



**AGREEMENT BETWEEN THE OFFICE OF ARTIFICIAL INTELLIGENCE POLICY,
THE DIVISION OF PROFESSIONAL LICENSING, AND EXPECT FITNESS, INC.**

Section 1. Parties

A. The Office of Artificial Intelligence Policy created in Utah Code § 13-72-201, an office within the Utah Department of Commerce (hereinafter “Office”).

B. The Division of Professional Licensing, a division within the Utah Department of Commerce (hereinafter “Division”).

C. Expect Fitness, Inc. (hereinafter “Participant”).

Section 2. Commencement Date and Participation Period

A. This Agreement shall be effective for twelve (12) months beginning on the Commencement Date.

B. The Commencement Date shall be the date on which Participant makes the AI technology available to customers and delivers written notice to the Office that the AI technology is available.

Section 3. Purpose and Authority

A. The Office is a state agency authorized to administer the Artificial Intelligence Learning Laboratory Program (Utah Code. § 13-72-301).

B. The Office may, in consultation with relevant agencies, negotiate and grant limited regulatory mitigation agreements to further the purposes of the Artificial Intelligence Learning Laboratory Program (Utah Code § 13-72-401).

C. The Division is a state agency that administers and enforces all licensing laws of Title 58, Occupations and Professions (Utah Code § 58-1-103).

D. Participant has applied to the Office for this regulatory mitigation and the applicant’s final proposal and safety protocol is incorporated in Schedule B of this Agreement (hereinafter referred to as the “Proposal”).

E. This agreement is a grant of regulatory mitigation only and does not constitute an endorsement or approval from the State of Utah or any of its political subdivisions of Participant's use of artificial intelligence technologies.

Section 4. Scope of Mitigation

A. The Office, in consultation with the Division, grants regulatory mitigation to Participant's provision of services using artificial intelligence technologies solely as outlined in the Proposal. The term of this Agreement, along with the term of any subsequent agreement extensions, shall constitute Participant's demonstration period.

B. The demonstration period and accompanying mitigation specified in Schedule A shall become effective on the Commencement Date, provided that, prior to or on such date, this Agreement has been signed by all parties.

C. Participant is subject to all applicable Federal, State, and local laws not expressly waived or modified by the terms of this Agreement, including any changes to existing law during the demonstration period (Utah Code § 13-72-401(7)). If relevant laws change during the demonstration period and affect the enforceability of any provision of this Agreement, the Office may require the parties to amend this Agreement. If such amendment is required, the terms and mitigation described in this Agreement will remain in full force and effect until any amendment is executed. If no new agreement can be made, this Agreement will be terminated effective on the day the relevant law went into effect or when the parties mutually agree no amendment can be reached, whichever date is later.

D. Except as related to the relief granted in this Agreement, nothing in this Agreement prevents any user of the Participant's AI technology, any third party, the State of Utah, or any of its subdivisions other than the Division, from seeking any legally available remedy from Participant under laws not expressly waived or modified by the terms of this Agreement in the event such user or third party is physically harmed as a result of using the Participant's AI technology.

Section 5. Scope of Activities

A. Participant shall perform all relevant activities in accordance with the methodologies and safety protocols set forth in the Proposal. The Proposal may be amended by Participant or the Office's Director (in consultation with the Division) as long as the amendment approval is in writing and signed by all Parties.

B. Participant may not use regulatory mitigation specified in this agreement to create or provide goods, services, or labor not specified in the Proposal.

Section 6. General Participant Obligations

Unless the Office determines otherwise in writing, Participant agrees as follows:

A. Capacity

Participant shall possess the technical expertise, financial resources, and capability to responsibly deploy and use the proposed artificial intelligence technology. Participant shall also have an effective plan to monitor and minimize both identified and potential risks from the activities of Participant's AI technology.

B. Safeguards

1. Participant shall abide by safeguards, including safety measures, testing protocols, quality assurance, and oversight methodologies outlined in the Proposal to protect users of Participant's AI technology from potential harm that may result from such activities. Participant shall abide by any other safeguards prescribed by the Office set forth in this Agreement.
2. Participant is fully responsible for the proper and efficient monitoring, operation, and maintenance of any activities stemming from the mitigation granted in this Agreement.
3. Participant's Terms of Service, Terms of Use, End User License Agreements, or any other agreements presented to or required of end users to engage in Participant's artificial intelligence technology shall not specifically disclaim, limit, restrict, or exclude Participant's legal liability for physical, medical, or legal harm resulting from the outputs of Participant's artificial intelligence technology authorized under this Agreement. This provision shall not limit Participant's pre-existing terms and agreements broadly applicable to Participant's nationwide operations. Prior to the Commencement Date, Participant shall provide the Office with copies of its then-current user-facing Terms of Service, Terms of Use, and End User License Agreements applicable to Participant's AI technology.

C. Registration

Participant must be registered to do business in the State of Utah.

D. Permissions

1. Participant may make public statements or engage in related publicity consistent with scope and purpose of this Agreement, except that Participant shall not include any statement in advertising, media, or promotional materials that implies the Office's or State of Utah's endorsement of Participant or Participant's technology. Factual statements will not be considered as implying any endorsement.
2. Except as related to the relief granted in this Agreement, Participant is responsible for obtaining and maintaining all necessary permits, licenses, and permissions required for the activities in Participant's Proposal from other federal, state, or local government agencies having jurisdiction over activities in the Proposal. Participant shall furnish any such permits and approvals to the Office upon request.

E. Data Security

1. Participant shall comply with all privacy and safe data usage requirements as set forth in the Proposal and as stipulated by the Office in this Agreement.
2. Participant shall not advertise a specific product or service to a Utah user engaging with Participant's artificial intelligence technology, unless Participant:
 - a. clearly and conspicuously identifies the advertisement as an advertisement; and
 - b. clearly and conspicuously discloses to the Utah user any sponsorship, business affiliation, or agreement that the supplier has with a third party to promote, advertise, or recommend the product or service.
3. Participant shall not sell, lease, license, or otherwise transfer identifiable user data or personal health information or derived metadata to any third-party.
4. Notwithstanding Section 6(E)(3), Participant may disclose user data, including derived metadata, solely under the following defined circumstances:
 - a. To cloud infrastructure, hosting, or technical service providers acting strictly on Participant's behalf for services necessary to engage in the activities described in Schedule B of this Agreement.
 - b. To licensed Utah pharmacists, pharmacies, or treating providers, solely as necessary to issue, transmit, and fulfill prescription orders or deliver telehealth care authorized by this Agreement.

- c. To the Office, the Division, or OAIP-vetted third-party auditors to fulfill mandatory reporting, statistical validation, and evaluation requirements under Section 6(H) and Section 20(E), provided that individual-level data shared for external validation is de-identified.
- d. As required to comply with applicable federal or state law, judicial orders, administrative subpoenas, or a request by a health regulatory authority, such as to support a submission for marketing authorization or conformity assessment.
- e. To third parties specifically designated by the user/patient upon receiving the user's explicit, affirmative consent or direct instruction in accordance with Section 20(D).
- f. For Participant's own internal operations or to Participant's service providers acting strictly on Participant's behalf, solely as necessary for internal or external audits and/or inspections for: (i) telemetry; (ii) safety and security, including incident response; and (iii) system performance evaluation and improvement; provided that no data disclosed under this subsection is sold, leased, licensed, or otherwise transferred to any third party for commercial use.

F. Cybersecurity

1. Participant shall implement reasonable protections against data leaks to minimize the risk of breach of confidential information in accordance with the data security and privacy protection protocols described in Participant's Proposal and with general cybersecurity best practices. These protections include, as applicable:
 - a. Keeping data system testing environments separate from production environments;
 - b. Maintaining reasonable server and storage capacity to enable continuous availability of data systems;
 - c. Formally managing technology assets through their lifecycle; and
 - d. Using integrity checking mechanisms to verify software, firmware, and information integrity.

2. Participant shall ensure that its cyber security framework is regularly updated to address emerging threats and vulnerabilities.

G. Disclosures

1. Participant shall abide by the disclosure requirements specified in Schedule A of this Agreement.

H. Reporting

1. Participant shall, for the duration of this Agreement, submit monthly, quarterly, and annual reports to the Office at ai@utah.gov. All reports shall include the information specified in Schedule A of this Agreement.

2. Subject to the Office's confidentiality obligation described in Section 10 of this Agreement, for the duration of this Agreement, the Office will make the quarterly reports, as submitted by Participant, available to the public.

3. Participants will share with OAIP-vetted third-party auditors de-identified individual level data from the pilot for external validation at a monthly, quarterly, and annual basis. Participant shall comply with all reasonable data sharing requirements, including the minimum number of samples required for statistical testing articulated in Schedule A.

J. Failure to meet obligations.

If Participant fails to meet any of the obligations set forth in this Section or Schedule A, the Office may request more comprehensive reports from Participant and a mutually agreeable plan for resolving any issues related to such obligations. Participant shall have at least thirty (30) business days to propose and implement a cure. The Office shall not unreasonably withhold or delay acceptance of Participant's proposed plan or cure. If, after good-faith collaboration and the expiration of the applicable cure period, Participant cannot put forward a plan to adequately resolve the issue, as determined by the Office, the Office may elect to terminate this Agreement. In the event the Office terminates this Agreement under this provision, the Participant shall be given 30 days to cease operations of the AI Technology in Utah ("Unwinding Period").

Section 7. Notice

All notices required to be given, by either Party to the other, shall be deemed fully given when delivered by email addressed and sent, with any required copies, as provided on the signature

page of this Agreement. Any party may change its notice address by giving the other party notice of the change in accordance with this Section.

Section 8. Indemnification

Participant agrees to hold the Office and the Division, including their agents, officers, and employees harmless from any claims, liabilities, damages, losses, or expenses arising from the services and technology provided by Participant under its Proposal and enabled by the mitigation granted in this Agreement.

Section 9. Intellectual Property

Nothing in this Agreement shall be construed to transfer, assign, license, or otherwise convey any intellectual property rights from one party to the other. Each party retains all right, title, and interest in and to any intellectual property (including algorithms, models, software, data structures, protocols, designs, developments, documentation, improvements, inventions, processes, techniques, technology, tools, and any other proprietary rights) it owns, develops, or otherwise controls, whether created before, during, or after the term of this Agreement, and regardless of whether such development occurs in connection with, in performance of, or independently of this Agreement. No rights are granted by implication, estoppel, or otherwise.

Section 10. Public Records

A. The Office is a governmental entity subject to the Government Records Access and Management Act, Utah Code §§ 63G-2-103 to 63G-2-901 (“GRAMA”). Accordingly, records in the Office’s possession, including this Agreement, may be subject to public disclosure. The Office’s confidentiality obligations shall comply with GRAMA. The Office will classify Participant’s application for regulatory mitigation and any reports required by Section 6(H) of this Agreement as protected records, where permitted by applicable law, in accordance with Utah Code §§ 63G-2-305 and 63G-2-309, except where explicitly stated in this Agreement or a Pilot Addendum

B. Participant shall submit all confidentiality claims to the Office in accordance with Utah Code § 63G-2-309 for any confidential, proprietary, or trade secret information. To the extent permitted by GRAMA, the Office shall treat Participant’s additional information (collectively, with Participant’s application and any required reports, “Participant Information”) submitted in connection with this Agreement or any Pilot Addendum as protected records in accordance with Utah Code § 63G-2-305, except where explicitly stated in this Agreement or a Pilot Addendum. The Office shall provide Participant with prompt written notice of any GRAMA request or other legal process seeking disclosure of Participant Information and, where permitted, a reasonable

opportunity to seek protection prior to disclosure. To the extent disclosure is required, the Office shall disclose only the portion required by law and use reasonable efforts to redact Participant Information. The Office shall use Participant Information solely for purposes of administering this Agreement and shall not use such information to develop or train artificial intelligence systems without Participant's prior written consent.

Section 11. Choice of Law, Venue, and Jurisdiction

This Agreement shall be governed by and construed pursuant to the laws of the State of Utah. The Parties will submit to the jurisdiction of the court of the State of Utah for any dispute arising out of this agreement or the breach thereof. Venue shall be in the Salt Lake Department, Third Judicial District in and for Salt Lake County, State of Utah.

Section 12. Termination

The Office or Participant may terminate this Agreement at any time, and for any reason, prior to the completion of the 12-month mitigation period or during any subsequent extension term. (Utah Code § 13-72-401(8)). Upon providing notice of termination by the Office, Participant shall be given an Unwinding Period. During this Unwinding Period, the Agreement continues in full force and effect. Termination shall be effective upon expiration of the Unwinding Period.

Section 13. Assignment, Transfer, and Collateral Use

Participant may not assign or transfer regulatory mitigation granted in this Agreement without the prior written consent of the Office. Approval of an assignment does not establish any legal relationship between the Office and any other third party. The Office shall not be liable for any act or omission committed pursuant to such an assignment.

Section 14. Entire Agreement

A. This Agreement, including all referenced documents and attachments, constitutes the entire agreement between the Parties regarding the subject matter hereof.

B. This Agreement, together with any amendments or addenda approved by the Office, supersedes any other written or oral understanding of the Parties. This Agreement may not be modified except by a written instrument executed by all Parties. This Agreement may be signed in counterparts, and may be signed electronically.

Section 15. Agreement Extension

Participant may request no more than two (2) extensions of up to 12 months for regulatory mitigation. Extension requests must be made no later than 30 days before the end of the ongoing period. The Office, in agreement with the Division, shall grant or deny an extension request before expiration of the initial demonstration period or any subsequent extension term in accordance with Utah Code § 13-72-403. In the event the Office, in agreement with the Division, denies the extension request, Participant shall be granted an Unwinding Period.

Section 16. Severability

If any portion of this Agreement is held to be invalid or unenforceable, the remaining portions of this Agreement will remain in full force and effect. Any invalid or unenforceable portions will be interpreted to give effect to the intent of the original portion. If such construction is not possible, the invalid or unenforceable portion will be severed from this Agreement but the rest of the Agreement will remain in full force and effect.

Section 17. Survival

Sections 4 (Scope of Mitigation); 8 (Indemnification) 9 (Intellectual Property); 10 (Public Records); 11 (Choice of Law); 16 (Severability); and Schedule A, and any other provisions that by their nature are intended to survive or expiration, will survive the termination or expiration of this Agreement.

Section 18. Signatures

The individuals executing this Agreement represent and warrant that they have the legal capacity and authority to do so on behalf of their respective legal entities.

IN WITNESS WHEREOF, the Parties have executed this Agreement and it shall be effective as of the Commencement Date specified in Section 2.


Zach Boyd (Sep 29, 2026 11:35:59 EDT)
ZACHARY BOYD, PhD
Director
Office of Artificial Intelligence Policy

09/29/2026

Date



MARK STEINAGEL
Director
Department of Professional Licensing

10/02/2026

Date



DARA COOK
Chief Executive Officer
Expect Fitness, Inc.

09/29/2026

Date

Schedule A

Section 19. Mitigation Offered

The Office, in agreement with the Division, grants Participant the following regulatory mitigation measures during the demonstration period articulated in Section 2 and Section 4 so long as Participant abides by the terms of this Agreement:

A. Participant may, using its artificial intelligence technology, provide an AI-augmented pelvic floor physical therapy platform with levels of clinician oversight in the state specified in Schedule B, under Utah Code § 58-24b.

B. The Division will, regarding the activities described in Schedule B of this Agreement, forgo any enforcement action against Participant under the following provisions solely for the use of Participant's artificial intelligence technology to provide an AI-augmented pelvic floor physical therapy platform with levels of clinician oversight, including any underlying definitional or licensing requirements on which these provisions rely or incorporate by reference, so long as Participant abides by the terms of this Agreement:

1. Utah Code §§ 58-1-501(1) and (2) and Utah Admin. Code R156-1-501(2)(b);
2. Provisions relating to unlawful conduct in Utah Code §§ 58-24b-501, 58-24b-503, 58-31b-501, 58-40-501, 58-67-501, 58-68-501, 58-70a-502, and 58-71-501;
3. Provisions relating to unprofessional conduct in Utah Code §§ 58-24b-502, 58-31b-502, 58-40-502, 58-40a-501, 58-67-502, 58-68-502, 58-70a-503 and 58-71-502;
4. Provisions relating to unprofessional conduct in Utah Admin. Code R156-24b-502, R156-31b-502, R156-40-502, R156-40a-502, R156-67-502, R156-68-502, R156-70a-503, and R156-71-502; and

C. The Division will forgo any enforcement action against Participant under Utah Code § 26B-4-704(6) and administrative rule UAC R156-1-602 provided that Participant's artificial intelligence technology meets all obligations of telehealth providers in Section 20(A) of this Agreement.

D. The Division will, regarding the activities described in Schedule B of this Agreement, forgo any enforcement action against any affiliated professional entity or provider employed or contracted by Participant or who licenses Participant's artificial intelligence technology who (1) acts in reliance on Participant's artificial intelligence technology to provide AI-augmented pelvic floor physical therapy with specified levels of clinician oversight and (2) does not interact

directly with a patient or other health care provider under the following provisions solely for the use of Participant's artificial intelligence technology in healthcare settings, in each case including any underlying definitional or licensing requirements on which these provisions rely or incorporate by reference:

1. Utah Code §§ 58-1-501(1) and (2) and Utah Admin. Code R156-1-501(2)(b);
2. Provisions relating to unlawful conduct in Utah Code §§ 58-24b-501, 58-31b-501, 58-40-501, 58-67-501, 58-68-501, 58-70a-502, and 58-71-501;
3. Provisions relating to unprofessional conduct in Utah Code §§ 58-24b-502, 58-31b-502, 58-40-502, 58-40a-501, 58-67-502, 58-68-502, 58-70a-503 and 58-71-502;
4. Provisions relating to unprofessional conduct in Utah Admin. Code R156-24b-502, R156-31b-502, R156-40-502, R156-40a-502, R156-67-502, R156-68-502, R156-70a-503, and R156-71-502; and

E. Participant's artificial intelligence technology is deemed in compliance with Utah Code §§ 13-77-103 and 58-24b-402 if Participant's artificial intelligence technology follows the protocols outlined in Schedule B.

F. The nonenforcement mitigation articulated in this Section applies only to actions authorized by this Agreement and does not preclude enforcement actions for other unlawful or unprofessional conduct.

G. No mitigation articulated in this section applies to any other services offered by Participant on Expect.fit or the Expect Fitness app. The mitigation articulated in this Agreement applies only to Participant's AI-augmented pelvic floor physical therapy platform with specified levels of clinician oversight as described in the Proposal. No mitigation articulated in this Section provides any exemption to, stay of enforcement of, or other mitigation from, any other provision of law related to such additional services.

Section 20. Additional Participant Obligations

In addition to the General Participant Obligations detailed in Section 6 of this Agreement, Participant agrees as follows:

A. Capacity

1. Participant's artificial intelligence technology shall adhere to all requirements as a telehealth provider as set forth in Utah Code § 26B-4-704, with the exception of the following:

a. Participant's artificial intelligence technology is deemed in compliance with Utah Code §§ 26B-4-704(2)(a)(i), (2)(b), (2)(c), and (2)(e) if Participant's artificial intelligence technology follows the protocols outlined in Schedule B of this Agreement.

b. Participant's artificial intelligence technology is deemed not in violation of § Utah Code § 26B-4-704(4) if Participant's artificial intelligence technology follows the protocols outlined in Schedule B of this Agreement.

c. Utah Code § 26B-4-704(5) shall not apply to Participant's artificial intelligence technology.

2. Participants shall maintain patient's electronic health records in a portable format or allow patients to promptly download or share their electronic health records upon request.

B. Safeguards

1. Prior to the Commencement Date specified in Section 2, Participant shall furnish the Office with a Certificate of Insurance or other satisfactory documentation evidencing the requisite professional liability insurance coverage. Participant shall possess and continuously maintain such professional liability insurance coverage throughout the duration of this Agreement.

2. Participant shall abide by the procedures and safety protocols in the Proposal and ensure that:

a. Activities described in the Proposal comply with applicable provisions of 45 CFR Part 164.

b. Any health care provider, as defined in 45 CFR § 160.103, who interacts directly with an individual residing in the State of Utah through a telehealth service, as defined in Utah Code § 26B-4-704(1)(h) is a provider, as defined in Utah Code § 26B-4-704(1)(f).

c. Participant does not utilize its artificial intelligence technology to authorize any treatment or care not identified in Schedule B of this Agreement.

C. Permissions

1. Participant shall not commence any succeeding phase without the prior written approval of the Office.
2. Participant acknowledges that the Office will require strict adherence to the statistical protocol for sequential gated performance established in the Office's most recent version of *Evidentiary Expectations for Healthcare AI Sandbox*.

D. Disclosures to Users and Pharmacists

1. Participant shall disclose the following to the user:
 - a. The name and contact information of Participant;
 - b. As may be applicable throughout the phases of the Proposal, that the user is interacting with generative artificial intelligence pursuant to Utah Code § 13-77-103(2);
 - c. The precise manner, means, and extent to which all user data and information, including all correspondence with Participant's AI technology, will be used or shared by Participant; and
 - d. That the user is engaging with a temporary offering of AI technology through an agreement with Utah's Office of Artificial Intelligence Policy. Participant shall share with users a phone number and/or website address provided by the Office where users may provide feedback regarding the use of Participant's AI technology.
2. Disclosures to users shall be provided in a clear and conspicuous form and a user shall acknowledge receipt of the disclosure before a user may access any functions of Participant's AI technology.

E. Notifications

The Office will receive access to a dedicated dashboard – accessible at any time – that automatically captures and makes available patient-reported adverse events, symptom worsening, new symptoms, pain during exercises, week-8 check-ins, clinical escalations, and

PHQ-2 $\geq$ 3 screening results. In addition to the dashboard, Participant will provide notifications for specific events as outlined below.

1. Immediate notification (end of the next business day): Any serious events should be reported to the Office as soon as feasible but no later than the end of the next business day after Participant becomes aware of such an event. Serious events include:

- a. Worsening of patient condition
 - i. Any case where a patient's condition worsened or required hospitalization or urgent/emergency care
 - ii. Any unexpected incident involving death or serious physical injury or mental trauma
- b. Data privacy
 - i. Any suspected data leak or unauthorized access to the model training/inference environment
 - ii. Any suspected data leak or unauthorized access to private health information
 - iii. Re-identification of user or patient data that was treated as de-identified
- c. Cybersecurity incidents including ransomware, denial of service, or other integrity compromises affecting clinical decision support
- d. Clinician oversight
 - i. Any licensed clinicians involved with the pilot that are terminated or removed from the pilot for cause.

2. Notification within 5 business days: Other adverse events should be reported to the Office as soon as feasible but no later than 5 business days after Participant becomes aware of such an event. Adverse events may include, as applicable:

- a. Any patient harms reported to or discovered by Participant since patient began using Participant's AI technology that are not subject to immediate notification

b. AI-generated medical recommendations or decisions where any of the following occur:

i. Misdiagnosis

ii. Missed diagnosis

iii. Delayed diagnosis

iv. Incorrect or incomplete treatment recommendation (including failure to recommend appropriate diagnostic workup or follow-up with AI or with a licensed provider)

v. Recommendation for medication

vi. Failure to identify a relevant contraindication (e.g., pregnancy, renal, or hepatic contraindications)

c. Failure to escalate a case that meets escalation thresholds articulated in the Proposal

d. AI encouragement of risky behavior, inappropriately delayed care-seeking, or discontinuation of a provider-prescribed treatment.

e. System failures

i. Instances where the AI model hallucinates facts about a patient's history

ii. Failure to escalate a case that meets escalation thresholds

iii. ID verification failure

iv. AI providing clinical advice or performing actions outside its defined regulatory or contractual scope

v. Loss, corruption, or unavailability of clinical records accessed by the AI

vi. Any failure in the authentication process that allows clinical recommendations or renews medications/procedures not intended for patient

- vii. Instances where the AI provides an output that is later determined to be dangerously incorrect

F. Reporting

Reports required under Section 6(H) shall include the following:

1. Monthly Reports: Monthly reports are to be sent to the office in a downloadable format via email to ai@utah.gov. If a shared document is being updated, an email with a downloadable version of the report is expected for tracking purposes. These reports should be submitted by the 15th of the following month (e.g. January's data should be submitted by February 15th). These reports should include, as applicable:

- a. Basic User Information

- i. Number of patients who were redirected during intake because of exclusionary diagnosis list (e.g., Grade 3 prolapse or active pelvic cancer) (#)
- ii. Total AI-processed care plans, categorized by symptom subtype (Stress, Urge, or Mixed Incontinence) (#)
- iii. Plans approved by the PT with and without substantive modification (#)
- iv. Agreement rate between PT and AI (%)
- v. Comparison of current agreement against baseline validation data (comparison)
- vi. Adherence rates (#)
- vii. User complaints (all complaints, technical or otherwise, deidentified but otherwise in their entirety)

- b. Auditable logic

- i. Applicable clinical-logic version
- ii. Material rules triggered

iii. Risk tier

iv. Disposition

v. Escalation Status

vi. Clinical Action Taken

vii. Substantive PT modification or rejection, if any

c. Breakdown of reasons for escalation

i. Total visits escalated to a human provider (#) and reasons for escalation (qualitative)

ii. Total agreement rate after escalation (denied/ approved by human provider) (#)

iii. Specific reasons for all escalations (qualitative)

d. Sensitivity analysis of escalation

i. Count of false positives or false negatives (#)

ii. Percentage of escalated interactions that actually needed human review (%)

e. De-identified, randomly sampled sources

i. Random sampling of intake case records: the patient's questionnaire responses and the resulting care plan, including cases where the reviewing clinician modified or rejected the resulting care plan

ii. Random sampling of logged free-text patient interactions: patient-physical-therapist messages, care-coordination and referral communications, provider-verification requests, and patient-initiated clinical-review requests, including cases where the AI and human provider disagreed

f. Observations from reviewing Clinicians

- i. Trends or observations made by clinicians overall (qualitative)
- ii. Random sampling of deidentified logs of clinician review (qualitative)
- iii. Quality of patient assessment and clinical reasoning (qualitative)
- iv. Clinical appropriateness of renewal decisions (yes/ no %)
- v. Accuracy of patient history taking (complete/ incomplete #)
- vi. Accuracy of automated ICD-10 diagnosis mapping
(Complete/Incomplete #)

g. Patient Demographics

- i. Patients who use the tool to completion more than once (#)
- ii. Breakdown of agreement rates and outcomes by age, gender, and pregnancy status (#)
- iii. Distribution of first visit user ages
- iv. Distribution of returning user ages
- v. Distribution of time and day patients use the tool
- vi. Deidentified and aggregated patient location data[OD3] , with higher-level aggregation applied as necessary to mitigate re-identification risk
- vii. Discovery of a systematic error where the AI provides incorrect prescription based on a patient's protected characteristics (age, race, gender, etc.) (qualitative)

h. Technical metrics

- i. Unplanned downtime (time)

- ii. Any model version updates or changes to the underlying algorithm/architecture (qualitative)

2. Quarterly Public Reports: Quarterly reports can be shared by the Company at any time, but must be submitted to OAIP at the time of their third monthly report. For example, if a contract is commenced on January 1st, the monthly reports would be submitted on February 15th, March 15th, and April 15th, where the Quarterly public data would be expected on April 15th. These reports should include, as applicable:

- a. AI-PT agreement rate (%)
 - i. Agreement rate broken down by each treatment class
- b. Total patients served (#)
- c. Number of AI-assisted visits (#)
- d. Disclosure of current pilot phase progress for urinary incontinence symptom subtype (Stress, Urge, or Mixed).

3. Final Report: To be submitted to the office no later than 30 days prior to the expiration of an ongoing 12-month demonstration period (e.g. if a contract commences on January 1, 2020, the Final Report *with an extension request* should be submitted by the company no later than December 1, 2020). If the agreement is renewed, an additional report will be required at the end of the second year, according to the same terms. The annual report should include, as applicable:

- a. Overview of deployment and scope
- b. Overall #s
 - i. Patients served (#)
 - ii. Adverse events (#)
 - iii. Agreement rate
- d. Impact analysis
- e. All user complaints

f. Any longitudinal data collected by the company

Schedule B



AI-Augmented Pelvic Floor Physical Therapy Platform

Pilot Proposal to the Utah Office of Artificial Intelligence Policy
Regulatory Mitigation Agreement Application
Under the Utah Artificial Intelligence Policy Act (UAIPA)

Public Edition · August 2026 (application originally submitted April 2026)

About this public edition

This public edition omits the platform's specific clinical-logic values (patent pending, and designed to be applied under licensed clinician review rather than as a self-treatment guide), security implementation details, and commercially confidential terms. The complete version is on file with the Utah Office of Artificial Intelligence Policy.

Executive Summary

Problem Statement: Pelvic floor dysfunction affects nearly half of Utah women and is highly treatable with physical therapy (PT) —yet Utah has only 5 board-certified pelvic floor physical therapists for 1.6 million adult female residents, leaving most patients untreated and at risk of far more costly surgical intervention. AI-augmented care extends clinician capacity and brings PT-supervised treatment to patients with no geographic access to a specialist.

Prevalence: Urinary incontinence is a "silent epidemic," affecting ~47%–63% of U.S. women — yet most go untreated due to stigma and access barriers. In Utah, a high-volume maternity state, 1 in 3 women experience incontinence after childbirth. (Milsom et al., 2019; Lee et al., 2021; Patel et al., 2022; Che et al., 2025; Thom & Rortveit, 2010)

Harms of Inaction: Incontinence is directly linked to social isolation, reduced quality of life, reduced physical activity, and a higher risk of postpartum depression. (Milsom et al., 2019; Gallego-Gomez et al., 2024)

Low-Risk Intervention: Pelvic floor physical therapy is conservative but highly effective — the realistic worst-case outcome is temporary muscle soreness, versus a drug interaction or surgical complication. This low-risk profile makes it the ideal first-line intervention and a strong candidate for AI-augmented delivery.

Proposed Solution: Expect is an AI-augmented pelvic floor PT platform that enables clinicians to oversee care at scale. In the initial pilot, licensed PTs review and approve 100% of the clinically validated and evidence-based AI-generated care plans before any recommendation reaches a patient. As safety and efficacy are established, lower-risk plans proceed with automated safeguards. This model scales PT capacity without replacing clinical judgment — extending specialist-level care to rural and frontier Utahns who may have limited access, at a fraction of the cost of surgical intervention.

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1. About You

1.1 What Is Your Product?

Expect is an AI-augmented pelvic floor physical therapy (PF-PT) platform that delivers clinically validated assessment, AI-generated treatment planning, and ongoing care management to women experiencing pelvic floor dysfunction — primarily urinary incontinence, pelvic pain, and related postpartum conditions.

The platform uses deterministic scoring algorithms and rule-based plan generation to analyze patient responses across validated clinical instruments for bladder and bowel health, pain, sexual symptoms, and prolapse (pressure, heaviness, or bulging in the vaginal area). It measures symptom severity, identifies potential diagnoses, and creates a personalized treatment plan for PT review, including standard medical diagnosis codes (ICD-10), exercises, supportive tools or behavior changes, safety precautions, and guidance on when to progress.

Expect follows a graduated, earned-autonomy model. During the initial calibration phase, 100% of AI-augmented plans are reviewed, edited, and approved by a licensed physical therapist before any treatment recommendation reaches the patient. As the AI demonstrates statistical reliability, low-risk plans may be auto-approved — limited to the lowest-risk cohort, with continuous random human audit, immediate reversion to 100% review after any adverse event, and permanent mandatory review for higher-risk patients. High-risk and complex patients always receive full PT review or referral to in-person therapy. The reviewing physical therapist retains full authority to modify, reject, or augment any AI output at any phase. This earned autonomy model ensures AI augments the clinician, never replaces them.

Expect made its name addressing the root causes of pregnancy-related complications through prenatal, postnatal, and pelvic floor fitness/physical therapy—and is the only platform where every workout is approved by OB/GYNs for safety. Its advisory includes 17 practicing OB/GYNs from top institutions, along with Harvard Medical School professor I-Min Lee, the foremost global expert on women's physical activity. Expect has active partnerships across federal, state and local government: a Cooperative Research and Development Agreement with the Veterans Health Administration (VHA) — the country's largest integrated health system — an IRB-approved study with the University of Alabama, and a contract with the Boston Public Health Commission. Expect is a member of the Advanced Medical Technology Association (AdvaMed), the world's largest medical technology association representing device, diagnostics and digital technology companies.

1.2 Who Does Your Product Serve?

Expect's AI-augmented pelvic floor physical therapy population serves women in Utah experiencing:

- Postpartum pelvic floor dysfunction (stress incontinence, urgency, pelvic organ prolapse symptoms)
- Chronic pelvic pain
- Urinary incontinence (Stress, urge, or mixed--affecting an estimated 47%-63% of women in the United States).
- Pelvic floor dysfunction related to aging (menopausal changes, deconditioning)

The platform specifically targets underserved populations:

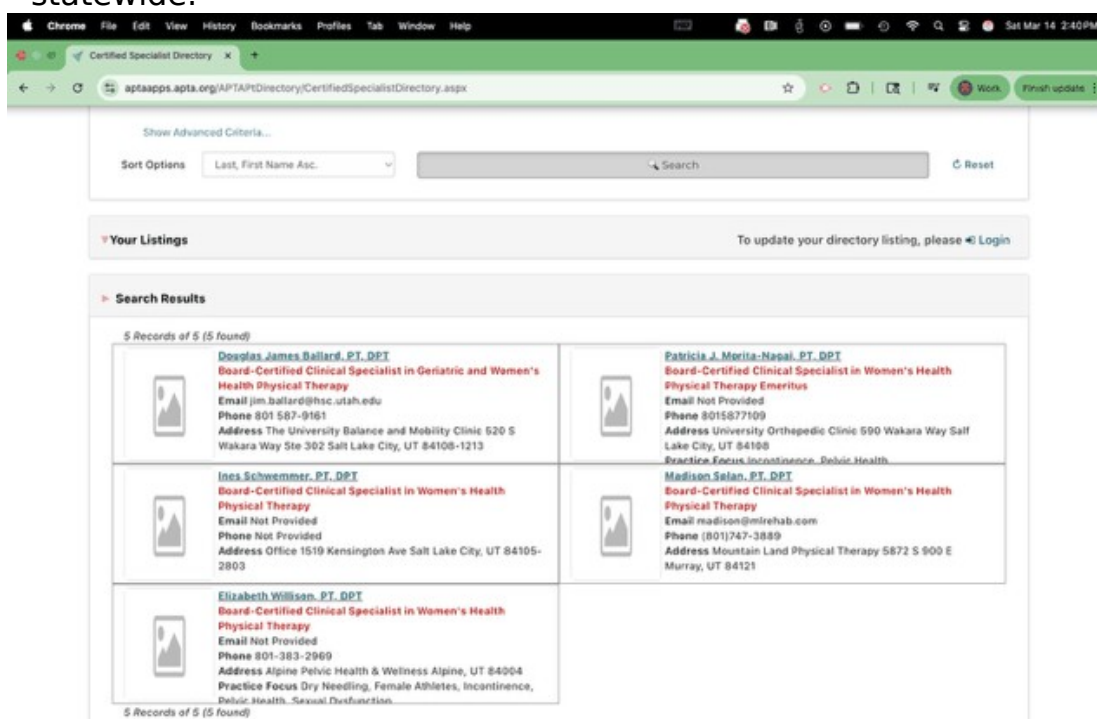
- Rural Utah residents more than 60 minutes from the nearest pelvic floor physical therapist provider
- Postpartum women within the first year after delivery, when pelvic floor symptoms are most treatable
- Women who avoid in-person pelvic floor physical therapy due to stigma, childcare barriers, or cost
- Underserved Utahns — including Medicaid beneficiaries, uninsured, and Medicare patients — with limited access to specialist pelvic floor physical therapy

1.3 Benefits to Utahns

Expands Access to Pelvic Healthcare

Utah is facing a severe shortage of women's health providers, creating significant barriers to care for residents. The urgent need for expanded access is highlighted by several critical data points:

- **Severe Provider Shortage:** There are only five board-certified women's health pelvic floor therapists available to treat the state's 1.6 million female residents, according to the American Board of Physical Therapy Specialties (ABPTS). Beyond the clinicians certified by ABPTS, the practicing pelvic-health workforce is somewhat larger; public provider directories suggest roughly 70 practicing pelvic rehab PTs statewide.



American Board of Physical Therapy Specialties Utah Women's Health Specialists

- **Extended Wait Times:** Due to this clinician scarcity, the Utah Department of Commerce's *2025 Periodic Review of Physical Therapy* specifically highlighted access issues for pelvic floor therapy noting that "Many [physical therapists] reported reasonable wait-times for patients of a few days, however certain specialties- such as pelvic health- could garner wait-times of up to a few weeks."
- **Rural Care Deserts:** This gap exacerbates an already critical statewide shortage of maternal and women's healthcare. The "Maternal Health in Utah: Risk Factors, Workforce Gaps, and Access to Care" report from the Kem C. Gardner Policy Institute notes that limited provider availability forces some women in rural Utah to travel

four to five hours just to access in-person care. Some women even cross state lines.

Increases Workforce Capacity and Efficiency

The proposed platform significantly expands healthcare workforce capacity by enabling any Utah-licensed physical therapist to deliver evidence-based pelvic floor care with AI-augmented clinical decision support, increasing the number of patients each provider can effectively serve. Because the platform also generates compliant documentation, it substantially reduces administrative workload and improves efficiency. This efficiency gain is especially important for serving rural populations, where provider shortages are most pronounced.

Addresses a Major Unmet Need in Women's Health

Urinary incontinence affects over half of U.S. women, yet most go untreated due to stigma and access barriers. Even when women do seek help, they are often met with generic, one-size-fits-all guidelines that fail to address their specific, individual needs.

Supports Better Maternal Health Outcomes

Utah has among the highest birth rates in the nation. Approximately one-third of women experience urinary incontinence in the first year postpartum, and the prevalence after vaginal birth is about twice that after cesarean delivery, as shown in a systematic review published in the *British Journal of Obstetrics and Gynaecology*. Early intervention with pelvic floor physical therapy reduces long-term incontinence, pain, and surgical intervention rates. The platform's touchpoints also create structured opportunities for multidisciplinary care coordination during the highest-risk period for maternal mortality — the first 12 months postpartum. Each check-in interaction provides a natural gateway for mental health screening (the PHQ-2, a widely used two-item depression screening tool, is embedded in the intake battery) and can flag patients for cardiovascular follow-up, addressing two of the leading drivers of postpartum maternal mortality at a moment when women are actively engaged with their care.

Alleviates Patient Burden

Asynchronous delivery eliminates barriers of in-person visits (travel, childcare, time off work) and the scheduling constraints of synchronous telehealth. It allows women with irregular schedules or limited privacy to engage in care.

Delivers an Evidence-Based Intervention

High-quality evidence shows that pelvic floor muscle training (PFMT) delivered via telehealth/tele-rehabilitation is feasible, effective, and in some cases comparable to in-person care for urinary incontinence and pelvic floor

dysfunction. (Source: Hao et al. (2024) systematic review & meta-analysis; Lima et al. (2025))

Reduces Reliance on Higher-Cost Interventions

Physical therapy for **stress urinary incontinence** is clinically meaningful and economically compelling. According to the **American Physical Therapy Association's** 2023 report, *The Economic Value of Physical Therapy in the United States*, physical therapy for stress urinary incontinence was estimated to provide **\$10,129 in net benefit per episode of care**.

Improves Access for Rural and Underserved Patients

Rural Utah residents, Medicare beneficiaries, and underserved populations gain access to specialist-level PF-PT that was previously available only in urban centers. Accessible direct-pay ensures access for Medicaid patients pending telehealth policy change.

Provides Regulatory Innovation Data

The pilot generates real-world evidence on AI safety, efficacy, and patient experience in a controlled healthcare setting, informing future Utah AI policy across all healthcare domains.

1.4 End-to-End Customer Experience

This section walks through an intake for a typical postpartum patient, who can access the Expect platform from a website, either via desktop or mobile phone.

Landing Page

In our interview with the founder of one of Utah's largest pelvic floor physical therapy practices, we learned that patient education is central to this specialty. Our landing page is designed to help visitors recognize their symptoms and determine whether they may be a good fit for the program.

The screenshot shows the Expect landing page. At the top is a dark purple navigation bar with the 'EXPECT' logo and links for 'Patient View', 'PT Provider View', and 'Utah OAIP View'. The main content area has a light purple background. It starts with the heading 'Could pelvic floor therapy help you?' followed by a paragraph: 'Leaks, pressure, painful sex, constipation, or not feeling like yourself after birth can all be signs that pelvic floor therapy may help.' Below this is a section titled 'What sounds most like you?' with six buttons: 'I leak when I sneeze, cough, or laugh', 'I can't make it to the bathroom in time', 'I feel pressure or heaviness down there', 'Sex is painful or uncomfortable', 'I'm constipated or strain to go', and 'I have pelvic symptoms after birth'. A line of text states 'You don't need to know the medical name for the problem to get help.' Below this is a large pink button labeled 'Start My Assessment'. Underneath the button are two links: 'Returning patient? Sign in here' and 'Completing this for someone else?'. A section titled 'How it works' follows, containing three numbered steps: 1. 'Answer a few quick questions' (A 5-minute assessment about your symptoms. No medical knowledge needed.), 2. 'A licensed PT reviews your results' (A Utah Physical Therapist personalizes your care plan before you see it.), and 3. 'Get your plan — and support if you need more' (Personalized exercises at home. If you need in-person care, we'll help connect you.).

Expect landing page — AI disclosure and program overview

Informed Consent

Following the landing page, the patient is presented with a clear, plain-language informed consent form explaining that AI is used in their care, that all recommendations are reviewed by a licensed physical therapist during Phase 1, the protocols for care plan and anonymized data sharing, and the patient's eligibility for the program.

EXPECT

Patient View

PT Provider View

Utah OAIP View

Informed Consent

AI-Augmented Pelvic Floor Physical Therapy - Utah OAIP Pilot

Please read each statement and check the box to confirm you understand.

☒

I understand this platform uses AI to assist in my care. A licensed Physical Therapist oversees all AI-generated treatment plans. The level of clinical review may vary based on clinical complexity and program phase.

☒

I understand a licensed Utah PT maintains clinical oversight of AI recommendations. The AI supports – but never replaces – clinical judgment.

☒

I understand that if I report a concern about AI-supported care, Expect Health will provide a no-cost clinical review and, if clinically appropriate, corrective pelvic floor PT follow-up (telehealth or in-person, as available), subject to program terms.

☒

Data collected includes: intake responses, scores, adherence, chat interactions, and outcomes – all in HIPAA-compliant encrypted systems.

☒

I consent to de-identified data sharing with: (1) Utah OAIP for oversight, (2) researchers under IRB protocols, (3) external auditors, (4) anonymized public dashboards.

☒

I authorize Expect Health to share my assessment results, treatment plan, and progress reports with the medical provider I identify for care coordination purposes.

☒

I consent to receive electronic notifications about my care plan. I understand these notifications will link to a secure portal and will not contain sensitive health details directly.

☒

I understand this is a pilot under a Regulatory Mitigation Agreement with the Utah Office of AI Policy.

☒

I confirm that I am currently located in the state of Utah.

☒

I confirm I am at least 18 years old and provide this consent voluntarily.

← Back

Consent v1.2 · Mar 2025

I Agree → Continue →

Informed consent — plain-language AI disclosure and care plan sharing (Phase 1)

Public edition · August 2026 · Expect Fitness, Inc. · Complete version on file with Utah OAIP

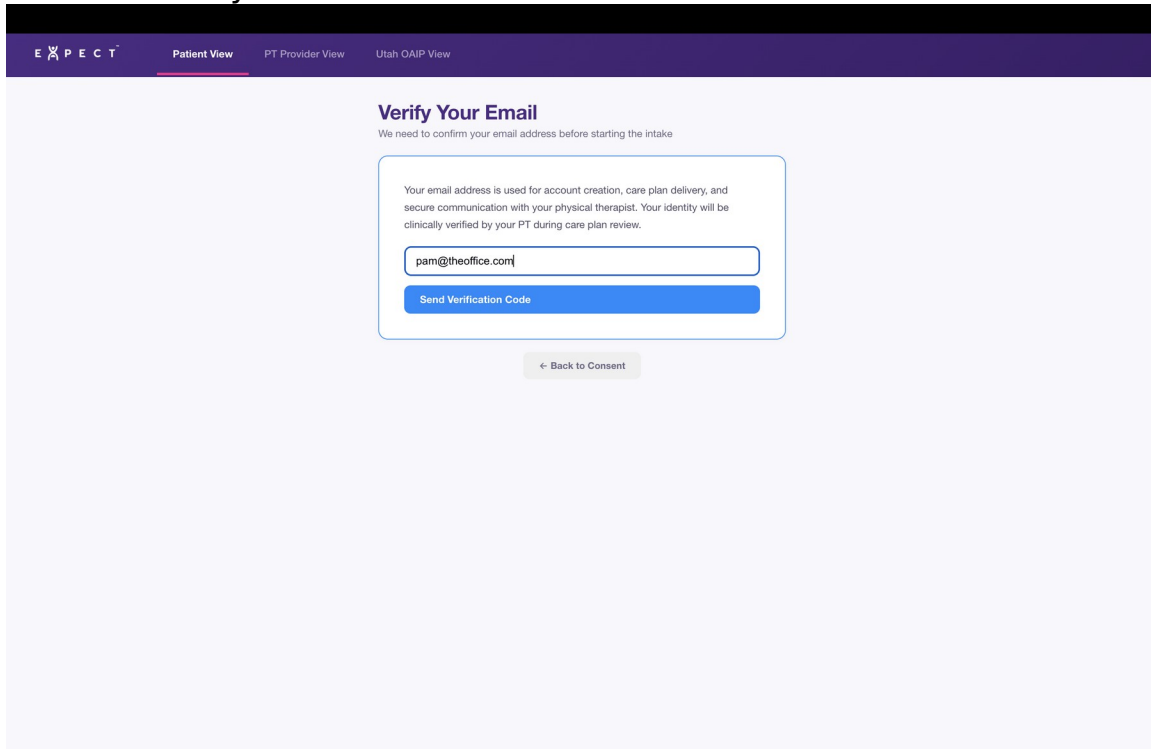
11

Step 2: Identity Verification, Safety/Eligibility Screening

Identity Verification

Patient identity and eligibility are confirmed through email-based account verification, patient attestation of identity/Utah residency/age 18+, and PT review of demographic consistency across intake responses.

Layered verification is applied at intake, with photo ID integration via a HIPAA-compliant identity verification vendor available if OAIP requires additional identity assurance.

The screenshot shows a web interface for 'Expect Fitness'. At the top is a dark purple navigation bar with the 'E X P E C T' logo on the left and three menu items: 'Patient View' (highlighted with a red underline), 'PT Provider View', and 'Utah OAIP View'. The main content area has a light purple background. It features a heading 'Verify Your Email' followed by the text 'We need to confirm your email address before starting the intake'. Below this is a white rounded rectangle containing explanatory text: 'Your email address is used for account creation, care plan delivery, and secure communication with your physical therapist. Your identity will be clinically verified by your PT during care plan review.' Underneath the text is a text input field containing 'pam@theoffice.com' and a blue button labeled 'Send Verification Code'. At the bottom of the white box is a grey button labeled '← Back to Consent'.

Email collection — low-friction entry point

EXPECT Patient View PT Provider View Utah OAIP View

Verify Your Email

We need to confirm your email address before starting the intake

We sent a 6-digit code to **pam@theoffice.com**

Demo mode: Your code is **463834**
In production, this code is sent via email only.

0 0 0 0 0 0

Verify

Change email or resend

← Back to Consent

Two-party authentication — email verification code

Demographics & Provider Selection

Upon consent, the patient completes standard demographic information, including sex assigned at birth (with appropriate pregnancy-status gating), insurance type, and referral source.

E
X
P
E
C
T

Patient ViewPT Provider ViewUtah OAJP View

Let's Get to Know You

Some basic information to get started.

1 / 11

What is your name?

First nameLast name

PamBeasley

What is your date of birth?

11/01/2000

What is your sex assigned at birth?

Female

Male

What is your current pregnancy status?

Currently pregnant

Postpartum (0-6 weeks)

Postpartum (6 weeks - 6 months)

Postpartum (6+ months)

Not recently pregnant

E X P E C T

Patient ViewPT Provider ViewUtah OAIP View

What was your most recent type of delivery?

Vaginal delivery

Vaginal with forceps or vacuum

Planned C-section

Emergency C-section

Approximately when did you deliver?

05/21/2015

How many total deliveries have you had? (Enter 0 if none)

2

What is your email address?

pam@theoffice.com

What is your phone number?

(801) 555-1212

How did you hear about us?

A healthcare provider referred me

Expect is built for seamless interoperability with Utah healthcare providers. To securely share care plans, route red flags, and guard against patients entering incorrect or fake clinician information, every patient is connected with a verified physician through a layered verification process, with concierge support available for providers who cannot be verified automatically.

Patients under the care of both an OB/GYN and a primary care physician may add an optional second provider through the same verified lookup flow, designating which provider is the primary recipient. Milestone transmissions are sent to both providers on file.

Safety & Eligibility Screening

Before any clinical questions are posed, the platform runs a safety gate for symptoms that require immediate physician or emergency intervention, because AI should never be the first line of defense for a medical emergency. This gate is particularly attuned for the populations we serve — postpartum women, as displayed in the below screenshot.

The screenshot shows the 'Expect' application interface. At the top is a dark purple navigation bar with the 'EXPECT' logo and three tabs: 'Patient View' (selected), 'PT Provider View', and 'Utah OAIP View'. Below the navigation bar, the main content area has a light purple background. The title 'Safety Check' is centered, with a subtitle 'We need to make sure you're safe to proceed.' and a progress indicator '2 / 11' in a purple pill. A red warning banner with a stop icon and the text 'STOP — Please call 911 or go to the nearest emergency room immediately.' is displayed. Below this, there are four question blocks, each with two radio button options: 'No' and 'Yes'. The first question is 'Are you experiencing any unexplained vaginal bleeding?' with 'No' selected. The second question is 'Do you currently have a fever — temperature above 100.4°F (38°C)?' with 'Yes' selected. Below the second question, a red warning banner states: '!! A fever at this level may indicate infection or a serious condition requiring medical evaluation. If you are postpartum, this is especially urgent. Please call 911 or go to the ER immediately.' The third question is 'Are you experiencing any chest pain or difficulty breathing?' with 'No' selected. The fourth question is 'Do you have a severe headache along with any changes in your vision?' with 'No' selected. The fifth question is 'Are you experiencing burning during urination, blood in your urine, or frequent urination along with a fever?' with 'No' selected.

Safety check — flagged response requiring confirmation

An important safety precaution: If a patient attempts to change a positive safety answer, the platform does not silently accept the update. It stops and actively confirms: *"You previously indicated a medical safety concern for this question. Please confirm you are intentionally changing this answer."* The patient must explicitly click *"Yes, I'm changing my answer"* — a deliberate friction point designed to force a conscious decision. This matters because patients under stress, rushing through intake, or feeling pressure to proceed may reflexively click past a flag they genuinely meant to raise. The confirmation modal requires them to own the change.

To further protect vulnerable populations, the platform takes this a step further. Any change to the safety check answers is logged as a `SAFETY_ANSWER_CHANGED` audit event, surfaced to the reviewing PT, visible in the OAIP Red Flags dashboard, and included in the encounter note transmitted to the patient's physician upon plan approval.

In addition, any red-flag halt triggers an automatic notification to the patient's provider on file, transmitted via HIPAA-compliant channels with verified destinations; unverified destinations are held pending verification before any transmission. Patients routed to emergency or urgent care also receive automated next-business-day outreach confirming whether the visit occurred — recorded as an auditable event — with automatic escalation to a human care-team call on any concerning response or non-response.

The screenshot shows the 'EXPECT' Patient View interface. At the top, there's a navigation bar with 'Patient View', 'PT Provider View', and 'Utah OAIP View'. Below this is a 'Safety Check' section with a progress indicator '2 / 11'. A red warning box states: 'STOP — Please call 911 or go to the nearest emergency room immediately.' Below this, there are three questions with 'No' and 'Yes' buttons:

- Are you experiencing any unexplained vaginal bleeding? (No button is highlighted)
- Do you currently have a fever — temperature above 100.4°F (38°C)? (Yes button is highlighted)
- Are you experiencing any chest pain or difficulty breathing? (No button is highlighted)

Between the second and third questions, there is a yellow warning box titled 'Safety Confirmation Required' with the text: 'You previously indicated a medical safety concern for this question. Please confirm you are intentionally changing this answer.' Below this text are two buttons: 'Yes, I'm changing my answer' (highlighted in red) and 'Cancel'.

Below the third question, there is a fourth question: 'Do you have a severe headache along with any changes in your vision?' with 'No' and 'Yes' buttons.

Safety check — confirmation modal for answer change

EXPECT

Patient ViewPT Provider ViewUtah OAIP View

Safety Check

2 / 11

We need to make sure you're safe to proceed.

Are you experiencing any unexplained vaginal bleeding?

No

Yes

Do you currently have a fever — temperature above 100.4°F (38°C)?

No

Yes

Are you experiencing any chest pain or difficulty breathing?

No

Yes

Do you have a severe headache along with any changes in your vision?

No

Yes

Are you experiencing burning during urination, blood in your urine, or frequent urination along with a fever?

No

Yes

← Back

Continue →

Safety check — all safety screening questions (page 1)

Eligibility Screening

The platform implements condition-specific clinical routing at the eligibility screening stage. Patients who report conditions outside the scope of conservative home-based pelvic floor PT are excluded from the AI-generated care plan pathway and instead receive reason-specific referral guidance with direct contact information for the appropriate Utah specialist. Where applicable, patients are also shown an in-person pelvic floor PT partner for complementary care. Patients whose conditions may resolve or be managed with specialist oversight are informed that they may return to the platform once cleared. All referral interactions — including phone call initiations and care coordination requests — are audit-logged for OAIP reporting and clinical follow-up.

The screenshot shows the 'Eligibility Screening' section of the Expect Fitness platform. The header includes the 'EXPECT' logo and navigation links for 'Patient View', 'PT Provider View', and 'Utah OAIP View'. The page title is 'Eligibility Screening' with a subtitle 'A few questions to confirm this program is right for you.' and a progress indicator '3 / 11'. The form contains six screening questions, each with 'No' and 'Yes' response buttons. The 'No' buttons are highlighted in pink.

EXPECT Patient View PT Provider View Utah OAIP View

Eligibility Screening

A few questions to confirm this program is right for you. 3 / 11

Have you been diagnosed with a neurological condition that affects your bladder or pelvic floor? (e.g., multiple sclerosis, spinal cord injury, Parkinson's disease, stroke)

☐ No ☐ Yes

Have you had pelvic mesh surgery or any other pelvic surgery that is still causing you problems?

☐ No ☐ Yes

Have you been told by a doctor that you have a significant pelvic organ prolapse (Grade 3 or higher)?

☐ No ☐ Yes

Do you have a known or suspected cancer in your pelvic area (bladder, uterine, cervical, ovarian)?

☐ No ☐ Yes

Do you currently have an active pelvic infection, fistula, or abscess?

☐ No ☐ Yes

Have you been diagnosed with interstitial cystitis with confirmed Hunner lesions?

☐ No ☐ Yes

Safety check — eligibility screening questions (page 2)

To boost intake completion rates, the platform uses adaptive gating: patients are shown only the sections of the assessment that apply to their symptoms. This reduces friction, minimizes unnecessary questions, and supports higher completion rates.

The screenshot shows the 'EXPECT' Patient View interface. At the top, there's a dark purple header with the 'EXPECT' logo and navigation links for 'Patient View', 'PT Provider View', and 'Utah OAIP View'. Below the header, the main content area is light purple. The title 'Symptom Screening' is centered, with a subtitle 'These questions determine which sections of the assessment apply to you.' and a progress indicator '4 / 11' in a purple pill. A progress bar with five segments is shown below the subtitle. The first question is: 'Over the past month, have you felt pain, pressure, or discomfort in your lower stomach, pelvis, bladder, or genital area?'. It has two radio button options: 'Yes' and 'No'. The second question is: 'Do your pelvic floor symptoms ever interfere with any vaginal penetration (e.g. sexual activity or intimacy, tampon use, or doctor exams)?'. It also has two radio button options: 'Yes' and 'No'. At the bottom, there are two buttons: '← Back' and 'Continue →'.

Symptom screening — gating questions for pain and sexual concerns

Specialist Approval Required for returnable-Orange exclusions. Patients whose intake triggers a returnable-Orange exclusion (mesh complications, Grade 3+ pelvic organ prolapse, active pelvic infection, IC with Hunner lesions, or high-risk pregnancy) are told that their treating specialist must review and approve their plan of care before it can be delivered. The platform provides a structured, clinician-verified re-entry pathway for conditionally excluded patients: the patient continues their intake, the platform-generated plan is held pending specialist review, and the plan is never delivered to the patient without specialist approval. Patients indicating high-risk pregnancy under MFM care follow this same pathway with their MFM provider, and patients within six weeks postpartum require OB-GYN approval before enrollment; once approved, the platform applies a “Gentle PF only” precaution to the generated care plan.

Step 3: Clinical Intake Assessment

The clinical intake is administered through a comprehensive suite of gold-standard, validated instruments selected for their rigor, international recognition, and established use in peer-reviewed research — criteria that strengthen clinical credibility and the comparability of outcomes for OAIP reporting.

Overview

Instrument	Primary Domain Assessed
ICIQ-UI Short Form	Urinary incontinence severity and subtype
FLUTS Filling/Voiding	Bladder filling and emptying symptoms
ICIQ-FLUTSsex	Sexual symptoms related to pelvic floor dysfunction
GUPI-F	Genitourinary pain and urinary symptom burden
PHQ-2	Depression screening
Bristol Stool Scale	Stool consistency
POPDI-6	Pelvic organ prolapse symptoms

ICIQ-UI Short Form — The platform begins the clinical intake with the *International Consultation on Incontinence Questionnaire-Urinary Incontinence Short Form* because this form captures the urinary symptoms most commonly affected by pregnancy, including leakage frequency, leakage volume, and quality-of-life impact. It produces a total score with validated severity bands (none, slight, moderate, severe, and very severe) as well as a subtype classification that guides exercise selection and program tier assignment. Stress incontinence — the most common postpartum

presentation — refers to leakage triggered by physical exertion or increased abdominal pressure, such as coughing, sneezing, laughing, or lifting. Urge incontinence refers to leakage preceded by a sudden, compelling need to urinate that cannot be deferred. Mixed incontinence combines both presentations.

The clinical distinction matters because stress and urge incontinence respond to meaningfully different interventions — stress incontinence is primarily addressed through pelvic floor muscle strengthening, while urge incontinence requires bladder retraining, urge suppression techniques, and behavioral modification alongside exercise. The ICIQ-UI SF captures which pattern predominates, allowing the platform to tailor the care plan accordingly rather than applying a generic pelvic floor protocol to all patients.

The screenshot shows a web-based assessment titled "Bladder Leakage" under the "Patient View" tab. The header includes the "EXPECT" logo and navigation links for "Patient View", "PT Provider View", and "Utah OAIP View". A progress indicator shows "5 / 13". The assessment instructions state: "ICIQ-UI Short Form — thinking about the past 4 weeks." The form contains three sections:

- How often do you leak urine?** with options: Never, About once a week or less often, Two or three times a week, About once a day, **Several times a day** (selected), and All the time.
- How much urine do you usually leak, whether you wear protection or not?** with options: None, **A small amount** (selected), A moderate amount, and A large amount.
- Overall, how much does leaking urine interfere with your everyday life? Please pick a number between 0 (not at all) and 10 (a great deal).**

ICIQ-FLUTS — Bladder leakage assessment (page 1)

Real-Time Consistency Check: The platform includes a real-time consistency checker that runs automatically across all intake instruments. As patients complete each section, the system cross-references answers for internal logic — flagging contradictions such as reporting no leakage in one section while indicating leakage interference in another. These contradictions are flagged to the patient, ensuring that clinical decisions are never driven by inconsistent self-report data. This is particularly important in an asynchronous telehealth model, where there is no clinician present during intake to catch these discrepancies in real time.

The screenshot displays the 'EXPECT' Patient View interface. At the top, there are navigation tabs: 'Patient View' (selected), 'PT Provider View', and 'Utah OAIP View'. The main content area is divided into several sections. The first section is a dropdown menu with 'All the time' selected. The second section asks 'How much urine do you usually leak, whether you wear protection or not?' with four radio button options: 'None', 'A small amount' (selected and highlighted in pink), 'A moderate amount', and 'A large amount'. The third section asks 'Overall, how much does leaking urine interfere with your everyday life? Please pick a number between 0 (not at all) and 10 (a great deal).' with a slider bar. The number '5' is displayed in the center of the slider, with 'Not at all' on the left and 'A great deal' on the right. The fourth section asks 'Under what circumstances does urine leak? Please select all that apply to you.' with eight radio button options: 'Never — urine does not leak' (selected and highlighted in blue), 'Leaks before you can get to the toilet', 'Leaks when you cough or sneeze', 'Leaks when you are physically active or exercising', 'Leaks when you have finished urinating and are dressed', 'Leaks when you are asleep', 'Leaks for no obvious reason', and 'Leaks all the time'. At the bottom, there is a yellow warning box with a triangle icon that reads: 'You reported leaking urine earlier, but selected 'Never — urine does not leak' here. Please review your answers.' Below the warning box are two buttons: '← Back' and 'Continue →'.

Consistency checker — contradiction flag displayed to patient

ICIQ-FLUTS — International Consultation on Incontinence Questionnaire, Female Lower Urinary Tract Symptoms — helps the platform better understand what kind of bladder symptoms a patient is experiencing. It looks separately at three areas: how the bladder feels when filling, what happens during urination, and what type of leakage is occurring. This matters because someone with strong urgency symptoms may need a different treatment approach than someone who has trouble emptying their bladder, even if their overall symptom scores look similar. A supplemental Leak Detail module adds more detail about leakage patterns, including urgency-related, stress-related, spontaneous, and nighttime leakage.

The screenshot shows the 'Urinary Symptoms' assessment form within the EXPECT platform. The header includes the EXPECT logo and navigation links for Patient View, PT Provider View, and Utah OAIP View. The form title is 'Urinary Symptoms' with a subtitle 'How your urinary function has been over the past 4 weeks.' and a progress indicator '6 / 13'. The first question is 'During the night, how many times do you have to get up to urinate, on average?' with radio button options: None, One (selected), Two, Three, and Four or more. The second question is 'How much does getting up at night to urinate bother you? (0 = not at all, 10 = a great deal)' with a slider scale from 0 to 10, where the value 2 is selected. The third question is 'Do you have a sudden need to rush to the toilet to urinate?' with radio button options: Never, Occasionally (selected), Sometimes, and Most of the time.

ICIQ-FLUTS — Urinary symptoms assessment (page 1)

ICIQ-FLUTS — Sudden urgency and frequency assessment

ICIQ-FLUTS — Voiding delay and hesitancy assessment

EXPECT Patient View PT Provider View Utah OAIP View

Do you stop and start more than once while you urinate?

Never

Occasionally

Sometimes

Most of the time

All of the time

Over the last week, how often have you had a sensation of not completely emptying your bladder after you finished urinating?

Not at all

Less than 1 time in 5

Less than half the time

About half the time

More than half the time

Almost always

Over the last week, how often have you had to urinate again less than two hours after you finished urinating?

Not at all

Less than 1 time in 5

I see than half the time

ICIQ-FLUTS — Stop-and-start stream assessment

EXPECT Patient View PT Provider View Utah OAIP View

Over the last week, how often have you had a sensation of not completely emptying your bladder after you finished urinating?

Not at all

Less than 1 time in 5

Less than half the time

About half the time

More than half the time

Almost always

Over the last week, how often have you had to urinate again less than two hours after you finished urinating?

Not at all

Less than 1 time in 5

Less than half the time

About half the time

More than half the time

Almost always

← Back

Continue →

ICIQ-FLUTS — Urinary symptoms assessment completion

Bowel Function Assessment — The platform asks a few simple questions about bowel habits, including how often the patient strains and how often they have bowel movements. It also uses the Bristol Stool Scale, which helps describe stool consistency. Together, these responses help identify possible constipation. If the answers suggest constipation — such as frequent straining, fewer than three bowel movements per week, or hard, lumpy stools — the platform adds constipation to the clinical assessment and recommends supportive bowel care, such as better toileting posture, fiber and fluid guidance, and techniques to make bowel movements easier. Looking at these measures together helps avoid missing constipation when it shows up in different ways.

The screenshot shows the 'Bowel Health' assessment form within the EXPECT platform. The header includes the EXPECT logo and navigation links for Patient View, PT Provider View, and Utah OAIP View. The form title is 'Bowel Health' with a subtitle 'A few questions about your bowel habits.' and a progress indicator '7 / 13'. The first question is 'Over the past month, how often have you experienced constipation or straining during bowel movements?' with options: Never, Rarely, Sometimes (selected), Often, and Almost always. The second question is 'How often do you typically have a bowel movement?' with options: Less than once a week, 1-4 times per week, 5-7 times per week (selected), 1-2 times per day, and 3 or more times per day. The third question is 'Which best describes your usual stool form? (Bristol Stool Scale)' with a visual scale of five dots and the text 'Type 1: Separate hard lumps, hard to pass'.

Bowel function assessment — straining and frequency

Bristol Stool Scale is a validated visual classification of stool form used internationally in gastroenterology and pelvic floor research. The patient selects from seven types with illustrations for each one: Types 1–2 indicate constipation, Types 3–5 represent normal stool form, and Types 6–7 indicate inflammation or diarrhea. Bristol type feeds into the platform's constipation composite alongside bowel movement frequency and straining severity.

Bristol Stool Scale — enhanced with inline SVG illustrations

POPDI-6 (Pelvic Organ Prolapse Distress Inventory-6) is a validated six-item screening instrument used in urogynecology and pelvic floor research to identify possible pelvic organ prolapse symptoms, meaning a feeling of pressure, heaviness, or bulging caused when pelvic organs shift downward. More concerning response patterns are flagged for closer PT review and may prompt additional support, such as pessary evaluation, where a clinician considers whether a removable vaginal support device could help relieve symptoms.

EXPECT

Patient View

PT Provider View

Utah OAIJ View

Prolapse Screening

8 / 13

POPDI-6 — pelvic organ prolapse symptom screening.

Pelvic Organ Prolapse Distress Inventory (POPDI-6)

#	Symptom	Response
1	Do you usually experience pressure in the lower abdomen?	☒ No ☐ Yes
2	Do you usually experience heaviness or dullness in the pelvic area?	☐ No ☐ Yes
3	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐ No ☐ Yes
4	Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	☐ No ☐ Yes
5	Do you usually experience a feeling of incomplete bladder emptying?	☐ No ☐ Yes
6	Do you ever have to push up on a bulge in the vaginal area to start or complete urination?	☐ No ☐ Yes

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Continue →

E X P E C T

Patient ViewPT Provider ViewUtah OAPV View

PRODRG — Pelvic organ prolapse distress screening

8 / 13

Prolapse Screening

POPDI-6 — pelvic organ prolapse symptom screening.

Pelvic Organ Prolapse Distress Inventory (POPDI-6)

#	Symptom	Response
1	Do you usually experience pressure in the lower abdomen?	☐ No ☒ Yes
Bother: Not at all <input checked="" type="button" value="Somewhat"/> Moderately Quite a bit		
2	Do you usually experience heaviness or dullness in the pelvic area?	☐ No ☒ Yes
Bother: Not at all <input checked="" type="button" value="Somewhat"/> Moderately Quite a bit		
3	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☒ No ☐ Yes
4	Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	☒ No ☐ Yes
5	Do you usually experience a feeling of incomplete bladder emptying?	☐ No ☒ Yes
Bother: <input checked="" type="button" value="Not at all"/> Somewhat Moderately Quite a bit		
6	Do you ever have to push up on a bulge in the vaginal area to start or complete urination?	☒ No ☐ Yes

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GUPI-F — Genitourinary Pain Index, Female helps the platform identify pelvic-area pain, urinary symptoms, and how much those symptoms affect daily life. It is paired with a simple 0–10 pain scale that captures the patient’s current pain, average pain over the past week, and functional impact.

If a patient reports pain, the platform asks two brief follow-up questions: where the pain is located and what makes it worse. For example, it asks whether pain is felt in the lower abdomen, pelvic floor, vaginal area, lower back, or hip, and whether it worsens with urination, bladder filling, sexual activity, tampon use, bowel movements, or prolonged sitting.

These patterns matter because they can point to different clinical concerns and may change the safest treatment approach. When certain pain patterns appear, the platform flags them for review by the licensed physical therapist before care begins. This gives the therapist structured information at intake to identify higher-risk cases early and make safer, more appropriate care decisions.

The screenshot shows a digital assessment form titled "Pain & Discomfort" with a subtitle "Genitourinary pain + current pain assessment. Over the past week." and a progress indicator "9 / 13". The form is divided into three sections. The first section asks, "In the last week, have you experienced any pain or discomfort in the following areas?" with a table of four items: "Entrance to the vagina", "Vagina", "Urethra (the small opening where urine comes out)", and "Below the waist, in the pubic or bladder area". Each item has "No" and "Yes" radio buttons; the "Yes" button for "Vagina" is selected. The second section asks, "In the last week, have you experienced any of the following?" with a table of four items: "Pain or burning during urination", "Pain or discomfort during or after sexual activity, tampon use, or any vaginal penetration", "Pain or discomfort as your bladder fills", and "Pain or discomfort relieved by voiding (went away or got better after urinating)". Each item has "No" and "Yes" radio buttons; the "Yes" button for "Pain or discomfort during or after sexual activity, tampon use, or any vaginal penetration" is selected. The third section asks, "How often have you had pain or discomfort in any of the areas mentioned above — including the vaginal entrance, vagina, urethra, pubic area, or bladder — over the last week?" with a text input field containing the word "Never".

	No	Yes
Entrance to the vagina	☒	☐
Vagina	☐	☒
Urethra (the small opening where urine comes out)	☒	☐
Below the waist, in the pubic or bladder area	☒	☐

	No	Yes
Pain or burning during urination	☒	☐
Pain or discomfort during or after sexual activity, tampon use, or any vaginal penetration	☐	☒
Pain or discomfort as your bladder fills	☒	☐
Pain or discomfort relieved by voiding (went away or got better after urinating)	☒	☐

How often have you had pain or discomfort in any of the areas mentioned above — including the vaginal entrance, vagina, urethra, pubic area, or bladder — over the last week?

Never

GUPI-F — Pain and discomfort assessment (page 1)

EXPECT Patient View PT Provider View Utah OAIP View

How often have you had pain or discomfort in any of the areas mentioned above — including the vaginal entrance, vagina, urethra, pubic area, or bladder — over the last week?

Never
Rarely
Sometimes
Often
Usually
Always

Which number best describes your AVERAGE pain or discomfort on the days you had it, over the last week? (0 = no pain, 10 = pain as bad as you can imagine)

No pain 2 Pain as bad as you can imagine

What is your current pelvic pain level right now? (0 = no pain, 10 = worst pain imaginable)

No pain 2 Worst pain imaginable

How does your pain affect your daily activities?

No effect
Mild — I can do most activities
Moderate — I avoid some activities
Severe — I am significantly limited
I cannot perform daily activities

GUPI-F — Pain frequency and functional impact

EXPECT Patient View PT Provider View Utah OAIP View

How often have you had pain or discomfort in any of the areas mentioned above — including the vaginal entrance, vagina, urethra, pubic area, or bladder — over the last week?

Never
Rarely
Sometimes
Often
Usually
Always

Which number best describes your AVERAGE pain or discomfort on the days you had it, over the last week? (0 = no pain, 10 = pain as bad as you can imagine)

No pain 2 Pain as bad as you can imagine

What is your current pelvic pain level right now? (0 = no pain, 10 = worst pain imaginable)

No pain 2 Worst pain imaginable

How does your pain affect your daily activities?

No effect
Mild — I can do most activities
Moderate — I avoid some activities
Severe — I am significantly limited
I cannot perform daily activities

When do you feel pain or discomfort? Select all that apply.

☐ During urination ☐ As my bladder fills (relieved by urinating) ☒ During sexual activity ☐ While inserting a tampon
☐ During bowel movements ☐ While sitting for long periods ☐ None of the above

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GUPI-F — Pain location and trigger mapping

ICIQ-FLUTSsex — International Consultation on Incontinence Questionnaire, Female Lower Urinary Tract Symptoms Sexual Function Module captures the

impact of urinary symptoms on sexual function, including vaginal dryness, dyspareunia (pain with intercourse), and leakage during sex. This domain is included because pelvic floor dysfunction and sexual health are clinically inseparable, and because patients rarely volunteer this information unprompted. Quantifying it at intake ensures the PT has a complete clinical picture and a documented baseline against which treatment response can be measured.

The screenshot shows a digital assessment form titled "Sexual Health" under the "EXPECT" logo. The form is for "Patient View" and includes a progress indicator "10 / 13". The assessment consists of three sections:

- Section 1:** "Do you have pain or discomfort because of a dry vagina?" with four radio button options: "Not at all" (selected), "A little", "Somewhat", and "A lot".
- Section 2:** "To what extent do you feel that your sex life has been affected by your urinary symptoms?" with four radio button options: "Not at all", "A little" (selected), "Somewhat", and "A lot".
- Section 3:** "How much does the impact on your sex life bother you? (0 = not at all, 10 = a great deal)". It features a horizontal slider with a red dot positioned at the value "4".

ICIQ-FLUTSsex — Sexual health impact assessment (page 1)

E X P E C T

Patient View PT Provider View Utah OAIP View

Do you have pain during sexual activity?

Not at all

A little

Somewhat

A lot

I don't have sexual activity

How much does pain during sexual activity bother you? (0 = not at all, 10 = a great deal)

4

Not at all A great deal

Do you leak urine during sexual activity?

Not at all

A little

Somewhat

A lot

I don't have sexual activity

How much does leaking during sexual activity bother you? (0 = not at all, 10 = a great deal)

EXPECT

Patient View

PT Provider View

Utah OAIP View

A lot

I don't have sexual activity

How much does pain during sexual activity bother you? (0 = not at all, 10 = a great deal)

4

Not at allA great deal

Do you leak urine during sexual activity?

Not at all

A little

Somewhat

A lot

I don't have sexual activity

How much does leaking during sexual activity bother you? (0 = not at all, 10 = a great deal)

3

Not at allA great deal

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Quality of Life

After completing the clinical instruments, the patient answers questions about how their symptoms affect daily life. This section captures what the scores alone cannot: the human cost of living with pelvic floor dysfunction. This information helps the reviewing PT understand not just how severe the symptoms are, but how much they matter to this particular patient — two people with identical scores can have very different levels of disruption depending on their lives, responsibilities, and goals.

The screenshot shows the 'Quality of Life' section of the EXPECT patient portal. The header bar is purple with the EXPECT logo and navigation links for 'Patient View', 'PT Provider View', and 'Utah OAIP View'. The 'Patient View' link is active. The main heading is 'Quality of Life' with a subtext 'How your symptoms have affected your life over the past week.' and a progress indicator '11 / 13'. The form contains three sections of questions, each with four radio button options. The first two sections have 'Some' selected, while the third has 'Mostly satisfied' selected.

Quality of Life
How your symptoms have affected your life over the past week.

11 / 13

Over the last week, how much have your symptoms kept you from doing the kinds of things you would usually do?

☐ None
☐ Only a little
☒ Some
☐ A lot

Over the last week, how much did you think about your symptoms?

☐ None
☐ Only a little
☒ Some
☐ A lot

If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

☐ Pleased
☒ Mostly satisfied
☐ Mixed — about equally satisfied and dissatisfied

Quality of life assessment — symptom impact on daily activities

Your History and Goals

The final clinical section shifts from “what is happening now” to “what got you here and what do you want.” For patients presenting with urgency, frequency, or overactive bladder symptoms, the platform conditionally asks about daily caffeinated beverage intake and water intake, as caffeine is a known bladder irritant and both over- and under-hydration can worsen urinary and bowel symptoms.

The screenshot shows a web interface for a patient form titled "Your History & Goals". At the top, there is a navigation bar with the "EXPECT" logo and three tabs: "Patient View" (which is active), "PT Provider View", and "Utah OAIP View". Below the navigation bar, the title "Your History & Goals" is displayed, followed by a subtitle: "A few more questions to help your PT create the best plan for you." In the top right corner of the form area, there is a small purple pill-shaped button containing the text "12 / 13". The form contains three question blocks, each with four radio button options. The first question is "How many caffeinated drinks (coffee, tea, soda, energy drinks) do you have per day on average?". The second question is "How many glasses of water (8 oz) do you drink per day on average?". The third question is "Over the past 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?". In each block, the second option is selected and highlighted with a pink border.

Question	Options	Selected
How many caffeinated drinks (coffee, tea, soda, energy drinks) do you have per day on average?	None 1 per day 2-3 per day 4 or more per day	2-3 per day
How many glasses of water (8 oz) do you drink per day on average?	1-3 glasses 4-5 glasses 6-8 glasses More than 8 glasses	4-5 glasses
Over the past 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?	Not at all Several days More than half the days	Several days

Patient history and goals (page 1)

This section also includes several features that are especially distinctive to the platform, including the Patient Health Questionnaire-2 (PHQ-2), a brief two-question screening tool used to identify possible symptoms of depression. This is deliberate: postpartum women and individuals with chronic pelvic pain carry elevated depression risk, and the comorbidity between pelvic floor dysfunction and depression is well established.

The platform implements a tiered response, from immediate crisis resources through clinician alert and physician notification. On a positive depression screen, the patient is immediately shown a maternal mental-health resource card with crisis lines, peer support, and local maternal mental health referrals — including the 988 crisis line, Huntsman Mental Health Institute mobile crisis team, and the Utah Maternal Mental Health Referral Network.

No patient data is shared; this is a display of resources. Three to five days after intake, the platform sends a brief follow-up with the same resource links. At higher severity, a clinical alert is sent to the reviewing PT with severity stratification, flagging the case for assessment of the patient's capacity to engage with a home exercise program. The PHQ-2 result and severity classification are included in the encounter note sent to the patient's referring physician with a recommendation for full PHQ-9 follow-up within 3-5 days — ensuring mental health follow-up responsibility sits with the appropriate licensed provider. The PT's role is detection, documentation, and routing, not ongoing mental health care. The depression flag is logged as an audit event, surfaced in the OAIP dashboard, and the PT can formally refer the patient to a maternal mental-health support organization via a checkbox documented in the clinical record. PHQ-2 item wording is validated and is not modified by the platform.

The screenshot displays two identical PHQ-2 screening questions. The first question asks, 'Over the past 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?'. The second question asks, 'Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?'. Both questions have four response options: 'Not at all', 'Several days', 'More than half the days', and 'Nearly every day'. In both cases, the 'Several days' option is highlighted with a pink border and text, indicating it is the selected answer.

PHQ-2 close-up — Patient Health Questionnaire-2 depression screening

The penultimate section of the intake captures the functional and behavioral context surrounding the patient's symptoms. The patient identifies which daily activities they are avoiding because of pelvic floor symptoms — exercise, social events, travel, sexual activity, lifting, or none. This is not a clinical instrument, but it is among the most clinically informative questions in the intake: it establishes the real-world cost of the patient's condition and provides a concrete baseline for measuring functional improvement at Week

8. Two patients with identical ICIQ scores may have very different levels of life disruption, and this question captures what the scores alone cannot.

The patient then reports any medications that might affect bladder function — diuretics, antihistamines, antidepressants, and other common drug classes that can cause or worsen urinary symptoms. A follow-up question asks whether the patient is modifying how they take any prescribed medication because of urinary symptoms (e.g., skipping doses or changing timing). An affirmative answer is a safety signal: a patient who stops taking blood pressure medication to avoid leaking has a problem that belongs with the prescribing physician, not a pelvic floor exercise program. A "yes" triggers a medication review referral in the care plan under the DIAPPERS framework — Delirium, Infection, Atrophic urethritis/vaginitis, Pharmaceuticals, Psychological disorders, Excess urine output, Restricted mobility, and Stool impaction — which identifies reversible, often medication-related causes of urinary incontinence.

The patient reports their prior treatment history — whether they have previously tried in-person pelvic floor PT, telehealth PT, self-directed Kegel exercises, pessary, biofeedback, medication, or surgery, or whether this is their first time seeking treatment. This history shapes the reviewing PT's approach: a patient who has never attempted pelvic floor training needs different guidance than one who has completed a full course of in-person therapy without sufficient improvement.

The screenshot displays the 'EXPECT' Patient View interface. The top navigation bar includes 'EXPECT', 'Patient View' (selected), 'PT Provider View', and 'Utah OAIP View'. The main content area contains several questionnaires:

- Are you avoiding activities because of pelvic symptoms? Select all that apply.**
Options: ☒ Exercise or sports, ☐ Social events, ☐ Travel, ☒ Sexual activity, ☐ Lifting (children, groceries, etc.), ☐ None — symptoms don't limit my activities.
- Are you taking any medications that might affect your bladder? (e.g., diuretics, antihistamines, antidepressants)**
Text input: diuretics
- Are you changing how you take any prescribed medication because of urinary symptoms? (e.g., skipping doses, changing timing)**
Options: No, Yes (highlighted in pink), Not sure.
- Have you had any prior treatment for pelvic floor issues?**
Options: ☒ None — this is my first time, ☐ Pelvic floor PT (in-person), ☐ Pelvic Floor PT (telehealth), ☐ Kegel exercises on my own, ☐ Other exercise, ☐ Pessary, ☐ Biofeedback device, ☐ Medication, ☐ Surgery.
- Which instruction style helps you find and activate your pelvic floor muscles?**
Text input: Body function: "Squeeze as if stopping yourself from peeing" (▲ Do not perform while urinating) or "Squeeze as if stopping yourself from passing gas" (don't squeeze your buttock muscles)

Exercise Cues — and Why It Matters

The platform asks each patient how they best receive instruction during physical exercise, then selects and sequences verbal cues in the care plan based on that preference — ensuring the patient receives the cueing approach most likely to produce a correct pelvic floor contraction, not a generic default.

This design is grounded in original research by Expect's own clinical team. Nicole Dugan, PT, DPT — a member of Expect's physical therapy staff — co-authored a 2025 mixed-methods study in the *Journal of Women's & Pelvic Health Physical Therapy*, ranked ninth most downloaded paper in the journal's 50-year history. Surveying 105 licensed pelvic health therapists across 35 states, the study found statistically significant differences in both perceived effectiveness and clinical likelihood of use across cueing strategies ($p < .0001$), with four distinct themes: imaginative language, command-based cues, bowel/bladder function cues, and breathing-coordinated cues. The highest-rated cues differed meaningfully from the most commonly assumed defaults — meaning a one-size-fits-all approach demonstrably leaves outcomes on the table. Expect embeds that research directly into the product. (Crane, Dugan et al., J Women's Pelvic Health Phys Ther, 2025)

Finally, the patient describes in their own words what they most want to be able to do more comfortably. This free-text goal becomes a reference point for the reviewing PT: it anchors the care plan to something meaningful to the patient, not just a number on a scale.

Exercise cueing preference — patient selects preferred instruction style

Step 4: Account Creation (Pre-Submission)

After the last question and before submission, the patient must: confirm their email and create a password. This ensures HIPAA-compliant electronic communication and prevents accidental PHI-adjacent notifications to wrong recipients via email verification.

EXPECT Patient View PT Provider View Utah OAIP View

Create Your Account

Set up your account to securely access your care plan. 13 / 13

Your Login Credentials

Email

pam@theoffice.com

Email from your intake — cannot be changed here

Create Password

8+ characters, 1 uppercase, 1 number

Confirm Password

Re-enter password

Your password must be at least 8 characters with at least 1 uppercase letter and 1 number. This account will be used to access your care plan securely.

← Back Create Account & Submit →

Account creation — secure credential setup before final submission

EXPECT Patient View PT Provider View Utah OAIP View

Create Your Account

Set up your account to securely access your care plan.

13 / 13

Your Login Credentials

Email

pam@theoffice.com

Email from your intake — cannot be changed here

Create Password

Confirm Password

Your password must be at least 8 characters with at least 1 uppercase letter and 1 number. This account will be used to access your care plan securely.

← Back Create Account & Submit →

Account creation — credentials entered with password visibility toggle

EXPECT Patient View PT Provider View Utah OAIP View pam@theoffice.com Report Issue



Thank you, Pam

Your assessment is complete. A licensed Physical Therapist will review your responses and create a personalized treatment plan.

What happens next

PT review within 24 hours → Your care plan will appear here

Intake completion — thank you screen with account confirmation

Step 5: AI Processing

The AI processes the intake in seven steps:

1. Computes validated scores across the full instrument battery: ICIQ-UI SF (0-21), ICIQ-FLUTS subscales — Filling (0-12), Voiding (0-12), and Incontinence (0-20) — ICIQ-FLUTSsex (0-12), GUPI-F (0-45), Pain Composite (0-10), PHQ-2 (0-6), Bristol Stool Scale (Types 1-7), and Constipation Composite (straining frequency + bowel movement frequency + Bristol type, flagged against Rome IV criteria)
2. Classifies incontinence subtype (Stress / Urge / Mixed / Continuous / Unclassified) and assigns a severity tier (Foundation / Beginner / Moderate / Advanced) per validated severity bands, with a Foundation tier for patients presenting without measurable incontinence; computes FLUTS subscale dominance to differentiate filling-predominant from voiding-predominant presentations, which drives meaningfully different treatment pathways even when ICIQ totals are similar
3. Generates ICD-10 diagnoses (including R32 for unspecified urinary incontinence as a fallthrough when subtype classification is indeterminate), including: suspected pudendal involvement flagged via a conservative clinical heuristic requiring mandatory PT review (G57.91); constipation (K59.00) when the Rome IV constipation composite is positive; and sexual dysfunction flagging when FLUTSsex score is non-zero, ensuring the referring physician receives a complete diagnostic picture
4. Risk-stratifies the patient across a four-band color-coded scheme: Red (urgent medical routing — no plan generated; e.g., unexplained vaginal bleeding, urinary retention, fever with pelvic/urinary symptoms, UTI with fever, chest pain, severe headache with visual changes, eclampsia/postpartum-eclampsia screening, severe rectal bleeding); Orange (not eligible until condition-appropriate treating clinician clearance — with the platform's Specialist Approval workflow allowing structured re-entry for returnable conditions; permanent ineligibility for suspected malignancy and neurogenic bladder); Yellow (eligible for the digital pathway with mandatory PT review of every plan and referral recommendation as noted); Green (eligible for the standard path; in the post-pilot earned-autonomy phase, this cohort enters auto-approval with continuous random PT audit, immediate reversion to 100% review after any adverse event, and permanent mandatory review for higher-risk patients). Red flag elevation to OAIP dashboard for any SAFETY_TRIGGER, CLINICAL_REGRESSION_FLAG, or depression_screen_positive audit event
5. Produces a draft treatment plan with personalized exercises — cueing selected per patient-stated learning preference, grounded in Crane & Dugan et al. (2025) — adjuncts drawn from the clinical library, precautions, and progression criteria; bowel management adjuncts are

- automatically added when the constipation composite is positive;
sexual health adjuncts are surfaced when FLUTSsex score is non-zero
6. If the patient has an active PRENATAL_FLAG, applies prenatal exercise substitutions and removes contraindicated positions (see Section 3.8, Prenatal Pelvic Floor Protocol)
 7. Stamps the plan with a clinical logic version identifier (CLINICAL_LOGIC_VERSION), enabling traceability of which algorithm version generated each plan. This version is also embedded in outcome records and audit events, ensuring that any future protocol refinement can be correlated with the exact algorithm state that produced prior results.

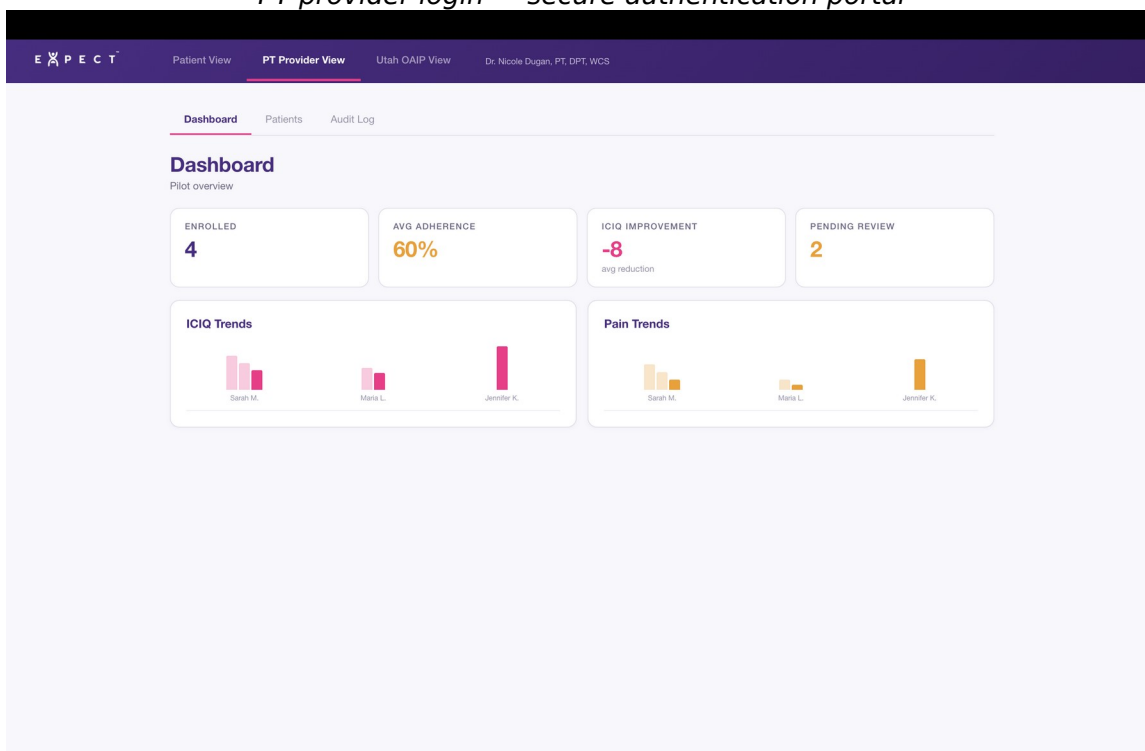
The AI drafts; clinicians decide. Autonomy is never granted — it is earned case-by-case, is always partial, and is revoked automatically on any safety signal.

Step 6: PT Review (Phase 1: 100% of Plans)

Once a patient completes their intake, a Utah-licensed physical therapist (PT) receives the complete intake in their provider dashboard, including all raw patient responses (expandable by section with scoring verification), computed scores, AI-generated diagnoses, eligibility screening results, PHQ-2 score, and the full treatment plan. The PT can edit every element: goals, exercises, adjunct recommendations, precautions, and progression criteria.

PTs access the provider portal via individual accounts (email + password, with hardened credential storage). Each PT's identity is captured in every audit event, enabling individual accountability and modification tracking. The provider view has three sub-tabs: (1) a Dashboard showing enrolled patients (fetched from the HIPAA-compliant database in real time, displaying name, submission date, ICIQ score, pain score, plan status, and review flags), average adherence, ICIQ/pain score trends, and pending reviews; (2) a Patients tab for reviewing individual cases, accessing full intake data, and managing care plans; and (3) an Audit Log with a de-identification toggle for PHI-safe review. A review timer is prominently displayed at the top of each case for CMS documentation.

PT provider login — secure authentication portal



PT provider dashboard — enrolled patients overview

EXPECT

Patient ViewPT Provider ViewUtah OAIP ViewDr. Nicole Dugan, PT, DPT, WCS

DashboardPatientsAudit Log

Patient Caseload

2 pending review - 4 total

New Intake — Pam Beasley

Completed just now - AI plan generated - Awaiting your review

Safety Answer Changed

Prolapse — Mild Symptoms

Review Now

PATIENT	ICIQ	PAIN	ADHERENCE	STATUS	NEXT RA
Sarah M. Age 32 - OB/GYN Week 6 Complete98/77 MetHigh Severity ICIQ	8 Moderate	2 Mild	87%	Active	02/26
Maria L. Age 28 - S&F 98/77 Met	7 Moderate	1 Mild	93%	Active	02/19
Jennifer K. Age 35 - Medicaid High Severity ICIQ	18 Severe	6 Moderate	0%	Review	02/24

PT caseload — new patient cards with ICIQ scores, pain scores, and review flags

EXPECT

Patient ViewPT Provider ViewUtah OAIP ViewDr. Nicole Dugan, PT, DPT, WCS

Safety Screening

CHANGED

Are you experiencing any unexplained vaginal bleeding?

No

Do you currently have a fever — temperature above 100.4°F (38°C)?

No

Are you experiencing any chest pain or difficulty breathing?

No

Do you have a severe headache along with any changes in your vision?

No

Are you experiencing burning during urination, blood in your urine, or frequent urination along with a fever?

No

SAFETY ANSWER CHANGED

Patient initially answered "Yes" to safety question(s) but later changed to "No":

• r.fever — changed at 10:53:29 AM

This answer change has been flagged in the encounter note and OAIP compliance log.

Eligibility Screening

Eligible

Refer patient to PSI Utah for maternal mental health support

Referral logged. This will be included in the encounter note sent to the referring physician.

ICIQ-UI Short Form

11/21 - Moderate

FLUTS — Filling

F: 2/12

FLUTS — Voiding

V: 0/12

POPDII-6 — Prolapse Screening

3/6 positive

FLUTSsex

Score: 4

GUPI + Pain

GUPI: 13/45 - Pain: 2/10

ICD-10 Diagnosis (AI Generated)

PT review — safety screening flags highlighted for attention

Public edition · August 2026 · Expect Fitness, Inc. · Complete version on file with Utah OAIP

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EXPECT Patient View **PT Provider View** Utah OAIP View Dr. Nicole Dugan, PT, DPT, WCS

ICIQ-UI Short Form 11/21 - Moderate

FLUTS — Filling F: 2/12

FLUTS — Voiding V: 0/12

POPD1-6 — Prolapse Screening 3/6 positive

FLUTSsex Score: 4

GUPI + Pain GUPI: 13/45 - Pain: 2/10

ICD-10 Diagnoses (AI-Generated)

N39.46 Mixed incontinence N94.89 Pelvic pain condition N94.10 Dyspareunia K59.00 Constipation, unspecified

N81.9 Pelvic organ prolapse, unspecified (suspected — exam confirmation recommended)

• Risk: Yellow — Elevated

Treatment Plan (Editable) Review

Goals (edit below)

Reduce ICIQ from 11 by ≥3 pts in 8 wks
 Improve bladder control confidence
 Reduce pain from 2/10 to ≤0/10
 Patient goal: "Exercise without leaking"

Exercise Prescription - Daily HEP + weekly check-in - 8 wks (reassess wk 4,8) + Add Exercise

Name	Sets	Reps	Hold	Freq
Quick-Flick Kegels	3	10	1s on/1s off	daily

PT review — ICIQ scores collapsed view with severity classification

EXPECT Patient View **PT Provider View** Utah OAIP View Dr. Nicole Dugan, PT, DPT, WCS

ICIQ-UI Short Form 11/21 - Moderate

How often do you leak urine? Several times a day +4

How much urine do you usually leak, whether you wear protection or not? A small amount +2

Overall, how much does leaking urine interfere with your everyday life? Please p... 5/10 +5

Under what circumstances does urine leak? Please select all that apply to you. Leaks before you can get to the toilet, Leaks when you cough or sneeze, Leaks when you are physically active or exercising

→ Mixed UI

FLUTS — Filling F: 2/12

FLUTS — Voiding V: 0/12

POPD1-6 — Prolapse Screening 3/6 positive

FLUTSsex Score: 4

GUPI + Pain GUPI: 13/45 - Pain: 2/10

ICD-10 Diagnoses (AI-Generated)

N39.46 Mixed incontinence N94.89 Pelvic pain condition N94.10 Dyspareunia K59.00 Constipation, unspecified

N81.9 Pelvic organ prolapse, unspecified (suspected — exam confirmation recommended)

• Risk: Yellow — Elevated

Treatment Plan (Editable) Review

Goals (edit below)

Reduce ICIQ from 11 by ≥3 pts in 8 wks
 Improve bladder control confidence
 Reduce pain from 2/10 to ≤0/10
 Patient goal: "Exercise without leaking"

PT review — ICIQ scores expanded with full instrument responses

EXPECT Patient View **PT Provider View** Utah OAIP View Dr. Nicole Dugan, PT, DPT, WCS

Treatment Plan (Editable) Review

Goals (edit below)

Reduce ICIQ from 11 by ≥3 pts in 8 wks
 Improve bladder control confidence
 Reduce pain from 2/10 to ≤0/10
 Patient goal: "Exercise without leaking"

Exercise Prescription · Daily HEP + weekly check-in · 8 wks (reassess wk 4,8) + Add Exercise

Name	Sets	Reps	Hold	Freq
Quick-Flck Kegels	3	10	1s on/1s off	daily
Endurance Kegels	3	10	5-10s	daily
Bridge + PF	2	10	5-10s	3x/wk
Diaphragmatic Breathing + PF	1	5	full cycle	daily

Recommended Adjuncts & Devices

- behavioral** **Bladder Training Program**
 Timed voiding schedule with progressive interval increases. Start with current voiding interval, increase by 15 min every 1-2 weeks. Include urge suppression techniques.
 Rx: Begin immediately alongside exercise program.
- device** **Vaginal Dilator Therapy**
 Graduated plastic or silicone dilator set for desensitization and tissue mobility.
 Rx: Start smallest size, progress per tolerance.
- behavioral** **Bowel Management Program**
 Toileting posture (squatting potty), fiber/fluid optimization, defecation dynamics training.
 Rx: Address constipation — straining worsens PF dysfunction.

PT review — AI-generated treatment plan with exercise prescription editing

The Expect platform is robust. To reduce documentation burden when adding adjunct recommendations, the platform includes a clinical shorthand expansion library. When a PT types a keyword — such as "pessary," "biofeedback," or "TENS"— the platform matches it against a curated reference library and auto-populates the full clinical description, dosing recommendation, and patient-facing language. This ensures consistency across PTs and eliminates the need to write adjunct descriptions from scratch for commonly prescribed interventions.

Pre-approval guardrails warn the PT if: review time is under 2 minutes, safety, depression or eligibility flags were positive, a safety answer was changed during intake, nerve pain indicators are present, the plan seems inconsistent with scores, modifications lack documented rationale, or the patient has an active prenatal protocol. The platform generates an editable encounter note which follows the standard SOAP format—Subjective, Objective, Assessment, and Plan—and is commonly used in healthcare documentation and billing and aligns with Centers for Medicare & Medicaid Services (CMS) documentation expectations.

The screenshot displays the 'PT Provider View' interface for Dr. Nicole Dugan, PT, DPT, WCS. At the top, there are tabs for 'Patient View', 'PT Provider View' (selected), 'Utah OAIP View', and 'Dr. Nicole Dugan, PT, DPT, WCS'. Below the tabs, there are two input fields: 'No lifting >15 lbs first 4 wks' and 'Adherence ≥80% × 2wk → add functional progressions'. A 'CPT Codes' section shows '97161 PT Eval - Low Complexity - 1u'. The main section is titled 'PT Review' with a timer '04:16' and a 'Pause' button. It includes a 'Clinical Notes / Modifications / Rationale' text area with the placeholder 'Document your clinical reasoning, any modifications, and rationale...'. Below this is a 'Regenerate Encounter Note' button. The 'Encounter Note (editable - review before approving)' section contains a 'Copy' button and a text area with the following content: 'Frequency: Daily HEP + weekly check-in. Duration: 8 wks (reassess wk 4,8).', 'CPT: 97161 - PT Eval - Low Complexity (1u)', 'Review time: 3m 51s', 'ATTESTATION: I have reviewed the AI-generated assessment, the patient's individual responses, and the treatment plan. This reflects my independent clinical judgment.', and 'Signed: [PT Name, DPT] - 2026-03-17T15:54:11.870Z'. At the bottom, a 'Pre-Approval Checks' section shows a warning: '! SAFETY ANSWER CHANGED: Patient initially indicated a safety concern but later changed their answer. Questions changed: rf_fever. Verify this was appropriate.' Below the warning are two buttons: 'Go Back & Fix' and 'I've reviewed - Approve Anyway'.

Pre-approval guardrail warnings displayed to PT before plan approval

Upon approval, the PT review interface confirms the provider routing destination; encounter notes are transmitted to the referring physician via HIPAA-compliant channels with verified destinations.

Step 7: Notification & Distribution

Upon approval, the encounter note is transmitted to the referring physician via HIPAA-compliant channels with verified destinations. If destination verification is pending, transmission is held until the destination is verified.

Over the course of an episode of care, the referring provider receives milestone notifications — a PT-reviewed Week 8 outcome summary, the Week 16 episode-closure note, and a PT-reviewed Month 12 outcome summary — plus condition-triggered notifications: depression-screening findings in the encounter note, red-flag halts, and any reported surgical referral or ER/urgent-care visit, transmitted when the event is first reported through any channel (Report a Problem, any check-in, or PT contact).

In Phase 2+, low-complexity cases may receive expedited review or auto-approval with continuous random human audit and immediate reversion to 100% review after any adverse event; high-complexity cases always receive full PT review. Case complexity is determined by the risk-band and review-flag system: any Orange-band history, Yellow-band condition, or active

clinical review flag classifies a case as high-complexity with mandatory full PT review; ICIQ severity is an input to that classification rather than the definition itself. See Section 3.1 for phase details.

Protocol Refinement from PT Feedback

Every time a PT reviews a care plan, the platform records what they changed and what they left alone. Over time, these decisions add up. The clinical team reviews the patterns — which exercises PTs consistently adjust, which recommendations they add, which thresholds they override — and uses that data to update the care plan rules. If PTs are routinely increasing hold times for a certain severity level, the team adjusts the rule so the platform generates the right prescription from the start. All updates are documented, versioned, and reported to OAIP before going live. This is clinicians refining the protocol based on evidence, not the system rewriting itself.

There is currently no standardized protocol for pelvic floor muscle training — a gap noted consistently across the research literature. The Expect pilot is structured to generate exactly this kind of data: a longitudinal record linking each patient's clinical profile to the care plan the platform generated, what the PT changed, and how the patient responded. Every plan approved as-is validates the current rules. Every modification identifies where they can be improved. The platform tracks agreement rates — the percentage of plans a PT approves without substantive changes — and reports them to OAIP monthly alongside modification patterns and cases of full override. The Phase 2 benchmark is 95% agreement: on 95 out of 100 cases, the PT approves the plan as generated. This creates a feedback loop in which clinical oversight does not merely check the platform's work — it actively makes the protocol better — and in which a Utah regulatory pilot generates clinical knowledge with national implications.

An immutable audit log records every action with the individual PT's identity for regulatory compliance.

Patient Report

After the PT sends the approved report to the patient (in Phase 1), the patient receives a HIPAA-compliant notification email: "You have a new document available in your secure Expect portal." No PHI appears in the email. The patient logs into the portal to view their full care plan.



Hi Pam,

You have a new document available in your secure Expect portal.

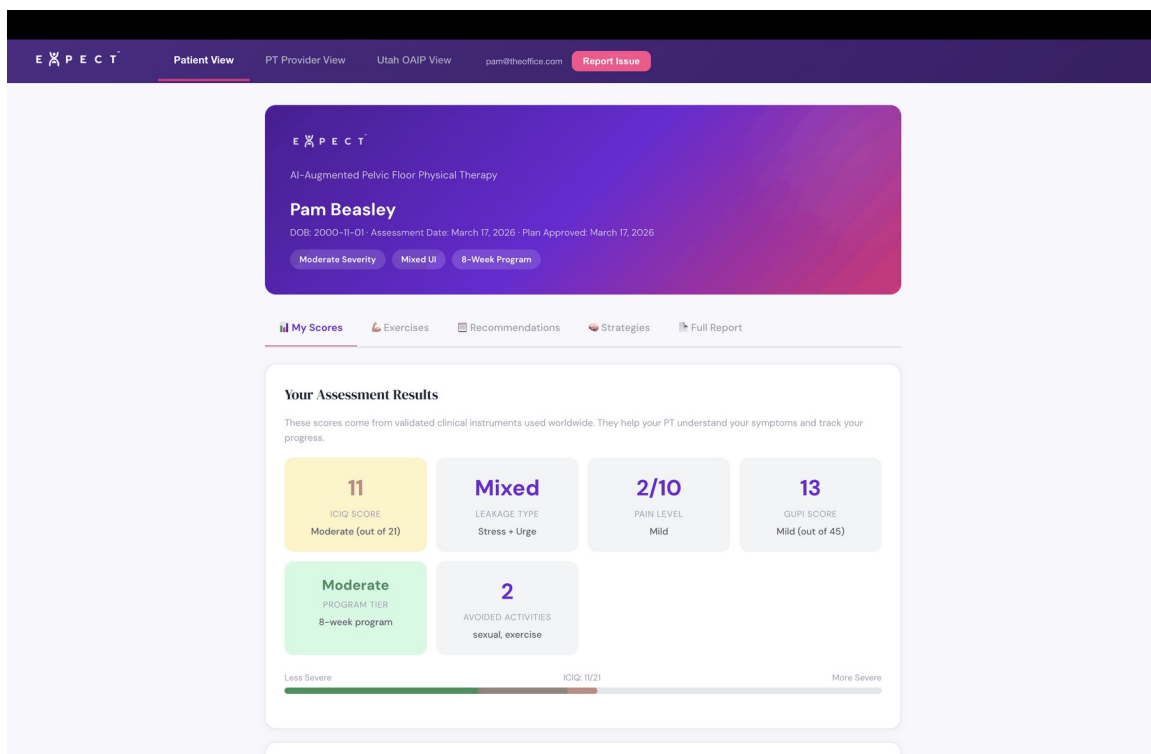
[Sign in to View](#)

For your security, this link will expire in 24 hours. If you did not request this, please ignore this email. Do not reply to this email. This inbox is not monitored.

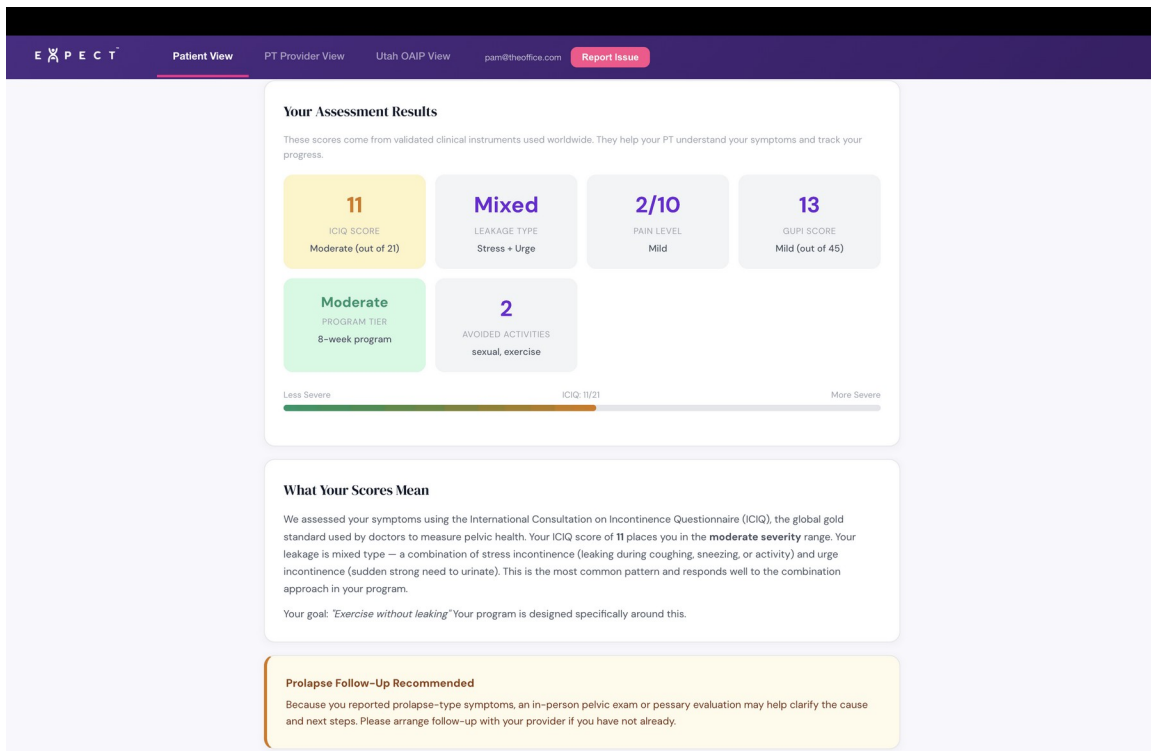
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Step 8: Care Plan Delivery & Ongoing Care

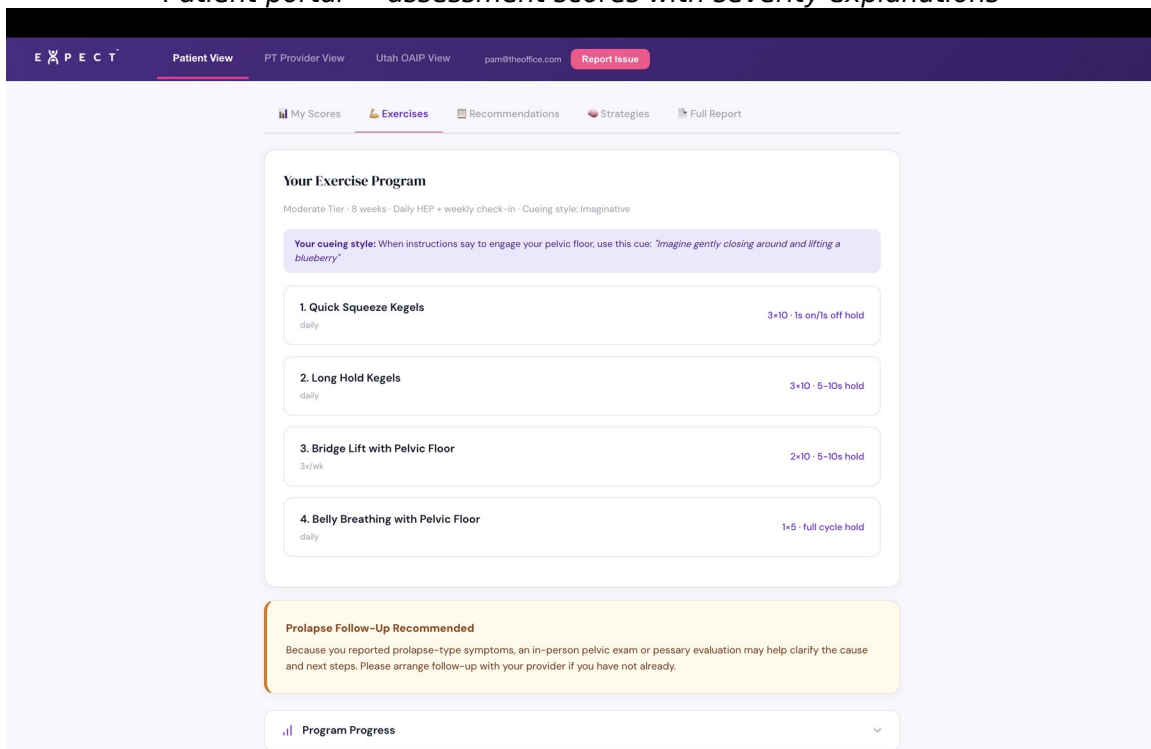
The patient views their personalized care plan in the secure portal across five tabs: Scores, Exercises, Recommendations, Strategies, and Full Report. An "Export for MyChart / EHR" button lets patients download a client-side PDF and upload it to their health system's patient portal — no PHI is transmitted externally.



Patient portal — care plan overview with assessment summary



Patient portal — assessment scores with severity explanations



Patient portal — exercises overview tab

EXPECT Patient View PT Provider View Utah OAIP View pam@theoffice.com **Report Issue**

My Scores Exercises Recommendations Strategies Full Report

Your Exercise Program

Moderate Tier - 8 weeks - Daily HEP + weekly check-in - Cueing style: Imaginative

Your cueing style: When instructions say to engage your pelvic floor, use this cue: "imagine gently closing around and lifting a blueberry"

1. Quick Squeeze Kegels

daily 3x10 - 1s on/1s off hold

- 1 Sit or lie comfortably.
- 2 **Imagine gently closing around and lifting a blueberry** as quickly and strongly as you can.
- 3 Immediately release completely.
- 4 Rest 2-3 seconds between each squeeze.
- 5 Do 8-10 squeezes per set, 2 sets.

Common mistakes: Holding the squeeze too long — this is about speed. Not fully releasing between squeezes. Holding your breath. Using buttock or thigh muscles.

Stop if: Stop if pain above 3/10.

Practice right before you cough, sneeze, or lift. This 'brace before you sneeze' technique (The Knack) is one of the most effective leak-prevention strategies.

2. Long Hold Kegels

daily 3x10 - 5-10s hold

- 1 Lie on your side with a pillow between knees.
- 2 Gently **imagine gently closing around and lifting a blueberry** to about 50-70% effort.
- 3 Hold for 5 seconds while breathing normally.

Patient exercises — personalized instructions with cueing

EXPECT Patient View PT Provider View Utah OAIP View pam@theoffice.com **Report Issue**

3. Bridge Lift with Pelvic Floor

3x/wk 2x10 - 5-10s hold

- 1 Lie on your back, knees bent, feet flat hip-width apart. Arms at sides. Spine neutral.
- 2 Inhale into your diaphragm to prepare.
- 3 Exhale — engage pelvic floor FIRST — lift a blueberry, then lift hips to a straight line from shoulders to knees.
- 4 Hold 5-10 seconds at top, breathing normally.
- 5 Slowly lower. Fully release pelvic floor.
- 6 Repeat 10 times, 2 sets.

Common mistakes: Lifting before engaging PF. Arching lower back. Moving too fast. Forgetting the pelvic floor engagement. Not fully releasing at bottom.

Stop if: Stop if low back pain or pelvic pressure. Back pain = core fatigue.

As this gets easier, try lifting one foot slightly at the top (marching bridge). Build to 10s holds.

4. Belly Breathing with Pelvic Floor

daily 1x5 - full cycle hold

- 1 Lie on your back with knees bent. One hand on chest, one on belly.
- 2 Breathe IN through nose for 4 seconds. Belly rises. Chest stays still. Pelvic floor relaxes.
- 3 Breathe OUT through pursed lips for 6 seconds. Gently lift your pelvic floor as you exhale.
- 4 EXHALE = gentle pelvic floor lift. INHALE = full pelvic floor release.
- 5 Do 5 full breath cycles. Rest 30 seconds. Repeat (2 sets).

Common mistakes: Breathing too fast — 4 seconds in, 6 seconds out. Only breathing into chest — make belly rise. Forgetting to fully relax on inhale. Tensing neck and shoulders.

Stop if: Should never cause pain. If dizzy, return to normal breathing.

The most important exercise in your program. Practice while watching TV, before sleep, during feeding time.

Patient exercises — common mistakes and stop conditions

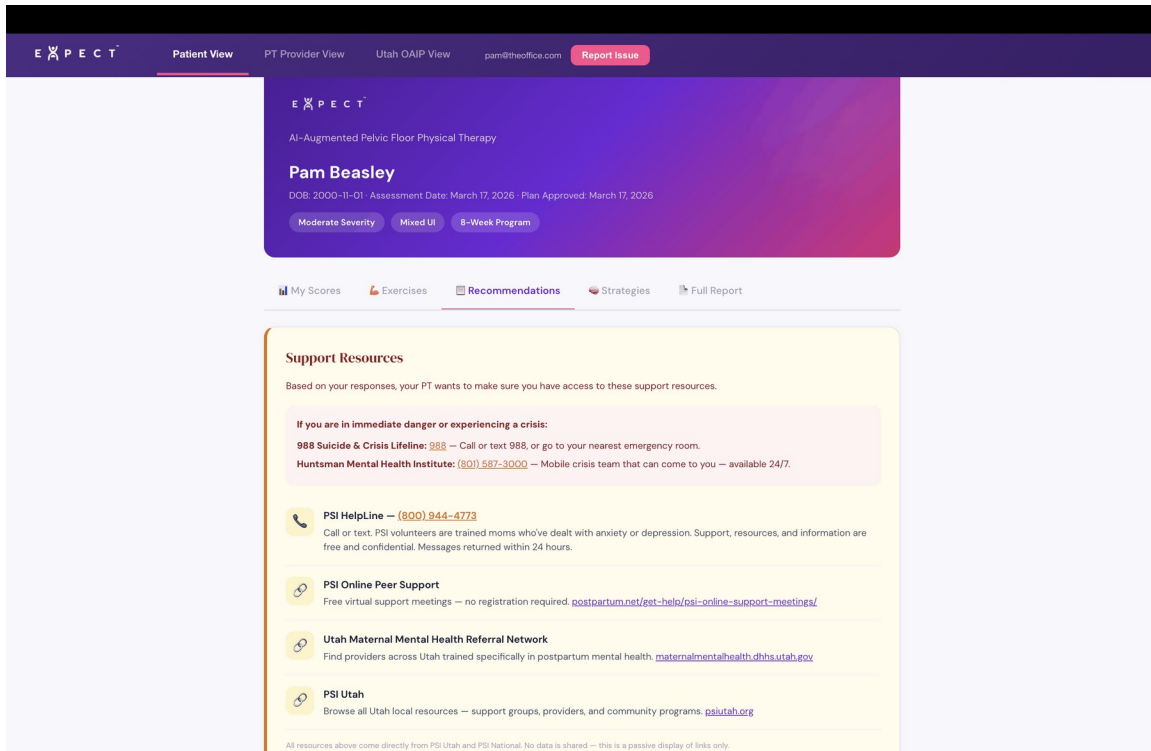
Patients may report concerns at any time through a persistent "Report a Problem" button offering six pathways: pain during exercises (severity

slider), worsening symptoms (severity-based triage into Critical / High / Moderate tiers), adverse events (categorized by type), instruction clarity questions, AI opt-out requests, and technical issues. All reports are logged in the immutable audit trail and surfaced in the OAIP safety dashboard.

Expect commits to a maximum response time for each severity tier of these pathways and for each clinical alert type (depression-screening alerts, ICIQ non-improvement, and surgical-referral escalation). Critical-tier reports and adverse events obligate outbound patient contact by the care team — a call or telehealth offer — within the committed windows, distinct from, and in addition to, PT review of the flagged case; lower tiers obligate review with contact at PT discretion.

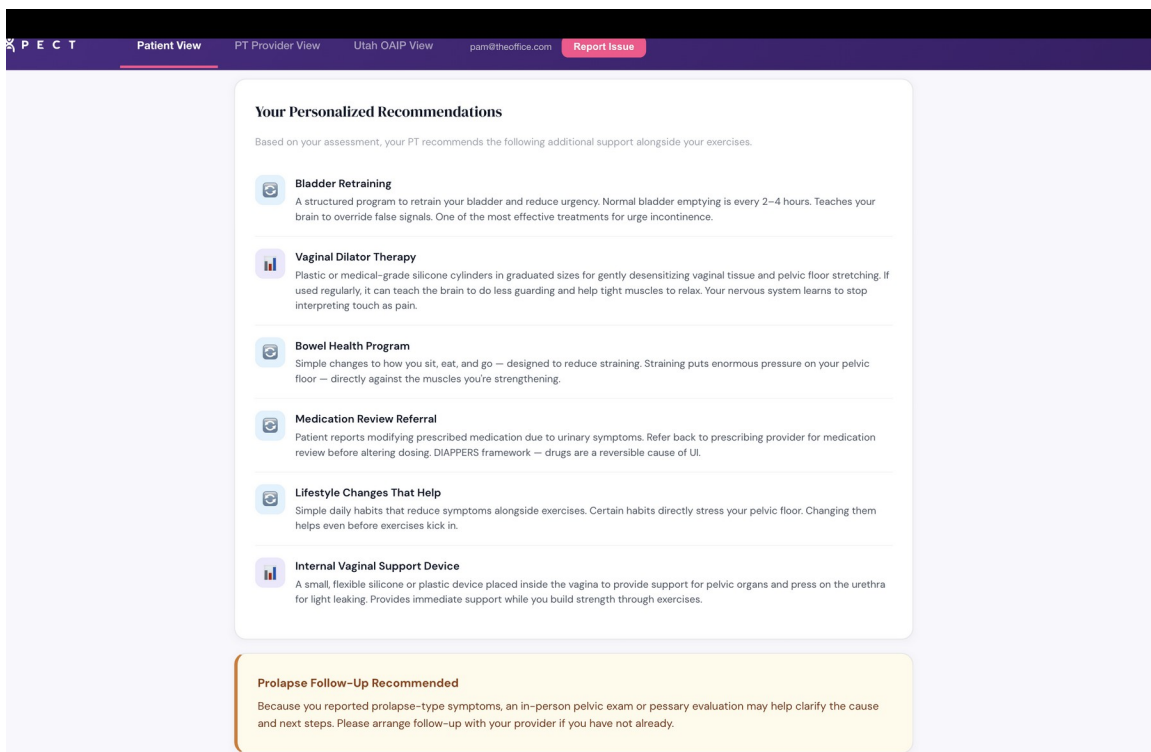
The screenshot displays the Expect Patient portal interface. At the top, a navigation bar includes 'Patient View', 'PT Provider View', 'Utah OAIP View', and a 'Report Issue' button. The main content area shows a patient profile for Pam Beasley, an AI-Augmented Pelvic Floor Physical Therapy patient, with a 'Report a Problem' overlay on the right. The overlay lists six reporting pathways: 1. I have pain during exercises, 2. My symptoms are getting worse, 3. I'm experiencing a new symptom, bleeding, or adverse reaction, 4. I don't understand the instructions, 5. I want to opt out of AI-assisted care, and 6. Technical issue with the platform. The main content area also shows a 'Your Exercise Program' section with a list of exercises, including '1. Quick Squeeze Kegels'.

Patient portal — Report a Problem with six reporting pathways

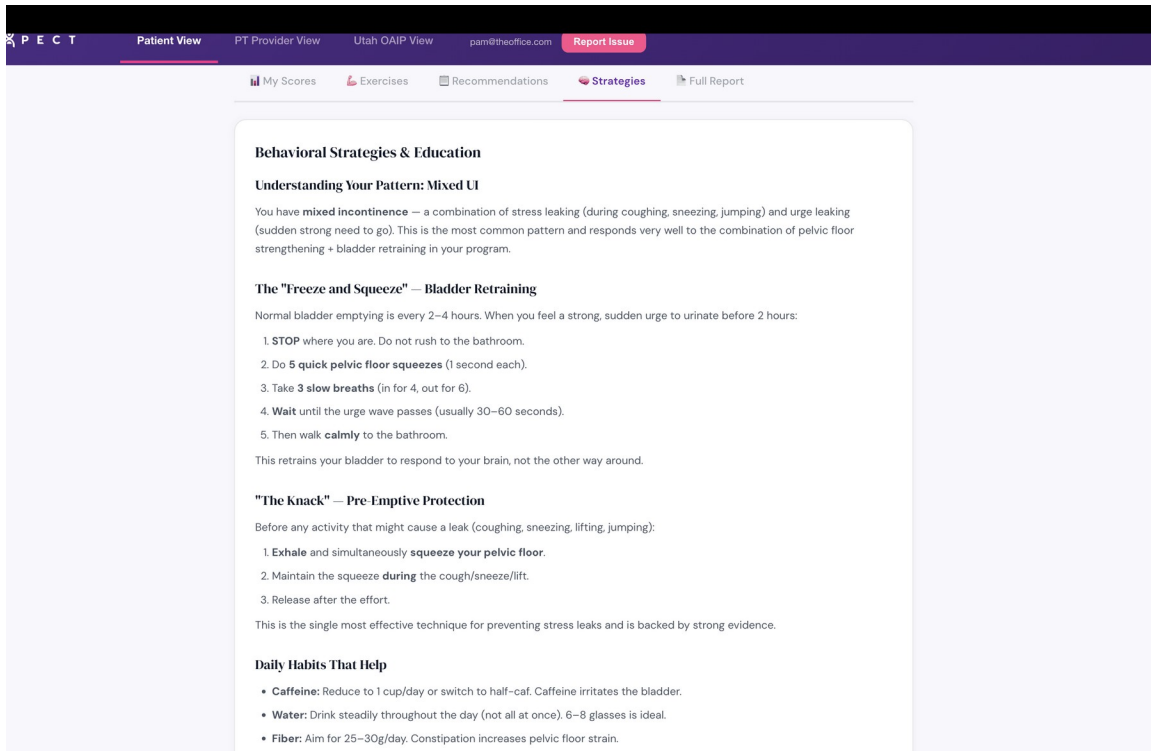


Patient portal — support resources and crisis line information

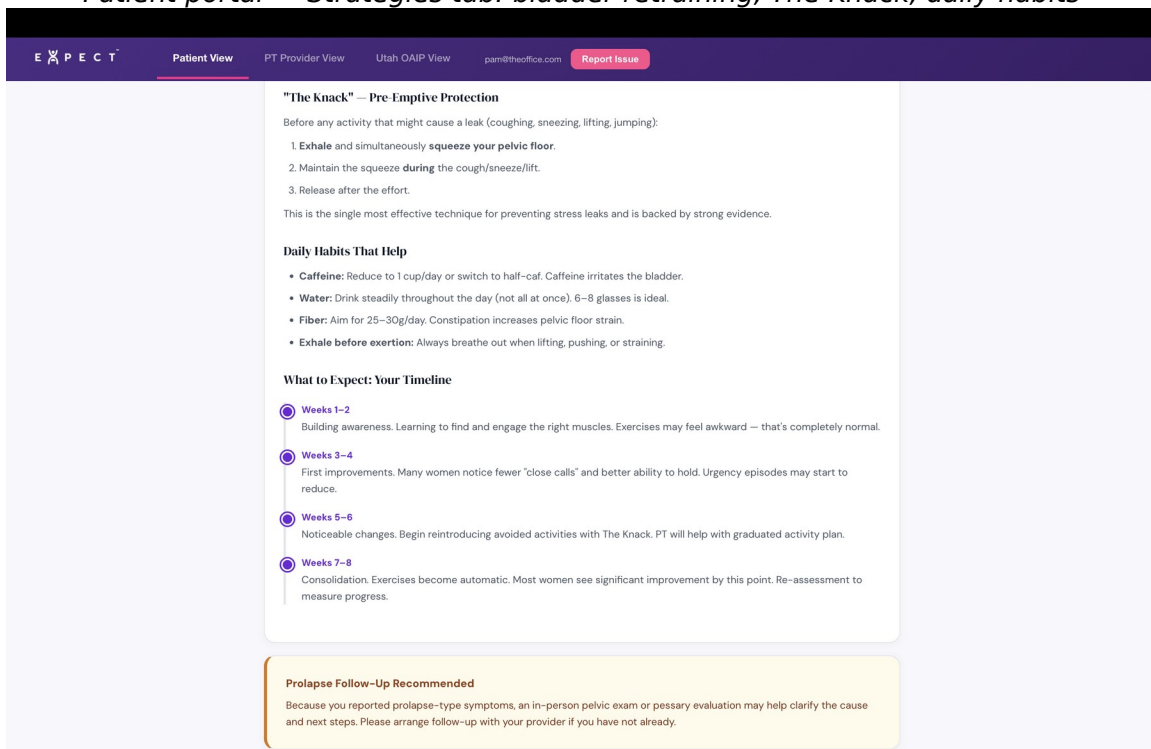
Patients with positive prolapse symptoms see a persistent recommendation for in-person pelvic exam or pessary evaluation



Patient portal — Recommendations tab: adjunct devices and behavioral programs



Patient portal — Strategies tab: bladder retraining, The Knack, daily habits



Patient portal — Timeline: what to expect over the program duration

The screenshot displays the 'Patient View' interface for 'Expect'. The navigation bar includes 'Patient View', 'PT Provider View', 'Utah OAIP View', 'pam@theoffice.com', and a 'Report Issue' button. The main content area is divided into three sections: 'Exercise Prescription', 'Adjunct Recommendations', and 'Plan Details'. Below these is a 'PT Attestation' box.

Exercise Prescription	
Quick Squeeze Kegels	10 reps x 3 sets, 1s on/1s off hold, daily
Long Hold Kegels	10 reps x 3 sets, 5-10s hold, daily
Bridge Lift with Pelvic Floor	10 reps x 2 sets, 5-10s hold, 3x/wk
Belly Breathing with Pelvic Floor	5 reps x 1 sets, full cycle hold, daily

Adjunct Recommendations	
Bladder Retraining	Begin immediately alongside exercise program.
Vaginal Dilator Therapy	Start smallest size, progress per tolerance.
Bowel Health Program	Address constipation — straining worsens PF dysfunction.
Medication Review Referral	Urgent: contact prescribing provider.
Lifestyle Changes That Help	Standard behavioral component of PF PT.
Internal Vaginal Support Device	Discuss with PT at review. Refer to urogynecology if symptoms persist or worsen.

Plan Details	
Frequency	Daily HEP + weekly check-in
Duration	8 wks (reassess wk 4,8)
Goal	Exercise without leaking
Precautions	Stop if pain >3/10 · Report bleeding/fever/UTI immediately · No lifting >15 lbs first 4 wks

PT Attestation

I have reviewed the AI-generated assessment, the patient's individual responses, and the treatment plan. This plan reflects my independent clinical judgment and is appropriate for this patient's presentation.

Signed: Nicole L. Dugan, PT, DPT, WCS — March 18, 2026

Plan status: Approved · Plan ID: TP-1773826565749

Patient portal — Full Report: clinical summary with PT attestation (page 2)

The platform is not designed to replace in-person pelvic floor PT — it is designed to work alongside it. When a patient's assessment triggers any of six clinical criteria — symptomatic prolapse, suspected pudendal neuralgia (nerve pain), positive depression screen, severe incontinence, significant pelvic pain, or vaginal bulge — the platform presents a warm handoff: a referral card showing the clinical reasons for the recommendation, a curated in-person provider with location, accepted insurance, and a click-to-call button, guidance on what to tell the clinic, and a "Request help finding care" option for patients who need assistance. This card appears at three points: after intake while awaiting PT review, in the care plan Recommendations tab, and in the printable Clinical Summary. The reviewing PT also sees the referral recommendation and can verify the routing or document modifications. The message to the patient is clear: if your symptoms suggest you need in-person care, we will help connect you.

(The PT review interface also displays the in-person referral recommendation, including the clinical triggers and the recommended provider, so the reviewing PT can verify the routing is appropriate and document any modifications.)

The patient follows the home exercise program with daily adherence logging, visible to both the patient (via an adherence heatmap) and the supervising

PT. Patients may opt in to daily push notifications reminding them to log exercises, delivered via Web Push API with no app install required. At Week 8, patients complete follow-up assessments and see contextual guidance based on their symptom trajectory — moderate concern patients are advised their PT will review updated recommendations, while high concern patients are directed to contact their provider promptly.

OAIP Oversight Experience

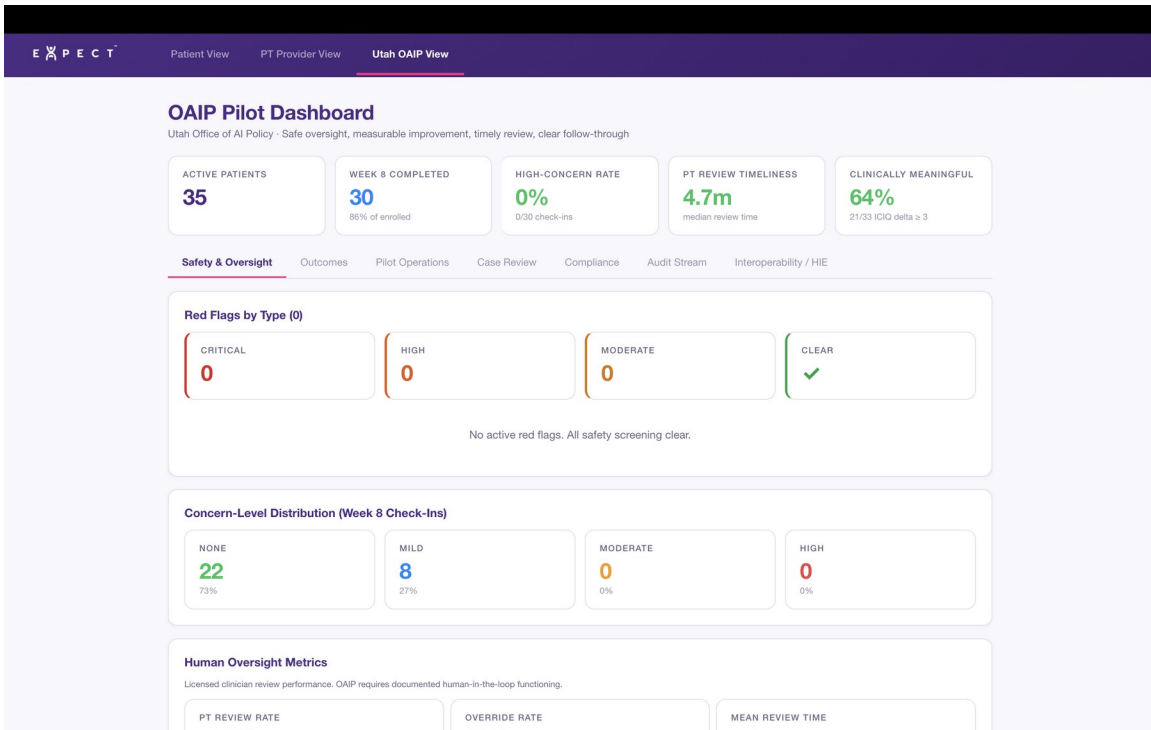
The OAIP has a dedicated compliance dashboard with seven views:

1. Safety & Oversight: Red flags grouped by severity and type, concern-level distribution from Week 8 check-ins, human oversight metrics (PT review completion rate, override/modification rate, mean and median review time, plans reviewed under 2 minutes, plan rejections, out-of-scope escalations), follow-up completion tracking, and baseline detection rates.
2. Outcomes: Aggregate baseline-to-Week-8 deltas across instruments, clinically meaningful improvement rate, worsening rates by domain and tier, adherence summary, outcomes by tier, equity and demographic analysis, long-term Month 12 outcomes, and biomarker discovery signals (see Section 5.3).
3. Pilot Operations: Completion funnel (intake submitted through Month 12), dropout analysis by stage, and follow-up schedule with overdue alerts.
4. Case Review: De-identified drill-down for flagged cases and AI-PT agreement detail with modification breakdowns.
5. Compliance: Phase status checklist and action buttons.
6. Live Audit Stream: Full event log with de-identification toggle (see Section 4.3).
7. Interoperability / HIE: FHIR R4 resource preview supporting future integration with Utah's statewide health information exchange and regional health-system HIE networks.

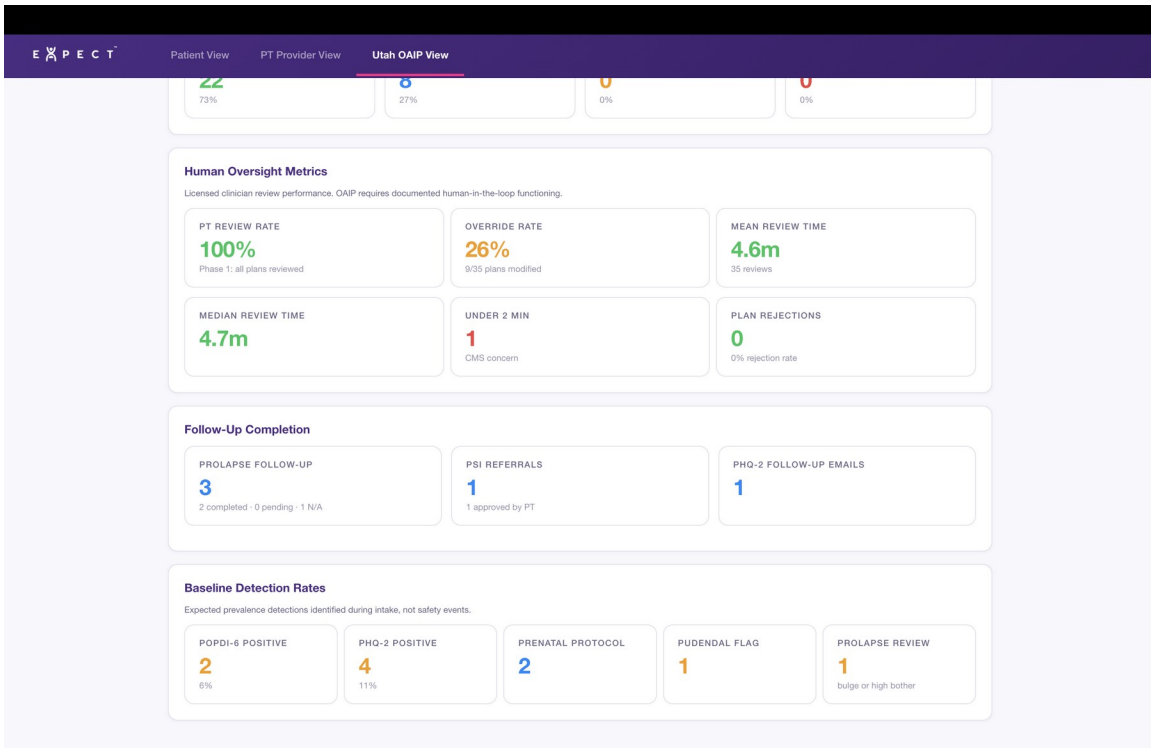
Details of each view are described in Appendix A.

The OAIP can access de-identified datasets, monthly/quarterly reports, and the full audit log at any time.

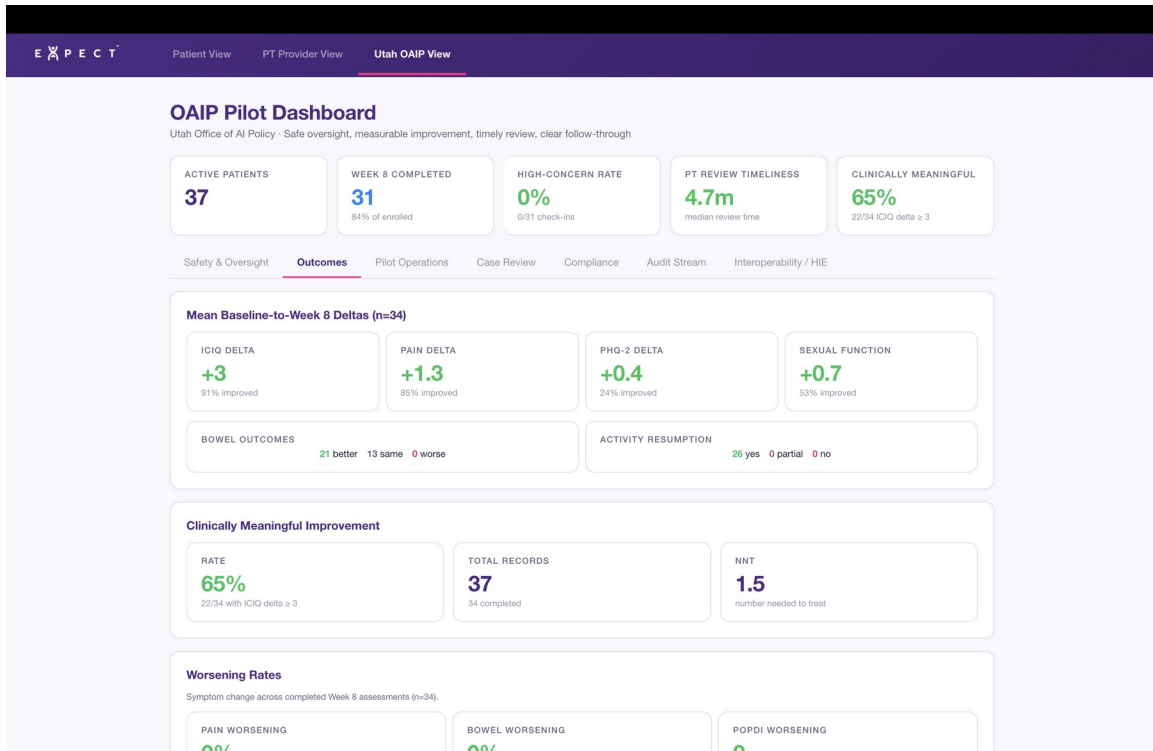
Quality of life measures collected at intake and at the Week 8 follow-up provide the primary patient-reported outcome data for OAIP pilot evaluation. While clinical instrument scores (ICIQ-UI SF, GUPI, FLUTS) measure symptom severity, quality of life data measures functional impact — whether the patient is avoiding fewer activities, experiencing less interference with daily responsibilities, and reporting improved emotional well-being. These paired measures allow the pilot to report not only whether AI-augmented care plans produce clinically meaningful symptom reduction, but whether that reduction translates to real improvements in how Utahns live, work, and participate in their communities. This is particularly relevant for the pilot's target populations — rural residents, Medicaid beneficiaries, and postpartum women — where access barriers mean that without this platform, many would receive no pelvic floor care at all. The quality of life delta between intake and follow-up provides the clearest evidence of whether AI-assisted clinical decision support, under PT oversight, can extend effective care to populations that the existing specialist workforce cannot reach.



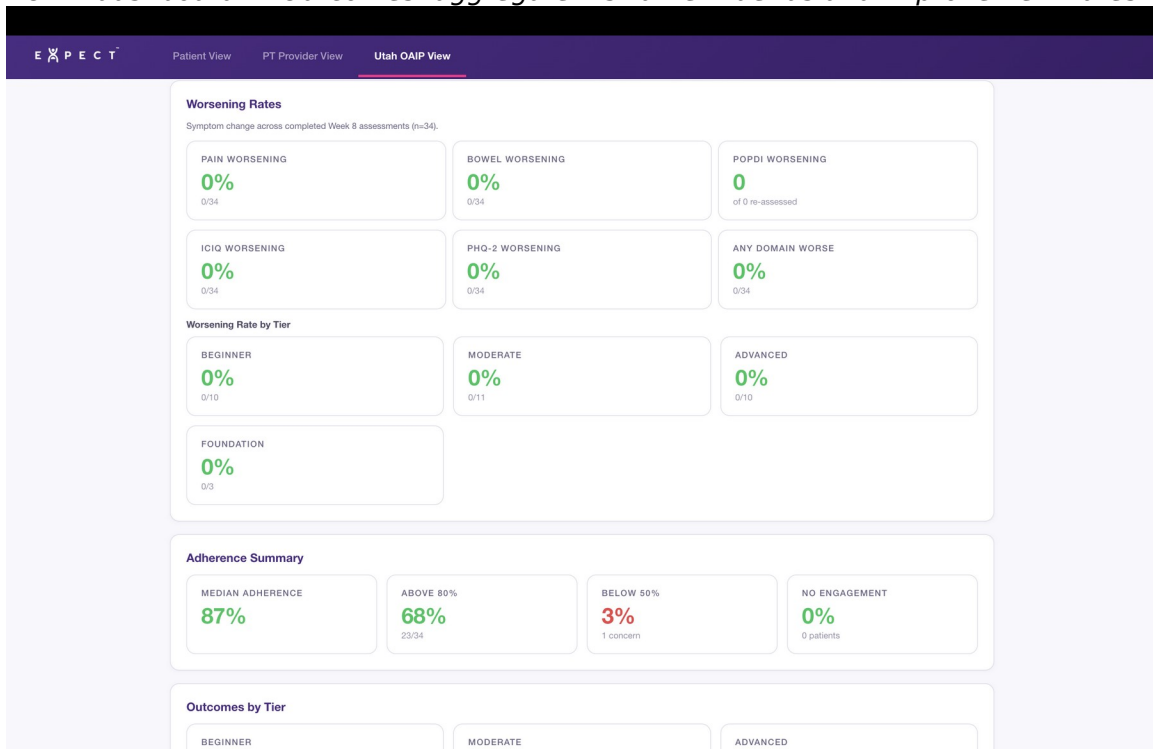
OAIP dashboard — Safety and Oversight: red flags, concern levels, and human oversight metrics



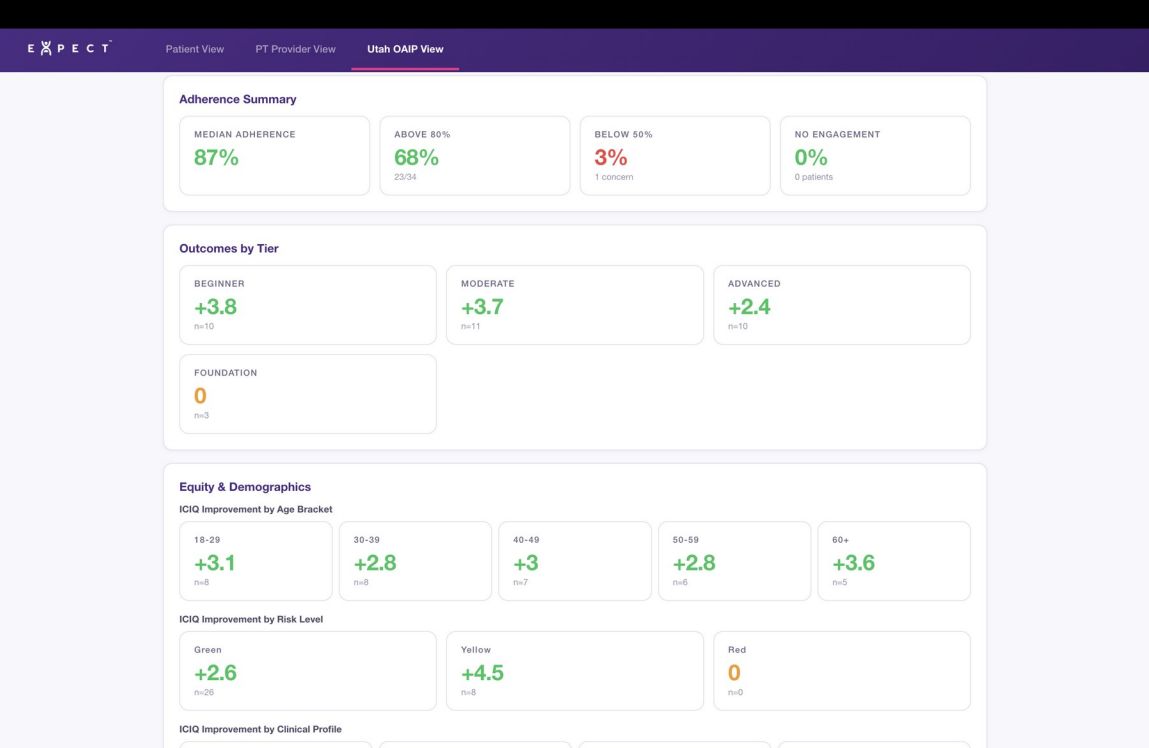
OAIP dashboard — Safety and Oversight: follow-up tracking and detection rates



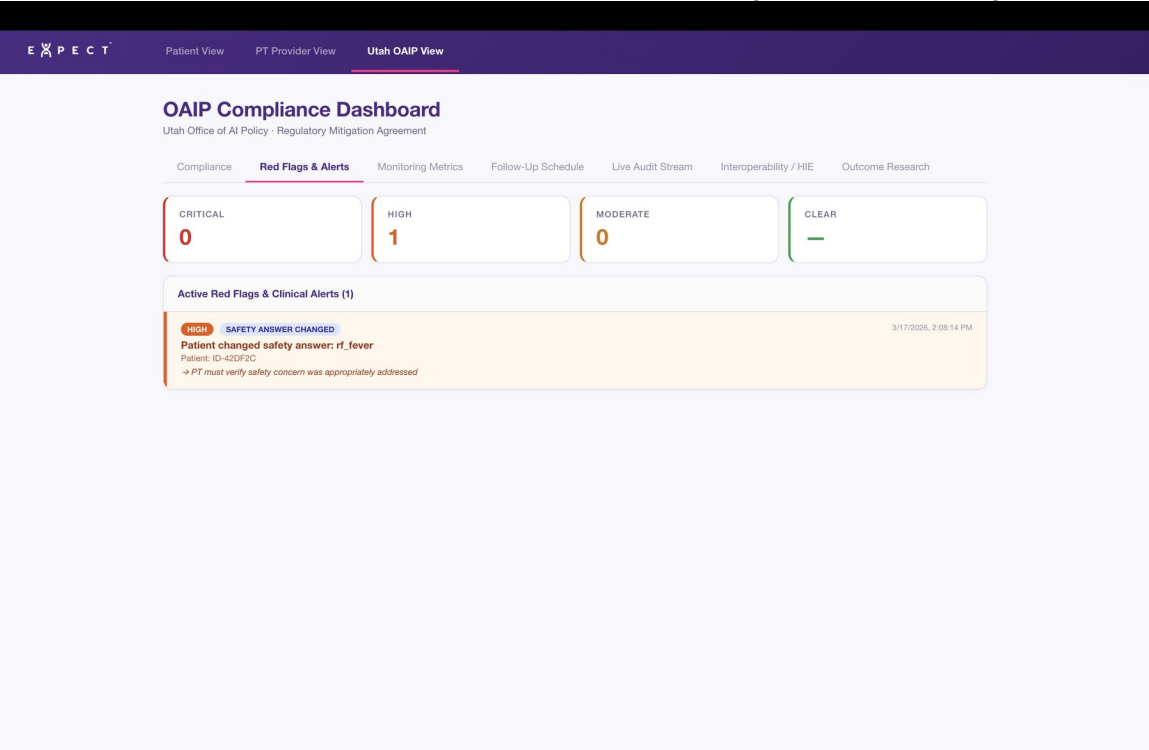
OAIP dashboard — Outcomes: aggregate instrument deltas and improvement rates



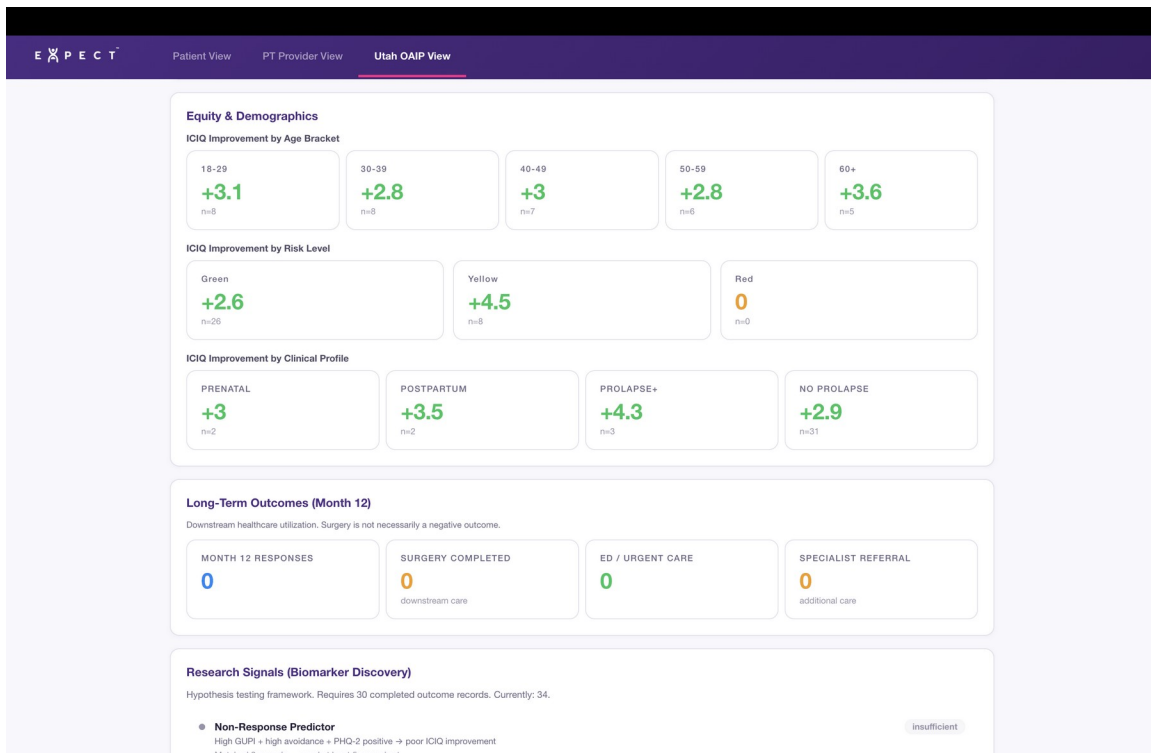
OAIP dashboard — Outcomes: worsening rates by domain and tier



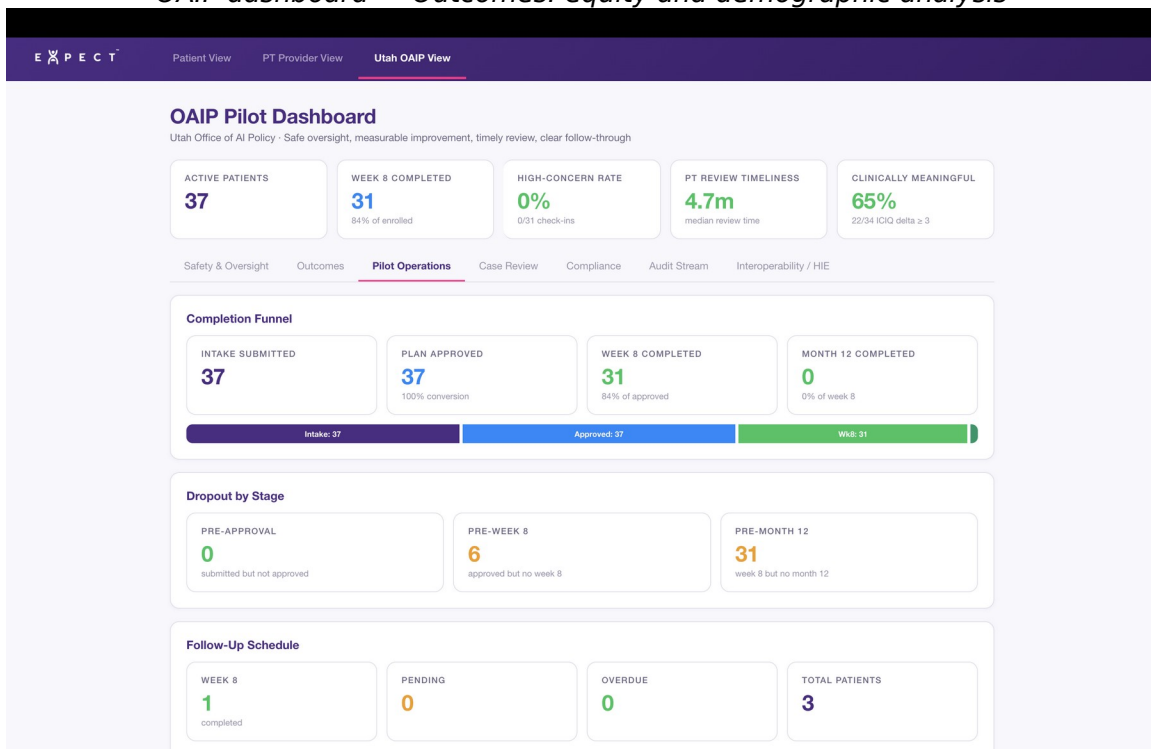
OAIP dashboard — Outcomes: adherence summary and outcomes by tier



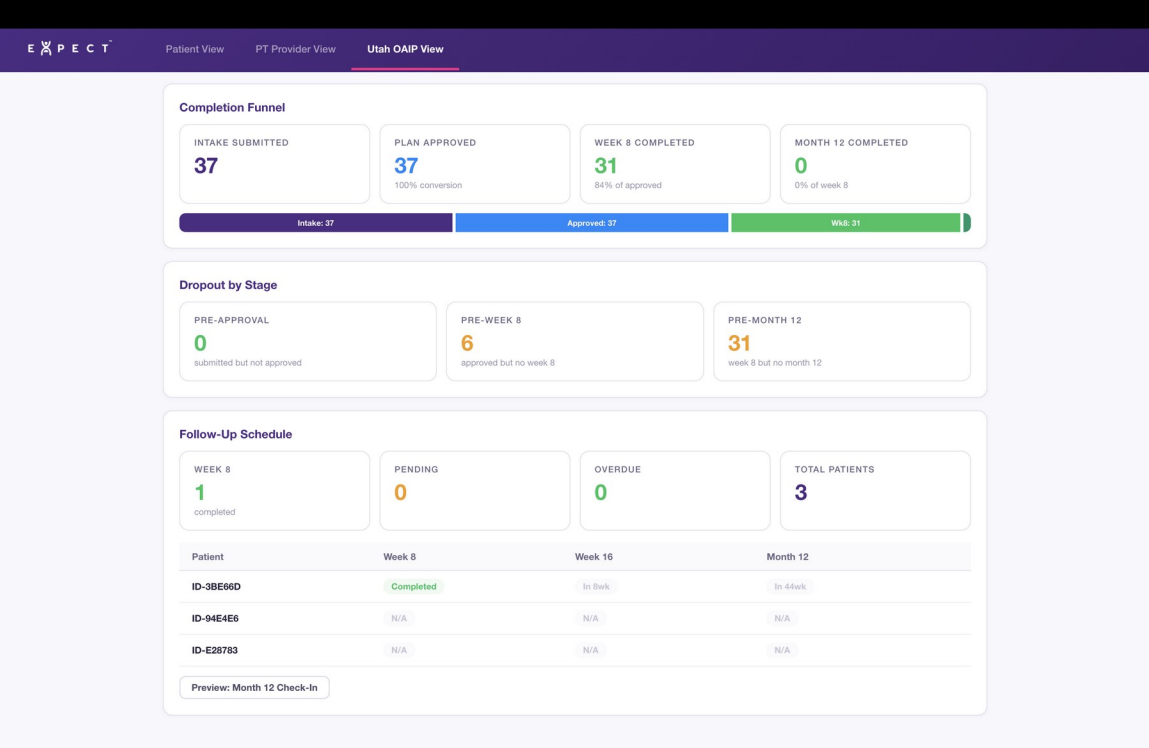
OAIP dashboard — Red Flags and Alerts: clinical signal types by severity



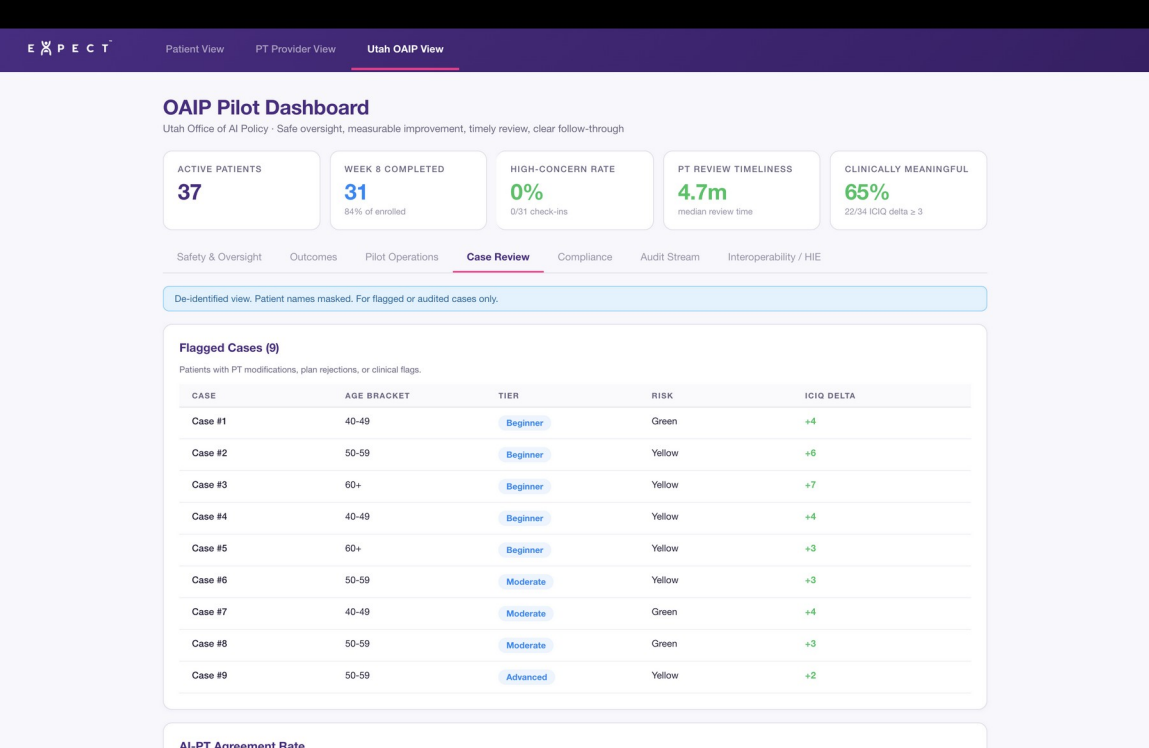
OAIP dashboard — Outcomes: equity and demographic analysis



OAIP dashboard — Pilot Operations: completion funnel and dropout analysis



OAIP dashboard — Pilot Operations: follow-up schedule with overdue alerts



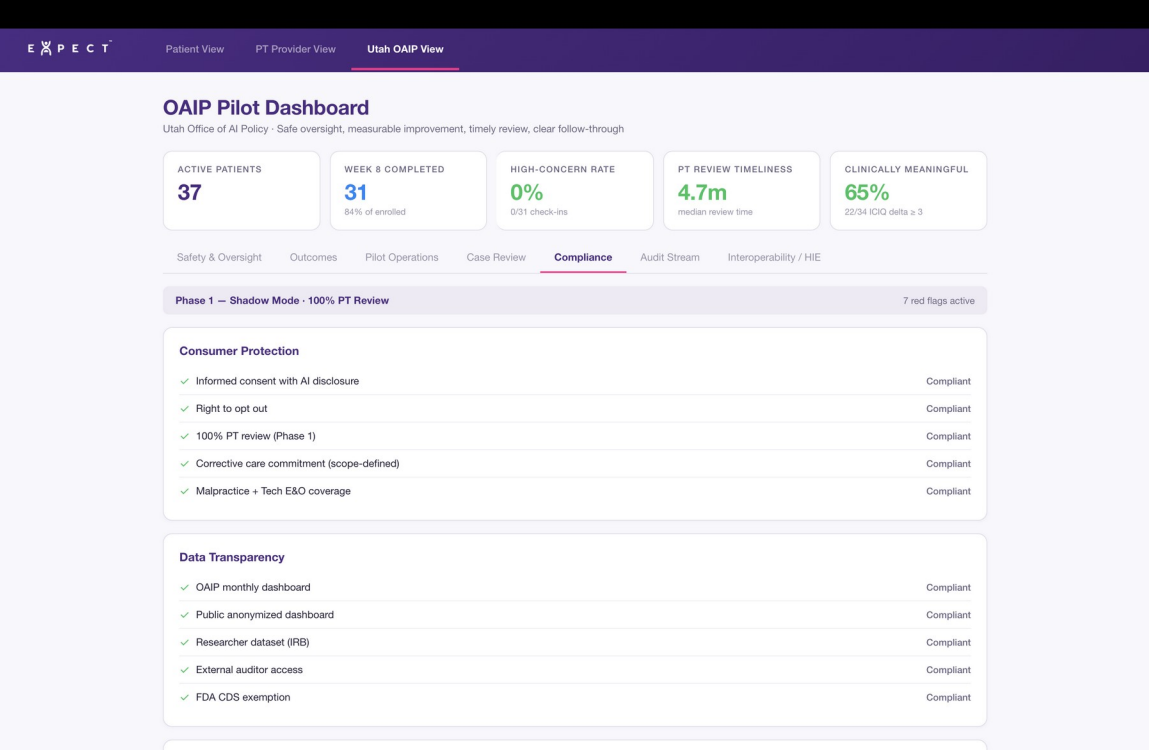
OAIP dashboard — Case Review: de-identified case drill-down

EXPECT Patient View PT Provider View Utah OAIP View					
AI-PT Agreement Rate AGREEMENT 75.7% 28/37 unmodified MODIFIED 9 WITH DIFFS 0 detailed tracking					
Outcome Records — De-Identified (37)					
RECORD	TIER	AGE	STATUS	ICIQ DELTA	RISK
DEMO-OR-1-17	Beginner	30-39	Complete	+5	Green
DEMO-OR-2-17	Beginner	40-49	Complete	+4	Green
DEMO-OR-3-17	Beginner	50-59	Complete	+6	Yellow
DEMO-OR-4-17	Beginner	18-29	Complete	+3	Green
DEMO-OR-5-17	Beginner	60+	Complete	+7	Yellow
DEMO-OR-6-17	Beginner	30-39	Complete	+3	Green
DEMO-OR-7-17	Beginner	40-49	Complete	+4	Yellow
DEMO-OR-8-17	Beginner	50-59	Complete	+2	Yellow
DEMO-OR-9-17	Beginner	18-29	Complete	+1	Green
DEMO-OR-10-1	Beginner	60+	Complete	+3	Yellow
DEMO-OR-11-1	Moderate	30-39	Complete	+4	Green
DEMO-OR-12-1	Moderate	40-49	Complete	+3	Green
DEMO-OR-13-1	Moderate	18-29	Complete	+5	Green
DEMO-OR-14-1	Moderate	50-59	Complete	+3	Yellow

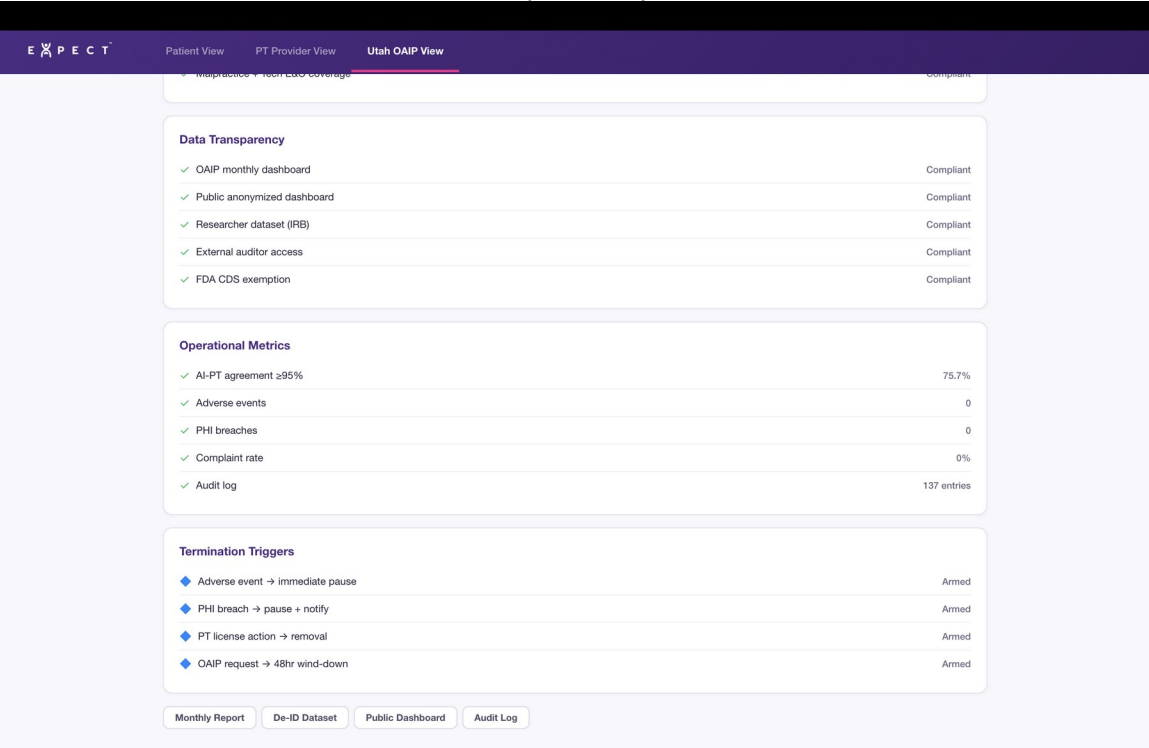
OAIP dashboard — Case Review: AI-PT agreement detail

EXPECT Patient View PT Provider View Utah OAIP View					
DEMO-OR-17-1	Moderate	60+	Complete	+3	Green
DEMO-OR-18-1	Moderate	18-29	Complete	+1	Green
DEMO-OR-19-1	Moderate	30-39	Complete	+4	Green
DEMO-OR-20-1	Moderate	50-59	Complete	+3	Green
DEMO-OR-21-1	Advanced	30-39	Complete	+3	Green
DEMO-OR-22-1	Advanced	18-29	Complete	+2	Green
DEMO-OR-23-1	Advanced	40-49	Complete	+3	Green
DEMO-OR-24-1	Advanced	50-59	Complete	+1	Green
DEMO-OR-25-1	Advanced	60+	Complete	+3	Green
DEMO-OR-26-1	Advanced	30-39	Complete	+1	Green
DEMO-OR-27-1	Advanced	40-49	Complete	+3	Green
DEMO-OR-28-1	Advanced	50-59	Complete	+2	Yellow
DEMO-OR-29-1	Advanced	18-29	Complete	+4	Green
DEMO-OR-30-1	Advanced	60+	Complete	+2	Green
DEMO-OR-31-1	Foundation	18-29	Complete	0	Green
DEMO-OR-32-1	Foundation	40-49	Complete	0	Green
DEMO-OR-33-1	Foundation	30-39	Complete	0	Green
DEMO-OR-34-1	Beginner	40-49	Pending	—	Green
DEMO-OR-35-1	Moderate	30-39	Pending	—	Green
OR-1-1773762	Moderate	18-29	Complete	+9	Yellow
OR-1-1773826	Moderate	18-29	Pending	—	Yellow

OAIP dashboard — Case Review: PT modification breakdowns



OAIP dashboard — Compliance: phase status checklist



OAIP dashboard — Compliance: action buttons and metric summary

2. Regulatory Relief Request

The regulatory relief requested for this pilot is set out in Schedule A of the Regulatory Mitigation Agreement between Expect and the OAIP. To avoid any inconsistency with that agreement, the detailed request is omitted from this public edition; the complete request remains on file with the OAIP.

3. Pilot Design

3.1 Duration and Timeline

Requested pilot duration: 12 months, with option for a single 12-month extension per UAIPA.

Enrollment Projections: Expect uses a tiered enrollment model for Phase 1 (est. Months 1-4): Minimum Viable = 50 patients (sufficient for safety data and primary outcomes analysis. Primary endpoint: ICIQ-UI SF reduction ≥ 3 points at Week 8 (unchanged from the originally accepted proposal). The ≥ 3 -point primary endpoint exceeds the published MCID of 2.5 points; a ≥ 4 -point reduction (strong-responder threshold) is tracked separately. Primary endpoint provides 80% power to detect a 3-point ICIQ change (SD ~ 4) with paired t-test), Target = 150 patients (powered for secondary outcomes and subgroup analysis), Stretch = 250 patients (full statistical power across all endpoints including biomarker discovery). Phase 2 targets 500 enrolled, Phase 3 targets 500 enrolled, for a total of approximately 700-1,250 patients over the 12-month pilot depending on Phase 1 tier achieved. Phase progression is gated by volume (250 consecutive AI-PT matches per subtype at the Stretch tier, or proportionally adjusted at lower tiers), not calendar, so if enrollment is slower than projected, Expect will request the 12-month extension permitted under UAIPA.

(See Table 2 below for phase details)

Phase	Duration	Description	Benchmark to Advance
Pre-Deployment	Months -2 to 0	Platform shared with OAIP for technical review. Informed consent language approved. Test patients (internal) complete full workflow. HIPAA technical safeguards fully implemented: persistent storage with encryption at rest on SOC 2 Type II audited infrastructure, individual PT	OAIP technical sign-off; no critical defects; consent approved; HIPAA technical safeguards verified before any real patient data enters the system

		authentication with hardened credential storage, session management with expiry and automatic timeout, and role-based API authorization (PT-only, OAIP-only, patient-self).	
Phase 1: Calibration Mode	Tiered enrollment: 50 (Minimum Viable), 150 (Target), 250 (Stretch) per diagnosis subtype (est. Months 1-4)	100% of AI-generated plans reviewed by PT before patient delivery. All scores, responses, and AI reasoning visible to PT. A minimum-review-time guardrail flags any review completed in under two minutes. Tiered enrollment: Minimum Viable = 50 patients (safety + primary outcomes; primary endpoint: ICIQ-UI SF reduction ≥ 3 points at Week 8, unchanged from the originally accepted proposal and exceeding the published MCID of 2.5; strong-responder threshold ≥ 4 points tracked separately), Target = 150 (secondary outcomes + subgroup analysis), Stretch = 250 (full power across all endpoints + biomarker discovery). Phase graduation volume-gated per Doctronic precedent.	AI-PT agreement rate $\geq 95\%$; zero adverse events; zero PHI breaches; PT satisfaction $\geq 4/5$; minimum 50 completed cases
Phase 2: High-Frequency Sampling	Months 4-8	AI plans for low-risk patients (lowest-risk cohort per validated severity bands) may be auto-approved	Sustained AI-PT agreement $\geq 95\%$; ICIQ improvement ≥ 3 pts avg; adverse events = 0;

		with PT spot-check (10% random audit, consistent with the Doctronic post-calibration standard) and immediate reversion to 100% review after any adverse event. Yellow Band and Orange Band remain 100% PT review. Target: 500 enrolled. Voice-assisted intake deployed for low-literacy and accessibility populations. Spanish-language support activated.	complaint rate <5%
Phase 3: Expanded Deployment	Months 9-12	Auto-approval threshold expanded. PT review for all high-risk and first-time patients. Medicare and commercial payer partnerships activated. Medicaid telehealth PT advocacy initiated using pilot outcomes data. Target: 500 enrolled.	Continued safety metrics; outcomes data sufficient for peer-reviewed publication; OAIP final review

3.2 Product Sharing for OAIP Review

Expect will provide the OAIP with:

- Full platform access (OAIP-specific dashboard view with all compliance metrics, audit log, and de-identified patient data)
- Source code access for the AI scoring and plan generation algorithms upon request
- Monthly video walkthrough of platform changes and new features
- Real-time access to the immutable audit log recording every system action
- A working demo environment with synthetic patient data for OAIP testing at any time

3.3 Benchmark Requirements for Phase Progression

(See Table 3 below)

Metric	Phase 1 Threshold	Phase 2 Threshold	Phase 3 Threshold
AI-PT Plan Agreement	$\geq 95\%$	$\geq 95\%$	$\geq 95\%$
Adverse Events	0	0	$< 0.5\%$ of enrollees
PHI Breaches	0	0	0
Patient Complaint Rate	$< 5\%$	$< 5\%$	$< 3\%$
ICIQ Score Improvement	Any measurable	≥ 3 pts avg at 8 wks	≥ 3 pts avg at 8 wks
PT Review Time (avg)	≥ 2 min	≥ 2 min (audited)	≥ 2 min (audited)
Patient Adherence	$> 50\%$	$> 65\%$	$> 70\%$
Consent Completion	100%	100%	100%

The following metrics must be met for 30 consecutive days before advancing to the next phase.

3.4 Failed Benchmark Plan / Phase Rollback

If any critical metric fails (adverse event, PHI breach, or AI-PT agreement $< 90\%$), or if any single adverse event is attributed to AI recommendation (the "One Strike" rule, consistent with the Doctrone corrective action model):

- **Immediate pause:** All AI auto-approvals suspended. Platform reverts to 100% PT review (Phase 1 mode) within 4 hours. A minimum of 50 consecutive successful cases must be completed under 100% review before any return to prior phase autonomy.
- **Root cause analysis:** Expect delivers a written incident report to OAIP within 48 hours.
- **Corrective action:** Platform modifications implemented and tested before resuming the prior phase.

- **OAIP approval required:** Phase re-advancement requires written OAIP sign-off after the corrective action is verified.
- **Termination triggers:** Any of the following triggers immediate pilot termination with 48-hour wind-down: (a) Serious patient injury attributable to AI error, (b) confirmed PHI breach affecting >10 patients, (c) PT license revocation, (d) OAIP request for any reason.

3.5 Pilot Wind-Down and Exit Plan

Upon pilot completion (Month 12), early termination, or OAIP-directed cessation, Expect will execute the following wind-down plan within 90 calendar days:

Patient Notification and Transition (Days 1-30)

- All enrolled patients notified within 72 hours of wind-down initiation via secure portal message and email.
- Patients currently mid-treatment receive a clinically appropriate transition plan reviewed and approved by the supervising PT, including a summary of progress, current care plan, and referral recommendations.
- Patients may download their complete care plan, assessment scores, and clinical summary as a PDF via the existing “Export for MyChart / EHR” feature at any time during the wind-down period.
- No new patients are enrolled after wind-down initiation. Patients who have completed their program are not affected.

Clinical Oversight During Wind-Down (Days 1-60)

- PT oversight continues for all active patients through the wind-down period. No patient is left without clinical support mid-treatment.
- The PT completes final clinical notes and encounter documentation for all active cases.
- Any adverse events or clinical concerns reported during wind-down are handled under the same protocols described in Appendix B.

Data Retention and Disposition (Days 30-90)

- Clinical records are retained per Utah and federal healthcare record retention requirements (minimum 7 years per Utah Code 58-24b and HIPAA).
- De-identified aggregate data collected during the pilot is retained for research reporting and OAIP compliance for the duration specified in the RMA plus 3 years.
- Patient-identifiable data is retained only as required by healthcare record retention law. Upon expiration of the retention period, data is securely deleted with documented chain of custody.

Platform Disposition

- If the pilot demonstrates safety and efficacy and Expect intends to continue operations in Utah, Expect will apply for full regulatory approval or an RMA extension before the wind-down period ends.

- If the pilot does not continue, the platform is decommissioned after the data retention obligations are fulfilled. Source code and algorithm documentation are preserved for audit purposes.
- Expect cooperates with any OAIP post-pilot review or audit for 12 months following wind-down completion.

3.6 Data and Outcome Sharing

Researchers: De-identified datasets (per HIPAA Safe Harbor) available to IRB-approved researchers via data use agreement. Dataset includes: anonymized demographics, validated instrument scores at intake and follow-up, treatment plan parameters, adherence metrics, and outcomes. No raw text responses or identifiable information. Expected availability: quarterly, beginning Month 6.

External Auditors: OAIP-approved external auditors receive full audit log access with PHI redacted via the role-based de-identified auditor view (see Section 4.3). Auditors may review AI scoring logic, plan generation algorithms, PT review records, and consent documentation. Access provided within 5 business days of request.

FDA

Expect concludes the platform qualifies for the Clinical Decision Support (CDS) exemption under 21st Century Cures Act Section 3060(a), because: (1) it is not intended to acquire, process, or analyze medical images or signals; (2) it is intended for the purpose of supporting clinical decision-making; (3) it provides the basis for the recommendation (validated instrument scores); and (4) the licensed PT makes the final treatment decision independently. Expect will share this analysis with the FDA upon request and will cooperate with any FDA inquiry during the pilot. The VHA CRADA (see Section 1.1) provides an additional channel for FDA engagement.

OAIP

The OAIP receives the most comprehensive data access. Full data governance, de-identification standards, and research sharing protocols are detailed in Appendix C. Summary of OAIP access commitments:

- Real-time compliance dashboard (accessible 24/7; see Section 1.4, OAIP Oversight Experience)
- **Monthly written reports covering:** enrollment, outcomes, adverse events, complaints, AI-PT agreement, system uptime, and consent rates
- Quarterly in-person briefings with Expect leadership and clinical team
- Immediate notification (within 4 hours) of any adverse event, PHI breach, or termination trigger

- Full audit log with complete event metadata
- Per-instrument Minimal Clinically Important Difference (MCID) tracking — meaningful change thresholds defined for ICIQ-UI SF (MCID 2.5 per published literature; pilot success threshold ≥ 3 ; strong responder ≥ 4), GUPI (≥ 6), POPDI-6 (≥ 6), FLUTSsex (≥ 1), PHQ-2 (≥ 1), and FLUTS composite (≥ 3) — surfaced in the OAIP dashboard's Outcomes tab with per-instrument and any-instrument meaningful-change rates.
- Regression Flag Aggregates dashboard — audit-log-derived counts of clinical regression flags (CLINICAL_REGRESSION_FLAG, FLUTS_REGRESSION, GUPI_URINARY_REGRESSION, FLUTSsex regression, BOWEL_REGRESSION, POPDI-6 worsening, PT_ALERT_NO_ICIQ_PROGRESS at Week 4 and Week 8) with Week-4 vs Week-8 split. Aggregate-only — no patient identifiers exposed.
- **Quarterly trajectory tracking per OAIP Change Request 3:** Number of patients referred out per period, de-identified reason category aligned with risk stratification, referral destination category (ER, urogynecology, in-person pelvic PT, OB-GYN, gastroenterology, other specialist), 30-day post-referral patient-reported outcome check-in for consenting patients.

Public

Expect will publish:

- A public-facing anonymized outcomes dashboard (updated monthly) showing aggregate enrollment, average symptom improvement, adherence rates, and safety metrics
- A plain-language summary of pilot findings at Months 6 and 12
- Peer-reviewed publication of pilot outcomes (targeted for Month 12-15)
- Consumer-facing FAQ addressing common questions about AI in healthcare

Proposed Reporting Process

(See Table 4 below)

Report Type	Frequency	Audience	Contents
Client Safety Report	Monthly	OAIP	Adverse events, red-flag triage outcomes, safety answer changes, clinical regression reports, exercise pain reports, complaint log, PT override rate, system downtime
Efficacy Report	Monthly	OAIP	ICIQ/GUPI/pain score changes, adherence, plan completion rates, time-to-

			improvement
Patient Feedback Report	Monthly	OAIP	NPS scores, qualitative feedback themes, opt-out rates, consent completion, clarity request counts
Public Dashboard	Monthly	Public	Aggregate enrollment, outcomes, safety metrics (no PHI)
Provider Report	Quarterly	PTs, OAIP	PT satisfaction, review time analysis, AI-PT agreement details, clinical workflow metrics
Comprehensive Pilot Report	Months 6, 12	OAIP, Public, Researchers	Full analysis of safety, efficacy, fairness, cost, and regulatory compliance

Expect — Utah OAIP Pilot Proposal

Addendum: Outcomes Follow-Up Protocol

Section 3.6 Supplement | March 2026 | Public edition

Overview

This addendum supplements Section 3.6 (Data and Outcome Sharing) of the Expect OAIP Pilot Proposal. It defines a three-checkpoint follow-up protocol designed to (1) generate outcomes data sufficient for value-based contracting with Utah Medicaid and commercial payers and (2) produce peer-reviewed-quality longitudinal evidence for OAIP reporting and public outcomes disclosure.

A single post-treatment check-in is insufficient for value-based billing purposes. Payers require demonstrated durability of outcomes — evidence that improvement holds 6–9 months after active treatment ends, not just at completion. The three-checkpoint structure below captures efficacy (Week 8), completion outcomes (Week 16), and long-term durability (Month 12).

Rationale: Why Three Check-Ins

Each checkpoint serves a distinct clinical and commercial purpose:

Week 8 — Early effectiveness checkpoint. This is the pilot’s primary early outcome measure and shows whether the program is beginning to work. It is based on a meaningful improvement in symptoms and is early enough to allow changes if a patient is not responding. It is also the point when sufficient monitoring and therapist-management activity have usually been captured.

Week 16 — Program completion outcome. This marks the end of the active treatment period and provides the clearest picture of what the full program achieved. It functions as the end-of-treatment assessment and documents clinical closure of the episode of care.

Month 12 — Long-term durability. This follow-up assesses whether benefits were maintained months after treatment ended. It is also the most useful point for evaluating longer-term outcomes, such as whether higher-cost interventions or emergency care were avoided.

Follow-Up Instrument Battery

The table below defines which instruments are administered at each checkpoint and their purpose in the billing and outcomes evidence chain.

Instrument / Question	Week 8	Week 16	Month 12	Purpose
ICIQ-UI SF (0-21)	✓	✓	✓	Primary outcome
Pain Composite (0-10)	✓	✓	✓	Secondary outcome
PHQ-2 (0-6)	✓	✓	✓	Mental health durability
Return to avoided activities?	✓	✓	✓	Functional outcome
Program satisfaction (NPS 0-10)	✓	✓	—	Patient experience
ED/urgent care visit for pelvic symptoms?	✓	✓	✓	Avoidable utilization
Referred for or had pelvic surgery?	✓	✓	✓	Surgical avoidance
Sought additional pelvic care?	✓	✓	✓	Care escalation tracking

Note: the three utilization questions are asked at every checkpoint, and a positive response at any checkpoint triggers a provider notification at the time it is first reported. Month 12 responses, with the most elapsed time, remain the primary data source for surgical-avoidance and avoidable-utilization analysis.

Check-In Journey

E X P E C T Patient View PT Provider View Utah OAIP View pam@theoffice.com [Report Issue](#)

Because you reported prolapse-type symptoms, an in-person pelvic exam or pessary evaluation may help clarify the cause and next steps. Please arrange follow-up with your provider if you have not already.

Program Progress

Your Week 8 Check-In is ready! [Start Check-In](#)
Takes about 4-5 minutes. Help us measure your progress.

Daily Exercise Tracking

Did you complete your exercises today?

Last 30 Days

■ Yes ■ Partial ■ No

0% Adherence

0 Days this month

Daily exercise reminders
Get a notification each evening to log your exercises [Turn On](#) [Not now](#)

[Export for MyChart / EHR](#)

This care plan was generated by Expect's AI-augmented platform and reviewed by a licensed Physical Therapist.
Expect is a participant in the Utah Office of AI Policy Regulatory Sandbox.
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Patient portal — program progress tracking with check-in gate

Program Progress

Your Week 8 Check-In is ready! [Start Check-In](#)
Takes about 4-5 minutes. Help us measure your progress.

Daily Exercise Tracking

Did you complete your exercises today?

Last 30 Days

■ Yes ■ Partial ■ No

0% Adherence

0 Days this month

Daily exercise reminders
Get a notification each evening to log your exercises [Turn On](#) [Not now](#)

[Export for MyChart / EHR](#)

Week 8 check-in — close-up of check-in notification and instructions

Prolapse Follow-Up Recommended

Because you reported prolapse-type symptoms, an in-person pelvic exam or pessary evaluation may help clarify the cause and next steps. Please arrange follow-up with your provider if you have not already.

Prolapse follow-up — close-up of in-person evaluation recommendation

Program Progress

Your Week 8 Check-In is ready!
Takes about 4-5 minutes. Help us measure your progress. [Start Check-In](#)

Daily Exercise Tracking

Did you complete your exercises today?

☒ Yes ☐ Partially ☐ No

[Log Today](#)

Last 30 Days

■ Yes ■ Partial ■ No

0%
Adherence

0
Days this month

Daily exercise reminders
Get a notification each evening to log your exercises [Turn On](#) [Not now](#)

[Export for MyChart / EHR](#)

Exercise logging — daily adherence tracking with push notification reminder

EXPECT Patient View PT Provider View Utah OAIP View pam@theoffice.com **Report Issue**

Week 8 Check-In
Step 1 of 9 Takes about 4–5 minutes

Bladder Leakage Check-In

How often do you leak urine?

Never

About once a week or less often

Two or three times a week

About once a day

Several times a day

All the time

Report a Problem X

1. I have pain during exercises
2. My symptoms are getting worse
3. I'm experiencing a new symptom, bleeding, or adverse reaction
4. I don't understand the instructions
5. I want to opt out of AI-assisted care
6. Technical issue with the platform

Next →

Week 8 check-in — overview with symptom report and issue flagging

EXPECT Patient View PT Provider View Utah OAIP View pam@theoffice.com **Report Issue**

Week 8 Check-In
Step 1 of 9 Takes about 4–5 minutes

Bladder Leakage Check-In

How often do you leak urine?

Never

About once a week or less often

Two or three times a week

About once a day

Several times a day

All the time

Next →

Week 8 check-in — ICIQ-UI SF re-administration

E

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P

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T

PT Provider View

Utah OAIP View

pam@theoffice.com

Report Issue

Week 8 Check-In

Step 2 of 9

Takes about 4-5 minutes

Pain Check-In

What is your pelvic pain level right now? (0 = no pain, 10 = worst pain imaginable)

1

No pain

Worst pain imaginable

What has your average pelvic pain been over the past week? (0 = no pain, 10 = worst pain imaginable)

1

No pain

Worst pain imaginable

How much has pain affected your daily activities this week? (0 = not at all, 10 = severely limited)

1

Not at all

Severely limited

← Back

Next →

E X P E C T

Patient ViewPT Provider ViewUtah OAIP Viewpam@thedfice.comReport Issue

Week 8 Check-In

Takes about 4-5 minutes

Step 3 of 9

Emotional Well-Being

Over the past 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?

Not at all

Several days

More than half the days

Nearly every day

Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

Not at all

Several days

More than half the days

Nearly every day

← Back

Next →

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Patient ViewPT Provider ViewUtah OAJP Viewpam@theoffice.comReport Issue

Week 8 Check-In

Step 4 of 9

Takes about 4-5 minutes

Sexual Symptom Check-In

Do you have pain or discomfort because of a dry vagina?

Not at all

A little

Somewhat

A lot

To what extent do you feel that your sex life has been affected by your urinary symptoms?

Not at all

A little

Somewhat

A lot

Do you have pain during sexual activity?

Not at all

A little

Somewhat

A lot

E X P E C T

Patient ViewPT Provider ViewUtah OAIP Viewpam@thedfice.comReport Issue

Somewhat

A lot

Do you have pain during sexual activity?

Not at all

A little

Somewhat

A lot

I don't have sexual activity

Do you leak urine during sexual activity?

Not at all

A little

Somewhat

A lot

I don't have sexual activity

← Back

Next →

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Patient View

PT Provider View

Utah OAJP View

pam@theoffice.com

Report Issue

Week 8 Check-In

Step 5 of 9

Takes about 4-5 minutes

Bowel Symptom Check-In

Have your bowel symptoms changed since starting the program?

Better

About the same

Worse

← Back

Next →

EXPECT

Patient View

PT Provider View

Utah OAP View

gam@thedfice.com

Report Issue

Week 8 Check-In

Takes about 4-5 minutes

Step 6 of 9

Prolapse Symptom Re-Assessment

Please answer these questions about your current prolapse symptoms so we can compare with your intake.

Do you usually experience pressure in the lower abdomen?

NoYes

Do you usually experience heaviness or dullness in the pelvic area?

NoYes

Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?

NoYes

Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?

NoYes

Do you usually experience a feeling of incomplete bladder emptying?

NoYes

Do you ever have to push up on a bulge in the vaginal area to start or complete urination?

NoYes

← Back

Next →

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Patient ViewPT Provider ViewUtah OAJP Viewpam@theoffice.comReport Issue

Week 8 Check-In

Step 7 of 9Takes about 4-5 minutes

Prolapse Follow-Up

At your intake, you reported prolapse symptoms. Did you follow up with a provider for a pelvic exam or pessary evaluation?

Yes

Not yet

Not applicable

← Back

Next →

E X P E C T

Patient ViewPT Provider ViewUtah OAIP Viewgarn@thedfice.comReport Issue

Week 8 Check-In

Takes about 4-5 minutes

Step 8 of 9

Return to Activities

At intake, you told us you were avoiding **sexual, exercise** because of your symptoms. Are you able to do any of these now?

Yes, I've resumed these activities

Partially — some but not all

Not yet

Tell us more (optional)

Feel so much better!

← Back

Next →

The screenshot shows a web interface for a 'Week 8 Check-In'. At the top, there is a navigation bar with the 'EXPECT' logo and links for 'Patient View', 'PT Provider View', 'Utah OAIP View', and a 'Report Issue' button. The main heading is 'Week 8 Check-In' with a sub-note 'Step 9 of 9' and a duration 'Takes about 4-5 minutes'. The central question is 'How likely are you to recommend this program to a friend or family member?'. Below the question is a horizontal slider scale from 'Not at all likely' to 'Extremely likely', with a red dot indicating a score of 10. At the bottom of the form are two buttons: '← Back' and 'Complete Check-In'.

Week 8 check-in — program satisfaction (NPS 0-10)

Trigger: 56 days (± 3 days) after care plan delivery date.

Estimated completion time: 4-5 minutes.

Primary purpose: Efficacy measurement; early intervention trigger if ICIQ has not improved.

Provider transmission: the Week 8 check-in generates a PT-reviewed outcome summary transmitted to the patient's provider on file, alongside the Week 16 episode-closure note committed below.

Instruments Administered

- ICIQ-UI SF (4 items, 0-21) — re-administered in full
- Pain Composite (3 items, 0-10) — current pain, weekly average, functional impact
- PHQ-2 (2 items, 0-6) — depression re-screen. Patients with prolapse symptoms at baseline also complete the full POPDI-6 instrument, enabling objective comparison of prolapse symptom burden over time (score delta computed and displayed; validation hints are displayed for incomplete bother answers)
- Return to avoided activities: "At intake, you told us you were avoiding [X, Y, Z activities] because of your symptoms. Are you able to do any of these now?" (Yes / Partially / Not yet)
- Program satisfaction: "How likely are you to recommend this program to a friend?" (NPS 0-10)
- Utilization questions — ER/urgent-care visit for pelvic symptoms, surgical referral or surgery, and additional pelvic care sought; a positive response triggers a provider notification at the time of report

Clinical Routing Logic

- Insufficient ICIQ improvement (deterministic per-domain threshold): PT receives alert; case flagged for clinical review and potential plan adjustment.
- Positive depression re-screen: PT receives alert; maternal mental health referral resources surfaced to patient.
- Reported surgical referral or ER/urgent-care visit: provider notification at the time of report; case flagged in the OAIP dashboard as CLINICAL_ESCALATION.
- Clinically significant pain worsening: CLINICAL_REGRESSION_FLAG logged; PT review required within 48 hours. Additional worsening flags are generated for all symptom domains using deterministic worsening thresholds per domain: PAIN_WORSENER, BOWEL_WORSENER (patient reports bowel symptoms worse), PROLAPSE_WORSENER (POPDI-6 score increased from baseline), and PROLAPSE_FOLLOWUP_NEEDED (prolapse symptoms present without provider follow-up). Combined signals are scored into tiered clinical concern levels (mild, moderate, high) to prioritize PT review.

Check-In 2: Week 16

Trigger: 112 days (± 5 days) after care plan delivery date.

Estimated completion time: 4–5 minutes.

Primary purpose: End-of-treatment outcomes; episode-of-care closure documentation; trajectory data (Week 8 $\rightarrow$ Week 16 trend).

Instruments Administered

- ICIQ-UI SF (4 items, 0–21)
- Pain Composite (3 items, 0–10)
- PHQ-2 (2 items, 0–6)
- Return to avoided activities (same question as Week 8)
- Program satisfaction NPS (0–10)
- Utilization questions — ER/urgent-care visit for pelvic symptoms, surgical referral or surgery, and additional pelvic care sought; a positive response triggers a provider notification at the time of report

Clinical Routing Logic

- Same routing logic as Week 8.
- Week 16 triggers formal episode-of-care closure in the PT dashboard, generating a final encounter note for fax transmission to the referring physician with outcome summary (ICIQ change, pain change, PHQ-2 change).
- For patients not meeting their improvement goal at their program's end, Expect is adopting a guideline-anchored extension standard anchored to NICE's minimum three-month standard for supervised

pelvic floor muscle training; the extension protocol is being finalized with Expect's clinical lead, and episode closure follows its outcome.

Check-In 3: Month 12

Trigger: 365 days (± 14 days) after care plan delivery date.

Estimated completion time: 6–7 minutes.

Primary purpose: Durability of outcomes; surgical avoidance documentation; avoidable utilization data; value-based contracting evidence package.

Provider transmission: the Month 12 check-in generates a PT-reviewed outcome summary — durability results and any reported surgical or emergency-department utilization — transmitted to the patient's provider on file.

Instruments Administered

- ICIQ-UI SF (4 items, 0–21)
- Pain Composite (3 items, 0–10)
- PHQ-2 (2 items, 0–6)
- Return to avoided activities

Utilization Questions

- "Since completing the Expect program, have you visited an emergency room or urgent care clinic for pelvic floor symptoms?" (Yes / No)
- "Since completing the Expect program, have you been referred for or undergone pelvic floor surgery?" (Yes / No — if yes: What procedure?)
- "Since completing the Expect program, have you sought additional pelvic floor care from another provider?" (Yes / No — if yes: What type of provider?)

Incentive

Month 12 response rates are supported by a standard research-participation courtesy disclosed in consent.

Clinical Routing Logic

- Surgical referral reported: PT receives alert; case flagged in OAIP dashboard as CLINICAL_ESCALATION.
- Clinically significant ICIQ regression from Week 16 baseline (deterministic threshold): PT receives alert for optional clinical outreach.
- Positive depression re-screen: Mental health referral resources re-surfaced; maternal mental-health resources displayed.

Reminder Cadence

Each check-in window opens for 14 days. The following reminder sequence is sent to non-completers. The same cadence applies to all three check-ins; timing is relative to the check-in window open date.

Day	Channel	Message
Day 0	Email	Check-in unlocked — 5 questions, takes 3 minutes. Your care team is tracking your progress.
Day 3	Email	Reminder: your progress check-in is waiting. Takes 3 minutes.
Day 7	Email + SMS	Final reminder: check-in closes in 7 days. Your responses help us improve care for Utah women.
Day 10	PT outreach	PT sends a brief personal message via secure portal: "Just checking in — your 8-week check-in is still open if you have a moment."
Day 14	Window closes	Non-responders flagged in dashboard. Counted as lost-to-follow-up in outcomes reporting.

All reminder emails are HIPAA-compliant (no PHI in email body; patient clicks through to secure portal). SMS reminders require prior consent, captured at enrollment.

Response Rate Targets

Check-In	Target Response Rate	Rationale
Week 8	≥ 80%	Patient is still active in the program; high engagement expected.
Week 16	≥ 75%	End of active program; reminder cadence reinforced by PT.
Month 12	≥ 65%	Long-term follow-up; incentive offered; three-touch reminder sequence.

If Month 12 response rate falls below 50%, Expect will report this limitation in OAIP outcomes reporting and peer-reviewed publication. Analyses will be conducted on both completers-only and intent-to-treat (last observation carried forward) bases.

OAIP Reporting Integration

Follow-up data integrates directly into the existing OAIP reporting structure defined in Section 3.6:

- **Monthly reports:** Aggregate check-in completion rates, mean ICIQ change at each checkpoint, PHQ-2 positive screen rates, and adverse event flags surfaced through check-in routing logic.
- **Quarterly reports:** Full outcomes trajectory (intake → Week 8 → Week 16) with de-identified demographic breakdowns for health equity analysis.
- **Month 12 report:** Complete longitudinal dataset including durability metrics, surgical avoidance rates, and utilization data. This report forms the primary evidence base for value-based contract proposals and the peer-reviewed publication targeted for Months 12–15.
- **Public dashboard:** Monthly aggregate ICIQ improvement and adherence rates updated in real time. Month 12 durability data added to the public dashboard upon collection.

Note on Pilot Proposal Integration

This addendum is intended to be incorporated into Section 3.6 of the OAIP Pilot Proposal as a formal supplement. The three-checkpoint follow-up protocol, reminder cadence, and response rate targets described here should be read as binding commitments for the purposes of the Regulatory Mitigation Agreement. All follow-up data collection, storage, and reporting procedures are governed by the data governance framework described in Appendix C of the main proposal.

3.7 Alignment with Approved Utah Sandbox Precedents

Expect's pilot design mirrors precedent approved under the Utah AI Regulatory Sandbox across four dimensions:

- **Volume-Based Gating:** consecutive supervised AI-PT matches per diagnosis subtype (Stress UI, Urge UI, Mixed UI) — 250 at the Stretch enrollment tier, or proportionally adjusted at lower tiers — prior to any AI autonomy, ensuring statistically significant validation rather than calendar-based phase advancement.
- **Liability Parity:** Malpractice insurance covers the AI algorithm as a distinct provider, holding the AI to the same liability standard as a licensed clinician.
- **10% Post-Calibration Audit Rate (Green cohort only):** After the calibration period (minimum 50 cases per subtype) and demonstrated $\geq 95\%$ AI-PT plan agreement on Green-cohort patients, 10% random PT audit applies to Green-cohort plans only. Yellow-flagged plans receive mandatory PT review of every plan with no auto-approval, in both Phase 1 and the post-pilot model. Orange-flagged patients re-entering the platform after specialist clearance receive mandatory PT review of every plan in perpetuity for the episode of care — any historical Orange flag confers permanent mandatory-review status. Red-flagged conditions never receive a generated plan.
- **Identity Verification:** Email-based verification at intake with HIPAA-compliant photo ID verification available if OAIP requires additional identity assurance.

Lower Risk Profile Than Approved Precedent: Doctronic's approved pilot authorizes AI to dispense medications--which carry risks of drug interactions, overdose, and allergic reactions. Expect prescribes pelvic floor exercises. The worst-case outcome is temporary muscle soreness, not a life-threatening adverse event.

Like Doctronic's medication refills, Expect's AI applies a deterministic protocol to validated scores--not open-ended clinical judgment. Severity bands determine exercise tier; ICD-10 codes map to score thresholds. Suspected pudendal neuralgia is flagged for mandatory PT review, never acted on autonomously.

3.8 Exclusionary Diagnosis List ("Safe Harbor" Scope)

To define a strict "Safe Harbor" of low-risk conditions, Expect organizes excluded and gated conditions into four tiers reflecting the Specialist Approval architecture described in Section 1.4 Step 2:

- A. Out-of-Scope (no clearance pathway, permanent ineligibility):
 - 1. Suspected pelvic malignancy (bladder, uterine, cervical, ovarian) — until ruled out by oncology / gynecology
 - 2. Neurogenic bladder / neurological condition affecting pelvic floor function (MS, spinal cord injury, Parkinson's, stroke) — pending protocol decision; may move to Continuing-Oversight Orange in a future revision
- B. Continuing-Oversight Orange (re-entry permitted via Specialist Approval workflow; mandatory specialist sign-off on the plan; mandatory PT review of every plan):
 - 1. Surgical mesh complications — clearance from Urogynecology / Urology
 - 2. Grade 3+ pelvic organ prolapse — clearance from Urogynecology / Urology / OB-GYN
 - 3. Interstitial cystitis with Hunner lesions — clearance from Urology / Urogynecology
 - 4. High-risk pregnancy — clearance from Maternal-Fetal Medicine / OB-GYN; patients advised to restrict activity receive education-only content pending clearance

C. Clearable-Lower Orange (re-entry permitted via Specialist Approval workflow):

- 1. Active pelvic infection, fistula, or abscess — clearance from PCP / OB-GYN / Urology / urgent care
- 2. Rectal pain or non-severe rectal bleeding — clearance from PCP / OB-GYN / GI / colorectal evaluation depending on severity

D. Red flags (acute halt — no plan generated, urgent routing):

- 1. Unexplained vaginal bleeding (heavy or with dizziness/faintness, or postpartum wound concern) → ER or same-day OB-GYN

2. Urinary retention (≥ 6 hours postpartum or with painful bladder fullness/distension; non-postpartum: unable to urinate with bladder pain/fullness) → urgent medical evaluation / ER
3. Fever with pelvic or urinary symptoms → ER or same-day PCP
4. UTI with fever (suspected pyelonephritis) → urgent PCP or ER
5. Chest pain → ER
6. Severe headache with visual changes → ER
7. Eclampsia / postpartum-eclampsia screening (new leg swelling, especially with headache or chest pain) → ER
8. Severe rectal bleeding (heavy bleeding, black stool, dizziness, fever, severe rectal pain, or postpartum wound concern) → urgent care / ER

E. Age restriction:

1. Patients under 18 years of age (screened via DOB validation at consent)

Active pregnancy is not an exclusion. Pelvic floor PT during pregnancy is evidence-based and recommended by ACOG and the International Continence Society. Patients with normal pregnancies receive a prenatal-adapted care plan (see Prenatal Pelvic Floor Protocol below). Patients indicating high-risk pregnancy under MFM care are routed through the Specialist Approval workflow described in Section 1.4. The platform-generated plan is held until the MFM approves. The Specialist Approval workflow is in active build for pilot launch.

This "negative scope" approach clarifies what the AI will never attempt, limiting the risk surface to well-defined, exercise-responsive conditions with established standards of care.

Prenatal Pelvic Floor Protocol

Patients who indicate "Currently pregnant" on the demographics screen are not excluded from the platform. Instead, the system applies a prenatal-adapted care pathway:

- **PRENATAL_FLAG** is set on the patient's record. A gentle inline note appears: "We'll tailor your care plan with prenatal-safe modifications so you can safely support your pelvic floor throughout your pregnancy." This is not a blocker.
- Two conditional screening questions are shown during eligibility screening — whether a clinician has designated the pregnancy high-risk, and, separately, whether the patient has been advised to avoid or restrict exercise. A clinician-designated high-risk pregnancy routes the patient through the Specialist Approval workflow with their MFM provider; the plan is held until they approve (see Section 1.4 Step 2, MFM-approval). A reported activity restriction delivers education-only content regardless of designation. A "no" to both allows the patient to proceed with the prenatal-adapted care plan.
- The AI plan generator automatically substitutes supine (lying-flat) exercises with incline or side-lying variants to avoid vena cava compression:

- Supine PF Activation becomes Incline PF Activation (30-45 degree incline with pillows)
- Bridge + PF becomes Incline Bridge + PF (incline with hip towel roll)
- Diaphragmatic Breathing + PF becomes Diaphragmatic Breathing + PF (Prenatal) (incline or seated)
- Diaphragmatic Breathing becomes Diaphragmatic Breathing + PF (Prenatal)
- Kegels (Quick-Flick and Endurance) and Pain De-Sensitization Breathing are position-neutral and remain unchanged.
- Each modified exercise displays a "Prenatal-adapted" badge and an inline explanation: "Modified for pregnancy -- lying flat on your back after the first trimester can compress a major blood vessel. This exercise has been adjusted to a supported incline or side-lying position."
- **A precaution block is added:** "Your exercises have been adapted for pregnancy. Avoid lying flat on your back -- use a wedge pillow or rolled towel under your right hip for any floor exercises. Stop any exercise that causes discomfort and contact your OB/GYN or midwife."
- The care plan is labeled "Prenatal Pelvic Floor Protocol."
- **The reviewing PT receives a clinical alert:** "Patient is currently pregnant. Exercise modifications for supine positioning have been automatically applied. Please review for trimester appropriateness."
- A PRENATAL_PROTOCOL_APPLIED flag is surfaced in the OAIP Red Flags dashboard at MODERATE (amber) severity. This is a clinical routing note, not a safety concern.
- Patients route to their selected provider as normal (OB/GYN if selected, PCP otherwise). There is no forced rerouting.

How Exclusions Are Screened

Six plain-language questions are always presented during the eligibility screening step of the clinical intake (Step 2 of the patient journey, Section 1.4), screening for the unconditional exclusions listed above (items 1-6). Conditional questions about clinician-designated high-risk pregnancy and clinician-advised activity restriction are shown only to patients who indicate active pregnancy on the demographics screen.

A "yes" to any unconditional exclusion question halts the intake flow and displays a condition-specific message directing the patient to their physician or specialist. No AI-generated plan is created. For the conditional questions, a "yes" on clinician-designated high-risk pregnancy routes the patient into the Specialist Approval pathway: education-only content is delivered immediately (the patient is never left without guidance), while the exercise plan is generated and held pending OB/MFM clearance; on recorded clearance, the plan is released through mandatory PT review (see Section 1.4, Step 2). A reported activity restriction delivers education-only content regardless of designation. A "no" to both allows the patient to proceed with

the prenatal-adapted care plan. Positive exclusion screens are prominently flagged in the PT review dashboard.

These screening questions use patient self-report. As with any clinical screening, false negatives are possible. The PT review layer provides a secondary safety net.

4. Risk Management

4.1 Foreseeable Risks and Mitigations

(See Table 5 below)

Risk Category	Specific Risk	Likelihood	Impact	Mitigation
AI Failure	AI generates incorrect diagnosis or inappropriate exercise prescription	Medium	High	Mandatory PT review of every AI output during calibration phase. Validated instruments limit AI interpretation scope. PT can reject/modify any recommendation at any phase. 12 pre-approval guardrail checks alert the PT to inconsistencies.
AI Failure	Algorithmic error in treatment plan generation	Low	High	Plan generation uses deterministic scoring algorithms, not free-text LLM generation. ICD-10 codes derived from validated score thresholds. No generative AI in the scoring pipeline. Pudendal neuralgia detection uses a conservative heuristic flag that requires mandatory PT review -- it is not acted on autonomously.
AI Failure	Systematic scoring error affecting multiple patients	Low	Very High	Scoring functions validated against published instrument scoring manuals. PT review catches individual errors. Monthly audit of 10% random sample by independent clinician.

Patient Safety	Patient experiences adverse event during prescribed exercise	Low-Medium	Medium-High	Red-flag triage screens for emergencies before intake. Pain >3/10 precaution on all plans. Patient can report symptoms via 6-pathway "Report a Problem" button (including exercise pain and worsening symptoms pathways with severity sliders). High-severity clinical regression reports are flagged as CRITICAL in the OAIP dashboard.
Patient Safety	Delay in care due to platform failure	Low	Medium	Patient retains access to referring physician throughout. Platform uptime SLA: 99.5%. Downtime notification within 1 hour. Reversion to phone-based PT consultation during extended outage.
System Failure	Server downtime or data loss	Low	High	HIPAA-compliant, SOC 2 Type II audited cloud infrastructure (BAA executed) with 99.9% uptime SLA. Automatic encryption at rest and in transit with continuous data replication and documented disaster-recovery objectives. Audit log stored in an append-only table with function-level access controls.
Data Privacy	PHI breach or unauthorized access	Low	Very High	HIPAA-compliant architecture: encryption in transit and at rest on SOC 2 Type II audited infrastructure, role-based view separation (Patient/PT/OAIP) enforced by server-side authentication and authorization, individual PT accounts with hardened

				credential storage, and session management with automatic timeout. Audit logs are part of the clinical record and are de-identified for all regulatory and external review via the role-based de-identified auditor view. Annual penetration testing. BAA with all subprocessors.
Consent	Patient does not understand AI involvement	Medium	Medium	10-item informed consent with plain-language AI disclosure. Mandatory checkbox for each item. Right to opt out prominently displayed (including via "Report a Problem" button). Consent version-controlled and logged.
Fairness	Platform inaccessible to non-English speakers or low-literacy patients	Medium	Medium	Spanish-language version planned for Phase 2. Plain-language questions (6th-grade reading level). Voice-assisted intake planned for Phase 2 to support low-literacy and visually impaired patients. Medicaid outreach in underserved areas.

4.2 Vulnerable Populations

(See Table 6 below)

Population	Risk	Protection
Early postpartum (<6 weeks)	Tissue healing; infection risk; postpartum depression	Gentle PF-only exercises prescribed. Precaution added automatically. Fever red flag specifically targets postpartum infection. PT alert for any postpartum <6wk patient.
Currently pregnant	Supine positioning risk (vena cava compression);	Conditional high-risk pregnancy screening. Supine

	exercise appropriateness varies by trimester	exercises auto-substituted with incline/side-lying variants. PT clinical alert for trimester review. PRENATAL_PROTOCOL_APPLIED flag (MODERATE severity) sent to OAIP. See Section 3.8, Prenatal Pelvic Floor Protocol.
Patients with severe/rare conditions	Conditions beyond platform scope (e.g., pelvic organ cancer, neurological disease)	Red-flag triage redirects to emergency or physician care. AI does not generate plans for patients with active red flags. 6 exclusion questions (plus 1 conditional for high-risk pregnancy) screen for conditions outside platform scope. Platform explicitly limited to PF dysfunction--not differential diagnosis of underlying pathology.
Patients with limited ability to consent	Cognitive impairment, language barriers	Consent requires active checkbox for each of 10 items. Age verification (18+). Plain-language design. Opt-out available at any time (including via "Report a Problem" button). No auto-enrollment.
Minors (<18)	Not appropriate for this platform	Age verification at consent via DOB validation (18-120 range). Platform restricted to adults 18+.
Severe Postpartum Depression (PPD)	PPD can impact cognitive function and decision-making capacity	PHQ-2 depression screening (a validated two-item instrument) is embedded at intake and at every check-in, with a tiered response from immediate crisis resources through clinician alert and physician notification: On a positive screen: The patient is immediately shown a maternal mental-health resource card comprising crisis lines, peer support, and local maternal mental health referrals, with a brief automated follow-up message re-delivering the same resources several days later. At higher severity: A depression_screen_positive audit event is logged with severity classification, and the case is flagged for the

		reviewing PT to verify the patient's capacity to engage with a self-directed home exercise program. The PHQ-2 result, severity classification, and a recommendation for physician follow-up are included in the encounter note transmitted to the patient's referring physician (OB/GYN or PCP), who holds responsibility for mental health follow-up. Surfaced as DEPRESSION_RISK in the OAIP Red Flags dashboard. Screening results are always included in the encounter note to the patient's physician. PHQ-2 item wording is validated and is not modified by the platform.
Patients with suspected pudendal neuralgia	Nerve-related pain requires specialized evaluation	System applies a conservative clinical heuristic for suspected nerve involvement. Flags with ICD-10 G57.91, adds precaution against prolonged sitting exercises, and triggers mandatory PT guardrail alert for nerve involvement evaluation.

The following vulnerable populations may use the platform, with specific protections.

4.3 Data Privacy

Data Collected and Stored

- **Demographics:** first name, last name, date of birth, zip code, pregnancy status, delivery date (postpartum patients), delivery type, delivery history
- **Clinical responses:** all validated instrument answers, red-flag screening, symptom triggers, bowel function, pain locations, prior treatment history, medications, patient goals
- **Computed scores:** ICIQ total/severity/subtype, FLUTS F/V/I, FLUTSsex, GUPI P/U/Q, pain composite/functional
- **Treatment plans:** AI-generated and PT-modified versions, including exercises, adjuncts, diagnoses, CPT codes
- **Communication:** secure messages between patient and PT

- **Behavioral data:** exercise adherence, login frequency, symptom reports
- **Administrative:** physician name/fax, insurance type/ID, referral source, consent records
- **Audit trail:** timestamped log of every system action with actor identification (30+ distinct event types tracked, including PAIN_WORSENER, BOWEL_WORSENER, PROLAPSE_WORSENER, and PROLAPSE_FOLLOWUP_NEEDED escalation flags)

Data Usage

- **Primary:** Deliver and manage individualized PF-PT care
- **Secondary:** Generate aggregate outcomes data for OAIP reporting and quality improvement
- **Tertiary:** De-identified datasets for IRB-approved research and public outcomes dashboard
- **Prohibited:** Data is never sold, used for advertising, shared with employers or insurers for coverage decisions, or used for any purpose not disclosed in the consent

EHR Interface

The platform generates FHIR R4-compliant data structures (Patient, Practitioner, and Observation resources with US Core profiles), viewable in the OAIP Interoperability / HIE tab as a preview. This data model supports future integration with Utah's statewide clinical health information exchange and regional health-system HIE networks.

Current interoperability is implemented through two channels:

1. HIPAA-compliant transmission: The primary method for transmitting encounter notes and care plans to referring physicians, via HIPAA-compliant channels with verified destinations.
2. Patient-directed EHR sharing: Patients can download their care plan as a secure PDF via the "Export for MyChart / EHR" feature and upload it to their patient portal (e.g., MyChart). This is entirely client-side--no PHI is transmitted externally. Downloads are logged as CARE_PLAN_DOWNLOADED audit events.

Full bidirectional EHR connectivity is planned for Phase 3 or the extension period, pending a statewide HIE partnership.

HIPAA Compliance

Expect is designed to achieve full HIPAA compliance before production deployment. During the sandbox/testing phase, the following safeguards are in place, with additional safeguards planned for production:

- **Technical safeguards (implemented): HIPAA-aligned technical safeguards on SOC 2 Type II audited infrastructure, including encryption in transit and at rest, comprehensive audit logging (30+ event types including PT_PLAN_MODIFIED with detailed diff capture), a role-based de-identified auditor view, role-**

based view separation (Patient, PT Provider, and OAIP views) with function-level authorization, individual clinician accounts with hardened credential storage, automatic session timeout, and required-field enforcement preventing submission of incomplete clinical instruments. All persistent data storage, authentication, and encryption are fully operational before any real patient data enters the system in Phase 1 (see Table 2, Pre-Deployment requirements).

- **Administrative safeguards:** HIPAA training for all personnel, incident response plan, designated Privacy Officer and Security Officer
- **Physical Safeguards:** HIPAA-compliant, SOC 2 Type II audited cloud infrastructure with BAA executed
- Business Associate Agreements executed with any partners
- Annual HIPAA risk assessment and penetration testing
- **PHI in audit logs: Audit logs are part of the clinical record and are de-identified for all regulatory and external review. The role-based de-identified auditor view provides visual de-identification for regulatory review but is not claimed as HIPAA Safe Harbor de-identification. Full Safe Harbor de-identification is applied only to datasets exported for research or public reporting (see Appendix C).**

4.4 Healthcare Fairness

Expect is specifically designed to address healthcare access fairness in Utah:

- **Accessible pricing:** Platform is designed for Medicare and Medicaid-comparable reimbursement rates, not premium pricing. Accessible direct-pay option for patients without telehealth PT coverage.
- **Rural access:** Asynchronous platform delivery eliminates the geographic barrier that concentrates specialists in Salt Lake City and Provo. It also eliminates privacy issues associated with video-based telehealth for patients living in crowded housing.
- **Cultural sensitivity:** Questions use plain, non-clinical language with layperson definitions for anatomical terms
- **Stigma reduction:** Home-based assessment reduces embarrassment associated with in-person pelvic exams
- **Spanish-language support:** Planned for Phase 2 to serve Utah's 14% Hispanic/Latino population
- **Voice-assisted intake:** Planned for Phase 2 to serve low-literacy and accessibility populations, supporting ADA/WCAG accessibility commitments and directly addressing rural Utah populations where health literacy rates are lower than urban centers.
- **Outcome tracking by demographics:** De-identified fairness analysis in monthly reports to detect disparate outcomes
- **Bidirectional Utah pelvic-floor PT referral network:** Partnership with an established Utah pelvic-floor physical therapy practice to

receive in-region patients Expect refers out. Specialist referral destinations are routed through established Utah health-system specialty departments (urology; urogynecology / female pelvic medicine and reconstructive surgery; maternal-fetal medicine; gynecologic oncology; and GI / colorectal). All referral relationships are non-remunerative, documented, and reviewed with counsel.

- **Caregiver-assisted intake for elderly / mild-cognitive-impairment populations (per OAIP Suggestion 4):** When a designated caregiver completes intake on behalf of an older adult, the platform automatically triggers a live telehealth PT consultation with both patient and caregiver present. Patients with significant cognitive impairment are not appropriate digital-pathway candidates; the platform routes them accordingly.

5. Feasibility

5.1 Organizational Resources

Leadership Team

- **Chief Executive Officer:** Dara Cook – Founder & CEO. Wharton School of Business BS Economics (Honors; Benjamin Franklin Scholar, Joseph Wharton Scholar), Harvard Business School General Management Program, Visiting Impact Entrepreneur at Stanford Center for Social Innovation (2024–present). Secured national payer reimbursement with Harvard Pilgrim and Tufts Health Plans (2.2 million+ covered lives), paid public health contract with the Boston Public Health Commission (funded by the U.S. Department of Health and Human Services), and Institutional Review Board-approved study at University of Alabama at Birmingham. Briefed the National Academies of Sciences, Engineering, and Medicine Committee on Clinical Preventive Services (2025). Advanced Medical Technology Association (AdvaMed) member.
- **Chief Product & Technology Officer:** Joseph Pacheco – Co-Founder & CPTO. UPenn BA (Philosophy & Computer Science). 10+ years building and scaling iOS and cloud-backed healthcare applications with expertise in human-centered design, analytics instrumentation, and privacy-preserving data handling. Leads platform architecture, secure build pipelines, and usability workflows. Previously conducted 1,400+ structured technical interviews at Triplebyte.
- **Clinical Director:** Nicole L. Dugan, PT, DPT, WCS -- Board-Certified Women's Health Clinical Specialist with 25+ years of pelvic floor PT

experience; faculty, Herman & Wallace Pelvic Rehabilitation Institute; co-author, Crane & Dugan (2025) cueing framework

- **Privacy & Security: Expect maintains designated Privacy and Security Officers.**

Expertise

- **Clinical:** Pelvic floor physical therapists with specialized certification (PRPC, WCS or equivalent)
- **Technical:** Software engineering team with healthcare AI experience
- **Regulatory:** Familiarity with Utah OAIPA, HIPAA, FDA CDS exemption framework, and state PT practice acts. AdvaMed membership provides ongoing access to regulatory intelligence and industry best practices
- **Research partnerships:** Collaborations with academic institutions for outcomes analysis and peer-reviewed publication
- **Federal collaboration:** VHA CRADA (see Section 1.1)

Liability Insurance

Expect maintains a comprehensive insurance framework.

- Commercial General Liability
- Medical Malpractice & Professional Liability
- Cyber & Data Liability
- Technology Errors & Omissions (Tech E&O)

Stakeholder Networks

- Expect maintains an established stakeholder network supporting the pilot: Utah-licensed in-person pelvic-floor PT practices that receive warm-handoff referrals and serve as independent clinical reviewers during the pilot; Utah maternal mental-health and health-policy organizations; a federal research collaboration (VHA CRADA, see Section 1.1); referring OB/GYN and primary-care networks; payer engagement toward covered-benefit inclusion; academic research collaborations for outcomes analysis and peer-reviewed publication; patient-advocacy partnerships for community outreach; AdvaMed membership (medtech trade association; Code of Ethics compliance); and direct engagement with the OAIP and the Utah Division of Occupational and Professional Licensing (DOPL). Specific partner identities and commercial terms are confidential and on file with the OAIP.

5.2 Evidence the Product Will Work

This platform is not a replacement for an in-person visit. It is an alternative to no care at all, or to the random, online, unskilled resources that patients are currently accessing on their own.

According to the official journal of the American Urogynecologic Society, fewer than half of patients referred to pelvic floor PT initiate therapy and only 15% complete a course of care, with time and travel cited among the barriers — concerns that are particularly acute for women in rural areas. (Fullerton ME, Mwesigwa PJ, Tandel MD, et al. Comparison of Pelvic Floor Physical Therapy Attendance Based on Referring Provider Specialty. *Female Pelvic Medicine and Reconstructive Surgery* 2022;28(1):57–63. PMID: 34261109.)

Expect is designed to reach the 50% of patients who will never access pelvic floor PT and the 85% of those who start but don't finish, while still referring patients to in-person care when clinically indicated.

Furthermore, a key component of first-line pelvic floor care is individualized behavioral training and education, which a digital platform is well-suited to deliver. It also extends access in ways brick-and-mortar care struggles to — including to women whose first language is not English.

Academic Literature

- Pelvic floor muscle training (PFMT) is the first-line treatment for stress urinary incontinence (Cochrane Review, 2018; NICE guidelines CG171)
- AI clinical decision support improves diagnostic accuracy and reduces clinical variability in physical therapy (Knott et al., 2023)
- The ICIQ-UI SF, ICIQ-FLUTS, ICIQ-FLUTSsex, and GUPI-Female are validated, widely-used instruments with established psychometric properties and published scoring manuals
- Patient-reported outcome measures (PROMs) are the standard of care for PF dysfunction assessment (ICS/IUGA joint report, 2022)

Digital-First Intervention Evidence

There is a growing evidence base supporting the efficacy of digital-first interventions for urinary incontinence, the primary use case for the platform:

- App-Based Treatment vs. Usual Care: Loohuis AMM, Wessels NJ, Dekker JH, et al. App-Based Treatment in Primary Care for Urinary Incontinence: A Pragmatic, Randomized Controlled Trial. *Annals of Family Medicine* 2021;19(2):102–109. PMID: 33685871. App-based pelvic floor muscle and bladder training was “at least as effective” as primary care. A 12-month follow-up in BJOG (2022) further concluded it is a “viable alternative to care-as-usual over one year.”
- Remote Pelvic Floor Muscle Training: Sjöström M, Umeåfjord G, Stenlund H, et al. Internet-based treatment of stress urinary incontinence: a

randomised controlled study with focus on pelvic floor muscle training. *BJU International* 2013;112(3):362–372. PMID: 23350826. RCT of 250 women with no face-to-face contact; significant improvement at 4 months, with follow-up reports documenting sustained effect at 1- and 2-year marks.

- Mobile App Efficacy & Durability: Asklund I, Nyström E, Sjöström M, et al. Mobile app for treatment of stress urinary incontinence: A randomized controlled trial. *Neurourology and Urodynamics* (the official journal of the International Continence Society) 2017;36(5):1369–1376. PMID: 27611958. A mobile app produced clinically relevant improvements in stress urinary incontinence symptom severity and quality of life.
- PFMT Effectiveness Meta-Analysis: Curillo-Aguirre CA, Gea-Izquierdo E. Effectiveness of Pelvic Floor Muscle Training on Quality of Life in Women with Urinary Incontinence: A Systematic Review and Meta-Analysis. *Medicina* (Kaunas) 2023;59(6):1004. PMID: 37374208 (PMC10301414). Establishes PFMT as the evidence-based first-line intervention for UI and recommends *against* routine biofeedback.

Pre-Deployment Testing

- Internal testing with synthetic patient data across >200 clinical scenarios
- Scoring validation against published instrument scoring manuals (100% concordance)
- Plan generation review by board certified PF-PT specialist and urogynecologists across severity levels
- Usability testing with prospective patients for intake flow, language clarity, and completion time
- Security assessment including HIPAA compliance review and vulnerability scanning
- Direct-to-consumer wellness platform is operational for technology validation only--serving as an infrastructure proof-of-concept without clinical outputs.

Related Service/Product

- **Expect Fitness:** Existing consumer health and fitness platform demonstrating team's ability to build, deploy, and maintain healthcare-adjacent technology at scale
- Platform architecture and user experience patterns validated through Expect Fitness user base

5.3 Proprietary Technology Innovation

Expect's platform includes two novel technology subsystems that go beyond the application of published clinical instruments. These subsystems are the subject of a nonprovisional patent filing and represent Expect's core intellectual property.

Adaptive Outcome Algorithm

The platform collects structured, PHI-free outcome records linking each patient's baseline clinical profile to their treatment parameters and Week 8 outcomes. Each outcome record is de-identified at creation, with no name, date of birth, or contact information retained. Outcome records support confound control: outcomes can be stratified to distinguish treatment effect from natural postpartum recovery.

As outcome records accumulate, the algorithm identifies which baseline profile + treatment parameter combinations produce the greatest clinical improvement. In Phase 1, this data is observational only -- the algorithm does not influence plan generation. In Phase 2 and beyond, the outcome data may be used to refine exercise selection, adjunct recommendations, and cueing strategies for patients with similar baseline profiles, creating an adaptive feedback loop that improves over time. This "learning from outcomes" capability is architecturally distinct from the deterministic scoring used for initial plan generation.

The adaptive algorithm's key innovation is that it operates entirely on de-identified, structured outcome data -- not on raw clinical text, images, or patient communications. This design enables continuous improvement while maintaining full HIPAA compliance and avoiding the privacy risks associated with large language model training on clinical data.

PT Modification Tracking and Protocol Refinement

Every PT interaction with an AI-generated plan is tracked as a structured data signal. The platform captures detailed diffs of PT modifications: which exercises were added, removed, or modified (with specific parameter changes such as sets, reps, hold times, and frequency); which adjuncts were added or removed; and which goals were revised. An AI-PT agreement rate is computed in real-time across all approved plans, measuring the percentage of plans the PT approved without substantive modification.

PT modification patterns are tracked longitudinally and reviewed by Dr. Dugan and the clinical team on a regular cadence to identify protocol improvements. For example, if PTs consistently add a specific adjunct for a patient profile the AI missed, the clinical team updates the plan generation rules in a future release. This is a clinician-driven protocol refinement process -- not automated model fine-tuning. No AI model is retrained or

updated based on PT edits without explicit clinical review and code-level changes approved by the clinical director.

The platform also provides a structured, clinician-verified re-entry pathway for conditionally excluded patients (the Specialist Approval workflow described in Section 1.4), which complements the subsystems described in this section. This addresses the OAIP-identified safety concern of dead-end exclusion screens that promise re-entry without providing a defensible mechanism.

Multi-Instrument Biomarker Discovery Engine

The platform includes a statistical analysis engine designed to discover novel multi-instrument patterns ("digital biomarkers") that predict treatment response, non-response, or dropout. Five pre-specified cross-instrument hypotheses are embedded in the platform, spanning treatment non-response prediction, earlier detection of suspected pudendal involvement, dropout risk, cueing-strategy interaction effects, and tier-boundary response patterns.

Each hypothesis is evaluated with standard effect-size and significance testing. A minimum of 30 completed outcome records is required before any signal analysis is performed.

The biomarker discovery engine's innovation is the systematic application of cross-instrument correlation analysis to pelvic floor treatment outcomes -- a combination that has not been explored in the published literature. The five validated instruments used in this platform (ICIQ-UI SF, ICIQ-FLUTS, ICIQ-FLUTSsex, GUPI-Female, and PHQ-2) have never been administered together in a structured digital workflow that enables automated pattern discovery across their combined score space.

All biomarker signals are exploratory hypotheses generated from pilot data. Full validation requires IRB-approved analysis with appropriate sample sizes and pre-registered protocols. The OAIP Outcome Research dashboard displays biomarker signals for transparency.

5.4 Path to Reimbursement

Billing Strategy: Expect uses existing CPT codes rather than waiting for new "Digital Therapeutic" CPT codes. Because a licensed Physical Therapist reviews and approves 100% of plans in Phase 1 (and retains supervisory authority in subsequent phases), the platform's output is billable as a physical therapy evaluation and plan of care under existing codes.

Codes Utilized: CPT 97161–97163 (PT Evaluation) with telehealth modifier. These are established, billable codes that do not require new legislation or payer-specific approvals.

Payer Strategy:

Expect's detailed payer strategy — including payer-specific sequencing, pricing, and coverage-advocacy plans — is commercially confidential and on file with the OAIP. In general, the platform is reimbursable today under established fee-for-service CPT codes with a telehealth modifier; fees are HSA/FSA-eligible; and accessible direct-pay pricing ensures that access is not gated by payer policy. Pilot evidence will support future coverage-policy advocacy, including for Utah Medicaid telehealth PT coverage.

6. Public Relations

6.1 Building Trust with Stakeholders and the Public

Expect addresses trust through five transparency commitments:

- **Transparency with patients:** Plain-language informed consent; clear AI disclosure at every interaction; right to opt out without penalty; access to their own data; direct communication channel with their PT; ability to download care plan PDF for sharing with other providers
- **Sandbox tenant for OAIP review:** OAIP reviewers receive access to a synthetic-data sandbox tenant (no real PHI) with persistent banner disclosure ('OAIP SANDBOX TENANT · Synthetic data only · No real PHI'), the de-identified auditor view enabled by default (PHI fields masked across all views), and pre-loaded demo patients exercising every routing path including the Specialist Approval workflow. Cross-role navigation (Patient View, PT Provider View, Utah View) is available to OAIP reviewers in this sandbox to validate the full intake → routing → PT review → care plan workflow end-to-end. In production, role-based navigation gates each user (patients see only the patient experience, PT users see only the PT Review Console, Utah/OAIP users see only the Utah OAIP Dashboard).
- **Transparency with providers:** PTs see every AI output alongside raw patient responses and can verify scoring independently. During calibration, the AI is a tool in the PT's hands. In later phases, PTs maintain oversight through continuous random audit with immediate reversion to 100% review after any adverse event, and retain authority to intervene on any case
- **Transparency with OAIP:** Real-time compliance dashboard (see Section 1.4), full audit log access with the role-based de-identified auditor view (see Section 4.3), immediate adverse event notification, quarterly in-person briefings, and cooperation with external auditors
- **Transparency with the public:** Monthly anonymized outcomes dashboard; plain-language pilot summaries at Months 6 and 12; peer-reviewed publication; consumer FAQ; a public trust page at utah.expect.care/trust; media engagement explaining the "doctor, not device" model
- **Transparency with the medical community:** Encounter notes faxed to referring physicians; adherence to CMS documentation standards; ICD-10 and CPT coding that integrates with existing billing workflows; presentation of findings at Utah PT association meetings
- **Clinical review by the physician community:** Through OAIP coordination, an OB/GYN member of the Utah medical board reviewed this proposal, and Expect adopted every suggestion. The resulting commitments — the provider-notification cadence, dual-provider support, committed escalation-response windows, emergent-triage

follow-through, and the case-complexity definition — are reflected throughout this document.

- **Federal credibility:** The VHA CRADA (see Section 1.1) signals acceptance for collaborative research by the nation's largest integrated healthcare system
- **Industry standards:** AdvaMed member company, operating under the AdvaMed Code of Ethics for ethical interactions with healthcare professionals
- **Clinical reviewer credibility:** Clinical oversight is led by Clinical Director Nicole L. Dugan, PT, DPT, WCS — a board-certified Women's Health Clinical Specialist with 25+ years of pelvic floor PT experience. Dr. Dugan is faculty at the Herman & Wallace Pelvic Rehabilitation Institute, developed the APTA Women's Health Residency Program at Penn Medicine, and co-authored the cueing framework used in this platform (Crane & Dugan, 2025). Full CV available on request. The platform is designed for referral by board-certified urogynecologists, the primary referral pathway into pelvic floor PT. The pilot's clinical partnership model extends beyond the founding clinical team. In-person pelvic floor PT partners serve as both referral destinations for complex cases and independent clinical reviewers, providing multi-clinician validation that the AI's recommendations are consistent with standard-of-care practice across different clinical settings. This cross-site agreement data — measuring whether independent PTs at separate practices concur with AI-generated recommendations — is a stronger validation signal than single-clinician review and directly supports the "earned autonomy" progression model described in Section 3.1.

Expect will proactively address potential public concerns by emphasizing:

- The AI earns autonomy through demonstrated safety--volume-gated supervised cases per subtype (250 at the Stretch enrollment tier, proportionally adjusted at lower tiers) before any auto-approval, with ongoing 10% audit and immediate rollback if any adverse event occurs
- The platform expands access to care that most Utah women currently cannot get
- Patient data is never sold or used for advertising
- If the AI causes harm, Expect pays for remedial care

APPENDIX A: Platform Technical Architecture

The Expect platform comprises the following components. The patient-facing application and OAIP dashboard are described in detail in Section 1.4. This appendix provides the technical reference.

- **Patient-Facing Web Application:** React-based responsive application. 10-step guided intake (100+ questions), informed consent (10 checkboxes), 5-tab care plan viewer, MyChart/EHR export (client-side PDF), 6-pathway symptom reporting, secure messaging. See Section 1.4 for full walkthrough.
- **PT Provider Dashboard:** Three-tab interface (Dashboard, Patients, Audit Log). 12 pre-approval guardrail checks, CMS-compliant encounter note, review timer. See Section 1.4, PT Provider Experience.
- **OAIP Compliance Dashboard:** Seven-tab interface (Safety & Oversight, Outcomes, Pilot Operations, Case Review, Compliance, Live Audit Stream, Interoperability / HIE). 11 clinical signal types. Five persistent summary cards (Active Patients, Week 8 Completed, High-Concern Rate, PT Review Timeliness, Clinically Meaningful Improvement) are always visible above the tab bar. Role-based de-identified auditor view (see Section 4.3). See Section 1.4, OAIP Oversight Experience. The Outcomes tab displays de-identified outcome records, live AI-PT agreement rate (computed from outcome records), tier-level outcome breakdowns, structured PT modification detail (exercise/adjunct/goal diffs), and biomarker discovery signals (see Section 5.3).
- **AI Scoring Engine:** Deterministic algorithms for ICIQ-UI SF (0-21), selected FLUTS F/V items (0-24), FLUTSsex (0-12), GUPI-Female (P/U/Q, 0-45), pain composite (0-10), POPDI-6 (0-100 distress score + symptom flags). Incontinence subtype classification. PHQ-2 depression screening with tiered clinical response. Bristol Stool Scale + bowel function composite. All plans, outcome records, and audit events include a CLINICAL_LOGIC_VERSION identifier for algorithm traceability.
- **AI Plan Generator:** Rule-based plan generation: ICD-10 mapping (up to 6 codes including R32 fallthrough and pudendal neuralgia), 4-tier exercise prescription (Foundation/Beginner/Moderate/Advanced), adjunct engine (9 recommendation types), risk stratification (Red/Orange/Yellow/Green four-band), precautions, progression criteria, and prenatal exercise substitution (see Section 3.8).
- **Audit Log: 30+ event types, ISO 8601 timestamps. Role-based de-identified auditor view (see Section 4.3). Append-only persistent storage with function-level access controls.**
- **Provider Routing: Encounter notes and care plans are transmitted to referring physicians via HIPAA-compliant channels with verified destinations, with concierge verification support. See Section 1.4, Step 7.**

- **Patient-Directed EHR Sharing:** Client-side PDF generation. See Section 1.4, Step 8.
- **FHIR R4 Preview:** FHIR R4 Bundle with US Core profiles. See Section 4.3, EHR Interface.
- **Outcome Record Engine: PHI-free structured outcome records linking baseline clinical profiles to treatment parameters and Week 8 outcomes, de-identified at creation. See Section 5.3.**

APPENDIX B: Patient Safety, Clinical Oversight, and Remediation Framework

Expect -- Utah OAIP Pilot

0. Intervention Risk Profile

Pelvic floor physical therapy is among the lowest-risk interventions in clinical medicine. The Expect pilot delivers exercise recommendations (bodyweight pelvic floor contractions, breathing coordination exercises, bridges) and behavioral guidance (bladder retraining, bowel management, fluid/caffeine management). The intervention:

- Involves no pharmaceuticals. No drugs are prescribed, dispensed, or recommended. No dosing risk, drug interaction risk, or adverse pharmacological reaction risk.
- Involves no implanted or invasive devices. Unlike intravaginal biofeedback devices, Expect's program is instruction-only. No device malfunction or infection risk.
- Involves no surgical or procedural risk. No anesthesia, incisions, ionizing radiation, or contrast agents.
- Produces predictable, bounded adverse events. The realistic worst-case outcome from an incorrectly prescribed pelvic floor exercise program is that it does not improve symptoms, or the participant experiences mild and self-limiting muscle soreness. This is categorically different from AI systems recommending medication dosages or surgical approaches where errors can produce irreversible harm.

The exercises prescribed -- Kegel contractions, diaphragmatic breathing, bridges, lifestyle modifications -- are widely recommended as self-care by ACOG, the International Continence Society, and the Academy of Pelvic Health Physical Therapy. The AI-supported workflow adds clinical structure, personalization, and oversight to exercises that millions of women already perform unsupervised.

1. Prevention-First Safety Architecture

The pilot is structured to reduce risk before remediation is needed:

- 100% clinician review of care plans before delivery (Phase 1). A licensed physical therapist reviews and approves every participant-facing plan using a standardized checklist. The reviewing clinician may modify any element. Average review time: 3--5 minutes per plan.
- Upfront clinical governance. A Board-Certified Women's Health Clinical Specialist (WCS) authored or reviewed the scoring algorithms, exercise library, escalation logic, and plan generation rules based on published evidence.
- Red-flag screening with immediate routing. Reported symptoms indicating urgent or emergent conditions are routed out of the platform to emergency or in-person medical care. No exercise plan is generated. Additionally, a safety gate mechanism tracks any subsequent attempt to change a positive safety answer, requiring explicit patient confirmation and logging the change as a SAFETY_ANSWER_CHANGED event for PT review and OAIP oversight.
- Standardized clinician review checklist. Documented separately (see Appendix D).
- Tiered escalation logic. Standard pathway, enhanced monitoring (elevated severity, high avoidance, medication modification), and clinical referral (high severity, complex presentation) based on validated severity scores and behavioral indicators.
- Pudendal neuralgia detection. The system flags suspected pudendal neuralgia using a conservative clinical heuristic based on reported pain patterns. This triggers ICD-10 code G57.91, a precaution against prolonged sitting exercises, and a mandatory PT review guardrail alert. The PT evaluates nerve involvement before progressing the exercise program.
- Prenatal exercise safety protocol. Pregnant patients receive prenatal-adapted care (see Section 3.8, Prenatal Pelvic Floor Protocol).
- Full audit logging. AI-generated draft outputs, clinician review actions (approve/modify/reject), timestamps, and participant-facing final plans are logged and available for regulatory review.

This prevention-first design materially lowers the expected corrective care frequency.

2. Incident Reporting and Expedited Clinical Review

If a participant reports a concern related to AI-supported care:

Step 1: Expedited Clinical Review (No Cost)

- Review of AI-generated draft output (pre-clinician review)
- Review of clinician-approved plan (post-review)
- Review of participant-reported symptoms, timeline, and adherence
- Review of relevant clinical notes and communications
- Root-cause classification

Participants report concerns through the six reporting pathways described in Section 1.4, Step 8. All reports are logged in the immutable audit trail and surfaced in the OAIP Red Flags dashboard.

Participants may also report concerns through a dedicated support channel or by contacting Expect directly. Expect will acknowledge receipt within 24 hours and triage based on clinical urgency. Emergent concerns are triaged immediately.

3. Root-Cause Classification

Reported concerns will be classified using a defined framework that adapts to the pilot phase:

- **Phase 1 (Calibration -- clinician-reviewed):** Every plan is reviewed by a licensed clinician before delivery. Review considers the AI-generated draft, the clinician's edits/approvals, and participant context.
- **Phase 2/3 (Graduated autonomy):** For auto-approved plans, analysis distinguishes between Protocol Adherence (the system applied the validated rules as designed, but the outcome was suboptimal) and Algorithmic Deviation (the system did not execute the rules/exclusions as designed). For clinician-reviewed plans, the Phase 1 framework applies.

Classification categories:

- **AI/System Deviation:** The platform failed to apply validated scoring logic, exclusions, or routing correctly (e.g., missed a red-flag criterion, selected an exercise outside the severity tier).
- **Clinical Review Miss:** A clinician-reviewed plan contained an issue that was not identified or corrected during review (Phase 1 clinician-reviewed plans only).
- **Protocol Limitation (Needs Refinement):** The system followed the validated protocol, but pilot learnings indicate the protocol needs adjustment for certain presentations.
- **Participant Execution/Adherence:** Non-adherence, misunderstanding, or deviation from instructions contributed to the issue.
- **Indeterminate/Multifactorial:** No single cause can be identified.

This classification supports safety review, quality improvement, and pilot reporting -- not assignment of legal liability.

4. Corrective Care Commitment

Step 3: Scope-Defined Corrective Care

If Expect's clinical review determines that corrective care is clinically appropriate and the issue was likely attributable (in whole or in part) to the AI-supported workflow and/or its clinical oversight process, Expect will provide:

Expect will provide expedited clinical review, clinician care-plan revision, corrective telehealth PT care, follow-up monitoring, and referral support for in-person pelvic floor PT evaluation where clinically indicated and reasonably available — at no cost to the participant, with documented root-cause analysis.

Corrective care is defined by scope of services, not participant-facing dollar caps.

Given the low-risk intervention profile (Section 0), the most likely corrective action is plan revision and additional clinician monitoring -- not emergency intervention or specialist referral.

5. Pilot Program Terms (Defined and Bounded)

- **Reporting window:** Concerns must be reported within 30 days of completing the assigned protocol or discontinuing pilot participation, whichever occurs first, unless delayed reporting is clinically justified.
- **Clinical review timeline:** Acknowledgment within 24 hours. Expedited clinical review initiated within 72 hours for non-emergent concerns.
- **Scope of corrective care:** Limited to clinically appropriate pelvic floor corrective services and follow-up support within the pilot model. Does not extend to unrelated conditions, pre-existing conditions unrelated to the pilot intervention, or care outside the scope of pelvic floor PT.
- **Service availability:** In-person referral support is subject to provider availability and geographic access. Telehealth follow-up is the default corrective modality.
- **Documentation:** Expect documents all reviews, classifications, corrective actions, and outcomes for audit and regulatory reporting.

6. Reporting and Continuous Improvement

Expect will maintain an incident and corrective action log and provide periodic reporting to Utah program administrators as required, including:

- Number and type of reported concerns (across all 6 reporting pathways)
- Triage outcomes and response times
- Root-cause classifications
- Corrective care actions provided
- Workflow, algorithm, or process changes implemented in response

This reporting supports the OAIP's oversight requirements and Expect's internal quality improvement process.

APPENDIX C: Data Governance, De-Identification, and Research Framework

1. Overview

This appendix describes how Expect collects, stores, de-identifies, and shares data generated through the Utah OAIP pilot. It addresses the four data-sharing commitments in the participant consent form: (1) Utah OAIP oversight, (2) IRB-approved research, (3) external auditors, and (4) anonymized public dashboards.

2. Data Collected

The platform collects the following categories of data during the pilot:

- **Clinical intake data:** Responses to validated instruments (ICIQ-UI SF, FLUTS, GUPI, NRS pain scales), symptom history, medication history,

activity avoidance, cue preference, pregnancy status, delivery date and type (postpartum patients), bowel function, and patient goals. All self-reported.

- **Demographic data:** Name, date of birth, contact information (for clinical communication only), referring provider.
- **Treatment plan data:** AI-generated draft plans, clinician-reviewed final plans, exercise prescriptions, adjunct recommendations, diagnostic codes, CPT codes.
- **Clinical governance data:** Clinician review timestamps, review duration, structured PT modification diffs (exercise adds/removes/parameter changes, adjunct changes, goal modifications), approval/rejection decisions, clinical notes.
- **Outcome data:** Follow-up instrument scores (ICIQ, pain), patient-reported outcomes, adherence metrics, satisfaction surveys.
- **Audit data:** Complete log of system interactions, AI outputs, clinician actions, and participant-facing deliverables.

3. Data Storage and Security

- **HIPAA compliance:** All individually identifiable health information (IIHI) is stored in HIPAA-compliant, SOC 2 Type II audited cloud infrastructure (BAA executed) with automatic encryption at rest and in transit and function-level access controls. Patient records, audit events, outcome records, and session data persist across sessions under those controls. The consent form transparently discloses the data storage approach.
- **Access controls:** The platform implements role-based view separation with three distinct views (Patient, PT Provider, OAIP), enforced by server-side authentication and authorization, with individual clinician accounts, hardened credential storage, session expiry with automatic timeout, and role-based function access enforced on every request. The role-based de-identified auditor view is available for regulatory review (see Section 4.3).
- **Retention:** Clinical records retained per Utah and federal healthcare record retention requirements (minimum 7 years). Pilot-specific data retained for the duration of the OAIP agreement plus 3 years for regulatory reporting.
- **Cyber liability coverage maintained (see Section 5.1)**

4. De-Identification Standard

All data shared outside the clinical treatment relationship is de-identified using the HIPAA Safe Harbor method (45 CFR 164.514(b)(2)), which requires removal of 18 specified identifiers:

Names, geographic data smaller than state, dates (except year) for individuals over 89, phone/fax numbers, email addresses, SSN, medical record numbers, health plan beneficiary numbers, account numbers,

certificate/license numbers, vehicle identifiers, device identifiers, web URLs, IP addresses, biometric identifiers, full-face photographs, and any other unique identifying number or code.

De-identification is performed programmatically before any data export. The de-identification process is documented and auditable.

Note: The role-based de-identified auditor view (see Section 4.3) provides display-level de-identification for real-time regulatory review, distinct from the full HIPAA Safe Harbor de-identification applied to research datasets and public reporting exports.

5. Data Sharing: Utah OAIP Oversight

Expect will provide the following to the Utah OAIP on a defined reporting schedule:

5a. Periodic Reporting (Quarterly or as Required)

- Total participant enrollment and demographics (de-identified, aggregated)
- **Clinical outcome metrics:** mean ICIQ score change, pain score change, adherence rates
- **Safety metrics:** incident reports filed, root-cause classifications, corrective actions taken
- **AI performance metrics:** clinician modification rate (% of plans modified during review), types of modifications
- **Consumer satisfaction:** aggregated satisfaction scores and qualitative themes
- **Operational metrics:** average review time, escalation rates, referral rates

5b. On-Demand Access

OAIP may request access to:

- Complete audit trail for any specific interaction (with participant consent or under regulatory authority)
- AI model/algorithm documentation (scoring logic, exercise selection rules, escalation thresholds)
- Incident investigation records
- Clinician review records (de-identified)

6. Data Sharing: IRB-Approved Research

Existing IRB-Approved Study: Expect has an active IRB-approved study at the University of Alabama at Birmingham (UAB). This study involves anonymized pelvic floor outcome data and has been reviewed and approved by the UAB Institutional Review Board.

For the Utah pilot, de-identified data may be shared with researchers under the following conditions:

- **IRB approval required:** Any research use of pilot data requires an active IRB approval from the researcher's institution, covering the specific use case.
- **Data Use Agreement (DUA):** A formal DUA must be executed between Expect and the receiving institution before any data transfer.

- **De-identification:** Only HIPAA Safe Harbor de-identified data is shared. No re-identification is permitted under the DUA.
- **Purpose limitation:** Data may only be used for the specific research purpose described in the IRB protocol and DUA.
- **No commercial resale:** Research data may not be sold, licensed, or transferred to third parties.
- **Publication:** Research findings may be published in peer-reviewed journals. Expect receives advance notice of publications using pilot data.

The UAB IRB study demonstrates Expect's existing institutional commitment to responsible research data practices. Extending this framework to the Utah pilot data follows the same governance model.

7. Data Sharing: External Auditors

External auditors may access pilot data under the following conditions:

- **Scope:** Audit access is limited to verifying compliance with OAIP requirements, HIPAA obligations, clinical governance protocols, and financial controls.
- **Authorization:** Audit access requires either (a) participant consent as described in the informed consent, (b) OAIP regulatory authority, or (c) legal process.
- **Data format:** Auditors receive the minimum necessary data for the audit scope. The role-based de-identified auditor view (see Section 4.3) allows auditors to review complete audit streams without exposure to raw patient identifiers. Individual-level clinical data is provided only when the audit requires it and only under appropriate confidentiality and data protection agreements.
- **Audit trail:** All audit access is logged with date, auditor identity, scope, and data accessed.

8. Data Sharing: Anonymized Public Dashboards

Expect will maintain a public-facing dashboard displaying anonymized, aggregated pilot metrics. This supports the OAIP's transparency objectives and Expect's commitment to public accountability.

8a. Dashboard Metrics (Examples)

- Total participants enrolled (count only)
- Aggregate symptom improvement (mean ICIQ score change pre/post)
- Aggregate pain reduction (mean pain score change)
- Adherence rate (% of participants completing assigned protocol)
- Satisfaction score (aggregate)
- **Safety:** number of reported concerns, number of corrective care actions
- **Clinician review metrics:** average review time, modification rate

8b. What is NOT Published

- No individual-level data
- No demographic breakdowns that could allow re-identification (e.g., no age x zip code x diagnosis)
- No proprietary algorithm details

- No clinician-identifiable information

Dashboard metrics will be updated quarterly or as required by OAIP terms.

9. Participant Rights

- **Right to access:** Participants may request a copy of their complete clinical record at any time. The patient care plan portal provides direct access to assessment scores, exercises, recommendations, strategies, and a printable full report. Patients may also download their care plan as a PDF via the "Export for MyChart / EHR" feature.
- **Right to withdraw:** Participants may withdraw from the pilot at any time. Withdrawal does not affect data already collected for safety reporting and regulatory compliance, but no new data will be collected.
- **Right to restrict:** Participants may request restrictions on specific data uses, subject to regulatory reporting requirements.
- **Right to be informed:** Participants are informed at enrollment of all data sharing practices through the informed consent.

10. Data Governance Contact

Questions about data practices may be directed to Expect's designated privacy contact: [To be provided in pilot materials].

APPENDIX D Clinical Reviewer Checklist -- Utah OAIP Pilot

PTs follow a standardized 7-step review checklist covering safety verification, tier assignment, adjunct verification, cue personalization, escalation, routing, and final sign-off (3–5 minutes per review).

This checklist corresponds to the prevention-first safety architecture described in Appendix B, Section 1. The complete checklist, including the platform's specific clinical-logic values, is on file with the Utah OAIP.

APPENDIX E: Operational Design, Pilot Phases, and Patient Experience

Expect -- Utah OAIP Pilot -- March 2026

1. The Access Gap in Utah

As described in Section 1.3, Utah has only five board-certified women's health pelvic floor physical therapists (per the American Board of Physical Therapy Specialties) for approximately 1.6 million adult women; public provider directories suggest roughly 70 practicing pelvic rehab PTs statewide. Wait times for pelvic health specialty care can reach several weeks even in urban areas; rural access is essentially unavailable. For many women, this pilot may be the only way they receive evidence-based pelvic floor care.

2. Clinical Evidence Base

The Expect protocol uses validated clinical instruments, peer-reviewed evidence, and a licensed clinician review layer.

2a. Validated Instruments

- **ICIQ-UI SF** (International Consultation on Incontinence Questionnaire, Short Form): The gold standard for measuring urinary incontinence severity. Validated, widely used in clinical trials and clinical practice globally.
- **FLUTS (Female Lower Urinary Tract Symptoms)**: Comprehensive symptom assessment instrument.
- **GUPI (Genitourinary Pain Index)**: Validated pain assessment for pelvic pain conditions.

2b. Evidence-Based Exercise Selection

The specific exercises in the Expect protocol (Bridge Lift, Quick Squeeze Kegels, Long Hold Kegels, Diaphragmatic Breathing) are directly linked to ICIQ score reduction through pelvic floor strengthening. Prenatal patients receive pregnancy-safe exercise substitutions (see Section 3.8). The protocol uses the validated "Imaginative Cueing" framework from Crane, Dugan et al. (2025), co-authored by Expect's Doctor of Physical Therapy. This paper is one of the most downloaded in the history of the Journal of Women's & Pelvic Health Physical Therapy. The framework statistically improves neuromuscular recruitment ($P < .001$).

2c. ICIQ Minimal Clinically Important Difference (MCID)

Mean ICIQ-UI SF score improvement ≥ 3 points across the pilot cohort (the platform's primary endpoint, exceeding the published MCID of 2.5 points; a ≥ 4 -point strong-responder threshold is tracked separately for additional clinical resolution). This means the pilot is not looking for "better numbers"--it is looking for clinically significant improvement that patients can feel.

3. Pilot Phases and PT Review Evolution

See Table 2 (Section 3.1) for complete phase definitions and benchmarks. In summary:

- **Phase 1 (Months 1-4)**: 100% PT review of all AI-generated plans. Target review time: 3-5 minutes. PT may modify, reject, or rebuild any plan.
- **Phase 2 (Months 5-8)**: Risk-stratified review. Low-complexity cases may receive expedited review; high-complexity cases remain 100% PT review.
- **Phase 3 (Months 9-12)**: Low-complexity plans may be auto-approved with retrospective audit. High-complexity cases continue prospective PT review.

Phase transitions require OAIP notification and approval. Any adverse event or safety concern can trigger a return to Phase 1.

4. Success and Failure Definitions

Primary success metric: Mean ICIQ-UI SF score improvement ≥ 3 points across the pilot cohort (the platform's primary endpoint, exceeding the

published MCID of 2.5 points; a $\geq$ 4-point strong-responder threshold is tracked separately for additional clinical resolution).

Secondary metrics:

- Patient satisfaction score $\geq$ 4.0/5.0
- Protocol adherence rate $>50\%$ (Phase 1), $>65\%$ (Phase 2), $>70\%$ (Phase 3), per the phased targets in Table 3
- Clinician substantive modification rate $< 5\%$ (Phase 1 benchmark, consistent with the $\geq 95\%$ AI-PT agreement benchmark in Section 3.3)
- Zero unresolved adverse events
- Pain score reduction in patients with baseline pain $\geq 3/10$

Failure triggers (any one triggers review):

- Adverse event rate $> 2\%$ of participants
- Clinician modification rate $> 10\%$ (indicates AI is generating poor plans; corresponds to the $< 90\%$ AI-PT agreement rollback trigger in Section 3.4)
- Mean ICIQ improvement < 3 points at 8-week mark
- Patient dropout rate $> 40\%$ before 4-week mark
- Any serious adverse event attributable to AI-supported workflow

Termination triggers:

- Any participant harm directly attributable to AI error not caught by PT review
- Loss of clinical oversight (PT unavailability exceeding 48 hours)
- OAIP directive to terminate
- Loss of insurance coverage

5. End-to-End Patient Experience (HIPAA-Compliant)

5d. Portal Notification Email (Draft)

Subject: New message from your Expect care team

Hi [First Name],

You have a new document available in your secure Expect portal.

[Button: Sign in to View]

For your security, this link will expire in 24 hours. If you did not request this, please ignore this email. Do not reply to this email. This inbox is not monitored.

6. Vulnerable Populations

See Section 4.2 and Table 6 of the main proposal for the complete vulnerable populations framework, including protections for pregnant patients, postpartum patients, rural residents, patients with pain, patients modifying medications, patients with high avoidance, low health literacy patients, patients in crisis, and patients with suspected pudendal neuralgia.