OBCE BOARD MEETING PUBLIC SESSION	**January 16-17, 2020** **8:30 AM** Holiday Inn Express & Suites Albany Meeting Room: Oregon State Room 105 Opal Court NE Albany, Oregon 97322
Board President: Franchesca Vermillion, DC	**Phone 503-378-5816** **Fax 503-362-1260**

Telephone access is available. Call 1-888-273-3658, and enter participant code: 103386.

8:00 AM **Meet and Greet with area licensees and the public**

8:30 AM **Convene Public Session**

I. PUBLIC COMMENTS
(Comments must be limited to 3-5 minutes. Notify the Board office in advance, if you wish to address the Board.)

II. CONSENT AGENDA Action
1. Today's agenda
2. November 14, 2019 Public Minutes

III. OCA Update Inform

IV. UWS Update Inform

V. ADMINISTRATIVE RULES
1. Discuss Fee Splitting Information and Advertising Rule (OAR 811-015-0045) Info/Action
2. Discuss adoption of OHA Healthcare Workforce fee Info/Action
3. Discuss Facilities Licensing Info/Action
4. Discuss Continuing Education rule language and CE Audit conflict Info/Action
5. **Rules Hearings** **9:00 AM** Action

OAR 811-010-0008 Fees
Outcome:

OAR 811-010-0068 Temp DC license for spouse of military personnel
Outcome:

OAR 811-010-0071 Board Members
Outcome:

OAR 811-015-0005 Records
Outcome:

OAR 811-015-0010 Clinical Justification
Outcome:

OAR 811-035-0005 Duties and Obligations of Chiropractic Physicians to Their Patients
Outcome:

OAR 811-035-0015 Unprofessional Conduct in the Chiropractic Profession
Outcome:

VI. DISCUSSION AND ACTION ITEMS

1. Review/Ratify 2019-2021 Legislatively Adopted Budget (LAB) — Action
2. Review Board Objectives and Goals — Info/Action
3. Discuss Exam Retake Frequency (FCLB poll) — Action
4. Sports Chiropractic and field-side injuries — Action
5. Administrative Policies — Action
    a. CE Audit Policy review
    b. Civil Penalty Citaion Policy review
6. Practice Policies — Action
    a. Hemp and marijuana-derived products policy (additions to policy)
    b. Radiographic mensuration analysis - Can a non-DACBR perform?
7. Continuing Education
    a. Staff tracking CE offerings — Action
    b. Needle EMG review — Action
    c. Concussion Training – request for approval — Action
    d. UWS CE request for review — Action
8. Chiropractic Assistant Training Syllabus (2011) — Action
9. Professional Assistance Program Update — Info
10. Guide to Policy & Practice Questions

VII. CORRESPONDENCE

VIII. WORK SESSION

1. OCPUG Review (Chapters 4 & 5)

VIX. IN THE MATTERS OF (following Executive Session)

OBCE BOARD MEETING PUBLIC SESSION	**November 14, 2019** **8:30 AM** Equitable Center Fourth Floor Conf Room 530 Center St NE Salem, OR 97301
Board President: Franchesca Vermillion, DC	**Phone 503-378-5816** **Fax 503-362-1260**

Board members present:	**Staff present:**
Franchesca Vermillion DC, President	Cassandra McLeod-Skinner JD, Exec. Director
Michelle Waggoner DC, Vice President	Donna Dougan, Admin Assistant
Seth Alley DC, Secretary	Kelly Beringer, Admin Assistant
Allen Knecht DC	Frank Prideaux DC, Healthcare Investigator
Ron Romanick DC	George Finch JD, Investigator
Amber Gies (fka Reed) JD, Public Member	Lori Lindley, Assistant Attorney General
Glenn Taylor, Public Member	
Others Present: Stan Ewald DC, Dan Miller DC, and Haylee Morse-Miller. Calling in were Vern Saboe DC, Julie Crispin LMT, and Mark Retzlaf.	

8:40 AM CONVENE

I. PUBLIC COMMENTS none

II. CONSENT AGENDA

1. Today's agenda
2. July 25, 2019 Public Minutes
3. September 19-20, 2019 Public Minutes

Issue: Review minutes.
Outcome: Minor edit made to July 2019 minutes. Adopt consent agenda as presented.

III. OCA Update

Dr. Vern Saboe: The OCA is looking at issues on the provider non-discrimination law and enforcement of HB 2468 (2015) implementation; working a coalition bill with OMA for preauthorization and transparency; and the expungement bill will be coming back next full session.

Dr. Saboe served on an advisory committee for a Kaiser Permanente study looking at outcomes of the OHA health policy of OHP patients receiving acupuncture, chiropractic care, and alternative care rather than opioids.

The Value-based Benefits Subcommittee is addressing other issues that effect chiropractic –low level laser, for example.

IV. UWS Update

Dr. Stan Ewald: The university is in the process of moving; the buildout is almost halfway done. Looking at March/April 2020 occupancy. Dr. Bill Moreau was recently hired.

V. ADMINISTRATIVE RULES

1. Discuss Proposed Fee Rule (New OAR 811-010-0008)

Issue: Review proposal.
Outcome: Enter rulemaking in January 2020; individual rules that currently have fee amounts will need to go through rulemaking to delete those amounts.

Proposal: Enter rulemaking in January 2020 for OAR 811-010-0008.
Motion: Taylor moved to accept the proposal; Vermillion seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

2. Discuss Board Members (OAR 811-010-0071)

Issue: Increase per diem and open scope for activities for which members are reimbursed.
Outcome: Enter rulemaking in January 2020.

Proposal: Enter rulemaking in January 2020 for OAR 811-010-0071.
Motion: Vermillion moved to accept the proposal; Alley seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

3. Discuss Proposed Active Duty Temporary DC License (New OAR 811-010-0087)

Issue: Director McLeod-Skinner asks for clarification as to form.
Outcome: Enter rulemaking in January 2020.

Proposal: Enter rulemaking in January 2020 for OAR 811-010-0087.
Motion: Vermillion moved to accept the proposal; Waggoner seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

4. Discuss Records (OAR 811-015-0005(3))

Issue: Director McLeod-Skinner brought forward this rule to review section (3); there is some conflicting language (deceased doctor versus departing employee).
Outcome: Enter rulemaking in January 2020.

Proposal: Enter rulemaking for OAR 811-015-0005.
Motion: Vermillion moved to accept the proposal; Reed seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

5. Discuss Fee Splitting Information and Advertising Rule (OAR 811-015-0045)

Outcome: Move to January 2020.

6. Rules Hearing **9:00 AM**

Rule Number	**Proposal** (e.g. Adopt as amended)	Motion to accept proposal made by	Second	Vote
811-010-0115	Adopt as amended	Taylor	Gies	Unanimous
811-015-0010	Accept amendments; keep open for more public comments in January 2020	Taylor	Romanick	Passed; Waggoner absent
811-035-0000	Adopt as amended	Taylor	Alley	Unanimous
811-035-0001	Adopt as amended	Vermillion	Knecht	Unanimous
811-035-0005	Move to January 2020			
811-035-0015	Move to January 2020			

Added Discussion: Facilities Licensing

- Should the Board propose a rule on facilities licensing? Oregon Board of Massage has rule language. Staff will bring a draft to January for possible rulemaking in March 2020.

12:00 PM Working lunch
1:20 PM Close rule hearing for today

VI. DISCUSSION AND ACTION ITEMS

1. 2020 Executive Board Elections & NBCE/FCLB Delegates

President – Taylor nominated Franchesca Vermillion DC; she accepted.
Vice President – Vermillion nominated Michelle Waggoner DC; she accepted.
Secretary – Waggoner nominated Seth Alley DC; he accepted.

Proposal: Accept slated nominations.
Motion: Taylor moved to close nominations and approve the full slate; Alley seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously. Appointments take effect January 1, 2020.

NBCE delegate – Allen Knecht, DC
NBCE alternate – Ron Romanick, DC
FCLB delegate – Glenn Taylor
FCLB alternate – Amber Gies, JD
Appointments accepted, and effective for 2020.

2. Review/Ratify APPR

Issue: Ratify APPR, and review Customer Service Survey summary.
Discussion: Discussion was had around different aspects of the survey and improvements made over the last year.
Outcome: Ratified.

3. Review/Ratify 2019-2021 Legislatively Adopted Budget (LAB)

Issue: Board needs to ratify.
Outcome: Bring back in January 2020.

4. 2020 Mandatory CE Requirements

Issue: Shall the Board mandate any CE for 2020?
Outcome: No specific CE subject is mandated for 2020.

5. NBCE/FCLB 2020 meeting attendance

Issue: Appoint delegates and alternates (above)
Outcome: New delegates will attend.

6. Elder/financial abuse - Duty to report/mandatory reporting

Issue: Would the Board like to repeat this training since new members are on board?
Outcome: Yes, but not until later in 2020 to include the new members who will be appointed in September.

7. Sports Chiropractic and field-side injuries

Move to January 2020

8. Practice Policies

a. Hemp and marijuana-derived products policy (additions to policy)

Move to January 2020

b. Radiographic mensuration analysis - Can a non-DACBR perform?

Move to January 2020

9. Chiropractic Assistant Training Syllabus (2011)

Move to January 2020

10. Professional Assistance Program Update

Move to January 2020

11. Request for Approval CE (Audit)

Issue: Is program allowed for renewal credit hours?
Outcome: As submitted, "round robins" was denied for CE credit. Future credit would be allowed if proper protocols were followed. Requestor can resubmit request for approval is they include syllabus, topic items, sign in/out sheet, handouts, objectives; licensed host and sponsor for CE with certificate of completion; within 30 days.

Proposal: Enter into rulemaking OAR 811-015-0025 Continuing Education.
Motion: Alley moved to enter into rulemaking for OAR 811-015-0025; Vermillion seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

12. **Request for Approval CE (CBD)** – *removed from agenda.*

13. Guide to Policy & Practice Questions

Move to January 2020

VII. CORRESPONDENCE

VIII. WORK SESSION

OCPUG Review (Chapters 4 & 5)

Move to January 2020

VIX. IN THE MATTERS OF

a. Case # 2019-5022 CA Applicant

Proposal: Certify with stipulation to notify current and future employers of history.
Motion: Vermillion moved to accept; Alley seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

a. Case # 2019-5009

Proposal: Issue a contingent case close with two file pulls (two files each) successfully passed. Pull patients treated by locum tenens or associate on Licensee's behalf – first file pull to happen within 60 days; second, in 120 days.
Motion: Knecht moved to accept; Gies seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

c. Case # 2019-3013

Proposal: No statutory violation with a letter of concern regarding new technology.
Motion: Vermillion moved to accept; Taylor seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously

d. Case #s 2019-1013, 2019-5013

Proposal: Issue Notice of Proposed Discipline. 6 months suspension, successfully and unconditionally pass PROBE and pass all aspects of EBAS; PROBE and EBAS should be completed within six months suspension timeframe; Board interview before approval to return to practice; $5,000 fine to be paid before return to practice. Suspension notice shall be posted per rule.
Motion: Alley moved to accept; Taylor seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously

e. Case # 2019-5010

Proposal: Approve final order.
Motion: Gies moved to accept; Vermillion seconded
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

f. Case # 2019-1012

Proposal: No statutory violation.
Motion: Gies moved to accept; Romanick seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye. Vermillion abstained.
Motion passed.

g. Case # 2019-1006

Proposal: Issue Notice of Proposed Discipline. $2,500 fine for unlicensed practice; refer to the Naturopathic Board. Pay fine within 90 days.
Motion: Taylor moved to accept; Romanick seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

i. Case # 2018-1027

Proposal: No statutory violation.
Motion: Knecht moved to accept; Gies seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously

j. Case # 2019-5005

Proposal: Insufficient evidence with letter of concern.
Motion: Gies moved to accept; Vermillion seconded.
Vote: Romanick, aye; Alley, aye; Taylor, aye; Knecht, aye; Gies, aye; Waggoner, aye; Vermillion, aye.
Motion passed unanimously.

4:45 PM Adjourn for the day

Prepared by Kelly Beringer, Administrative Assistant
Transcribed 12/3/19
Recording to be destroyed 12/3/2020 per OAR 166-350-0010(4)

Board and Commission Meeting Minutes Series documents the official proceedings of the board or commission meetings. Records may include agendas; minutes; meeting notices; items for board action; contested case hearings schedules; committee reports; exhibits; and related correspondence and documentation. Records may also include audio recordings of meetings used to prepare summaries. (Retention: (a) Minutes: Permanent, transfer to State Archives after 10 years; (b) Audio recordings: 1 year after transcribed, destroy; (c) Other records: 5 years, destroy.

Fee Splitting and OAR citations.

811-010-0110
Chiropractic Assistants
... (17) Unprofessional or dishonorable conduct is defined as: any unethical, deceptive, or deleterious conduct or practice harmful to the public; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic assistant performance; or a willful or careless disregard for the health, welfare or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a chiropractic assistant:

... (x) Splitting fees or giving or receiving a commission in the referral of patients for services.

and

811-035-0015
Unprofessional Conduct in the Chiropractic Profession
Unprofessional conduct means any unethical, deceptive, or deleterious conduct or practice harmful to the public; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic practice; or a willful or careless disregard for the health, welfare, or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a chiropractic physician:

... (25) Splitting fees or giving or receiving a commission in the referral of patients for services;

Sent: 5/2/2012 11:57:49 AM

Subject: [OBCE_Publication] Update on Fee-Splitting Rule and Online Advertising

Update on Fee-Splitting Rule
& Online Advertising

Doctors,

Since July 2011, the OBCE has communicated (several times) 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.

Sprig Health has 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.

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 a 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 a 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 a 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.

Dave McTeague, Ex. Dir.,
Board of Chiropractic Examiners
Oregon.obce@state.or.us
http://www.oregon.gov/OBCE/index.shtml

Sent: Monday, January 23, 2012 4:42 PM
Subject: [OBCE_Publication] Groupon - 2nd Notice - Fee Splitting

Doctors,

It has come to the OBCE's attention that a small number of chiropractic clinics may still be using Groupon type advertising programs.

If you are advertising a discounted coupon for chiropractic exam and treatment using a program which splits the coupon fee between the advertiser and the chiropractic clinic, the OBCE has determined that is fee-splitting in violation of administrative rule.

Here is the OBCE's statement issued last July (it can found on our home page under Current Topics, the 4th link down)
http://www.oregon.gov/OBCE/pdfs/OBCE_Stmt_Groupon_and_Fee_Splitting_7_21_2011.pdf

However, if the chiropractic clinic buys advertising at a flat rate and the coupon fee is not split on a per patient basis that would not be in violation.
Please share this information with your colleagues on the chance that they do not have an email registered with the Board of Chiropractic Examiners.

Dave McTeague, Executive Director
Oregon Board of Chiropractic Examiners

Sent: Monday, July 25, 2011 11:49 AM
Subject: [OBCE_Publication] OBCE Statement regarding Groupon and Fee Splitting Rule

OBCE decides not to amend fee-splitting rule
July 25, 2011

(Groupon issue)

The Oregon Board of Chiropractic Examiners (OBCE) declined to begin rulemaking to amend the prohibition on fee-splitting at their July 21st meeting at the University of Western States. This decision means Groupon type fee-splitting arrangements are still prohibited for chiropractic physicians.

The OBCE has been reviewing the issues of Groupon and similar internet or other marketing programs for several months. They had potential draft language produced by the Administrative Rules Advisory Committee along with a dissent by one of their members outlining the potential problems with the language. (Note: the Summer 2011 BackTalk quoted testimony in support of Groupon.)

Arn Strasser DC, appeared before the OBCE and made a statement in opposition to changing the rule, stating, "…The question is, what do schemes such as Groupon, where we would join restaurants, nail parlors and tanning salons, along with medical providers such as dentists and cosmetic surgeons, do to our credibility and how the public perceives us? In my opinion, offering discounted services in a fee splitting arrangement with companies such as Groupon undermines our credibility…" (Link to full statement:

http://www.oregon.gov/OBCE/pdfs/Strasser_Stmt_GroupOn_Opposed.pdf) (Note: the Summer 2011 BackTalk quoted testimony in support of Groupon.)

OBCE members were concerned that changing the rule would create the potential for problems and unintended consequences. They cited the difficulty in trying to craft a workable exemption.

The OBCE also heard that two other such marketing programs had changed their setup for health professionals from a fee-splitting arrangement to a flat fee marketing program (Living Social and Fox 12 Daily Deal). OBCE members wondered why Groupon could not do the same thing? (The question has been posed to Groupon but no answer has been received yet.) They felt it would be better if the advertisers changed their program for health professionals, instead of the OBCE amending the fee-splitting rule prohibition.

The OBCE members stated that chiropractic clinics who have utilized Groupon would not be sanctioned as previously many have clearly not understood that this is fee-splitting. However, now the profession has been informed several times that fee-splitting arrangements such as the current Groupon program violate the rule. The OBCE recommends that chiropractic physicians refrain from marketing programs that include a split fee in the referral or recruitment of patients.

The OBCE does not plan on revisiting this issue at their next meeting.

Any comments sent to the OBCE at Oregon.obce@state.or.us are shared with the board members.

OAR 811-035-0015
Unprofessional Conduct in the Chiropractic Profession
…Unprofessional conduct shall include, but not be limited to, the following acts of a Chiropractic physician: …
(24) Splitting fees or giving or receiving a commission in the referral of patients for services.

Dave McTeague, Ex. Dir.
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http://www.oregon.gov/OBCE
Data Classification: Level 2 - Limited

"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."

FEE SPLITTING AND COMMISSIONS

ABS Health Center, Inc. Marketing Plan

The Oregon Board of Chiropractic Examiners advises that a chiropractic physician who participates in a marketing plan recently offered by ABS Health Center, Inc. based in Cincinnati, Ohio would be in violation of Administrative Rule 811-035-0015, prohibition on fee-splitting in the referral of patients for services.

ABS Health Center, Inc. attempted to enlist an Oregon chiropractic physician whereby they proposed to "..bill back a marketing fee of $1,000 for every $3,500 cash patient closed (29% if the amount collected is less than $3,500)" in return for an agreement whereby ABS leases a spinal decompression device for the doctor's office and conducts direct mail & broadcast media to recruit patients to use this device.

Any Oregon chiropractic physician who agreed to this would be in violation of the Oregon Board of Chiropractic Examiner's Administrative Rule 811-035-0015 which states,

> "Unprofessional conduct means any unethical, deceptive, or deleterious conduct or practice harmful to the public; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic practice; or a willful or careless disregard for the health, welfare or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a Chiropractic physician:…
>
> (24) Splitting fees or giving or receiving a commission in the referral of patients for services."

In a letter to ABS, Executive Director Dave McTeague also said, "We note that you have attempted to draw a distinction between Insurance/Medicare/Medicaid and cash pay patients, stating that fee splitting is OK if it involves cash pay patients. This letter is to inform you that the Oregon Board of Chiropractic Examiner's administrative rule does not make this distinction and that fee splitting for chiropractic patients of the magnitude proposed is illegal in Oregon." (5/18/06)

Adjustments or Other Minor Gifts for Patient Referrals

The practice of extending a free adjustment or other minor gift to patients referring a new patient for services is not a violation of the Board's administrative rule, unless in the Board's opinion the practice grows to be deceptive, unethical, deleterious or harmful to the public.

OAR 811-035-0015 states: "Unprofessional conduct means any *unethical, deceptive, or deleterious conduct or practice harmful to the public*; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic practice; or a willful or careless disregard for the health, welfare or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a Chiropractic physician: ....(24) ***splitting fees or giving or receiving a commission*** in the referral of patients for services. (emphasis added).

Commissions and Fees

Webster's Ninth New Collegiate Dictionary's definition of "commission," which speaks specifically to money, was considered.

The Board noted that any gratuity between professionals and any business entity for patient referrals is unethical and harmful to the public. Any practitioner offering anything to another practitioner in exchange for a patient referral is subject to possible sanctions for unprofessional conduct.

The Board suggests that chiropractors needing further advice or legal opinion in regard to this policy, should contact their own attorney. (3/20/97)

Recently a licensee asked the Board about solicitations from a company in New York (ChiroAppointment.com). They claim to have names of patients who are interested in Chiropractic care. ChiroAppointment.com charges $40 per referral. The Board determined this is definitely a violation of the fee splitting rule, OAR 811-035-0015 (24). See the article in the Summer 2009 BackTalk.

Donating to a Non-Profit

The Board was asked if a non-profit organization (i.e. private school) could advertise to their members (i.e. parents) that if they utilize the services of a particular chiropractic physician, the physician will donate 10% back to the non-profit organization. The Board determined this is not "fee splitting" and does not violate the spirit of OAR 811-035-0015(24). (11/20/03)

Leasing Agreements and Professional Referrals

In May of 2003, the Board reviewed the following question regarding business practices under a multiple discipline clinic setting. The following response from the OBCE is not in any way legal opinion but only presents information about choices.

For a chiropractic physician who is leasing/renting office space, office personnel/billing services, that also leases/rents to other types of licensed professionals: Do "walk-in" patients requesting chiropractic services constitute a "referral" by the front desk person to that doctor? **No**.

> New OBCE policy: In review of this question the Board explored whether a "referral" by a parent company or other health care provider constitutes fee splitting in percentage of gross lease arrangements (or percentage of pay arrangements). The Board received legal advice that it has broad authority to interpret the meaning of the fee splitting rule (OAR 8110-035-0015 (24)).

Therefore the Board has determined that a chiropractor or health professional who enters into percentage of gross leasing arrangement, and who may refer patients or receive referrals from the other party, does not constitute "fee splitting" if the business agreement is entered into prior to any patient base and there is not a true commission or fee paid per patient back to the chiropractor or other health professional. This same logic also holds true for percentage of patient base rate of pay. (5/28/03)

Merchant Fees (Visa, MasterCard, Discover card charges)

The OBCE does not consider it a violation of the fee-splitting rule for an advertiser to charge a merchant (i.e. 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.

Online sales of coupons

Online sales of coupons or other services in which the prospective patient/customer pays a fee which then is shared between the advertising and the chiropractic clinic business are a violation of 811-035-0015 (24) Splitting fees or giving or receiving a commission in the referral of patients for services." Following this ruling many of these advertisers modified their program to a flat rate advertising contract which does not violate this rule."

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 a 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 a 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 a 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. (05/02/12)

Draft 1 – Adding reference to OHA Healthcare Workforce fee

811-010-0086

Annual Registration

The license period for chiropractic physicians in Oregon is a period equal to 12 months, expiring on the last day of the licensee's birth date month. Licensees must comply with ORS 684.090, 684.092, and 684.094 as it applies to their license status.

(1) At least 30 days prior to the renewal due date, the Board shall provide, by mail or electronic mail to the address on record, a notice of the requirements of ORS 684.090 and ORS 684.092.

(2) As part of the annual registration, all licensees must complete the required healthcare workforce data survey and pay the fee established by the Oregon Health Authority pursuant to ORS 676.410

~~(2)~~(3) Active licensees must pay to the Board the annual $425 registration fee and meet the requirements of ORS 684.092 during the 12 months prior to the expiration of the Certificate of Registration.

~~(3)~~(4) Licensees may apply for a $315 senior active license if the licensee meets and provides proof of the following requirements:

(a) Is 60 years of age or older; and

(b) Has held an active chiropractic license for at least 25 years.

~~(4)~~(5) Senior active licensees shall fulfill the requirements of ORS 684.092 except that continuing chiropractic education shall not be less than 6 hours per year.

~~(5)~~(6) Active licensees may apply for a $225 inactive license, if the licensee is not engaged in the practice of chiropractic in Oregon.

~~(6)~~(7) Inactive licensees do not have to fulfill the requirements of ORS 684.092.

~~(7)~~(8) Inactive licensees who want to reinstate their active license during the same license year shall pay the full active annual registration fee and provide proof of compliance with ORS 684.092.

~~(8)~~(9) Inactive licensees who apply for reinstatement after five or more years after the date of transfer to inactive license, or who cannot demonstrate to the satisfaction of the Board they have been in active practice during the preceding five years, may be required to establish their competency in the practice of chiropractic by:

(a) Receiving a passing grade on all or part of an examination required by the Board; or

(b) Submitting a license verification showing proof of active chiropractic practice and any disciplinary actions from all state boards where licensure is maintained; or

(c) Petition the Board to show proof licensee has been actively involved in a health profession in another capacity for a minimum of at least one year of the last five.

~~(9)~~(10) A license that is not renewed on time may not be renewed except:

(a) Upon written application and payment to the Board of the fee for the license category plus a delinquent fee of $125 for each week or portion thereof, not to exceed $500.

(b) Upon compliance with or exemption from the requirements of ORS 684.092.

~~(10)~~(11) All licensees shall submit to a criminal background check during renewal at an interval to be determined by the Board.

(a) Licensees will not be required to submit to a new criminal background check, if one has been submitted to the Board in the last six years, unless under Board investigation, or for some other Board-determined purpose. Licensee shall provide a complete set of fingerprints or LiveScan Transmittal Verification form, and the criminal background check results obtained

Commented [kjb1]: With new Fees rule set to be adopted in Jan 2020, this may be the time to remove these renewal fees too

from any state or local law enforcement agency, or from any other agency approved by the Board. Licensees shall use forms or methods prescribed by the Board.

(b) Licensees must pay to the Board the current actual cost of conducting the state and federal background check.

(c) The criminal background check fee will be in addition to the renewal fee and payable by the licensee.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.090 & 684.092
History:
BCE 12-2019, amend filed 10/10/2019, effective 10/10/2019
BCE 4-2017, f. 4-27-17, cert. ef. 1-1-18
BCE 3-2015, f. 6-8-15, cert. ef. 7-1-15
BCE 3-2013, f. 10-8-13, cert. ef. 11-1-13
BCE 1-2007, f. & cert. ef. 11-30-07
BCE 2-2004, f. & cert. ef. 6-7-04
BCE 2-2002, f. & cert. ef. 5-29-02
BCE 3-2000, cert. ef. 8-23-00
CE 2-1995, f. & cert. ef. 10-30-95
CE 1-1993, f. 3-1-93, cert. ef. 4-1-93
Reverted to 2CE 1-1986, f. 4-14-86, ef. 5-1-86
Suspended by CE 1-1989(Temp), f. & cert. ef. 7-28-89
2CE 1-1986, f. 4-14-86, ef. 5-1-86
2CE 1-1978, f. 6-16-78, ef. 7-1-78
Reverted to 2CE 9, f. 10-16-70
2CE 13(Temp), f. & ef. 4-13-76 through 8-10-76
2CE 9, f. 10-16-70

676.410 Information required for renewal of certain licenses; confidentiality; data collection; fees; rules. (1) As used in this section, "health care workforce regulatory board" means the:

(a) State Board of Examiners for Speech-Language Pathology and Audiology;

(b) State Board of Chiropractic Examiners;

(c) State Board of Licensed Social Workers;

(d) Oregon Board of Licensed Professional Counselors and Therapists;

(e) Oregon Board of Dentistry;

(f) Board of Licensed Dietitians;

(g) State Board of Massage Therapists;

(h) Oregon Board of Naturopathic Medicine;

(i) Oregon State Board of Nursing;

(j) Respiratory Therapist and Polysomnographic Technologist Licensing Board;

(k) Oregon Board of Optometry;

(L) State Board of Pharmacy;

(m) Oregon Medical Board;

(n) Occupational Therapy Licensing Board;

(o) Physical Therapist Licensing Board;

(p) Oregon Board of Psychology; and

(q) Board of Medical Imaging.

(2) An individual applying to renew a license with a health care workforce regulatory board must provide the information prescribed by the Oregon Health Authority pursuant to subsection (3) of this section to the health care workforce regulatory board. Except as provided in subsection (4) of this section, a health care workforce regulatory board may not approve an application to renew a license until the applicant provides the information.

(3) The authority shall collaborate with each health care workforce regulatory board to adopt rules establishing:

(a) The information that must be provided to a health care workforce regulatory board under subsection (2) of this section, which may include:

(A) Demographics, including race and ethnicity.

(B) Education and training information.

(C) License information.

(D) Employment information.

(E) Primary and secondary practice information.

(F) Anticipated changes in the practice.

(G) Languages spoken.

(b) The manner and form of providing information under subsection (2) of this section.

(4)(a) Subject to paragraph (b) of this subsection, a health care workforce regulatory board shall report health care workforce information collected under subsection (2) of this section to the authority.

(b) Except as provided in paragraph (c) of this subsection, personally identifiable information collected under subsection (2) of this section is confidential and a health care workforce regulatory board and the authority may not release such information.

(c) A health care workforce regulatory board may release personally identifiable information collected under subsection (2) of this section to a law enforcement agency for investigative purposes or to the authority for state health planning purposes.

(5) A health care workforce regulatory board may adopt rules to perform the board's duties under this section.

(6) In addition to renewal fees that may be imposed by a health care workforce regulatory board, the authority shall establish fees to be paid by individuals applying to renew a license with a health care workforce regulatory board. The amount of fees established under this subsection must be reasonably calculated to reimburse the actual cost of obtaining or reporting information as required by subsection (2) of this section.

(7) Using information collected under subsection (2) of this section, the authority shall create and maintain a health care workforce database that will provide data, including data related to the diversity of this state's health care workforce, upon request to state agencies and to the Legislative Assembly. The authority may contract with a private or public entity to establish and maintain the database and to perform data analysis. [2009 c.595 §1175; 2011 c.630 §23; 2013 c.14 §9; 2015 c.318 §40; 2015 c.380 §1; 2017 c.6 §24]

Note: Section 3, chapter 380, Oregon Laws 2015, provides:

Sec. 3. (1) For individuals applying to renew a license to practice a regulated profession with the Oregon Board of Dentistry, Board of Licensed Dietitians, Oregon State Board of Nursing, State Board of Pharmacy, Oregon Medical Board, Occupational Therapy Licensing Board and Physical Therapist Licensing Board, the amendments to ORS 676.410 by section 1, chapter 380, Oregon Laws 2015, apply to applications to renew a license to practice a regulated profession that are submitted on or after January 1, 2016.

(2) For individuals applying to renew a license to practice a regulated profession with the State Board of Examiners for Speech-Language Pathology and Audiology, State Board of Chiropractic Examiners, State Board of Licensed Social Workers, Oregon Board of Licensed Professional Counselors and Therapists, State Board of Massage Therapists, Oregon Board of Naturopathic Medicine, Respiratory Therapist and Polysomnographic Technologist Licensing Board, Oregon Board of Optometry, Oregon Board of Psychology and Board of Medical Imaging, the amendments to ORS 676.410 by section 1, chapter 380, Oregon Laws 2015, apply to applications to renew a license to practice a regulated profession that are submitted on or after the date on which rules are adopted for health care workers regulated by a health care workforce regulatory board pursuant to ORS 676.410 (3). [2015 c.380 §3; 2017 c.6 §25]

Board of Massage Therapists
Chapter 334
Division 20

SANITATION, FACILITY AND BUILDING REQUIREMENTS

334-020-0005
Facilities and Sanitation

(1) Permanent and Mobile structures:

(a) All permanent structures and mobile facilities where a LMT routinely conducts massage and bodywork must:

(A) Be established and maintained in accordance with all local, state and federal laws, rules & regulations;

(B) Obtain a facility permit to operate;

(i) Notify the Board office in writing,

(a) Of any change of the permitted Facility's name, business location, operation status, ownership, email or mailing address within 30 days of change.

(b) A Facility Permit Transfer Application must be submitted and approved by the Board prior to the Facility providing of massage therapy services under new ownership, under a new business or assumed business name.

(ii) A permitted Facility must display its permit in a location clearly visible to anyone entering the facility;

(iii) A permitted Facility must display original licenses of its LMT employee(s) in a location inside the premises, clearly visible to the general public.

(iv) A permitted Facility is required to include its permit number in all massage therapy advertisements, including but not limited to: written, electronic, televised and audio advertisements, service menus, business cards, flyers, websites, and other means of promotion of the permitted Facility.

(C) Facilities exempted from the permit process:

(i) Clinic or facility owned or operated by a person authorized to practice a profession by a health professional regulatory board, as defined in ORS 676.160;

(ii) A career school licensed under ORS 345.010 to 345.450; and

Clinics of a board approved massage therapy program.

(D) Provide a finished lavatory that

(i) Is well maintained,

(ii) Provides a system for sanitary disposal of waste products,

(iii) Is capable of being fully closed and locked from the inside,

(iv) Supplies hot and cold running water,

(v) Is supplied with liquid soap and single use towels,

(vi) Is supplied with toilet paper at each toilet;

(E) Dispose of refuse sewage in a manner described by local and state law; and

(F) Follow applicable laws pertaining to public spas, pools, baths and showers.

(b) All treatment spaces must:

(A) Provide for client privacy, both in-house and on-site;

(B) Be designated as used only for massage at the time of services;

(C) Provide for sufficient heating, cooling and ventilation for client comfort; and

(D) Provide illumination during cleaning.

(c) The facility and treatment space must be:

(A) Cleaned regularly and kept free of clutter, garbage or rubbish;

(B) Maintained in a sanitary manner; and

(C) Maintained free from flies, insects, rodents and all other types of pests.

(2) Outcall/On-site

Any temporary location where the LMT conducts massage and bodywork, the LMT must provide and utilize:

(a) Safe, sanitized and well-maintained equipment, tools and preparations;

(b) Sanitary linen practices; and

(c) Client privacy practices.

Statutory/Other Authority: ORS 687.121
Statutes/Other Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121
History:
BMT 1-2018, amend filed 11/21/2018, effective 01/01/2019
BMT 1-2015, f. 3-12-15, cert. ef. 7-1-15
HB 88, f. 3-16-56, Renumbered from 333-035-0012, MTB 2-1985, f. & ef. 1-23-85; MTB 1-1986, f. & ef. 1-29-86; Renumbered from 334-010-0030, MTB 1-1992, f. & cert. ef. 7-28-92; BMT 2-1998, f. & cert. ef. 7-22-98; BMT 1-2009, f. 2-13-09, cert. ef. 3-1-09; BMT 2-2013, f. 11-26-13, cert. ef. 1-1-14

334-020-0015
Equipment

(1) All equipment and tools used in conjunction with a treatment on a client must:

(a) Be approved by a nationally recognized testing laboratory when applicable;

(b) Be maintained on a regular basis; and

(c) Be cleaned between each use.

(2) Cushions on tables and chairs, as well as bolster and pillows, must be covered with impervious material that is cleaned after every use.

(3) Topical preparations must be:

(a) Stored in a manner that maintains the integrity of the product and prevents spoilage and contamination;

(b) Dispensed in a manner that prevents contamination of the unused portion; and

(c) Dispensed in a manner that prevents cross-contamination between clients.

(4) Topical preparations such as ice cubes, plasters, herbal wraps and any other similar product that comes in contact with the client must be used only once and then disposed of in a sanitary manner.

Statutory/Other Authority: ORS 687.121
Statutes/Other Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121
History:
BMT 4-2011, f. 12-1-11, cert. ef. 1-1-12
BMT 1-2009, f. 2-13-09, cert. ef. 3-1-09
BMT 2-1998, f. & cert. ef. 7-22-98
Renumbered from 334-010-0040, MTB 1-1992, f. & cert. ef. 7-28-92 (and corrected 8-6-92)
MTB 1-1986, f. & ef. 1-29-86
MTB 1-1979, f. & ef. 5-22-79
HB 88, f. 3-16-56, Renumbered from 333-035-0016

334-020-0050
Linens

(1) When linens are used they must be routinely cleaned and stored in a manner which reasonably assures the sanitary use for each client.

(2) The use of soiled linens is prohibited.

(3) All soiled linens must be:

(a) Immediately placed in a receptacle that closes and prevents cross-contamination;

(b) Handled as little as possible;

(c) Laundered in a manner that eliminates the risk of spreading parasites, communicable diseases and infections; and

(d) Laundered in a manner that removes all residue of topical preparations.

Statutory/Other Authority: ORS 687.121
Statutes/Other Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121
History:
BMT 3-2009, f. & cert. ef. 7-2-09
BMT 1-2009, f. 2-13-09, cert. ef. 3-1-09
BMT 2-1998, f. & cert. ef. 7-22-98
Renumbered from 334-010-0075, MTB 1-1990, f. & cert. ef. 4-20-90
MTB 1-1986, f. & ef. 1-29-86
MTB 1-1979, f. & ef. 5-22-79
HB 88, f. 3-16-56, Renumbered from 333-035-0030

334-020-0055

Communicable Disease Control

(1) All therapists must always practice communicable disease prevention and control.

(2) LMT's are required to follow the communicable disease guidelines as adopted by the Board.

Statutory/Other Authority: ORS 687.121
Statutes/Other Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121
History:
BMT 1-2009, f. 2-13-09, cert. ef. 3-1-09
HB 88, f. 3-16-56, Transferred from 333-035-0032; MTB 1-1979, f. & ef. 5-22-79; MTB 1-1986, f. & ef. 1-29-86; Renumbered from 334-010-0080, MTB 1-1992, f. & cert. ef. 7-28-92 (and corrected 8-6-92); BMT 2-1998, f. & cert. ef. 7-22-98

Continuing Education Rule Conflict

The continuing education rule conflicts with other sections in the same rule, and with the Board's CE Audit Policy.

First,

> OAR 811-015-0025(4) states, "(4) Courses or activities determined by licensees to meet the criteria of sections (9) and (10) are presumed to be approved until or unless specifically disapproved by the Board. Licensees will be informed of any disapproved courses in a timely manner. The Board will **not** retroactively disapprove course credits. The Board will maintain a list of disapproved courses available for review by licensees."

The above statement is incorrect. The Board does retroactively disapprove course credit. See the next reference in the same rule....

> OAR 811-015-0025(13) regarding the CE audit states, "(13) Any licensee who has submitted inadequate, insufficient, or deficient CE records or who otherwise appears to be in noncompliance with the requirements of this rule will be given written notice by the Board and will have 30 days from the date of notice to submit additional documentation, information or written explanation to the Board establishing the licensee's compliance with this rule. The Board may issue civil citations for noncompliance of this rule."

Second, and supporting the fact that the Board disapproves CE ....

> The Board's CE Audit Policy procedures states, "OBCE staff will perform the initial CE audit, allowing for the 30 day response period. Once proof of CE are submitted by the audited licensees, staff will review for the number of hours, proof of completion, and appropriateness of CE taken.
>
> If questionable CE have been submitted, staff will notify the licensee of an additional 30 days to remedy the missing, or inappropriate CE."

Staff recommends that the reference in OAR 811-015-0025(4) be amended as follows:

> "(4) Courses or activities determined by licensees to meet the criteria of sections (9) and (10) are presumed to be approved until or unless specifically disapproved by the Board. ~~Licensees will be informed of any disapproved courses in a timely manner. The Board will not retroactively disapprove course credits.~~ The Board will maintain a list of disapproved courses available for review by licensees."

kjb

811-015-0025

Continuing Chiropractic Education

(1) Continuing chiropractic education (CE) is to improve the competence and skills of Oregon chiropractic licensees, and to help assure the Oregon public of the continued competence of these licensees within the statutory scope of practice.

(2) In order to renew a license or certificate, each licensee shall complete an affidavit attesting to successful completion of education per their license or certificate status:

(a) Chiropractic physician active status - 20 hours;

(b) Chiropractic physician senior active status - 6 hours; or

(c) Chiropractic assistant - 6 hours.

(3) Continuing education course or activity hours must be completed during the preceding license or certification period. A licensee may not claim more than 20 hours of continuing education completed in one 24 hour period. Courses shall not be taken simultaneously. Each licensee shall maintain records as required in section (11) to support the attestation of completed hours.

(4) Courses or activities determined by licensees to meet the criteria of sections (9) and (10) are presumed to be approved until or unless specifically disapproved by the Board. Licensees will be informed of any disapproved courses in a timely manner. The Board will not retroactively disapprove course credits. The Board will maintain a list of disapproved courses available for review by licensees.

(5) The Board may require specific courses as part of a licensee's annual relicensure hours for an upcoming license or certificate period.

(6) Any chiropractic physician who is also actively licensed in a healthcare profession with prescriptive rights is exempt from the over-the-counter, non-prescriptive substances requirements of sections (6) and (7).

(7) Any chiropractic physician holding an initial license is exempt from continuing education for the first year of licensure, except for four (4) hours relating to over-the-counter, non-prescriptive substances and any specific courses required by the Board.

(8) Any chiropractic physician changing license status from inactive to active or senior active shall take four (4) hours of the required hours relating to over-the-counter, non-prescriptive substances prior to changing license status and any specific courses required by the Board.

(9) Approved continuing chiropractic education shall be obtained from courses or activities which meet the following criteria:

(a) They do not misrepresent or mislead;

(b) They are presented by a chiropractic physician, licensed here or in another state, other appropriate health care provider, or other qualified person;

(c) They exclude practice-building subjects and the principle purpose of the program may not be to sell or promote a commercial product. However, the mere mention of practice-building concepts shall not disqualify a program’s eligibility for CE credit.

(d) The material covered shall pertain to the practice of chiropractic in Oregon or be related to the licensee's specific practice;

(e) Continuing education hours for Board activities must assist in assuring the competence and skills of the licensee; and

(f) Shall be quality courses or activities adequately supported by evidence or rationale as determined by the Board.

(10) The Board may accept credit hours from courses, seminars or other activities. Completion of other activities as chiropractic continuing education is defined as follows:

(a) Continuing medical education (CME);

(b) Video or audio-taped continuing education courses or seminars, unless specifically required by the Board to be taken in person;

(c) Online courses;

(d) Being an original author of an article, published in a peer reviewed journal, given in the year of publication;

(e) Participation in a formal protocol writing process associated with an accredited health care institution or state or government health care agency;

(f) Participation on a Board committee, or assisting with a National Board of Chiropractic Examiners' (NBCE) examination or test writing committee;

(g) Participation in a research project, approved by the Board, related to chiropractic health care directed by an educational institution or other qualified chiropractic organization;

(h) Teaching courses at an accredited health care institution;

(i) Teaching chiropractic continuing education courses;

(j) CPR courses; and

(k) Instruction related to OAR 811-015-0030, minor surgery/proctology rotation; and

(l) Any other course or activity specifically authorized by the Board.

(11) All licensees are required to keep full, accurate, and complete records:

(a) A verification of attendance for all CE courses or activities showing hours claimed for relicensure credit, and or proof of completion signed by the sponsor and licensee.

(b) Video or audio-taped courses shall be supported through record-keeping with a letter, memo, or on a form provided by the Board, that includes the dates and times, vendor’s or presenter’s name/s, total hours claimed for each course, location, and includes the following statement: “I swear or affirm that I viewed or listened to these continuing education courses in their entirety on the dates and times specified in this report.”

(c) A copy of a published article including the date of publication;

(d) A written record of hours in clinical protocol development and research projects. The record shall include the names and addresses of the institutions involved, name of supervisors, and their signatures verifying hours.

(e) For licensees claiming CE hours under the provisions of (10)(f), for participation on a Board committee, or assisting with a National Board of Chiropractic Examiners' (NBCE) examination or NBCE test writing committee, certification from the Board or NBCE.

(f) For licensees claiming CE hours under the provisions of (10)(h), a record of employment by health care institutions, signed by their supervisor, a copy of the course syllabus if applicable, and verification of hours.

(g) For licensees claiming CE hours under the provisions of (10)(i), licensee shall obtain and keep verification of the course taught including, the dates of the course, a syllabus and the sponsoring organization.

(h) For licensees claiming CE hours under the provisions of (10)(k), a record of the dates, topics/procedures, and hours.

(12) The Board will generate a random computer list of a minimum of 10% or up to 100% of renewing licensees, who will have their CE records audited and reviewed to ensure compliance with this rule. Licensees shall respond to this request within 30 days by supplying the Board with verification of their CE courses or activities as provided in section (11).

(13) Any licensee who has submitted inadequate, insufficient, or deficient CE records or who otherwise appears to be in noncompliance with the requirements of this rule will be given written notice by the Board and will have 30 days from the date of notice to submit additional documentation, information or written explanation to the Board establishing the licensee's compliance with this rule. The Board may issue civil citations for noncompliance of this rule.

(14) At its discretion, the Board may audit, by attendance, the content of any program in order to verify the content thereof. Denial of an audit is grounds for disapproval.

(15) Any licensee seeking a hardship waiver from their continuing education requirements shall apply to the Board, in writing, as soon as possible after the hardship is identified and prior to the close of licensure for that year. Specific details of the hardship must be included. In order to approve an application for a hardship waiver, the Board, within its discretion, must find that such hardship exists.

(16) The Board shall maintain and make available, through its web page and electronic communications to licensees, a list of disapproved courses, if any. The Board may disapprove a course or CE activity after giving the sponsor and/or licensees the opportunity to provide additional information of compliance with the criteria contained in this rule, and opportunity for contested case hearing under the provisions of ORS 183.341, if requested. Any CE sponsor or licensee may request the Board to review any previously disapproved course at any time.

Statutory/Other Authority: ORS 684.155
Statutes/Other Implemented: ORS 684.092
History:
BCE 12-2019, amend filed 10/10/2019, effective 10/10/2019
BCE 5-2017, amend filed 10/20/2017, effective 11/01/2017
BCE 3-2008, f. & cert. ef. 12-23-08
BCE 1-2007, f. & cert. ef. 11-30-07
BCE 1-2002, f. & cert. ef. 2-6-02
BCE 3-2000, cert. ef. 8-23-00
CE 4-1997, f. & cert. ef. 11-3-97
CE 1-1997, f. & cert. ef. 3-4-97
CE 4-1996(Temp), f. & cert. ef. 9-27-96
CE 1-1996, f. & cert. ef. 2-28-96
2CE 5-1985, f. 11-13-85, ef. 12-1-85
2CE 1-1984, f. 7-16-84, ef. 8-1-84
2CE 1-1978, f. 6-16-78, ef. 7-1-78

811-010-0008 Fees

All fees paid under these rules are non-refundable and are not prorated.

(1) The following fees apply to chiropractic physician applicants and licensees:

(a) Initial application and examination fee: $100;

(b) Initial application and examination fee for reciprocity candidates: $100;

(c) Initial license fee: $150;

~~(a)~~(d) Oregon Health Authority's Healthcare workforce survey: $2

(e) Active annual registration fee: $425;

(f) Senior active annual registration: $315;

(g) Inactive annual registration: $225; and

(h) Delinquent fee for late renewal during the 30 days immediately following the renewal date: $125 per week, not to exceed $500.

(2) The following fees apply to chiropractic assistant applicants and certificate holders:

(a) Initial application for certification fee: $50;

(b) Examination: $35;

(c) Initial certification: $50;

(d) Annual renewal: $75;

(e) Delinquent fee for late renewal during the 30 day grace period immediately following the renewal date: $25; and

(f) Delinquent fee for late renewal after the 30 day grace period: $50.

(3) The criminal background check fee applies to both chiropractic physicians and assistants: $41.25.

(4) If issued, the following fees apply to civil penalty citations:

a) Failing to maintain current email, business and mailing addresses with the Board: $50;

b) Failing to pay any fines or fees owed to the Board: $50 per month of non-payment, not to exceed $500 total;

c) Failing to comply with continuing education requirements:

i) Chiropractic physicians: $250 plus $50 per credit hour not completed, or proof provided;

ii) Chiropractic assistant: $12.50 per credit not completed, not to exceed $75;

d) Failing to attend the Introduction to the Board meeting when required by the Board: $250;

e) Failing to notify the Board within 10 days that licensee is convicted of a misdemeanor or felony, or arrested for a felony crime: $125 per week, not to exceed $500;

f) Failing to release patient records upon written request within 30 days: $250;

g) Failing to provide notice when leaving, selling, or retiring from the chiropractic office where the chiropractic physician has provided chiropractic services no later than 30 days prior to the last date the chiropractic physician worked at that location: $500.

Commented [kjb1]: Discuss whether these fees will apply to new Temp DC / military personnel rule

Commented [kjb2]: Per OHA agreement, this fee is effective through 12/31/2020

Commented [kjb3]: Discuss whether these fees will apply to new Temp CA / military personnel rule

OAR 811-010-0068
Temporary Chiropractic License for Spouses or Domestic Partners of Active Duty Armed Forces of the United States Stationed in Oregon:

(1) A temporary license to practice chiropractic shall be issued to the spouse or domestic partner of an active duty armed forces personnel when the following requirements are met:

(a) A completed application and payment of fee is received by the Board;

(b) Satisfactory evidence of having graduated from a school, college, institution, or university of ~~dentistry~~ chiropractic accredited by the ~~Commission~~ Council on ~~Dental Accreditation of the American Dental Association~~Chiropractic Education; or

(c~~b~~) Satisfactory evidence of having graduated from a ~~dental~~ school, college, institution or university accredited by the Council on Chiropractic Education ~~school~~ located outside the United States or Canada~~, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language~~; ~~and~~

(d~~c~~) Submission of a copy of the military orders assigning the active duty member to an assignment in Oregon; ~~and~~

(e~~d~~) The spouse or domestic partner holds a current license in another state to practice ~~dentistry~~ chiropractic at the level of application; ~~and~~

(f~~e~~) The license is unencumbered and verified as active and current through processes defined by the Board; and

(g~~f~~) Satisfactory evidence of successfully passing a clinical examination administered by any state, national testing agency, or other Board-recognized testing agency.

(2) The temporary license shall expire on the following date, whichever occurs first:

(a) Oregon is no longer the duty station of the active armed forces member; or

(b) The license in the state used to obtain a temporary license expires; or

(c) ~~Two years~~13 months after the issuance of the temporary license.

(3) Temporary license holders are responsible to comply with ORS Chapter 684, OAR 811, and any other laws and rules governing the practice of chiropractic and chiropractic physicians.

(4) This temporary license is not renewable. If the dates in section two of this rule are exceeded and the spouse or domestic partner continues to practice in Oregon, the spouse or domestic partner must apply for an active Oregon license. This license must be obtained using the processes and fees established for permanent licensure. Continuing to work in Oregon when the temporary license has expired will be considered practicing without a valid license and is subject to Board action.

811-010-0071

Board Members

(1) Members of the Oregon Board of Chiropractic Examiners shall maintain a position of strict neutrality and confidentiality.

(2) Board members shall receive a per diem of $200 a day for board meetings, conference attendance, and presentations.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.150
History:
BCE 9-2019, amend filed 07/31/2019, effective 07/31/2019
BCE 1-2017, f. & cert. ef. 1-6-17
BCE 2-2009, f. & cert. ef. 12-22-09
BCE 1-1998, f. & cert. ef. 2-5-98
2CE 1-1978, f. 6-16-78, ef. 7-1-78
2CE 9, f. 10-16-70

811-015-0005

Records

(1) Failure to keep complete, accurate, and minimally competent records on all patients shall be considered unprofessional conduct.

(a) Each patient shall have exclusive records which shall be clear, legible, complete, and accurate 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.

(b) Every page of chart notes will identify the patient by name and one other unique identifier (date of birth, medical record number, etc.), and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service, and author of the record.

(c) Clear, legible, complete, accurate, and minimally competent records shall contain the following:

(A) A description of the chief complaint or primary reason the patient sought treatment from the licensee.

(B) Documentation of any significant event that affects the chief complaint of the patient or the general history of the health of the patient.

(C) An accurate record of the diagnostic and therapeutic procedures that the licensee has employed in providing chiropractic services to the patient, including, but not limited to:

(i) Height, weight, blood pressure, and pulse upon examination, and subsequent visits, as clinically indicated;

(ii) Examinations and the results of those examinations;

(iii) Diagnoses;

(iv) Treatment plan, any subsequent changes to the treatment plan, and the clinical reasoning for those changes;

(v) Dates on which the licensee provided clinical services to the patient, as well as the services performed, and clinical indications for those services;

(vi) Areas of the patient’s body where the licensee has provided care;

(vii) Patient’s response to treatment;

(viii) Therapeutic procedures must be clearly described including information such as providers involved, timing, setting, and tools used, as appropriate.

(D) Documentation of informed consent for examination and treatment.

(E) Other clinically relevant correspondence, including, but not limited to: telephonic or other patient communications, referrals to other practitioners, and expert reports.

(d) A chiropractic physician shall maintain billing records for services performed for which payment is received from or billed to the patient, an insurance company, or another person or entity who has assumed the financial responsibility for the payment of services performed to the patient. Such records will be maintained for the same amount of time as other patient records. At a minimum, a billing record will include the date of the patient encounter or financial entry, a notation of the services performed either by description or code, common codes such as the AMA Current Procedural Terminology (CPT) codes may be used without additional explanation or legend, and the fee charged for the services billed. If third party payors are billed, the billing instrument (CMS 1500 form or its successor) should be retrievable. Such information may be maintained on a handwritten or printed ledger, with the assistance of a computer or other device either by direct entry or with a particular program or application, or by an alternative method. To the extent billing records do not contain patient health care records not kept elsewhere, they are not considered part of the clinical record.

(e) Such information as described in section (d) must be readily available upon request of the patient, an agent of the patient, an insurance carrier or entity responsible for the payment of the services, or by the Board or other entity with a legal right to review such information.

(2) Practitioners with dual licenses shall indicate on each patient's records under which license the services were rendered.

(3) A patient's original health care and billing records shall be kept by the chiropractic physician a minimum of seven years from the date of last treatment. However, if a patient is a minor, the records must be maintained at least seven years from the time they turn 18 years of age.

(a) If the treating chiropractic physician is an employee or associate, the duty to maintain original records shall be with the chiropractic business entity or chiropractic physician that employs or contracts with the treating chiropractic physician.

(b) Chiropractic physicians shall be responsible for keeping an available copy of all authored reports for seven years from the date authored.

(4) If a chiropractic physician releases original radiographic films to a patient or another party, upon the patient's written request, they should create an expectation that the films will be returned, and a notation shall be made in the patient's file or in an office log where the films are located (either permanently or temporarily). If a chiropractic physician has radiographic films stored outside their clinic, a notation shall be made in the patient's file or in an office log where the films are located and the chiropractic physician must ensure those films are available for release, if requested by the patient.

(5) The responsibility for maintaining original patient records may be transferred to another chiropractic business entity or to another chiropractic physician as part of a business ownership transfer transaction.

(6) A chiropractic physician shall establish a plan for custodianship of these records in the event they are incapacitated, become deceased, are or will become unable to maintain these records pursuant to paragraph (7).

(7) Except as provided for in paragraph (7)(e) of this rule, a chiropractic physician who is an independent contractor or who has an ownership interest in a chiropractic practice shall provide notice when leaving, selling, or retiring from the chiropractic office where the chiropractic physician has provided chiropractic services.

(a) Notification shall be sent to all patients who received services from the chiropractic physician during the two years immediately preceding the chiropractic physician's last date for seeing patients. This notification shall be sent no later than thirty days prior to the last date the chiropractic physician will see patients.

(b) The notice shall include all of the following:

(A) A statement that the chiropractic physician will no longer be providing chiropractic services at the practice;

(B) The date on which the chiropractic physician will cease to provide services; and

(C) Contact information that enables the patient to obtain the patient's records.

(c) The notice shall be sent in one of the following ways:

(A) A letter sent through the US Postal Service to the last known address of the patient with the date of the mailing of the letter documented, or

(B) A secure electronic message.

(d) In the event of an illness, unforeseen emergency, incarceration, or other unanticipated incident, a chiropractic physician is unable to provide a thirty day notice as required by paragraph (7)(a) of this rule, the chiropractic physician shall provide such notice within thirty days after it is determined that the physician will not be returning to practice.

(e) Paragraph (7) of this rule does not apply to the chiropractic physician who is departing as an employee of another Oregon licensed chiropractic physician. It is the employer's responsibility to maintain continuity of care, or to comply with this rule, if patient care will be terminated upon an employee's leaving employment or retiring.

(f) In the event a chiropractic physician dies or becomes incapacitated and unable to practice, and there is no other chiropractic physician associated with the practice, the deceased, incapacitated, or unavailable chiropractic physician's executor, guardian, administrator, conservator, next of kin, or other legal representative shall notify the Board in writing of the management arrangement for the custody and transfer of patient files and records. This individual shall ensure the security of, and access to, patient files

and records by the patient or other authorized party, and must report plans or arrangements for permanent custody of patient files and records to the Board in writing within 180 days. Transfer of patient files and records must occur within one year of the death of the chiropractic physician.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.155
History:
BCE 12-2019, amend filed 10/10/2019, effective 10/10/2019
BCE 11-2018, amend filed 10/09/2018, effective 10/10/2018
BCE 2-2015, f. & cert. ef. 4-10-15
2CE 1-1978, f. 6-16-78, ef. 7-1-78; CE 5-1995, f. & cert. ef. 12-6-95; CE 4-1997, f. & cert. ef. 11-3-97; BCE 3-2000, cert. ef. 8-23-00; BCE 2-2006, f. & cert. ef. 2-9-06; BCE 5-2013, f. & cert. ef. 11-27-13; BCE 3-2014, .f & cert. ef. 8-7-14; BCE 6-2014, f. & cert. ef. 9-5-14

811-015-0010
Clinical Justification and Standard of Care

An Oregon licensed chiropractic physician provides care for many conditions using a variety of therapeutic procedures, including but not limited to chiropractic adjustment and manipulation. There is one standard of care for all patients, irrespective of the condition, service, or advice provided. All chiropractic physicians licensed under ORS chapter 684 are subject to the following:

(1) Clinical ~~rationale~~justification, within accepted standards and understood by ~~a group of~~ peers, must be shown for all opinions, diagnostic, and therapeutic procedures. The singular accepted standard of care includes obtaining a history that informs the examination, conducting an examination that informs the diagnosis, and using the diagnosis to inform the management plan which includes relevant outcome markers.

(2) "Accepted standards" means skills and treatment which are recognized as being reasonable, prudent, and acceptable under similar conditions and circumstances.

(3) For neuro-musculoskeletal conditions, a~~A~~ll initial ~~examinations~~ and subsequent ~~re-~~ examinations performed by a ~~chiropractor~~ chiropractic physician to determine the need for ~~chiropractic~~ treatment ~~of neuro-musculoskeletal conditions~~ shall include a functional chiropractic analysis. ~~-~~Some combination of at least two of the following PARTS exam constitutes a functional chiropractic analysis:

P — Location, quality, and intensity of pain or tenderness produced by palpation and pressure over specific structures and soft tissues;

A — Asymmetry of sectional or segmental components identified by static palpation;

R — The decrease or loss of specific movements (active, passive, and accessory);

T — Tone, texture, and temperature change in specific soft tissues identified through palpation;

S — Use of special tests or procedures.

(4) Chiropractic physicians shall treat their patients as often as necessary to allow for~~insure~~ favorable progress. ~~-~~Evidence~~-~~-based outcomes management shall determine whether the frequency and duration of curative chiropractic treatment is, has been, or continues to be necessary. ~~-~~Outcomes management shall include both subjective, or patient-driven, information as well as objective, provider-driven, information. ~~-~~In addition, treatment of neuro-musculoskeletal conditions outside of the Oregon Practices and Utilization Guidelines ~~— NMS Volume I, Chapter 5,~~ may be considered contrary to accepted standards. Chiropractic physicians treating outside of the Practices and Utilization Guidelines ~~— NMS Volume I, Chapter 5,~~ bear the burden of proof to show that the treatment, or lack thereof, is clinically justified.

(5) Copies of any independent examination report must be made available to the patient, the patient's attorney, the treating doctor, and the attending physician at the time the report is made available to the initial requesting party.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.155
History:
BCE 1-2007, f. & cert. ef. 11-30-07
BCE 1-2005, f. 1-28-04, cert. ef. 2-1-05
BCE 2-2003, f. & cert. ef. 12-11-03
CE 1-1995, f. & cert. ef. 10-30-95
2CE 1-1978, f. 6-16-78, ef. 7-1-78

BERINGER Kelly * BCE

From: Vern Saboe <
Sent: Sunday, December 15, 2019 7:49 PM
To: MCLEOD-SKINNER Cass * BCE; BERINGER Kelly * BCE
Cc: Franchesca Vermillion; Chris Zander, DC; Jan Ferrante; Vern Saboe
Subject: Jan. 16-17 OBCE Meeting in Albany, "Clinical Justification Rule - Language"
Attachments: OBCE Board Rule Hearing, Clinical Justification Language, Dec. 12, 2019 OCA Response.pdf

Dear President Vermillion,

The OCA is in agreement with the attached version of the proposed changes to the clinical justification rule language. Our initial concern was the possible removal of any mention of the OCPUG within the CJ rule language that currently provides a nexus to OCPUG and our new (2017) treatment algorithm and summary statements. This document within OCPUG provides guidance to chiropractic physicians as per when to re-assess their patients which includes administration of evidence-based patient outcome assessment tools (self-reporting psychometrics for pain and disability/activity intolerances).

Sincerely,

Vern Saboe Jr., DC, DACAN, FICC, DABFP, DACO, FACO

Director of Governmental Affairs, Oregon Chiropactic Association
Oregon Delegate and Member Legislative Advisory Committee, American Chiropractic Association
Past Member, State of Oregon, Health Evidence Review Commission (HERC, 2011-2015)
Member, HERC Subcommittee for Value-based Benefits
Member, EviCore/Regence Physical Medicine Advisory Council
Member, American Academy of Motor Vehicle Injuries, Advisory Council

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Website: www.drvernsaboe.com

"Time is a tyrant. It consumes choices left unmade. The only choices that live are the ones that are taken – when you choose the good, when you choose to move with God, nothing can stop you from fulfilling God's purpose for your life."

Edwin McManus, "Chasing Daylight"

CODE OF ETHICS

811-035-0005
Duties and Obligations of Chiropractic Physicians to Their Patients

(1) ~~(1)~~ The health and welfare of the patient shall always be the first priority of chiropractic physicians and expectation of remuneration shall not affect the quality of service to the patient.
(2)
~~(1)~~(3)

(2) The patient has the right to informed consent regarding examination, therapy and treatment procedures, risks and alternatives, and answers to questions with respect to the examination, therapy, and treatment procedures, in terms that they can be reasonably expected to understand.

(a) Chiropractic physicians shall inform the patient of the diagnosis, plan of management, and prognosis in order to obtain a fully informed consent of the patient during the early course of treatment.

(b) In order to obtain the informed consent of a patient, the chiropractic physician shall explain the following:

(A) In general terms, the examination procedure or treatment to be undertaken;

(B) Any alternative examination procedures or methods of treatment; and

(C) Any risks, to the examination procedure or treatment

(3) Chiropractic physicians have the right to select their cases and patients. The patient has the right to continuity of care once the chiropractic physician has agreed to treat the patient. The chiropractic physician may terminate the patient-doctor relationship only when the patient has been given reasonable notice. It is permissible for the chiropractic physician to terminate the patient-doctor relationship when the patient fails to cooperate.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.150
History:
BCE 8-2019, amend filed 05/30/2019, effective 05/31/2019
BCE 2-2009, f. & cert. ef. 12-22-09
BCE 2-2003, f. & cert. ef. 12-11-03
CE 2-1995, f. & cert. ef. 10-30-95
2CE 1-1984, f. 7-16-84, ef. 8-1-84
2CE 4-1983, f. 9-28-83, ef. 10-15-83
2CE 1-1979, f. 1-17-79, ef. 2-1-79

CODE OF ETHICS

811-035-0015
Unprofessional Conduct in the Chiropractic Profession

Unprofessional conduct means any unethical, deceptive, or deleterious conduct or practice harmful to the public; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic practice; or a willful or careless disregard for the health, welfare, or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a chiropractic physician:

(1)(a) Engaging in any conduct or verbal behavior with or towards a patient that may reasonably be interpreted as sexual, seductive, sexually demeaning or romantic (also see ORS 684.100).

(b) A licensee shall not engage in sexual relations or have a romantic relationship with a current patient unless a consensual sexual relationship or a romantic relationship existed between them before the commencement of the doctor-patient relationship.

(c) "Sexual relations" means:

(A) Sexual intercourse; or

(B) Any touching of sexual or other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the licensee for the purpose of arousing or gratifying the sexual desire of either licensee or patient.

(d) In determining whether a patient is a current patient, the Board may consider the length of time of the doctor-patient contact, evidence of termination of the doctor-patient relationship, the nature of the doctor-patient relationship, and any other relevant information.

(e) A patient's initiation of, or participation in, sexual behavior or involvement with a licensee does not change the nature of the conduct nor lift the prohibition.

(2) Charging fees for unnecessary services;

(3) Failing to teach and/or directly supervise persons to whom chiropractic services have been delegated;

(4) Practicing outside the scope of the practice of chiropractic in Oregon;

(5) Charging a patient for services not rendered;

(6) Intentionally causing physical or emotional injury to a patient;

(7) Directly or indirectly engaging in threatening, dishonest, or misleading fee collection techniques;

(8) Soliciting or borrowing money from patients;

(9) Possessing, obtaining, attempting to obtain, furnishing, or prescribing controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs; illegally using or dispensing controlled drugs;

(10) Aiding, abetting, or assisting an individual to violate any law, rule, or regulation intended to guide the conduct of chiropractic physicians or other health care providers;

(11) Violating the rights of privacy or confidentiality of the patient unless required by law to disclose such information;

(12) Perpetrating fraud upon patients or third party payors, relating to the practice of chiropractic;

(13) Using any controlled or illegal substance or intoxicating liquor to the extent that such use impacts the ability to safely conduct the practice of chiropractic;

(14) Practicing chiropractic without a current Oregon license;

(15) Allowing another person to use one's chiropractic license for any purpose;

(16) Resorting to fraud, misrepresentation, or deceit in applying for or taking the licensure exam or obtaining a license or renewal thereof;

(17) Impersonating any applicant or acting as a proxy for the applicant in any chiropractic licensure examination;

(18) Disclosing the contents of the licensure examination or soliciting, accepting, distributing, or compiling information regarding the contents of the examination before, during, or after its administration; Notwithstanding this section, the Ethics and Jurisprudence Examination is open book and there is no restriction on applicants discussing answers to individual questions between themselves or with others;

(19) Failing to provide the Board with any documents requested by the Board;

(20) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except attorney-client privilege;

(21) Failing to answer truthfully and co~~n~~mpletely any question asked by the Board on an application for licensure or certification, or during the course of an investigation, or any other question asked by the Board;

(22) Failing to comply with state and federal laws regarding child and elderly abuse, and communicable diseases;

(23) Claiming any academic degree or certification, not actually conferred or awarded;

(24) Disobeying a final order of the Board;

(25) Splitting fees or giving or receiving a commission in the referral of patients for services;

(26) Making an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Board, to truthfully and fully answer any questions posed by an agent or representative of the Board regarding a board proceeding, or to participate as a witness in a Board proceeding;

(27) It shall be considered unprofessional conduct for a licensee to own or operate a clinic or practice as a surrogate for, or be employed by, an individual or entity who could otherwise not own and/or operate a chiropractic clinic under OAR 811-010-0120; and

(28) Chiropractic physicians holding an ownership interest as described in OAR 811-010-0120 may be held responsible, entirely or in part, for staff who provide patient services. This includes a responsibility to render adequate supervision, management, and training of staff or other persons including, but not limited to, chiropractic physicians, student interns, chiropractic assistants and/or others practicing under the licensee's supervision. Chiropractic physicians with staff may be held responsible, entirely or in part, for undue influence on staff or a restriction of an associated chiropractic physician from using their own clinical judgment.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.155
History:
BCE 8-2019, amend filed 05/30/2019, effective 05/31/2019
BCE 14-2018, amend filed 11/21/2018, effective 11/22/2018
BCE 7-2014, f. & cert. ef. 10-28-14
BCE 1-2014, f. & cert. ef. 1-29-14
BCE 2-2009, f. & cert. ef. 12-22-09
BCE 2-2003, f. & cert. ef. 12-11-03
BCE 2-2000, f. & cert. ef. 5-4-00
BCE 1-1999, f. & cert. ef. 4-7-99
CE 3-1996, f. & cert. ef. 9-26-96
CE 2-1996(Temp), f. & cert. ef. 5-31-96
CE 6-1995, f. & cert. ef. 12-19-95

Board of Chiropractic Examiners

January 16, 2020 Public Agenda

Discussion & Action Item # 1

(OBCE) 2019-2021 Legislatively Adopted Budget (LAB)

Available electronically upon request (227 pages)

Email the OBCE at Oregon.obce@oregon.gov

The business we are in	**Agency Mission:** The mission of the Oregon Board of Chiropractic Examiners is to protect the public by regulating the practice of chiropractic. (2019)		
What we want to be known for	**Vision** To protect the health, safety, and welfare of the public in all matters of chiropractic care by setting a national standard in educating, licensing, and regulating our licensees.		
What beliefs guide our actions	**Values** 1. Integrity – a commitment to acting honestly, ethically, and fairly. 2. Accountability – a willingness to accept responsibility for actions in a transparent manner. 3. Excellence – an expectation of the highest quality work and innovation. 4. Professionalism – a dedication to provide equitable, caring service to all Oregonians with compassion and respect. 5. Equity – create and foster a consistent environment where everyone has access and opportunity to thrive.		
Accomplishments that define our success	**Key Goal/Objectives** *<Insert agency goals/objectives here>*	**Key Goal/Objectives** *<Insert agency goals/objectives here>*	**Key Goal/Objectives** *<Insert agency goals/objectives here>*
How we achieve the objectives	**Strategies/Initiatives** *<Insert agency strategies/initiatives here>*	**Strategies/Initiatives** *<Insert agency strategies/initiatives here>*	**Strategies/Initiatives** *<Insert agency strategies/initiatives here>*

How we determine we are making progress	**Evaluation/Measure/Outcomes** *<Insert agency evaluations/measures/* *outcomes here>*	**Evaluation/Measure/Outcomes** *<Insert agency evaluations/measures/* *outcomes here>*	**Evaluation/Measure/Outcomes** *<Insert agency evaluations/measures/* *outcomes here>*

From: Timothy Ray [mailto:
Sent: Monday, June 03, 2019 4:25 PM
To: FINCH George * BCE <George.FINCH@oregon.gov>
Subject: Sports Chiropractic care of field side injuries

Dear Mr. Finch,
Thank you very much for taking the time to speak with me today. I appreciated your insights very much.

As requested, I would like to approach the OBCE to discuss and discover if we can arrive at a clearer perspective regarding sports chiropractic care outside our offices when working with schools and sports teams.

I feel we could collaboratively produce a chapter in the education manual and outline a similar template form as the OBCE Chart Note Template Guide for this aspect of care.

I feel this will provide clarity to protect the athlete's we serve and the state's chiropractors while minimizing liability risk's involved in this category of practice.

Sincerely,

Dr. Tim Ray

From: FINCH George * BCE <George.FINCH@oregon.gov>
Sent: Wednesday, June 5, 2019 8:11 AM
To: MCLEOD-SKINNER Cass * BCE <Cass.MCLEOD-SKINNER@oregon.gov>; PRIDEAUX Frank * BCE <Frank.PRIDEAUX@oregon.gov>
Cc: DOUGAN Donna * BCE <Donna.DOUGAN@oregon.gov>
Subject: FW: Sports Chiropractic care of field side injuries

Dr. Ray called me the other day. We chatted about DC's serving as team Doc's especially with regard to treating minors. He expressed concern that t blanket consent signed by parents at the start of the school year for student athletes may not cover treatment provided in the course of a season, only emergent care. I agreed this may be problematic as when the team Doc finds issues that would benefit from treatment, the parent/guardian is not available to consent on behalf of the minor student. He would like to speak to these issues at the next meeting, and hopes to work with us to provide greater clarity to UWS students and practitioners.

This is one of my hypotheticals posed to UWS students; how do they appropriately obtain consent, triage, and document conditions on the sidelines when it is more than emergent care (stabilize a joint until EMS arrives).

Thoughts?

Oregon Board of Chiropractic Examiners	Effective Date: March 15, 2018 Date approved/ratified: March 15, 2018
Continuing Education Audit Policy and Procedures	

POLICY

The Oregon Board of Chiropractic Examiners complies with OAR 811-015-0025 in auditing the continuing education credits attested to by chiropractic physicians for license renewal purposes. The OBCE shall abide by the following procedures for processing audit results and compliance by licensees.

PROCEDURES

1. **Continuing Education Audit procedure.**

   OBCE staff will perform the initial CE audit, allowing for the 30 day response period. Once proof of CE are submitted by the audited licensees, staff will review for the number of hours, proof of completion, and appropriateness of CE taken.

   If questionable CE have been submitted, staff will notify the licensee of an additional 30 days to remedy the missing, or inappropriate CE.

2. **Board Review.**

   If the licensee does not remedy the missing or inappropriate CE pursuant to staff's request, the case will be opened for Board review at the next regular meeting of the Board.

3. **Discipline.**

   Upon review of the CE audit case, the Board may propose appropriate discipline, including but not limited to:

   $250 fine
   $50 per credit not completed or proof provided

This licensee will be notified of such proposed discipline through a Notice of Proposed Disciplinary Action (NOPD), with attached hearing rights, response deadlines, and due process. This NOPD is considered a negative board action, is a public record, and is reportable to the National Databank.

Even if the licensee fulfills the requirements notified after issuance of the NOPD, the Board shall issue a Default Order, a Stipulated Order, or grant the licensee a hearing, depending on the status of the case.

4. **Chiropractic Assistants CE Audit.**
   The above policy and procedure also applies to Chiropractic Assistant CE audits except for the proposed discipline for violation. For CAs who are not in compliance, the Board may propose a maximum fine of $75.

Oregon Board of Chiropractic Examiners	Effective Date: March 15, 2018 Date approved/ratified: October 4, 2018
Civil Penalty Citation Policy and Procedures	

POLICY

OAR 811-035-0036 allows for the issuance of a Notice of Civil Penalty Citation for violations of the Oregon Administrative Rules that the Board deems minor in degree. The Board delegates its authority to issue said Notices to the Board's Executive Director and staff. Minor violations include, but are not limited to:

a. Failing to maintain current email, business, and mailing addresses with the Board;
b. Failing to pay any fines or fees owed to the Board;
c. Failing to comply with continuing education requirements;
d. Failing to attend the Introduction to the Board meeting when required by the Board;
e. Failing to notify the Board within 10 days when licensee or certificate holder is convicted of a misdemeanor or felony, or is arrested for a felony crime;
f. Failing to release patient records upon written request within 30 days;
g. Failing to provide notice when leaving, selling, or retiring from the chiropractic office where the chiropractic physician has provided chiropractic services no later than 30 days prior to the last date the chiropractic physician saw patients.

Instances in which the Board issues a Notice and Final Order that assesses a penalty under this rule are not considered part of a licensee's disciplinary history and therefore will not be considered in the event a licensee commits a violation that is the type generally considered part of a licensee's disciplinary history. Violations listed above are considered non-disciplinary by the Board and will not be reported to the National Practitioners Data Bank (NPDB) or the Healthcare Integrity and Protection Data Bank (HIPDB).

The Board may include a violation listed above in a licensee's disciplinary history if the licensee does not correct the violation, the licensee engages in repeat violations of the cited statute or rule, or the Board identifies the violation in conjunction with the investigation of other violations that are generally considered part of a licensee's disciplinary history.

PROCEDURES

1. **Issuance of Notice of Civil Penalty Citation.**

   The OBCE's Executive Director and staff will issue a Notice of Civil Penalty Citation that includes response time and hearing rights as violations become known. Payment of citations is required within 30 days of Notice issuance. The licensee may request a hearing or default on the citation per the procedure found in the Administrative Procedures Act.

2. **Publication of Citations.**

   Citations, and the payment thereof, will not be posted or made public in any way unless said citation is determined to be part of a larger case and multiple violations of law or rule.

COST

Cost per violation shall not exceed $500. The cost schedule is as follows:

$50.00	a. Failing to maintain current email, business, and mailing addresses with the Board.
$50.00 per month of non-payment not to exceed $500.00 total	b. Failing to pay any fines or fees owed to the Board.
DC: $250 + $50 per credit not completed or proof provided. CA: $12.50 per credit not completed, $75 max.	c. Failing to comply with continuing education requirements. *See OBCE Continuing Education Audit Policy and Procedures*
$250.00	d. Failing to attend the Introduction to the Board meeting when required by the Board.
$125.00 per week not to exceed $500.00 total	e. Failing to notify the Board within 10 days when licensee is convicted of a misdemeanor or felony, or who is arrested for a felony crime.
$250.00	f. Failing to release patient records upon written request within 30 days.
$500.00	g. Failing to provide notice when leaving, selling, or retiring from the chiropractic office where the chiropractic physician has provided chiropractic services no later than 30 days prior to the last date the chiropractic physician saw patients.

Oregon Board of Chiropractic Examiners	Effective Date: _____, 2019 Date approved/ratified: _____, 2019
Hemp and Marijuana Derived Products	

POLICY

The purpose of this policy is to provide licensees with guidance regarding the use and recommendation of hemp and marijuana derived products.

Authority:

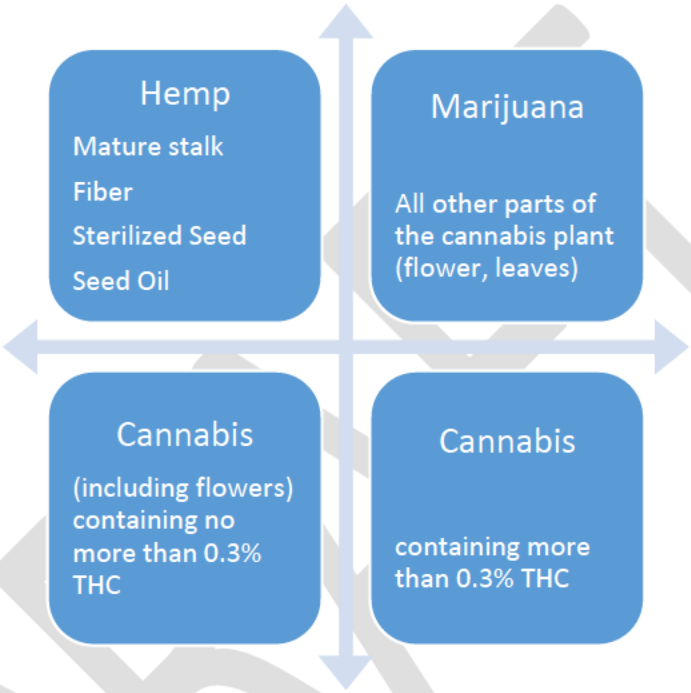
1) ORS 475 and OAR 333 detail the requirements for medical marijuana
2) ORS 571 details the requirements for the sale and use of CBD products
3) ORS 614 details the regulations around recreational marijuana.
4) ORS 676.150 details health professionals' duty to report
5) ORS 684 details the scope of practice for chiropractic physicians
6) OAR 811-015-0010, Clinical Justification
7) OAR 811-015-0070 Scope of Practice Regarding Examinations, Test, Substances, Devices, and Procedures
8) Oregon Retail Sale of Cannabidiol (CBD) Products FAQ: https://www.oregon.gov/pharmacy/Imports/Cannabidiol_CBD_Informational_6.2019.pdf
9) FDA Regulation of Cannabis and Cannabis-Derived Products, Including Cannabidiol (CBD) https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd (last visited October 31, 2019)
10) FDA and Marijuana: Questions and Answers https://www.fda.gov/newsevents/publichealthfocus/ucm421168.htm#dietary_supplements (last visited December 26, 2018)
11) Statement from FDA Commissioner Scott Gottlieb, M.D., on signing the Agriculture Improvement Act of and the agency's regulation of products containing cannabis and cannabis-derived compounds, https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm628988.htm (last visited December 26, 2018)

Definitions:

"Industrial hemp" has the meaning as defined by ORS 571.300 (2017). By definition, such products contain an average tetrahydrocannabinol (THC) concentration that does not exceed 0.3 percent on a dry weight basis.

"Marijuana" and "cannabinoid products" have the meaning defined in ORS 475B.015 (2017).

"Cannabinoid," "cannabinoid product," "cannabinoid concentrate," "cannabinoid extract," "cannabinoid tincture," and other similar terms regarding has the definition specified by OAR 845-025-1015 (2019) and ORS 475B.791.



Regulatory Oversight

	Medical Marijuana	Recreational Marijuana	Industrial Hemp
Product	Marijuana	Marijuana products and CBD products derived from marijuana or industrial hemp.	CBD products derived from industrial hemp containing <.3% THC.
Location of Sales	Designated growers or medical marijuana dispensaries.	Licensed OLCC recreational marijuana dispensaries.	Any retail location.
Restriction on Sales	Must have a medical marijuana card. Individuals with a qualifying medical condition and a recommendation for medical marijuana from	Must be >21 years of age or older. Source of CBD must be labeled – hemp or marijuana.	None. Unless the product is used for the sale of inhalant delivery systems and their

	an attending physician may apply for a medical marijuana card.		components, then must be 21 years of age or older.
Regulatory Body	OHA	OLCC	ODA

PROCEDURES

1. **Medical Use of Cannabidiol (CBD)**
   As of the date of the enactment of this policy, the U.S. Food and Drug Administration (FDA) continues to ban the use of CBD in food products and restrict its use as a dietary supplement. Based "on the evidence, FDA has concluded that THC and CBD products are excluded from the dietary supplement definition under sections 201(ff)(3)(B)(i) and (ii) of the FD&C Act, respectively. Under those provisions, if a substance (such as THC or CBD) is an active ingredient in a drug product that has been approved...or has been authorized for investigation as a new drug for which substantial clinical investigations have been instituted and for which the existence of such investigations has been made public, then products containing that substance are outside the definition of a dietary supplement. FDA is not aware of any evidence that would call into question its current conclusions that THC and CBD products are excluded from the dietary supplement definition under sections 201(ff)(3)(B)(i) and (ii) of the FD&C Act."

   The FDA has also issued warning letters to companies selling CBD products claiming that they prevent/treat diseases like cancer, diabetes, psychiatric disorders, etc. Examples: "soothing tincture for chronic pain," "CBD can successfully reduce anxiety symptoms," "For many, CBD holds the answers to treating depression."

2. **Clinical Justification.**
   The Board's existing rules require that the chiropractic physician utilize clinical rationale and justification that, "within accepted standards and understood by a group of peers, must be shown for all opinions, diagnostic and therapeutic procedures. Accepted standards mean skills and treatment which are recognized as being reasonable, prudent and acceptable under similar conditions and circumstances."

3. **Scope of Practice.**
   In considering the inclusion of new substances in the practice of chiropractic, the Board may take into account all relevant factors and practices, including, but not limited to: the practices generally and currently followed and accepted by persons licensed to practice chiropractic in the state, the teachings at chiropractic schools accredited by the Council on Chiropractic Education or its successor at any time since 1974, relevant technical reports published in recognized journals, and the desirability of reasonable experimentation in the furtherance of the chiropractic arts.

A chiropractic physician may utilize substances that are supported in peer reviewed literature, which has clinical rationale, valid outcome assessments measures, is consistent with generally recognized contraindications to chiropractic procedures, and where the potential benefit outweighs the potential risk to the patient.

4. **Current Conclusions**

As chiropractic physicians do not have prescription rights within Oregon statute, there is no statutory authority to allow chiropractic physicians to recommend or prescribe marijuana, CBD, hemp, or products derived from these substances.

According to the FDA, under the FD&C Act, it is illegal to market and sell CBD as a dietary supplement.
https://www.oregon.gov/pharmacy/Imports/Cannabidiol_CBD_Informational_6.2019.pdf

Additionally, chiropractic physicians cannot sell recreational marijuana unless properly licensed through the OLCC to do so.
(https://www.oregon.gov/olcc/marijuana/Pages/FAQs-Licensing-General.aspx.)

Chiropractic Quality Assurance Commission

Frequently Asked Questions Regarding Cannabis Health & Beauty Aids (CHABA)

Question 1

What is a cannabis health and beauty aid (CHABA)?

As defined in RCW 69.50.575 a CHABA is a product containing parts of the cannabis plant which:

1. Is intended for use only as a topical application to provide therapeutic benefit or to enhance appearance;
2. Contains a THC concentration of not more than 0.3 percent;
3. Does not cross the blood-brain barrier; and
4. Is not intended for ingestion by humans or animals.

Question 2 (adapted from Department of Health's Massage Practitioner FAQ)

May chiropractors use cannabis health and beauty aids in their practice?

The Chiropractic Quality Assurance Commission (CQAC) has determined that items defined in statute as CHABA are legal for chiropractors to use in their practice. While CQAC has made this determination, chiropractors should ensure that other relevant state and federal agencies permit the use of CHABA.

Question 3 (adapted from Department of Health's Massage Practitioner FAQs)

May chiropractors use cannabis-infused oils or lotions in their practice?

CQAC has determined that topical products, such as oils and lotions that meet the definition of a CHABA in RCW 69.50.575 (*see* Question 1) are legal for chiropractors to use in their practice. While CQAC has made this determination, chiropractors should ensure that other relevant state and federal agencies permit the use of CHABA.

CQAC has also determined it is not within the scope of practice of chiropractors to use any products, including topical lotions and oils that contain more than 0.3% THC on their clients even if the product is the subject of a medical marijuana authorization or the patient requests and provides the product for the chiropractor to use.

Question 4

May chiropractors use cannabidiol (CBD) products in their practice?

CQAC has determined that chiropractors may use items defined as CHABA in their practice. A CBD product may or may not meet the statutory definition of a CHABA. It is the responsibility of the licensed chiropractor to ensure any CBD product they use meets in definition of a CHABA product as defined in RCW 69.50.575 (*See* Question 1). While CQAC has made this determination, chiropractors should ensure that other relevant state and federal agencies permit the use of CHABA.

Question 5

May a chiropractor sell cannabis health and beauty aids (CHABA) as part of their practice?

CQAC has determined that chiropractors may sell items defined in statute as CHABA. While CQAC has made this determination, chiropractors should ensure that other relevant state and federal agencies permit the sale of CHABA.

RETHWILL CHIROPRACTIC CLINIC

1445 SE Pine Street
Roseburg, OR 97470
P (541) 672-8984
F (541) 672-4426

October 4, 2019

OCT - 9 2019

O.B.C.E.
Attention: Dr. Frank Prideaux
530 Center Street NE
Salem, OR 97301

RE: Is it within the scope of practice for DCs to perform radiographic mensuration analysis without a DACBR certificate?

Dr. Prideaux:

As per your request and recommendation I am providing to you and the Board documents regarding computer-assisted x-ray analysis. Over 25 years ago I began utilizing manual x-ray analysis to determine the location and severity of spinal ligament common in auto collisions. This is a separate and distinct test, NOT a standard radiographic "read". It is a specific analysis that cannot be performed in a doctor's/radiologist's office without specialized computerized equipment. Our office bills for the service (CPT code 76499) and has never had any problems getting reimbursed. A little over a year ago I began leasing DXD x-ray software due the fact that it is more accurate and less time consuming than measuring manually. *"There is a 26% error rate subjectively when analyzing these improprieties by hand mensuration"*. (Siegler and Howe,inter & Intra examiner reliability of the upper cervical marking system; JMPT 1985 8 (2):75-80). This past year I continued to bill for the service, CPT code, 76499, without any issues until recently.

I received an Explanation of Benefits from USAA Insurance Company in Daphne, Alabama and the service was recently denied. One of USAA's chiropractic medical records reviewer who I believe arbitrarily "decided" that the service should only be performed by a medical or chiropractic radiologist. I have had to deal with this D.C's arbitrary decisions a couple of other times before for frivolous denial of services which I later received payment for.

Anyhow, I am requesting to get an official opinion from the Oregon Board regarding chiropractors utilizing computer-assisted x-ray analysis without a DACBR certification. The CPT billing code 76499 is not the issue. The issue regards an I.M.E. making an arbitrary decision to deny payment based on him feeling it should be performed by a radiologist. I disagree and I believe that it is within the scope of all DC's. The AMA and International

Chiropractors Association (ICA) also believe it to be within a chiropractor's scope of practice, as documented below.

Measuring manually, although time consuming, is very simple to do and does not necessitate any further medical knowledge than what any DC already possesses from his/her chiropractic education. Not only is utilizing computer-assisted software more accurate and less time consuming, it is also much simpler to do. The vertebral bodies are the focus of the test/analysis. The doctor simply plots four points at the corners of the vertebral bodies of the cervical spine and the computer does the rest.

The doctor, Todd Cielo, D.C., who I lease the software from, provides about an hour+ training online by connecting his computer to mine. An extensive, long-drawn out training is simply unnecessary. Prior anatomical/medical knowledge that chiropractors already possess reduces the need for extensive training. Once the training is concluded online, Dr. Cielo requires that doctors email him 7-10 reports for him to review and to confirm that doctors are plotting the points accurately. Computer-assisted x-ray analysis is that simple and easy to do. Once Dr. Cielo feels that the doctor has a good grasp on his technique, he releases them to be on their own with no further reviews. Should any issues arise we simply contact him.

Please find enclosed documents regarding computer-assisted x-ray analysis, aka CRMA or DRMA Computerized Radiographic Mensuration Analysis or Digital Radiographic Mensuration Analysis. I believe that limiting only radiologists to perform CRMA/DRMA by USAA's chiropractor is over-reaching, and to circumvent future issues for myself and eventually other DCs, I thought it best to ask for an official opinion. I have enclosed other documentation to assist the Board in coming to an official opinion.

Please find enclosed a copy of the PCCRP which is the Official X-ray Guideline of the International Chiropractors Association (ICA) which states, "Recent advances in computer and radiographic technology has made it possible to both ascertain and analyze spinal x-rays with computer-assisted methodology. It is becoming increasingly common for spinal healthcare providers, such as chiropractors, to use computer assisted methods to analyze spinal displacements. These computer methods are at least as reliable and valid as traditional 'by hand" radiographic analytical techniques. The current PCCRP guideline panel considers computer assisted radiographic analysis to be a reliable and valid procedure for spine analysis". My assumption may be wrong, but I see no intention (as per the ICA's quoted opinion above) to limit computer-assisted software to only radiologists.

Also of further significance, on page 23 of the AMA Guidelines to the Evaluation of Permanent Impairment, 6th Ed., Section 2.3a Who Can Perform Impairment Ratings, it states "Impairment evaluation requires medical knowledge; therefore doctors who are qualified in allopathic or osteopathic medicine or chiropractic medicine use the Guides to evaluate permanent impairment".

The following are URLs of three companies either selling or leasing their x-ray measuring software that I hope you find helpful:

1. www.dxdxray.com

2. www.drmatech.com

3. www.postureanalysis.com/x-ray-analysis-for-chiropractic/

Please accept this letter as a formal request to get an official opinion from the Oregon Board regarding chiropractors utilizing computer-assisted x-ray analysis without a DACBR certification. I appreciate your help in this matter.

Kind regards,

Kurt V. Rethwill, DC
KVR;mcc

Practicing Chiropractors' Committee on Radiology Protocols (PCCRP) For Biomechanical Assessment Of Spinal Subluxation In Chiropractic Clinical Practice

Accepted for Inclusion in the
National Guideline Clearinghouse July 2009

Official X-ray Guideline of the International Chiropractors Association (ICA)

Editors
Deed E. Harrison, DC (Chair)
Donald D. Harrison, PhD, DC, MSE
Christopher Kent, DC, JD
Joseph Betz BS, DC

7. For spinal instability, post spinal surgical cases, and recent spinal fracture cases, post radiographs may need to be taken at an increased frequency.[28]

Early and Late X-rays of a Patient Following Sustained Trauma

Post-traumatic progressive cervical ligamentous instability and spinal deformity may occur in spite of initial apparently normal spine radiographs. Patients at risk for the development of this problem are generally under the age of 25 and have >1.5mm of horizontal displacement and >5° of angular displacement on initial cervical x-rays.[28]

E. Position on Computerized analysis of radiographs.

Recent advances in computer and radiographic technology has made it possible to both ascertain and analyze spinal x-rays with computer assisted methodology. It is becoming increasingly common for spinal health care providers, such as chiropractors, to use computer assisted methods to analyze spinal displacements. These computer methods are at least as reliable and valid as traditional 'by hand' radiographic analytical techniques. The current PCCRP guideline panel considers computer assisted radiographic analysis to be a reliable and valid procedure for spine analysis.[21-25,29-47]

F. Position on Videoflouroscopy or Digital Motion X-ray Analysis

Videoflouroscopy can demonstrate different motion patterns between normal and pathologic spines.[48] Cineradiography adds another diagnostic method of evaluating suspected soft –tissue injuries of the cervical spine by demonstrating motion during active exercise. It is reasonable to anticipate that abnormal motion will accelerate degenerative changes in the spine and will complicate the cineradiographic analysis. The cineradiographic study will have its greatest value in patients who show normal spines on standard roentgenograms and before degenerative changes have occurred.[49] The incidence of apophysial joint abnormalities detected by cineradiography is higher than by plain roentgenograms. The cineradiographic study is of benefit in demonstrating either excessive or decreased mobility. It has proved of value in localizing the areas of abnormalities which correlate well with symptoms.[50]

Summary

The PCCRP Guidelines developed and put forth above are evidence based recommendations for radiographic analysis of the spine for chiropractors in clinical practice. These PCCRP guidelines are consistent with previous historical works in the chiropractic literature. The remainder of this document provides the scientific rationale, evidence, reliability, validity, and clinical utility of the current PCCRP Guideline for Spine Radiography for the Assessment of Spinal Subluxation in Children and Adults.

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SPECIAL SECTION

PRACTICE software

A More Accurate Way to Diagnose Ligament Laxity

By Todd Cielo, DC

As chiropractors, we consult with patients daily in our offices, maneuvering through questions and answers to formulate a plan of treatment and diagnosis. A major challenge we face as clinicians, of course, is knowing the concrete difference between subjective and objective findings.

Objective vs. Subjective Findings: Our Challenge

Subjective findings are focused on complaints like muscle spasm, headaches, numbness, antalgic lean, radicular pain, restricted range of motion, etc. Subjective findings are the patient's complaints in their words, or their perception of pain, sensory changes, motor changes, or range-of-motion alterations. We label these subjective findings with medical terminology that fit the patient's description of complaints. The precision and accuracy come into account when we locate the cause of these symptoms so insurance companies understand the reasons for medical necessity.

These types of symptoms need to be correlated with imaging diagnostics that explain a particular symptom, pattern or area of complaint *objectively*. Without some sort of concrete evidence that explains a patient's spinal condition, we merely have symptoms with no forensic evidence to prove medical necessity of treatment.

We need objective documentation that provides insurance companies valid reason for continued care and payment for rendered services. We also need to provide attorneys the arsenal for defending the patient's spinal injury, future medical necessity and permanent impairment to the jury.

In short, we as a profession need to sharpen our documentation and quantify our patient's injury objectively. One way we can do this by utilizing *learned treatises*. This term is defined as common literature that we as physicians commonly agree on for evaluating, diagnosing and quantifying a patient's injury in court. In utilizing such literature as the *AMA Guides* and Yochum & Rowe's *Essentials of Radiology*, we have a platform we can use to objectively measure an injury from a scientific standpoint without our opinion.

The AMA guides have DRE differentiators for this type of spinal evaluation. The differentiators are subjective and objective categories. The five common subjective qualifiers are muscle guarding, atrophy / weakness, loss of reflexes, asymmetrical range of motion, and loss of bowel function. The three objective qualifiers are electrodiagnostic evidence, bladder studies (cauda equine syndrome) and loss of motion segment integrity.

All of our patients have some form or fashion of these subjective complaints. I prefer to focus on the objective differentiators that patients can't malinger or alter in any way. So, when I go to testify in court to prove a patient's injury, I correlate subjective symptoms with objective findings that are concrete.

Motion Segment Integrity

One of the objective differentiators chiropractors fail to diagnose properly is alteration of motion segment integrity (AOMSI). The *AMA Guides* recognize linear stress views of radiographs as the best form of diagnosing George's Line. Yochum and Rowe (page 149) state that if there is a break in George's Line on a radiograph, this could be a radiographic sign of instability due to ligament laxity.

Yochum and Rowe describe specific subluxations as anterolisthesis and retrolisthesis. When these mechanical alterations of the spine occur, the posterior longitudinal ligament and anterior longitudinal ligament is stressed, disrupted and/or insufficient. These are the movements that need to be measured for verification of ligament instability.

When there is hypermobility in any given segment, we do not want to adjust that segment and increase that mobility more. Our objective is to increase function and mobility in vertebral segments that are hypomobile and locked up, causing nerve interference. Chiropractors needs these measurements that analyze these segments in the "stress" views to determine whether the vertebrae are hyper-or hypomobile and quantify in the normal (0-1 mm), abnormal (1.0-3.5 mm) or ratable (above 3.5 mm) range. These parameters are important to determine which segments to adjust, as well as document ligament laxity for the patient, insurance company and legal counsel.

For the cervical region, the *AMA Guides* state that if translation (total anterior and posterior movement) is greater than 3.5 mm (height of two quarters stacked), then the patient qualifies for category IV 25-28 percent permanent impairment (5th edition, page 392 or 6th edition, page 564). Dominant motion at the cervical and lumbar spine, where most pathology occurs, is flexion and extension (pages 378-79).

We learned this type of evaluation in chiropractic school through the lines of mensuration analysis, hand-utilizing rulers, protractors and pencils. However, this type of evaluation has a 26 percent error rate when calculated (Siegler and Howe, *JMPT*, 1985).

Computerized Mensuration Analysis

Fortunately, this type of evaluation also can be performed using computed radiographic mensuration analysis (CRMA). Allowing the computer to do the measuring increases our accuracy and reliability. By analyzing three simple X-ray stress views (plain film, DICOM, or DMX) in our offices, we can diagnose ligament laxity, (728.4), which is a huge value driver in the injury arena.

Computed radiographic mensuration analysis allows us to accurately and reliably diagnose ligament laxity (728.4). Ligament laxity objectively quantifies a patient's spinal injury regardless of symptoms, disc lesions, range of motion, reflexes, age or gender.

Ligament laxity objectively quantifies a patient's spinal injury regardless of symptoms, disc lesions, range of motion, reflexes, age or gender. This simple evaluation is often overlooked, even though it constitutes medical necessity from an injury standpoint. By simply plotting the four ends of the vertebral body's cortices, George's Line can be measured objectively, documented accurately, and the patient then can be placed in a DRE category for verification of permanent impairment. Quantification of ligament laxity (code 728.4) is a crucial element of demonstrating instabilities in a specific spinal region.

For example, consider a patient with a break in George's Line at C4-5 visually on the flexion view of my Davis series. One of my diagnoses is ligament laxity (728.4) on the patient's initial visit due to the break with the anterolisthesis. No measurement is required because ligament laxity has no parameters to follow.

Now, when you want to issue a patient an impairment rating, we utilize the *AMA Guides* for clarification and quantification of the translation in millimeters. The patient's total translation is at 3.71 mm at level C4-5; thus the patient qualifies for DRE category IV at 25 percent impairment rating.

I perform second opinions for attorneys and other doctors in my current practice. The patient has a flexion / extension series or MRI the majority of the time. When I review the findings and the radiologist documents anterolisthesis in the flexion or neutral views, that gives me medical necessity to take stress views. So, I perform my motion X-ray or DICOM views in flexion, extension, neutral and possibly APOM, if symptomatology calls for it, in mm. If I can correlate the MRI instability findings to the stress views that are measured digitally, then I can show instability of the posterior longitudinal ligament and anterior longitudinal ligament (PLL / ALL) and that there will be regression of the adjacent disc.

In so doing, not only are we documenting one of the most overlooked diagnoses for subluxation, but we also are doing the patient justice by quantifying a significant instability. This clarification and quantification will help the patient legally, objectively and most importantly, clinically. ■

Dr. Todd Cielo, *a graduate of Life University, has practiced in Tampa, Fla., for 14 years, specializing in ligament laxity analysis, digital motion X-ray and objective impairment rating. For more information, visit* **www.cielochiropractic.com**.

IN THE CIRCUIT COURT, SEVENTH JUDICIAL CIRCUIT, IN AND FOR FLAGLER COUNTY, FLORIDA

CASE NO: 2013-CA-65

DANIELLE HURD,
Plaintiff,

v.

MICHAEL PERROTTA and
LUIGI PERROTTA,
Defendants,
_____/

ORDER DENYING DEFENDANTS' MOTION TO EXCLUDE TESTIMONY AND REPORTS OF THE PLAINTIFF'S EXPERT, TODD CIELO, DC

THIS CAUSE, having come before the Court on July 28, 2016, upon Defendants' Motion to Exclude Testimony and Report of Plaintiff's Expert, Todd Cielo, D.C., and the Court having heard argument of counsel, and the Court being otherwise fully advised in the premises, the Court makes the following findings:

1. The Court finds that the Plaintiff has met her burden of proof to establish the admissibility of Dr. Cielo's testimony by a preponderance of the evidence.

2. The Court finds that Dr. Cielo's testimony and DXD reports are both reliable and relevant to the facts of this case and are admissible pursuant to F.S. 90.702 which was enacted by the Florida Legislature effective July 1, 2013 establishing the standards set forth in Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579 (1193).

3. Dr. Cielo offered testimony regarding the nature and extent of the Plaintiff's permanent impairment pursuant to the AMA Guidelines for evaluation of impairment. The AMA Guidelines is an authoritative text which is routinely used by medical physicians and chiropractors when rendering opinions regarding the nature and extent of a patient's permanent injury. Dr. Cielo

provided testimony using a software program which provided measurements in millimeters of the Plaintiff's cervical spine sliding over one another which is known as anterolisthesis and/or retrolisthesis.

4. Dr. Cielo's DXD software is sufficiently reliable as it uses the same algorithm employed in other computerized software programs that utilize a Picture Archive Communication System or PACS.

5. That Dr. Cielo is highly qualified to render opinions in this case. I note that Dr. Cielo has testified extensively in the past utilizing his software program both in deposition and trial and that his testimony has never been stricken or excluded.

6. Dr. Cielo's testimony is based on his review and analysis of objective evidence including flexion extension x-rays and a digital motion x-ray. In this regard, Dr. Cielo did not offer "pure opinion" testimony. I also find that Dr. Cielo in rendering his opinions employed principles and methodology generally accepted as reliable within his field of expertise.

7. Dr. Cielo testified that the error rate in using his software is essentially zero.

8. Dr. Mark Murphy, the Plaintiff's treating neurosurgeon, also reviewed the flexion extension x-rays based on his computerized software program which employed the same algorithm as Dr. Cielo's software program. Dr. Murphy's findings were very similar to those of Dr. Cielo which attests to the accuracy and reliability of Dr. Cielo's software. → this is the same software we use in our office.

9. This Court has carefully reviewed two deposition transcripts of Dr. Cielo taken in this case on July 14, 2016 and a voir dire transcript in the case of Grace v. Robertson, Case No. 12-CA-001711 dated June 18, 2013. In Dr. Cielo's deposition and voir dire testimony, he provided detailed testimony regarding his opinions and the software program at issue in this case. I find that Dr. Cielo's testimony regarding the nature and extent of Plaintiff's permanent injury and the use of the

Please Note:
Dr. Todd Cielo, D.C. is not a chiropractic radiologist, yet Florida's 7th Judicial Circuit recognizes him as a D.C. and validates his testimony

software program are sufficiently reliable and relevant to the facts in this case. As with all other admissible evidence, expert testimony is subject to being tested by "[v]igorous cross-examination, presentation of contrary evidence and careful instruction on the burden of proof." Daubert, 509 U.S. at 596.

It is hereby CONSIDERED, ORDERED AND ADJUDGED:

1. Defendants' Motion to Exclude Testimony and Reports of Plaintiff Expert, Todd Cielo, DC, is DENIED.

DONE AND ORDERED in Chambers at Kim J. Hammond Justice Center, 1769 E. Moody Boulevard, Bunnell, Flagler County, Florida 32110, this _____ day of August, 2016.

CLERK OF CIRCUIT COURT & COMPTROLLER SUUM CUIQUE FLAGLER COUNTY

08/05/2016

HONORABLE SCOTT DUPONT

cc: Keith C. Warnock, Esquire
John Wilkerson, Esquire
Brandy Rood, Esquire

from: AMA Guidelines to the Evaluation of Permanent Impairment 6TH EDITION 6th Ed.

the part that remains after the first and other impairments have been applied. Multiple impairments are combined using a mathematical formula, listed in the Combined Values Chart.

According to this method, multiple impairments are successively combined by first combining the largest number with the next largest remaining number, and then further combining it with the next largest remaining number, and then further repeating the process until all given impairment numbers are combined. The resulting final impairment value is always equal to or less than the collective sum of all the impairment values taken individually.

2.2d Combining Impairments in and Between Organ Systems

To determine whole person impairment where multiple organ systems are involved, the physician should begin with an estimate of the individual's most significant (primary) impairment and evaluate other impairments in relation to it. It may be necessary for the physician to refer to the criteria and estimates in several chapters if the impairing condition involves several organ systems. Related but separate conditions are rated separately and impairment ratings are combined unless criteria for the second impairment are included in the primary impairment.

The examining physician should avoid duplication and/or inflation of the rating by careful consideration of the underlying pathophysiology in relation to the primary organ system. Nonspecific dysfunction or dysfunction due to the need to adhere to a complex treatment regimen will be captured by the rating for "Burden of Treatment Compliance" (BOTC; see Section 1.8i in Chapter 1 and Appendix B).

2.3 Use of the *Guides*

As referenced in Chapter 1, the *Guides* provides concepts, definitions, and rules to evaluate patients with injuries or illnesses and to translate this evaluation into an impairment number to assist legal and other systems to calculate compensation.

The *Guides* is of value only if the medical diagnosis is correct; an incorrect diagnosis leads to an incorrect impairment rating. The most important element of the *Guides* remains the physician's accurate diagnosis. The increasing complexity of the *Guides* does not replace the synthesis of clinical judgment with medical knowledge. In fact, the converse is true. The increasing complexity of the *Guides* and its impairment ratings requires an accurate diagnosis. Rating permanent impairment by analogy is permissible only if the *Guides* provides no other method for rating objectively identifiable impairment.

2.3a Who Performs Impairment Ratings?

Impairment evaluation requires medical knowledge; therefore, mostly doctors who are qualified in allopathic or osteopathic medicine or chiropractic medicine use the *Guides* to evaluate permanent impairment. For the purpose of determining impairment, the appropriate health regulatory agency in a given jurisdiction is the best-suited authority to determine the definition of doctor in regard to who uses the *Guides* to rate impairment in that jurisdiction.

It must be emphasized, however, that even though the *Guides* is mainly written by and for medical doctors, nonphysician evaluators may analyze an impairment evaluation to determine if it was performed in accordance with the *Guides*.

The accurate use of the *Guides* requires a fundamental understanding of anatomy, physiology, pathology, and other appropriate clinical sciences along with a good understanding of the issues related to impairment and disability assessment. Additionally, the knowledge of key concepts and philosophy underlying the *Guides*, as outlined in Chapter 1 and here, along with the thorough understanding of the appropriate chapters of the *Guides* are essential for a credible impairment rating.

2.3b Examiner's Roles and Responsibilities

The physician's role in performing an impairment evaluation is to provide an independent, unbiased assessment of the individual's medical condition, including its effect on function, and of limitations to the performance of Activities of Daily Living, or ADLs (as listed in Table 1-1). Although treating physicians may perform impairment ratings on their patients, it is recognized that these are not independent and therefore may be subject to greater scrutiny. Performing an impairment evaluation requires considerable medical expertise and judgment.

Thorough, complete and accurate reporting by the rating physician affords the best opportunity to communicate details of the impairment and its impact, if any, on the patient, in a forum acceptable to other medical professionals and interested parties, such as claims professionals, attorneys, and adjudicators. Reporting should follow the format and guidelines set forth by the *Guides*; this will help ensure that information provided is consistent, reliable, and sufficient to enable a fair and competent determination of benefits to which the patient may be entitled.

Cascade Spine & Injury Center

Jonathan W. McClaren, D.C.
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Anna Mele, LMT
Holly Ann Polinkus, LAc

Celene Cruz, CA

Jennifer Hernandez, CA
Billing Department

Monday, December 02, 2019

Oregon Board of Chiropractic Examiners
Attn: Cass McLeod-Skinner
530 Center Street NE, Suite 620
Salem, OR 97301

RE: Needle EMG Approval

Members of the Board:

I write to you today to request that I may be approved to perform needle electromyography (EMG) procedures under my license. I have recently completed a comprehensive certificate program in electrodiagnostics from the Clinical Neurodiagnostic Institute. All course credits were accredited by Palmer College of Chiropractic-Florida. The course was conducted by Professor Donald Dishman, D.C., M.Sc., D.I.B.C.N., F.I.A.C.N., D.I.B.E.

I have included the documents suggested by Dr. Frank Prideaux, and I have asked Dr. Dishman to send a copy of these documents directly to the Board as well.

I trust that the Board will find this training to be sufficient to approve me. Please contact me with any questions or concerns.

Thank you.

Yours In Health,

Jonathan McClaren, DC

Clinical Neurosciences Institute, LLC

CERTIFICATE OF COMPLETION

Comprehensive Course in Electrodiagnostic Medicine
150 hours, October 13, 2019

Dr. Jonathan W. McClaren

J. Donald Dishman, D.C., M.Sc., FIACN
Director of Education and Research

Clinical Neurosciences Institute, LLC

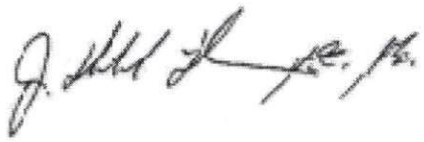
OFFICIAL TRANSCRIPT

Student: McClaren, Jonathan W., D.C.

Date of Transcript: 11/14/19

1. EDX 01 – Introduction to Principles and practices of Electrodiagnosis – 15 hours – date completed:1/20/19
2. EDX 02 – Neuropathy and Radiculopathy of the Upper Extremity – 15 hours – date completed: 2/17/19
3. EDX 03 – Motor and Sensory Nerve Conduction studies of the Upper Extremity Practicum – 15 hours – date completed: 3/10/19
4. EDX 04 – Polyneuropathy, Neuropathy and Radiculopathy of the Lower Extremity – 15 hours – date completed: 4/7/19
5. EDX 05 – Motor and Sensory Nerve Conduction studies of the Upper Extremity Practicum – 15 hours – date completed: 5/5/19
6. EDX 06 – Introduction to Needle Electromyography – 15 hours – date completed: 6/2/19
7. EDX 07 – Needle Electromyography of the Upper and Lower Extremity Practicum – 15 hours – date completed: 7/21/19
8. EDX 08 – Evoked Potentials and Introduction to Intraoperative Monitoring – 15 hours – date completed: 8/11/19
9. EDX 09 – Case reviews, Interpretive Reporting, coding/reimbursement – 15 hours – date completed: 9/15/19
10. EDX10 – Comprehensive Course Review and Certification Examinations – 15 hours - date completed: 10/13/19

This transcript reflects the true and actual completion of the continuing medical credits for the above-captioned individual. All coursework was completed at Clinical Neurosciences Institute, LLC and accredited by Palmer College of Chiropractic.



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Clinical Neurosciences Institute, LLC
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ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

Lead Instructor: J. Donald Dishman, D.C., M.Sc., D.I.B.C.N., F.I.A.C.N., D.I.B.E.

MODULE 1 – Introduction to Principles and Practices of Electrodiagnosis

Saturday: Lecture

10:00 a.m. - 11:00 p.m.

- Welcome, overview of course and texts
- What is EDX: A detailed explanation of Electrodiagnosis
- Clinical utility of Electrodiagnostic studies
- Types of Neuropathies
- Classifications of peripheral nerve injury

11:00 a.m. - 12:00 p.m.

- Clinical presentations/symptomatology warranting EDX referral
- Implementation of Electrodiagnostic testing within the neurological examination
- Components of an Electrodiagnostic Examination
- An overview of Electrodiagnostic Instrumentation

12:00 p.m. - 1:00 p.m.

- Explanation and function of modern EDX equipment, including preamplifiers, filters, stimulator, etc.
- Troubleshooting Electrodiagnostic Instrumentation
- Sequencing of an Electrodiagnostic procedure
- Purpose of Nerve Conduction Studies (NCS)

1:00 p.m. - 2:00 p.m.

- Purpose of Nerve Conduction Studies (NCS)
- Motor concepts of NCS
- Sensory concepts of NCS
- Normative data and site measurements

2:00 p.m. - 3:00 p.m.

- Clinical Utility of NCS
- Most common peripheral neuropathies and clinical presentation
- Interpretation of Nerve Conduction Data: amplitude and latency
- Median, Ulnar, and Peroneal mononeuropathies

3:00 p.m. - 4:00 p.m.

- Overview of needle EMG principles and clinical utility in diagnosis
- Proper selection of needle electrodes
- Sequence and explanation of EMG exam
- Physiology of Insertional activity, spontaneous activity, recruitment, MUAP (Motor Unit Action Potentials)
- Introduction to the Late Responses (H reflex and F waves)

4:00 p.m. - 5:00 p.m.

- Patho-anatomy of radiculopathies: Most commonly affected root levels
- Pathophysiology of radiculopathies
- Radiculopathy signs and symptoms
- Non-trauma related causes of radiculopathies (*i.e. expansile lesions, metastatic disease, etc.)*
- Localizing the level of the lesion: differentiating between radiculopathy, plexopathy and mononeuropathy

5:00 p.m. - 6:00 p.m.

- Introduction to bioinstrumentation used in Electrodiagnosis
- Electrodiagnostic specificity and sensitivity
- Overview of evoked potentials
- Types of evoked potentials: *SSEP, VEP, BAEP*
- Clinical utility and implication of evoked potentials

Sunday: Lecture

8:00 a.m. - 9:00 a.m.

- Overview of Macro anatomy of the peripheral nervous system
- Anatomical overview of the Brachial Plexus
- Roots, Trunks, Divisions, Cords, and terminal branches of the brachial plexus
- Brief overview of upper extremity innervation

9:00 a.m. - 10:00 a.m.

- Overview of micro anatomy of the peripheral nervous system
- Principles of peripheral nervous system physiology
- Propagation of action potentials through saltatory conduction
- Effects of Wallerian degeneration on saltatory conduction

10:00 a.m. - 11:00 a.m.

- Principles of peripheral nervous system pathophysiology
- Common anatomical entrapment sites
- Neurodegenerative diseases and neuropathies
- Metabolic polyneuropathies

11:00 a.m. - 12:00 p.m.

- Principles of Electrodiagnostic interpretation
- Clinical importance of bilateral testing
- Clinical correlation of increased terminal latency
- Clinical correlation of decreased amplitude

12:00 p.m. - 1:00 p.m.

- Common anatomical variances and anastomosis
- Clinical implications of under stimulation
- Notating incidental findings
- Clinical implication of absent waveforms (CMAPS, SNAPS)
- Brief explanation of NCS interpretation for guidance of EMG examination
- Differentiating between nerve involvement and root involvement

1:00 p.m. - 2:00 p.m.

- Patient tolerance of NCS and EMG examinations
- Clinical significance of surface impedance and temperature
- Case-based review of Electrodiagnosis and practical utility
- Carpal Tunnel Syndrome case presentation including:
    - Patient history and physical examination findings
    - Differential diagnoses
    - NCS and EMG interpretation, conclusion and recommendation for care

2:00 p.m. - 3:00 p.m.

- Case-based review of Electrodiagnosis and practical utility
- Diabetic Polyneuropathy case presentation including:
- Patient history, physical examination findings, and laboratory results
- Differential diagnoses
- NCS and EMG interpretation (emphasis on bilateral presentation), conclusion and care recommendation

ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

MODULE 2 – Neuropathy and Radiculopathy of the Upper Extremity

Saturday: Lecture

10:00 a.m. - 11:00 a.m.

- Comprehensive review of neuromusculoskeletal upper extremity anatomy
  - Origin and Insertion
  - Action
  - Innervation
- Review of Brachial Plexus; roots, trunks, divisions, cords, branches emphasized relative to Electrodiagnostic applications
- Median nerve: anatomical course and muscular innervation
-

11:00 a.m. - 12:00 p.m.

- Common entrapment sites of the Median nerve
- Carpal Tunnel Syndrome & Pronator Teres Syndrome
- Ulnar nerve: anatomical course and muscular innervation
- Entrapment sites and clinical relevance for mononeuropathy

12:00 p.m. - 1:00 p.m.

- Clinical presentation of ulnar mononeuropathy
- Ulnar CMAP wave morphology
- Radial nerve: anatomical course and muscular innervation
- Possible entrapment sites and common injuries causing radial nerve neuropathy

1:00 p.m. - 2:00 p.m.

- Superficial radial nerve and first dorsal interossei muscle
- Review of common anomalies: Martin Gruber anastomoses
- Introduction to motor nerve conduction studies of the median nerve
- Montage for median motor nerve conduction study: 2 sites

2:00 p.m. - 3:00 p.m.

- Introduction to sensory nerve conduction studies of the median nerve
- Montage for median sensory nerve conduction study: antidromic and orthodromic
- Overview of saltatory conduction and the effect of temperature on conduction velocity
- Secondary tests for carpal tunnel syndrome

3:00 p.m.- 4:00 p.m.

- Introduction to motor nerve conduction studies of the ulnar nerve
- Montage for ulnar motor nerve conduction studies: 3 sites
- Introduction to sensory nerve conduction studies of the ulnar nerve
- Montage for ulnar sensory nerve conduction study: antidromic and orthodromic

4:00 p.m. - 5:00 p.m.

- Introduction to motor nerve conduction studies of the radial nerve
- Montage for radial motor nerve conduction study: 2 sites
- Introduction to sensory nerve conduction studies of the radial nerve
- Montage for radial sensory nerve conduction study

5:00 p.m. - 6:00 p.m.

- Causative mechanisms for radial neuropathies
- Classification of peripheral nerve injury: latency and amplitude
- Overall review of common nerve conduction techniques

- Clinical applications in carpal tunnel syndrome
- Ulnar neuropathies
- Radial neuropathies
    - (journal manuscripts on each neuropathy to be distributed)

Sunday: Lecture

8:00 a.m. - 9:00 a.m.

- Overview of upper extremity lesions
- Brachial plexus lesions
    - Traction injuries
    - Stingers
- Clinical presentation and patient history

9:00 a.m. - 10:00 a.m.

- Infiltrative lesions of the brachial plexus
    - Metastatic brachial plexopathy
    - Apical lung tumors
- Incidental findings
- Horner's Syndrome

10:00 a.m. - 11:00 a.m.

- Erb's point: site 3/4
- Mononeuropathies
- Bilateral mononeuropathies
- Correlative nerve conduction techniques
- NCS interpretation guides EMG examination

11:00 a.m.- 12:00 p.m.

- Overview of Cervical Radiculopathy
- Review of common mechanisms of radiculopathy
- Patient presentation and symptomatology
- Pre-ganglionic vs. Post-ganglionic
- SNAPs and Pre-ganglionic lesions

12:00 p.m. - 1:00 p.m.

- Timing and EMG examinations
- Needle EMG muscle selection for cervical radiculopathy
- Emphasis on nerve root contribution and nerve innervation
- review of NCS
- Chronodispersion

1:00 p.m.-2:00 p.m.

- EMG for upper extremity neuropathies and radiculopathies
- Motor Unit Action Potentials (MUAPs) vs. Compound Muscle Action Potentials (CMAPs)
- Anatomy of muscle fibers and motor units
- Physiology of motor units

2:00 p.m. - 3:00 p.m.

- EMG for chronicity of injury
- Bi-phasic, tri-phasic and poly-phasic morphology
- Signs of denervation: positive sharp waves and fibrillation potentials
- Signs of reinnervation

ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

MODULE 3 – Motor and Sensory Nerve Conduction Studies of the Upper Extremity Practicum Laboratory

Lead Instructor: J. Donald Dishman, D.C., M.Sc., D.I.B.C.N., D.I.B.E.

Saturday: Hands on Practicum

10:00 a.m. - 11:00 a.m.

- Introduction to the electromyographic instrument and overview of functions
- Set-up and connection of pre-amplifier and stimulator
- Electrodes: Ground, reference and active
- Leads: specific for ground, reference and active electrodes

11:00 a.m. - 12:00 p.m.

- Specific operation of the Cadwell Wave instrument hardware and software
- New Study: input of patient information for report generation
- Exam selection
- Customization of test sequence for ease of operator performance

12:00 p.m. - 1:00 p.m.

- Introduction to normative data
- Filters: High-frequency/low pass filters
- Low-frequency/high pass filters
- Notch: 60Hz

1:00 p.m. - 2:00 p.m.

- Review neuromuscular anatomy relevant to the median nerve
- Median motor nerve conduction technique laboratory exercises
- Median sensory nerve conduction technique: anti-dromic
- Median sensory nerve conduction technique: orthodromic

2:00 p.m. - 3:00 p.m.

- Evaluating decreased amplitude: lesion vs. anomaly
- Martin Gruber Anastomoses: how to confirm
- Clinical importance of measurements for conduction velocity
- Clinical importance of surface temperature and conduction velocity

3:00 p.m.-4:00 p.m.

- Review neuromuscular anatomy relevant to the ulnar nerve
- Ulnar motor nerve conduction technique laboratory exercises
- Ulnar sensory nerve conduction technique: antidromic
- Ulnar sensory nerve conduction technique: orthodromic

4:00 p.m. - 5:00 p.m.

- Dorsal Ulnar Cutaneous sensory nerve conduction technique
- Review neuromuscular anatomy relevant to the radial nerve

- Radial motor nerve conduction technique laboratory exercises
- Radial sensory nerve conduction technique: antidromic

5:00 p.m. -6:00 p.m.

- Radial Nerve Palsy/ *Saturday Night Palsy*
- Traumatic causes of radial neuropathy
- Wrist drop and differential dx
- Normal wave morphology of radial nerve NCS

Sunday: Hands on Practicum

8:00 a.m. - 9:00 a.m.

- Median nerve: motor and sensory nerve conduction techniques, laboratory exercises
- Ulnar nerve: motor and sensory nerve conduction techniques, laboratory exercises
- Radial nerve: motor and sensory nerve conduction techniques, laboratory exercises
- Specialized secondary nerve conduction techniques for carpal tunnel syndrome confirmation

9:00 a.m. - 10:00 a.m.

- Median nerve H-reflex technique, laboratory exercises
- Electrophysiological equivalent to DTR
- Clinical significance of H-reflexes: afferent & efferent
- Median nerve F-waves

10:00 a.m. - 11:00 a.m.

- Carpal tunnel syndrome protocols, laboratory exercises
- Ulnar neuropathy at the Cubital tunnel
- Ulnar neuropathy at the Tunnel of Guyon
- Clinical Interpretation of increased latency/decreased amplitude and site significance

11:00 a.m. - 12:00 p.m.

- Clinical utility of anti-dromic vs. Ortho-dromic sensory nerve conduction studies
- Medial antibrachial cutaneous nerve innervation
- Electrode montage and stimulation site for Medial antibrachial cutaneous sensory nerve conduction study
- Lateral anti-brachial cutaneous nerve innervation

12:00 p.m. - 1:00 p.m.

- Electrode placement and site stimulation for lateral anti-brachial cutaneous sensory nerve conduction study
- Dorsal ulnar cutaneous sensory nerve conduction study: clinical application for localizing level of lesion
- DUC electrode montage and set-up
- Reiteration of importance of gain and sweep speed for motor vs. Sensory nerve conduction studies

1:00 p.m. - 2:00 p.m.

- Artifacts and common technical difficulties:
    - Stimulus artifacts
- Nerve length measurement
- Waveform measurements
    - Onset-to-peak vs. Peak-to-trough

2:00 p.m. - 3:00 p.m.

- Repetitive nerve stimulation and neuromuscular transmission
- RNS and clinical utility for myasthenic conditions
- Review of NCS of the upper extremity:
    - Motor
    - Sensory
    - F-waves
    - H-reflex

MODULE 4 – Polyneuropathy, Neuropathy and Radiculopathy of the Lower Extremity

Instructor: Prof. J. Donald Dishman, D.C., M.Sc., FIACN

Saturday: Lecture

10:00 a.m. - 11:00 a.m.

- Comprehensive review of lower extremity neuromusculoskeletal anatomy emphasized relative to electrodiagnostic applications
- Lumbosacral plexus
- Tibial Nerve
- Peroneal Nerve

11:00 a.m. - 12:00 p.m.

- Saphenous nerve
- Sural nerve
- Superficial Peroneal nerves
- Review of lumbar nerve roots and innervation

12:00 p.m. - 1:00 p.m.

- Review of peritoneum and its contents relative to nerve locations
- Review of gluteal muscles and their innervation
- Review of external rotators of the hip:
    - Piriformis
    - Superior/Inferior gemellus
    - Obturator internus/externus
    - Quadratus Femoris

1:00 p.m. - 2:00 p.m.

- Sciatic nerve anatomy relative to the piriformis and deep external rotators
- Common Fibular nerve at the fibular head/neck
- Superficial and Deep fibular nerve anatomy
- Superficial and Deep fibular nerve anatomy and innervations

2:00 p.m. - 3:00 p.m.

- Superficial and Deep fibular nerve anatomy and actions
- Sural nerve anatomy and clinical implications for electrodiagnosis
    - Most distal sensory nerve
    - Diabetic polyneuropathy

3:00 p.m. - 4:00 p.m.

- Anatomy and motor nerve conduction studies of the Tibial and Peroneal nerves
- Sciatic nerve anatomy and its influence on the motor nerve conduction study of the tibial and Peroneal nerves
- Electrode montage for the Tibial motor nerve conduction study
- Electrode montage for the Peroneal motor nerve conduction study
- Deep fibular nerve anatomy relative to performance of the deep fibular nerve motor conduction study

4:00 p.m. - 5:00 p.m.

- Review the reflex arc
- Review the anatomy of the tibial nerve relative to the H reflex
- Review of the H reflex electrode placement
- Anatomy of the sensory nerves relative to Electrodiagnostic applications
- Sensory nerve conduction studies of the Sural nerve

5:00 p.m. - 6:00 p.m.

- Sensory nerve conduction studies of the Superficial Peroneal (fibular) nerve
- Sensory nerve conduction studies of the saphenous nerve
- Review of superficial fibular nerve anatomy and its relevance to the sensory nerve conduction study
- The Sural nerve and the relevance of anatomy and physiology for polyneuropathy
- Review placement of electrodes for the performance of the sensory nerve conduction study of the Sural nerve
- Sural nerve anomalies vs. Absent response

Sunday: Lecture

8:00 a.m. - 9:00 a.m.

- Lumbar radiculopathy and Electrodiagnostic protocols
- Review of innervations of lower limb from nerve root perspective
- Review the mechanisms of HNP
- Overview and survey of current theories of HNP pathophysiology

9:00 a.m. - 10:00 a.m.

- Differences in cervical versus lumber spine HNP and radiculopathy
- Review needle EMG selection for lumbar radiculopathy
- Review cause/etiology of radiculopathy other than HNP
- Schwannoma and Neurofibroma and their clinical presentations

10:00 a.m.-11:00 a.m.

- Evaluation of the H reflex as a tool for radiculopathy diagnosis
- Review nerve conduction studies of the lower limb and their influence on radiculopathy diagnosis
- Clinical utility of F-wave of the lower extremity
- Review of common neuropathies of the lower extremity and introduction to polyneuropathy

11:00 a.m. - 12:00 p.m.

- Intro to polyneuropathy
- Various types of polyneuropathy
    - Acquired
    - genetic
    - Idiopathic
- Locations and timing of polyneuropathies: length-dependent vs. non length-dependent
- Diabetes as an etiology of polyneuropathy

12:00 p.m. - 1:00 p.m.

- Pathophysiology of Diabetes and it's effect on the peripheral nervous system
- Autonomic findings associated with diabetic polyneuropathy
- Clinical signs and symptoms associated with DM induced polyneuropathy
- Genetic polyneuropathies – HMSN types I and II

1:00 p.m. - 2:00 p.m.

- Anatomy of the Femoral and Obturator nerve and motor conduction studies
- Femoral nerve anatomy and unique architecture in inguinal region
- Review of all upper lumbar pure sensory nerves and their receptive fields
    - Subcostal nerve
    - Iliohypogastric
    - Ilioinguinal
    - Lateral femoral cutaneous nerve

2:00 p.m. - 3:00 p.m.

- Etiology and pathophysiology of femoral nerve lesions
- Obturator nerve anatomy and muscular innervations
- Tibial nerve H-reflex pathway, theory and technique
- Comprehensive review of the physiology of the stretch reflex

ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

MODULE 5 – Motor and Sensory Nerve Conduction Studies of the Lower Extremity Practicum Laboratory

Saturday: Hands on Practicum

10:00 a.m. - 11:00 a.m.

- Review of Tibial nerve pathways
- Review of Tibial nerve motor nerve conduction technique
- Tibial nerve motor nerve conduction montage
- Tibial nerve NCS laboratory exercises

11:00 a.m. - 12:00 p.m.

- Crural fascia, pulse width & stimulation
- Medial and lateral plantar nerves: sensory branches of Tibial nerve
- Medial and lateral plantar nerves and innervation
- Electrode montage for medial and lateral plantar nerves

12:00 p.m. - 1:00 p.m.

- Review of Peroneal nerve pathway
- Review of Peroneal nerve motor nerve conduction technique
- Peroneal nerve motor nerve conduction montage
- Peroneal nerve NCS laboratory exercises

1:00 p.m. - 2:00 p.m.

- Tibial nerve H-reflex
- Electrode montage of Tibial nerve H-reflex
- Clinical conditions affecting the latency and amplitude of the H reflex
- Utilization of the H reflex as a tool for lumbar radiculopathy diagnosis

2:00 p.m. - 3:00 p.m.

- The H reflex as a tool specifically for the evaluation of the patency of the S1 nerve root
- H reflex and its uses other than radiculopathy
- The effect of Diabetic polyneuropathy on the H reflex
- Review of F-waves of Tibial and Peroneal nerves

3:00 p.m. - 4:00 p.m.

- Laboratory exercises in Tibial nerve H-reflex technique
- Laboratory exercises: F-waves of Tibial and Peroneal nerves
- Review of Sural nerve pathway
- Review of Sural nerve sensory nerve conduction montage

4:00 p.m. - 5:00 p.m.

- Sural nerve NCS laboratory exercises
- Review of Superficial Peroneal nerve pathway
- Review of Superficial Peroneal nerve sensory nerve conduction montage
- Superficial Peroneal NCS laboratory exercises

5:00 p.m. - 6:00 p.m.

- Review of Saphenous nerve pathway
- Review of Saphenous nerve sensory nerve conduction montage
- Saphenous nerve NCS laboratory exercises
- Notch filter for sensory NCS
-

Sunday: Hands on Practicum

8:00 a.m. - 9:00 a.m.

- Review of Peripheral nerve anatomy
    - Emphasis on innervation and nerve root contribution
- Interpretation of lower extremity NCS
- Length-dependent conduction velocity
- Common peroneal (fibular) nerve at fibular head and neck: most common mono-neuropathy of the lower extremity
- Tarsal tunnel syndrome

9:00 a.m. - 10:00 a.m.

- Review of lower extremity nerve conduction techniques
    - Tibial Motor
    - Peroneal Motor
    - Tibial H-Reflex
    - Femoral Motor
- Review of lower extremity nerve conduction techniques, continued..
    - Sural Nerve
    - Superficial Peroneal Nerve
    - Saphenous Nerve

10:00 a.m. - 11:00 a.m.

- Review of ancillary sensory nerve conduction studies:
    - Review of Lateral Femoral Cutaneous nerve anatomy and innervation
    - Electrode montage for Lateral Femoral Cutaneous sensory nerve conduction study
    - Clinical presentation and etiology of LFC neuropathy
    - Review of Medial Plantar nerve, anatomy and innervation

11:00 a.m. - 12:00 p.m.

- Review of ancillary sensory nerve conduction studies:
    - Electrode montage for medial plantar sensory nerve conduction study
    - Review of Lateral Plantar nerve, anatomy and innervation
    - Electrode montage for medial plantar sensory nerve conduction study
    - Tarsal tunnel syndrome and its effect on NCS

12:00 p.m. - 1:00 p.m.

- Open lab session: nerve conduction techniques
- Students will continue to practice developing their psychomotor skills for Nerve Conduction Studies focusing on the following:
    - Proper placement of electrodes: Active/Record, Reference, and Ground
    - Proper stimulation site, accurate measurements from record –stim
    - Proper orientation of diode (cathode/anode)

1:00 p.m. - 2:00 p.m.

- Development of psychomotor skills, continued:
    - Input of site-to-site measurement for accurate nerve conduction velocity
    - Properly marking onset – peak for accurate measurement of both velocity and amplitude for CMAPs
    - Properly marking peak – trough for accurate measurement of both velocity and amplitude for SNAPs

2:00 p.m. - 3:00 p.m.

- Case presentations: thorough examples of the clinical presentation, history, and examination findings warranting an Electrodiagnostic referral
    - Students will analyze and interpret NCS data and form differential diagnoses
    - Recommendations will be made as to selecting the appropriate samples for EMG, with an emphasis on clinical utility and EMG theory
    - Report conclusion will be revealed, and the floor will be open for discussion.

ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

MODULE 6 – Introduction to Needle Electromyography (EMG)

Saturday: Lecture

10:00 a.m. - 11:00 a.m.

- Basic overview of Electromyography
  - Motor unit action potentials (MUAPs)
- Peripheral anatomy for Needle EMG: Upper extremity
  - Muscle Origin & Insertion
  - Innervation
  - Nerve root contribution

11:00 a.m. - 12:00 p.m.

- Peripheral anatomy for Needle EMG: Lower extremity
  - Muscle Origin & Insertion
  - Innervation
  - Nerve root contribution

12:00 p.m. - 1:00 p.m.

- Basic Elements of EMG examination
- Insertional Activity
- Analysis of Spontaneous Activity
  - Positive sharp waves (PSW) and fibrillation potentials
- Analysis of Motor Unite Action Potentials (MUAPs)

1:00 p.m. - 2:00 p.m.

- Recruitment Patterns of MUAPs
- Motor Unit Potentials and morphology
- Normal and Abnormal motor unit potentials
  - Audiovisual demos

2:00 p.m. - 3:00 p.m.

- Clinical Electrophysiologic Correlations: Overview and Common Patterns
- Common mononeuropathies: confirmation through EMG
  - Median Neuropathy at the wrist and proximal Median Neuropathy
  - Ulnar Neuropathy at the Elbow and at the Wrist
  - Radial Neuropathy

3:00 p.m. - 4:00 p.m.

- Common mononeuropathies, continued..
  - Peroneal Neuropathy
  - Femoral Neuropathy
  - Tarsal Tunnel Syndrome
  - Facial and Trigeminal Neuropathy

4:00 p.m. - 5:00 p.m.

- Clinical utility of EMG in assessment and diagnosis, contin.
  - Polyneuropathies: common etiologies
  - Radiculopathies
  - Brachial Plexopathy
  - Lumbosacral Plexopathy

5:00 p.m. - 6:00 p.m.

- Clinical utility of EMG in assessment and diagnosis, continued..

    - Proximal Neuropathies of the shoulder and arm
    - Sciatic Neuropathy
- Anatomical review of commonly sampled muscles
- Contraindications to needle electromyography

Sunday: Lecture

8:00 a.m. - 9:00 a.m.

- Review of Spontaneous potentials and signs of denervation
- Positive Sharp Waves vs. Fibrillation Potentials
    - Polarity
- Satellite potentials
    - Signs of reinnervation
- Normal vs. Abnormal morphology of MUAPs
    - Serrations: A sign of chronicity

9:00 a.m. - 10:00 a.m.

- Wallerian degeneration: electrophysiological evidence of denervation
- EMG and Motor Neuron Disease
- Amyotrophic Lateral Sclerosis and its variants
    - Electrophysiological findings

10:00 a.m.- 11:00 a.m.

- Atypical Motor Neuron Disease
- Overview of Myopathy
    - Muscular Dystrophy
- Myotonic Muscle Disorders

11:00 a.m. - 12:00 p.m.

- Periodic Paralysis Syndromes
- Disorders of Neuromuscular Junction
    - Myasthenia Gravis
    - Lambert Eaton

12:00 p.m. - 1:00 p.m.

- The Audible Component of EMG
- Waxing and Waning
- MUAP
- Spontaneous potentials: PSW and fibrillation potentials
- 'Dive Bomber' sound

1:00 p.m. - 2:00 p.m.

- Clinical correlation, case-based presentations employing the use of nerve conduction studies, late responses, and needle EMG
- NCS interpretation dictates muscle selection for EMG
- Mono-polar vs. Concentric needles
- Clinical considerations for needle selection

2:00 p.m. - 3:00 p.m.

- Overview and Summary review of normal and abnormal motor unit potentials and spontaneous potentials
- Commonly sampled muscles for EMG examinations
    - Emphasis on nerve innervation and nerve root contribution
- Occupational Safety and Health Administration standards
    - Universal Precautions

ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

MODULE 7 – Needle EMG of the Upper and Lower Extremity Practicum Laboratory

Saturday

10:00 am -11:00 am

- Introduction to needle EMG instrumentation settings and demonstration
- Importance of safety and obtaining informed consent
- Comparing monopolar versus concentric needle montage/set ups and demonstrarion
- Overview of how to record and save needle EMG waveforms
- Spontaneous potential analysis, gain and sweep settings

11:00 am -12:00 pm

- Demonstration of septic techniques using needle EMG
- Ground placement and noise reduction techniques
- Proper protocol and steps in performing nEMG
- Review of fibrillation potentials and positive sharp waves

12:00 pm – 1:00 pm

- Instruction and demonstration of nEMG techniques in the cervical paraspinal muscles
- Learner exercises in proper instrumentation set up and needle EMG safety
- Learner exercises in how to insert the needle and aspectic technique
- Exercises in insertional activity and spontaneous potential analysis

1:00 pm – 2:00 pm

- Demonstration of needle EMG techniques of the upper limb (deltoid, biceps and triceps)
- Divide into Dr/Patient groups per machine and practice upper limb **(Group A Dr)**
- Deltoid
- Biceps brachii
- Triceps

2:00 pm – 2:15 pm – Break

2:15 pm – 3:00 pm

- Demonstration of needle EMG techniques of the upper limb (deltoid, biceps and triceps)
- Divide into Dr/Patient groups per machine and practice upper limb **(Group B Dr)**
- Deltoid
- Biceps brachii
- Triceps

3:00 pm – 4:00 pm

- Demonstration of needle EMG techniques of the upper limb (brachioradialis, pronator teres, flexor carpi radialis)
- Divide into Dr/Patient groups per machine and practice upper limb **(Group A Dr)**
- Brachioradialis
- Pronator teres
- Flexor carpi radialis

4:00 pm – 5:00 pm

- Demonstration of needle EMG techniques of the upper limb (brachioradialis, pronator teres, flexor carpi radialis)
- Divide into Dr/Patient groups per machine and practice upper limb **(Group B Dr)**
- Brachioradialis
- Pronator teres
- Flexor carpi radialis

5:00 pm – 6:00 pm

- Demonstration of needle EMG techniques of the upper limb (extensor digitorum communis, extensor carpi ulnaris, extensor indicis proprius)
- Divide into Dr/Patient groups per machine and practice upper limb **(Group A Dr)**
- Extensor digitorum communis
- Extensor carpi ulnaris
- Extensor indicis proprius

Sunday

8:00 am – 9:00 am

- Demonstration of needle EMG techniques of the upper limb (extensor digitorum communis, extensor carpi ulnaris, extensor indicis proprius)
- Divide into Dr/Patient groups per machine and practice upper limb **(Group B Dr)**
- Extensor digitorum communis
- Extensor carpi ulnaris
- Extensor indicis proprius

9:00 am -9:15 am – Coffee Break

9:15 am-10:00 am

- Demonstration of needle EMG techniques of the hand (abductor pollicis brevis, abductor digiti minimi, first dorsal interosseous)
- Divide into Dr/Patient groups per machine and practice hand **(Group A Dr)**
- Abductor pollicis brevis
- Abductor digiti minimi
- First dorsal interosseous

10:00 am – 11:00 am

- Demonstration of needle EMG techniques of the hand (abductor pollicis brevis, abductor digiti minimi, first dorsal interosseous)
- Divide into Dr/Patient groups per machine and practice hand **(Group B Dr)**
- Abductor pollicis brevis
- Abductor digiti minimi
- First dorsal interosseous

11:00 am – 12:00pm

- Demonstration of needle EMG techniques of the lower limb (vastus med/lat, biceps femoris long/short heads, Gluteus medius/maximus
- Divide into Dr/Patient groups per machine and practice hand **(Group A Dr)**
- Vastus med/lat
- Biceps femoris (ling and short heads)
- Gluteus maximus and medius

12:00 pm – 1:00 pm

- Demonstration of needle EMG techniques of the lower limb (vastus med/lat, biceps femoris long/short heads, Gluteus medius/maximus
- Divide into Dr/Patient groups per machine and practice hand **(Group B Dr)**
- Vastus med/lat
- Biceps femoris (ling and short heads)
- Gluteus maximus and medius

1:00 pm – 2:00 pm

- Demonstration of needle EMG techniques of the lower limb (tibialis anterior, fibularis longus, med/lat gastrocnemius)
- Divide into Dr/Patient groups per machine and practice hand **(Group A Dr)**
- Tibialis anterior
- Fibularis longus
- Med/lat gastrocnemius

2:00 pm – 3:00 pm

- Demonstration of needle EMG techniques of the lower limb (tibialis anterior, fibularis longus, med/lat gastrocnemius)
- Divide into Dr/Patient groups per machine and practice hand **(Group B Dr)**
- Tibialis anterior
- Fibularis longus
- Med/lat gastrocnemius

3:00 pm class adjourned

ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

Module 8 - Evoked Potentials - Lecture

Saturday

10:00 am – 11:00 am

- Introduction to evoked potentials
- Theory and principle behind evoked potentials
- Types of evoked potentials – SEP, BAER, VEP
- Introduction the clinical utility of evoked potentials

11:00 am -12:00 pm

- Evaluation of the peripheral nervous system and the large-fiber sensory tracts in the CNS
- Localization of the anatomical site of somatosensory pathway lesions
- Identification of impaired conduction caused by axonal loss or demyelination
- Confirmation of a non-organic cause of sensory loss

12:00 pm – 12:15pm – Coffee Break

12:15 pm – 1:00 pm

- Standards for evoked potential equipment
- Gain should be adjusted in steps no greater than 2.5-1
- Common Mode Rejection should be at least 80 dB (10,000:1) at highest sensitivity of the amplifier when common mode signal is applied between both inputs and neutral
- Noise level of the amplifier must not exceed 2 uV rms with inputs connected to neutral and with a bandpass of 0.1-5,000Hz

1:00 pm – 2:00 pm

- Analog-to-digital conversion
- Nyquist Frequency
- Differential Amplification
- Amplifier Gain
- Display Gain and Sweep Speed
- Bandpass filtering – high/low cut

2:00 pm – 3:00 pm

- EP montage nomenclature – 10-20 system of electrode placement
- Obligate peaks – cortical, subcortical, spine and peripheral
- Near and far field potentials
- Anodal blocking
- Stimulus frequencies and characteristics

3:00 pm – 4:00 pm

- Anatomy and pathways for SSEP - Dorsal Column – Medial Lemniscus
- Upper limb stimulation sites – Median and Ulnar
- Lower limb stimulation sites – posterior tibial nerve
- Review of brachial and lumbar plexus
- Cerebral cortex processing and somatosensory cortex locations – Brodmann area 3,1,2

4:00 pm – 4:15 pm – Coffee Break

4:15 pm – 5:00 pm

- SSEP waveform generaton, recognition and correct cursor placement
- Dermatomal evoked potentials (DEPs)and clinical utility
- Location of stimulation points for DEPs – L4, L5, S1, C5, C6, C8
- Recording montage for upper and lower limbs for DEPs

5:00 pm – 6:00 pm

- General troubleshooting concepts for noise reduction in the performance of evoked potentials
- Excessive stimulus artifact and how to reduce by effective ground electrode placement
- 60Hz notch filter and when it is appropriate and not appropriate
- Types of artifacts and how to reduce them : motor artifact and visual artifact reduction

Sunday

8:00 am - 9:00 am

- Introduction to brainstem auditory evoked potentials
- External anatomy of the ear
- Anatomy and physiology of the middle and inner ear
- Physiology of sound production and conduction
- Central nervous system auditory pathway anatomy
- Location of peaks and their neural generators

9:00 am - 9:15 am – Coffee Break

9:15 am -10:00 am

- Introduction of visual evoked potentials (VEPs) – theory and principles
- Review of anatomy of the eye and retinal structures
- Anatomy and physiology of the visual pathway
- Technique considerations – patterns, colors
- Filtration – high/low cut

10:00 am – 11:00 am

- Optimal stimulation strategies for VEPs
- Laboratory requirements and set up for VEPs
- Impedance reduction strategies and noise reduction
- International Federation of Clinical Neurophysiology guidelines for optimal electrode placement
- Optimal waveform recognition and cursor placement

11:00 am – 12:00 pm

- Clinical applications of VEPs – strengths/weaknesses
- Use in Glaucoma and retinopathies
- Multiple sclerosis utility combined with MRI and SEPs
- Possible use with review of literature to support VEP and SEP in the mTBI patient
- Normative versus abnormal data – crossed asymmetry and hemifield stimulation

12:00 pm – 12:15 pm – Refreshment Break

12:15 am – 1:00 pm

- Overview of clinical utility of all types of Eps
- Introduction to the use of EPs for procedure monitoring -IONM
- Concepts and principles of intraoperative neuromonitoring
- Why DCs perform much of the IONM in the USA and avenues for training
- Terminology used in IONM and types of EP modalities commonly used
- The role and responsibilities of the intraoperative neurophysiologist

1:00 pm – 2:00 pm

- Details of common modalities employed during IONM
- Somatosensory Evoked Potentials (SEP) in IONM
- Trans Cranial Motor Evoked Potentials (TcMEP) in IONM
- Spontaneous Electromyography (sEMG)
- Triggered Electromyography (tEMG)
- Brainstem Auditory Evoked Potentials in IONM

2:00 pm – 3:00 pm

- Review of Somatosensory evoked potentials (SEPs) and the anatomy pathway tested
- Practical utility of SEPs combined with nerve conduction studies and conventional needle EMG
- DEPs versus SEPs and their clinical utility in the woek up of a radiculopathy patient
- Overview of all EPs and how they can potentially complement other Edx procedures in clinical use
- Summary of the field of Evoked Potentials and Question and Answer session

3:00 pm - Class Adjourned

ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

MODULE 9 – Case reviews, Interpretative reporting, and coding/reimbursement and medicolegal issues of EDX

Saturday

10:00 am – 11:00 am – Lecture

- Electrodiagnostic report writing introduction
- Vital information required in all reports
- Minimal patient information required for proper interpretation
- Tabular versus written formats
- Requirements for saved data

11:00 am -11:15 am – Coffee Break

11:15 am - 12:00 pm – Lecture

- Proper cursor marking correction in reports
- Reporting of physical examination findings and placement in report
- Edx findings versus Edx impression
- Relevance of electrophysiological data to final clinical impression

12:00 pm – 1:00 pm – Lecture

- Review of actual case – upper limb, carpal tunnel syndrome (CTS)
- CTS data and its significance in the case and final impression
- Review of actual case – upper limb, ulnar neuropathy at the elbow (UNE)
- UNE data and its significance in the case and final impression

1:00 pm – 2:00 pm – Lecture

- Review of actual case – upper limb, cervical radiculopathy secondary to HNP (Radic)
- Radic data and its significance in the case and final impression
- Review of actual case – upper limb, ulnar neuropathy at the wrist (UNW)
- UNW data and its significance in the case and final impression

2:00 pm – 3:00 pm – Lecture

- Review of actual case – lower limb, tarsal tunnel syndrome (TTS)
- TTS data and its significance in the case and final impression
- Review of actual case – lower limb, fibular nerve lesion at popliteal fossa (FNP)
- FNP data and its significance in the case and final impression

3:00 pm – 3:15 pm – Coffee Break

3:15 pm – 4:00 pm – Lecture

- Review of actual case – lower limb, lumbar stenosis (LS)
- LS data and its significance in the case and final impression

- Review of actual case – lower limb, lumbar radiculopathy secondary to HNP (Radic)
- Radic data and its significance in the case and final impression

4:00 pm – 5:00 pm – Lecture

- Review of actual case – lower limb, polyneuropathy secondary to diabetes and alcoholism (Poly)
- Poly data and its significance in the case and final impression
- Review of actual case – lower limb, polyneuropathy secondary to severe Vitamin B deficiency (Poly)
- Poly data and its significance in the case and final impression

5:00 pm – 6:00 pm – Lecture

- Review of lecture material regarding polyneuropathy
- Types and etiology of Polyneuropathy
- Length dependent acquired poly and non-length dependent
- Genetic polyneuropathy – Charcot-Marie-Tooth
- Edx manifestations of polyneuropathy and the value of the H-rflex

6:00 pm – Class adjourned

Sunday

8:00 am – 9:00 am – Lecture

- Introduction to third party payor requirements and coding
- Prior coding versus new CMS guidelines in 2013 and its impact
- Letters of medical necessity
- Minimal patient information and criteria to perform Edx testing

9:00 am – 10:00 am – Lecture

- Case examples and how one would code the Edx sample case
- ICD codes, CPT codes and Edx application
- Documentation standards in SOAP notes to justify Edx testing
- Proper procedure and protocols for charting of requisition and results

10:00 am – 10:15 am – Coffee Break

10:15 am – 11:00 am – Lecture

- Obtaining medical authorization and documentation various types of third-party payors
- HIPAA rules and how it effects the Edx practitioner
- Informed consent, written versus verbal
- Contraindications to Edx in general and also needle EMG

11:00 am – 12:00 pm – Lecture

- Lecture review of the late responses: H-reflex and F-waves
- Physiology and performance, proper acquisition of H-reflex
- Pitfalls and artifacts of the H-reflex
- Clinical applications of the tibial H-reflex: radiculopathy versus polyneuropathy

- Age related changes in the H-reflex and motor neuron excitability

12:00 pm – 1:00 pm – Lecture

- Compare and contrast the H-reflex of the tibial nerve versus the median nerve and clinical applications in lumbar and cervical radiculopathies
- Compare and contrast H-reflex versus F-waves and their clinical strengths and weaknesses
- The use of late responses in polyneuropathy – aids in differentiation of poly from radiculopathy from plexopathy
- F-waves evaluation criteria; F-min latency, F-max latency, chronodispersion – clinical applications in polyneuropathy

1:00 pm – 2:00 pm – Lecture

- Review of actual case – upper limb, the man with a polyneuropathy, CTS and a C6 radiculopathy
- His Edx data and its significance in the case and final impression
- Differential aspects of the NCS, needle EMG and late response data to derived impression
- Review of actual case – lower limb, the woman with alcoholism, diabetes and lumbar stenosis
- Discussion of case based on Edx features of all of her comorbidities

2:00 pm – 3:00 pm – Lecture

- Closing comments and discussion on general principles of Edx interpretation
- Concepts of demyelination versus axonal loss and how this affects nerve conduction waveforms and what it means to our Edx impression
- Focal mononeuropathies such as CTS and what hallmark featres are sen on nerve conduction studies – increased distal latencies, loss of amplitude, etc.
- Radiculopathy secondary to HNP Edx principles – SNAPs rarely affected but sometimes CMAP amplitude loss
- Review of needle EMG findings in radiculopathy

3:00 pm – Class adjourned

ELECTRODIAGNOSTICS CERTIFICATE PROGRAM - SYLLABUS

MODULE 10 – Course Review of Hands on Practical NCS and needle EMG techniques and Program Examinations

Saturday

10:00 am – 11:00 am – Practical Lab Exercises

- Review of instrumentation set up and basic operational parameters
- Dr./Patient pairings to practice: (Dr. Group A)
    1. Median nerve motor study w/ F-waves bilaterally
    2. Ulnar nerve motor study w/F-wave bilaterally
    3. Radial nerve motor study bilaterally
- Dr./Patient pairings to practice: (Dr. Group B)
    1. Median nerve motor study w/ F-waves bilaterally
    2. Ulnar nerve motor study w/F-wave bilaterally
    3. Radial nerve motor study bilaterally

11:00 am – 12:00 pm – Lecture

- review of upper extremity neuromusculoskeletal anatomy – brachial plexus and UE nerves
- review of common nerve conduction techniques and clinical applications in carpal tunnel syndrome, ulnar neuropathies and radial neuropathies
- review of lower extremity anatomy including the lumbosacral plexus
- review of common nerve conduction studies of the lower limbs including deep and superficial fibular, sural and saphenous
- review of Tibial nerve H-reflex set up

12:00 pm – 12:15 pm – Refreshment Break

12:15 pm – 1:00 pm – Practical Lab Exercises

- Dr./Patient pairings to practice: (Dr. Group A)
    1. Tibial nerve motor study w/ F-waves bilaterally
    2. Deep fibular motor nerve motor study w/F-wave bilaterally
    3. Tibial nerve H-reflex bilaterally
- Dr./Patient pairings to practice: (Dr. Group B)
    1. Tibial nerve motor study w/ F-waves bilaterally
    2. Deep fibular nerve motor study w/F-wave bilaterally
    3. Tibial nerve H-reflex bilaterally

1:00 pm – 2:00 pm – Lecture

- Review of clinical electrophysiology
- Review of action potential generation and cell membrane physiology as it relates to Edx
- Saltatory conduction and how demyelination effects it – manifestation on Edx studies
- Axonal loss and focal conduction block and how it manifests on nerve conduction studies
- Review of Edx instrumentation parameters – amp, pre-amp, impedance reduction techniques
- Filtration – notch filtration, high and low cut filters and when to modify

2:00 pm – 3:00 pm – Lecture

- Review of needle EMG techniques
- Review of motor unit potentials and spontaneous potentials
- Fibrillation potentials and positive sharp wave audio/video review
- Abnormal motor unit potentials – polyphasia and neuropathic motor unit recognition

3:00 pm – 4:00 pm – Lecture

- Review of the innervation and practical localization for needle EMG placement of all commonly sampled muscles of the upper extremity
- Review of the innervation and practical localization for needle EMG placement of all commonly sampled muscles of the lower extremity
- Review of localization and technique for needle EMG of the paraspinal muscles

4:00 pm – 4:15 pm – Refreshment Break

4:15 pm – 5:00 pm – **COMPREHENSIVE FINAL COURSE WRITTEN EXAMINATION – Part 1**

5:00 pm – 5:15 pm – Break

5:15 pm – 6:00 pm - **COMPREHENSIVE FINAL COURSE WRITTEN EXAMINATION – Part2**

Sunday

8:00 am -9:00 am - Lecture

- Review of technique of SEPs of the median and ulnar nerves
- Review of technique of SEPs of tibial and fibulr nerves
- Ambient noise reduction techniques in evoked potentials
- Review of BAER techniques and clinical applications
- Review of the anatomy of the somatosensory pathway and proper electrode placement

9:00 am – 9:15 am – Coffee Break

9:15 am – 10:00 am – Practical Lab Exercises

- Dr./Patient pairings to practice: (Dr. Group A)

1. Median nerve antidromic sensory conduction study
2. Ulnar nerve antidromic sensory conduction study
3. Radial nerve antidromic sensory conduction study

- Dr./Patient pairings to practice: (Dr. Group B)

1. Median nerve antidromic sensory conduction study
2. Ulnar nerve antidromic sensory conduction study
3. Radial nerve antidromic sensory conduction study

10:00 am – 11:00 am

- Dr./Patient pairings to practice: (Dr. Group A)

1. Sural nerve antidromic sensory conduction study
2. Superficial nerve antidromic sensory conduction study

- Dr./Patient pairings to practice: (Dr. Group B)

1. Sural nerve antidromic sensory conduction study
2. Superficial nerve antidromic sensory conduction study

11:00 am – 12:00 pm – FINAL COMPREHENSIVE LAB PRACTICAL EXAMINATION – **GROUP A**

11:00 am – 12:00 pm – Open Lab practical exercises – Group B

12:00 pm – 12:30 pm – Refreshment Break

12:30 pm – 1:30 pm - FINAL COMPREHENSIVE LAB PRACTICAL EXAMINATION – **GROUP B**

12:30 pm – 1:30 pm - Open Lab practical exercises – Group A

1:30 pm – 2:30 pm – Review of Final written examination (full class live)

2:30 pm – 3:00 pm – review of practical examination (full class live)

3:00 pm – Class Adjourned

Oregon Board of Chiropractic Examiners	Effective Date: October 4, 2018 Date approved/ratified: October 4, 2018
NEEDLE ELECTROMYOGRAPHY (EMG)	

ISSUE

Whether performing Needle EMG is within the scope of practice for chiropractic physicians.

POLICY

Chiropractic physicians are allowed to perform diagnostic Needle EMG on an individual basis, to be reviewed by the Board, depending on undergraduate, graduate, and post-graduate studies, training, and work.

Course: Concussion 201
Credit Hour(s): 3.0
Instructors: Evan Mladenoff, DC, DICAK
Educational Objectives:

Hour 1

- Discuss the Inflammatory Cascade
- Identify the mechanics of concussion that results in inflammation
- Describe the neuro-chemical cascade of concussion

Hour 2

- Perform physical exam protocols in inflammation as it relates to concussion
- Perform Neurological exam protocols in inflammation as it relates to concussion
- Apply Chiropractic exam protocols in inflammation
- Utilize advanced examination protocols in inflammation

Hour 3

- Perform structural treatment protocols to treat inflammation related to concussion
- Utilize phytonutrient protocols to treat inflammation related to concussion
- Use specific therapeutic protocols to resolve inflammation with literature citations

Course: Concussion 202
Credit Hour(s): 3.0
Instructors: Evan Mladenoff, DC, DICAK
Educational Objectives:

Hour 1

- Discuss the Selye Stress Response
- Discuss the mechanics of concussion that results in the inflammatory response
- Describe the cortisol cascade response associated with concussion

Hour 2

- Perform physical exam protocols in the stress response
- Perform Neurological exam protocols in the cortisol cascade
- Apply Chiropractic exam protocols in the cortisol cascade
- Utilize advanced examination protocols in evaluating the stress response

Hour 3

- Perform chiropractic treatment protocols to treat the stress response
- Utilize nutritional protocols to treat inflammation related to the stress response and concussion
- Use evidenced based therapeutic protocols to address the cortisol cascade associated with concussion with literature citations

Course: Management of Common Conditions 203
Credit Hour(s): 2.0
Instructors: Todd Turnbull, DC
Educational Objectives:

- Recognize concussion signs and symptoms.
- Differentiate concussion grades.
- Identify anatomical structures related to concussions.
- Describe pathophysiology as it relates to concussions.
- Determine appropriate exam procedures for diagnosing concussions.
- Apply diagnostic skills to on-field and clinic settings.
- Interpret diagnostic tests to evaluate concussion progress.
- Design treatment plans based on exam findings.
- Demonstrate manual manipulation techniques to address concussion symptoms.
- Compare pre- and post-treatment findings to support care plans.

Course: Management of Common Conditions 215
Credit Hour(s): 3.0
Instructors: Todd Turnbull, DC
Educational Objectives:
Hour 1

- Discuss concussion causes and pathophysiology.
- Introduce return to play guidelines.
- Explore other return to lifestyle guidelines.
- Understand modifying factors for RTP.
- Examine concussion grading procedures.

Hour 2

- Review tools for concussion evaluation.
- Understand the health concerns of pediatric athletes.
- Incorporate strategies for pediatric patients.
- Apply pediatric RTP guidelines for football.

Hour 3

- Investigate medico-legal issues of RTP.
- Explore appropriate documentation standards.
- Read state concussion law development.
- Compare professional Position Papers.
- Discuss the role of Chiropractors.

Course: Management of Common Conditions 217
Credit Hour(s): 3.0
Instructors: Todd Turnbull, DC
Educational Objectives:
Hour 1

- Describe pathophysiology as it relates to concussions.
- Discuss the diagnosis and prognosis of concussions.
- Review concussion red flags and dangers of manipulation.
- Understand the health concerns of pediatric athletes.
- Explore diagnostic tests to evaluate concussion status.

Hour 2

- Demonstrate non-thrust treatment techniques.
- Introduce the half-somersault maneuver for vertigo relief.
- Address cranial nerve lesions with manipulation techniques.
- Explore sleep strategies for concussed patients.
- Incorporate nutritional support for better brain function.
- Discuss cardio exercise to stimulate blood flow to the brain.

Hour 3

- Apply mobility exercises to improve musculoskeletal function.
- Integrate PreActive StretchingSM protocols to improve agility.
- Explain return to lifestyle guidelines.
- Understand modifying factors for RTP.
- Compare professional Position Papers.
- Discuss the role of Chiropractors and concussions.

EVAN MLADENOFF, D.C., D.I.C.A.K.

EDUCATION

1985	Acupuncture Society of America Diplomate
1984	International College of Applied Kinesiology Teaching Diplomate
1981	International College of Applied Kinesiology Diplomate
1980	International Academy of Clinical Acupuncture Fellow
1978	International College of Applied Kinesiology Graduate
1978	Canadian Memorial Chiropractic College Doctor of Chiropractic
1974	University of Toronto, Canada B.S. in Physiology and Biochemistry
1971	Malvern Collegiate Institute, Toronto, Canada Graduated

PROFESSIONAL WORK EXPERIENCE

1990 – present	NFL Players Association – Kansas City Chiefs 2nd Opinion Consulting Physician
1985 – present	Los Angeles Chiropractic College – Whittier, CA Post Graduate Faculty
2016	IAAF World Indoor Track and Field Championships – Portland, OR Meet Physician
1993 – 2005	Kansas City Chiefs – Game Day Doctor Team Applied Kinesiologist
2000 – 2007	Logan Chiropractic College Post Graduate Instructor

1994	American Football Conference Championships – Buffalo, NY Attending Physician, Kansas City Chiefs
1985 – 1989	Parker College of Chiropractic – Dallas, TX Post Graduate Faculty and Faculty Member
1978-1979	Canadian National Canoe Team – Team Doctor World Championships in Belgrade, Yugoslavia 1978 World Championships in Duisberg, West Germany 1979

PROFESIONAL AFFILIATIONS AND POSITIONS

2014 – present	International College of Applied Kinesiology Education Committee
1984 – 1989	International College of Applied Kinesiology Chairman, Athletic Advisory Board

PUBLICATIONS

2015	The 30-Day Stress Makeover (BOOK) MYA Publishing – Leawood, KS
2003	Stressed Out – Headed for Burnout (BOOK) MYA Publishing – Leawood, KS
2001 (BOOK)	Enzyme Therapy: Bringing the Body Back from Injury and Illness MYA Publishing – Leawood, KS

LECTURES GIVEN

July 2019	ICAK – If You Inflame It You Mame It The NeuroInflammation of Concussion– San Diego, CA
April 2019	New Mexico Chiropractic Assoc Convention - If You Shake It You Break It – Concussionology, Albuquerque, NM
August 2018	Florida Chiropractic Physicians Assoc. The Chiropractic Advantage To Concussions., Orlando, FL
August 2018	ICAK Chicago, IL. If You Shake It You Break, Int'l College of Applied Kinesiology
2016-2017	100 Hr Applied Kinesiology Fundamentals – Tempe, AZ

August 2016	WuXing Kinesiology Missouri CHiropracic Assoc Convention – Branson, MO
July 2016	ICAK Gladiator Kinesiology – LasVegas NV
January 2016	WuXing Chiropractic – MSCA District 2, Springfield MO
2015	ICAK The Performance Matrix – Chicago, IL
2014	WuXing Kinesiology – MSCA District 2
2014	ICAK WuXing Kinesiology – Washington, DC
2007	The Whole Stress System – Pittsburgh, PA
2007	Stressed Out Headed for Burnout – Wichita, KS and Philadelphia, PA
2007	6 Steps to Restoring Normal Joint Function – Springfield, MA and Baton Rouge, LA

REFERENCES AVAILABLE UPON REQUEST

Todd Turnbull, DC, CCSP

SUMMARY OF QUALIFICATIONS

Since graduating from Life University in 1991, I have operated a sports practice focused on helping athletes unleash their full potential. In 2001, I completed the Certified Chiropractic Sports Physician program at Palmer University.
As a post-graduate faculty member for several Chiropractic institutions, I have developed courses for ChiroCredit.com and written numerous articles on Concussions, Disc Herniations, Rehabilitation and Soft Tissue Diagnosis and Treatment.
Pre-Active Stretching℠ is the trademarked rehabilitation program I created which is utilized by Portland Fire and Rescue, LaSalle high school and other sports teams and clinics.
I developed **Myotonic Facilitation Technique** which is a neuro-muscular integration treatment approach.
The **Happy Brain Concussion Care** program I created incorporates **Trauma-Free Treatment**℠ protocols to address brain injured people.
My mission is to develop awareness of brain injury screening and create access to **Trauma-Free Treatment**℠ around the world to help health care providers deliver intelligent, effective treatment for their patients.

EDUCATION

2000 – 2001	Palmer University CCSP
1987 – 1991	Life University DC
1999 – 2003	West Virginia University BA Regents
1985 – 1987	Kennesaw State University Pre-Chiropractic Studies
1983 – 1985	University of Alaska Anchorage Biology Major

PROFESSIONAL WORK EXPERIENCE

2008 – present	Turnbull Clinic – Portland, OR Clinic Director
1993 – 2007	Turnbull Chiropractic & Sports Injury Clinic – Morgantown, WV Clinic Director
1991 – 1993	Hopwood Chiropractic Center – Hopwood, PA Associate Doctor

PROFESIONAL AFFILIATIONS AND POSITIONS

2001 to present	American Board of Chiropractic Sports Physicians
2006 to present	Post Graduate Faculty/Course Instructor - ChiroCredit.com/OnlineCE.com Wallingford, CT [2012-present] - Life University Marietta, GA [2015] - Texas Chiropractic College Pasadena, TX [2007-2012] - Southern California University of Health Sciences Whittier, CA [2006]
2012 – 2013	Portland Fire and Rescue, Exercise/Stretching Consultant – Portland, OR Injury Prevention Consultant - Stretching Program Coordinator
2015 to present	Oregon Chiropractic Association - Communication Director, Functional Chiropractic Council

PUBLICATIONS

2003	**A Postural Scene: Stance supports Good Riding** The ProRider. Winter 2003.
2004	**Loosen Up! Exercise Ankles and Calves** The ProRider. Winter 2004.
2005	**For Powerful Spins, Give These a Whirl** The ProRider. Winter 2005.
2009	**Subscapularis Injury: Diagnosis and Treatment** Dynamic Chiropractic. 2009 Jul 1; Vol. 27, Issue 14

2009	**Lumbar Disc Evaluation and Correction** Dynamic Chiropractic. 2009 Jul 29; Vol. 27, Issue 16
2010	**Soft Tissue Diagnosis: Is it a Labral Tear or a Pectineal Pinch?** Dynamic Chiropractic. 2010 Jan 15; Vol. 28, Issue 02
2013	**Protocols for Managing Lumbar Disc Injuries** Dynamic Chiropractic. 2013 Feb 1; Vol. 31, Issue 03
2013	**Becoming the Concussion Expert in Your Community: What You Need to Know** Dynamic Chiropractic. 2013 May 1; Vol. 31, Issue 09
2015	**Patellar Tendonitis: Diagnosis and Treatment** Dynamic Chiropractic – January 1, 2015, Vol. 33, Issue 01
2015	**How We Can Help the Injured Brain** Dynamic Chiropractic. April 1, 2015, Vol. 33, Issue 07
2015	**Reducing the Autogenic Inhibition Reflex: Making Weak Muscles Strong**, Dynamic Chiropractic. May 15, 2015, Vol. 33, Issue 10
2015	**Create a Cutting-Edge Practice: Build a Concussion Rehab Clinic** DC Practice Insights. 2015 August.
2015	**Tailor-made Knee Pain: The Sartorius Muscle** Dynamic Chiropractic. November 15, 2015, Vol. 33, Issue 22
2016	**Piriformis Syndrome: A Pain in the Rear** Dynamic Chiropractic. February 15, 2016, Vol. 34, Issue 18
2016	**Pre-Active Stretching** DVD [Therapeutic Rehabilitation protocols] July 2016
2017	**Successful Interprofessional Treatment of Juvenile Rheumatoid Arthritis: A Case Report**, J. Boothby, T. Turnbull, S. Coffman Integrative Medicine: A Clinician's Journal. April/May 2017, Vol 16, No. 2
2017	**Visual Error Scoring System: A Concussion Tool** Dynamic Chiropractic. May 1, 2017, Vol. 35, Issue 10
2017	**Lumbopelvic Fixation: Address the Lattisimus**

Dynamic Chiropractic. October 1, 2017, Vol. 35, Issue 10

LECTURE & PRESENTATIONS

2007 – 2016	**Myotonic Facilitation Technique: Soft Tissue Diagnosis and Treatment** (sponsored by Texas Chiropractic College)
Fall 2008	**Myotonic Nutrition** with Dr. David Seaman, DC (sponsored by Anabolic Labs and Maryland Chiropractic Association)
2011 – present	**PreActive Stretching Rehabilitation** (sponsored by American Council on Exercise)
2012 – present	**Lumbar Disc Herniation Management** (sponsored by University of Bridgeport / ChiroCredit.com)
2012 – present	**Cervical Disc Herniation Management** (sponsored by University of Bridgeport / ChiroCredit.com)
2014 – present	**Concussion Management** (sponsored by University of Bridgeport / ChiroCredit.com)
2014 – present	**Return to Play Guidelines for Chiropractors** (sponsored by University of Bridgeport / ChiroCredit.com)
2015 – present	**Shoulder Pain Management** (sponsored by University of Bridgeport / ChiroCredit.com)
Fall 2015	**Concussion Management** (sponsored by Life University)
2016 – present	**Concussion Rehabilitation** (sponsored by University of Bridgeport / ChiroCredit.com)
Fall 2016	**Visual Error Scoring System: A Concussion Tool** (Oregon Chiropractic Association)
2017 – present	**Acute Concussion Management** (sponsored by University of Bridgeport / ChiroCredit.com)

Winter 2017	**Successful Interprofessional Treatment of Juvenile Rheumatoid Arthritis**, (Oregon Chiropractic Association)
Fall 2017	**Lumbar Disc Management** (Oregon Chiropractic Association)
March 2018	**Lumbar Disc Management, Myotonic Facilitation Technique** (Anglo-European College of Chiropractic, UK)
May 2018	**Myotonic Facilitation Technique: Upper Extremities** (Florida Board of Chiropractic Medicine)
September 2018	**Acute Concussion Management** (Oregon Chiropractic Association)
February 2019	**Post-Concussion Case Study** (Oregon Chiropractic Association)
May 2019	**Acute Concussion Management** (Oregon Chiropractic Association)

UNIVERSITY of Western States
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Oregon Board of Chiropractic Examiners
530 Center St. NE, Suite 620
Salem, OR 97301

November 15, 2019

Dear Oregon Board of Chiropractic Examiners:

I am writing to request permission for the University of Western States Center for Teaching and Learning (CTL) to provide CE credit to UWS DC-licensed faculty members for attending CTL-sponsored faculty development workshops. Workshops for DC faculty are offered approximately every other month and focus on the development of teaching skills as they are used and applied in chiropractic education.

The overarching goals of the CTL workshop series are to:

- **Facilitate Collaboration:** We aim to facilitate collaboration, foster dialogue and build a sense of community at UWS
- **Advance Teaching**: We strive to support faculty in their teaching by sharing best practices and encouraging self-reflection and continuous improvement
- **Connect Faculty with Resources**: We provide instructional design and assessment consultations, offer technology training, and connect faculty to high-quality, relevant and evidence-informed resources
- **Explore New Ideas:** We encourage faculty to try out new ideas and provide a safe space to do so

We would like to request permission for the workshop series for the 2019 – 2020 academic year (Summer 2019 – Spring 2020) to qualify as CE credit. Enclosed you will find outlines for three representative workshops our department offers, along with the CV/resumes of the presenters.

Thank you in advance for your consideration. Please let us know if you'd like any additional information.

Sincerely,

Denise Dallmann, ND, MS

Denise Dallmann, ND, MS
Dean, Center for Teaching and Learning
503-251-2800
ddallmann@uws.edu

Faculty Development Representative Workshop #1

Workshop Title

Faculty Book Club Reading and Facilitated Discussions

Workshop Description

The Faculty Development Committee (FDC) and Center for Teaching and Learning are co-hosting a UWS Summer 2019 Faculty Book Club. We have selected the Essential Skills for a Medical Teacher, Second Edition by Ronald Harden and Jennifer Laidlaw for our book. Several of our faculty have read this book as part of the International Association of Medical Science Educators Essential Skills in Medical Education (ESME) course and highly recommend it.

This book club is for faculty interested in:

- Diving more deeply into teaching practices such as collaborating and working as a team, outcomes-based teaching, learning about "authentic" curriculum, teaching with large groups, e-learning and clinical assessment to name a few.
- Sharing and brainstorming teaching ideas with your fellow UWS colleagues
- Refreshing your memory from the ESME course

Meeting Schedule

Session #1: 7/16/19 from 1:40 – 2:30 OR* 7/18/19 from 11:40 – 12:30 (50 minutes)
Session #2: 8/06/19 from 12:40 – 1:30 OR* 8/08/19 from 12:40 – 1:30 (50 minutes)
Session #3: 9/05/19 from 11:40 – 12:30 (50 minutes)
Session #4: 10/15/19 from 11:40 – 12:30 OR* 10/17/19 from 12:40 – 1:30 (50 minutes)
Session #5: 11/05/19 from 12:40 – 1:30 OR* 11/07/19 from 12:40 – 1:30 (50 minutes)

*Faculty can choose from either session and similar topics are covered at both sessions

Facilitators

Mia Crupper, ND
Denise Dallmann, ND, MS
Jayme Gallegos, PhD

Sample Facilitation Questions

1. Teaching is not simply the adoption of a "cookbook of recipes" developed by others. Professional judgement and intuition needs to be combined with the understanding of the best evidence available so that the teacher can arrive at the correct decision and take the appropriate action. With regard to your teaching, consider where you are on the continuum between opinion-based teaching and evidence-based approaches, as shown in Figure 5.2, and whether you might move further to the right.
2. Is there scope within your program for the introduction of interprofessional education?
3. Think about how you keep up to date in your own discipline or field of interest. Can similar methods be adopted with regard to your responsibilities as a teacher?
4. Where on the OBE inventory does your school or postgraduate body lie? Are you well on the way to an outcome-based approach or are you still at the early stages of implementation?

Total CE Hours Proposed

5.0 hours maximum. Not all faculty attended all five meetings; CE credit would be awarded based on number of hours attended for each individual.

Faculty Development Representative Workshop #2

Workshop Title
Essentials of Hybrid Course Design

Workshop Description
This 50-minute presentation introduces the essentials of hybrid course design. We will cover course design terms and definitions; hybrid course design best practices and useful tools; and a discussion on the pros and cons of implementing a hybrid course. Join us if you are interested in learning more about course design, exploring the idea of hybridizing a course, redesigning an existing hybrid course, or looking for others with whom to collaborate.

Workshop Learning Outcomes
After completing this workshop, participants will be able to:

- Define key terms used in course design.
- Describe components of an effective hybrid course design.
- Explain hybrid course design and implementation best practices.
- Identify differences between hybrid and traditional course design.
- Determine conditions that make a course suitable for hybrid design, and not.

Workshop Schedule
October 15, 2019 from 12:40 – 1:30

Presenter
Catherine Sybrant, MEd

Total CE Hours Proposed
1.0 hour

Faculty Development Representative Workshop #3

Workshop Title

Raising the bar: Creating multiple-choice questions to assess higher-order thinking skills

Workshop Description

This workshop provides an overview of developing multiple-choice questions that focus on higher-order thinking skills. We will discuss levels of learning as defined by Bloom's taxonomy in the context of multiple-choice questions. We will also review the components of multiple-choice questions and some of the dos and don'ts when writing multiple-choice questions. Finally, you will have to the opportunity to review and critique examples of multiple-choice questions.

Workshop Learning Outcomes

After completing this workshop, participants will be able to:

- Define higher-order thinking skills using Bloom's taxonomy.
- Identify the components of a multiple-choice question.
- Discuss the dos and don'ts of creating quality multiple questions.
- Develop multiple-choice questions that assess higher-order thinking.

Workshop Schedule

November 19, 2019 from 12:30 – 1:30

Presenter

Cecelia Martin, EdD

Total CE Hours Proposed

1.0 hour

Jayme Renée Gallegos, Ph.D.

EDUCATION:

B.S. Molecular and Cellular Biology, University of Arizona, Tucson, Dec 2000
B.A. English, concentration in British Literature, University of Arizona, Tucson, May 2001
Ph.D. Biochemistry and Molecular Biology, Oregon Health & Science University, Portland, Jan 2008

TEACHING:

BSC 5217, University of Western States – Lead instructor Histology lecture and laboratory Winter and Spring 2013-current
BSC 5314, University of Western States – Lead instructor Human Development lecture, Spring and Summer 2013-current
BSC 5103, University of Western States – Gross Anatomy I laboratory instructor (back and extremities), 2013-current
BSC 5203, University of Western States – Gross Anatomy II laboratory instructor (head and neck), 2013-current
BSC 5304, University of Western States – Gross Anatomy III laboratory instructor (abdominal and pelvic viscera), 2013-current
MSN 8132, University of Western States – Nutrigenetics and Nutrigenomics, Winter 2019
MSCI 611, Oregon Health and Science University – Gross Anatomy, Imaging and Embryology instructor for Medical Class, Physician's Assistants and Radiation Technology Students, attended for credit Fall 2010, teaching Fall 2011 and 2012
CELL 611, Oregon Health and Science University – Histology: The Structure and Function of Cells in Tissues instructor, Spring 2010
CELL 605, Oregon Health and Science University – Model Systems Biology, *Xenopus* and chicken lectures, Summer 2008
CELL 616, Oregon Health and Science University – Advanced Topics in Cancer Research, Spring 2009, co-lecturer with Dr. Molly Kulesz-Martin, "Chemical and Viral Carcinogenesis Models" for segment on use of a breast cancer model system; Discussion leader for in-class journal club

UCHM 250, University of Western States – Instructor, General Chemistry II, Summer 2018
BIT 102, Portland Community College – Current Topics in Biotechnology instructor, Summer 2011, Summer 2012, Summer 2013
BIT 110, Portland Community College – Introduction to Biotechnology instructor, Fall 2011
BIT 201, Portland Community College – Immunochemical Methods instructor, Spring 2010, Spring 2012, and Spring 2013
BIT 215, Portland Community College - Protein Purification, Winter 2013
BIT 280a/b – Portland Community College, Cooperative Education Seminar and Work Experience, Summer 2013
BI 101, Portland Community College – Introduction to Biology for Non-Majors, instructor (both online and in class), every term from Fall 2011 – Fall 2013, Summer 2017
BI 112, Portland Community College – Cell Biology for Health Occupations, instructor, Spring 2010, Spring 2011, Summer 2011, Fall 2011, and Spring 2012
BI 231, Portland Community College - Anatomy and Physiology, term 1, instructor, Summer 2011 and Fall 2012

BI 232, Portland Community College - Anatomy and Physiology, term 2, instructor, Winter 2012 and Winter 2013
BI 233, Portland Community College - Anatomy and Physiology, term 3, instructor, Summer 2012

EMPLOYMENT:

December 2013 – present, Assistant Professor Basic Sciences
University of Western States
Doctor of Chiropractic Program, Department of Basic Sciences
Lead lecturer for Histology and Human Development Classes
Assistant instructor for Gross Anatomy laboratories

Jan 2019 – present, Instructor
University of Western States
Master of Science Program in Human Nutrition and Functional Medicine
Lead Instructor for Nutrigenetics and Nutrigenomics

March 2010 – present, Instructor Biology, Instructor Biotechnology
Portland Community College
Departments of Biotechnology and Biology
Biology and Biotechnology classes online and in class

February 2013 – December 2013, Co-Chair Biotechnology
Portland Community College
Department of Biotechnology
Biotechnology Classes and Administrative Duties

September 2011 – 2012, Instructor
Oregon Health and Science University
Department of Allied Health and the Medical School
Gross Anatomy, Imaging and Embryology

March 2008 – March 2010, Postdoctoral Fellow
Laboratory of Dr. Molly Kulesz-Martin
OHSU Department of Dermatology
Examination of p53 family member regulation by Piasy and Trim32

July 2002 – Jan 2008, Graduate Research Assistant
Laboratory of Dr. Hua Lu
OHSU Department of Biochemistry and Molecular Biology
Dissertation: "Regulation of the Transcription factor p63 by βTrCP."

April 2001 – July 2002, Research Technician
University of Arizona Transgenic Core Facility/Laboratories of Dr. Robert Erickson and Drs. Randall Heidenreich and William Garver
University of Arizona Department of Pediatrics
Biochemical and animal analysis of Neimann-Pick, type C protein (NPC-1) / rare disease mapping / maintenance of core mouse colony

Aug 2000 – April 2001, Research Technician/Lab Manager
Joan B. and Donald R. Lung Injury Laboratory, Dr. Mark Witten
University of Arizona Pediatrics Department, Tucson, AZ
Murine lung damage due to JP-8 jet fuel, cigarette, and airborne microparticulate exposure and relationship to cancer development

Aug 2000 – June 2002, Tutor in Science and English
Campus Tutoring, LLC, Tucson, AZ
Part-time tutoring of undergraduates in Biology, Chemistry, English

Oct 1997 – Aug 2000, Student Researcher
Laboratory of Dr. Jesse Martinez
University of Arizona Cancer Center / Undergraduate Biology Research Program
Honor's Thesis: "p53 conformation and its relationship to translocation and activation."

ADMINISTRATION / INSTITUTIONAL SERVICE:

Member of the UWS Equity Team
Member of the UWS Core Values Committee
Member of the UWS Faculty Development Committee
Faculty Sponsor and member of the UWS Student and Staff Gardening Club
Member of Department Hiring Committees for Anatomists
Chair of the UWS Faculty Senate Assessment Committee
Co-Founder and Co-Chair of the UWS Faculty Journal Club
Secretary of the Faculty Senate
Vice President of Faculty Senate
Member of the UWS Admissions Committee
Member of the UWS Technology Advisory Committee

Co-Chair of the PCC Biotechnology Department
SAC Chair of the PCC Biotechnology Department
SAC Distance Learning Liaison of the PCC Biotechnology Department

COURSE DEVELOPMENT:

BSC 5217, University of Western States – Winter 2013 - present
BSC 5314 face to face and hybrid, University of Western States – Spring 2013 - present
MSN 8132 online, University of Western States – Winter 2019 – present
UCHM 250 online, University of Western States – Summer 2018
BIT 201, Portland Community College – Spring 2010 (with Cortny Williams)
BI 101 hybrid, Portland Community College – Fall 2010 - Fall 2013
BIT 102 online, Portland Community College – Winter 2012

RESEARCH MENTORSHIP:

Nathan Donley – OHSU graduate student rotation, Spring 2008, p73 binding to Piasy,
Gavin Young – Lake Oswego High School student, Summer 2008, basic technique, p53 subcloning
Summer 2009, Piasy binding to p65 (NF-κB)
Aaron Wortham – OHSU graduate student rotation (co-mentor with Y Liu), Summer 2008, and also
Current assistance in formal graduate laboratory training
Piasy binding to p65
Alison McCleod – OHSU graduate student rotation (co-mentor with Y Liu), Fall 2008, Piasy binding to p65
Brendon Hart – Lewis and Clark undergraduate, Murdoh Scholar, Summer-Winter 2009-2010, mapping the Pias family-Trim32 interaction sites

PUBLICATIONS:

Gamification to Enhance Student Engagement and Motivation in Histology. JR Gallegos, S Taliaferro, and L Takaki. In preparation.
NF-κB repression by Pias-mediated sumoylation. Y Liu, A Wortham, JR Gallegos, R Bridges, J Lagowski, M Kulesz-Martin. In preparation.
Multistage Carcinogenesis: Cell and Animal Models. In *Comprehensive Toxicology, 2nd edition, Vol. 12 Developmental Toxicology*. Kulesz-Martin M, Gallegos JR, and Liu Y. Charlene McQueen, Thomas B. Knudsen, Eds. Pergamon Press. 2010.
$SCF^{\beta TrCP1}$ activates and ubiquitylates TAp63γ. Gallegos JR, Litersky J, Lee H, Nakayama K, Nakayama K, Sun Y**,** Lu H. *Journal of Biological Chemistry*, 2008 Jan 4;283(1):66-75; 2007, e-pub ahead of print.
The p53 tumor suppressor opens gateways for cancer therapy. In *Gene Therapy:*

Therapeutic Mechanisms and Strategies, Third edition. Dai MS, Gallegos JR, Lu H. Nancy Smyth Templeton, Ed. Marcel Dekker, Inc. 2008.

Balance of Yin and Yang: ubiquitylation-mediated regulation of p53 and c-Myc. *Neoplasia.* Dai MS, Gallegos JR, Lu H. 2006 Aug;8(8):630-44.

SAG/ROC-SCF beta-TrCP E3 ubiquitin ligase promotes pro-caspase-3 degradation as a mechanism of apoptosis protection. Tan M, Gallegos JR, Gu Q, Huang Y, Li J, Jin Y, Lu H, Sun Y. *Neoplasia.* 2006 Dec;8(12):1042-54.

Niemann-Pick C1 protein regulates cholesterol transport to the trans-Golgi network and plasma membrane caveolae. Garver WS, Krishnan K, Gallegos JR, Michikawa M, Francis GA, Heidenreich RA. *Journal of Lipid Res.* 2002 Apr;43(4):579-89.

Conformational phenotype of p53 is linked to nuclear translocation. Gaitonde SV, Riley JR, Qiao D, Martinez JD. *Oncogene* 19, Aug 2000, 4042 – 4049.

Conformational phenotype of p53 is linked to nuclear translocation, JR Gallegos, MCB Honors' thesis, Dec 2000

ABSTRACTS:

"p73 regulation by Trim32 and Piasy E3 ligases in cancer." Gallegos JR, Kulesz-Martin M. American Association for Cancer Research National Conference. Denver, Colorado, 2009.

"SCF$^{\beta TrCP1}$ ubiquitylates and activates TAp63γ." Gallegos JR, Litersky J, Lee H, Nakayama K, Nakayama K, Sun Y, Lu H. American Association for Cancer Research National Conference. San Diego, California, 2008.

"SCF$^{\beta TrCP1}$ ubiquitylates and activates TAp63γ." Gallegos JR, Litersky J, Lee H, Nakayama K, Nakayama K, Sun Y, Lu H. Society for Chinese Bioscientists of America, Annual Northwest Regional Symposium. Portland, Oregon, 2007.

"SCF$^{\beta TrCP1}$ ubiquitylates and activates TAp63γ." Gallegos JR, Litersky J, Lee H, Nakayama K, Nakayama K, Sun Y, Lu H. 23rd Annual Student Research Forum, Portland, Oregon, 2006.

"SCF$^{\beta TrCP1}$ ubiquitylates and activates TAp63γ." Gallegos JR, Litersky J, Lee H, Nakayama K, Nakayama K, Sun Y, Lu H. 13th Annual International p53 Workshop, New York City, New York, 2006.

"βTrCP1 is a ubiquitin ligase for p63." Gallegos JR, Litersky J, Lee H, Nakayama K, Nakayama K, Sun Y, Lu H. Program in Cell and Molecular Biology Annual Retreat, Portland, Oregon, 2005.

"βTrCP1 is a ubiquitin ligase for p63." Gallegos JR, Litersky J, Lee H, Nakayama K, Nakayama K, Sun Y, Lu H. Society for Chinese Bioscientists of America, Annual Northwest Regional Symposium, Portland, Oregon, 2005. (Talk)

"βTrCP1 is a ubiquitin ligase for p63." Gallegos JR, Litersky J, Lee H, Nakayama K, Nakayama K, Sun Y, Lu H. 22nd Annual Student Research Forum, Portland, Oregon, 2005.

"A potential role for the SSRP1 protein in tumorigenesis." Gallegos JR, Lee H, Lu H. Program in Cell and Molecular Biology Annual Retreat, Portland, Oregon, 2004.

"A potential role for the SSRP1 protein in tumorigenesis." Gallegos JR, Lee H, Lu H. Annual Student Research Forum, Portland, Oregon, 2004.

FUNDING:

University of Arizona Undergraduate Biology Research Program funding
June 1997 – August 2000

University of Arizona Honors College Undergraduate Research Grant
April 1999 - May 2000

OHSU Department of Dermatology Predoctoral Training Grant, NIH (T32-CA106195)

September 2004 – Jan 2005
OHSU Immunology and Ophthalmology Predoctoral Training Grant, NIH
May 2005 – Jan 2008
OHSU Cancer Biology Postdoctoral Training Grant, NIH (T32-CA101690-05)
March 2008 – February 2009
OHSU Pulmonary Critical Care Postdoctoral Training Grant, NIH (T32-HL083808)
April 2009-present

CERTIFICATES:

Essential Skills in Medical Education (ESME) Certification, Spring 2017

AWARDS:

PCC Award for Assessment, Biotechnology 2013
Bio-Link Annual Workshop Fellowship, 2013
Society for Chinese Bioscientists of America, Annual Northwest Regional Conference
2nd place poster, 2007
Honorary member of the American Association for the Advancement of Science
2004
Society for Chinese Bioscientists of America, Annual Northwest Regional Conference
2nd place talk, 2005
Membership in Phi Beta Kappa Honors Society, May 2000

PROFESSIONAL SOCIETIES:

International Association for Medical Science Educators (IAMSE) 2017 - present
Phi Beta Kappa, 2000 – present
American Association for the Advancement of Science, 2004 – 2013
American Association for Cancer Researchers (AACR)/Women in Cancer Research (WICR),
2008 – 2013
Bio-Link Initiative for Bioscience Instructors, 2013

VOLUNTEER/COMMUNITY SERVICE:

UWS Gross Anatomy Lab Tours for PCC Pre-medical Careers Club, Rock Creek Campus (Fall and Spring 2014, 2015 and 2016) as well as Parkrose High School, Madison High School, Portland Adventist Academy, and Sabin Academy
Art Literature Series Teaching at Tualatin Elementary, 2017, 2018, 2019
PCC Chemistry Student Conference 2012 and 2013, Judge Student Posters
Oregon Museum of Science and Industry (OMSI) – Spring 2010 to Summer 2012, aid to the Grants Department doing grant research, editing and development
OHSU Student Research Forum 2009, Judge Cancer I Talks
OHSU Student Research Forum 2008, Judge Epithelial Biology Talks
Kim's Tae Kwon Do, OHSU team, brown belt and assistant instructor

Denise Dallmann, ND, MS

PROFESSIONAL SUMMARY

Higher education administrator with advanced degrees in both medicine and education. Passionate about helping students, faculty and institutions achieve their highest potential. Experience ranges the full continuum from teaching in the classroom to execution of institutional strategic plans. Hard-working, collaborative and gets things done.

AREAS OF EXPERTISE

Strategic Planning & Execution	Staff & Faculty Leadership
• Winning cooperation at all organizational levels • Developing & launching new academic programs • Budgeting & financial planning • Managing projects on time & on budget	• Leading effective & high-performing teams • Managing change • Leading & developing faculty • Initiating student services programs
Teaching Adult Learners	**Assessment & Evaluation**
• Applying teaching & learning theory to the development of curriculum for adult learners • Using technology and LMS systems • Supporting students in achieving their educational goals	• Assessing effectiveness of programs and services • Initiating & executing continuous improvement initiatives • Leading accreditation & compliance projects

EDUCATION

Doctorate, *Naturopathic Medicine,* National University of Natural Medicine
Master of Science, *Educational Leadership and Policy* with concentration in *Postsecondary, Adult and Continuing Education,* Portland State University
Graduate Certificate, *Student Affairs in Higher Education*, Portland State University
Bachelor of Arts, *Biology*, University of California, Santa Cruz

PROFESSIONAL EXPERIENCE

Dean, Center for Teaching and Learning **5/2018 - Present**

University of Western States

- Provide university leadership in the areas of teaching and learning
- Coordinate faculty development initiatives such as new faculty orientation, teaching workshops and book clubs for 150+ full-time and adjunct on-ground and remote health sciences faculty
- Provide consulting to the deans, and faculty in the areas of curriculum design and revision, program planning and assessment, and online program development
- Supervise a team of three instructional designers and a director of academic assessment
- Oversee the successful implementation, integration and functionality of the institution's educational software systems such as Moodle, Panopto, Zoom, eMedley, and more.

Academic Dean / Chief Academic Officer **6/2016 – 3/2018**

American College of Healthcare Sciences
All programs are online and the institution has approximately 1000 students worldwide and 35 faculty nation-wide

- Assist president and executive team with developing and administering the institution's strategic plan
- Supervise, hire, train and mentor 40+ staff and faculty, including the associate dean, program directors, faculty, an instructional designer, and the librarian
- Oversee the effective delivery of curriculum at the associate's, bachelors and master's degree level
- Developed comprehensive system for practice improvement across the institution including program reviews and assessment; survey development, execution and review; and ongoing curriculum updates
- In collaboration with the president, manage the institutional reaccreditation process, including writing a 500-page self-evaluation report, creating 81 exhibits, and preparing for the on-site evaluation

Associate Dean, School of Undergraduate Studies and Distance Education **9/2013 – 6/2016**
Director of Curriculum and Faculty Development

National University of Natural Medicine, Portland, OR

- Enabled the college to become a university by developing and launching two undergraduate degree programs.
- Created and launched the NUNM Center for Teaching and Learning, a professional development hub for 200+ full-time and adjunct health sciences faculty
- Provided consulting to the provost, deans, and faculty in the areas of curriculum design and revision, program planning and assessment, and online program development
- Co-led complete revision of the four-year Doctor of Naturopathic Medicine curriculum
- Coordinated and taught faculty development activities including workshops, symposia, book clubs and online courses
- Recruited, hired, trained and mentored new faculty

Internship Coordinator (Graduate Assistant) **9/2012 – 9/2013**

Portland State University, Honors College, Portland, OR

- Supported Honors College students in successfully finding and completing their internships
- Developed and taught an online course for internship students – the first of its kind at PSU

Dean, Academic Affairs **5/2006 – 8/2012**
Interim Executive Director
Program Director

Carrington College, Portland, OR

- Served as interim executive director/campus president on multiple occasions. Maintained stable campus operations despite frequent changes in leadership
- Received the DeVry "PRIDE" award for integrity, dedication and excellence – an award reserved for the top 3% in an organization of 90,000 employees
- Achieved an 86% institutional graduation rate – the highest among a network of ten campuses nation-wide
- Won "Best-practice Award" for creating and maintaining a successful Institutional Advisory Board
- Co-created a faculty handbook and faculty onboarding materials used at all ten Carrington campuses
- Supervised & mentored 65 direct reports including full-time and adjunct faculty, program directors, student services, registrars and library staff;
- Managed academic affairs of seven allied health programs with a peak of 800+ students
- Supervised complete curriculum revision for five allied health programs

PROFESSIONAL ASSOCIATIONS:

- International Association of Medical Science Educators
- Online Learning Consortium
- Quality Matters
- Teaching Professor / Magna Publications
- The Chronicle of Higher Education – Subscription only

Catherine Sybrant

Education

Master of Arts in Education, Adult Education and Training, University of Phoenix Online, AZ
Bachelor of Arts in Liberal Arts, Hawaii Pacific University, Honolulu, HI

Professional Experience

Instructional Designer, University of Western States, Portland, OR 02/18-Present

- Rapidly designed new online clinical counseling program aligned with CACREP standards.
- Designed and facilitated a new online faculty orientation and faculty development workshop.
- Assist faculty with designing new online and hybrid chiropractic program courses.
- Provide consultation, training, and administration for campus educational software, including Blackboard Open (Moodle), Zoom, Panopto, Class Climate, and eMedley.
- Streamlined administration of student course evaluations and wrote an SOP.

Instructional Design Specialist, Southcentral Foundation, Anchorage, AK 09/16-01/18

- Partnered with clinical professionals to develop online presentations via Mediasite.
- Provided consultation and coaching for clinicians creating conferences presentations.
- Designed and developed Adobe Captivate eLearning courses for hospital emergency codes.
- Collaborated with subject matter experts to design Chemical Dependency Counselor (CDC) training modules, including learning outcomes aligned with Alaska certification competencies.

Instructional Designer and HR Generalist, ClearCall Solutions, Chandler, AZ 02/15-06/16

- Hired as instructional designer to create leadership development and technician training programs and transitioned to human resources generalist after first company reorganization.
- Researched and presented benefits (401k, medical, STD, etc.) to managers and employees.
- Coordinated benefits open enrollment, including technical support for online application.
- Managed multiple improvement projects, including revising multiple SOPs.
- Designed and administered employee online communications portal on Zywave.

Lead Curriculum Developer, Grand Canyon University, Phoenix, AZ 07/11-02/15

- Led team of curriculum developers to complete assigned online and hybrid courses.
- Partnered with deans, professors, librarians, editors, and media designers to design and develop entire degree program and individual courses and formatted in LoudCloud LMS.
- Partnered with web developers to design interactive pages and online tutorials.
- Identified course improvement opportunities and investigated and resolved user issues.

Student Employment Administrator

- Collaborated with over 100 department hiring managers, human resources, payroll, financial aid, academics, and information technology to employ over 1500 students annually.
- Hired and coached a small team of off-site community-based student workers.
- Earned a Professional in Human Resources (PHR) certification (expired 2016).
- Designed and delivered training to guide students and staff through student employment.
- Received Customer Service Award for exceeding internal and external service expectations.

Director of Career Services, Everest College Online, Tempe, AZ 01/07-04/11

- Selected, hired, trained, and coached team to provide individualized career guidance.
- Designed and delivered career services training for large student services advisor team.
- Designed online new student orientation course in eCollege LMS.
- Led social media initiatives on Facebook and LinkedIn to connect with online students.
- Received Corinthian Parthenon Award for exceeding performance expectations.

Academic Counselor, University of Phoenix Online, Tempe, AZ 08/04-09/06

- Welcomed new students and provided orientation to the online learning platform.
- Identified barriers to success and coached students to create and execute on action plans.
- Tracked all student interactions on UOP proprietary student information system.
- Created and led individual and group academic counselor trainings.
- Received Top Performer Award for exceeding student services expectations.

Training Manager, Pointe Hilton Resorts, Phoenix, AZ 01/97-09/98

- As the first resort training manager, designed and developed Pointe Leadership University.
- Facilitated Frontline Leadership, increasing skill levels and inter-departmental cooperation.
- Partnered with department leaders to develop and improve customer service training.
- Designed, facilitated, coordinated, and tracked classes for all levels of resort employees.
- Assisted human resources team with on-site job fairs and led weekly new hire orientation.

Orientation Coordinator, Alaska Job Corps Center, Palmer, AK 01/94-09/96

- Designed and continually updated new student orientation program for 16-24 year-olds.
- Experimented with different approaches, including adventure education games, guided imagery, hands-on exercises, facilitated group work, private journaling, etc.
- Built strong supportive relationships with center leaders, partnering in student success.
- Advised and coached students through exploration of center vocations and career paths.
- Assisted in the organization and coordination of Alaska native cultural celebrations.
- Recruited, trained, and supervised new student peer mentors, supporting students from across Alaska.

Volunteer Experience

Career Coach, Fresh Start Women's Resource Center, Phoenix, AZ 09/06-06/11

- Facilitated workshops and creatively coached clients one-on-one in interviewing, resume writing, presentation, and job search skills.

Facilitator/Instructional Designer

- Created, developed, and facilitated series of self-development classes.
- Promoted the Fresh Start classes in a Channel 3 "Your Life from A to Z" interview.

Cecelia Gayle Martin
Director of Assessment
Office of Institutional Effectiveness
University of South Alabama, 307 University Boulevard Drive,
Mobile, Alabama 36688
Email:

EDUCATION

University of South Alabama, Ed.D., Educational Leadership, December 2017, Mobile, Alabama
University of South Alabama, M.A., Sociology, August 1987, Mobile, Alabama
University of South Alabama, B.S., Medical Technology, August 1981, Mobile, Alabama

EMPLOYMENT

Current Position

2008	Director of Assessment, University of South Alabama, Mobile, Alabama

Teaching Experience

1992-Present	Instructor at the University of South Alabama
1995-2000	Instructor at Spring Hill College
1993-2000	Instructor at the University of Mobile
1987-1991	Instructor at the University of Maryland

Research Experience

2005-2008	Institutional Research Analyst II, University of South Alabama, Mobile, Alabama
2004-2005	Project Manager, Institute for Social Science Research, University of Alabama, Tuscaloosa, Alabama
2001-2005	Lead Evaluator, Institute for Social Science Research, University of Alabama, Tuscaloosa, Alabama
2000-2005	Research Associate with the Institute for Social Science Research, University of Alabama, Tuscaloosa, Alabama
1999-2005	Research Assistant, Dr. J. Steven Picou, University of South Alabama, Mobile, Alabama
1997-1999	Research Assistant, Dr. J. Stephen Thomas, University of South Alabama, Mobile, Alabama

1995-1999	Research Assistant, Dr. G. David Johnson, University of South Alabama, Mobile, Alabama
1993-1994	Field Coordinator for Interviewing, MARFIN Grant, University of South Alabama, Mobile, Alabama
1992-1995	Research Assistant to Dr. J. Stephen Thomas, University of South Alabama, Mobile, Alabama
1989	Research Assistant to Dr. George Ritzer, University of Maryland, College Park, Maryland
1988-1989	Research Assistant to Dr. Kurt Finsterbusch, University of Maryland, College Park, Maryland
1988	Interviewer for Cohen and Associate, Washington, D.C.
1986-1987	Evaluator for Sea Grant Extension Agency, Mobile, Alabama
1986-1987	Research Assistant to Dr. J. Stephen Thomas, University of South Alabama, Mobile, Alabama

Other Work Experience

1991-1992	Medical Technologist, University of South Alabama Medical Center
1981-1986	Medical Technologist, University of South Alabama Medical Center

PUBLICATIONS

2016 Martin, Cecelia. White Paper on Class Climate Use at the University of South Alabama. Scantron Corporation.

2015 Styron, Ronald., Jessica Bonner, Jennifer Styron, James Bridgeforth, and Cecelia G. Martin
"Cyberbullying: A Study of K-12 Teacher Preparation." *Journal of At-Risk Issues 19*(2).

2007 Marshall, Brent K, J. Steven Picou, Cecelia Martin Formichella, and Keith Nicholls
"Environmental Risk Perceptions and the White Male Effect: Pollution Concerns Among Deep-South Coastal Residents." *Journal of Applied Sociology/Sociological Practice.* Vol.23, 2, 31-49.

2006 Picou, J. Stephen, Cecelia Martin Formichella, Brent K. Marshall and Catalina Arata
"Community Impacts of the *Exxon Valdez* Oil Spill: A Synthesis and Elaboration of Social Science Research." in S. Braund and J. Cruse (Eds.)

Three Decades of Balancing Oil Development and People: A Synthesis of Research on the Socioeconomic Effects of Offshore Oil Development in Alaska. Anchorage, AK: Minerals Management Services/University of Alaska: Anchorage Press.

2005 Bolland, John, Brad E. Lian, and Cecelia Martin Formichella
"The Origins of Hopelessness among Inner City African Americans.
American Journal of Community Psychology, 36, 3-4, 293-305.

2000 Formichella, Cecelia Martin and Martha Daughdrill
"Counting the homeless: A Night-Time Adventure Through the Streets of Mobile." *The Harbinger* Vol. XIX, 8, 4, 9.

1998 G. David Johnson, Cecelia Martin Formichella, J. Stephen Thomas, Dulal Bhaumik, Frank Verlion de Gruy, III and Catherine A. Riordan
"Stress and Distress among Shrimp Fishermen of the Gulf of Mexico."
Human Organization 57, 4, 404-413.

1998 G. David Johnson, Cecelia Martin Formichella and David Bowers
"Do Drug Courts Work? An Outcome Evaluation of a Promising Program."
Journal of Applied Sociology 15, 1, 44-62.

1998 Formichella, Cecelia Martin and Joe Formichella
"An Alternative to the War on Drugs: The Drug Court." *The Harbinger* Vol. XVI, 6, 1, 9.

1997 Thomas, J. Stephen, Cecelia Martin Formichella, G. David Johnson and Catherine Riordan
"Shrimp Fishers on the Eve of Bycatch Regulations." *Fisheries Bycatch Consequences and Management*. Alaska Sea Grant Report 97-02.

1997 Formichella, Cecelia Martin
"Review of Caught in the Net: The Conflict between Shrimpers and Converationists, by Anthony V. Margavio and Craig J. Forsyth." *Rural Sociology* 62, 1, 145-146.

1996 Johnson, G. David, Catherine A. Riordan, J. Stephen Thomas and Cecelia Martin Formichella
"Social Support as a Buffer in a High Stress Occupation: Shrimp Fishermen of the Northern Gulf of Mexico Coast." *Sociological Spectrum* 16, 4, 401-420.

1992 Finsterbusch, Kurt, Cecelia Martin Formichella, Meredith Ramsay and Dan Kuennen

"An Evaluation of a Wide Range of Job-Generating Activities for Rural Counties." *Journal of the Society of Community Development* 23, 1, 103-eoa.

1990 Finsterbusch, Kurt, Cecelia Martin Formichella, Meredith Ramsay And Dan Kuennen
"How Rural Counties Grow." *Sociological Practice*, 8, Spring,167-182.

1989 Formichella, Cecelia Martin and J. Stephen Thomas
"Rational Exchange and Trust: Business Relationships in a Fishing Community." *Sociological Spectrum*, 9, 259-268.

1987 Formichella, Cecelia Martin and J. Stephen Thomas
"Equilibrating Relationships between Buyers and Sellers in a Gulf Coast Community." *Sociology and Social Research*, 71, 4, 271-274.

1987 Thomas, J. Stephen and Cecelia Martin Formichella.
Shrimp Processing Industry in Bayou La Batre. Center for Economic and Business Research, Research Report Number 11, September.

PAPERS/PRESENTATIONS

2018 Martin, Cecelia and David Williams
"A Model for Develop for Student Learning Outcomes Assessment." Southern Association of Colleges and Schools Commission on Colleges, New Orleans, Louisiana, December.

2018 Martin, Cecelia and David Williams
"Student Learning Outcomes: The Foundation for Quality Assessment." Indiana University Purdue University, Indianapolis, Indiana, October.

2017 Estis, Julie and Cecelia Martin
"What Happens When You Try a New Way of Teaching? Student Opinions of Team-Based Learning." Southern Association of Colleges and Schools Commission on Colleges, Dallas, Texas, December.

2017 Martin, Cecelia
"Engaging Faculty in Assessment Practices." Conference on Teaching and Learning, Mobile, Alabama, May.

2017 Estis, Julie and Cecelia Martin.

"What happens when you try a new way of teaching? Student Opinions of Team Based Learning." Conference on Teaching and Learning, Mobile, Alabama, May.

2016 Martin, Cecelia and Philip Carr.
"Developing a Process for Reinvigorating General Education." Southern Association of Colleges and Schools Commission on Colleges, Atlanta, December.

2016 Martin, Cecelia.
Class Climate Roundtable. Southern Association of Institutional Research, Charlotte, October.

2016 Martin, Cecelia
"Shed a Light on Learning Outcomes in Course Evaluations" Panelist. Class Climate, August.

2016 Martin, Cecelia
"Reduce, Reuse, Recycle: Supporting All Your Survey Needs with Class Climate" Panelist. Class Climate, July.

2016 Martin, Cecelia
"Team Taught Courses are on the Rise: How Do We Handle Course Evaluations Now?" Panelist. Class Climate, June

2016 Martin, Cecelia and Madhuri Mulekar. "Institution-Level Assessment of Writing Courses at the University of South Alabama. Conference on Teaching and Learning, Mobile, Alabama, May.

2016 Martin, Cecelia, Philip Carr, and Robert Coleman.
"Reinvigorating the Core: Foundations for Academic Success."
Conference on Teaching and Learning, Mobile, Alabama, May.

2013 Carr, Nicole, Cecelia G. Martin, and Krista Harrell
"Learning Communities and First Year Experience Courses: A Match Made in Heaven?" National Learning Community Conference, Corpus Christi, Texas, November.

2013 Bridgeforth, James, Cecelia G. Martin, Ronald Styron, Jennifer Styron and Jessica Bonner
*"*Cyberbullying and Campus Housing: Ensuring Student Safety and Institutional Support". Paper presented at the annual meeting of the Mid-South Educational Research Association Conference: Pensacola, Florida, November.

2012 Carr, Nicole and Cecelia G. Martin
"Making a Difference Learning Together: Wide Scale Omplementation of Learning Communities at the University of South Alabama." National Learning Community Conference, Indianapolis, Indiana, November.

2008 Joseph, Beatriz and Cecelia G. Martin
"Institutional Effectiveness as Determined by Alumni and Non-returning Students." Paper presented at the annual meeting of the Association for Association for Institutional Research, Atlanta, Georgia.

2008 Martin, Cecelia G. and Beatriz Joseph
"Predictors of Students' Satisfaction with Their Educational Experience: Preliminary Findings from the NSSE Survey, 2006." Paper presented at the annual meeting of the Alabama Association for Institutional Research, Jacksonville, Alabama, April.[1]

2007 Joseph, Beatriz and Cecelia G. Martin
"Non-Returning Students and Satisfaction with Their Educational Experience: An Indicator of Institutional Accountability." Paper presented at the annual meeting of the Southern Association for Institutional Research, Little Rock, Arkansas, October.

1 Best paper award.

2007 Joseph, Beatriz and Cecelia G. Martin
"Institutional Effectiveness as Determined by Alumni and Non-returning Students." Paper presented at the annual meeting of the Alabama Association for Institutional Research, Normal, Alabama, April.[2]

2006 Formichella, Cecelia Martin, J. Steven Picou and Brent K. Marshall
"Social Change as an Expected Consequence of Disasters." Paper presented at the annual meeting of the Southern Sociological Society, New Orleans, Louisiana, March.

2002 Picou, J. Steven, Cecelia Martin Formichella and Keith Nicholls
"Perceptions of Seafood Risk among Residents along the Alabama Gulf Coast." Paper presented at the annual meeting of the Society for Applied Sociology, Sacramento, CA, October.

2001 Formichella, Cecelia Martin, John Bolland and Martha Daughdrill
"A Preliminary Assessment of the Etiology of Hopelessness." Paper presented at the annual meeting of the Mid-South Sociological Association. Mobile, Alabama, October.

2001 Picou, J. Steven, Cecelia Martin Formichella, Keith Nichols, and G. David Johnson
"A Preliminary Assessment of Environmental Awareness among Residents of Mobile and Baldwin County." Paper presented at the Alabama Center for Estuarine Studies Scientific Advisory Committee, Dauphin Island, Alabama, April.

2000 Daughdrill, Martha and Cecelia Martin Formichella
"Gaps and Action Planning: Reaching Out to the Homeless, Our Neighbors." Paper presented at the Mobile Area Conference on Homelessness. Mobile, Alabama, October.

2000 Picou, J. Steven, Cecelia Martin Formichella, G. David Johnson and Keith Nicholls
"An Environmental Profile of Coastal Alabama Residents." Paper presented at the Alabama Center for Estuarine Studies Scientific Advisory Committee, Dauphin Island, Alabama, April.

1999 Picou, J. Steven, Cecelia Martin Formichella, G. David Johnson and Keith Nicholls
"Environmental Attitudes and Knowledge of Alabama Coastal Residents: A Baseline for Developing Sustainable Coastal Management Strategies." Paper presented at the annual meeting of the Mid-South Sociological Association. Jackson, Mississippi, October.

2 Best paper award.

1998 Johnson, G. David, Cecelia Martin Formichella, J. Stephen Thomas and Catherine Riordan
"Distress and Work: Determining the Differences between Land-Based and Maritime Workers Residing in Rural Coastal Communities." Paper presented at the annual meeting of the Southern Sociological Association, Atlanta, Georgia, April.

1997 Johnson, G. David, Cecelia Martin Formichella, J. Stephen Thomas and Catherine Riordan
"Distress and Work: Comparisons between Land-Based and Maritime Workers Residing in Rural Coastal Communities." Paper presented at the annual meeting of the Mid-South Sociological Association, Huntsville, Alabama, November.

1997 Johnson, G. David, Cecelia Martin Formichella, and David Bowers
"Do Drug Courts Work? An Outcome Evaluation of a Promising Program." Paper presented at the annual meeting of the Mid-South Sociological Association, Huntsville, Alabama, November.

1997 Thomas, J. Stephen, Catherine Riordan, G. David Johnson and Cecelia Martin Formichella
"Fishermen in Distress or Distress in Rural Coastal Communities." Poster presented at the Faculty Research Symposium. University of South Alabama, Mobile, Alabama, May.

1996 Thomas, J. Stephen, G. David Johnson, Cecelia Martin Formichella, and Catherine Riordan
"Fishermen in Distress or Distress in Rural Coastal Communities." Poster Session at the Mississippi-Alabama Sea Grant Annual Grantees Retreat. Gulf Shores, Alabama, November.

1996 Johnson, G. David, Cecelia, Formichella, J. Stephen Thomas, Dulal Bhaumik, Frank Verlion deGruy and Catherine Riordan
"Determinants of Mental Disorder among Shrimp Fishermen: A Test of the Social Stress Model." Paper presented at the Mini-Conference on Environmental Problems: Issues, Statistical Models, and Methods, Department of Mathematics and Statistics. University of South Alabama, Mobile, Alabama, September.

1996 Johnson, G. David, Cecelia Martin Formichella, J. Stephen Thomas, Dulal Bhaumik, Frank Verlion de Gruy, and Catherine Riordan
"Determinants of Mental Disorder among Shrimp Fishermen: A Test of the Social Stress Model." Paper presented at the Paper presented at the annual meeting of the Mid-South Sociological Association, Little Rock, Arkansas, October.

1996 Thomas, J. Stephen, Cecelia Martin Formichella, G. David Johnson and Catherine Riordan
"Shrimp Fishermen on the Eve of Bycatch Regulations." Paper presented at the annual meeting of the American Fisheries Society, Dearborn, Michigan, August.

1995 Thomas, J. Stephen, Cecelia Martin Formichella, G. David Johnson and Catherine Riordan
"Shrimp Fishermen on the Eve of Bycatch Regulations." Invited presentation to the Mississippi Marine Resources Division, Biloxi, Mississippi, October.

1995 Thomas, J. Stephen, G. David Johnson, Cecelia Martin Formichella and Catherine Riordan
"Bycatch: The Social Dimensions." Invited Presentation to the Marine Fisheries Advisory Committee, Department of Commerce, Galveston, Texas, August.

1995 Formichella, Cecelia Martin, G. David Johnson, J. Stephen Thomas, Frank Verlion deGruy, lll Catherine Riordan and Arvind Shah
"Mental Distress and Health Care Utilization among Gulf Coast Shrimp Fishermen, Gulf-Wide." Paper presented at the annual meeting of the American Sociological Association, Washington, D.C., August.

1995 Formichella, Cecelia Martin, G. David Johnson, J. Stephen Thomas, Frank Verlion de Gruy, and Catherine Riordan
"Occupational Stress and Mental Distress among Gulf of Mexico Shrimp Fishermen." Paper presented at the annual meeting of the Society for Applied Anthropology Association, Albuquerque, New Mexico, April.

1994 Johnson, G. David, Cecelia Martin Formichella, J. Stephen Thomas, Frank Verlion de Gruy and Catherine Riordan
"Mental Distress and Health Care Utilization among Gulf Coast Shrimp Fishermen in an Alabama Community." Paper presented at the annual meeting of the Mid-South Sociological Meetings, Lafayette, Louisiana, October.

1994 Thomas, J. Stephen, G. David Johnson, Cecelia Martin Formichella and Catherine Riordan
"A Model for Decision-Making Among Red Snapper Fishermen in the Gulf of Mexico." Paper presented at the annual meeting of the Society for Applied Anthropology, Cancun, Mexico, April.

1994 Thomas, J. Stephen, G. David Johnson, Cecelia Martin Formichella and Catherine Riordan
"The Social Science We Need, the Social Science We Get." Paper presented at the annual meeting of the American Fisheries Society, Little Rock, Arkansas, February.

1988 Formichella, Cecelia Martin
"Ideological Types of Organizations." Paper presented at the annual meeting of the Mid-South Sociological Association, Mobile, Alabama, October.

1987 Thomas, J. Stephen, Cecelia Martin Formichella, Michael Jepson and Gunn-Bente Olsen
"Optimism among Commercial Fishermen in a Gulf Coast Community." Paper presented at the annual meeting of the American Anthropological Association, Chicago, Illinois, November.

1987 Thomas, J. Stephen and Cecelia Martin Formichella
"Predictors of Stability in Equilibrating Relationships." Paper presented at the annual meeting of the Alabama-Mississippi Sociological Association, Florence, Alabama, February.

1987 Formichella, Cecelia and J. Stephen Thomas
"Equilibrating Relationships between Buyers and Sellers in a Gulf Coast Community: A Preliminary Report." Paper presented at the annual meeting of the Mid-South Sociological Association, Jackson, Mississippi, October.

TECHNICAL REPORTS

2008 Picou, J. S. and Cecelia G. Martin
Environmental Perceptions, Socio-Economic Impacts and Resource-Use of "Snowbirds" in the Alabama Coastal Zone. Final Report Submitted to the Alabama Center for Estuarine Study. Mobile, Alabama.

2007 Picou, J. S. and Cecelia G. Martin
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2006 Picou, J. Steven and Cecelia Martin Formichella
Community Impacts of Hurricane Ivan: A Case Study of Orange Beach, Alabama. Final Report Submitted to the Natural Hazards Research and Applications Information Center, University of Colorado, Boulder, Colorado.

2003 Picou, J. Steven, Cecelia Martin Formichella, and Wayne Isphording

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2003 Picou, J. Steven, Keith Nicholls and Cecelia Martin Formichella
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2002 Bolland, John, Martha Daughdrill, Debra McCallum and Cecelia Martin Formichella
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2001 Picou, J. Steven, Cecelia Martin Formichella, G. David Johnson and Keith Nicholls
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2001 Daughdrill, Martha, Cecelia Martin Formichella, John Bolland and Debra McCallum.
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1999 Johnson, G. David and Cecelia Martin Formichella
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1999 Formichella, Cecelia Martin, G. David Johnson, Mark Moberg, J. Steven Picou, J. Stephen Thomas and Lee S. Yokel
Profiling User-Groups of the Mobile Bay System. Report submitted to the Mobile National Estuary Program.

1997 Johnson, G. David and Cecelia Martin Formichella
Report on Blount High School Students' Survey of Ninth and Tenth Graders. Report submitted to the Prichard Community Partnership and a Coalition for a Drug Free Mobile County.

1996 Formichella, Cecelia Martin and J. Stephen Thomas
An Overviewof the Gulf States Commercial and Recreational Licensing System. Report submitted to Dr. David Griffith, East Carolina University, "Identifying and Defining Fishers and Gear in North Carolina to Develop Licensing as an Effective Management Tool."

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1993 Thomas, J. Stephen, G. David Johnson, Cecelia Martin Formichella and Catherine Riordan
"Perceived Social and Economic Effects of Current Management Policies on Red Snapper Fishermen Operating in the Gulf of Mexico: A report to the Gulf of Mexico Fishery Management Council." Report submitted to the Gulf of Mexico Fishery Management Council.

1993 Thomas, J. Stephen, G. David Johnson, Cecelia Martin Formichella and Catherine Riordan
"*Preliminary Report of Gulf of Mexico Red Snapper Fishermen Survey: Fishermen' Preferred Regulatory Options."* Report submitted to Gulf of Mexico Fishery Management Council.

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1987 Formichella, Cecelia Martin, J. Stephen Thomas and Michael Jepson.
An Evaluation and Needs Assessment of Key and Potential End Users of Sea Grant Extension. Final report submitted to Sea Grant Extension.

FUNDED RESEARCH PROJECTS

2005 "When Natural Disasters Strike: The Consequences for Survivors" (J. Steven Picou). Funded by the Natural Hazards Research and Applications Information Center, University of Colorado at Boulder.

2004-2005 "Patterns of Seafood Consumption among Residents of the Coastal Regions of Alabama and Mississippi" (J. Steven Picou). Funded by the Mississippi-Alabama Sea Grant Consortium. r.

2004-2005 "Assessing Public Awareness of the Benefits of Oyster Reef Restoration: Laying the Technical Groundwork for an Educational Outreach Program" (J. Steven Picou). Funded by the Alabama Oyster Reef Restoration Project.

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2000-2005 "Strengthening Neighborhood Investment in Substance Abuse Program for Youth" (John Bolland). Funded by the Center for Substance Abuse Treatment, Substance Abuse, Mental Health Services Administration Department of Health and Human Services.

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1997 "Profiling User-Groups of the Mobile Bay System: A Proposal" (J. Stephen Thomas, G. David Johnson, Mark Moberg and J. Steven Picou). Funded by the Mobile Bay National Estuary Program, Environmental Protection Agency.

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1992 "Decision-Making by Shrimp Fishermen as Reasoned Action: Behavioral Determinants of Bycatch Characteristics and Projected Effects by Bycatch Regulations on Labor Decisions" (J. Stephen Thomas, G. David Johnson and Catherine Riordan). Funded by Marine Fisheries Initiative (MARFIN), National Marine Fisheries Service, US Department of Commerce.

1992 "Developing a Model for Alternative Economic Strategies for Red Snapper Fishermen" (J. Stephen Thomas, G. David Johnson and Catherine Riordan). Funded by Gulf of Mexico Fishery Management Council.

PROFESSIONAL SERVICE

1996 Session chairperson at the Society for Applied Sociology, Atlanta, Georgia.
1995 Member of Gulf States Marine Fisheries Commission
1994 Discussant at the Mid-South Sociological Society, Lafayette, Louisiana.

CONSULTANT ACTIVITIES

2003-2010 Consultant with Dr. J. Steven Picou
2002 Consultant to Drs. J. Steven Picou and Keith Nicholls
1998 Consultant to the Coalition for a Drug Free Mobile County
1998 Consultant with Dr. J. Stephen Thomas to Florida Department of fish and Wildlife
1997 Consultant with Dr. J. Stephen Thomas to Florida Division of Forestry
1995 Consultant with Dr. J. Stephen Thomas to Dr. David Griffith, East Carolina University
1995 Consultant with Dr. J. Stephen Thomas to Alabama Marine Resources Division

UNIVERSITY SERVICE

2008-present	General Education Committee
2008-present	University Assessment Advisory Committee
2008-2015	Faculty Development
2010-2015	University Committee on Electronic Learning
2012-present	Student Affairs Assessment Committee
2013-present	Common Read Advisory Committee
2013-present	QEP Advisory Council
2014-present	University Writing Committee
2014-present	USA Advisory Council of International Education
2016-present	University Sustainability Committee
2016-present	University Registrar Advisory Committee

COURSES TAUGHT

Introduction to Sociology
Social Problems
Social Problems in the Workplace
American Society
Deviant Behavior
Criminology
Juvenile Delinquency
Corrections

SOFTWARE

Microsoft Office Suite
SPSS
Nuventive Improve
Class Climate
Qualtrics

FACULTY ADVISOR

1999	Linda Pennington. “Child Molester Tracking Program for Mobile County.”
2002	Walter Jeznach. “Broken Windows: The Effects of the Neighborhood Physical Characteristics on Hopelessness among Adolescents.”
2005	Regina McCracy “The Stigma of Welfare.”
2005	Marjorie Robinson “The Impacts of Homelessness on Mothers and Their Children.”
2006	Farra Scott-Green “The Effects of Mass Media on the Cultural Perceptions of Various Social Groups.”
2008	Jacquice Stone

"African American Men What It Means to Be a Father: The Effect of Mother Only Households."

CERTIFICATIONS

2012	Quality Matters Peer Reviewer
2013	Certified Face-to-Face Facilitator
2016	Team-Based Learning Training
2016	Student Affairs Assessment through National Association Student Personnel Association
2017	SACSOC Institutional Effectiveness Evaluator
2019	Master Reviewer for Quality Matters

REFERENCES

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University Registrar
390 Alumni Circle MH 1100
Mobile. AL 36688

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Associate Professor for Educational Leadership
75 S. University Blvd., UCOM 3100
Mobile, AL 36688

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Distance Learning & Assessment Analyst
310 Alumni Circle
ILC 115
University of South Alabama
Mobile, AL 36688-0002

Oregon Board of Chiropractic Examiners

Chiropractic Assistant Initial Training
8 Hours Didactic Requirements AND 4 Hours Hands-on

1. Licensing & Regulation: **30 minutes (1/2 hour)**
   Scope of practice
   Board recommends add'l training for CAs who perform massage/soft tissue work
   Duty to Report: To whom does this apply?
   Supervision required at all times (DC in office)

2. Principles of Chiropractic: 6**0 minutes (1 hour)**

3. Basic Medical Terminology: **60 minutes (1 hour)**
   - Subluxation/joint dysfunction
   - Sprain/strain
   - Contusion
   - Tendinitis
   - Bursitis
   - Ligament vs. Tendon
   - Joint capsule
   - Rotator cuff
   - Fracture vs. broken bone vs. cracked bone (all the same)
   - Hypertonicity / Hypotonicity
   - Traction / Distraction
   - Cryotherapy
   - Trigger point therapy
   - Effleurage
   - Physiotherapy / Modality
   - Prone / Supine
   - Therapeutic Exercise
   - Activities of Daily Living (ADL)
   - Outcomes measures (e.g. Oswestry, NDI, VAS pain scale)
   - S.O.A.P. (explain parts)

4. Boundaries: **45 minutes (3/4 hour)**
   - Draping
   - CA/patient power differential (applies also to DC/patient)
   - Sexual/Personal/Cultural boundaries:
     - Language
     - Professional touch (inform patient/permission)
     - Dating patients (no!) and how to respond if asked out by a patient
     - Cultural differences that may require extra care or change in procedures

5. Patient Positioning: **15 minutes (1/4 hour)**
   - Bolsters prone and supine
   - Side-lying head support
   - Be aware of injured body parts, and communicate with the patient and DC

6. HIPAA: What happens in the clinic, stays in the clinic!: **30 minutes (1/2 hour)**
   - Patient information may not be used for personal use
   - Charts/patient information in common areas (verbal and written)
   - Computer screens: (Appointment Calendars/Scheduling/Account balances)
   - Release of records requirements:
     i. When family members are treated in the same clinic, can you share information? What is *required* before any information can be shared?
     ii. Confidentiality extends to friends, coworkers, employees, injured workers!

7. Sanitation/Safety: **30 minutes (1/2 hour)**
   - Equipment (tables, physiotherapy, exercise)
   - Laundry (gowns/towels/shorts etc)
   - Personal
   - Other OSHA

8. Basic Anatomy: **75 minutes (1 hour 15 minutes)**
   Spine, muscles, bone, bony landmarks
   Phases in treatment and healing

9. Indications and Contraindications for physiotherapy modalities, exercise, soft tissue therapies **105 minutes (1 hour 45 minutes)**

10. (Understanding) CPT Timed Codes & General Chart Noting: **30 minutes (1/2 hour)**

    - *Each* author of any written information in the chart must be identified on *each* page
    - Procedure vs. Modality (e.g. 97039 vs. 97139)
    - Attended vs. Unattended (e.g. US vs. EMS)
    - Time matters:
      i. Procedures & Modalities with codes that require start and stop times, (includes setup and post-treatment cleanup)
      ii. Procedures & Modalities with codes that are billed in 15 minute increments: (8-23 minutes, includes setup and post-treatment cleanup)
      iii. What to do if less than 8 minutes of treatment time: (code modifier -52)

** The remaining 4 hour training is required as HANDS ON and
MUST cover all of hydrotherapy, electrotherapy and physiotherapy **
When recording this training, you MUST identify each specific therapy taught!

Changes made in September 2019 incorporated

TABLE OF CONTENTS

INTRODUCTION

The Oregon Chiropractic Practice and Utilization Guidelines (OCPUG)

This document was first published in 1991 by the Oregon Board of Chiropractic Examiners (OBCE or Board) with the goal of outlining a healthcare resource for Oregon chiropractic physicians. This document has undergone several iterations to reflect emerging research and clinical experience in the hopes that it would continue to become a more useful tool for practitioners. The OBCE will continue to review and update this document for this purpose. This resource is not designed to cover the complete scope of chiropractic practice in Oregon, nor is it directed at any other individual or group besides Oregon licensed chiropractic physicians and those who practice under their supervision.

ACKNOWLEDGMENTS

The OBCE expresses sincere gratitude to the following individuals who have been instrumental over the years in helping to author and revise this document through cooperation, research, and debate:

Scott Abrahamson, DC	Larry Hanberg, DC	William McIlvaine, DC	Michael Vissers, DC
Michael Burke, DC	Mitchell Hass, DC	Daniel Miller, DC	Arthur Walker, DC
John Colwell, DC	Charles Hathaway, DC	Craig Morris, DC	J-P Whitmire, DC
Steven Cranford, DC	Janis Isselman, DC	Mitzi Naucler, JD	Michael Whitton, DC
Kimberly DeAlto, DC	Allen Knecht, DC	Steven Oliver, DC	Gary Zimmerman, DC
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David Duemling, DC	Michael G. Lang, DC	David Peterson, DC	
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Meridel Gatterman, DC	Anthony Marrone, DC	Ron Romanick, DC	
Richard Gorman, DC	Joyce McClure, DC	LaVerne Saboe, Jr., DC	
Dominga Guerrero, DC	Bonnie McDowell, RPT, DC	Edmonde Samuel, DC	

In addition, thank you to the authors and researchers of all the source materials referenced in this document.

CHAPTER I

GOALS AND OBJECTIVES FOR CLINICAL PRACTICE

As a primary health care provider and as a portal of entry to the health delivery system, an Oregon chiropractic physician is led by these goals to accomplish their associated objectives.

I. Therapeutic Relationship

A. GOAL: Establish a professional doctor-patient relationship with the individual seeking care and appropriately triage their health issue(s) as well as their complaint(s) being presented.

B. OBJECTIVES:

1. Establish rapport in an atmosphere of physical comfort conducive to information gathering.

2. Provide for the presence of a third party, as required, to assist or observe in recording information, allaying apprehension, or other circumstances.

3. Elicit a thorough case history through written and/or oral means and provide a permanent record of findings with due regard for a patient's ethnic, cultural, or linguistic background.

4. Include within each case history, chief complaint, present health and relevant past health, including history of injury, disability, and cognitive assessment.

5. Assess the reliability of information presented.

II. Examination

A. GOAL: Provide such examination and diagnostic procedures and/or refer for additional diagnosis and management, as indicated by clinical relevance.

B. OBJECTIVES:

1. Specify which examination and diagnostic procedures are pertinent to the patient's complaint and present condition of health or past health issue.

2. Perform such examination and diagnostic procedures within statutory scope of practice and clinic capabilities, consistent with efficient exploration of the condition presented.

3. Assess the sensitivity, specificity, and predictive value of examination procedures selected.

4. Conduct examination and diagnostic procedures in an objective manner, remaining impartial with respect to etiology and extent of condition.

5. If referring for outside examination or diagnostic procedures, explain the clinical relevance and justification for additional testing to the patient.

6. Assess historical and physical data to identify relative or absolute contraindications for chiropractic care.

7. If referring to another health care provider, include relevant information pertaining to the referral and document such referral made.

8. Accurately record examination findings in the patient's case file consistent with universal health standards, administrative rules, and statutes.

III. Diagnosis

A. GOAL: Arrive at provisional diagnoses or clinical impressions consistent with the presenting complaint(s) and the results of examination and diagnostic procedures conducted.

B. OBJECTIVES:

1. Gather and interpret the results of all examination and diagnostic procedures, differentiating between normal and abnormal findings, and determine the relevance of the presenting complaint(s).

2. Determine subsequent evaluation procedures appropriate to the continued investigation of the patient's condition and establish a clinical impression or diagnosis.

3. Rule in or rule out the pathophysiological processes responsible for the patient's presenting complaint(s).

4. Record objectively supported differential diagnoses or clinical impressions, complicating factors and/or concomitant conditions using scientifically and/or clinically sound diagnostic procedures and language.

IV. Prognosis and Decision to Treat and/or Refer

A. GOAL:

1. Provide patient with PARQ.

2. Arrive at an initial prognosis and determine whether to accept the patient for chiropractic care and/or refer to another health care provider.

B. OBJECTIVES:

1. Determine the patient's initial prognosis.

2. Determine whether the condition is amenable to chiropractic care and is within the scope of chiropractic practice. Provide patient with report of findings.

3. If any portion of the patient's condition is not treatable within the scope of chiropractic practice, refer to the appropriate health care provider, forwarding any diagnostic tests or relevant information in an expedient manner. Document the referral.

V. Treatment Plan

A. GOAL: Generate an appropriate treatment plan with recommended re-evaluation dates.

B. OBJECTIVES:

1. Provide a treatment plan including procedures and modalities consistent with accepted standards of practice.

2. Record and date the treatment plan, including expected length and intensity of treatment, and projected re-evaluation dates.

3. If there are any general or specific considerations or contraindications for care, note them in the case file, modify the plan appropriately, and/or refer the patient to another provider.

4. Provide the patient with report of findings and with a PARQ. Obtain and record informed consent from the patient.

5. Records should be in a format that permits interpretation by other health care providers.

VI. Monitoring

A. GOAL: Assess the effectiveness of the treatment and make appropriate amendments to the treatment plan to provide efficacious care for the presenting complaint(s).

B. OBJECTIVES:

1. Perform ongoing assessment of both subjective and objective findings, documenting them in the patient record.

2. Initiate an appropriate re-evaluation to account for exacerbations, aggravations, waxing or waning of a chronic condition, or re-injury.

3. Evaluate new objective findings, integrating them with historical data, modify diagnoses and treatment appropriately, including a potential referral to a different discipline to provide timely, efficacious, and continuous care.

4. Generate reports of the patient's current condition that include information in a format a third-party representative will be able to clearly understand. Include clinical impression and treatment or modified treatment plan so that decision-making on authorization of services will be appropriate and timely.

VII. Discharge

A. GOAL: Decide on the appropriate discontinuation of care either at the endpoint of treatment or when no further improvement in the patient's condition can reasonably be expected. This responsibility includes the determination of follow-up care when necessary.

B. OBJECTIVES:

1. Release the patient from curative care:

   a. At the request of the patient;
   b. Patient non-compliance;
   c. When the objectives of the treatment plan have been achieved; or

d. When patient has achieved maximum medical improvement.

2. Document the necessity of follow-up care and inform the patient and any necessary ancillary personnel.

CHAPTER II

CHIROPRACTIC CLINICAL APPLICATION, DIAGNOSIS, AND TREATMENT PROCEDURES

SEQUENCE OF CLINICAL APPLICATION

The methods for appropriate clinical decision-making must be consistent with primary health care provisions and portal of entry procedures and standards. Each step taken in reaching a clinical impression provides an opportunity for the chiropractic physician to decide to continue further, refer the patient to another provider, or obtain a second opinion. The following is a general sequence of procedures that is commonly followed by the chiropractic physician. It is intended as a guideline, not as an exhaustive list.

I. Intake Interview of Patient

- A. History of presenting illness
- B. Past medical history
- C. Family medical history
- D. Personal, social, and socio-economic history

II. Examination and Diagnostic Procedures

- A. Physical examination
  1. General
  2. Specific to the presenting complaint(s)
  3. Chiropractic examination of spine and extremities
- B. Psycho-social assessment
- C. Laboratory examination (ordered or performed when clinically indicated)
- D. Diagnostic imaging (ordered or performed when clinically indicated)
- E. Special examinations (ordered or performed when clinically indicated)
  1. Gynecological examination
  2. Proctological examination
  3. Obstetrical examination
  4. Minor surgical examination
  5. Electrodiagnostic evaluation
  6. Vascular evaluation

III. Diagnostic and/or Clinical Impression

IV. Prognosis and Decision to Treat and/or Refer

V. Chiropractic Therapeutic Care and Patient Management

VI. Re-evaluation and Appropriate Modification of the Diagnostic Impression and Treatment Plan (if indicated)

VII. Conclusion of Treatment

CHIROPRACTIC DIAGNOSTIC PROCEDURES

I. History

A necessary component of clinical fact-finding through subjective offerings by the patient. The history may include, but is not limited to, the following:

A. Presenting condition
   1. Location
   2. Chronology
   3. Quality
   4. Severity
   5. Setting (circumstances)
   6. Modifying factors
   7. Associated symptoms (review of systems)
   8. Prior treatment(s)

B. Past medical history
   1. Accidents and injuries
   2. Previous illnesses
   3. Surgeries
   4. Medications

C. Family medical history
   1. Parents
   2. Grandparents
   3. Siblings

D. Personal, social, and socio-economic history
   1. Description of job
   2. Exercise
   3. Diet
   4. Habits/hobbies

II. Examination and Diagnostic Procedures

A. Psycho-social assessment

B. Physical examination shall include:
   1. Vitals, including but not limited to height, weight, blood pressure, and pulse
   2. Examination specific to presenting complaint(s)

C. Physical examination, when clinically indicated, may also include, but not be limited to:
   1. Heart, lungs, and abdomen
   2. EENT
   3. Integumentary examination
   4. Orthopedic and neurological tests
   5. Static and motion palpation of the spine and/or extremities
   6. Postural analysis
   7. Muscle testing including dynamic, isokinetic, static, and/or manual analysis

D. Laboratory examination

   1. Clinical laboratory testing may be necessary when the history and/or other examination findings indicate, including but not limited to blood, urine, saliva, hair, mucus, or stool.

   2. Biopsies of superficial structures may also be performed with additional Oregon minor surgery certification.

E. Diagnostic imaging

While diagnostic imaging procedures may be vital to diagnosis and case management, the decision to use any diagnostic imaging procedure should be based on clinical necessity following an adequate case history and physical examination.

F. Special examinations/evaluations

1. Gynecological examination
2. Proctological examination
3. Obstetrical examination
4. Minor surgical evaluation
5. Electrodiagnostic evaluation
6. Vascular evaluation
7. Laboratory evaluation
8. Diagnostic imaging evaluation

G. Other clinically indicated examination/evaluation procedures that comply with the OBCE rules.

III. Diagnosis and/or clinical impression

A. Severity
B. Acute vs. chronic
C. Location of lesion and/or disease
D. Etiology
E. Complicating factors
F. Concomitant conditions

IV. Prognosis and decision to treat and/or refer

The decision to treat and/or refer is made after appropriate examination and a differential diagnosis has been established. Consideration of the contraindications to the proposed treatment should be taken at this time as well as consideration of consultation and/or acquiring a second opinion.

When possible and/or appropriate, a prognosis should be given at the time that a diagnosis is made. The prognosis may change as the condition of the patient and the response to treatment changes. A referral to a different healthcare provider or discipline is appropriate when clinically indicated.

CHIROPRACTIC THERAPEUTIC CARE AND PATIENT MANAGEMENT

A. Manual therapy
   1. Adjustment
   2. Manipulation
   3. Mobilization
   4. Soft tissue manipulation

B. Physiological therapeutics
   1. Heat and/or cold
   2. Hydrotherapy
   3. Electrotherapy
   4. Phototherapy
   5. Mechanotherapy

6. Therapeutic and/or rehabilitation exercise
7. Orthotics
8. Bracing and taping

C. Nutritional supplementation, recommendations, and/or over the counter medications

D. Counseling within chiropractic scope of practice

E. Treatment in special areas
1. Gynecology
2. Obstetrics
3. Proctology
4. Minor surgery

V. Re-evaluation and assessment

VI. Conclusion of Treatment

CHAPTER III

RECORD KEEPING AND REPORT WRITING

The quality of a physician's ability to provide efficacious health care is dependent on their ability to gather, organize, analyze, and make decisions on clinical data. Good decisions are the result of accurate and complete facts being retrievable from a patient's records.

Therefore, documentation of the patient's medical history, presenting complaint(s), progression of care, diagnosis, prognosis, and treatment plan should be reflected in the record keeping and written reports of the patient file. Some aspects of this file have been included in Chapter I. Components of this file should include:

I. Patient History and Examination Records

There is considerable variation in how physicians develop and record a clinical history and examination findings. The reader is referred to Chapter I, Sections I and II for a summary of the suggested guidelines.

II. Chart Notes

Chart notes should be recorded at each visit in a form which may be understood by any medical/healthcare provider. While the patient's history indicates their status at the time of the initial visit or at the onset of a new condition, the progress record (often called chart notes) reflects the patient's state of health at subsequent points of time.

The minimum acceptable records should create a story of the patient's response to the physician's management of their case. This story should be legible and clear enough to allow another medical/healthcare provider to assume management of the case after an initial review of the chart notes. Full SOAP charting at each visit, while recommended, is not required, but components of the file should include:

A. Subjective complaints

The patient's complaints should be recorded at each visit (in the patient's own words when possible) indicating improvement, worsening or no change, or any significant event since the last visit with provider.

B. Objective findings

Changes in the objective signs of a condition should be noted at each visit in the doctor's own words.

C. Assessment or diagnosis

It is not necessary to update this category at each visit. However, periodic clinical re-evaluations should be performed and these results included in the daily entries with any amendments in the diagnosis.

D. Plan of management

A provisional plan of management should be recorded initially and further entries should be made as this plan is modified and/or as a patient's condition changes and treatment is altered accordingly. Changes in procedures should be noted.

E. Procedures

Daily recording of procedures performed should include descriptions of therapeutic procedures performed, soft tissue techniques, modalities used, exercises prescribed, nutritional supplementation, over the counter medications, or prescribed diet and activity instructions. Patient response to therapies, and who provided those therapies, should be noted.

III. Written Reports

A. History
   1. Presenting complaints
   2. Past medical history
   3. Family health history
   4. Patient's personal, social, and socio-economic history

B. Examination findings
C. Assessment, diagnosis, or clinical impression
D. Plan of management and/or response to treatment
E. Prognosis and/or outcome expectations

IV. Ancillary Documentation

A. Correspondence (sent and received)
B. Specialty reports (diagnostic imaging, lab nerve conduction studies, etc.)
C. Communications (telephone log, dialogue with specialists and/or providers co-managing case or concomitant conditions that may have effect on presenting complaint, and family or friends of the patient, etc.)

CHAPTER IV

CHIROPRACTIC MANAGEMENT ALGORITHM (Rev. 01/2018)

The following curative care algorithm, developed and accepted by a subcommittee of the OBCE (2014-2016), presents a clinical management path for the chiropractic physician to facilitate efficient patient recovery. The emphasis is on management of the patient, not on a specific pathophysiology.

Rehabilitation

Rehabilitation is treatment designed to facilitate the process of recovery from injury, illness, or disease. The goal of rehabilitation is to promote recovery, improve function, and to help the patient become self-reliant in management of their health. This generally involves transitioning the patient from passive to active care so as to achieve efficient patient recovery.

Pediatric patients

Pediatric evaluations require age appropriate inquiry and examination to determine treatment plans; this management may need to be modified.

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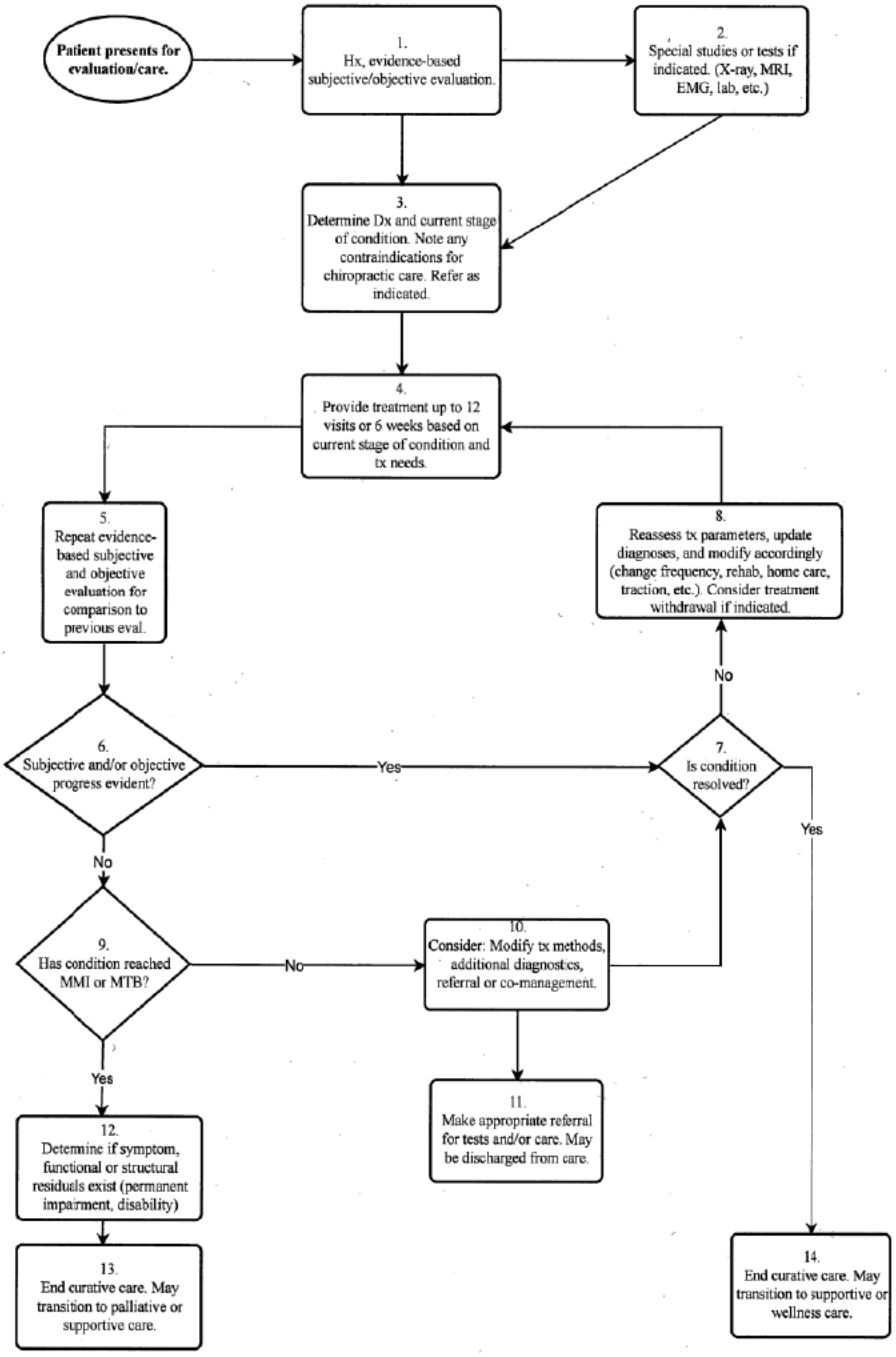
Changes made in September 2019 incorporated



The following recommendations correlate and refer to the steps in the algorithm:

Box 1: History, Subjective/Objective Evaluation	Chiropractors should conduct a medical history of the presenting condition and a past medical history including illnesses, hospitalizations, surgeries, and prior musculoskeletal conditions. The history should consider red flags and psychosocial risk factors. Subjective-based outcome assessment tools (OATS) of good reliability and validity should be used at this time to establish a baseline for pain, function, and/or disability. Chiropractors should perform a physical examination appropriate to the presenting complaint(s). Procedures should be chosen according to specificity and sensitivity, and have a relatively high likelihood for ruling in or out a specific condition. A physical examination should be neither more nor less than the presenting condition(s) require(s).
Box 2: Imaging and Special Studies	Chiropractors should determine the clinical necessity of additional testing that would improve their ability to accurately diagnose and/or provide treatment for the presenting condition(s). This testing can include, but is not limited to: diagnostic imaging, radiographs, laboratory, EMG, functional capacity, etc. Clinical necessity should be reflected in the records including the concerns warranting the study and how the results will influence management.
Box 3: Determine Diagnosis, Stage of Condition, and any contraindications to care	Based on history and examination, chiropractors should determine and document a diagnostic impression expressed in generally accepted terminology. The diagnostic impression clarifies the details of the diagnosis, including stage of condition (acute, sub-acute, repair, remodeling, chronic), and contributing and complicating factors. If any of the patient's conditions are outside the scope of practice or clinical capacity of the specific chiropractor, or if treatment is contraindicated, then a referral to a different provider should be made and documented.
Box 4: Treatment Plan	Chiropractors should formulate a treatment plan appropriate to the diagnostic impression and the patient's presentation. This should include the frequency and duration of treatment, specific therapies, and goals for each. The treatment plan should not exceed 12 visits or 6 weeks before an updated evaluation for curative care (example: 3x/week for 4 weeks acute, or 2x/week for 6 weeks subacute). Proposed treatment plan(s) and prognosis should be discussed in the context of the report of findings and PARQ conference. Informed consent shall be documented.
Box 5: Re-Evaluation	An updated evaluation of the subjective OATS and objective/functional examination should be performed at regular intervals, or whenever clinically relevant, to determine patient progress, efficacy of care, and necessity of additional treatment. Intervals between re-evaluations

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	should not exceed 12 visits or 6 weeks, depending on the patient's current condition and treatment goals. See above examples.
Box 6: Determine if progress is shown	A comparison of the new evaluation findings (from Box 7) to the previous evaluation findings should be performed to determine progress (OATS, functional, etc.). Patient progress should be determined by comparing previous to current findings and assessed by the physician for clinically meaningful change. (OATS specific, ICA guidelines, etc.) **If progress is shown, go to box #7. If no improvement, go to box # 9.**
Box 7: Is Condition Resolved?	The chiropractor should determine if the condition has resolved (subjectively, functionally, structurally, etc.). This should be goal-specific. Possible endpoints of care should be when patient is at pre-injury status or maximum medical improvement. **If resolved, go to box #14. If not resolved, go to box #8.**
Box 8: Modify Treatment if indicated	As treatment continues, the diagnoses should be amended based on the patient's clinical presentation. If indicated, the chiropractor should modify treatment, including but not limited to: changing the frequency of visits, modifying modalities, updating home care instruction, etc. If appropriate, treatment frequency may be proportionately decreased in order to determine the patient response to daily living without care prior to the next evaluation.
Box 9: Has condition reached Maximum Medical Improvement or Therapeutic Benefit?	If the patient is not showing progress with care, then the chiropractor should determine whether the patient has reached maximum medical improvement (MMI) or maximum therapeutic benefit (MTB). MMI refers to a date from which further recovery or deterioration is not anticipated. MTB refers to when provided care no longer provides benefit, but other options may still exist for improvements. **If MMI/MTB, then go to box #12. If not, go to box #10.**
Box 10: Modify Case Management	If the patient is not progressing and is not considered MMI or MTB, the chiropractor should consider psychosocial factors and other treatment options. Examples of other or additional treatment options include, but are not limited to: referral to another provider, referral for additional testing, adding or removing therapeutic modalities from the treatment plan, etc. **If referral is indicated, go to box #11. To continue care, go to box #7 (May do both)**
Box 11: Referral and/or Discharge	See box #2 and #3 to determine appropriate referral needs. It is possible that chiropractic care is terminated at this time, even if the patient's condition can benefit from a different care provider. Any referrals should be documented in the patient records.
Box 12: Residual Findings/ Permanent Impairment	When a patient's condition has reached MMI or MTB, if any residuals are still evident (subjective, functional, objective, structural, etc.), the chiropractor should determine if a permanent impairment evaluation and/or disability rating is indicated. All residuals should be documented and discussed with the patient. MTB patients may be referred out.

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Box 13: End curative care with residuals.	Curative care should be ended after MMI or MTB has been determined and residuals (if any) should be documented. The patient may be transitioned into supportive care or palliative care if indicated.
Box 14: End curative care.	When ending curative care, the patient may be transitioned to supportive or wellness care, if indicated.

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Maintenance Care:

The term "maintenance care" is not well-defined at this time in scientific literature and is inherently vague. For purposes of this document, the OBCE will forego its use.

Supportive Care:

Supportive care is ongoing treatment/care for patients who have reached MTB but who may fail to sustain these benefits and may progressively deteriorate without treatment. In addition, it is intended to minimize exacerbations and degenerative sequelae. Supportive care sometimes includes the return to curative care for the waxing and waning of chronic conditions. It follows appropriate application of active and passive treatments including rehabilitation and/or lifestyle modifications. It is appropriate when alternative care options, including home-based self-care or referral have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other therapeutic protocols.

Wellness Care:

The purpose of chiropractic wellness care is to enhance and optimize a patient's physical well-being and potentially prevent the future onset of symptoms. It is not limited to spinal manipulation but could include any element of the chiropractor's scope of practice.

Nothing in the existing laws or rules of the Board announce a separate standard of care for "wellness care," "maintenance care," "curative," or "palliative" care. All require that the patient is entitled to an appropriate physical examination, a report of findings following the examination, including a clinical impression, and recommendations for care, followed by a PARQ, in order to obtain informed consent from the patient prior to rendering therapeutics.

Palliative Care:

Palliative care is treatment to temporarily improve a patient's quality of life without anticipation of overall improvement.

~~CHIROPRACTIC MANAGEMENT ALGORITHM~~

~~This algorithm develops a clinical management path for the chiropractic patient; to facilitate their recovery in the shortest time and the most cost effective manner possible. The algorithm is presented primarily to organize the chiropractic physician's application of diagnostic and therapeutic interventions. The emphasis is on management of the patient and not on management of a particular pathophysiology. This is because any one patient may present with multiple pathophysiologies or their clinical course may progress through multiple pathophysiological states requiring management modification.~~

~~An algorithm provides a visual tool for communication of expected diagnostic and therapeutic applications from the Oregon Board of Chiropractic Examiners to practicing chiropractors, from the individual D.C. to his patient and from the D.C. to third parties involved with any particular patient. Key points are defined for the referral to another physician and/or health care provider and for the reporting of information to patients and to involved third party payors. Concurrent allopathic and/or psychological management is incorporated into this scheme and the algorithm identifies the usual protocol for chiropractic management alternatives of a patient at maximum clinical improvement.~~

~~The algorithm is organized into three basic sections: diagnostics, therapeutics and maximum clinical improvement. The diagnostics section includes history, examination, data collection, special studies or examinations ordered by the D.C., allopathic procedures ordered by the D.C. and allopathic procedures ordered by any consulting discipline; including but not limited to, allopathic, osteopathic, psychiatric or psychological. The therapeutic section defines three feedback loops originating with the clinical reevaluation of patients who are showing poor progress, multiple exacerbations or no response to the provisional management plan. The maximum clinical improvement section defines four categories of patients and describes appropriate management alternatives at that juncture.~~

~~The sequence of this algorithm begins with consultation, history of present illness, physical examination and collection of data to confirm and analyze the medical history. Based on this information a clinical impression is rendered. This initial impression may be modified by any special studies or examinations ordered as they may identify complicating conditions which will naturally modify the resulting treatment plan or prognosis.~~

~~At this point, prior to treatment, the D.C. may desire a medical or surgical consultation. The consultation may result in a referral for medical management or feedback into chiropractic management with concurrent medial treatment. Based on these clinical impressions, a provisional treatment plan is formulated with a time line and goals for expected subjective and objective response. After reporting this to the patient, treatment is initiated.~~

~~Treatment response is monitored and documented objectively and subjectively in the patient's records. Appropriate progress to treatment usually confirms the initial clinical impressions and a more accurate prognosis can be formulated and reported to the patient, third party payors and~~

~~employers, if indicated. Assuming continued improvement with treatment, the management may be modified based on the patient's stage of recovery until maximum clinical improvement is reached.~~

~~For patients making poor progress, patients with multiple exacerbations or patients showing no response to treatment, clinical re-evaluation is indicated. At this point, the D.C. may elect four courses of action: **first**, to redefine the prognosis, goals and time line and continue with treatment; **second**, to modify the patient's management with his consent; **third**, to refer the patient to another physician and/or health care provider; **fourth**, to perform other special studies or examinations as indicated by the re-evaluation. This final option loops into the diagnostic section of the algorithm allowing the clinical impressions to be altered or modified. This resulting modified impression and treatment plan may include additional chiropractic or conservative therapies, concurrent allopathic or psychological treatment or referral to other disciplines. After the patient's consent is obtained, modified treatment is continued.~~

~~Usually four groups of patients exist at maximum clinical improvement. Those who are asymptomatic and without objective findings are discharged. Those who are asymptomatic with objective findings may be clinically re-evaluated and their management modified or given an~~

~~appropriate referral. Patients who are still symptomatic and retain objective findings may be referred for impairment rating, work capacity evaluation and/or vocational rehabilitation if it is appropriate. These patients should be instructed in or referred to self help and pain management programs and often require some supportive or maintenance treatment. Patients who are symptomatic but without objective findings may be instructed in or referred to self help or pain management programs, other appropriate health care providers or discharged.~~

~~This algorithm was developed utilizing the combined experience of chiropractic physicians and the academic departments at Western States Chiropractic College and is not considered the only approach to chiropractic patient management in the State of Oregon. Further refinement and validation of this scheme is expected. We are not implying that this algorithm actually improves the clinical outcome of any particular patient group progressing through a course of chiropractic treatment. However, it does represent a tool for clinical decision making and stresses three chronological phases in patient management: diagnostics, therapeutics and maximum clinical improvement. It also allows for feedback loops returning to the diagnostic section based on information obtained in the therapeutics section of this model.~~

~~ALGORITHM~~

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CHAPTER V

TREATMENT PARAMETERS FOR COMMON NMS CONDITIONS

The following treatment parameters are to be used only as guidelines. These are estimates of treatment and/or healing time for commonly encountered categories of neuromusculoskeletal conditions. Disorders outside the NMS system are not addressed by this document. As stated in the preamble, this is an ongoing and dynamic process. These parameters will be amended or modified as new research and expert clinical judgments fill in the inevitable gaps in this process.

The suggested parameters do not reflect the protracted healing time and disability that may result from individual conditions complicated by such factors as previous injuries, congenital or developmental defects, systemic diseases, degenerative disorders, obesity, smoking, psychosocial compromise and others. In such conditions, or if the natural history of an injury is interrupted by aggravations, exacerbations, or flare-ups; applicable treatment guidelines could be modified or extended. However, benefit of care should be supported by subjective and objective documentation.

CATEGORY I
0 - 6 WEEKS TREATMENT

1. ~~Mild-moderate strain~~1st degree/Grade I strains
2. ~~Mild sprain~~1st & 2nd degree/Grade I & Grade II sprains
3. ~~Mechanical/joint dysfunction (uncomplicated)~~Subluxation/mechanical joint dysjunction
4. ~~Subluxation (uncomplicated)~~
5. ~~4.~~ Acute & chronic facet syndrome
6. ~~5.~~ Contusion
7. ~~6.~~ Mild-moderate tendinitis, capsulitis, bursitis, synovitis
8. ~~7.~~ Mild sacroiliac syndrome
9. ~~8.~~ ~~Acute M~~myofascial pain syndrome
10. ~~9.~~ ~~Mild symptomatic degenerative joint disease~~Included in mechanical joint dysfunction
11. ~~10.~~ Headaches: vertebrogenic, muscle contraction, migraine, ~~vascular~~acute & chronic or episodic
12. ~~11.~~ Torticollis (~~acquired~~)non-congenital)

CATEGORY II
2 - 12 WEEKS TREATMENT

1. Moderate-marked strain
2. ~~Moderate sprain~~3rd degree/Grade II sprains
3. ~~Post traumatic mild-moderate myofibrosis~~
4. ~~3.~~ Post traumatic periarticular fibrosis and joint dysfunction with marked tendinitis, bursitis, capsulitis, synovitis
5. ~~4.~~ Chronic tendinitis, bursitis, capsulitis, synovitis
6. ~~Chronic facet syndrome~~
5.
7. ~~Moderate sacroiliac syndrome~~
8. ~~Chronic S~~sacroiliac syndrome with marked myofascial pain syndrome
9. ~~Chronic M~~myofascial pain syndrome recurrent
10. ~~Mechanical/joint dysfunction (complicated)~~
11. ~~Subluxation (complicated)~~
8. Subluxation/mechanical joint dysfuction with instability
12. ~~Moderate symptomatic degenerative joint disease~~
13. ~~9.~~ ~~Mild inter-vertebral disc syndrome w/o myelopathy~~Disc tear/protrusion without myelopathy

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~~14. Chronic headaches: vertebrogenic, muscle contraction, migraine, vascular~~
~~15.~~10. Mild temporomandibular joint dysfunction
~~16.~~11. Symptomatic spondylolisthesis (must list grade & with or without pars defect)
~~17. Mild clinical joint instability~~

CATEGORY III
1 - 6 MONTHS TREATMENT

1. ~~Chronic~~ F~~f~~acet syndrome associated with clinical vertebral instability - measurable instability 3mm or more
2. Marked strain associated with post traumatic myofibrosis ~~and/or~~with joint dysfunction
~~3. Marked sprain with associated instability/dysfunction~~
~~4.~~3. Thoracic outlet syndromes
~~5.~~4. ~~Moderate inter-vertebral disc syndrome w/o myelopathy~~Inter-vertebral disc protrusion with migration but without myelopathy
~~6.~~5. Peripheral neurovascular entrapment syndromes (identify what?)
~~7.~~6. Moderate to marked temporomandibular joint dysfunction
~~8.~~7. ~~Adhesive capsulitis (frozen joint)~~Manipulation & rehabilitation of adhesive capsulitis (frozen joint)
~~9.~~8. Partial or complete dislocation – identify what structures – not all require follow up

CATEGORY IV
2 - 12 MONTHS TREATMENT

1. Interverterbral disc protrusion without cord compression, with or without radiculopathic symptoms
~~1.~~2. Marked inter-vertebral disc syndrome w/o myelopathy, with or without radiculopathy
~~2.~~3. Lateral recess syndrome – needs clarification
~~3.~~4. Intermittent neurogenic claudication – needs more precise definition
~~4.~~5. Acceleration/deceleration injuries of the spine with myofascial complications (whiplash) with measurable instability
~~5.~~6. Cervicobrachial sympathetic syndromes/brachial plexus syndromes
~~6.~~7. ~~Sympathetic dystrophies~~Complex regional pain syndrome
~~7.~~8. ~~Severe strain/sprain of cervical spine with myoligamentous complications~~Grade III sprains & strains

RE-ASSESSMENT

The following circumstances are offered as an indication for reassessment by the treating physician. Clinical evidence or special circumstances may support continued treatment and/or work loss beyond these guidelines.

However, lack of justification for such management would indicate the need for consultation/ second opinion and/or special examination.

1. Daily treatment exceeding two consecutive weeks
2. Treatment 3x/week exceeding six consecutive weeks
3. Authorized full time work loss for longer than four consecutive weeks
4. No objective or subjective improvement noted within the guideline parameters as outlined in this chapter.

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CHIROPRACTIC CARE

The previous categories of care pertain to acute care or initial primary therapy. Because chiropractic education and training also includes the application of rehabilitative care and maintenance care, the following provides an appropriate explanation for the administration of these forms of treatment.

REHABILITATIVE CARE: The rehabilitation protocol of Chiropractic Rehabilitation Association are the accepted clinical chiropractic standards for rehabilitative care. These are updated annually and are available in the administrative office of the Oregon Board of Chiropractic Examiners.

MAINTENANCE CARE includes both preventive and supportive care.

Preventive care involves the reduction of the incidence and/or prevalence of illness, impairments, and risk factors, and the maintenance of optimal functions.

Supportive care sustains previous therapeutic gains that might otherwise progressively deteriorate. Supportive care follows appropriate application of acute care and rehabilitation and includes concurrent life style modification efforts. In addition, it is intended to minimize complications and degenerative sequelae.

Appropriateness of Maintenance Care

Preventive care is considered to be appropriate in an outwardly healthy individual who may have no symptoms and in whom signs of illness or impairment may be absent, minimal or subclinical. Preventive care may be inappropriate when it interferes with other appropriate primary care or when the risk of preventive care outweighs the benefits.

Supportive care is appropriate for a patient who has reached maximum therapeutic benefit (maximum medical improvement), and in whom periodic trial of therapeutic withdrawal fail. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home-based self-care and life style modification, have been considered and attempted. Supportive care is appropriate in patients who display persistent and/or recurrent signs of illness or impairments.

Supportive care may be inappropriate when it interferes with other appropriate primary care or when the risk of supportive care outweighs the benefits, e.g. physician dependence, somatization illness behavior, or secondary gain.

Guidelines for determining frequency and duration of maintenance care should be based upon the definitions provided above, with the understanding that clinical circumstances and other considerations, such as age, occupation, etc., as determined by the attending chiropractic physician, will alter duration and frequency needs and that application of care will result in reasonable differences in patient status. The determination of frequency and duration is subject to clinical judgment and at times may require peer review and further consultation.

Chiropractic doctors commonly recommend monthly visits for the purpose of supportive care. More frequent visits may be clinically justified.

Preventive care is usually applied less frequently, but would rarely be less than once per year.

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CHAPTER VI

CHIROPRACTIC GLOSSARY OF COMMONLY USED TERMS

Acute - ~~common usage:~~ of recent onset (hours or days); sharp; poignant; having a short and relatively severe course. ~~(1)~~

Adhesion - a fibrous band or structure by which parts adhere abnormally. ~~(1)~~

Adjustment - a chiropractic word of art; as defined by Janse, it is a specific form of direct articular manipulation utilizing either long or short leverage techniques with specific contacts and is characterized by a dynamic thrust of controlled velocity, amplitude and direction. ~~(3)~~

Algorithm - a mechanical procedure for solving a certain kind of mathematical problem; a step-by-step method of solving a problem, as in making a diagnosis. ~~(1)~~

Alignment - the act of aligning; the adjusting of a line. ~~(2)~~

Analysis - separation into component parts; the act of determining the component parts of a substance. ~~(1)~~

Anomaly - marked deviation from the normal standard, especially as a result of congenital defects. ~~(1)~~

Arthritis - inflammation of a joint. ~~(1)~~

Arthrosis – 1. Articulation or line of juncture between two bones; 2. degenerative joint disease of the truly movable joints of the spine or extremities. ~~(10)~~

Asymmetry - lack or absence of symmetry of position or motion. Dissimilarity in corresponding parts or organs of opposite sides of the body which are normally alike. ~~(1)~~

Barrier - a boundary of any kind. ~~(2)~~

Anatomic barrier - the limit of anatomical integrity; the limit of motion imposed by an anatomic structure. Forcing the movement beyond this barrier would produce tissue damage. ~~(7)~~

Elastic barrier (physiologic) - the elastic resistance that is felt at the end of passive range of movement; further motion toward the anatomic barrier may be induced passively. ~~(7)~~

Chiropractic – is defined in Oregon pursuant to ORS 684.010.

~~Chiropractic practice - chiropractic is a discipline of the scientific healing arts concerned with the pathogenesis, diagnostics, therapeutics and prophylaxis of functional disturbances, pathomechanical states, pain syndromes and neurophysiological effects related to the static and dynamics of the locomotor system, especially of the spine and pelvis. (13)~~

~~Chiropractic science - chiropractic science is concerned with the investigation of the relationship between structure (primarily the spine) and function (primarily the nervous system) of the human body that leads to the restoration and preservation of health. (12)~~

Commented [CMS3]: This change was made by the board in March, 2018.

Chronic - long standing (>6 weeks~~, months or years~~). Symptoms may range from mild to severe. ~~(1)~~

Compensation - the counterbalancing of any defect of structure or function. ~~(1)~~ Changes in structural relationships to accommodate for foundation disturbances and maintain balance. ~~(5)~~

Contraction - a shortening or reduction in size; in connection with muscles, contraction implies shortening and/or development of tension. ~~(1)~~

Contracture - a condition of fixed high resistance to passive stretch of a muscle resulting from fibrosis of the tissues supporting the muscle or joint. ~~(1)~~

Diagnosis - the art of distinguishing one disease from another. ~~(1)~~

Clinical diagnosis - diagnosis based on signs, symptoms and laboratory findings during life. ~~(1)~~

Physical diagnosis - determination of disease by inspection, palpation, percussion and auscultation. ~~(1)~~

Discogenic - ~~common usage;~~ caused by derangement of an inter-vertebral disc. ~~(1)~~

Discopathy - any pathological changes in a disc. ~~(3)~~

Displacement - removal from the normal position or place; ~~(1);~~ as pertaining to vertebral displacement, it refers to a disrelationship of the vertebra to its relative structure. ~~(5)~~

Facet Syndrome - common usage: back pain and dysfunction caused by a lesion of a posterior facet joint. This may be accompanied by referred pain in the lower extremity.

Fibrosis - the formation of fibrous tissue. ~~(1)~~

Fibrositis - inflammatory hyperplasia of the white fibrous tissue of the body, especially of the muscle sheaths and fascial layers of the locomotor system. ~~(1)~~

Fixation - (dynamic fault) - the state whereby articulation has become temporarily immobilized in a position which it may normally occupy during any phase of physiologic movement. The immobilization of an articulation in a position of movement when the joint is at rest, or in a position of rest when the joint is in movement. ~~(8)~~

Functional - affecting the function but not the structure; said of disturbances with no detectable organic cause; idiopathic. ~~(1)~~

Health - a state of optimal physical, mental, and social well-being and not merely the absence of disease and infirmity. ~~(1)~~

Hyper - ~~beyond~~ over or excessive. ~~(1)~~

Hypo - under or deficient. ~~(1)~~

Instability - quality or condition of being unstable; not firm, fixed or constant. ~~(15)~~

Ischemic compression - application of progressively stronger ~~painful~~ pressure on a trigger point for the purpose of eliminating the point's tenderness. ~~(4)~~

Joint dysfunction - joint mechanics showing area disturbances of function without structural change--subtle joint dysfunctions affecting quality and range of joint motion. They are diagnosed with the aid of motion palpation, and stress and motion radiography investigation. ~~(14)~~

Joint play - discrete, short range movements of a joint independent of the action of voluntary muscles, determined by springing each vertebrae in the neutral position. ~~(5)~~

Manual Therapy - ~~common usage:~~ therapeutic application of manual force. Includes such procedures as massage, active relaxation, passive stretch, exercises, joint mobilization, thrust manipulation, immobilization and stabilization. ~~(18)~~

Manipulation - passive maneuver in which specifically directed manual forces are applied to ~~vertebral~~ spinal and ~~extravertebral~~ extra-spinal articulations of the body, with the object of restoring mobility to restricted areas. ~~(17)~~

Massage - the systematic therapeutical friction, stroking and kneading of the body. ~~(1)~~

Mobilization - the process of making a fixed part movable. ~~(1)~~ A form of manual therapy applied within the physiological passive range of joint motion and is characterized by non-thrust passive joint manipulation. ~~(17)~~

Myofascial pain syndrome - pain and/or autonomic phenomena referred from active myofascial trigger points with associated dysfunction. ~~The specific muscle or muscle group that causes the symptoms should be identified. (4)~~

Myofascial trigger point - a hyper-irritable spot, usually within a taut band of skeletal muscle or in the muscle's fascia, that is painful on compression and that can give rise to characteristic referred pain, tenderness, and autonomic phenomena. A myofascial trigger point is to be distinguished from cutaneous, ligamentous, periosteal and non-muscular fascial trigger points. Types include active, latent, primary, associated, satellite and secondary.~~(4)~~

Myofascitis - a) Inflammation of a muscle and its fascia, particularly at the fascial insertion of muscle to bone;~~.~~
b) Pain, tenderness, other referred phenomena, and the dysfunction attributed to myofascial trigger points. ~~(4)~~

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Myofibrosis - replacement of muscle tissue by fibrous tissue. ~~(1)~~

Nerve interference - a chiropractic term used to refer to the interruption of normal nerve transmission (nerve energy). ~~(5)~~

Neurogenic - ~~this word is often used to mean~~ originating in nerve tissue; example: "the cause of the disorder is neurogenic." ~~(11)~~

Neuropathy - a general term denoting functional disturbances and/or pathological changes in the peripheral nervous system. ~~(1)~~

Neurophysiologic effects - a general term denoting functional or aberrant disturbances of the peripheral or autonomic nervous systems. The term is used to designate nonspecific effects related to: a) motor and sensory functions of the peripheral nervous system; b) vasomotor activity, secretomotor activity and motor activity of smooth muscle from the autonomic nervous system, e.g., neck, shoulder, arm syndrome (the extremity becomes cool with increased sweating); c) trophic activity of both the peripheral and autonomic nervous system, e.g., muscle atrophy in neck, shoulder, arm syndrome. ~~(15)~~

Objective - pertaining to those relations and conditions of the body perceived by another, as objective signs of disease. ~~(1)~~

Osteophyte - a degenerative exostosis secondary to musculotendinous stress. ~~(10)~~

Palpation - a) The act of feeling with the hand. ~~(1)~~

Motion palpation - palpatory diagnosis of passive and active segmental joint range of motion. ~~(5)~~

Static palpation - palpatory diagnosis of somatic structures in a neutral static position. ~~(5)~~

Prognosis - a forecast as to the probable outcome of an attack of disease; the prospect as to recovery from a disease as indicated by the nature and symptoms of the case. ~~(1)~~

Referred pain - pain felt in a part other than that in which the cause that produced it is situated. ~~(1)~~

Restriction - limitation to movement. Describes the direction of limited movement in subluxated and/or dysfunctional joints. ~~(5)~~

Sacroiliac Syndrome - pain over one sacroiliac joint in the region of the posterior superior iliac spine. This may be accompanied by referred pain in the leg. ~~(9)~~

Scoliosis - an appreciable ~~lateral~~ deviation in the normally straight vertical line of the spine. ~~(1)~~

Functional scoliosis - ~~lateral~~ deviation of the spine resulting from poor posture, foundation anomalies, occupational strains, etc., that are still not permanently established. ~~(5)~~

Structural scoliosis - permanent ~~lateral~~ deviation of the spine; such that the spine cannot return to neutral position. ~~(5)~~

Short leg - an anatomical, pathological or functional leg deficiency leading to dysfunction. ~~(6)~~

Sign - an indication of the existence of something; and objective evidence of a disease, i.e. such evidence as is perceptible to the examining physician, as opposed to the subjective ~~sensations~~ (symptoms) of the patient. ~~(1)~~

Spondylitis - inflammation of the vertebrae. ~~(1)~~

Spondyloarthrosis - arthrosis of the synovial joints of the spine. ~~(10)~~

Spondylolisthesis - anterior or posterior slippage of a vertebral body on its caudal fellow. ~~(10)~~

Spondylolysis - is defined as an interruption in the pars interarticularis which may be unilateral or bilateral. ~~(10)~~

Spondylophytes - degenerative spur formation arising from the vertebral end plates and usually projecting somewhat horizontally. ~~(10)~~

Spondylosis - degenerative joint disease as it effects the vertebral body end plates. ~~(10)~~

Spondylotherapy - the therapeutic application of percussion or concussion over the vertebrae to elicit reflex responses at the levels of neuromeric innervation to the organ being influenced. ~~(3)~~

Sprain - joint injury in which some of the fibers of a supporting ligament are ruptured but the continuity of the ligament remains intact. ~~(1)~~

Spur - a projecting body as from a bone. ~~(1)~~

Strain - an overstretching and tearing of musculotendinous tissue.

Stress - the sum of the biological reaction to any adverse stimulus, physical, mental or emotional, internal or external that tends to disturb the organism's homeostasis; should these compensating reactions be inadequate or inappropriate, they may lead to disorders. The term is also used to refer to the stimuli that elicit the reactions. ~~(1)~~

Subacute - less than acute, between acute and chronic. ~~(1)~~

Subjective - pertaining to or perceived only by the affected individual; may or may not be perceptible to the senses of another person.

Subluxation/Vertebral - vertebral subluxation is an aberrant relationship between two adjacent articular structures that alteration in the biomechanical and/or neurophysiological reflections of these articular structures, their proximal structures, and /or body systems ~~that~~ may be directly or indirectly affected by them. ~~(16)~~

Symptom - ~~any subjective evidence of a patient's condition, i.e., such evidence as perceived by the patient. (1)~~a physical or mental feature which is regarded as indicating a condition of disease, particularly such a feature that is apparent to the patient.

Syndesmophyte - inflammatory ossification of a ligament. ~~(19)~~

Technique - any of a number of physical or mechanical ~~chiropractic~~ procedures used in the treatment of patients. ~~(5)~~

Trigger point - see myofascial trigger point. ~~(4)~~

~~CHAPTER VII~~

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