Appendix H: Reflection on the Phases of the Process

Phase I: Preparation
- Examine resources available
  - What expertise is available within the department or system?
    - Is a statistician available?
    - Is an information technologist available?
    - Is a computer technologist available?
    - Could other clinicians be involved in designing the process?
  - How much funding is available?
  - What software resources are available?
- Examine patient population
  - What standardized outcome measures are available for the patient population?
  - What tools will have the least ceiling effect or floor effect for the patient population treated?
  - What is the minimum data set required to assist in quantifying clinical experience?

Phase II: Altering the Process Involved in the Delivery of Care
- Was the level of completed records reasonable?
- Should the process be altered to increase the number of completed records?

Phase III: Procedural Changes after the Episode of Care
- Is the process the most efficient that it can be within the resources and finances available?
  - If very little finances were available initially, would it be more cost-effective to increase the front end costs of using software designed to capture outcomes to actually save on the final costs related to time?
  - Maintaining the described process, could the spreadsheets be more "automated?"
- Do the reports generated meet the outcome goal of quantifying clinical experience?
  - Do the reports have eye appeal?
  - Are the reports at the most simplified level to quantify clinical experience?
  - Do the reports contain enough information to assist with self-reflection?
  - Do the reports provide enough information to begin to join clinical expertise with literature?
- What clinically relevant information can be gained from Appendix B?
  - Is there a reasonable amount of records with completed outcome data?
  - How much of the pie is comprised of discharge reasons for the following reasons: "never returned" or "attendance issues?" Does this represent a disconnect between the clinician and the patient? Does this represent a lack of perceived value of the services? Were the anticipated expectations not met?
  - How much of the pie is compromised of discharge reasons for insurance issues? Should administrative processes that involve education on insurance coverage/benefits need to be analyzed and potentially changed?
  - How much of the pie is compromised of "referred to physician" or "services inappropriate?" Does this seem reasonable? Does it appear that appropriate patients are being referred? Does this part of the pie represent the physical therapist as the musculoskeletal expert with differential diagnostic abilities? Does this part of the pie represent poor decision-making or lack of clinical competency?
  - What are the top 3 body parts treated clinically? Does this happen to coincide with any known distribution of body parts published in literature? If the distribution is surprising, was a particular population market targeted in messages to the public about physical therapy services? If a particular population was targeted, did the distribution reflect a change in distribution?

- How does the distribution of the pie chart for duration of symptoms reflect on the time frame of when physical therapy services are initiated? Could this distribution be altered via targeted education to the public or referral sources?
- Which gender seems to dominate use of services? Could this information be used to assist in determining the gender to target when educating the public?
- The age distribution pie chart is probably dependent on the population of people that reside or work in the local area. If the clinic is located near a large school system with a large sports roster, does it appear that the young athletes are being seen at a reasonable distribution? If the community has a large senior center, does the volume of geriatric patients seem adequate? If the clinic is near an industrial park, does the volume of 36-55 year olds seem adequate?
- What clinically relevant information can be gained from Appendices C through G?
  - Can the clinician reflect on the discharge scores?
  - Can the clinician have an idea of the potential effect that occurred?
  - Does the number of visits and duration of time seem reasonable and broadly within published literature?
  - Does the functional outcome bar graph easily identify if change occurred?
  - How does the pie chart for discharge reasons appear? How about the number of visits within each discharge reason? Does it appear that clinical decisions are being made in a timely fashion? How much of a variance in number of visits between discharge reasons for "goals met" and "minimal progress/plateau" is reasonable?
  - What is the distribution of preferred practice patterns?
  - What is the clinician's preference for treatment units? How do the treatment units relate do the distribution of preferred practice patterns? Does the distribution of treatment units seem to generally coincide with published literature?
  - What about the duration of complaints? When are services initiated for this particular body part? Should public or referral education be targeted to alter the current distribution?
  - Does the distribution by gender have an unexpected finding?
  - Is there any surprising information with the age distribution pie chart?
  - After looking at the clinical summaries, is there any component that is surprising? Is there any information that leads the clinician to want to change something to improve? Is there any information that leads the clinician to be an "expert" to share and reflect with other colleagues?