

Detailed measure descriptions

The following measures and their descriptions are presented under the same headings and order as in Tables 3, 4, and 5 in the manuscript.

1. Quality measures supporting care that gets results (effective; efficient).....1
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3. Quality measures supporting care that is responsive to patients' needs and preferences (patient-centered; timely; equitable).....8

1. Quality measures supporting care that gets results (effective; effective)	Description and rationale
Process	
P1. Clinical evaluation	
P1.1 Percentage of patients with documented past health history prior to initiating care	Health history refers to past hospitalizations and other health-related events leading to interventions by healthcare providers. Prior to initiating care, a past health history should be documented in the clinical record. This measure is based on best practice and care standard recommendations that draw from the ethical principle of beneficence. Documenting past health history helps ensure pertinent information is available to inform a justified clinical evaluation and working diagnosis and ensure safety. Note: Review of systems and past health history data may be collected and documented in concert with each other, or separately, by health organizations.
P1.2 Percentage of patients with documented condition-specific history prior to initiating care	Documenting a condition-specific history is based on best practice recommendation and care standards that draw from the ethical principle of beneficence. Prior to initiating care, a condition-specific history should be obtained and documented in the clinical record. Documenting a condition-specific history offers pertinent information such as symptom onset, location, duration, progressivity, recurrence, variation, severity, and activity limitations. Obtaining a condition-specific history helps ensure pertinent information is available to inform a justified and safe clinical evaluation, working diagnosis, and care plan.
P1.3 Percentage of patients whose clinical record includes a review of systems (e.g., cardiovascular, pulmonary, etc.)	Documenting a review of symptoms/problems associated with major body systems helps fill potential gaps in condition-specific and general health histories. This measure is based on best practice recommendation that draws from the ethical principle of beneficence. Prior to initiating care, a review of systems should be documented in the clinical record. Documenting a review of systems helps ensure pertinent information is available to inform a reasoned and justified clinical evaluation, working diagnosis, care plan, and to ensure safety. Note: A review of systems, condition-specific history, and past health history data may be collected and documented in concert with each other, or separately, by health organizations.
P1.4 Percentage of patients assessed with valid functional and/or symptom outcome measures as a baseline	Clinical guidelines, care standards, and best practices recommendations for chiropractic care consistently suggest measuring clinical outcomes with valid instruments, beginning with obtaining baseline measures when care is initiated for a new problem. Currently, there is no consensus on which outcome instruments are most important. It is anticipated that this measure will eventually be modified to designate specific instruments (e.g., Neck Disability Index, Lower Extremity Functional Scale) for different conditions (e.g., neck pain, headache, migraine, low back pain), and different aspects of a condition (pain severity, disability, pain interference, etc.).
P1.5 Percentage of patients whose response to care is regularly assessed	Assessing response to care is based on a care standard recommendation that draws from the ethical principle of beneficence. Regularly assessing response to care is a process that gathers information to inform and ensure timely clinical management decisions such as discharge, continued care, and referral.

P1.6 Percentage of visits where the need for additional visits is assessed

Best practice recommendations and clinical guidelines consistently suggest providers engage in a formal process to assess and justify the need for additional visits when recommended or scheduled. The recommendations are related to the quality domains of safety, efficiency, and effectiveness. Providing unneeded care places patients at greater risk for unneeded dependency on providers, adverse events and financial burden. Providing unneeded care also reduces the availability of health care services for those in need, and the effectiveness of care. Factors to consider when rendering an opinion on the need for additional visits can include, but are not limited to, patient goals, condition-specific history, health history, response to care, symptom changes, working diagnosis, patient preferences, the potential for dependency, and likelihood of further improvement.

P2. Clinical screening

P2.1 Percentage of patients assessed for psychological and social risk factors for poor outcome and/or chronicity

Clinical guidelines, care standards, and best practice recommendations consistently suggest providers screen for psychological and social risk factors that can impede clinical outcomes and/or increase risk for chronicity. Screening is a systematic process designed to help identify relevant psychological and social factors that can negatively influence a person's capacity to improve so they can be subsequently addressed.

P2.2 Percentage of patients screened for opioid use

Screening for opioid use is a best practice recommendation related to the role chiropractic practitioners have in providing health promotion and clinical preventive services. Screening is recommended because of the high prevalence of opioid use and potential negative health ramifications such as greater risks for dependence and suicide. Screening helps inform the potential need to collaborate with prescribers toward the goal of reducing opioid use and preventing or reducing dependence.

P2.3 Percentage of patients screened for tobacco use

Screening for tobacco use is a best practice recommendation related to the role chiropractic practitioners have in providing health promotion and clinical preventive services. Tobacco use increases risk factors for numerous chronic diseases. Screening adolescents and adults for tobacco use offers key information to inform the health history, clinical evaluation, and management decisions. Screening identifies patients for whom it is appropriate to offer information about negative health effects related to tobacco use and a variety of cessation interventions. Tobacco use screening and brief cessation interventions including counseling and/or medication can effectively support cessation efforts. Successful tobacco cessation lowers the risk of heart disease, lung disease, and stroke.

P2.4 Percentage of patients screened for physical activity level

Physical activity screening is a best practice recommendation related to the chiropractic focus on musculoskeletal health and the role chiropractic practitioners have in providing health promotion and clinical preventive services. Physical activity carries few risks and multiple health benefits including reduced risk for common chronic diseases.

P3. Care planning

P3.1 Percentage of visits with a current care plan

Care plans document a planned course of care as recommended in a care standard and clinical guideline. Care plans are derived from information such as a working diagnosis, patient goals, patient preferences, and shared decision making. The purpose of this measure is to ensure a plan of care relevant to the care provided on any given visit is present in the clinical record.

P3.2 Percentage of care plans based on a clinical evaluation

This measure is based on a care standard and clinical guideline recommending that all care plans which document a planned course of care should be based on a clinical evaluation offering up-to-date information about a working diagnosis, patient goals, and patient preferences. The purpose of this measure is to ensure all care plans (initial or subsequent) are based on a clinical evaluation rather than created or extended based only on factors like patient or provider preference. Basing care plans on a clinical evaluation provides the information needed to appropriately justify care.

P3.3 Percentage of care plans including 5 components: 1) Active therapies such supervised or unsupervised exercise; 2) Manual therapies such as joint manipulation, and myofascial therapies; 3) Education about one's condition including pain physiology when appropriate; 4) Self-management advice and/or activities; and 5) Therapeutic goals. *Multimodal interventions are not required at each visit during a care plan

Guidelines and care standards consistently recommend multimodal chiropractic care regardless of patient population or condition. The rationale supporting multimodal care plans is grounded in the multidimensional nature of health problems. Because symptoms are influenced by many factors, it is important to consider interventions that address those that contribute to symptoms including but not limited to interventions addressing a variety of biological tissues (e.g., muscle, joint, fascia, nerve) behaviors, beliefs, habits, and other factors that may help perpetuate a problem, limit a person's self-efficacy or capacity to self-monitor and self-manage, or contribute to chronicity. The most common recommended elements are described as: 1) Active therapies, in which patients take an active role in performing, such as exercise or mindfulness interventions; 2) Manual therapies are sometimes described as passive therapies because providers perform the main component. However, some manual therapies require active participation of patients, such as proprioceptive neuromuscular facilitation and some myofascial-oriented therapies; 3) Education is the process of helping patients understand a condition, how treatment addresses the problem, how and when to seek care, and how to better self-monitor and interpret symptoms; 4) Self-management advice and/or activities are focused on building and reinforcing self-efficacy and self-management capacity and preventing unneeded dependence on providers; and 5) Therapeutic goals, which can facilitate patient engagement in care planning and aid in clinical re-evaluation. Because 1 or more components may not be appropriate for every care plan due to factors such as patient preference, treatment history, or contraindications, documenting reasons why a component is excluded should offer sufficient evidence to ensure these components were thoughtfully considered. The metric for this measure currently measures a pass/fail dichotomous outcome (e.g., all categories are included, or all categories are not included). A metric assessing the number of components may be more appropriate.

Outcome

O1. Clinical outcomes

O1.1 Percentage of patients assessed during a re-evaluation using a valid functional and/or symptom outcome measure

Clinical guidelines, best practice recommendations, and care standards consistently recommend assessing response to care using valid functional and/or symptom instruments. Such assessment offers evidence that care is or is not effective and safe. Because no clearly objective, sensitive, and reliable biomarkers for most neuro-musculoskeletal conditions exist, there is currently no gold-standard functional or symptom outcome instrument. Instead, many possible validated instruments can be used, depending on body region (e.g., low back, neck, head, lower extremity, upper extremity), functional limitations (e.g., disability, mobility), and other associated symptoms or problems (e.g., pain severity, pain interference). As quality measures for chiropractic care continue to develop, specific instruments for a variety of conditions may be recommended.

O1.2 Return to work time for patients with a work-related injury

A lower calculated performance time (measured in days, weeks, or months) for this measure indicates higher quality as it relates to the effectiveness of care. However, because return to work time is influenced by many factors, such as symptom and condition severity, age, occupation, complicating factors, and capacity for an employer to accommodate modified duties, these factors would need to be considered when interpreting results.

Structure

S1. Supports best practices

S1.1 The organization requires obtaining a health history prior to clinical evaluation and management

Organizational support for the clinical process of obtaining and recording a health history helps ensure pertinent information is available to inform a justified clinical evaluation, working diagnosis, and patient safety. Health history refers to past hospitalizations and other health-related events leading to interventions by healthcare providers. This measure is based on best practice and care standard recommendations that draw from the ethical principle of beneficence. Demonstration of this measure may exist as policy-level documents that offer guidance about performance expectations, efficient methods to support obtaining and documenting health history information, and administrative or peer review audits.

S1.2 The organization requires obtaining a condition specific history prior to clinical evaluation and management

Organizational support for the clinical process of obtaining and recording a condition-specific history helps ensure pertinent information is available to inform a justified and safe clinical evaluation and working diagnosis. The measure is based on best practice recommendations and care standards that draw from the ethical principle of beneficence. Demonstration of this measure may exist as policy-level documents that offer guidance about performance expectations, efficient methods to support obtaining and documenting condition specific history information, and administrative or peer review audits.

S1.3 The organization supports screening for psychosocial risk factors for poor outcome and/or chronicity

Organizational support for the clinical process of screening to identify psychological and social factors negatively influencing a person's capacity to improve demonstrates a recognition and commitment to care for people, rather than conditions, and facilitates addressing relevant factors to improve health outcomes. Demonstration of this measure may exist as policy-level documents that offer guidance about performance expectations, efficient methods to support screening and documenting results, and administrative or peer review audits.

S1.4 The organization supports diagnostic imaging consistent with clinical guidelines and best practices

An organization's support for guideline-congruent diagnostic practices helps ensure safety, costs, and other harms by reducing unnecessary and wasteful imaging. This measure relates to the Safe (avoiding harm) and Efficient (avoiding waste) domains of healthcare quality. Demonstration of this measure may exist as policy-level documents that offer guidance about performance expectations, ready access to imaging guidance for providers, access to and support for relevant training and administrative or peer review audits.

S1.5 The organization expects regular monitoring and re-evaluation to inform discharge, continued care, and referral decisions

Regularly assessing care response helps inform timely management decisions such as the need for additional visits and preventing unneeded care through discharge, and referral. Demonstration of this measure may exist as policy-level documents that offer guidance about performance expectations, efficient methods to document the results of this process in the clinical record, and administrative or peer review audits.

S1.6 The organization supports multimodal chiropractic care

Organizational support for multimodal chiropractic care is demonstrated by policy and procedures that encourage and support providers in employing interventions that address symptoms, behaviors, beliefs, knowledge, skills, and other factors that influence symptoms and a person's capacity to self-monitor and self-manage a problem. Demonstration of this measure may exist as policy-level documents that offer guidance about performance expectations, efficient methods to support documenting multimodal care plans, engaging in multimodal care, and administrative or peer review audits.

S1.7 The organization supports advice to stay active for patients with low back pain

This measure is recommended by a care standard, which suggests organizations maintain policy or policy-like statements supporting advice to stay active.

S2. Organizational framework

S2.1 The organization has employment training procedures

The presence of structured new employee training procedures represents the practical application of a strategy that seeks to maximize the provision of high-quality care.

S2.2 The organization has a reporting/supervisory structure

A coordinated organizational structure that includes supervision and clear lines of responsibility offers frameworks that can help employees work efficiently in teams toward maximizing the provision of high-quality care.

S2.3 The organization has a future planning strategy

Organizations with the resolve to avoid the status quo are focused on improvement through future planning because patient, employee, and community needs may change over time, and systematic quality improvement requires organizations to engage in cycles that collect and analyze data, identify factors to improve quality, and formally plan to address known factors with policy, procedures, and infrastructure. Demonstration of this measure may exist as documents that offer information about future planning, such as strategic plans.

S2.4 The organization maintains a current database of professional credentials for all providers

A credential database offers an organization information on the available clinical expertise (and gaps in expertise) that can influence the quality of care. A credential database, for example, reviewed in concert with internal referral pathways may identify the need to hire providers with specific training and/or expertise. Alternatively, such identification can inform an organization of the need to develop an external referral pathway (outside a health organization) to ensure select patients are referred to an appropriate provider.

S3. Supports quality assessment/improvement

S3.1 The organization conducts regular audits to ensure regulatory compliance

Regular auditing is a standard practice across health organizations designed to collect data on the efficiency and effectiveness of a variety of processes. Regulatory compliance helps ensure patient and employee safety and acts to identify and address factors to prevent unintended harm. Demonstration of this measure may exist as results from audits conducted to ensure regulatory compliance and policy designating periodic compliance audits.

S3.2 The organization conducts regular audits as part of a quality improvement program

Health organizations conducting regular audits as part of a quality improvement program demonstrate the practical application of, and a sustained commitment to, quality improvement. Quality improvement cycles focus on sequentially and systematically studying and addressing internal factors for the purpose of maintaining and improving the quality of care offered to patients and assessing how an organization meets, can meet, or should meet community health needs. Demonstration of this measure may exist as results from quality improvement audits, analysis and interpretation of results, and documentation of how quality improvement program audits informed follow-up activities.

2. Quality measures supporting care that protects patients from errors and does not cause harm (safe)	Description and rationale
Process	
P1. Clinical management	
P1.1 Percentage of patients with a documented list of current medications	Documenting a current medication list is based on a quality measure originally developed by the United States Centers for Medicare and Medicaid that draws from the ethical principle of beneficence. Documenting current medications helps ensure vital information is available to inform a clinical evaluation, potential need for referral, working diagnosis, and decisions about safety. Prior to initiating care, a current medication list should be documented in the clinical record.
P1.2 Percentage of patients whose vital signs are recorded	Vital signs such as temperature, heart rate, respiratory rate, weight, height, and blood pressure can be used to help identify potentially serious pathology and support management decisions. This measure was derived from best practice recommendations. The metric for this measure has not been fully developed. For example, it is yet to be determined how often vital signs should be recorded to represent a component of quality.
P1.3 Percentage of patients who receive a clinical examination for a presenting problem	Clinical guidelines and best practice recommendations consistently state physical examination, appropriate to the complexity of a presenting problem, is a critical component of chiropractic clinical management and an ethical responsibility of providers. Examination is needed to identify potentially serious pathology and to inform working diagnoses and clinical management decisions.
P1.4 Percentage of patients screened for signs and symptoms of serious pathology (i.e. red flags)	Clinical guidelines, best practice recommendations and care standards consistently state screening for signs and symptoms of conditions indicating potential serious pathology is a fundamental component of chiropractic clinical management. Information gained from screening can inform subsequent decisions about diagnostic testing, treatment, monitoring, and referral.

P1.5 Percentage of patients screened for the possibility of pregnancy prior to obtaining radiographs

Screening patients for the possibility of pregnancy prior to obtaining radiographs is a process focused on preventing avoidable harm to a fetus. The measure is based on a best practice recommendation. Information obtained from screening can inform a clinical benefit vs. fetal risk analysis, which can then be used to either justify or avoid imaging, consistent with radiographic guidelines. In cases where imaging may be justified (e.g., some instances where a high suspicion of fracture exists), extra precautions may then be undertaken to reduce fetal exposure to ionizing radiation (e.g., tighter beam collimation, patient positioning to avoid pelvic irradiation, extra radiation shielding).

P1.6 Percentage of patients at risk for self-directed violence referred to an appropriate provider

A professional responsibility for chiropractic providers is to help ensure the safety of patients. This measure is derived from a best practice recommendation focused on ensuring people at risk for self-directed harm are connected with professionals specifically trained and experienced in addressing related thoughts and behaviors.

P2. Older adults

P2.1 Percentage of patients over age 40 screened for major risk factors for osteoporosis

Though osteoporosis is more commonly observed in postmenopausal women over the age of 50, screening earlier offers additional time to take action to prevent osteoporosis. However, clear evidence obtained from high-quality studies is not yet available to determine the ideal age to initiate screening. Screening for major risk factors for osteoporosis can be performed by 1) obtaining a detailed health and family history; 2) using online risk calculators such as QFracture (<https://qfracture.org/>) and FRAX (<https://frax.shef.ac.uk/FRAX/>) for those whose health or health/family history suggests potential risk. Bone mineral density studies are not first-line screening procedures. These studies can subsequently be used to further confirm and quantify bone density for people identified at higher risk.

P2.2 Percentage of patients with new/recent osteoporotic fracture referred to a primary care or other relevant provider

Pharmacological management may be needed as part of a comprehensive osteoporotic fracture prevention plan. Such plans may also involve activities recommended by chiropractors or other professionals such as fall prevention, enhanced nutritional intake, performing safe physical exercise, and lifestyle modifications such as assessing alcohol intake and avoiding tobacco use.

P2.3 Percentage of older adults screened for abilities to independently carry out activities of daily living

Aging adults are more likely to experience challenges with hearing, sight, coordination, and cognition that can negatively affect the capacity to carry out activities of daily living. Activities of daily living include bathing, toileting, eating, and walking. Higher-level functional activities include tasks like cooking, writing, and driving. People with difficulty carrying out 1 or more activities of daily living may be at risk for other health-related problems. Identifying individuals who have difficulty performing these activities gives providers an opportunity to refer them to an appropriate specialist or community resource for further evaluation, care, or assistance.

P2.4 Percentage of older adults offered advice on balance, strength, and endurance exercises to prevent falls

Aging adults are more likely to experience challenges with balance, strength, flexibility, and endurance, which can increase risk for falls and subsequent morbidity. Offering advice on these activities is considered a best practice focused on preventing negative fall-related health consequences.

Outcome

O1. Safety

O1.1 Adverse event rate

Health care providers have a responsibility to help ensure that appropriate procedures are in place to reduce/eliminate avoidable harm to patients and to offer data to better inform consent processes. To engage in a quality improvement cycle that seeks to reduce harms, reporting actual, or potential, adverse events is necessary. The metric for this measure is currently generic. Continued development of adverse event measures may include identifying specific categories for anatomic region, symptoms, body systems, severity, and interventions. A lower calculated adverse event rate indicates fewer adverse events and generally better performance when accounting for conditions treated, severity, patient population characteristics, and other potentially relevant clinical factors.

Structure

S1. Safety-related organizational infrastructure

S1.1 The organization has infection control and prevention protocols

Infection control and prevention protocols demonstrate a health organization's commitment to prevent unintended harm. Infection control protocols are day-to-day procedures applied by employees consistent with the application of a separate but related structure quality measure: See "Training procedures for hand hygiene, personal protective equipment, and environmental cleaning.

S1.2 Training procedures are in place for hand hygiene, personal protective equipment, and environmental cleaning

Essential aspects of quality care include protecting patients from errors and preventing harm. Training procedures are needed to ensure employees engage in activities, such as using equipment appropriately to prevent harm to patients and employees. Training procedures related to hand hygiene, personal protective equipment and environmental cleaning are intended to prevent avoidable harms. This organizational characteristic is closely related to the measure: "The organization has infection control and prevention protocols"

S1.3 Screening for serious pathology (i.e. red flags) is expected by the organization

Clinical guidelines, best practice recommendations and care standards consistently state screening for signs and symptoms of conditions indicating potential serious pathology is a fundamental component of chiropractic clinical management. Information gained from screening can inform subsequent decisions about diagnostic testing, treatment, monitoring, and referral. Demonstration of this measure may exist in different forms, such as policy-level documents that offer guidance about performance expectations and administrative or peer review audit procedures.

S1.4 A referral pathway is in place for patients at risk for self-directed violence

A referral pathway for patients at risk for self-directed violence represents the infrastructure needed to ensure successful application of a process quality measure: "Percentage of patients at risk for self-directed violence referred to an appropriate provider." The measure is based on a best practice recommendation focused on ensuring at risk individuals are connected with professionals specifically trained and experienced in addressing related thoughts and behaviors.

S1.5 The organization prioritizes safety through incident reporting, clinical risk management, and adverse event reporting

To engage in a quality improvement cycle that seeks to reduce harms, reporting actual or potential adverse events, safety incidents, and safety risks is needed. The measure was derived from a care standard to help ensure that appropriate working and clinical practices are in place to reduce/eliminate avoidable harm to patients and employees.

S1.6 A referral pathway is in place for patients with signs and/or symptoms of conditions outside the scope of chiropractic care

Established referral pathways enable providers with a process designed to help connect patients with other providers with the appropriate training and expertise for a health need. This measure supports process measures such as: Percentage of patients at risk for self-directed violence referred to an appropriate provider; Percentage of patients with new/recent osteoporotic fracture referred to a primary care or other relevant provider; and Percentage of patients screened for signs and symptoms of serious pathology (i.e. red flags).

S1.7 The organization expects examination of a body region prior to delivering care to the area

Clinical guidelines and best practice recommendations consistently state physical examination, appropriate to the complexity of a presenting problem, is a critical component of chiropractic clinical management and an ethical responsibility of providers. Examination is needed to identify potentially serious pathology and to inform working diagnoses and clinical management decisions. This measure can be demonstrated in different ways such as policy-level documents that communicate expectations for clinical evaluation, efficient documentation processes, and administrative or peer review audits.

S1.8 The organization supports screening older adults for abilities to carry out activities of daily living

Aging adults are more likely to experience challenges with hearing, sight, coordination, and cognition that can negatively affect the capacity to carry out activities of daily living. Activities of daily living include bathing, toileting, eating, and walking. Higher-level functional activities include tasks like cooking, writing, and driving. People with difficulty carrying out 1 or more activities of daily living may be at risk for other health-related problems. Identifying individuals who have difficulty carrying out activities gives providers an opportunity to refer them to an appropriate specialist or community resource for further evaluation, care, or assistance. This measure can be demonstrated as policy-level documents that communicate expectations for screening, access to valid screening tools, administrative or peer review audits, and referral pathways for individuals identified through the screening process.

3. Quality measures supporting care that is responsive to patients' needs and preferences (patient-centered, timely, equitable)

Description and rationale

Process

P1. Beneficence and respect for persons

P1.1 Number of days between request and an appointment for chiropractic care

This measure demonstrates how effective an organization is in offering timely access to care. Timeliness is one of 6 quality domains originally proposed by the Institute of Medicine and supported by the Agency for Healthcare Research and Quality. Timely access to care prevents harmful delays that can contribute to chronicity and worsening symptoms. Timely access also offers an early opportunity to identify and address serious pathology. A lower calculated performance time (e.g., days) for this measure indicates higher quality.

P1.2 Percentage of patients receiving care only after completing an informed consent process

Guidelines, best practices, a care standard, and other regulatory bodies require providers to uphold the ethical and legal responsibility to ensure people are informed about their care and offer consent before any care is administered. This measure is aligned with the patient-centered domain of healthcare quality to help ensure care that is respectful of and responsive to individual patient preferences, needs, and values.

P1.3 Percentage of patients involved in care planning and decision-making

Clinical guidelines regularly recommend patient involvement in care planning and decision-making. This measure relates to the healthcare quality domain, Patient-centered, which is focused on providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring patient values guide all clinical decisions. The metric for this measure represents a clinical process led by providers and documented in the healthcare record. A separate measure assesses the effectiveness of this process (percentage of patients reporting involvement in their care planning and decision-making).

Outcome

O1. Patient experience

O1.1 Percentage of patients reporting involvement in their care planning and decision-making

Clinical guidelines regularly recommend patient involvement in care planning and decision-making. This measure relates to the healthcare quality domain, Patient-centered, which is focused on providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring patient values guide all clinical decisions. A separate measure assesses the extent to which providers document patient involvement in care planning and decision-making (percentage of patients involved in care planning and decision-making). The metric for this measure, derived from patient survey data, offers data on the effectiveness of shared decision-making processes.

O1.2 Percentage of patients reporting satisfaction with care

Satisfaction with care may relate to any quality domain (Safe, Effective, Patient-centered, Timely, Efficient, Equitable). However, the measure primarily relates to assessing if care meets people's needs, expectations, and identifying factors considered important to patients and communities. Currently, the metric assesses global satisfaction with care. Health organizations desiring to know more about satisfaction can obtain more detailed information relative to quality domains. For example, they may obtain data about patients' satisfaction with appointment scheduling processes, the timeliness of appointments, interpersonal interactions, and if needs or expectations are met.

Structure

S1. Supports timely access to care

S1.1 The organization supports scheduling timely chiropractic care

Timeliness is one of 6 quality domains originally proposed by the Institute of Medicine and supported by the Agency for Healthcare Research and Quality. Timely access to care prevents harmful delays that can contribute to chronicity and worsening symptoms. Timely access also offers an early opportunity to identify and address serious pathology. Demonstration of this measure may exist as policy-level documents offering guidance about performance expectations, efficient methods to support scheduling, and regular needs assessments related to: patient population, demand for services, available providers, equipment, physical space, etc.

S2. Supports autonomy and beneficence

S2.1 The organization requires informed consent from a patient, parent, or legal guardian prior to delivering clinical services

The related process measure: "Percentage of patients receiving care only after completing an informed consent process" is based on guidelines, best practices, a care standard, and regulations that uphold the ethical and legal responsibility of providers to ensure people are informed about their care and offer consent before any care is administered. This measure is aligned with the patient-centered domain of healthcare quality to help ensure care that is respectful of and responsive to individual patient preferences, needs, and values. This measure can be demonstrated through policy-level documents that communicate expectations for consent, guidance for engaging in and efficiently documenting a consent process, and administrative or peer review audits.

S2.2 The organization expects providers to communicate an explanation of the suspected/confirmed condition to patients

The measure is aligned with the patient-centered domain of healthcare quality, which focuses on ensuring that care is respectful of and responsive to individual patient preferences and needs. It is also aligned with the process measure: Percentage of patients receiving care only after completing an informed consent process. Making informed decisions about care requires an understanding of one's condition, how treatments interact with a condition, potential benefits and risks, and options. This measure can be demonstrated through a variety of methods such as policy-level documents that communicate expectations, communication training offered by or supported by an organization, guidance and infrastructure for engaging in and documenting the process, and administrative or peer review audits.

S2.3 The organization supports continuity of ongoing care with the same provider during the course of a care plan

Organization's supporting continuity prioritize care that avoids wasting equipment, time, and ideas. Continuity of care may also relate to safety and patient-centered quality domains. Some research has reported higher continuity is related to lower mortality and higher patient satisfaction. Consistency of care with the same provider can be negatively affected by factors such as unexpected appointment cancellations and lack of provider availability. The measure can be demonstrated through methods such as policy-level documents that communicate expectations and infrastructure that supports continuity in the form of scheduling methods, employing a sufficient number of providers, and scheduling provider shifts to promote continuity.

S2.4 Costs of chiropractic care are transparent

In healthcare, costs can vary widely for similar or identical services. Cost transparency demonstrates an organization's support for offering information to patients about the financial burdens associated with receiving evaluation and care. Cost transparency enables patients to make informed cost-benefit decisions about receiving chiropractic services. However, for some services and payment plans, out-of-pocket costs may not be readily available, especially prior to receiving care, as reimbursement from insurance carriers can differ from anticipated amounts and actual costs may remain unknown until a diagnosis is made and treatment options are explored.

S2.5 The organization supports shared decision-making among providers and patients

Clinical guidelines regularly recommend patient involvement in care planning and decision-making. This measure relates to the healthcare quality domain, Patient-centered, focused on care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring patient values guide all clinical decisions. The measure supports the clinical process measure: "Percentage of patients involved in care planning and decision-making" and the outcome measure: "Percentage of patients reporting involvement in their care planning and decision-making." The measure can be demonstrated through a variety of methods such as policy-level documents that communicate expectations, training support to enhance shared decision-making skills among providers, and providing efficient means of documenting shared decision-making in health records.

S2.6 The organization recognizes the responsibility of providers to refer, co-manage, and/or communicate with other healthcare professionals when clinically indicated and authorized by patients

Referral is a process for facilitating the right care, at the right time, and from an appropriately trained and experienced provider. The measure can be demonstrated through policy-level documents that communicate key expectations of providers to engage in referral and/or co-management when clinically indicated and in a process that includes shared decision-making. This structural measure is aligned with process measures for screening and clinical evaluation, designed, in part, to identify patients who need to be referred to other providers or who could benefit from co-management. This measure is also related to other structure measures (e.g., referral pathways) that demonstrate the infrastructure needed for providers to meet expectations.

S2.7 The organization encourages interventions to support patient self-management capacity such as education and active care approaches

The prolonged use of passive interventions can contribute to preventable dependency on providers and/or their services. A variety of evidence-based educational and active care interventions can be used to help prevent dependency and/or improve patient self-efficacy and self-management capacity. This measure can be demonstrated through policy-level documents that communicate expectations of providers and infrastructure that supports the delivery of educational and active care approaches. This measure is closely related to the clinical process measure "Percentage of care plans including 5 components:" 1) Active therapies such supervised or unsupervised exercise; 2) Manual therapies such as joint manipulation, and myofascial therapies; 3) Education about one's condition including pain physiology when appropriate; 4) Self-management advice and/or activities; and 5) Therapeutic goals.

S2.8 The organization collects data from patients about their care

Patients are the most important stakeholders in health care, and their data represents key information regarding clinical outcomes, the experience of care, and clinical and clerical processes used by the health organization. Patient-derived data can offer information about the effect of quality improvement activities relative to every quality domain: patient-centered, safe, efficient, effective, timely, equitable.

S3. Protects privacy

S3.1 The organization secures patient records according to regulatory requirements

A core responsibility of a health organization is to protect patients. This responsibility extends to protecting records that contain sensitive information regulated by local and federal law.

S4. Supports a multidimensional-health approach

S4.1 The organization maintains the capacity to connect patients with psychological resources (e.g., mental health providers) and social resources (e.g., community groups, religious organizations)

Clinical guidelines, care standards, and best practice recommendations consistently emphasize the importance of screening for psychological and social risk factors that can impede clinical outcomes, increase the risk of chronic conditions, or indicate separate health-related needs. Screening, however, is not useful if needs are not addressed. This measure represents the organizational infrastructure that facilitates connecting patients with needed resources when identified through formal screening or other methods. Demonstration of this measure can exist as referral pathways.

S4.2 Resources are available for mind-body interventions such as Cognitive-Behavioral Therapy and Mindfulness-Based Stress Reduction

Non-pharmacological interventions such as mindfulness-based stress reduction and cognitive behavioral therapy are commonly recommended for patients with chronic musculoskeletal pain. Maintaining resources for connecting patients with these interventions is consistent with best practice recommendations and a person-centered approach recognizing pain is influenced by many factors that can extend beyond anatomical/biological explanations. Demonstration of this measure can potentially exist with the presence of referral pathways to providers trained in these intervention methods.