued as part of the Quality Program. 100% of calls to the nurse advice line for a medical issue were followed up within 2 days, exceeding the goal of 90%.

Stamps Health Services performed several quality studies in 2019. One study looking at compliance with rectal screening for gonorrhea for at risk individuals showed a lack of improvement with time, indicating further work is needed in this area. A second study showed significant improvement in the number of flu vaccinations given in Women’s Clinic as a result of providing a refrigerator in Women’s Clinic to store the vaccine. A similar success in increasing administration of first dose of Gardisil vaccine was seen in Women’s Clinic by incorporating vaccination as part of routine care and making the vaccine available in the Women’s clinic.

Quality assurance activities monitored Prescribing error rates, urinary tract isolates’ antibiotic sensitivity, Lab and radiology turn-around times for test results, and review of medications and medication allergies by nursing staff. No significant deviations from expectations were identified. SHS also participated in a benchmarked study through AAAHC looking at compliance with Medication Reconciliation for the time period July-December 2019. Stamps demonstrated 100%
compliance with documentation of designated pharmacy, documentation of known medication allergy, and documentation of medication list update.

Stamps Health Services remains strongly invested in providing high quality care to our students. This report demonstrates this commitment and illustrates the success that SHS has achieved in this endeavor.

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, PAC-Vice-Chair
- Dr. Frank Pickens
- Helen Ukoh, Diagnostics Manager
- Huei Chu, Medical Assistant
- Denise Fair, RN
- Sarah Morales, CHES

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. (130 chlamydia, 41 gonorrhea, 1 HIV, 7 Syphilis, 1 Lyme disease, 1Hep B, 1 Hep C, 5 potential fox bites, I Salmonella and Campylobacter.
- Surveillance cultures were done monthly with entire building covered over the course of the year. Only finding was the downstairs water fountain culture growth of B diminuta. 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.
- Latent TB treatment surveillance was done. Findings shared with providers included better treatment success with shorter 4 month medication source.
- PDSA on adherence cultures for at risk patients for rectally sexually transmitted diseases was initiated. Conclusion expected in 2020.

Metrics:
- Reportable Disease Reporting- Goal: 100%
- **Results:** Reportable disease reporting continues to improve. Actual reporting was 94% and 100% after provider reminder. Goal achievement occurred after rare provider reminders.

![Reportable Diseases Compliance 2019](image)

**Other Communicable Diseases**
- For 2019, Strep and flu case load and % positivity was within expected ranges with typical seasonality. Cases of chlamydia and gonorrhea continued a 10% increase per year (each over the past 5). Rare cases of syphilis, hepatitis, HIV, Lyme disease and GI infectious diseases provide to be all episodic and were all treated.

![Strep 2019](image)
2.2 Pharmacy and Therapeutics Committee

Members
- Nina Thoman PharmD- Chair
- Paula Gaffney, RN
- Benjamin Holton, MD
- Angelo Galante, MD
- Marjan Kirkland, NP
- Cindy Naivar, CMA(AAMA), CPC
- Steven Terry, PA-C
- Marjan Kirkland, FNP-C
- John Scuderi- 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
- Annual Formulary Review – The Pharmacy’s Annual Inventory was completed on June 28, 2019. Documentation was forwarded to the Director of Health Operations for upload to PolicyTech.
- Prescribing Event Data
  - Type A 0.22% (47 events)
  - Type B 0.21% (44 events)
  - Type A/B 0.43%
  - Type C 0.08% (16 events)
  - Type D 0.19% (38 events)
  - Medicat/Rcpia Updated 62%
  - Total New Scripts = 20,424
- Dispensing Event 0.01% (2 events)
- Education regarding event data – The pharmacy staff contacts the provider at minimum for any Type A and B events. All events are submitted to the SHS Senior Director as they occur for review.
- DUR – Medications Added Upon Review
- Ondansetron (Zofran) 4mg/2ml Injection
- Xofluza
- Tetracaine 0.5% Ophthalmic Solution (15ml bottle changed to 4ml)
- Promethazine (Phenergan) 25mg Suppository

Reviewed and updated committee charter.
2.3 Medicine Committee

Members
- Emily Richardson, MD- Chair
- Benjamin Holton, MD
- Diane Heath, MD
- Steven Terry, PA-C
- John Scuderi-Director, Health Operations
- Shan Baker, WNP–Women’s Health Mgr.
- Shannon Croft, MD-Lead Psychiatrist
- Julie Powell, NP
- Melanie Thomas, RN
- Brain Humphries, MA

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

Objectives: What are the results of the committee’s review and evaluation of the objectives. (Please list each objective and results)
- Peer review activities: hypertension quality study (accuracy of BP measurement by support staff, response to abnormal BP level by provider.
- Monitoring adherence to the standard of care: hypertension quality study; universal depression screening
- Review of clinical policies and procedures: reviewed appropriate method of BP measurement with support staff, with written guidelines.
- Monitoring effectiveness and efficiency of clinical operations: use of pop-up alerts in Medicat for positive suicide screens; administering Gardasil vaccine in Women's Clinic.

The objectives revisions for the upcoming year include: (Please list each)
- Continuation of hypertension quality study
- Assessment of increased HPV vaccine administration rates, now that Women's Clinic has joined TIA as a point-of-care administration site.
- Continued evaluation of Stamps' role in promoting safer use of e-scooters.
1. Performance: What are the results of performance improvement projects selected for the year? (Please list each project and result)

- Hypertension quality study: Reduction in number of encounters documenting elevated blood pressures was noted after initial intervention, which focused on accurate measurement of BP by support staff. Provider response to confirmed elevated readings still displayed significant room for improvement. As the next intervention, providers were asked to include "elevated blood pressure" as a diagnosis code for the visit, and to schedule the patient for subsequent nurse visits to reassess BP (at a minimum - additional or alternative interventions to be made at provider's discretion). Further analysis did not show significant change in provider response rate.

- Depression screening: Implementation of a pop-up alert for positive suicide responses improved visibility of this response in the chart, reducing the likelihood that a positive response would be overlooked.

- Gardasil administration in Women's Clinic: Monitoring of numbers of Gardasil vaccines administered at SHS is ongoing, to assess the impact of Women's Clinic joining TIA as an administration site. Initial data revealed an overall increase in number of Gardasil vaccines given for the same time periods in 2018 and 2019, but only a small portion of the increase was attributable to Women's Clinic. A more longitudinal assessment is expected to show further increase.

- Monitoring of visits for e-scooter accidents has been challenging due to the lack of an appropriate ICD-10 code for tracking. The overall rate of visits for such accidents was noticeably higher in warm weather months. Inclement weather, higher prices for use, and a reduction in the number of scooter companies in the Atlanta market were all felt to be contributing to a reduction in reported accidents during the latter quarter of 2019/early 2020. GTPD/CRC now have a joint program for bike and e-scooter safety, which has monthly classes. Dr. Holton has attended these classes when able. Free helmets are available at the RideSmart classes.

Any revisions in the plan/program performance improvement indicators/measures for the upcoming year?

- Depression screening has been successfully implemented and will no longer be directly followed in this committee, unless a change in program status occurs.

- Hypertension quality study will be ongoing, with new interventions and follow-up assessments to be made. A new flag system outside each primary care clinic exam room may improve provider response rates if utilized effectively.

- Assessment of Gardasil administration in Women's Clinic will be ongoing.

- Monitoring of trends in e-scooter safety issues will be ongoing.
3. Goals

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

Objective 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 Medicat 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.
Final Action Plan Status: For patients with elevated readings of >140 systolic and /or >90 diastolic, 10 of 16 (62.5%) achieved normal BP on either on repeat check the same day or at a subsequent visit. Additional measures are needed to improve the percentage of patients achieving a normal blood pressure.

Objective 3.1.2: Improve the documentation of patient visit procedures.

Responsible Person(s): Benjamin Holton MD
Measurement 1: Percent of audited patient records that document Time Out, a signed consent statement, and written discharge instructions.
Benchmark 1: 80% of audited patient records will demonstrate evidence of: Time Out (practitioner checks patient's identification and confirms procedure or purpose of visit with patient), A signed consent statement, and written discharge instructions
Action Plan/Project: Audit patient records to identify the percent that demonstrate compliance with documenting Time Out, a signed consent statement, and discharge instructions.
Final Action Plan Status: Selected chart review of patients who had procedures for Primary Care and Women’s Clinic for the time periods of December-May 2019 for Women’s clinic and March-May 2019 for Primary Care Clinic shows 100% of charts had a signed consent, 66.7% had Time Out documented, and 74.1% had written discharge instructions documented. 59.3% of charts had all three documented. We did not meet our goal of 80% for documentation of all three factors. We have seen improvement towards our goal, particularly with regard to signed consents. This is in part due to resolution of technical issues within our electronic medical record that was causing signatures on consents not to be captured. We will continue to monitor this parameter and improve our documentation of patient visit procedures. Since it is a requirement for our AAAHC accreditation we feel this is better served as a quality assurance initiative.
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.

Objective 3.2.1: Reduce the wait-time between a new psychiatry patient's initial contact with SHS to his/her first appointment with a psychiatrist.

Responsible Person(s): Shannon Croft MD
Measurement 1: Wait-time from new psychiatry patient's first contact with SHS to his/her first appointment with a psychiatrist
Benchmark 1: The average wait time from the new psychiatry patient's initial contact with SHS to his/her first appointment with a psychiatrist will be <10 business days (FY 18 was 20 business 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.
Final Action Plan Status: An average wait time of 9.8 days from when a student contacts the psychiatry clinic to when they are seen by a psychiatrist. With opening of the CARE center, this tracking is no longer needed. We are discontinuing this objective.

Objective 3.2.2: Improve the outpatient therapy referral process to transition patients 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 outside provider referral.
Action Plan/Project: Provide a timely referral to patients and conduct a follow-up with outside provider to ensure the patient is continuing therapy.
Final Action Plan Status: A chart review of 25 randomly selected patients suggested that 44% of patients (11 out of 25 patients) were not connected to therapy 1-2 months following the psychiatrist’s recommendations. 56% (i.e., 14 patients) were connected. Patients completing a visit to an outside provider continues to be a challenge. Our benchmark of 75% was ambitious and likely too high of a benchmark since there are a number of factors that impact a successful referral not within our control. We will continue to measure this but believe a new benchmark of 65% better reflects a successful referral process.

Objective 3.2.3: Increase the number of GT faculty, staff, and students receiving the flu vaccine.

Responsible Person(s): Benjamin Holton MD
Measurement 1: # of flu shots administered by Stamps Health Services.
Benchmark 1: >4500 flu shots administered.
Action Plan/Project: Provide flu clinics throughout the flu season and vary the locations throughout the campus.
Final Action Plan Status: In FY19 we had given 5585 flu shots, exceeding our goal by 24%. Students=5322, Faculty/Staff= 263. We will continue to monitor.
Objective 3.2.3: Increase the number of GT faculty, staff, and students receiving the flu vaccine.
Responsible Person(s): Benjamin Holton MD
Measurement 1: # of flu shots administered by Stamps Health Services.
Benchmark 1: >4500 flu shots administered.
Action Plan/Project: Provide flu clinics throughout the flu season and vary the locations throughout the campus.
Final Action Plan Status: In FY19 we had given 5585 flu shots, exceeding our goal by 24%. Students=5322, Faculty/Staff= 263. We will continue to monitor.

3.3 HEALTHCARE DELIVERY-Optimize health care delivery processes to ensure quality, safety, and efficiency and to reduce health disparities.

Objective 3.3.1: Improve the documentation of patient identification in the Travel/Immunization/Allergy and Primary Care clinics.

Responsible Person(s): Benjamin Holton MD
Measurement 1: Percent of patients presenting TWO identifying documents
Benchmark 1: >= 80% of Travel/Immunization/Allergy and Primary Care clinic patients will present TWO identifying documents
Action Plan/Project: Create a template in Medicat to accommodate patients demonstrating evidence of two identifying documents and educate staff on the new requirements.
Final Action Plan Status: For the time period sampled (week of April 22-26), 95.67% of charts in Primary Care and Women’s Clinic documented that the student was identified using two or more patient identifiers. In Travel/Immunization/Allergy clinic, 98.59% of charts for patients receiving a vaccination and 100% of charts for students receiving an allergy shot documented that the student was identified using two or more patient identifiers. Overall, 96.11% of students were identified using two or more identifiers. This exceeds our goal of 80%, and it is a significant improvement from the midyear rate of 85.45%. These data demonstrate that adding this prompt to the templates in Primary Care, Women’s clinic, and TIA clinic were an effective mechanism to encourage compliance with correct identification of patients. This compliance goal is completed; however, we will continue to use this mechanism to encourage correct identification of patients and continue to monitor this as a Quality Assurance measure.

3.4 FINANCIAL-Manage financial resources to optimize delivery of care while controlling the costs of care.

Objective 3.4.1: Improve payment collections at time of patient discharge.

Responsible Person(s): John Scuderi
Measurement 1: Amount ($) of Bursar uploaded per month
Benchmark 1: Reduce the total amount ($) of charges uploaded to the Bursar by 25% from FY 18 (baseline for FY 18 was $108,940). The 25% reduction would then be a benchmark of $81,275.
Action Plan/Project: Require patients to complete a checklist sheet for their visit, the last item of which includes checking-out at the discharge desk, paying his/her bill and returning the completed checklist.
Final Action Plan Status: For the reporting period, the percentage of discharged patients has increased from 57% to 61%. The goal to reduce the total amount ($) of charges uploaded to the Bursar by 25% will not be measurable until the next reporting period. A 4 percentage point
increase in discharges may not yield the goal since not all discharged patients have associated charges. Efforts continue to increase the number of discharged patients in order to capture more patients with charges. Will continue to monitor and evaluate ways to improve collections at time of patient discharge.

3.5 WORKPLACE EXPERIENCE- Enhance the workplace experience for Stamps employees to improve and better utilize their skill sets and promote positive interpersonal interactions.

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

**Responsible Person(s):** Benjamin Holton MD  
**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:** Work to enhance the workplace experience.

**Final Action Plan Status:** Steps that Stamps has taken to cultivate a culture of mutual respect and support for all employees include participation in a book club discussing Rebuilding Trust in the Workplace, two luncheons to encourage fellowship among staff (one prior to school starting, one after students left for Winter Break), a morale committee, development and implementation of a Director’s Fund for Professional Development, increased transparency with hiring through a selection committee, and increased communication in All-Staff meeting regarding activities of the Governing Board.

Human Resources, in conjunction with the office of the Associate Vice President for Campus Services, commissioned the Employment Law Services law firm to conduct interviews with all SHS employees about the workplace environment during the fall of 2018. A report detailing the findings from those interviews was shared with Campus Services leaders, HR leadership, and Stamps leadership. The findings of the report have also been shared with SHS employees. Steps are ongoing to comply with many of the recommendations made in the report. This goal will be discontinued at this time pending a new workplace climate survey report. However, SHS is committed to continuing to address the workplace experience for all employees and to create a workplace that is built on integrity, community, and transparency.

Objective 3.5.2: Ensure employees are knowledgeable of GaTech human resource policies and operating procedures.

**Responsible Person(s):** Benjamin Holton MD  
**Measurement 1:** Participation in WLPD classes and HR refresher sessions  
**Benchmark 1:** Reduce the number of employee grievances.  
**Action Plan/Project:** Require employees to attend 5 learning sessions to improve their knowledge of human resources policies and procedures. Two sessions will be formal classes offered at through the Workplace Learning and Professional Development department of Human Resources: Preparing for Performance Management Conversations-Manager or Employee Editions and Progressive Discipline for Improved Performance (WLPD).
The remaining three sessions will be organized and offered in collaboration with the Campus Services HRBP and the Human Resources Manager in Stamps: FMLA, ADA, and Protocols for Addressing Violations in Procedures and Processes.

**Final Action Plan Status:** Joint Management Team received FMLA training on July 17, 2019. The Governing Board, Joint Management and individual departments spent time reviewing general HR policies and other operational procedures. Due to timing, we have several initiatives planned for FY19 but these will carry over to FY20. The initiatives include Strength finders, revision of mission and vision statement, and receiving training in Giving and Receiving Feedback. At this point, this is goal is complete.
## 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 events, risk assessments, occurrence reporting and management of SHS policy and procedure manual.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ensuring that risks to health and safety are eliminated or controlled when planning the design of new projects, purchasing new equipment; and prior to introducing construction.</td>
<td>None</td>
<td>No incidents reported</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 needed.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Documentation of timely notification to the professional liability insurance carrier when adverse or reportable events occur.</td>
<td>No issues to report</td>
<td>None</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 policies and processes, is provided to all staff within 30 days of commencement of employment, annually thereafter, and when there is an identified need.</td>
<td>No issues to report</td>
<td>We continue to evaluate our onboarding process and work with hiring managers.</td>
</tr>
</tbody>
</table>
Incident Management Review

- The governing board reviews all incident reports as they are reported. Data from each incident report is recorded and used to evaluate trends and risk. Each incident is assigned a risk assessment score (RAS) 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>SEVERITY</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Catastrophic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>High probability of death to staff or patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Major</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>High probability of injury, illness or harm to staff or patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Moderate</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Medium probability of injury, illness or harm to staff or patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Minor</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Unlikely to cause injury illness or harm to staff or patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Negligible</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>None possibility of causing injury or harm to staff or patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- There were a total of 8 reported incidents in 2019 representing a fifty percent decrease in reported incidents from prior year. We did not find any cause/effect and believe this variation to be random.

![Risk Management CY2019 Incident Location](image)
Each incident is categorized and reported by incident type. Of the eight total incidents, five involved the prescribing, dispensing, administration and storage of medications.

Of the eight total incidents, we also report by incident subtype.

All incidents were reviewed and the following action(s) were taken to remedy the risk.
- Medication-Pharmacy and medical staff worked to improve accuracy of prescriptions.
- Staff and Patient Injury-Provided education to staff on safe clinical practices.
- Reported incident(s) as applicable to the Quality Committee or subcommittee for review.

A risk assessment score (RAS) is assigned to each incident. Of the eight total reported incidents, five were minor in nature unlikely to cause injury illness or harm to staff or patients and three were medium in nature with a probability of injury, illness or harm to staff or patients.
Risk Management CY2019
Risk Assessment Score

- Minor: 5
- Moderate: 3
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. Providers are given feedback on their individual performance. Below are summary data from this study:

NOTE: Although peer review activities are ongoing, peer review is not included in this report due to time constraints related to campus COVID-19 testing and vaccine administration planning.
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 2019, 200 calls were received. This is a 17 percent increase over 2018.

![Nurse Advice Line Calls Per Month]

- To better understand call patterns, we look at time of call and age of caller. No anomalies were observed.

![Time Call Received]

- Calls are defined as medical (85%) or as other (15%). Other includes general categories shown below.
- 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.

90% of calls related to an acute medical issue will have a follow up phone call within 2 business days 2019.
7. Quality Improvement

Quality Project Name: AREARS (Active Review evaluating appropriate rectal screening)
Project Owner: Stephen Holbrook MD
Start Date: September 1, 2019
End Date: December 31, 2019
Cycle: 1

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. Data a significant prevalence of rectal infections in patients having penetrative rectal sex. In one multicenter study of over 11,000 MSM presenting to a sexually transmitted infection (STI) clinic and tested for rectal gonorrhea, 10 percent tested positive. Anorectal gonorrhea may be the only site of infection in up to 40 percent of MSM. These observations are particularly concerning because gonococcal proctitis in MSM is associated with an approximately threefold increase in the risk of acquisition of HIV infection. Prevalence of infection may be high in women reporting receptive anal intercourse. In the review of studies evaluating extragenital gonococcal infection, the prevalence of rectal infection among women ranged from 0.6 to 36 percent (median 2 percent). As an example, in one study of 2084 women at a STI clinic, three percent were found to have rectal gonorrhea; of those, 30 percent did not have concomitant genital infection.

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: Improve screening rate on patients with at risk behaviors for extragenital STI’s. Base rate has been noted as 40% screening with indicated necessity. Goal is to improve to 90% screening with indicated necessity.

3. A description of the data that will be collected in order to determine the organization’s current performance (i.e., study methodology.) Data is obtained from patients completing previsit STI screening questionnaire. A query of this MEDICAT self-reported questionnaire was accomplished and tabulated. All patients reporting for STI screening are highly encouraged to complete this form.

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 6 months of 2019 there were 115 patients who answered the screening questionnaire positive for penetrative rectal sex. Of these: 46 visits with a positive question response had the test ordered. (40%) 69 visits with a positive question response did not have the test ordered. (60%)

5. A comparison of the organization’s current performance in the area of study against the previously identified performance goal. There is little established data on this performance in college health services literature.

6. Implementation of corrective action(s) to resolve identified problem(s).
Literature review and data collection have occurred. Next, provider education of all appropriate staff of importance of extragenital screening and collection methods.

7. **Re-measurement** (a second round of data collection and analysis to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.
This will occur after education, with expected timeframe of September 1 to Dec 31, 2019.

8. **Communication of the findings of the quality improvement activities.**
Both written and oral presentation of findings with appropriate staff demonstrating changes (if any) that were recorded.
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. Data a significant prevalence of rectal infections in patients having penetrative rectal sex. In one multicenter study of over 11,000 MSM presenting to a sexually transmitted infection (STI) clinic and tested for rectal gonorrhea, 10 percent tested positive [2]. Anorectal gonorrhea may be the only site of infection in up to 40 percent of MSM [3,4]. These observations are particularly concerning because gonococcal proctitis in MSM is associated with an approximately threefold increase in the risk of acquisition of HIV infection [5]. Prevalence of infection may be high in women reporting receptive anal intercourse. In the review of studies evaluating extragenital gonococcal infection, the prevalence of rectal infection among women ranged from 0.6 to 4 percent (median 2 percent) [1]. As an example, in one study of 2084 women at a STI clinic, three percent were found to have rectal gonorrhea; of those, 30 percent did not have concomitant genital infection [6].

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:
   Improve screening rate on patients with at risk behaviors for extragenital STI’s.
   Base rate has been noted as 40% screening with indicated necessity.
   Goal is to improve to 90% screening with indicated necessity.

3. A description of the data that will be collected in order to determine the organization’s current performance (i.e., study methodology.)
   Data is obtained from patients completing previsit STI screening questionnaire. A query of this MEDICAT self-reported questionnaire was accomplished and tabulated.
   All patients reporting for STI screening are highly encouraged to complete this form.

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 last 6 months of 2019
   There were 174 patients who answered the screening questionnaire positive for penetrative rectal sex:
   Of these:
   59 visits with a positive question response had the test ordered. (34%)
   115 visits with a positive question response did not have the test ordered. (66%)
   Of these:
   46 visits with a positive question response had the test ordered. (40%)
   69 visits with a positive question response did not have the test ordered. (60%)

5. A comparison of the organization’s current performance in the area of study against the previously identified performance goal.
Nominal results indicate trend toward less ordering in second data collection after initial intervention(s). Previous results had 40% test ordering with positive results. I have discussed findings with three providers and lab with the following themes:

- Potential flaw in data.
- There are patients who actively refuse rectal swabs.
- There are patients who put “yes” in box instead of “No” or receptive anal sex.
- Lack of adherence to accepted care standard.
- Knowledge deficit verses not providing standard of care (?barriers).
- Barrier to obtaining specimens (in room vs lab—self vs assisted collection).

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

Literature review and data collection have occurred. Next, provider education of all appropriate staff of importance of extragenital screening and collection methods.

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

This will occur after education, with expected measurement timeframe of September 1 to Dec 31, 2019.

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

- Can “reeducate” providers. Might suggest this time both a group session and targeting each provider individually for 5 min.
- For data collection—actually go through charts to see if not obtaining specimen was reasonable Not actually “yes”, “no rectal sex since last screening”, “refuse”). Would result in a cleaner data set.
- Since will have chart data—can give each provider own scorecard at end of data collection.
- Have medicat “automatically order” rectal swabs for all that answer “yes”
- It is a barrier for sample collection—either provider has to walk to lab to get sample collection swab and collect in room—or someone has to give patient swab to collect. (Patient collects urine in lab bathroom—could they not do swab also?)

**List of references goes below**

Quality Project Name: Women’s Health Flu Vaccine Administration
Project Owner: Shan Baker
Start Date: November 1, 2018
End Date: March 1, 2019
Cycle: 1

PLAN
1. In keeping with Best Practice Standards and expert recommendations, Stamps Health Services (SHS) recommends vaccination with Influenza Vaccine each Flu season.
2. Previously, there was no vaccine storage capability in Women’s Health, and staff had to get vaccine on an as needed basis from the Immunization Clinic.
3. Measurable Goal: Our goal was to increase the number of Influenza vaccines administered in Women’s Health.

DO
4. In October 2018, a refrigerator was purchased and installed in the Women’s health area. Influenza vaccine stock was obtained and an inventory system was created.

STUDY
5. For the period of November 1, 2017 – March 1, 2018 – 4 doses of influenza vaccine were administered in Women’s Health.
6. For the period of November 1, 2018 – March 1, 2019 – 71 doses in influenza vaccine were administered in Women’s Health.

ACT
7. We anticipate higher Women’s Health vaccine numbers for the 2019/2020 flu season since we will be able to begin vaccinations with our in clinic stock earlier in the semester.
Quality Project Name: HPV Vaccine Uptake
Project Owner: Shan Baker
Start Date: April 1, 2019
End Date: September 30th 2019
Cycle: 1 - Updated

PLAN

1. In keeping with Best Practice Standards and expert recommendations, Stamps Health Services (SHS) recommends vaccination with Gardasil 9 HPV vaccine (3 doses) for all unimmunized patients within the approved age range.
2. Currently, all patients with the student health insurance plan (SHIP), and patients with no health insurance, who qualify for the adult vaccine program, are instructed to schedule HPV vaccine administration with the Immunization Clinic. This often requires a separate appointment on a different date. Patients with private insurance receive HPV vaccine through Stamps Health Services pharmacy.
3. Measurable Goal: SHS would like to increase the number of new Gardasil 9 vaccine starts by offering the first HPV vaccine dose to qualified patients as part of the scheduled Women’s Health visit (at the time of a routine annual or STI screening visit).

DO

4. Women’s Health will pilot this study. Each patient in Women’s Health who is scheduled for routine care will be offered Gardasil vaccine if not already immunized. If the patient decides to begin the vaccine series, the first dose will be administered before the patient leaves the clinic.
   *See attached protocol: Administration of Gardasil 9 in the Women’s Health Clinic

STUDY

5. For the period of April 1 to September 30, 2018 - 156 patients received Dose 1 of HPV vaccine.
6. After implementation of the Women’s Health HPV vaccine protocol, numbers for HPV Dose 1 will be compared to the same time frame from 2018. The goal is to increase the number of Dose 1 HPV vaccines given by making the process more convenient for patients.
7. Update: For the period of April 1 to September 30th, 2019 – 212 patients received Dose 1 of HPV Vaccine. 13 of the doses were administered in the Women’s Health Clinic.

ACT

8. HPV Dose 1 administrations increased overall and 13 were administered in Women’s Health. The Cycle 2 goal is to increase the number of doses given in Women’s Health. The study period will be adjusted in order to capture high volume clinic times. Cycle 2 will run from January 1, 2020 to December 31st 2020
Quality Project Name: Same Day Appointments  
Project Owner: Benjamin Holton MD  
Start Date: November 1, 2018  
End Date: March 1, 2019  
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.

**ACT**

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

8.1 Pharmacy
Nina Thoman, Pharmacy Manager

Prescribing and Dispensing Events

- 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.

- 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 = \( \leq 0.30\% \)
  - Dispensing events = 0%
  - Provider compliance on updating Rcopia within 2 business days = 100%

- 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 Oty, 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 prescribed

- **Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).**
  The event results based on 20,424 newly prescribed SHS prescriptions are as follows:

<table>
<thead>
<tr>
<th></th>
<th><strong>SHS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Event Rate</td>
<td>0.43%</td>
</tr>
<tr>
<td>Dispensing Event Rate*</td>
<td>0.01%</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 = 0.22%** (47 events), **Type B = 0.21%** (44 events), **Type C = 0.08%** (16 events), and **Type D = 0.19%** (38 events).

*Pharmacy had 2 dispensing events for Cycle 14. Based upon above classification, the two events are categorized as Type B events. Incident reports were completed for both events at the time, and submitted per SHS Policy to the Risk Manager.*

- **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 not at goal.
  - Medicat/Rcopia Updated- SHS is not at goal (62% corrected).

- **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 14. The pharmacist will communicate any Type A and B events to the SHS Senior Director on a as they occur to be discussed with the provider(s). As the majority of the events are due to incomplete/incorrect sig, I suggest the heads of each department reiterate with their providers to review the prescription in its entirety for accuracy one last time prior to “signing and sending” the prescription to ANY pharmacy.

  Our review of provider compliance on updating Rcopia within 2 business days found that 62% (84 correctable errors) were in compliance. The pharmacy currently calls or sends a medicat message to the provider to serve as the reminder to update the EHR.

  - **Dispensing Events**- The 2 events involved the wrong strength of medication. Both events were resolved/corrected by the pharmacist, and incident reports were completed.

- **Re-measurement (15th round of data collection and analysis to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.)** We will perform cycle 15 (January 2020 - December 2020).

- **Communication of the findings of the quality improvement activities.**
  Results will be presented to the P&T Committee for review and additional guidance. The SHS Senior Director will also receive the data for review.
### 4-year tending data

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Prescribed</strong></td>
<td>2,858 newly prescribed SHS</td>
<td>26,544 newly prescribed SHS</td>
<td>27,027 newly prescribed SHS</td>
<td>20,244 newly prescribed SHS</td>
</tr>
<tr>
<td><strong>prescriptions</strong></td>
<td>prescriptions</td>
<td>prescriptions</td>
<td>prescriptions</td>
<td>prescriptions</td>
</tr>
<tr>
<td><strong>Prescribing</strong></td>
<td>0.48%</td>
<td>0.43%</td>
<td>0.46%</td>
<td>0.43%</td>
</tr>
<tr>
<td><strong>Event Rate</strong></td>
<td><strong>Dispensing</strong></td>
<td><strong>Event Rate</strong></td>
<td><strong>Event Rate</strong></td>
<td><strong>Event Rate</strong></td>
</tr>
<tr>
<td></td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.01%</td>
</tr>
</tbody>
</table>
Urinary Tract Isolates
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. 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. During this study year, two findings occurred: For the positive cultures, our resistance pattern was similar to previous years. Bactrim was 92% effective for ecoli—therefore appropriate to use for our population. Second finding was there was a higher percentage of negative cultures than previous. Direct chart review of all 50 cases was completed. Cultures were included in study not in the intended method. Cultures were done and no treatment given for 3 people (design is only for patients who would receive an antibiotic anyway). 3 males were included (again not in study design as this is for simple UTI only—and all three had negative findings). One patient with kidney stone and one gonorrhea found. Plan to provide clearer instructions when follow up UTI study occurs in the fall of 2020.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>E. coli</td>
<td>80%</td>
<td>76%</td>
<td>89.7%</td>
<td>72.5%</td>
<td>61.0%</td>
<td>62.2%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Staph. aprophyticus</td>
<td>9%</td>
<td>8%</td>
<td>5.1%</td>
<td>17.5%</td>
<td>14.0%</td>
<td>24.3%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Kleb. pneumoniae</td>
<td>3%</td>
<td>5%</td>
<td>2.6%</td>
<td>5.0%</td>
<td>8.3%</td>
<td>8.1%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Proteus mirabilis</td>
<td>3%</td>
<td>0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.8%</td>
<td>0.0%</td>
<td>5.0%</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>
<td>20.0%</td>
</tr>
</tbody>
</table>

*Includes: Group B beta-hemolytic Streptococcus; Corynebacterium; E. coli (ESBL)
Notes for 2019 study: 53% of negative cultures reported as Contaminants - “Single or Multiple organisms present, each less than 10,000 cfu/ml.” 47% reported as “No Growth”
No E. coli (ESBL) isolated 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;2019
Laboratory Monthly Turnaround Time (CBC-TAT) report
Reference Laboratory

Goal: \( \geq 98\% \) of ordered CBCs reported in less than 30 minutes.
Result: \( \geq 98\% \)
Variance Analysis: May- Staffing issue, August- Instrument error, December- Difficult blood draw

TEST NOT PERFORMED (TNP): due to hemolysis, wrong test, wrong sample, mislabeled, difficult stick, etc.
Goal: \( \leq 1\% \) of TNP for any reason
Variance Analysis: None
Laboratory Monthly Turnaround Time (CMP-TAT) report
Goal: $\geq 95\%$ of reference laboratory CMP reported within the established TAT of 48 hours.
Result: $\geq 97\%$
Variance Analysis: March and July- Excessive delays in basic labs. Discussed issue with Quest rep.

![Laboratory Turn Around Time 2019](image1)

Unacceptable Proficiency Testing Error
Goal: $\leq 5$ per year
Result: Within goal
Variance Analysis: ?????

![Unacceptable PT Result(160) 2019](image2)
Hematology - Hematocrit (Hem-5D) (%) Abbott Cell-Dyn Ruby

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

<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>202</td>
<td>44.5</td>
<td>1.2</td>
<td>41 - 48</td>
<td>0.11</td>
</tr>
</tbody>
</table>

**SAMPLE ABT-01**

![Bar chart showing hemoglobin results for SAMPLE ABT-01 with an acceptable range of 41-48% and a result of 44%.

**SAMPLE ABT-02**

![Bar chart showing hemoglobin results for SAMPLE ABT-02 with an acceptable range of 30-35% and a result of 32%.

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**SAMPLE ABT-03**

<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>203</td>
<td>21.5</td>
<td>0.7</td>
<td>20 - 23</td>
<td>0.06</td>
</tr>
</tbody>
</table>

**SAMPLE ABT-04**

<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>203</td>
<td>32.7</td>
<td>0.8</td>
<td>30 - 35</td>
<td>0.07</td>
</tr>
</tbody>
</table>
### SAMPLE ABT-05

<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>203</td>
<td>21.4</td>
<td>0.7</td>
<td>20 - 23</td>
<td>0.06</td>
</tr>
</tbody>
</table>

**Diagram:**

- **Your Result:** 21
- **Acceptable Range:**
- **Percent:**
8.8 Radiology
Tabarrion Stoves, Radiology Coordinator

Radiology overread turnaround times
Goal: 98% of x-rays are reviewed by the radiologist within 24 hours.
Variance Results: March-Aris had some staff changes, which prevented our studies from being received and read by a radiologist.

Radiology Overread External Misses
Goal: <2% of total over reads
Results: No misses reported
Variance Analysis: No variances
Review of Allergies and Current Medications by Medical Assistant
Goal: 100% of allergies and current medications are documented by the Medical Assistant in Women's Health and Primary Care.
Results: 97% - Continue to monitor.

![Allergies and Medications Review 2019](image)

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

![Vital Signs Surveillance 2019](image)
9.0 Benchmarking

Student Health Fees

Each year we benchmark against student health fees within our Institute selected peer group. Recognizing service, funding and population differences amongst the various Institutions, the Student Health Fee at Georgia Tech remains highly competitive.

Regents'Advisory Committee-Health

The Regents'Advisory Committee-Health Stamps was established by the University System of Georgia (USG) as a mechanism for USG health center to share data, ask questions and benchmark. For FY19, the following topics were discussed and this information for benchmarking purposes as well as best practice.

- New students immunization records submission practices.
- Policy and Procedure for dispensing controlled substances.
- Providing services to students after graduation.
- Td and Tdap requirements.
AAAHC Institute for Quality Improvement Medication Reconciliation Study July-December 2019

Stamps Health Services regularly participates in benchmarking performed by AAAHC. We use this information for benchmarking purposes as well as best practice.

**Sample:** 26 primary care organizations voluntarily registered and 18 participated in the study. Study materials instructed participating organizations to randomly assign charts over a 6-month period (July through December 2019) for study documentation. The AAAHC Institute also directed participating organizations not to pre-determine a specific provider (unless there was only one), since this may not accurately represent the organization’s charts. Study instructions summarized that organizations should provide as representative a sample of charts as possible.

The 18 organizations submitted data on a combined total of 424 unique (not the same Patient ID) charts including medication (with a maximum of 35 charts per organization).

Because the purpose of this study is quality improvement, the report includes 15-35 charts per organization for best performer analyses, comparing performance among organizations.

Stamps ID#: 1601
Background Information on Participating Organizations

Annual Volume by Organization

Chart-specific Information

**Designated Pharmacy**

Percent Of Charts with Documentation Patient (Asked if) Had Designated Pharmacy (or Not) by Organization

Best Performer insights have been provided by select organizations that performed well in more than one Medication Reconciliation category in this report.

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1601</td>
<td>In their electronic health record, they set a default that all electronic prescriptions are sent to their in-house retail pharmacy. They do ask each patient if they approve of the designation or if they want to change to another pharmacy. Students almost always consider location, cost, and service in determining their pharmacy preference.</td>
</tr>
</tbody>
</table>
Allergies

Percent of Charts with Documentation Patient (Asked if) Had Any Known Medication Allergy (or Not) by Organization

Medication List

Percent of Charts with Medication List Updated at the Visit by Organization