

OBCE Key Issues Survey

The recent Key Issues Survey (conducted late February to March 2012) provided lots of information and comments to the Board in preparation for their strategic planning meeting held last March. Over 285 Chiropractic physicians provided 94% of the responses reviewed by the Board. The Survey is on the OBCE's website and responses are still coming in.

Key findings include:

- Top Issues Facing the Profession.

Protecting the public	17%
Maintaining professional standards	14%
Protecting the profession	13%
Fair treatment of chiropractors	9%
Educating the public about chiropractic	9%
Sexual Misconduct or boundary violations	8%
Promoting quality in chiropractic care	8%
Overregulation	4%
Independent Medical Examinations/Chart Reviews	4%
Excessive Treatment	4%
Competition from other professions	3%
Patient record keeping quality	3%
Unlicensed practice	3%
Advertising issues	>1%

- 76% rated the OBCE Good/Excellent, while 18.5% said Fair/Poor, 5% didn't know
- Twice as many say the OBCE is doing a better job (20%) than a worse job (10.5%), 64% said about the same.
- 46% have visited the OBCE Web page in the last year, 38% in the last month



The OBCE's March meeting featured a day long planning session. Left to right (Cookie Parker Kent-Public Member, Tom Rozinski-Investigator, Douglas Dick-Public Member, Daniel Coté DC-OBCE Vice President (standing), and Kelly Beringer-Administrative Assistant)

What's Inside BackTalk

President's Report.....	2
Record Keeping Issues	3
Fee-Splitting Rule & Online Advertising	4
One Doctor's Recovery Story	5
Policy & Practice Questions.....	6
Disability Awareness in the Clinical Setting ..	8
Administrative Rules Update	12
Cultural Competency Committee	12
Licensing & CE	13
Vern Saboe DC on Key Commission	15
Newly Licensed DCs	16



President's Report

Ann Goldeen DC

Recently the OBCE had a day long planning session to identify our challenges and top issues. This was important as our challenges are growing while our resources are limited. We reviewed the OBCE Key Issues Survey results and took to heart the many positive comments and no small number of biting criticisms. We set short-term and long-term goals as well as updated our Strategic Plan.

Our top short term goal is more regular and focused communication with the profession and public. With over 80% of the chiropractic physicians in our OBCE Publication email list, we will communicate on specific issues more frequently.

Other short term goals include:

- More board meetings by telephone to help us stay on top of increasing complaints and cases. Complaints/cases rose from 69 in 2010 to 130 in 2011, so our agendas have been full.
- A greater focus on rehabilitative and preventive approaches. We are increasing the number of mentoring plans in response to complaints.
- We are requiring CE in specific problem areas such as boundaries and record keeping to reduce complaints and better serve our patients.

Moving to semi-independent status as a state agency is both a high priority short and long-term goal. This would allow the OBCE to be more flexible and nimble to meet our mission of public protection. It would give us more independence to manage our own affairs and save on state agency costs. Currently, there are three health licensing boards with this status (physical therapy, optometry and massage therapy). Most of the other 14 health boards are also requesting semi-independent state agency status.

Other long term goals include:

- Review/update statutes and rules. While we review individual rules as needed, we haven't had a comprehensive look at all our statutes and rules for some time.

CONTINUED ON PAGE 3

The mission of the Oregon Board of Chiropractic Examiners is to serve the public, regulate the practice of chiropractic, promote quality, and ensure competent ethical health care.

BackTalk is the official newsletter of the Board of Chiropractic Examiners. The Board's next two regular meetings are July 19, 2012 in Portland and September 20, 2012 in Salem. For information, go to the OBCE web site at www.oregon.gov/obce or call the Board office at (503) 378-5816.

Board Members

Ann Goldeen DC
President, Astoria

Daniel Coté DC
Vice-President, Silverton

Douglas Dick
Secretary, Public member

Huma Pierce DC
Beaverton

Todd Bilby DC
Corvallis

Christine Robinson DC
Medford

Estelle Parker-Kent
Public member

Staff Directory

Telephone: (503) 378-5816

Email: oregon.obce@state.or.us

Dave McTeague (503) 373-1620
Executive Director
Administration • Legal questions
Board issues • Practice questions

Kelly Beringer (503) 373-1573
Administrative Assistant
DC license renewal & information
CA certification, renewal & information
Continuing education • Practice questions

Donna Dougan (503) 373-1579
Administrative Assistant
DC applicants • Examinations
Peer Review • Contracts

Thomas Rozinski (503) 373-1615
Investigator/Compliance • Complaints
Investigations • Probation monitoring

Shari Barrett (503) 373-1614
Office Specialist I • DC lists, Record
requests • Meeting coordinator
License verifications

Record Keeping Issues

By Todd Bilby DC

The OBCE is regularly encountering both hand written and electronically generated chart notes that do not meet minimal standards. In an effort to bring more Doctors of Chiropractic into compliance, the OBCE will require all Oregon DCs to complete six (6) hours of continuing education in documentation during 2013.

“Blaming software for inaccurate electronic records is not acceptable in most cases.”

Hand written chart notes are often found to be incomplete and/or illegible. Travel card style documentation and chart notes that are technique specific rarely comply with Oregon Administrative Rule (OAR) 811-015-0005(1)(a) (i.e. “The Dead Doctor Rule”). This rule states, “Each patient shall have exclusive records which shall be sufficiently detailed and legible as to allow any other Chiropractic physician to understand the nature of that patient’s case and to be able to follow up with the care of that patient if necessary.”

Electronic health records (EHR) are frequently found to be inaccurate. Doctors are always responsible for the accuracy of their chart notes. Blaming software for inaccurate electronic records is not acceptable in most cases. Pervasive inaccuracies can lead to a records violation and OBCE discipline. OAR 811-015-0005(1) states, “It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations.” The following EHR specific problem areas have been identified:

- 1) Chart notes fail to demonstrate patient improvement over time or explain lack of improvement.
- 2) Subjective and objective findings are not presented in a manner that is clear and logical. (This is especially true when unedited cut and paste findings are carried forward.)
- 3) Treatment plans fail to reflect changes in exam findings.
- 4) Treatment plans and treatment frequency do not correlate, and discrepancies are not explained.
- 5) There is no correlation between exam findings and mechanisms of injury and discrepancies are not explained.
- 6) Exam findings are not addressed during treatment.
- 7) Chart notes and examination findings are not unique for individual cases.

The 2013 continuing education coursework will specifically address the components required for records compliance. Bringing all Oregon Doctors of Chiropractic into compliance will serve to protect the public by assuring DCs are documenting care that is competent, complete, and accurate. Competent documentation will help demonstrate to the public that Oregon Doctors of Chiropractic are providing the absolute best health care possible.

President’s Report – Goals

CONTINUED FROM PAGE 2

- We plan to propose adding a part-time chiropractic position to our staff in our next budget (or alternatively more resources for chiropractic consultants). The medical, nursing, physical therapy and pharmacy boards all have their respective professional on staff. We need the additional help for the Board and Peer Review Committee, and our investigator needs this chiropractic expertise to help review complaint files and records. We know the Legislature is adverse to adding staff to any state agency, but this is needed.

Fee-Splitting Rule & Online Advertising Update

Since July 2011, the OBCE has communicated that online coupon sales where the fee is split on a per patient basis between a chiropractic clinic and the advertising company violates the OAR 811-035-0015 (24) prohibitions against “splitting fees or giving or receiving a commission in the referral of patients for services.”

Since then there have been additional developments and questions.

Groupon and Living Social now offer flat-fee advertising contracts which do not violate the rule. DCs should make sure they are signing this version of any contract. These contracts may have provisions in which the advertiser holds the revenues in trust until the promotion has concluded and then deducts their flat fee from the total.

Merchant Fees (Visa, MasterCard, Discovery card charges) The OBCE also adopted a policy that it does not consider it a violation of the fee-splitting rule for an advertiser to charge a merchant (chiropractic clinic) for the actual costs related to Merchant Fees. Typically these run in the 2 to 3% range of the purchase cost. Merchant Fees specifically relate to the typical charges that vendors, such as those listed above, charge the merchant for the cost of using their credit card transaction service.

SprigHealth.com has a web site where patients may schedule an appointment. Sprig Health is in the process of modifying their chiropractic program to come into compliance with the rule.

One online advertiser purportedly has charged a “flat fee” which is the coupon sales total. Since under this arrangement the cost to the chiropractic clinic would rise or fall depending on the per patient sales, the OBCE has determined this also violates the rule.

The Washington State Chiropractic Quality Assurance Commission is also addressing this issue. They are asking if the coupon fee-splitting programs violate their anti-rebate rule. The OBCE doesn't have jurisdiction over DCs licensed in Washington State.

Questions and Answers

Question: Is it fee splitting if the doctor's portion of the split is donated to a non-profit charity?

Answer: Yes, as the advertiser still receives a split on a per patient basis.

Question: A DC/L.Ac. asks if she can advertise on Groupon as an L.Ac.

Answer: The OBCE would not have jurisdiction as long as “chiropractic” & “DC” are not referenced in the advertisement. However, caution is advised.

Question: A DC has an LMT in office; can that person advertise with a fee-splitting coupon advertiser?

Answer: If the LMT is part of the chiropractic clinic, the answer is No.

Question: A DC has an LMT in office, can that person advertise with a fee-splitting coupon advertiser, but also say that a free chiropractic exam is part of the offer, but the chiropractor gets no payment?

Answer: The answer is No.

One Doctor's Recovery Story

As I laid in the intensive care unit for five days with IV's taped to my arms and hooked up to numerous monitors, I had plenty of time to reflect. How did I get here? What is going to happen to my practice? Why had my weight dropped 30 pounds in the last few years? What had become of my once seemingly perfect life? When can I get out of here to get my next fix?

I grew up in an alcoholic family, and seeing the wreckage that was caused, I was adamant to take a different path. Probably somewhat as a diversion, I immersed myself in school and sports. I decided early in high school that I wanted to be a chiropractor. I was very focused on achieving my goal, and graduated from Western States Chiropractic College at 23 years of age. I did quite well academically, despite working over 30 hours per week my entire four years at WSCC. I was also very active in competitive bodybuilding, winning numerous state and regional titles.

When I graduated from Western States, all of my goals were coming together as planned. However, along with that came a sense of invincibility. I was a young successful doctor, driving a \$50,000 car, living in a beautiful home, traveling to exotic locations with my wife and son, winning bodybuilding competitions. Unfortunately, I didn't really appreciate the life that I had. I had worked hard, and I deserved all of these materialistic accolades. I had a sense of entitlement.

This sense of entitlement is what ultimately led me down a very dark path. Slowly, my values began to change. The path that I promised myself I would never take didn't look so intimidating anymore. I started hanging out with the wrong crowd. What started out as partying on the weekends quickly evolved into a daily habit of drugs and alcohol.

I began losing all the material things that I had worked for over 20 years- the house, the cars,

the vacations. More importantly, I was losing my personal relationships, my dignity, and my health. Amazingly, my practice was still thriving. The downside of this, however, was that I still had plenty of money to support my addiction. Thus, as long as I was working, it was hard to admit that I had a problem.

The aforementioned trip to the hospital in February of 2009 was when I hit my bottom. A friend found me passed out in my office after work. He rushed me to the hospital, where, after



a series of tests, I was diagnosed with atrial fibrillation, congestive heart failure, and cardiomegaly. My left ventricular ejection fraction was measured at 22 (normal is 65), which essentially meant my heart wasn't pumping enough blood and oxygen throughout my body. After five days in the ICU, I left the hospital against medical advice.

I went back to work the day after I left the hospital. The recent near-death experience wasn't enough to make me change my lifestyle. I was back at work and making money- I must not have a problem.

This all changed about a month later when I got a fateful call from the investigator from the Oregon Board of Chiropractic Examiners. Apparently one

CONTINUED ON PAGE 7

The latest Public Protection Report is online at <http://www.oregon.gov/OBCE/>

Policy & Practice Questions

Question: *May chiropractors in Oregon administer an Epipen to a person who is suffering from anaphylactic shock and unable to inject the Epipen by him/herself?*

Answer: Yes. In 2007 the OBCE sponsored legislation which clarified in ORS 684.025 that chiropractic physicians may provide emergency first aid.

Question: *I have been reading your guide on testimonials and I wanted to clarify what we are considering. We would like to film our patients, without a script about their experience with their problem, our office, our treatment, and their results. We are happy to put any disclaimer that is deemed important by the board, but feel that testimonials are extremely important to marketing chiropractic. I have noticed that most chiropractic websites have testimonials. Please advise if it is ok to use honest, unscripted patient reports on our website.*

Answer: You're referring to the Federal Trade Commission's guide which is found on the OBCE's website. The OBCE doesn't have any rules prohibiting testimonials. It's probably best to obtain a written permission statement from any patients who provide testimonials. There is a rule which says advertising must not be deceptive or misleading.

Question: *Is ordering a CPAP machine and/or a sleep study within the DC's scope of practice?*

Answer: Yes, whether insurance will pay or not is another question.

Question: *Is it within the scope of practice for a Doctor of Chiropractic in the state of Oregon to treat toenail fungus with laser therapy?*

Answer: Yes, as this is for treatment of a condition. Previous legal advice has advised the OBCE that use of lasers by chiropractic physicians for strictly cosmetic purposes is not within the

chiropractic scope of practice, an example of this would be hair removal.

Question: *Are chiropractic physicians allowed to participate in multi-level sales or marketing plans?*

Answer: Chiropractic physicians periodically ask the OBCE if there are rules prohibiting this. Often the DC is looking for a way to tell a patient it is illegal or against the rules.

Some multi-level sales plans have the potential to run afoul of Oregon's law against pyramid schemes. A paper prepared by the Oregon Attorney General's office "Multi-level Sales Plans in Oregon" which addresses these issues is available by calling the Board office. However, a private attorney should be consulted for specific legal advice.

A DC's direct participation in a multi-level marketing plan with his/her patients has the potential to be a violation of the fee-splitting prohibition. This would be the case if the DC recruits patients to sell products such as vitamins or supplements and then earns a commission off the down stream sales.

A DC may purchase products such as vitamins or supplements wholesale from any outlet and then retail those products to the clinic's patients. It wouldn't matter if the seller was the end point of a multi-level sales plan as long as no fee-splitting or commission was involved.

Question: *May a certified chiropractic assistant (CCA) give a one-hour relaxation massage to a patient of the attending DC, if the DC does not actually enter the room during the one hour session?"*

Answer: The Board's policy is as follows: "All CCA provided therapies must be performed under the supervision of a chiropractic physician who must

CONTINUED ON PAGE 7

Policy...

CONTINUED FROM PAGE 6

always be on premise. A CCA could provide a full body massage if the chiropractic physician prescribes it and provides instruction on how to do it. Whatever therapy is provided by a CCA has to be justified by the results of the history, examination, and diagnosis for each chiropractic patient, as governed by the Oregon Chiropractic Practice and Utilization Guidelines and other applicable administrative rules. A CCA may not provide any therapy that is not part of chiropractic patient care.”

Question: *Does this mean the supervising chiropractic physician should be entering the treatment room periodically or seeing the patient during the same appointment for massage therapy (performed by the CCA)?*

Answer: No, the OBCE’s policy doesn’t say that, although it may be advisable as regards the

particular patient’s needs. We would presume there is other contact between the doctor and patient.

If a chiropractic clinic decides to have CCAs provide full body massages without having a meaningful patient relationship, the OBCE appreciates the concerns that would rise. That said, massage can be an important part of a chiropractic wellness program. Abuses of this privilege could lead to additional OBCE rulemaking mandating additional training for CCAs who provide full body massages or limiting their scope in this area.

Question: *May a chiropractic physician perform the Epley Maneuver as a canalith repositioning procedure for treatment of benign paroxysmal positional vertigo?*

Answer: Yes, this is well within the Oregon chiropractic scope of practice.

Recovery...

CONTINUED FROM PAGE 5

of the various tests that were done at the hospital revealed high levels of several different illicit drugs. Unbeknownst to me, positive drug tests on medical professionals are automatically reported to their respective state board. After several phone calls and meetings with the board and its investigator, my chiropractic license was suspended.

In order to reapply for relicensure I first was required to complete a 30-day in-patient drug and alcohol rehabilitation program. I was still in denial that I had a problem, but nonetheless began the 30-day program at Hazelden with hopes that upon completion I would get my license back. Much to my dismay, I soon came to the realization that this was the first of many hoops I was going to have to jump through.

After completing my program at Hazelden, I was required by the Board to enroll in a 12-month out-patient rehabilitation program, regularly attend 12-step recovery meetings, and pass random UA’s for five years. While participating in the 12-step program and working with a sponsor, it soon became apparent that my problems went much

deeper than drug and alcohol abuse. The most difficult and ultimately freeing steps were those that involved letting go of resentments and admitting my part in them, and making amends to those that I had hurt due to my addictions.

I was cleared by the Board to return to work after over six months of being off. Initially, returning to my chosen profession was my only goal. But, I have gotten so much more back in the last three years—my health, healthy relationships, and my dignity. However, the biggest blessing of all is to share my experience, strength, and hope with others. If you are struggling with addiction, the first step is to admit you have a problem. Once you do that, I promise you that as you work through the steps your life will get better exponentially—mine did! I can honestly say that my life is now better than it has ever been. However, I have to always keep in mind that I am only one drink or drug away from losing it all.

** If you think that you may have a problem with addiction, the author is willing to meet with you. Contact Dave McTeague at the OBCE anonymously and he will provide you with contact information.*

Disability Awareness in the Clinical Setting

By Janice Justice DC

Chiropractors are health care providers covered under the Americans with Disability Act (ADA). The ADA was designed to ensure individuals with disabilities are afforded equal opportunity without placing undue burden on the businesses. This article will address ADA compliance with practical solutions for providing effective communication, policy and procedure modification and access feasibility.

ADA defines disability as *"a physical or mental impairment that substantially limits one or more of his or her major life activities."* Major life activities include: walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself and performing manual tasks. Conditions that impact life activities are 1) Impairments: visual, speech, hearing, mobility 2) Chronic Conditions: Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, Epilepsy 3) Diseases: HIV, TB, Cancer, Heart Disease, Diabetes 4) Mental Issues: Emotional Illness, Learning Disability 5) Social Issues: Drug Addiction, Alcoholism

Effective communication begins with determining the extent of any comprehension difficulties and identifying what works best for this specific patient. Never assume that you know the needs of your patient - ALWAYS ASK and ACCOMMODATE to the best of your ability. Patients should be interviewed and treated in quiet, well lit environments. Auxiliary aids such as interpreters, readers, large printed materials, brailled materials, closed captioning for video materials, charts, pictures and models should be available. Be patient and check-in often for understanding. Explain thoroughly all aspects of the visit so that the patient is not confused with procedures. Speak directly to the patient even when interpreters and family members are present. Write out diagnosis, therapies and care plan for the patient to take home. Doctors need to recognize that even if a patient receives effective

chiropractic care, the doctor may still violate the ADA if the doctor did not "effectively communicate" with the patient. (CRS Report for Congress, Order Code 97-826A *ADA Requirements Concerning the Provision of Interpreters by Hospitals and Doctors*)

Allow more scheduled time for patients needing assistance with intake forms, gowning and transfer. Prepare ahead of time for room modification, auxiliary aids, and additional staff for lifting and interpreters/readers. Train your staff for these procedural changes and make sure they know how to identify and respond to TTY calls as well as scheduling interpreters and readers. The patient may have a list of interpreters or readers who they work well with - use their referrals.

You are not allowed to charge the patient or insurance company for these extra services or extra time.

Doctors are responsible for contacting and paying for a licensed medical interpreter for the deaf and readers for the blind. Using a family member to interpret

is not satisfactory because they might not understand the medical terminology necessary for the patient to make an informed decision.

You are in violation of ADA if you refuse care because of the cost of interpreters. Usually an interpreter is only required for the initial history, exam and care plan directives. Routine visits may not require an interpreter but must be evaluated case by case. The ADA assists businesses with this expense by giving a Tax Credit. A Tax Credit is subtracted from your tax liability AFTER you have calculated your taxes. This credit is for architectural adaptation, special equipment acquisition, interpreters, readers and cost of any communication aids. A credit of 50% of expenditures is given with a maximum of \$5,000 after the first \$250 of expenses.

Service animals are individually trained to perform tasks for people with disabilities. You may



Dr. Janice Justice
with her service dog
Scooter.

CONTINUED ON PAGE 9

ask if the animal is a service animal and what tasks the animal has been trained to perform. You may not ask for special ID cards for the animal or about the person's disability. Allergy or fear of dogs is not a valid reason for denying access. The service animal must be in control by the owner at all times. If the animal poses a direct threat to the health and safety of others they can be removed from the premises, however, the clinic must give the patient other options for obtaining service and goods without the animal present. Never touch or interact with a service animal. They are not pets and are working under strict team cooperation.

Access modifications can be as simple as rearranging lobby furniture and adding hallway grab bars to expensive ramp additions and widening of doors. ADA requirements must be based on common sense, "readily achievable" and "without much expense or difficulty" (www.ada.gov/reg2.html and www.ada.gov/reg3a.html) (Tax Deduction incentive). When patients cannot access your clinic, consider home care services and home delivery of products.

Specific Considerations for Impairments

Hearing Impairment

Obtain the patient's attention by waving your hand before you begin to speak. Make sure your mouth is visible and clear of hands, gum or food for better visibility. Do not shout. Speak at a natural pace. Use shorter and less complex sentences with frequent checking-in for understanding. Use visual aids and write out whatever is needed for better comprehension.

Explain the treatment sequence. Once the patient is prone, they will not hear or see you. This can be stressful if they do not know what you are doing or what is expected of them. Explain how they can communicate with you during the treatment. (Example: raise their hand if they feel pain). Keep hand contact with the patient as you move around the table so that they know where you are at all times.

Have your patient remove or turn off a hearing aid if you are doing any testing or adjusting that requires covering of the ear. Otherwise a

loud piercing feedback sound will be generated. (Example: shoulder depression test, cervical rotary adjustments)

Making appointments through the clinic website might be easier for patient and staff rather than calling through TTY/Captel.

Visual Impairment

Introduce yourself, your location, your position in the clinic and your goal with the patient. (Example: "Hello Mr. Smith, I am Susan, at your left side, the office manager and I am ready to

"The simple question, "How can I be of assistance to you?" is the most powerful ADA compliance tool."

take you to the treatment room down the hallway in front of you"). Never touch or grab the patient, ask them if they would like to take your arm to lead them to the treatment room. Direct lighting that does not produce glare or shadows is best. Throughout the visit, verbally describe what you are doing as well as your findings and plan. Introduce anyone coming into the room to assist you.

Mobility/Wheel Chair Etiquette

Sit down when talking to a patient in a wheel chair so that their viewing angle is more comfortable. Do not touch or move a person in a wheel chair until you have full permission. Do not open doors or pick up items without request from the patient.

Staff needs to be properly trained to assist with transfers to minimize the risk of injury to both themselves and patient. They must know their physical limits.

It is a common experience for people who use wheel chairs to be told that a place is accessible when it is NOT. Is your clinic accessible? Consider distance from handicapped parking, weather, curbs, hills, stairs, 32 inches when door

CONTINUED ON PAGE 10

Survey...

CONTINUED FROM PAGE 1

- The BackTalk newsletter is still the number one source of information (68%), but the OBCE Publication emails are catching up (65%) and with the OBCE Web page (50%) also increasing. 21% said they received information about the OBCE from the Oregon DCs listserve.
- More information is needed about chart note requirements (58%), continuing education (57%), Policy & Practice Questions (53%) and administrative rule proposals (44%)
- 61% agree that fee-splitting online coupon sales should be prohibited, 22% disagreed.
- 55% said the OBCE was doing enough to address boundary issues, while 16% said do more and 15% said do less.
- 64% want to keep the current rule defining current patient instead of specific waiting periods before a doctor could have a personal relationship with a former patient.
- 38% of DC respondents employ chiropractic assistants, 62% do not.
- 60% oppose increasing the chiropractic assistant initial training from 12 to 20 hours.
- 80% of DCs said they are able to obtain quality continuing education, only 2% said they could not.
- 41% of DCs said they use electronic record keeping systems.
- 90% of DCs say other DCs could understand their patient records and carry on care
- 43% of DCs say that as much as 50% or more of other DCs' charts do not meet minimum standards
- 56% of DCs say they understand the clinical justification rule, 22% do not, and 18% don't know.
- 70% of the survey respondents are male, 30% are female.
- 46% of DCs have attended the OBCE's New Doctor Meetings.
- 40% are sole practitioners-no associates; another 17% have LMT associates; 13% practice with one or more DCs; 14% share office space but are separate businesses; and 10% are in multi-disciplinary clinics with MDs, PTs, NDs, etc.

CONTINUED ON PAGE 11

Disability Awareness...

CONTINUED FROM PAGE 9

is opened 90 degrees, ability to maneuver in the clinic with clear floor space next to the table of 30 by 48 inches and handicapped toilet facilities. (See *Access to Medical Care for Individuals with Mobility Disabilities* www.ada.gov/medcare_mobility_ta/medcare_ta.htm)

The simple question, "How can I be of assistance to you?" is the most powerful ADA compliance tool.

Communication is the greatest form of healing. Offer your patients the highest level of care with awareness and response to their unique needs.

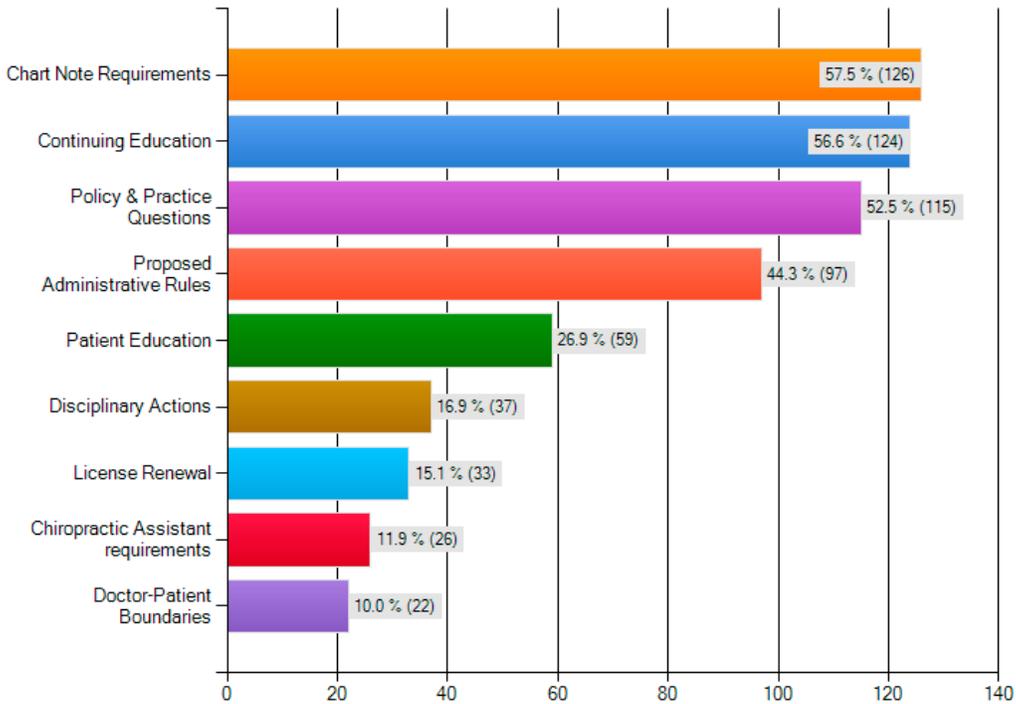
Janice Justice DC provides Disability Awareness Training for chiropractic clinics as well as chiropractic assistant initial training. She can be reached at drjanicejustice@gmail.com for more information.

For more information: www.ada.gov, 800-514-0301

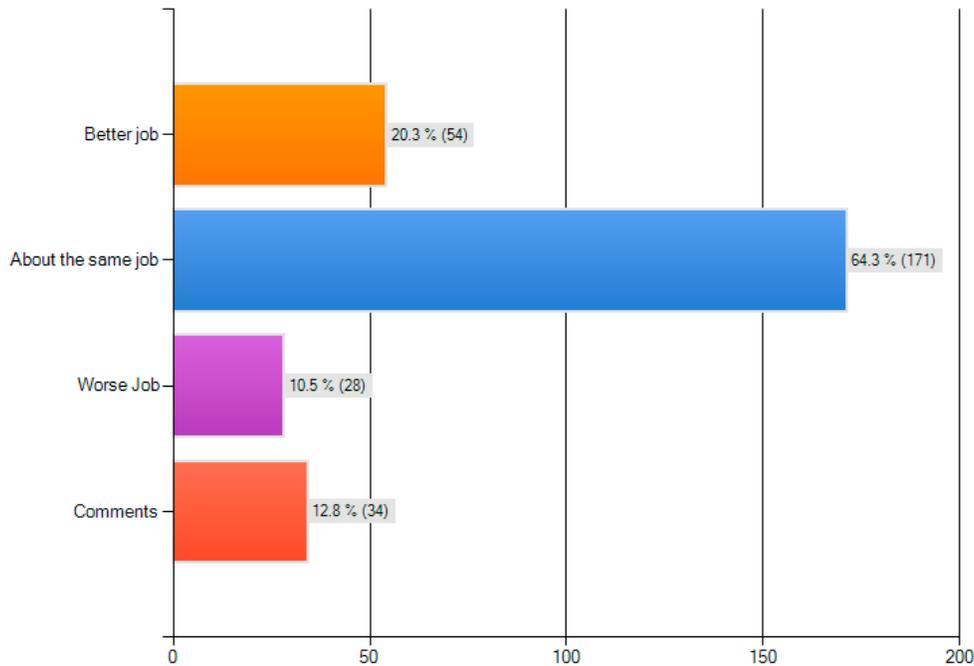
Survey...

CONTINUED FROM PAGE 10

In what areas would you like to receive more information from the OBCE? (Please mark all that apply.)



In the last two years, overall do you think the OBCE is doing a better job, about the same job, or worse job?



Administrative Rules Update

Foreign Chiropractic Colleges

Foreign chiropractic colleges can now be considered for OBCE approval on a case by case basis. Once approved, the OBCE may accept their graduates for licensure in Oregon. Under this new rule, Australia's Murdoch University's School of Chiropractic was recently approved for licensure in Oregon.

Amendments to OAR 811-020-0006 state, "This Board may also approve those programs that are mutually recognized and endorsed by (the U.S.) CCE through membership in the Councils on Chiropractic Education International (CCEI), on a case-by-case basis."

Currently, the CCEI is composed of the U.S. CCE, Australasia CCE, Canadian Federation of Chiropractic Regulatory and Educational Accrediting Boards and the European CCE. They have agreed on a common set of standards that all the CCEs and their accredited colleges must meet.

Dry Needling Rule

The rule for certifying DCs in dry needling (OAR 811-015-0036) that was adopted in May of 2011 has been stayed by the Oregon Court of Appeals. That means the rule isn't in effect and DCs may not yet perform dry needling. The Oregon Association of Acupuncture and Oriental Medicine filed their brief on the main issue in April 2012 and the OBCE's brief will be filed in June 2012. There will be responding briefs following that and then oral argument will be scheduled. The OBCE and the Department of Justice attorneys representing the Board believe our interpretation of the law is correct. We'll find out if the Court of Appeals agrees. In the meantime, all we can do is ask for the profession's patience. The different court filings and arguments are all posted on the OBCE's web page: See Update on Dry Needling Rule under Current Topics at <http://www.oregon.gov/OBCE/>

Chiropractic Assistant Applications

Recent rule amendments to OAR 811-010-0110 create a six-month life of application and makes most fees non refundable. See Kelly's full explanation on Page 13.

Two DCs Appointed to Cultural Competency CE Committee

Drs. Huma Pierce and Jason Young have been appointed to the Oregon Health Authority's newly formed Cultural Competence Continuing Education Committee. The Committee's charge is to promote cultural competence continuing education for health care professionals. They join 26 other members representing a broad group of culturally and professionally diverse Oregonians from health professional licensing boards and health provider organizations. The Committee's charge is to:

- Develop and recommend a definition of cultural and linguistic competency
- Evaluate other states' and national entities' Cultural Competence continuing education options for licensed health care providers
- Identify existing continuing education standards relative to cultural competence currently used by other organizations, states, or national bodies.
- Identify Cultural Competence Continuing Education Standards for Oregon health care providers.
- Develop a list of continuing education opportunities relating to Cultural Competence that meet the proposed standards and make the list available to each of the health professions' licensing boards.

Licensing & CE

By Kelly Beringer, Administrative Assistant



Hello everyone,

I am talking about changes to the CA rule and application process, and the Board's CURRENT boundaries CE requirement for Doctors (deadline December 31, 2012); BOTH are important to read.

Regarding Oregon Administrative Rule Chapter 811, Division 10, Rule 811-010-0110 Chiropractic Assistants: The Board decided to make changes to the rule due to the growing number of CA applications which have been submitted but NOT completed. Many of the applicants have not responded to the Board's request for more information due to misdemeanor and felony charges found in the background check. Many others are simply incomplete because the applicant did not provide the required training, did not answer questions on the application, did not submit the SSN form, or did not submit an exam. Some have even sent the exam ONLY, and I have no means of contacting them to explain the full requirements.

The rule changes, in brief, are:

- The \$25 application and \$35 examination fees are now non-refundable;
- The \$50 license fee may be refunded, IF requested prior to 60 days; thereafter it is non-refundable
- Regarding the \$35 examination fee, IF the OBCE determines to require a national examination in lieu of the current state examination, the \$35 fee to Oregon will be waived.
- In circumstances *beyond the applicant's control*, the Board *may* determine to refund all, or a portion of the fees; and lastly,
- The Board will maintain an incomplete application file for up to six months; thereafter the applicant will need to re-apply.

The full text of the rule can be found on our website under Laws and Rules: <http://cms.oregon.egov.com/OBCE/Pages/index.aspx>

On the second matter of the Board's CURRENT CE requirement for Doctors of Chiropractic to complete education covering boundaries:

On May 3, 2011, the OBCE posted its statement of concern and aggressive action regarding boundary violations by licensed Oregon DCs. This statement was also mailed to every licensee who has an email on file with the Board, and "snail mailed" to everyone else.

On December 19, 2011 the OBCE sent another "email blast" to the license body informing

CONTINUED ON PAGE 14

Licensing & CE

CONTINUED FROM PAGE 13

them of the NEW continuing education requirement for 2012 – **two hours CE addressing boundaries**. This announcement was also posted on the board's website on the Continuing Education page, and is still posted. The deadline to complete these two hours is by calendar year's end December 31, 2012, AND proof of completion MUST BE submitted by the licensee to the OBCE immediately upon completion.

In addition, Board staff has been posting eligible programs on the website when they become available; there are live and online programs that will meet the Board's expectations. Follow this link to the Board's Continuing Education page http://cms.oregon.egov.com/OBCE/Pages/ContEduc.aspx#NEW_2012_2013_CE_Req_mt and scroll down to the yellow highlighted section titled, "Current List of Available Boundaries / Ethics Courses (update 5/10/2012)" and the green section title "Qualified Online Education."

Please be aware that a program that does not at least significantly address boundary violations between adult patients and physicians may NOT meet the board's expectation and requirements.

And finally, yes, you may submit your proof of completion with your 2012 license renewal. Also, if you have already renewed, and are planning to complete the boundaries hours between now and December 31, 2012, send the hours immediately to the OBCE; do NOT wait to send the hours with your 2013 renewal; you will not be in compliance.

You can always call or email me for clarification. Happy Spring and Summer! ■



Dr. Todd Bilby, OBCE member, led the discussion with 32 new licensed doctors in Milwaukie on June 7th. He was joined by Dr. Kimberly DeAlto, Peer Review Committee member.

Dr. Saboe to Represent Complementary and Alternative Medical (CAM) Providers on New Oregon Health Care Commission



Dr. Vern Saboe DC, Albany has been appointed to the "Health Evidence Review Commission" (HERC) by Governor Kitzhaber. The HERC was created by the 2011 Oregon State Legislature as part of the Governor's Health Care Transformation program. Dr. Saboe was

also appointed to the HERC's Subcommittee on Evidence-based Guidelines.

(The Oregon Chiropractic Association was instrumental in amendments to HB 2100 that designated one seat on the HERC go to a complementary alternative medical provider; specifically a chiropractic physician, naturopathic physician or a licensed acupuncturist.)

The HERC's goal is to ensure resources are not spent on unproven interventions or on expensive interventions when less costly but just as effective treatments are available.

They will consider both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance using peer-reviewed medical literature and solicit testimony and information from the health care community and the public to build a consensus on clinical practice guidelines.

"The key for the chiropractic profession as per having a seat on the Health Evidence Review Commission (HERC) is its charge of developing "Evidence-based Guidelines" for various interventions treatment, diagnostic etc., in cooperation with OHSU's Center for Evidence-based Policy," said Dr. Saboe. "The very first guidelines the HRC produced were the draft "State of Oregon Low Back Pain Guidelines. However this draft had too much of a focus on medications and spinal surgery." Dr. Saboe authored an evidence-based critique (submitted by the OCA) of that first draft. "These guidelines are now final and in fact spinal manipulation is

the only non-drug intervention recommended by the State of Oregon for the first four weeks of an acute episode/injury of back pain."

Oregon has had an ongoing multi billion dollar budget crisis and health care is an ever increasing portion of the state budget, accounting for 16 percent of the state general fund budget. Recently the federal government announced a commitment of \$1.9 billion over five years towards the state's overhaul of Medicaid health care program for low income Oregonians. Spending those dollars on the most effective care is essential.

The HERC will develop a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire Oregon population to be served.

The HERC will consist of thirteen individuals including medical physicians, a dentist, a public health representative, and a behavioral health provider such as a social worker, alcohol and drug treatment provider or psychologist or psychiatrist, as well as participants representing consumers, pharmacy, insurance industry, and complementary and alternative medicine providers (CAM).

CAM providers constitute medical interventions not taught in medical schools and generally not available in US hospitals. Chiropractic, massage, herbal medicine, meditation, acupuncture, naturopathy, lifestyle diet, mega vitamins, and homeopathy are the most commonly used CAM therapies in the US.

Dr. Saboe previously served the OBCE's Subcommittee on Rating of Scientific Evidence and participated in the Nominal Panel which produced three chapters of the Educational Manual for Evidence Based Chiropractic. He served two terms on the OBCE's Peer Review Committee and was previously appointed by the Governor to his "Health Systems Transformation Team" Dr. Saboe has lobbied the Legislature on behalf of the state association since 2005.

BackTalk

Oregon Board of
Chiropractic Examiners
3218 Pringle Road SE
Suite 150
Salem, Oregon 97302
www.oregon.gov/obce
503 378-5816

PRSR STD
US POSTAGE
PAID
SALEM, OR
PERMIT No. 81

BackTalk

NEW LICENSED DCs

June 16, 2011 to May 30, 2012

Samuel T. Adams
Monica J. Adkins
Jeffrey A. Albing
Gagandeep S. Arora
James W. Biser
Brian E. Bodtker
Cindy D. Brock
Jesse O. Brockey
Brandi A. Burland
Raymond A. Capone III
Bradley H. Capp
Lori A. Carroll
Clinton J. Daniels
Danielle E. Dubeta
Shannon N. Eder
Caroleigh J. Elliott
Mark C. Erickson
Stanley C. Ewald
Casey D. Frieder
Donald W. Fuegy
John B. Garland
Adam C. Goulet
Joseph F. Graffeo
Richard D. Hall
Adam J. Hamilton

Jeffrey K. Harris
Connealy A. Huerter
Jason Jandl
Justin R. Jelen
Kelly J. Kalk
Bryant L. Kitchen
Brenda B. Ku
Chad R. Lamer
Anita L. LeBlanc
Jesse W. Lensegrav
Audrey E. Long
Bruce A. MacDonald
Brenden J. Leomo
Nicholas S. Locke
Jacob P. Malpass
William P. Martindale
Marie H. Mason
Ryan E. McCormic
Grayson S. Michel
Sara M. Nulle
Ian A. Nurse
Jennifer N. Oconnell
Devin S. Orton
Timothy Q. Pham
Anthony Q. Pham

Caleb Runne
James C. Ryan
Jordan E. Sajovic
Lupe J. Sanchez IV
Ian D. Sheppard
Joseph A. Shepro
Patrick N. Stromer
Brenda I. Taylor
Peter A. Throm
Matthew L. Usel
Anatoliy P. Vergulyanets
Wesley W. Wallis
Elizabeth J. Washak
Anthony U. Weber
Kalli M. Welch
Sean R. White
Jordan W. Wilde
Brook A. Young
Megan L. Zetter

Doctors, please share BackTalk with your chiropractic assistants and office staff.

