UNIVERSITY of Western States

Quality Patient Care Outcomes Report

UWS Campus Health Center
Fiscal Year 2021

Purpose of this Report

This report examines annual outcomes for quality patient care indicators established for the UWS Campus Health Center (CHC). Indicators are reviewed by the quality patient care committee (QPCC) to identify opportunities for improvement.

Annual Outcomes

The QA program tracks a variety of indicators, each with corresponding performance thresholds. The QPCC is responsible for reviewing and updating the indicators on an annual basis, as appropriate. Many of these indicators are new and, as such, do not have historical data for comparative analysis. Additionally, where appropriate, thresholds may not yet be established for indicators in which multiple years of data are required to determine an appropriate target.

Licensure

For compliance purposes, all CHC practitioners must maintain active licenses and certifications appropriate for clinical care. As such, indicators 1.1 and 1.2 ensure that 100% of clinicians maintain an active chiropractic license and basic life support/CPR certification on an annual and biennial basis, respectively.

FY20 Updates

No updates to report.

FY21 Outcomes

All clinicians were up to date with both active licenses (indicator 1.1) and basic life support/CPR (indicator 1.2) for FY21.

Indicator	Target	FY20	FY21
1.1 % active licenses (annual)	**100%**	100%	100%
1.2 % current basic life support/CPR (biennial)	**100%**	100%	100%

FY22 Plans

All indicator targets met; no additional actions planned at this time.

Patient Feedback Survey

The university surveys patients annually about their satisfaction with clinical services provided by UWS. Survey questions were adapted from the Consumer Assessment of Healthcare Provider and Systems (CAHPS) surveys promoted by the Agency for Healthcare Research and Quality (AHRQ). Questions are designed to solicit patient feedback about access and convenience of facilities, the quality of care delivered by clinical providers, the level of service provided by reception and office staff, and patients' overall impression of the clinical experience. In FY17, the DCP modified the survey to include new questions specific to patients' perceptions of integrated healthcare delivery, consistent with the university's updated core themes.

FY20 Update

While the existing survey was revised to better align with DCP program goals and CCE meta-competencies, the survey's launch (scheduled for March 11, 2020) coincided with the emergence of COVID-19 in the community and the university clinic's closure. The first iteration of the revised survey was postponed until FY21.

FY21 Outcomes

Although the QPCC established indicators 2.1 and 2.2 in FY20, FY21 is the first time for tracking with established targets. Overall patient satisfaction (Indicator 2.1) remains high, continuing to meet the 92% threshold. Indicators 2.2a-c are new, examining performance of aggregated items related to three domains. Since no prior data existed for these comparisons, the target was arbitrarily set at 85 percent. The QPCC reevaluated these targets for FY21, and determined they would be monitored and analyzed, but would not have separate thresholds of achievement. Indicator 2.2d examines a single net-promoter like item in which respondents indicate overall satisfaction with their clinical experience. Although still exceeding the 85 percent target for the indicator item, this item scored lower than the other indicators. Please see the FY21 Patient Satisfaction Outcomes Report (Appendix A) for a complete analysis.

Indicator	Target	FY17	FY18	FY19	FY20	FY21
2.1 Patient satisfaction survey responses % positive (aggregated)	**92%***	99%	96%	98%	N/A**	97%
2.2a Facilities, access, and conveniences % positive	**Monitor**				N/A	94.2%
2.2b Office staff % positive	**Monitor**				N/A	95.2%
2.2c Clinical providers % positive	**Monitor**				N/A	98.7%
2.2d Overall experience % positive	**85%**				N/A	93.1%

*The institutional effectiveness and planning committee increase the target from 75% to 92% for FY19 due to multiple years exceeding the target.
**The survey was not administered in FY20 due to the timing of the COVID-19 pandemic.

FY22 Plans

Plans for FY22 include the following:

- Reevaluate target for indicator 2.2d
- Determine the need to add an additional indicator related to likelihood a current patient would refer a new patient

Patient Grievance/Dissatisfaction

Patient grievances or dissatisfaction are complaints reported outside of the annual feedback survey.

FY20 Update

Indicator 3.1 was new for FY20. As such, there are no updates to report.

FY21 Outcomes

At the start of FY21, the clinic established new procedures for patients to report dissatisfaction via webform to provide patients the opportunity to provide feedback or submit complaints on an ongoing basis. As seen in the table below, no complaints were submitted for FY21.

Indicator 3.2	Target	FY21
Grievance/Complaints Filed	**N/A**	0

FY22 Plans

Plans for FY22 include the following:

- Evaluate if additional opportunities should be made available for patients to report grievances or dissatisfaction
- Establish a target once two years of data are available.

Actionable Infractions

The DCP tracks actionable (disciplinary) infractions. Infractions are reported incidents of student violations of clinical internship manual protocols that rose to the level of a disciplinary action beyond a verbal warning. Example consequences include a clinical suspension or writing a report.

FY20 Update

There are no updates to report from FY20.

FY21 Outcomes

Indicator 4.1: Quarterly Infractions	Target	SU-20	FA-20	WI-21	SP-21
% of interns completing clinical internships without an actionable infraction	**90% each term**	100%	97.1%	91.7%	100%

The table above presents the percentage of students completing their clinical internship each term without an actionable infraction for each of the four academic terms in FY21. The target was met for each term. The table below presents the fiscal year total for the last four years, which also met the target. The associate vice president for clinical internship (AVPCI) indicates that all FY21 infractions were managed via the existing process and resolved without follow-up incidents.

Indicator 4.2: Annual Infractions	Target	FY18	FY19	FY20	FY21
% of interns completing clinical internships without an actionable infraction	**95% annually**	96.2%	97.4%	98.8%	98.1%

FY22 Plans

All indicator targets met; no additional actions planned at this time.

Chart Audits

The chart audit system is designed to enhance clinician learning and improvement by reviewing the practices of fellow providers and feedback about their care from peers via completed audits. Additionally, data is utilized to drive both curricular and patient care improvements. Quarterly reports provided to clinicians are used to highlight areas in need of attention and improvement.

FY20 Update

The chart audit process continues to operate as designed. Instrument modifications were implemented as planned and appeared to have the desired results. See FY21 outcomes section for details. As planned, audited charts were selected from the most recent three months of patient care, rather than the prior twelve months as utilized in FY20. This update reduced the lag between the review of audit data and patients with managed care after clinicians have received feedback.

FY21 Outcomes

The number of audits was reduced to three per clinician per term as planned. This strategy allows for each clinician to be assessed up to 12 times per fiscal year. Although this approach ensures a large enough

sample size for individual practitioner trend data, due to clinician attrition, the sample size was lower than anticipated (only 90 compared to 108). Regardless, the sample size remains above the 70 charts required the Bureau of Primary Care for HRSA audits.[1] As such, indicator 5.1 was met for the third year in a row.

Indicator 5.1:	Target	FY19	FY20	FY21
Number of Chart Audits Completed	70	122	122	90

Indicator 5.2 is ≥80% achievement of patient chart audit indicators (overall score). As seen in the table below, the FY21 outcome of 87.9% improved somewhat over FY20. Although targets are not established for each individual audit category, the QPCC will explore the need for additional thresholds in FY22. The following sections will address categories scoring below the 80% target for the entire instrument.

Category	Target	FY19 n=122	FY20 n=122	FY21 N=90
History – Chief Complaint				83.3%
History – P/F/S* Health and Review of Systems**		73.0%	81.1%	95.6%
Exam		76.2%	73.0%	76.7%
Diagnostic Testing		96.7%	96.7%	98.9%
Diagnosis		79.5%	78.7%	82.2%
Management Plan		71.3%	72.1%	88.9%
Informed Consent		80.3%	85.2%	76.7%
Outcome Assessment		83.6%	86.1%	86.7%
Treatment Outcomes		91.8%	95.9%	95.6%
Safety Precautions		92.6%	98.4%	94.4%
Overall (Indicator 5.2)	**80.0%**	**82.8%**	**85.2%**	**87.9%**

*P/F/S = past, family, and social health

**Starting in FY21, the chief complaint component of the history was audited separately from the past/social/family health history and review of systems. As such, prior year data evaluates all these interview components.

History - Chief Complaint

This most significant change in FY21 was the addition of a separate chief complaint component of the audit instrument. Previously, there was only one section dedicated to all aspects of a patient interview. Analysis revealed that the majority of errors and omissions stem from the chief complaint and as such, the new section was added in response to feedback from clinicians, and the need to better analyze data for curricular improvement. It appears this strategy was effective, with a significant improvement in the past/family/social and review of systems aspect of the history and a lower performing chief complaint.

As seen in the table below, the two most common missing components were treatment history, mechanism of injury (MOI), and onset of symptoms. Similar trends have been identified for students as part of clinical skills assessment (CSA) exams. Please note the percentages in the table below do not add up to 100% as more than one component may be identified as missing per chart.

Chief Complaint Component Missing	n = 15
Treatment Hx	53%
MOI	40%
Onset	40%
Location	27%

[1] From "Reporting Instructions for the 2019 Health Center Data," by the Bureau of Primary Health Care, https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2019-uds-manual.pdf

Chief Complaint Component Missing	n = 15
Modifying Factors	20%
Additional Complaints	20%
Chronology	13%
Quality	13%
Associated Sx	13%
Severity	0%

History – P/F/S Health and Review of Systems*

As previously mentioned, the past, family, and social health (P/F/S health) aspect of the patient interview improved significantly in FY21, with only four of ninety charts not meeting desired standards. Of these four, medical history was the most common omission.

History Component Issue	n = 4
Medical	75%
Surgical	50%
Family	50%
Review of Systems	25%
Social/Substance	25%

Physical Exam

Exam outcomes improved in FY20 from 73.0 percent to 76.7 percent. Many of the issues identified relate to neurological examinations (most common in FY20 was vitals), followed by posture. Based on a review of comments left by the clinicians, it appears as though the additional instruction added to the audit tool in FY21 may have reduced some of the more subjective assessments observed in the past. Perhaps the most notable trend from the comments related to unclear or poor documentation of exam findings. Multiple clinicians indicated chart notes often did not include what side a procedure was performed, or if performed bilaterally. This finding was frequently associated with neurological procedures.

Exam Component Omitted	n = 21
Neuro	43%
Posture	33%
Vitals	24%
Gait	24%
Entire Exam	24%
ROM	19%
Orthopedic Testing	19%
Palpation	10%
All Complaints	5%

Diagnosis

Diagnosis improved from 78.7% to 82.2%. Significant changes were made to the diagnosis section of the audit tool for FY21 to better understand the nature of issues. Specifically, the options for feedback expanded to include themes (see table below) identified by clinician comments. The most frequent issues related to missing diagnoses on the problem list, followed by missing pre-existing diagnoses.

Diagnosis Issues	n = 16
Missing diagnoses	50%
Missing pre-existing diagnoses	31%

Diagnosis Issues	n = 16
Diagnoses without supported exam findings	19%
Diagnoses not supported	19%
Missing Re-exam date	6%

Management Plan

Management plan improved significantly from 72.1 percent to 88.9 percent. A few changes were made to the management section of the audit tool for FY21 to better understand the nature of issues. Additionally, the instructions from this section were expanded to help improve interrater reliability. Furthermore, several clinician weekly meetings were dedicated to discussing management plan best practices, develop consensus and identify optimal documentation strategies. The most common management plan issues related to a missing plan or a plan that does not seem justifiable based on history and exam findings. It would be useful to add an item in FY22 that examines if there is a single management plan for a patient rather than one for each problem.

Management Plan Issues	n = 10
No Plan	30%
Not Justifiable	30%
Missing Problems	20%
Out of Date	10%
Insufficient Documentation	10%
Active Problems Only	0%

Informed Consent/PARQ

Informed consent (IC) declined from 85.2 percent to 76.7 percent in FY21. The audit tool was updated to include additional options to provide more useful data regarding the nature of underlying consent issues. For the second year in a row, a missing PARQ or PARQ documented in the wrong place is the most common issue for this component. Several follow-up conversations were held with clinicians regarding IC, especially regarding protocol expectations. Work has begun but is not yet complete on this project.

Informed Consent Issues	n = 21
PARQ missing or in wrong place	62%
PARQ missing for all modalities	48%
Signed IC form missing	19%
IC missing for some modalities	10%
PARQ and IC missing for all problems/modalities	5%
PARQ/consent not current	0%

Outcome Measures

Outcome measures performed almost the same in FY21 as FY20. Significant changes were made to this section of the audit tool for FY21 to better understand the nature of issues. These modifications have helped hone in on issues related to appropriate validated tools available but not utilized.

Outcome Assessment Issues	n = 12
Appropriate validated tool not utilized	75%
Only subjective measures	33%
No baseline	8%
Not reassessed	8%

Outcome Assessment Issues	n = 12
Not updated	8%
No measures	0%
Not applicable	0%
Documentation inconsistent	0%

Treatment Outcomes

Treatment measures performed almost the same in FY21 as FY20. Significant changes were made to this section of the audit tool for FY21 to better understand the nature of issues. Please note that out of the four charts not meeting treatment outcome criteria, only two provided feedback related to the underlying issue. As such, the percentages in the table are not a complete representation of issues. Additionally, the sample size is too small to identify clear trends.

Treatment Outcome Issues	n = 4
No outcome measures	25%
No improvement	25%
Not Align with Plan	0%
No additional evaluation	0%

Safety Concerns

There were five charts with identified safety concerns in FY21 compared to two in FY20. One was missing a personal history of cancer and family history of diabetes/cardiovascular disease on the problem list, two warranted additional follow-up/management related to elevated blood pressure, and two had concerns identified, but not easily located in care coordination note(s) and FYI flag(s). It is important to note that none of these concerns are emergent in nature and that such a low percentage of reported treatment outcome and safety issues speaks highly of the quality of care delivered in the Campus Health Center (CHC). Please note that one of the five charts not meeting treatment outcome criteria neglected to include feedback related to the underlying issue.

Safety Issues	n = 5
Not Easily Located in Chart	40%
Unidentified Concerns	40%
Poor documentation	0%
Risk with Identified Concerns	0%

Auditor/Clinician Analysis

Average chart scores were also examined for both the auditor and the clinician under evaluation. This analysis revealed only one clinician with overall scores for FY21 below the 80% benchmark, an improvement from FY20. The auditor analysis looked at how often the evaluator marked a clinician's chart down for not meeting identified standards. Two auditors assigned significantly lower scores than the overall overage, while a few assigned significantly higher scores. This outcome suggests a "hawks and doves" phenomenon in which some auditors are far more aggressive and selective when evaluating charts while others are much more forgiving. The AVPCI will be following up with clinicians individually regarding their annual outcomes. Opportunities for additional discussion and training regarding tool usage may also be helpful in addition to calibration exercises during the next fiscal year.

FY22 Plans

The following actions are planned for FY22:

- QPCC will explore the need for individual audit category targets

- Modify the current audit tool for use in off-site CBI clinics
- Complete work to update informed consent protocols
- Convene workgroup of CMO, clinical and didactic faculty to develop neurological examination protocols. Integrate into curriculum as appropriate.
- Convene workgroup of CMO, clinical and didactic faculty to review and revise PARQ and informed consent protocols. Integrate into curriculum as appropriate.

Policies and Procedures Manual Review

The intern, lab and diagnostic imaging, and infection control manuals are updated annually to ensure policies and procedures are up to date. The intern manual is reviewed by clinical internship staff, while clinic staff members review the other two manuals.

FY20 Updates.

There are no updates to report.

FY21 Outcomes

The intern manual review (indicator 6.1) occurred on schedule for all four academic terms in FY21. The lab and diagnostic imaging manual underwent review (indicator 6.2), resulting in the creation of new policies related to needlestick and blood borne pathogen protocols. These new policies are waiting for final review by the university policy committee. Once approved, it is anticipated the updated manual will be published during the summer 2021 term. The infection control manual was updated as scheduled (indicator 6.3).

Policy and Procedure Indicators	Target	FY20	FY21
6.1 Intern manual	**Reviewed quarterly**	Completed	Completed
6.2 Lab and diagnostic imaging manual	**Reviewed annually (June)**	Completed	Completed*
6.3 Infection control manual	**Reviewed annually (June)**	Completed	Completed

*Review completed but updated manual not published at the end of the fiscal year

FY22 Plans

The following are planned for FY22:

- Publish new policies related to needlestick and blood borne pathogens
- Finalize lab and diagnostic imaging manual

HIPAA

The QA plan tracks three indicators related to the Health Insurance Portability and Accountability Act (HIPAA) to ensure the security of patient records. These indicators include low-level incidents (i.e., misdirected information, incorrect documentation), high-level breaches (i.e., publicly reported offenses), and monthly HIPAA walkthroughs.

FY20 Updates

While the university has historically tracked HIPAA incidents, it was not tracked and stored in a retrievable location. A new process was implemented for FY21, including regular HIPAA walkthroughs and a process for tracking low and high-level incidents.

FY21 Outcomes

Two low-level incidents (indicator 7.1) were reported for FY21, and clinic personnel followed appropriate protocols. As such, the target was met. Additionally, no high-level breaches were identified for FY21

(indicator 7.2). The HIPAA walkthrough checklist was completed monthly for FY21 as planned (indicator 7.3).

HIPAA Indicators	Target	FY20	FY21
7.1 Low-level incidents	**≤ 2 Incidents**	0	2
7.2 High-level breaches	**0 Incidents**	0	0
7.3 HIPAA walkthroughs	**Complete checklist monthly**	N/A	12

FY22 Plans

No actions are planned at this time.

Patient Care Safety Incidents

Patient care safety incidents are classified as either low-level or high-level and are reported annually. A low-level incident is defined as any action that requires medical attention. This does not include a patient reporting "soreness" or aggravation of existing symptoms following treatment. A high-level incident is defined as any adverse reaction or patient injury resulting from treatment, causing permanent or long-term impairment.

FY20 Updates

There are no updates to report.

FY21 Outcomes

No low or high-level incidents were reported for FY21. There is some confusion regarding the new process in place for reporting incidents. While high-level incidents are reported via the SafeApp, low-level incidents are reported via webform after being triaged by the associate dean for clinical internship. It is now clear that the front desk was not fully aware of this process, and as a result, it is possible some incidents were not reported or tracked as appropriate. As such, the committee is not yet confident in the data to establish a target for low-level incidents.

Patient Care Safety Indicators	Target	FY20	FY21
8.1 Low-level incidents	**TBD**	0	0
8.2 High-level incidents	**0**	0	0

FY22 Plans

The following actions are planned for FY22:

- The QPCC will establish a target for indicator 5.1 (low-level incidents)
- Review protocol for reporting incidents and revise as appropriate. Socialize updated protocol with students, clinical faculty and front desk staff.
- Determine feedback loop for feeding safety incident data into the curriculum for instructional improvements, as appropriate.

Equipment Safety

The QA plan tracks two indicators related to the safety of equipment utilized in clinical care. These indicators include a calibration check of therapeutic/diagnostic equipment (ultrasound, electric stimulation, laser, hydrocollators and dynamometers), and inspection of all rehabilitation room equipment.

FY20 Updates

There are no updates to report.

FY21 Outcomes

The university utilizes an outside vendor to assess and calibrate all therapeutic and diagnostic equipment in the clinic (indicator 9.1). Additionally, the rehab room equipment (indicator 9.2) has historically been inspected regularly by a clinical educator. The move to the new campus vastly expanded the rehab room, resulting in the acquisition of additional new equipment. As such, the QPCC has recommended quarterly inspections for FY21. Some needed repairs were identified as a result of these inspections which will be completed early in FY22.

Equipment Safety Indicators	Target	FY20	FY21
9.1 Calibration check	**Completed once annually by an outside vendor**	Yes	Yes
9.2 Rehabilitation room equipment inspection	**Completed once quarterly**	N/A	Yes

FY22 Plans

The following actions are planned for FY22:

- Complete repairs identified as a part of inspection.
- Review rehabilitation room equipment inspection schedule and modify frequency if indicated.

Facility Safety

Two inspections are conducted per year by the executive director of emergency management (EDEM) to identify potential clinic facility safety risks. These inspections address the following ten clinical safety standards in alignment with recommendations from the Occupational Safety and Health Administration (OSHA).

i. Hazard communication
ii. Bloodborne pathogens
iii. Ionizing radiation
iv. Exit routes
v. Electrical
vi. Emergency action plan
vii. Fire safety
viii. Medical and first aid
ix. Personal protective equipment (PPE)
x. Secured patient information

The QA program tracks both low-level and high-level facility safety incidents. Low-level incidents are defined as any event that impacts or could potentially impact the safety of individuals. High-level is defined as any incident that requires medical attention. Furthermore, the EDEM plans to conduct regular trainings for both DCP clinicians and clinic staff to reinforce safety practices.

FY20 Updates Outcomes

There are no updates to report.

FY21 Outcomes

Facilities only conducted one of the two inspections utilizing 10 clinical safety standards. As such, indicator 10.1 did not attain the desired target. New protocols for facility safety incident reporting were implemented

as planned via the SafeApp (previously TIPS reporting tool). No low-level (indicator 10.2) or high-level (indicator 2.3) incidents were reported for FY21.

Clinic Facility Safety Indicators	Target	FY20	FY21
10.1 Conduct inspections utilizing 10 clinical safety standards	**Twice per year**	N/A	1
10.2 Low-level facility safety incidents	**≤ 15**	0	0
10.3 High-level facility safety incidents	**0**	0	0
10.4 Regular (shorter) scenario-based trainings	**One per month (5-10 mins each)**	N/A	0
10.5 Biannual (longer) trainings	**Two per year (30 mins each)**	N/A	0

Due to an ongoing focus of responding to COVID safety protocols, scenario-based (indicator 10.4) and longer safety trainings (indicator 10.5) did not commence as planned. The executive director of emergency management anticipates these will begin in early October of the fall term.

FY22 Plans

The following actions are planned for FY22:

- Conduct two inspections utilizing 10 clinical safety standards and achieve indicator 10.1 target.
- Commence trainings to support indicators 10.4 and 10.5.
- Reevaluate targets as appropriate.
- Measure risk reduction levels with safety standard measurements.

Appendix A – Annual Patient Feedback Survey

UNIVERSITY of Western States

Patient Feedback Survey Outcomes Report

Campus Health Center
Fiscal Year 2021

Purpose of the Survey

The university surveys patients annually about their satisfaction with clinical services provided by UWS. Clinical staff utilizes survey data to improve the patient experience in UWS clinics.

Survey Updates

Many survey questions were adapted from the Consumer Assessment of Healthcare Provider and Systems (CAHPS) surveys promoted by the Agency for Healthcare Research and Quality (AHRQ). Questions are designed to solicit patient feedback about access and convenience of facilities, the quality of care delivered by clinical providers, the level of service provided by reception and office staff, and patients' overall impression of the clinical experience. In FY17, the DCP modified the survey to include new questions specific to patients' perceptions of integrated healthcare delivery, consistent with the university's updated mission goals (previously known as core themes).

With the departure of the chief clinical excellence officer (CCEO) in late winter of 2020, the office of institutional effectiveness assumed responsibilities for the annual patient feedback survey. With input from the DCP dean and associate dean of clinical internship (ADCI), UWS updated the survey to better align with DCP program goals and CCE meta-competencies. Questions were added to better segment the survey into four separate categories (facilities/access/conveniences, office staff, clinic providers, and overall experience) for analysis purposes (indicator 2.2). Many of the items are either new or modified enough from prior iterations that there is limited prior year data available for comparative analysis.

To facilitate data collection, the associate vice president for indicational effectiveness (AVPIE) developed a plan to transition to electronic survey administration methods to replace the current labor-intensive paper-based process. Additionally, while the data was collected, aggregated, and shared in the past, this is the first formal report published with detailed analysis.

Methods

The office of institutional effectiveness (OIE) developed this survey utilizing a web-based survey instrument hosted online by Survey Monkey™. Active patients (those utilizing clinic services within the past year) were emailed a unique link to complete the survey using the email on file. Patient identities were not collected in association with responses to ensure confidentiality. "NA" responses received no numerical value, and therefore, did not affect mean or percentage calculations.

On May 10, 2021, OIE sent a link via Survey Monkey to 950 patients. Of these, 82 emails bounced back (8.6%), and 17 (1.8%) opted out of receiving Survey Monkey emails. OIE sent reminder emails on May 15, 2021, May 19, 2021, May 24, 2021, and May 28, 2021, to encourage participation. One survey was completed onsite utilizing an iPad available at the clinic front desk. Data collection closed on May 31, 2021.

Response Rate and Demographics

Of the patients surveyed in FY21, 174 completed the survey for a 20% response rate (Table1 below). It is important to note that results from this survey fail to capture the majority opinion of UWS patients. Response rates are not available for prior year surveys, as it was not possible to manually track participation. While the number of responders declined significantly utilizing electronic surveys, the population of patients surveyed was much broader than in prior years. The Quality Patient Care Committee (QPCC) will discuss strategies for improving the FY22 response rate.

Table 1: Survey Response Rates

	FY17	FY18	FY19	FY20*	FY21
Surveys Sent					868**
Responders	304	369	339		174
Response Rate	N/A	N/A	N/A		20%

*Survey not administered.
**Bounced emails excluded.

Table 2 presents the response rate by gender identity. Majority (64.6%) of respondents identified as female. This percentage is consistent with data indicating 60% of chiropractic patients identify as female[1].

Table 2: Response Rate by Gender Identity

Gender Identity	# Respondents	% of Total Respondents
Female	113	64.6%
Male	56	32.0%
Transgender	0	0.0%
Non-binary	2	1.1%
Prefer not to answer	3	1.7%

Table 3 presents the response rate by self-identified age group. The groups distinguish minors from patients receiving Medicare.

Table 3: Response Rate by Age Group

Age	# Respondents	% of Total Respondents
Under 18	2	1.2%
18-64	139	84.2%
65+	23	13.9%

Table 4 presents the response group by self-identified race/ethnicity. Analysis revealed the need to include several additional race/ethnicities for the next iteration of the survey.

Table 4: Response Rate by Race/Ethnicity

Race/Ethnicity	# Respondents	% of Total Respondents
White or Caucasian	130	74.7%
Hispanic or Latino	9	5.2%
Prefer Not to Answer	9	5.2%
Asian or Asian American	8	4.6%
Native Hawaiian or Other Pacific Islander	5	2.9%

[1] The Journal of Chiropractic Education (2012). *Diversity in the Chiropractic Profession: Preparing for 2050* [Online]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3391776/

Race/Ethnicity	# Respondents	% of Total Respondents
Black or African American	4	2.3%
One or more race/ethnicity	3	1.7%
American Indian or Alaska Native	2	1.1%

Table 5 presents response rate by self-identified provider. Dr. Armington's patients were the most likely to respond. Drs. DeLapp and Davies had the fewest responses. This is likely due to the fact that both clinicians separated from the university in 2020.

Table 5: Response Rate by Self-identified Clinical Provider

Clinical Provider	# Respondents	% of Total Respondents
Armington	37	22.0%
Bergstrom	21	12.5%
Kawaoka	17	10.1%
Ross	16	9.5%
Ondick	14	8.3%
Hartung	13	7.7%
Moreau	13	7.7%
Vuky	13	7.7%
Ginter	11	6.5%
DeLapp	7	4.2%
Davies	5	3.0%

Quality Patient Care Indicators

The quality patient care committee developed the indicators in Table 6 to track performance and identify opportunities for improvement. All five indicators met the performance target for FY21. Indicator 2.1 examines the percentage of positive agreement responses or all items with an agreement scale. The indicator has been tracked for multiple years as part of other institutional effectiveness measures. It should be noted that this indicator does not include two new survey items related to overall satisfaction (examined as part of indicator 2.2d) and likeliness to refer patients (examined separately).

Indicators 2.2a-d are new and did not have prior year comparative data. The QPCC reevaluated these indicators for FY21 and determined they would be monitored and analyzed but would not have separate thresholds of achievement. It is worth noting that when disaggregated by age and race/ethnicity, there was no significant difference in outcomes for any of the indicators. Individuals identifying as non-binary did have lower levels of satisfaction than those identifying as male or female. It is important to recognize that the sample only includes two individuals (or 1.1% of respondents) identifying as non-binary. As such, these results should be interpreted with caution.

Table 6: Quality Patient Care Indicator Performance

Quality Patient Care Indicators	Target	FY17	FY18	FY19	FY20	FY21
2.1 Patient satisfaction survey responses (aggregated % positive agreement)	**92%***	99%	96%	98%	N/A**	97%
2.2a Facilities, access, and conveniences (aggregated % positive agreement)	**Monitor**				N/A	94.2%

Quality Patient Care Indicators	Target	FY17	FY18	FY19	FY20	FY21
2.2b Office staff (aggregated % positive agreement)	**Monitor**				N/A	95.2%
2.2c Clinical providers % positive (aggregated % satisfied)	**Monitor**				N/A	98.7%
2.2d Overall satisfaction (% satisfied item)	**85%**				N/A	93.1%

*The institutional effectiveness and planning committee increased the target from 75% to 92% for FY19 due to multiple years exceeding the target.
**The survey was not administered in FY20 due to the timing of the COVID-19 pandemic.

Results

Survey items are classified into three domains – facilities, access, and convenience; office staff; and clinical providers. Each group of items is discussed in more detail in the following paragraphs.

Table 7 presents the percent positive and mean score for each of the items related to facilities, access, and convenience. The lowest scoring items related to the cost of care, both how well it was explained to patients and their perception regarding costs.

Table 7: Outcomes for Facilities, Access, and Convenience Items

Facilities, Access, and Convenience Items	% Positive	Mean
I can get appointments when I want to be seen.	97.6%	5.56
The lobby and waiting area are comfortable and clean.	97.0%	5.64
I was seen in a timely manner.	97.0%	5.60
My check-in at the front desk was a seamless experience.	96.4%	5.56
The treatment rooms are comfortable and clean.	93.4%	5.33
The cost of care was clearly explained to me.	88.0%	5.20
The cost of care is reasonable.	86.2%	5.19

Table 8 presents the percent positive and mean score for each of the items related to office staff. The lowest scoring item relates to helpful responses from office staff related to matters of scheduling and billing.

Table 8: Outcomes for Office Staff Items

Office Staff Items	% Positive	Mean
Respect my confidentiality and privacy.	97.6%	5.67
Are friendly and professional.	97.0%	5.61
Provide helpful responses to my questions related to scheduling and billing.	91.0%	5.55

Table 9 presents the percent positive agreement and mean score for each of the items related to clinical providers. All thirteen items scored above the target and have a multiyear history of strong performance. Items with a (*) are utilized for Mission Fulfillment indicator 3.1.1 (degree to which providers approached their encounters from an integrated health perspective) and will be further analyzed in the FY21 *Annual University Appraisal* report.

Table 9: Outcomes for Clinical Provider Items

Clinical Providers Items	% Positive	Mean
Communicate with me in a professional manner.	98.2%	5.73
Engage in hygiene practices that meet my needs.	98.2%	5.73
Ask questions about my overall health and wellbeing, not just the issue I came in about.*	98.2%	5.61
Take the time to answer my questions.	97.6%	5.67
Explain things to me in a way I can understand.	97.6%	5.64
Are compassionate and seem concerned about my well-being.	97.6%	5.65
Respect my confidentiality and privacy.	97.0%	5.70
Ask questions about my life circumstances (examples include: stress level, family situation, employment, hobbies, exercise, interests, etc.).*	97.0%	5.50
Provide me with the information I need to make informed decisions about my care.	97.0%	5.66
Develop a plan of action with me to achieve my health goals.	97.0%	5.59
Respect my personal and/or family values, cultural background, and preferences.*	96.4%	5.65
Offer suggestions about various approaches to care, such as different types of treatments, self-care, changes to my activities of daily living and/or working with other providers.*	96.4%	5.55
Listen carefully to me and try to understand my needs.*	95.8%	5.56

A new item for the FY21 survey examines overall satisfaction with care (Table 10). While this item meets the 92% target, it is a lower performing item. It is unclear what might lead to a disconnect between high levels of agreement for most of the specific survey items but lower levels of satisfaction with overall care.

Table 10: Overall Satisfaction Outcome

Overall Satisfaction*	% Satisfied	Mean
What is your overall satisfaction with your care at UWS health centers?	93.1%	5.25

*Utilizes 6-point satisfaction rating scale.

Table 11 presents how likely patients are to refer friends and family to UWS health centers. It is important to note that this item utilizes a 3-point scale for analysis rather than a 6-point scale. As such, it is not appropriate to compare the likeliness to refer directly with the percent positive and percent satisfied data for items. There is not a target established for this item. Respondents indicating they were uncertain or unlikely to refer patients were presented with a follow-up option to describe why. Reasons include the length of the visit (too long), cost (same as private clinics, expensive without insurance/uninsured, perception that student care should be discounted), no longer accepting OHP/Care Oregon, and treatment room comfort (temperature too warm).

Table 11: Likeliness to Refer Outcome

Likely to Refer	Likely to Refer	Uncertain	Unlikely to Refer	Mean
How likely are you to refer friends and family to UWS health centers?	82.4%	13.9%	3.6%	2.82/3.00

*Utilizes 3-point rating scale.

Open-ended Responses

Respondents were given the opportunity to respond to one open-ended question at the conclusion of the survey.

Table 12: Comment Themes from Open-ended Item

"What is one thing we could do to make your visits with us better?"	
Emergent Themes	**Key Words/Phrases**
Appointments take too long (13)	• "Appointments are long and drawn out. After extensive examination, mobilization/adjustments seem minimal and a waste of time." • "The intake time was really long and left little time for treatment. I might be nice for interns to check in with patients about any time constraints they may have." • "Please have the interns go faster. They always ask me the same questions when I come in and repeat the same exam stuff every visit. It takes a lot of time"
Treatment room temperature too warm (6)	• "Those rooms get very hot! Especially when there are multiple interns/docs/observers/patients in there. Please add fans or some sort of AC" • "The temperature regulation in the treatment rooms is not well regulated, it is often very hot in there" • "Air circulation/ Air conditioning in the treatment rooms. It gets very hot and stuffy in there"
Exam rooms too small (5)	• "Treatment rooms are quite small and if I bring a bag it has to go on the floor. It would be good to have a table or shelf to put patient belongings on." • "treatment rooms are very small. Need a basket or bowl to put keys, etc..." • "Larger exam rooms"
Waiting room improvements (4)	• "Maybe artwork and/or plants in the waiting area." • "add more hospitality touches to the waiting room and patient rooms, it's very sad and sparse" • "Water cooler in the waiting room" • "Reorganize the front desk check-in vs check-out seating positions. Patients coming from the front door have to cross to the far desk for check-in. And patients coming from the clinic have to cross to the far desk for check-out. It's counterintuitive"
Cost (4)	• "Less expensive visits for non-students" • "Charge a flat reasonable rate" • "discounted cost for being treated by students"

Discussion

Two of the lowest scoring items on the survey relate to cost. Both were included in prior iterations of the survey, and multiyear data for analysis is presented in Table 13 below. The decline for both the percent positive and the mean in FY21 is significant when compared with prior years' data. Additionally, multiple comments also indicate dissatisfaction with the cost of being treated by student interns.

Related to cost, patients indicated lower satisfaction with office staff providing helpful responses to questions related to scheduling and billing. It is unclear from the statement whether dissatisfaction is related to schedule and/or billing, and as such, it is recommended the question be reworded to address each topic separately for the next survey iteration.

Table 13: Response Rate by Self-identified Clinical Provider

Survey Item	**FY17**		**FY18**		**FY19**		**FY20***		**FY21**	
The cost of care is reasonable.	98.3%	5.74	91.8%	5.46	97.0%	5.67			88.0%	5.20
The cost of care was clearly explained to me.	97.6%	5.62	94.2%	5.46	95.5%	5.55			86.2%	5.19
Office staff provide helpful responses to my questions related to scheduling and billing.									91.0%	5.55

*The survey was not administered in FY20 due to the timing of the COVID-19 pandemic.

Still meeting the target at 93.4%, the item "The treatment rooms are comfortable and clean" score much lower than other items related to facilities and access. Dissatisfaction with treatment rooms may correlate

with both the size and warm temperature identified in the comments. Although the room size cannot be addressed, it may be worth considering what additional improvements could be made to accommodate patient belongings or maximize space when there are multiple students and or providers in the room with the patient. Although the item “The lobby and waiting area are comfortable and clean” scored higher at 97% positive agreement, it is worth noting several comments and recommendations from patients for improvement in this area of the clinic. The addition of a water cooler, plants and art may make the area seem more welcoming to future patients.

Lastly, patient comments indicate a dissatisfaction related to the duration of appointments with students. Specific comment themes allude to frustration from patients regarding the number of questions asked of them at each visit and a desire for more time designed to treatment rather than interviewing.

The Quality Patient Care Committee will review the results and develop recommendations for improvement. Additionally, the committee will discuss strategies for increasing the response rate in FY22.

Appendix A: Survey Items and Results

Legend:
SA=Strongly Agree
A=Agree
SLA=Slightly Agree
SLD=Slightly Disagree
D=Disagree
SD=Strongly Disagree
NA=Not Applicable (not factored into percentage calculations)
% Pos=Percentage of positive responses (aggregation of SA, A, and SLA)
Mean=average score out of 6.00

Item	SA	A	SLA	SLD	D	SD	N/A	n	% Pos	Mean
Please rate your level of agreement with each of the following statements related to facilities, access, and convenience.										
I can get appointments when I want to be seen.	65.3%	29.9%	2.4%	0.6%	1.2%	0.6%	0.0%	167	97.6%	5.56
My check-in at the front desk was a seamless experience.	68.3%	26.9%	1.2%	1.2%	1.2%	1.2%	0.0%	167	96.4%	5.56
I was seen in a timely manner.	70.1%	26.3%	0.6%	0.6%	1.8%	0.6%	0.0%	167	97.0%	5.60
The cost of care is reasonable.	59.3%	24.0%	3.0%	3.0%	4.2%	4.8%	0.0%	164	86.2%	5.19
The cost of care was clearly explained to me.	52.1%	30.5%	5.4%	5.4%	3.0%	1.8%	0.0%	164	88.0%	5.20
The lobby and waiting area are comfortable and clean.	72.5%	24.0%	0.6%	1.8%	0.6%	0.6%	0.0%	167	97.0%	5.64
The treatment rooms are comfortable and clean.	59.9%	25.1%	8.4%	2.4%	3.0%	1.2%	0.0%	167	93.4%	5.33
Office staff at the clinic...										
Are friendly and professional.	70.1%	26.3%	0.6%	1.2%	1.2%	0.6%	0.0%	167	97.0%	5.61
Provide helpful responses to my questions related to scheduling and billing.	62.3%	26.9%	1.8%	1.2%	1.2%	0.6%	6.0%	167	91.0%	5.55
Respect my confidentiality and privacy.	71.9%	24.0%	1.8%	0.0%	1.2%	0.0%	1.2%	167	97.6%	5.67
My clinical providers (doctors, students/interns, etc.) ...										
Engage in hygiene practices that meet my needs.	76.0%	21.0%	1.2%	1.2%	0.0%	0.0%	0.0%	166	98.2%	5.73
Ask questions about my overall health and wellbeing, not just the issue I came in about.	68.9%	23.4%	6.0%	1.2%	0.0%	0.0%	0.0%	166	98.2%	5.61
Ask questions about my life circumstances (examples include: stress level, family situation, employment, hobbies, exercise, interests, etc.).	61.1%	28.1%	7.8%	1.8%	0.0%	0.0%	0.0%	165	97.0%	5.50
Offer suggestions about various approaches to care, such as different types of treatments, self-care, changes to my activities of daily living	61.7%	28.7%	6.0%	1.2%	0.0%	0.0%	0.0%	163	96.4%	5.55

Item	SA	A	SLA	SLD	D	SD	N/A	n	% Pos	Mean
and/or working with other providers.										
Listen carefully to me and try to understand my needs.	65.3%	28.7%	1.8%	1.2%	1.2%	0.6%	0.0%	165	95.8%	5.56
Respect my personal and/or family values, cultural background, and preferences.	67.1%	26.9%	2.4%	0.6%	0.0%	0.0%	0.0%	162	96.4%	5.65
Respect my confidentiality and privacy.	73.1%	22.8%	1.2%	0.6%	0.6%	0.0%	0.0%	164	97.0%	5.70
Provide me with the information I need to make informed decisions about my care.	67.7%	28.1%	1.2%	0.0%	0.6%	0.0%	0.0%	163	97.0%	5.66
Explain things to me in a way I can understand.	67.1%	29.3%	1.2%	1.2%	0.0%	0.0%	0.0%	165	97.6%	5.64
Take the time to answer my questions.	70.7%	25.1%	1.8%	0.6%	0.6%	0.0%	0.0%	165	97.6%	5.67
Communicate with me in a professional manner.	73.7%	24.0%	0.6%	0.6%	0.0%	0.0%	0.0%	165	98.2%	5.73
Are compassionate and seem concerned about my well-being.	71.3%	23.4%	3.0%	0.6%	0.0%	0.6%	0.0%	165	97.6%	5.65
Develop a plan of action with me to achieve my health goals.	67.1%	24.6%	5.4%	0.0%	1.2%	0.0%	0.0%	164	97.0%	5.59

Legend:
VS=Very Satisfied
S=Satisfied
SS=Slightly Satisfied
SD=Slightly Dissatisfied
D=Dissatisfied
VD=Very Dissatisfied
% Pos=Percentage of positive responses (aggregation of VS, S, and SS)

Item	VS	S	SS	SD	D	VD	n	% Pos	Mean
I can get appointments when I want to be seen.	61.5%	25.3%	6.3%	0.6%	1.1%	0.6%	174	93.1%	5.25/6.00

Legend:
LR=Likely to Refer
U=Uncertain
UR=Unlikely to Refer

Item	82.4%	13.9%	3.6%	n	Mean
How likely are you to refer friends and family to UWS health centers?	61.5%	25.3%	6.3%	165	2.79/3.00

Appendix B – Revised Chart Audit Tool

Audit Information

As a reminder, when auditing the chart, please review all visits occurring since the last re-examination.

Auditor
Please select your last name from the list.

Clinician
Select the clinician who is responsible for the patient chart being audited.

Patient MRN
Document the MRN for the patient whose chart is being audited.

Date of Most Recent Patient Evaluation
Enter the date of the patient encounter that began the episode being audited. This will typically be either the patient's first appointment if they are new, or their most recent re-evaluation. *** Please note that the date auto-fills with the current calendar year. If their most recent evaluation was in the prior year, be sure to correct this. ***

Chief Complaint History

All relevant components of the chief complaint history are included based on the initial clinical presentation, and subsequently updated as indicated. Elements include location, onset/mechanism of injury (MOI), chronology, quality, severity, modifying factors, associated systems and treatment history. Additionally, the chief complaint history adequately addresses more than one presenting complaint, as appropriate.

- ☐ Yes
- ☐ No

Chief complaint issues (select all that apply)

- ☐ Complaint locations missing or incomplete
- ☐ Onset / mechanism of injury (MOI) missing or incomplete
- ☐ Chronology (frequency, duration, intensity) missing or incomplete
- ☐ Quality missing or incomplete
- ☐ Severity / intensity missing or incomplete
- ☐ Modifying factors missing or incomplete
- ☐ Associated symptoms missing or incomplete
- ☐ Treatment history missing or incomplete
- ☐ Adequately addressed one, but not all presenting complaints

Chief complaint history comments or other issues
Please identify additional chief complaint issues and/or explain your selection(s) as needed.

Past Health and Family History

All components of the patient's past and family health history are based on the initial clinical presentation. These history components are updated completely every three years, while subsections may be updated more frequently, as indicated. Elements include a history, review of systems, medical/past health history, surgical history, family history, social/substance history. These areas may be focused as appropriate for the case presentation.

- ☐ Yes
- ☐ No

Issues (select all that apply)

- ☐ Review of systems missing or incomplete
- ☐ Medical/past health history missing or incomplete
- ☐ Surgical history missing or incomplete
- ☐ Family history missing or incomplete
- ☐ Social/substance history missing or incomplete

Past health and family history comments or other issues

	Please identify additional past health or family history issues and/or explain your selection(s) as needed.
Examination	
All components of the examination warranted by the clinical presentation are performed, appropriately documented, and subsequently updated as indicated. Examination elements includes all vital signs (bilateral blood pressure preferred, but unilaterally acceptable unless otherwise indicated), posture, range of motion, orthopedic testing, neurological testing, musculoskeletal palpation, and other examinations as appropriate. Please note that not all components may be necessary based on patient presentation (i.e., comprehensive neurological evaluation not warranted for presentation with no neuro symptoms). Do not mark “no" if minimally required procedures are performed to support a diagnosis, but auditor would have performed different or additional tests. ☐ Yes ☐ No	Issues (select all that apply) ☐ Vital signs missing or incomplete ☐ Posture missing or incomplete ☐ Gait assessment missing or incomplete ☐ Range of motion missing or incomplete ☐ Orthopedic testing missing or incomplete ☐ Neurological testing missing or incomplete ☐ Musculoskeletal palpation missing or incomplete ☐ Physical examination missing or incomplete ☐ Exam addressed one but not all presenting complaints Examination comments Please identify additional examination issues and/or explain your selection(s) as needed.
Diagnostic Testing	
The use (or lack of use) of diagnostic testing is clinically justified and appropriate based on applicable guidelines and standards of care. ☐ Yes ☐ No	Diagnostic testing issues ☐ Studies not clinically justified ☐ Justified studies not obtained Diagnostic testing comments Please identify additional diagnostic testing issues and/or explain your selection(s) as needed.
Diagnosis & Problem List	
Diagnosis(es) and other real/potential health concerns are included on the problem list with appropriate accuracy and specificity based on subjective and objective findings. The problem list is inclusive of both newly diagnosed and pre-existing conditions. The re-exam date is included in the first line of the problem list. ☐ Yes ☐ No	Diagnosis and problem list issues (select all that apply) ☐ The re-exam date is not included in the problem list. ☐ Problem list is missing diagnosis(es) based on identified pre-existing conditions ☐ Diagnosis(es) missing from problem list, but addressed in history or exam (excludes pre-existing conditions) ☐ Diagnosis(es) included on problem list without corresponding history or exam findings, as appropriate (excludes pre-existing conditions) ☐ Diagnosis(es) included on problem list appear to be inaccurate or not supported based on history and exam findings (i.e.,

	diagnostic procedures indicate a different diagnosis(es) than included in the chart) Diagnosis and problem list comments Please identify additional diagnosis or problem list issues and/or explain your selection(s) as needed.
Management Plan	
The management plan(s) is(are) justifiable based on the problem list and clinical goals and documented with appropriate specificity. Documentation is sufficient for care to be directed by a provider unfamiliar with the case. *Do not mark "no" if missing outcome measures – these are addressed in a subsequent section.* ☐ Yes ☐ No	Management plan issues ☐ No management plan is included ☐ Plan does not address all problems being managed ☐ Plan only focuses on active problems ☐ Plan is not justifiable/rational based on clinical goals ☐ Plan is out of date or has not been updated to include new clinical information available ☐ Documentation is insufficient for care to be directed by a provider unfamiliar with the case. Management plan comments Please identify additional management plan issues and/or explain your selection(s) as needed.
PARQ/Informed Consent	
There is documentation of a PARQ conference and a signed informed consent form for the current treatment modalities. The PARQ should be easily located within the chart and addresses all current conditions. The informed consent is current for all interventions/modalities. ☐ Yes ☐ No	PARQ/Informed consent issues (select all that apply) ☐ PARQ documentation missing or in wrong place ☐ PARQ documentation present for some, but not all conditions being treated ☐ Signed informed consent missing ☐ Informed consent is present for some, but not all intervention/modalities ☐ PARQ /informed consent is not current ☐ Documentation was not completed for all/any interventions/modalities PARQ/Informed consent comments Please identify additional PARQ/informed consent issues and/or explain your selection(s) as needed.
Outcome Assessment	
Appropriately selected assessment measures (at least one objective in nature) are established at the onset of treatment and corresponding baseline is documented. Measures are reassessed periodically thereafter provide important information about the effectiveness and appropriateness of care. Where appropriate, at least one validated outcome	Issues with outcome assessment ☐ No outcome measures are included ☐ Only subjective measures included ☐ A validated outcome assessment (paper) tool was appropriate, but not included ☐ No baseline(s) documented for some or all measures

assessment (paper) tool is utilized (do not mark “no” when there is no appropriate tool). ☐ Yes ☐ No	☐ Outcomes not reassessed at appropriate intervals ☐ Outcomes selected are not applicable to clinical circumstance ☐ Outcome documentation is inconsistent ☐ Measures not updated as appropriate (i.e., activity selected in which a patient is no longer engaged) Outcome assessment comments Please identify additional outcomes assessment issues and/or explain your selection(s) as needed.
Treatment Outcomes	
Care in subsequent visits aligns with the treatment plan. There is documented evidence of satisfactory subjective and/or objective response to care or timely initiation of appropriate additional evaluation/management. If the patient is asymptomatic or engaged in maintenance/palliative care and is responding appropriately, please select the appropriate “asymptomatic/maintenance/palliative care patient” option below. ☐ Yes ☐ No ☐ Asymptomatic/maintenance/palliative care patient	Issues with treatment outcomes ☐ Care provided does not align with treatment plan ☐ No outcome measures established in which to assess response to care ☐ No evidence of subjective or objective improvement in response to care ☐ No initiation of additional evaluation as appropriate due to poor response to care Treatment outcomes comments Please identify additional treatment outcomes issues and/or explain your selection(s) as needed.
Safety Precautions	
Relative and absolute contraindications to care and other identifiable safety issues, if any, are appropriately documented via applicable care coordination note(s) and FYI flag(s), and appropriately used to drive safe care. If no concerns are applicable, then mark "Yes". ☐ Yes ☐ No	Patient safety issues (select all that apply) ☐ Concerns present and identified, but not easily located in care coordination note(s) and FYI flag(s) ☐ Concerns present but not identified ☐ Concerns inappropriately documented ☐ Concerns documented but not followed Safety precautions comments Please identify additional patient safety issues and/or explain your selection(s) as needed.
Comments	
If you have any additional comments regarding this chart, please note them here (optional).	