

<b>OBCE RULES ADVISORY COMMITTEE MEETING NOTES</b>	<b>April 25, 2017 10:30 AM</b>
	<b>Meeting held at:</b> Willamette Education Services District - Marion Room, 2611 Pringle Road SE Salem, OR 97302
<b>Board President: Jason Young, DC</b>	<b>Phone 503-378-5816 Fax 503-362-1260</b>

<b>Board members present:</b>	<b>Staff present:</b>
Jason Young DC, President	Cassandra Skinner JD, Executive Director
	Kelly Beringer, Admin Assistant
<b>RAC members present:</b>	
Judith Allan, DC	Larry Lubcke, DC, DABCO
Leah Bowder, LMT	Tracy Holland, CT, CA
William Pleau, DC	Joyce McClure, DC, DACBR, CES
Stan Ewald, DC, MPH, M.Ed.	Edith Dal Mas, DC, DACBR
<b>RAC members absent:</b>	
John Combe, LMT	Amanda Tipton, DC

**Regarding RAC Meetings: RAC committees are ad hoc committees of the OBCE. These committees do not make policy but rather function to perform research, develop proposals, and assist in drafting rules for the consideration by the OBCE. This document is a record of the discussion of this committee and is not intended to be verbatim.**

**ACTION ITEM(S):**

- 1. DC and CA Practice Surveys:** Dr. Young will draft initial survey to be sent out to DCs with staff providing RAC members draft for review and comment before sending to DC base. Separate survey for CAs, which will also be drafted by Dr. Young, reviewed by the RAC, then sent out to CA base. 1 CE will be credited for taking the survey, no complaint disclaimer for non-anonymous survey takers.
- 2. Next RAC meeting.** Staff will schedule next meeting via Doodle. Will utilize web-based tools (not just telephonic) to provide wider participation by members.

**MEETING SUMMARY:**

Dr. Young called the meeting to order and welcomed and thanked RAC members for their interest and participation.

Purpose of the meeting is to determine interest in moving forward with a tiered CA program and, if so, what it should look like.

- Massage Therapist: own license, not assistant; is portable and not reliant on professional oversight
- Most states will accept any certificate from accredited college as license to practice
- Intent: for everyone employed in DC office would be certified? Yes. This intent is not clear from current draft. (Including front desk/reception and billing staff? I didn't think this was the intent.

Might want to clarify. I did think there was an option for these other staff to receive basic training in HIPAA, chiropractic philosophy etc, as an OPTION)

Viewpoints from group:

**Pleau:** tiered CA program is a good idea; customize training to meet office's needs.

- Soft tissue training would be useful for those who do a lot of it in their offices
  - o LMT wouldn't need it
  - o Should have exemptions
- Need to fill in more of details of tiered specialties: training and duties.

**McClure:** agree re: massage therapy piece; pay scales aren't high for CAs – opportunity to get better pay and paid

- Greater knowledge base for DC to utilize
- OBCE had discussed tiered CA structure about 5 years ago
  - o Cognizant of trainings, recertification, CE costs
    - Increasing costs would be prohibitive

**Holland:**

- What is the profession at large in country doing about CA and CA techs to establish best practices?
  - o NBCE CCCE
  - o ASCT from Palmer (Associate Degree)
  - o 6-8 programs at colleges
    - Far exceeds requirements here except at UWS
- Chiropractic Technician – level of training and cost
  - o Obtained her certificate in 1983
  - o 1 year program, 96 credit hours, 4 quarters, anatomy/physiology, clinical sciences, x-ray tech, dynamics
  - o Registered radiologic technologist
- Difference between AARCT/AARRT
- Program at Palmer
  - o Associate degree, 2 year, includes soft tissue, anat/phys, ortho, neuro, x-ray
    - Everything except qualifying and adjusting

**McClure:** How many (%) DCs/offices who take own x-rays on site?

**Dal Mas:** Number is decreasing

- Equipment costs
- Availability of centers
- Dr. Dal Mas will get #
- Need to know how # effects
- LXMO – fighting to keep this

**Ewald:** irrelevant to add x-ray if they're already certified to do that (other certifications)

- Weekend manipulation courses
  - o Wouldn't want blanket statement

**Holland:** training (cont'd)

- Patient communication re: what DC does
- HIPAA, boundary issues

**Dal Mas:** LXMO – CAs, Mas, Pos. Assist.

- Operate/take x-rays for physician in office
- Same standard of care for ASRT
- Standard of care for CAs?
  - o No malpractice insurance
- Dictates what they have to be trained with
  - o Core module before tested
- Amer. Rad. Technologist
  - o Different needs in office
- Annual recertification program?
- Will need to require much higher level of training

**Ewald:** bottom line on initial tier:

- DC is ultimately responsible for HIPAA, ethics, boundaries, etc.
- Necessary for board to decide addl training/certification requirement? Should automate part of training
- More robust training program with identified competencies rather than DC training in base
  - o Needs to grow into something

**McClure:**

Base level of education for front desk/any patient contact

- Optional program for any DC to get
- Prepackaged program – possible for OCA to deliver
  - o HIPAA, OSHA, duty to report, boundaries, communication skills
  - o Could be online
  - o Should be free and optional

Other levels of training

- Need competencies
- If program from accredited school, go forward with exam without more training hours.
- UWS has experience in developing competencies and could assist.

**Lubcke:**

- Financially feasible
- Step back and look at landscape
  - o What have other professions required?
  - o How's it working?
  - o What's justification for new rules or hurdles?
  - o Gotta be sold to profession
  - o What's in it for them?
  - o How will it help average office and protect public?
- Medical Assistant (MA)

- CAs have far less training, MAs far more privileges
- More supervised
- Would need to expand training of CA to expand reach of doctor

**Pleau:** financial piece

- Colleges/universities with MA training programs
- Different model than no training & office pays for CA training
- Significant change

**Lubcke:** Multi-disciplinary clinics

- MAs on staff
  - Brutal position – amount of workload is huge and longevity is small
  - 5-10 years – how many still employed?
- Should see landscape/success

**Allan:** Has anyone tested the waters?

- What do DCs need?
- Survey to help in process
- What are CAs currently doing and what do they want?
- Are DCs utilizing CAs to do ortho test?
- Affordability of hiring the CA?

**Young:** could increase new patient numbers or re-exams in a day

- Would pay that person more
- Paradigm shift
- Could be more lucrative based on DC's model

**McClure:** within last 8 years, NBCE was talking about CA pretest

- Make available online on OBCE website
- Could require
- Nuance in interpreting tests makes CA doing these inappropriate for ortho/neuro
- Not all things are interpreted similarly (negatives as positives, etc.)
- Previous iteration:
  - Have tier that was therapy exercise or rehab
  - Might be level of posture screening, etc.
  - Exercise + manipulation is far superior than manipulation alone, and having CA assist implementing this will help deliver better standard of care for DC tx plans

**Dal Mas:**

- MA is trained in separate program before DC office
- More expensive
- Most DCs
  - Have employee and want to add function to employee
    - Limit cost at that
  - If extra capacity, need extra training
  - Time out of office for training

- UWS – evening programs for working adults
  - o Requires dedicated student
  
- Clinical internship during clinical hrs supervised
  - o Already trained
  - o World of difference in training and cost
  - o Most DCs won't want to spend the \$
  - o Tier level can allow expansion
    - Do we want to regulate that?
  
- CAs who have LXMO license
  - o Not sure if they're making more \$ w/LXMO addition
  
- Do CAs get better earning power with tiers?
  
- Creating value?

**Holland:** No, don't get paid more with more knowledge

- Capability of trained CAs to speed up ability of DC to get more done in a day
  
- "cheap associate"
  - o Could do history
  - o X-rays, physiotherapy, physio trainings
  
- Associate DCs
  - o Does tier program bump up those associate DCs?
  
- Do DCs really want OJT CAs?
  - o Want to stay with them
  
- Where do we want model to be?
  
- Is it board's job to make sure training happens?
  - o No, board's job sets standards and requirements

**Pleau:** survey DCs in state is a fantastic start

- What, how many, how?
  
- Understand need
  
- MAs are applying for jobs for CAs
  
- Would love blood draws to be done
  
- Make use of training they already have
  
- MAs can't work under DC license
  - o No precedent
  
- Farm out blood draws to lower level
  
- Add 4<sup>th</sup> category of MA?

**Young:** Group participation in creating chart that includes:

- Soft tissue
  
- Imaging tech
  
- Rehab
  
- Clinical assistant
  
- Physiotherapy

- Basic certification – allow the CA to do?
  - o Get more certification
  - o Could put more PT
  - o Or one certification with all the specialties included

**Ewald:**

- Education & Public Protection
- - UWS massage therapy – no problem, at night with clinicals
  - o LMT
- - Provide education
- Public protection concern
  - o Extensive amount of training with costs and CEs
  - o Survey is a good idea

**McClure:** ortho/neuro testing

- Level of training that is cost proportionate & useful
  - o ROM testing, example
  - o Billion different tests
- Good leadership principle: trust but verify
- Risks of false negatives

**Holland:**

- Would want opportunity to demonstrate what she knows as to testing
  - o Increased training time
  - o Very valid concern

**Ewald:** Associate DCs have gone through 4 years of training, board exams, medical malpractice, etc.

**Pleau:** take to extreme – DCs never see patients

- Physician assistant has more training

**Holland:** programs are taught in CCE

- Compare which profession learns what
- Time spent learning ortho/neuro is equivalent

**Ewald:** Not just ortho/neuro, but basic science curriculum is different

**Dal Mas:** consequences of push of a button

- Public protection issues

Consensus? Tier level is good idea?

- Need feedback
- Who will regulate each tier?

**Lubcke:** practice in different flavors

- What is wanted?

- What is possible?

**McClure:** no matter what we do, need a transition plan

**Young:** Challenges:

- \$ cost of training – where is financial burden?
- Can we get adequate training for competency?
- Who determines competency?
- What's the standard?
- Is there demand?
- Multiple practice models – sure of all of them?
- Transition
- What are already out there for tiered programs?

RAC came up with possible survey questions – see drafts. Survey to go out separately to DCs and CAs.

Action Items determined. See above.

**Meeting Adjourned.**

Prepared by Cass McLeod-Skinner, OBCE, Executive Director

Finalized - July 14, 2017

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