UNIVERSITY of Western States
Office of Institutional Effectiveness

Quality Patient Care Outcomes Report

UWS Campus Health Center
Fiscal Year 2020

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.

Relevant History

As a result of university organizational changes, oversight of the program's patient quality (QA) assurance initiatives has undergone several transitions since 2010. At the time, the QA system in place was determined to be ineffective for providing meaningful feedback that could be used for improvement by the former vice president of clinics (VPC) and was discontinued in 2011. This system was replaced by Centers for Medicare & Medicaid Services (CMS) meaningful use indicators in 2014 and utilization of an annual patient feedback survey.

In late 2018, the VPC determined the new measures and revised thresholds for "meaningful use" released by CMS did not provide the clinical system nor the DCP with meaningful data that allowed for sufficient monitoring and opportunities to improve patient care outcomes. As such, the tracking of electronic health record (EHR) meaningful use indicators was discontinued in favor of redeveloping an effective and sustainable chart audit process.

In early 2019, the VPC developed and implemented a new chart audit system, based on clinician peer-review of patient files, to directly evaluate practical quality care processes. As a foundation for the system, the VPC developed a chart audit tool, which evaluates elements of patient history, examination, diagnostic testing, diagnosis, management plan, informed consent, outcome assessment, treatment benefit, and safety.

In February 2020, with the departure of the VPC, the administration of chart audits and the annual patient feedback survey transitioned to the associate vice president of institutional effectiveness (AVPIE). The AVPIE assessed QA practices in place and determined that while there was clearly a system to collect and evaluate patient data to improve the delivery of care in the campus health center (CHC), there were no indicators or corresponding thresholds for performance that were tracked by the DCP as required by the Council of Chiropractic Education (CCE). Consequently, the AVPIE developed a comprehensive Patient Quality Assurance Plan (Appendix A) document with various stakeholders' input. This document includes clearly articulated goals of the QA program, roles and responsibilities of participant groups, and quality patient care indicators. Additionally, the newly formed quality patient care committee (QPCC) was convened to finalize the QA plan and chartered to review patient QA data regularly and recommend actions to be taken in response to indicator performance below established thresholds.

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 attending clinicians maintain an active chiropractic license and basic life support/CPR certification on an annual and biannual basis, respectively.

FY20 Outcomes

All clinicians were up to date with both active licenses (indicator 1.1) and basic life support/CPR (indicator 1.2) for FY20.

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

FY21 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 Outcomes

With the departure of the chief clinical excellence officer (CCEO) in late winter of 2020, the AVPIE 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). Additionally, to facilitate data collection, the AVPIE developed a plan to transition to electronic methods of survey administration to replace the current labor-intensive paper-based process.

Unfortunately, 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 AVPIE determined the survey would be postponed until the clinic resumed operations, and timing is more optimal to yield an adequate response rate. As such, there is no data available for FY20 analysis. The table below presents prior year data for indicator 2.1; indicator 2.2 is new for FY20, and as such, there is no data available.

Indicator	Target	FY16	FY17	FY18	FY19	FY20
2.1 Patient satisfaction survey responses % positive (aggregated)	**92%***	94%	99%	96%	98%	N/A**
2.2a Facilities, access, and conveniences % positive	**85%**					N/A
2.2b Office staff % positive	**85%**					N/A
2.2c Clinical providers % positive	**85%**					N/A

Indicator	Target	FY16	FY17	FY18	FY19	FY20
2.2d Overall experience % positive	**85%**					N/A

*The strategic plan and core theme 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.

FY21 Plans

Plans for FY21 include the following:

- Launch revised patient satisfaction survey in the spring of 2021.

Patient Grievance/Dissatisfaction

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

FY20 Outcomes

Indicator 3.1 is new for FY20. Previously, there was not a system to track such complaints. UWS updated its website in late spring of 2020 to provide patients the opportunity to provide feedback or submit complaints on an ongoing basis. Submitted complaints will be tracked and monitored for FY21. The QPCC recommended deferring finalizing the patient grievance/dissatisfaction indicator until there is sufficient data collected to analyze utility.

FY21 Plans

The QPCC will analyze data collected for indicator 3.1 and develop plans for ongoing collection and analysis.

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 Outcomes

Indicator 4.1: Quarterly Infractions	Target	SU-19	FA-19	WI-20	SP-20
% of interns completing clinical internships without an actionable infraction	**90% each term**	98.6%	98.3%	100.0%	100.0%

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 FY20. The target was met for each term. The table below presents the fiscal year total for the last three years, which also met the target. The AVPCI indicates that all FY20 infractions were managed via the existing process and resolved without follow-up incidents.

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

FY21 Plans

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

Chart Audits

The chart audit system is designed to drive 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 Outcomes

As previously mentioned, UWS developed and piloted a new chart audit tool (Appendix B) in the spring 2019 term. A review of 59 patient charts during that period revealed that 82.8% of all elements in audited charts met the criteria for quality care. Audit results for charts that did not meet the established criteria were shared with respective attending clinicians for review and clarification. Initial plans called for each clinician to complete ten audits per term, but the VPC reduced this number to 5 early in FY20 due to time constraints.

The number of audits will be reduced further to 3 per clinician per term, which allows for each clinician to be assessed 12 times per fiscal year. This strategy ensures a large enough sample size for individual practitioner trend data and will lead to an annual sample size of roughly 108 charts – far above the 70 charts required the Bureau of Primary Care for HRSA audits.[1] As such, indicator 5.1 is to ensure a minimum of 70 patient chart audits are completed by clinicians on an annual basis. This target has been achieved the past two fiscal years.

Indicator 2.2 is ≥80% achievement of patient chart audit indicators (overall score). As seen in the table below, this FY20 outcome of 85.2% improved somewhat over FY19. Although targets are not established for each individual audit category, the QPCC will explore the need for additional thresholds in FY21. The following sections will address categories scoring below the 80% target for the entire instrument.

Category	Target	FY19 n=122	FY20 n=122
History		73.0%	81.1%
Exam		76.2%	73.0%
Diagnostic Testing		96.7%	96.7%
Diagnosis		79.5%	78.7%
Management Plan		71.3%	72.1%
Informed Consent		80.3%	85.2%
Outcome Assessment		83.6%	86.1%
Treatment Outcomes		91.8%	95.9%
Safety Precautions		92.6%	98.4%
Overall (Indicator 5.2)	**80.0%**	**82.8%**	**85.2%**

While history outcomes improved in FY20 (see table on next page), further analysis of the data indicates the majority of errors and omissions stem from the chief complaint history. Many clinicians often indicated that the chief complaints' individual components were missing (onset, mechanism of injury (MOI), associated symptoms) rather than identifying deficiency in the chief complaint. Charts in which the patient presented with multiple problems often had either components of or the entire chief complaint missing for additional problems. 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.

[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

History Component Issue	n = 23
Chief Complaint	78%
Onset	4%
MOI	9%
Associated Symptoms	4%
Review of Systems	13%
Medical History	13%
Social/Substance	2%
Surgical	4%

Exam outcomes declined in FY20 from 76.2% to 73.0%. Many of the issues identified relate to vitals. For example, blood pressure not performed bilaterally, or some, but not all of the vitals were performed. This presents an opportunity for clinicians to review established protocols regarding vitals. Additionally, it is clear physical exam procedures are an area in which clinician preference may have impacted outcomes. One example is a comment indicating that the auditor "would have done McKenzie evaluation," but it appears as though an otherwise sufficient examination was conducted. Additional language will be added to the audit tool, and follow-up discussion will occur with clinicians to support objectivity in assessment.

Exam Component Issue	n = 33
Vitals	45%
Range of Motion (ROM)	30%
Neurological Testing	24%
Orthopedic Testing	27%
Palpation	12%
Physical Exam Procedure	21%
Posture	15%

Diagnosis declined slightly from 79.5% to 78.7% in FY20. Further analysis indicates the three options offered for auditors to select from regarding issues may not accurately reflect the complexity of diagnosis challenges.

Diagnosis Issues	n = 26
Incomplete	62%
Inaccurate	8%
Not justifiable	23%

While the majority of the issues identified relate to "incomplete" diagnosis(es), the comments reveal that "inaccurate" and "not justifiable" may have been used interchangeably. It is recommended these be combined in future iterations of the audit tool. Additionally, "incomplete" appears to relate to the following three separate issues:

1. The problem list is missing diagnosis(es) based on identified pre-existing conditions
2. Diagnosis(es) missing from problem list but addressed in history or exam (excludes pre-existing conditions)
3. Diagnosis(es) included on problem list without corresponding history or exam findings, as appropriate (excludes pre-existing conditions).

As such, the audit tool will be updated to reflect these options to better understand the nature of diagnostic issues.

Management plan continues to score below 80 percent, although it improved slightly from 71.3% to 72.1% in FY20. For two years in a row, the most significant issue relates to diagnosis(es) missing from the problem list. From the comments, it is clear that, in addition to missing one or more problems, occasionally, there is a chart missing a management plan completely. The follow-up options for auditors to select from make it challenging to identify an entire management plan is missing; this will be added as an additional option to the FY21 tool. It would also be helpful for future data to elucidate if problems missing are pre-existing conditions in which a patient has already received a diagnosis or those evaluated as part of the visit and not included on the problem list.

Management Plan Issues	n = 34
Not justifiable	12%
Poor documentation	12%
Missing problems	59%
Not Updated/Current	24%

There also appears to be a lack of consensus from the clinicians regarding management plan expectations and corresponding components. Interrater reliability may improve from expanding instructions in this section of the audit tool to better outline management plan components.

Informed consent is another area in which it may be useful to conduct follow-up conversations with clinicians, especially regarding expectations for where the protocol is for written and verbal consent and corresponding documentation procedures. In the next version of the tool, it is recommended that additional follow-up items be included for instances when PARQ (procedures, alternatives, risks, questions) documentation is present for some, but not all conditions being treated. Additionally, informed consent may be present for some, but not all interventions/modalities. These options may provide more useful data regarding the nature of underlying informed consent issues.

Informed Consent Issues	n = 18
PARQ missing or in wrong place	61%
Signed form missing	28%
PARQ/Consent Not Current	6%
Missing for All Modalities	39%

Outcome measures are another area that would benefit from further clinician follow-up and discussion. For example, many auditors marked down charts and indicated that while sufficient measures were included, they could be strengthened by including specified tools. For example, the Patient Specific Functional Scale (PSFS) was included, but the chart was marked down for not also including Neck Disability Index (NDI) or Oswestry tools. Furthermore, agreement is required regarding how many outcome measures are required, including the number of objective versus subjective measures, and if a validated tool is must be included. It is important to consider that there may not be an appropriate validated tool for assessing all conditions, and it appears as though several charts were marked down for not including a “paper” tool in these cases. This presents an additional opportunity for clinicians to coordinate with didactic faculty regarding expectations. The tool would be further improved by including options for indicating when no measures were included and a not applicable option if measures are present, but enough visits have not yet occurred to adequately assess response to care.

Outcome Assessment Issues	n = 17
No baseline	18%
Not reassessed	12%
Measures not appropriate	6%
Inconsistent documentation	6%

In general, there were very few treatment outcome issues, but several issues with the audit tool may be impacting accurate evaluation. Most auditors included “other” responses regarding the nature of individual issues. Many of these comments indicated cases in which not enough visits had yet occurred to adequately assess the patient’s response to care. It is worth noting that this section appears not to ask auditors to assess if the documented treatment plan is being followed, and it is recommended the tool be updated accordingly. Once added, outcomes related to this component may change. Additionally, this section does not currently address how to assess asymptomatic patients or those currently engaged in maintenance care.

Treatment Outcome Issues	n = 5
No improvement	20%
No further evaluation	0%

Only two charts identified possible safety issues. One related to the possibility a recommended supplement could interact with other prescriptions the patient is taking for a condition not fully evaluated at UWS. The other related to a potential diagnosis issue and may not have been appropriate to rule as a safety issue. 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).

Safety Issues	n = 2
Unidentified Concerns	50%
Poor documentation	0%
Risk with Identified Concerns	50%

Average chart scores were also examined for both the auditor and the attending clinician under evaluation. This analysis revealed three attending clinicians with overall scores for FY20 below the 80% benchmark, one of which is no longer employed at the university. The auditor analysis looked at how often the evaluator marked an attending 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 associate vice president for clinical internship (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.

One final issue identified as part of data analysis relates to the criteria for chart selection. Charts are randomly assigned to clinicians on a quarterly basis, selecting from a pool of patients receiving treatment in the prior 12 months. Part of the audit process is sharing outcomes with attending clinicians to improve future documentation and care plans. The duration of this timeframe creates a significant lag between the review of audit data and patients with managed care after clinicians have received feedback. Conditions do not exist for the collection of longitudinal data to adequately assess quality improvement over time. As such, it is recommended the audit process only identify charts from the most recent three months of patient care in FY21. While there will still be a lag, it is significantly shorter than in prior years.

FY21 Plans

The following actions are planned for FY21:

- Update schedule to 3 audits per clinician, per academic term
- QPCC explore the need for individual audit category targets
- Update criteria for chart selection to only include those with active care in the prior three months
- Conduct audit tool training with clinicians regarding:
    - Exam: do not mark “no" if minimally required procedures are performed to support a diagnosis, but the auditor would have performed different or additional tests.

    - Management plan:
        - Do not mark down for outcome measures in this section.
        - Agreement regarding management plan components.
        - Determine the need for additional options if prognosis or re-examination date is missing.
    - Informed consent:
        - Agreement regarding written versus verbal informed consent.
    - Outcome measures:
        - Agreement regarding:
            - Required use of validated or "paper" tool
            - The number of outcome measures required
            - Recommended use of objective versus subjective measures
- Update audit tool to include the following:
    - Divide history into separate chief complaint and past health/family history sections
    - Diagnosis
        - Update all options to better understand what problems are missing from the list – pre-existing conditions or those evaluated in-office
    - Management plan
        - Expand instructions to include agreed-upon components of the management plan
        - Add option for when no management plan is included
    - Informed consent – include options for when:
        - PARQ documentation present for some, but not all conditions being treated
        - Include option for when informed consent is present for some, but not all interventions/modalities
    - Outcome measures – include options for when:
        - No measures included
        - Only subjective measures included
        - Measures not updated as appropriate (i.e., activity selected in which a patient is no longer engaged)
    - Treatment outcomes – include options for when:
        - Managing asymptomatic/maintenance care patient
        - Care does not align with the treatment plan
        - No outcome measures established in which to assess response to care

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 Outcomes

The intern manual review (indicator 6.1) occurred on schedule for all four academic terms in FY20. The lab and diagnostic imaging (6.2) and infection control manuals (6.3) were reviewed and updated accordingly as part of the move to the new campus in the spring of 2020.

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

FY21 Plans

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

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 Outcomes

No low-level incidents or high-level breaches were reported for FY20. While the university has historically tracked HIPAA incidents, it was not tracked and stored in a retrievable location. As such, there is no prior year data for analysis. Additionally, the HIPAA walkthrough checklist is a new process for FY21 and no data is available for FY20.

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

FY21 Plans

The following actions are planned for FY21:

- Begin monthly HIPAA walkthroughs

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 Outcomes

No low or high-level incidents were reported for FY20. While the university has historically tracked HIPAA incidents, it was not tracked and stored in a retrievable location. As such, there is no prior year data for analysis. The QPCC established a zero-level target for high-level patient safety incidents but deferred establishing a target for low-level incidents until data is available for analysis.

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

FY21 Plans

The following actions are planned for FY21:

- The QPCC will establish a target for indicator 5.1 (low-level incidents)

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 Outcomes

The university has hired an outside vendor to assess and calibrate all therapeutic and diagnostic equipment in the clinic for several years (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, with the frequency of inspection to be evaluated at the end of the year.

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

FY21 Plans

The following actions are planned for FY21:

- Begin quarterly rehabilitation room equipment inspections

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 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 Outcomes

Indicator 10.1 (see table below) is new for FY21, and as such, there is no FY20 data available. No low or high-level safety incidents were reported for FY20. While the university has historically tracked facility safety

incidents, this data was not previously tracked and stored in a retrievable location. Additionally, the difference between low and high-level incidents was not well defined. As such, there is no prior year data for analysis of indicators 10.2 and 10.3. Indicators 10.4 and 10.5 are also new for FY21.

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

FY21 Plans

The following actions are planned for FY21:

- Commence biannual clinic facility safety inspections
- Commence both short and long trainings for staff and clinic faculty
- Reevaluate targets as appropriate.

Appendix A – Patient Quality Assurance Plan

UNIVERSITY of Western States
Office of Institutional Effectiveness

Patient Quality Assurance Plan

Purpose

The UWS quality assurance (QA) program for the campus health center (CHC) is designed to measure the structure, process, and outcomes of care. This information is then used to continuously improve the quality of patient care and inform student learning.

Program Goals

The goals of the UWS QA program are as follows:

1. Establish and maintain an effective and sustainable plan for collecting data related to the structure, process, and outcomes of patient care.
2. Establish and maintain measures of quality patient care, including corresponding thresholds of achievement.
3. Identify problems or opportunities to improve patient care as well as clinical structures and functions.
4. Develop recommendations informed by QA data to improve the quality of patient care and student learning.

Roles and Responsibilities

Institutional Effectiveness

The UWS QA program is housed within the office of institutional effectiveness, with direct oversight by the associate vice president (AVPIE). The AVPIE has the following responsibilities:

1. Chair the quality patient care committee (QPPC), develop meeting agendas, and publish meeting minutes according to university standards.
2. Maintain data collection tools, with the support of the clinic information systems analyst (CISA).
3. Maintain all data collected via the QA process and take necessary steps to assure confidentiality, as appropriate.
4. Aggregate and analyze QA data with the support of the CISA.
5. Prepare and distribute quarterly and annual reports, including the *Quality Patient Care Outcomes Report*, to appropriate personnel.
6. Provide training for clinical and support personnel in the areas of quality assurance procedures.

Clinical Internship

Housed within the college of chiropractic, the associate dean of clinical internship (ADCI) oversees aspects of quality assurance related to the student/intern experience, including:

1. Investigate and track student/intern infractions and determine the need for resulting disciplinary action.

2. Facilitate the student/intern chart audit process.
3. Investigate incident reports related to patient safety, share outcomes with the quality patient care committee (QPCC), and other parties, as appropriate.
4. In accordance with recommendations from the QPCC, assist with the investigation of problems and incidents, and determine actions for remediation, when appropriate.

Doctor of Chiropractic Program Administration

When an adverse event involving patient care occurs, these incidents are triaged through the ADCI, who informs the appropriate party. The doctor of chiropractic program dean (DCPD) is notified and oversees the investigation of any risk management related incident. Additionally, the DCPD is responsible for the sharing of QA data or outcomes with committees or faculty in which to improve DC program effectiveness.

Clinical Faculty

Each UWS clinical faculty member is required to complete three (3) chart audits each term. Two clinicians serve as the faculty representatives on the quality patient care committee (QPCC). These faculty representatives are responsible for serving as a liaison among other clinical faculty to ensure communication is shared, and input is gathered.

Executive Director, Clinic Business Operations and Finance

The executive director of clinical business operations and finance (ED-Clinics) oversees the daily operations of UWS clinics. The ED-Clinics serves as the liaison regarding front desk and operational concerns. This individual manages complaints from patients regarding service or business operations.

Executive Director, Emergency Management, Safety, Security, and Campus Operations

The executive director of emergency management, safety, security, and campus operations (ED-Safety) oversees the safety and security of UWS clinical facilities. The ED-Safety directly oversees any facilities and safety concerns.

HIPAA Privacy Officer

The HIPAA privacy officer (HPO) is responsible for overseeing the university's HIPAA privacy program and ensuring the enforcement of privacy policies to protect the integrity of patient health information (PHI). The HPO oversees ongoing employee privacy training, conducts risk assessments, and develops HIPAA-compliant procedures where necessary. Additionally, the HPO investigates incidents in which a breach of PHI may have occurred, reports breaches as necessary, and ensures patients´ rights in accordance with state and federal laws. The university chief technology officer (CTO) serves as the HIPPA security officer.

Clinic Health Care Business Analyst (CHCBA)

The CHCBA supports the chart audit process by:

1. Identifying patient charts meeting audit requirements and assigning medical record numbers to clinicians for scheduled assessments.
2. Providing aggregate data to the AVPIE for analysis.
3. Developing and maintaining patient QA dashboard data to meet the needs of the AVPIE and QPCC.
4. Updating and maintaining data collection instruments to meet the needs of the AVPIE and QPPC.

Quality Patient Care Committee (QPCC)

Responsibilities of the QPCC include the following:

1. Maintain a collection of quality patient care indicators.
2. Establish and adjust, as appropriate, performance thresholds for indicators.
3. Review patient QA data on a quarterly basis.
4. Recommend action steps to be taken for measures performing below the established threshold, as appropriate.
5. Provide input regarding patient feedback survey instruments and corresponding administration schedule.
6. Provide input regarding chart audit instruments and corresponding administration schedule.
7. Develop and implement processes and procedures to examine inter-rater reliability.

The committee meets at least once per term to review the collected data. Additional meetings may be called as needed to support the development and continuous improvement of QA initiatives.

Membership of the QPCC is composed of the following individuals:

- Associate Dean, Clinical Internship (ADCI)
- Associate Vice President, Institutional Effectiveness (Chair) (AVPIE)
- Attending Clinician, A Shift
- Attending Clinician, B Shift
- Clinic Health Care Business Analyst (CHCBA)
- Dean, College of Chiropractic (DCPD)
- Executive Director, Clinic Business Operations and Finance (ED-Clinic)
- Executive Director, Emergency Management, Safety, Security, and Campus Operations (ED-Safety)
- HIPAA Compliance Officer

Patient Chart Audit

The chart audit system is designed to drive clinician learning and improvement through review of the practices of fellow providers and through feedback about their care from peers via completed audits. Quarterly reports provided to clinicians are used to highlight areas in need of attention and improvement.

Criteria for Chart Selection

Charts are selected by the CHCBA based on the following criteria for a patient seen in the past 6-months for at least five (5) visits in the course of care:

1. New patient
2. Existing patient with a new problem
3. Existing patient reestablishing as a new patient

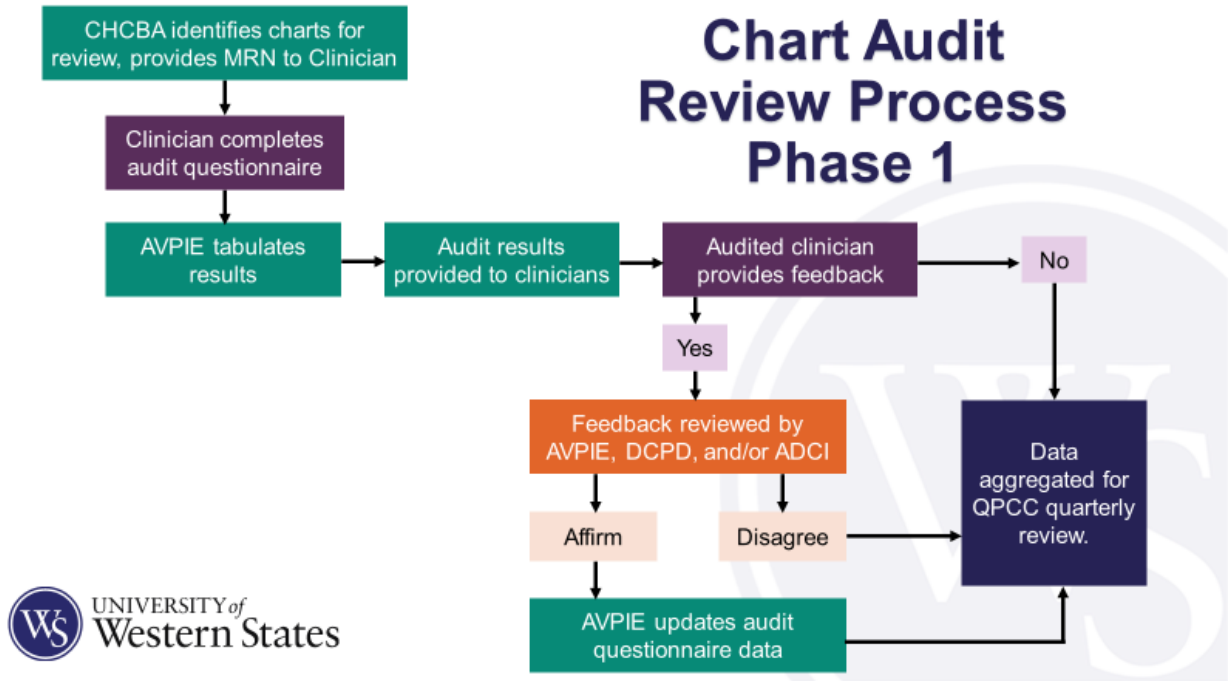
Schedule

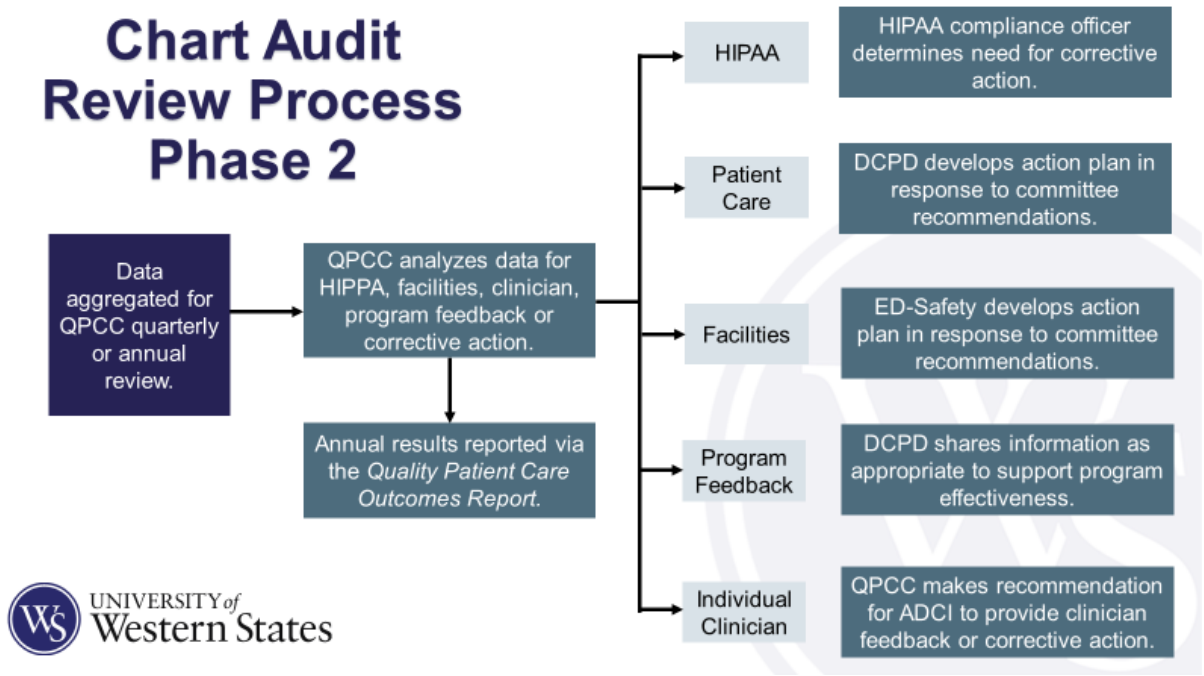
Each clinician reviews three charts per academic term in accordance with the schedule outlined in the table below. This strategy ensures that each clinician is audited 12 times each academic year, which ensures a large enough sample size for individual practitioner trend data. Additionally, if each clinician audits 12 charts per year, the annual sample size will consist of roughly 108 charts.

Week	Day	Activity
1	Friday	Feedback from prior term provided to DCP committees, if appropriate.
2	Monday	Clinicians assigned three (3) charts by CHCBA.
7	Friday	All three (3) charts due.
8	Friday	Clinicians provided report of data by AVPIE.
9	Friday	Clinician response/dispute due.
10	TBD	QPCC Committee meets to review term data.
11 - 13	N/A	Clinicians provided feedback or need for corrective action by the ADCI.

Process

The chart audit process occurs in two phases. As seen in the figure below, Phase 1 is the audit conducted by each clinician.





Phase 2 is the review of the collected audit data by the QPCC.

Indicators of Quality Patient Care

The QA program currently tracks the following indicators with corresponding thresholds. The QPCC is responsible for reviewing and updating the indicators on an annual basis, as appropriate.

1. Licensure
   - 1.1 100% of attending clinicians maintain an active chiropractic license on an annual basis
   - 1.2 100% of attending clinicians maintain current basic life support/CPR certification on a biannual basis.
2. Patient feedback survey
   - 2.1 ≥92% positive responses for all items included in the annual patient feedback survey.
   - 2.2 ≥85% positive responses for all items included in each category
     a. Facilities, access, and convenience
     b. Office staff
     c. Clinic providers
     d. Overall experience
3. Patient grievance/dissatisfaction – indicator/target TBD.
4. Actionable infractions
   - 4.1 ≥90% of students/interns complete the clinical internship without an actionable (disciplinary) infraction each term.
   - 4.2 ≥95% of students/interns complete the clinical internship without an actionable (disciplinary) infraction annually.

5. Patient chart audits
    5.1 A minimum of 70 patient chart audits are completed by clinicians on an annual basis.
    5.2 ≥80% achievement of (aggregate) patient chart audit indicators
6. Clinic policies and procedures manual is reviewed, and updated as appropriate
    6.1 Intern manual – reviewed quarterly by clinical internship staff
    6.2 Lab and diagnostic imaging – reviewed annually each June
    6.3 Infection control – reviewed annually each June
7. HIPAA
    7.1 Low-level incidents (i.e., misdirected information, incorrect documentation) – target is ≤ 2 incidents per fiscal year
    7.2 High-level breaches (i.e., publicly reported offences) – target is zero incidents per fiscal year
    7.3 HIPAA walkthroughs – target is complete checklist monthly
8. Patient care safety incidents reported annually.
    8.1 Low-level – target TBD. Defined as any action that requires any sort of medical attention. This does not include a patient reporting “soreness” or aggravation of existing symptoms following a treatment.
    8.2 High-level – target zero incidents. Defined as any adverse reaction or patient injury caused as a result of treatment causing permanent or long-term impairment.
9. Equipment safety
    9.1 Calibration check – target is once annually completed by outside vendor
    9.2 Rehabilitation room equipment – target is once quarterly (frequency to be evaluated at the end of FY21)
10. Clinic facility safety
    10.1 Inspection – conduct two inspections per year using the following 10 clinical safety standards:
        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
    10.2 The number of low-level (any action that impacts or could potentially impact persons) facility safety incidents reported annually – target is no more than 15 incidents per year
    10.3 High-level (any action that requires any sort of medical attention) facility safety incidents reported annually – target is zero incidents
    10.4 Regular shorter scenario-based trainings for staff and clinicians – target is one 5 to 10-minute training per month
    10.5 Biannual longer trainings for staff and clinicians – target is two 30-minute trainings per year

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.

Attending Clinician
Select the attending 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).	