OBCE BOARD MEETING PUBLIC SESSION	**November 17, 2022 8:00 AM** **Meeting location:** OBCE office 530 Center St NE, Suite 620 Salem, OR 97301 **Zoom conference will also be available:** https://us06web.zoom.us/j/85895848453?pwd=SklDZWVtZkZkMW4wRDJEMFdhZ29nQT09 Meeting ID: 858 9584 8453 Password: 033031

Board President: Franchesca Vermillion, DC Phone 503-378-5816 info@obce.oregon.gov

November 17, 2022

8:00 AM Convene Public Session

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

2. CONSENT AGENDA Action
a. Today's agenda
b. September 21-22, 2022, Public Board Minutes

3. EXECUTIVE DIRECTOR REPORT Inform/Action

4. OCA Update Inform

5. UWS Update Inform

6. 9:00 AM RULE HEARINGS
a. **OAR 811-010-0045 Chiropractic Students** – Updating language to accurate terms and including further definition of CA process.
b. **OAR 811-010-0093 Guide to Policy and Practice** – Updating rule with current addition date
c. **OAR 811-010-0110 Chiropractic Assistants** – General rule update with a focus on the renewal process and application language
d. **OAR 811-035-0045 Unprofessional Conduct in the Chiropractic Profession** – Updating to include language about CAs within rule

7. ADMINISTRATIVE RULES REVIEW and DISCUSSION Action
a. None

8. DISCUSSION AND ACTION ITEMS
a. 2023 Executive Board Elections Action
b. Rules Advisory Committee Liaison Action

c. Review/Ratify Annual Performance Progress Report (APPR) — Inform
d. Customer Satisfaction Survey Summary — Inform
e. 2021-23 Legislatively Adopted Budget — Action
f. 2023 Mandatory CE Selections — Action
g. CDC, Oregon OSHA, and OHA changes — Inform/Action
h. DCs Administering Covid-19 Vaccinations - OCA — Inform
i. OB/GYN Certification Process – Vermillion — Inform/Action
j. Chiropractic Classes – DOC — Inform/Action

9. CORRESPONDENCE

a. Customer Satisfaction Survey – public comment — Inform
b. Note to the Board – Knecht, A — Inform

10. EXECUTIVE DIRECTOR EVALUATION – to be discussed in Executive Session

11. WORK SESSION

a. CA Syllabus Review — Action
b. CA Training Manual — Action

12. EXECUTIVE SESSION

The Board of Chiropractic Examiners will now go into Executive Session pursuant to ORS 192.660(2)(f), ORS 192.660(2)(l), ORS 192.660(2)(h), ORS 684.185, 676.175(1) and 684.100(10) concerning discipline, litigation, and exempt public records**.**

Representatives of the news media and designated staff will be allowed to attend the Executive Session. All other members of the audience are asked to leave the room. Representatives of the news media are specifically directed not to report on any of the deliberations during the Executive Session except to state the general subject of the session as previously announced.

No decision will be made in Executive Session. At the end of the Executive Session, we will return to open session and welcome the audience back into the room.

13. IN THE MATTERS OF (following Executive Session)

OBCE BOARD MEETING PUBLIC SESSION	**September 21-22, 2022 8:00 AM** **Meeting location:** Eagle Crest Resort 1522 Cline Falls Rd, Board Rm A Redmond, OR 97756 **Zoom conference will also be available:** https://us06web.zoom.us/j/87587955221?pwd=K2g0WEVqL2QwOVlicGFZdkRhN1krUT09 Meeting ID: 875 8795 5221 Password: 598765

Board President: Franchesca Vermillion, DC Phone 503-378-5816 info@obce.oregon.gov

Board member Attendees:	**Staff Attendees:**
Franchesca Vermillion DC, President	Cass McLeod-Skinner JD, Executive Director
Michelle Waggoner DC, Vice President	Mackenzie Purnell, Administrative Specialist II
Seth Alley DC, Secretary (attended virtually)	Miriam Lara, Administrative Specialist II
Karen Baranick DC	Lori Lindley, Assistant Attorney General
Lori Schmidt JD, Public Member	Craig Kawaoka, DC, MeD, Healthcare Investigator
Glenn Taylor, Public Member	Heather Gilker, Office Specialist
Allen Knecht DC (virtual, absent second day)	Gina Sullivan, Investigator II
Public Attendees: Emily Coates, LFO; Vern Saboe, DC; Sharron Fuchs, DC; Dr. Stein, DC; Valeen Tripoli, DC; Carol S, DC.	

September 21-22, 2022

8:00 AM Meet and Greet

8:30 AM Convene Public Session

1. **PUBLIC COMMENTS –** No comments made.

2. **CONSENT AGENDA**

   a. **Today's agenda**

   Outcome: Adopted.

   b. **July 21, 2022 Public Board Minutes**

   Outcome: Adopted.

3. **EXECUTIVE DIRECTOR REPORT**

   Report was received by the Board.

4. **OCA Update – Dr. Vern Saboe**

   OCA update was provided by Dr. Vern Saboe and received by the Board.

5. UWS Update

None.

6. 9:00 AM RULE HEARINGS Action

a. **OAR 811-015-0025 Continuing Chiropractic Education**

Outcome:
Vermillion moved to adopt rule as amended; Taylor, second. Alley, aye; Knecht, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passed.

7. ADMINSTRATIVE RULES

a. **OAR 811-010-0093 Guide to Policy and Practice Questions**

Issue: Version reference update

Outcome: Vermillion moved to enter rulemaking in September; Waggoner, second. Alley, aye; Knecht, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passed.

8. DISCUSSION AND ACTION ITEMS

a. **Spinal Screening Requirements - Kawaoka** Inform/Action

Issue: Question from staff.

Outcome:
Sent to Policy & Practices committee workgroup to determine if policy will be created.

b. **2023 Board Meeting Schedule** Action

Outcome:
- January 18-19, Portland Medical Board Office/Oregon State Bar/UWS
- March 30, virtual
- May 24-25, LaGrande, Pendleton, or Medford
- July 27, virtual
- September 27-28, Sunriver
- November 30, virtual

c. **November Introduction to the Board** Action

Outcome:
November 9, 2022 4-7pm; Schmidt, Baranick to attend

d. **CA Process updates/issues - Purnell** Inform/Action

Outcome:
Bring back CA rule redline for review in November.

Bring DC/CA student application process rule redline in November.

e. **ETSDP Application Review – Wet Cupping** Inform/Action

Outcome:

OBCE liaison: Karen Baranick
Boothby: yes

LoGiudice: yes
Patterson: yes

Vermillion moved to approve committee members; Taylor, second. Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

f. **Use of NCRME acronym in signature/title - McGehee** Inform/Action

Outcome:
Referred to the P&P committee, current policy does not allow use of the "NCRME" acronym.

g. **Minor Consent to Treat – Legislative Concept 591 (2023)** Inform

Outcome:
OBCE reports that the draft was submitted and approved as a legislative concept for 2023 legislative session.

h. **Board Best Practices Questionnaire** Inform/Action

Outcome:
No action - questionnaires were submitted for incorporation into the Annual Performance Progress Report.

i. **Signature Blocks** Inform/Action

Outcome:
Signature title issues and OBCE jurisdiction. No board action.

9. CORRESPONDENCE

a. None

11:30 AM Working Lunch included

10. WORK SESSION

a. **InLumon Board Portal Review and Training – Board Members** Inform

Outcome: Training received.

The board entered into Executive Session on 9/22.

b. **Education Manual for the Evidenced-Based Practice Manual** Inform/Action

Outcome:
Archival and historic document. Watermark for OBCE archived documents to be added. No posting on website.

Vermillion moved to archive the document as of 9/21/2022; Schmidt, seconds. Alley, aye; Knecht, aye; Baranick, aye; Schmidt, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passed.

11. EXECUTIVE SESSION

12. IN THE MATTERS OF (following Executive Session)

Case # 2020-1020
Proposal: No Statutory Violation
Motion: Taylor moved to accept the proposal; Schmidt, second.
Vote: Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

Case # 2018-1014, 2018-1023, 2018-5016
Proposal: Issues demand for payment by October 31, 2022
Motion: Vermillion moved to accept the proposal; Baranick, second.
Vote: Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

Case # 2020-3003
Proposal: Letter of Concern
Motion: Vermillion moved to accept the proposal; Alley, second.
Vote: Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

Case # 2022-5004
Proposal: Insufficient Evidence
Motion: Vermillion moved to accept the proposal; Schmidt, second.
Vote: Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

Case # 2019-5023
Proposal: Notice of Proposed Discipline for unlicensed practice, $10,000 to be paid within 90 days
Motion: Baranick moved to accept the proposal; Schmidt, second.
Vote: Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

Case # 2021-3003
Proposal: Insufficient Evidence with Letter of Concern
Motion: Waggoner moved to accept the proposal; Schmidt, second.
Vote: Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

Case # 2022-5003
Proposal: No Statutory Violation with Letter of Concern
Motion: Baranick moved to accept the proposal; Vermillion, second.
Vote: Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

Case # 2020-1010
Proposal: Insufficient Evidence
Motion: Schmidt moved to accept the proposal; Baranick, second.
Vote: Alley, aye; Schmidt, aye; Baranick, aye; Taylor, aye; Waggoner, aye; Vermillion, aye. Motion passes.

5:30 PM Adjourn for the Day

Prepared by Mackenzie Purnell, Administrative Specialist 2; 10/31/2022

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.

Executive Staff Report
November 17, 2022 Board meeting

To: Board of Chiropractic Examiners
From: Cass McLeod-Skinner, Executive Director

Board Meeting details: **November 17, 2022**
Virtual via Zoom

2021-23 Budget
As of the close of August, we have an estimated ending cash balance of $622,731.77 which translates to 7.37 months of expenditure reserve.

inLumon Update and Board Material
You should be receiving this material through our inLumon Board Portal, which is one aspect of our full inLumon roll out occurring in the next few weeks. Please let Mackenzie know if you experience any problems.

2023 Board Meeting Dates and Locations

Jan. 18-19 – Retreat – Location TBD, Willamette Valley

March 30 – virtual

May 24-25 – La Grande, Pendleton, or Medford

July 27 - virtual

Sept. 27-28 - Sunriver

Nov. 16 or 30 - virtual

Current Licensee Statistics

Licensee Types	**12/21**	**01/22**	**02/22**	**03/22**	**04/22**	**05/22**	**06/22**	**07/22**	**08/22**	**09/22**	**10/22**	**11/22**
DC - Active	1229	1222	1221	1217	1206	1224	1233	1240	1231	1227	1228	1209
DC - Inactive	219	222	248	252	256	248	255	259	251	252	256	223
DC - Senior	412	413	411	414	423	445	443	442	442	439	442	437
DC - Initial	74	76	78	77	75	71	72	66	62	63	63	66
DC Total	**1934**	**1933**	**1958**	**1960**	**1960**	**1988**	**2003**	**2007**	**1986**	**1981**	**1989**	**1935**
CA - Initial	376	377	395	407	419	434	461	379	397	394	396	394
CA - Renewing	966	973	971	978	982	986	998	917	858	863	858	834
CA Total	**1342**	**1350**	**1366**	**1385**	**1401**	**1420**	**1459**	**1296**	**1255**	**1257**	**1254**	**1228**
TOTAL	**3276**	**3283**	**3324**	**3345**	**3361**	**3408**	**3462**	**3303**	**3241**	**3238**	**3243**	**3163**

***** Includes Senior and Initial DCs.

AGENCY 811 - Board of Chiropractic Examiners

2021-23 Budget to Actuals Summary Report

OPERATING OTHER FUNDS	Legislatively Adopted Budget (LAB)	2021-23 Revenue & Expenditures		Projections	Difference between LAB Budget and Projections
		Actuals as of Month End	% Earned/Spent		
$ 2,146,466.00					
Beginning Balance:					
AY Beginning Balance	$ 395,755	$ 600,248	N/A		N/A
Revenue:					
Revenue less Transfers out	$ 2,006,536	$ 1,391,262	69%	$ 2,821,320	$ (814,784)
Expenditures:					
Personal Services	$ 1,226,396	$ 585,333	48%	$ 1,150,976	$ 75,420
Services and Supplies	$ 947,114	$ 528,403	56%	$ 876,302	$ 70,812
Special Payments	$ -	$ -	0%	$ -	$ -
Total Expenditures	**$ 2,173,510**	**$ 1,113,736**	**51%**	**$ 2,027,278**	**$ 146,232**
Adjust for Accrued Accounts Receivable		$ (171,310)		$ (171,310)	
Net Ending Cash	$ 228,781	$ 706,464		**Net Position** (Projected AY Ending Cash)	$ 794,042 Within Budget

Outstanding AR owed to agy		(171,310.24)
Projected ending cash	$	622,731.77
Working Cap		7.37 Months

BOARD OF CHIROPRACTIC EXAMINERS

Actuals Highlighted

2021-23 CASH FLOW

	2021 JUL Actuals	2021 AUG Actuals	2021 SEP Actuals	2021 OCT Actuals	2021 NOV Actuals	2021 DEC Actuals	2022 JAN Actuals	2022 FEB Actuals	2022 MAR Actuals	2022 APR Actuals	2022 MAY Actuals	2022 JUN Actuals	2022 Mo. 13 Actuals	2022 JUL Actuals	2022 AUG Actuals	2022 SEP Projections	2022 OCT Projections	2022 NOV Projections	2022 DEC Projections	2023 JAN Projections	2023 FEB Projections	2023 MAR Projections	2023 APR Projections	2023 MAY Projections	2023 JUN Projections	2023 Mo. 13 Projections	ACTUALS BIENNIUM TO DATE	ACTUALS + PROJECTIONS	AY23 LAB	PROJECTION TO FIN PLAN (over)/under
Beginning Cash Balance	600,247.54	601,112.36	628,512.60	540,971.91	560,322.31	564,323.56	555,668.18	967,144.61	945,419.15	969,764.56	959,552.95	963,921.66	957,782.57	814,370.58	954,341.31	859,908.30	819,805.86	810,548.03	793,713.14	781,192.46	780,922.26	785,247.38	793,453.06	804,215.23	799,633.50	810,145.83	788,534.71	600,247.54	600,247.54	395,755.00	
REVENUE																					20% Fee Increase									
0205 OTHER BUSINESS LICENSES	2,400.00	975.00	450.00	3,292.00	700.00	1,250.00	3,275.00	1,500.00	1,075.00	1,025.00	1,450.00	2,950.00	25.00	3,450.00	2,075.00	1,726.13	1,726.13	1,726.13	1,726.13	1,726.13	1,726.13	1,726.13	1,726.13	1,726.13	1,726.13	1,726.13		25,892.00	43,153.33	42,775.00	(378.33)
0210 OTHER NONBUSINESS LIC & FEES	57,907.50	75,140.25	65,396.25	70,866.50	60,801.25	61,050.75	79,021.25	55,448.75	75,887.50	66,109.50	72,142.50	76,535.00	10,037.50	56,893.75	80,131.25	72,000.00	72,000.00	72,000.00	72,000.00	86,400.00	86,400.00	86,400.00	86,400.00	86,400.00	86,400.00	86,400.00		963,369.50	1,769,769.50	1,887,274.00	117,504.50
0410 CHARGES FOR SERVICES	10.00	10.00	325.00	5.00	120.00	20.00	200.01	10.00		35.00	15.00	10.00		5.00		63.75	63.75	63.75	63.75	63.75	63.75	63.75	63.75	63.75	63.75	63.75		765.01	1,402.52	2,060.00	657.48
0505 FINES AND FORFEITS	600.00	850.00	100.00	100.00	1,600.00	391,812.50	(3,000.00)	400.00	2,600.00	175.00	100.00	100.00	(143,727.92)	148,576.20	122.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00		400,407.78	407,657.78	86,000.00	(321,657.78)
0705 OTHER SALES INCOME																												-		27.00	27.00
0975 OTHER REVENUE	404.00	466.00	430.00	418.00	366.00	368.00	502.00	358.00	486.00	438.00	452.00	476.00	58.00	358.00	512.00	406.13	406.13	406.13	406.13	406.13	406.13	406.13	406.13	406.13	406.13	406.13		6,092.00	10,153.33		(10,153.33)
TOTAL REVENUE	61,321.50	77,441.25	66,701.25	74,681.50	63,587.25	454,501.25	79,998.26	57,716.75	80,048.50	67,782.50	74,159.50	80,071.00	(133,607.42)	209,282.95	82,840.25	74,921.02	74,721.02	74,921.02	74,921.02	89,321.02	89,321.02	89,321.02	89,321.02	89,321.02	89,321.02	89,321.02		1,396,526.29	2,232,136.47	2,018,136.00	(214,000.47)
REVENUE TRANSFER OUT																														
2443 TRANSFER OUT TO OHA										(5,264.00)														(5,800.00)	-	-		(5,264.00)	(11,064.00)	(11,600.00)	(536.00)
TOTAL TRANSFERS										(5,264.00)														(5,800.00)				(5,264.00)	(11,064.00)	(11,600.00)	(536.00)
AVAILABLE REVENUE	61,321.50	77,441.25	66,701.25	74,681.50	63,587.25	454,501.25	79,998.26	57,716.75	80,048.50	73,046.50	74,159.50	80,071.00	(133,607.42)	209,282.95	82,840.25	74,921.02	74,721.02	74,921.02	74,921.02	89,321.02	89,321.02	89,321.02	89,321.02	95,121.02	89,321.02		1,391,262.29	2,821,320.01	2,402,291.00	(419,029.01)
										Job Rotation Jan, Feb, Mar		Job Rotation Apr, May	Job Rotation June															from PS Projections un ess highlighted		
PERSONAL SERVICES																														
3110 CLASS/UNCLASS SALARY	26,533.60	17,139.54	17,449.77	19,857.61	24,623.77	28,197.24	16,613.46	28,148.28	25,564.90	15,057.23	30,639.48	28,137.08		34,360.98	33,375.08	36,356.12	34,156.12	34,556.12	36,156.12	36,734.02	30,199.61	32,399.61	30,199.61	32,999.61	30,199.61		345,698.02	679,554.61	778,438.00	98,783.39
3160 TEMPORARY APPOINTMENTS				723.93	2,004.10	2,291.60	2,022.00	2,182.08	2,367.43	2,022.00	2,481.24	2,373.36		2,157.60	2,671.20	2,671.20	2,671.20	2,671.20	2,671.20	2,671.20	2,671.20	2,671.20	2,671.20	2,671.20	2,671.20	2,671.20		23,296.54	50,008.54		(50,008.54)
3170 OVERTIME PAYMENTS	2,003.67													1.11		-	-	-	-	-	-	-	-	-	-	-		2,004.78	2,004.78		(2,004.78)
3180 SHIFT DIFFERENTIAL																														463.00
3190 ALL OTHER DIFFERENTIAL	980.10	980.10	235.08	889.19	1,323.55	1,354.22	534.76	7,165.95	1,108.96	346.24	859.57	1,053.40		8,986.93	1,336.20	1,355.26	1,355.26	1,355.26	1,355.26	1,374.15	1,207.43	1,207.43	1,207.43	1,207.43	1,207.43	1,207.43		27,154.25	39,986.58	22,333.00	(17,653.58)
3210 ERB ASSESSMENT	7.20	4.80	7.20	9.60	9.60	9.60	9.60	9.60	9.60	9.60	12.00	12.00		12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00		134.40	254.40	296.00	41.60
3220 PUBLIC EMPLOYES' RETIREMT	5,561.71	3,132.89	1,620.69	2,340.09	3,170.11	3,252.18	1,321.30	4,287.13	3,302.21	2,421.21	4,699.46	5,246.11		7,243.31	6,359.69	6,389.51	6,389.51	6,389.51	6,389.51	6,456.23	5,850.88	5,850.88	5,850.88	5,850.88	5,850.88	5,850.88		53,958.09	115,226.76	133,262.00	18,035.24
3221 PENSION BOND CONTRIBUTION	1,652.96	1,014.69	524.91	757.92	1,026.75	1,053.33	427.93	1,388.54	1,069.54	784.21	1,522.09	1,700.37		2,357.06	2,059.83	2,069.48	2,069.48	2,069.48	2,069.48	2,091.09	1,895.02	1,895.02	1,895.02	1,895.02	1,895.02	1,895.02		17,340.13	37,184.23	42,824.00	5,639.77
3230 SOCIAL SECURITY TAX	2,249.36	1,369.79	1,337.68	1,626.58	2,118.26	2,416.50	1,453.10	2,845.15	2,198.34	1,321.03	2,588.67	2,393.54		3,455.87	2,834.37	3,071.85	2,903.55	2,934.15	3,056.55	3,101.37	2,588.74	2,757.04	2,588.74	2,802.94	2,588.74			30,208.24	58,601.90	61,294.00	2,692.10
3240 UNEMPLOYMENT ASSESSMENT																	-	-	-	-	-	-	-	-	-	-		-			0.00
3250 WORKERS' COMPENSATION	4.99	5.22	4.06	6.43	7.87	8.83	6.15	7.65	8.59	5.88	8.47	8.21		9.59	10.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46		102.40	217.00	235.00	18.00
3260 MASS TRANSIT	177.09	108.71	66.80	131.42	165.28	170.64	108.02	208.12	174.22	100.76	164.63	183.56		256.19	220.66	242.30	229.10	231.50	241.10	244.68	204.47	217.67	204.47	221.27	204.47			2,236.10	4,477.11	4,808.00	330.89
3270 FLEXIBLE BENEFITS	5,246.30	5,246.30	4,159.71	4,965.21	5,897.69	6,155.89	4,744.58	6,987.91	6,987.91	4,402.70	5,881.86	6,851.18		7,836.23	7,836.23	7,836.23	7,836.23	7,836.23	8,093.07	8,093.07	8,093.07	8,093.07	8,093.07	8,093.07	8,093.07	8,093.07		83,199.70	163,359.89	195,939.00	32,579.11
3455 VACANCY SAVINGS																														(13,496.00)
3465 RECONCILIATION ADJUST																														
TOTAL PERSONAL SERVICES	44,416.98	29,002.04	25,405.90	31,307.98	40,346.98	44,910.03	27,240.90	53,230.41	42,791.70	26,470.86	48,857.47	47,958.81		66,676.87	56,715.72	60,015.40	57,633.90	58,066.90	60,055.74	60,789.27	52,733.89	55,115.39	52,733.89	55,764.89	52,733.89		585,332.65	1,150,975.81	1,226,396.00	75,420.19
SERVICES AND SUPPLIES																														
4100 INSTATE TRAVEL		145.65	123.29								227.93	8,547.67		2,418.08	895.53	-	-	200.00	-	-	-	200.00	-	200.00	-	-			12,958.15	24,854.00	11,895.85
4125 OUT-OF-STATE TRAVEL			776.16	165.56					801.17	748.24	617.20	1,071.12		597.27	1,076.70	-	-	-	-	-	-	-	-	-	-	-		5,853.42	5,853.42	9,215.00	3,361.58
4150 EMPLOYEE TRAINING		660.00	2,190.59	(590.00)			2,027.00	600.00	371.40	1,044.00	751.75				987.95	-	-	1,427.00	-	427.00	-	-	-	-	-	-		8,042.69	9,896.69	5,504.00	(4,392.69)
4175 OFFICE EXPENSES		44.00	403.80	435.28	669.00	1,151.94	503.43	867.88	866.74	808.39	599.54	212.00	620.39	567.10	1,974.74	1,095.35	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39		9,724.23	17,283.48	28,033.00	10,749.52
4200 TELECOMM/TECH SVC & SUPP	408.10	348.75	1,128.08	1,195.97	688.65	809.70	669.83	1,087.45	722.21	1,103.93	778.79	968.74	487.46	46.42	338.85	2,064.05	812.17	1,063.53	812.17	812.17	1,063.53	812.17	812.17	1,063.53	812.17	812.17		10,782.93	21,722.76	16,729.00	(4,993.76)
4225 STATE GOVERNMT SRVC CHRGS	0.10	166.45	45,835.98	0.10	866.23		0.10	863.55	0.10	18,384.23	0.10				866.23	66.00	66.00	932.13	66.00	66.00	932.13	66.00	66.00	932.13	66.00	66.00		66,983.17	70,307.56	96,342.00	26,034.44
4250 DATA PROCESSING	398.00	54.98	545.97	862.12	647.86	1,985.36	168.04	449.49	74.95	2,000.27	268.59	724.38	86.81	183.18	258.58	1,570.00	1,199.00	479.00	1,325.00	989.00	479.00	479.00	479.00	479.00	653.00	479.00		8,708.58	17,318.58	4,505.00	(12,813.58)
4275 PUBLICITY & PUBLICATIONS				30.00			78.83	565.00	33.00		528.12	696.00	468.00	53.00		100.83	-	408.24	-	200.00	408.24	-	-	408.24	-	-		2,441.95	3,967.49	3,647.00	(320.49)
4300 PROFESSIONAL SERVICES	92.41	6,117.50	20.60	714.90	319.00	4,459.80			2,769.35	53.70	20.60	264.79	20.60	1,576.80	4,257.50	5,058.71	956.43	4,257.68	956.43	956.43	4,257.68	956.43	956.43	4,257.68	956.43	956.43		20,697.55	45,224.31	67,187.00	21,962.69
4315 IT PROFESSIONAL SERVICES	2,573.13		536.00	487.00	457.00	7,444.50	399.00	434.00	366.00	380.00	450.00	466.00			25,467.75	6,340.14	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71		39,460.38	100,267.67	62,955.00	(37,312.67)
4325 ATTORNEY GENERAL LEGAL FEES		7,330.40	7,647.20	12,314.49	6,277.69		25,696.00	7,367.80		12,049.40	3,152.60	10,122.60	3,949.00		7,178.65	17,645.64	8,822.82	8,822.82	8,822.82	8,822.82	8,822.82	8,822.82	8,822.82	8,822.82	8,822.82	8,822.82	8,822.82		103,085.83	208,959.70	266,997.00	58,037.30
4375 EMPLOYEE RECRUITMENT & DEV																-	-	-	-	-	-	-	-	-	-	-		-		1,072.00	1,072.00
4400 DUES AND SUBSCRIPTIONS			117.20			678.00	1,800.00		65.00	175.00		(0.27)				357.69	357.69	357.69	1,057.69	2,157.69	357.69	532.69	357.69	357.69	357.69	357.69		2,834.93	9,444.50	5,499.00	(3,945.50)
4425 FACILITIES RENT & TAXES	12,567.96	4,189.32		4,189.32	4,705.30		4,189.32	8,453.15	5,789.35	4,213.83	4,213.83	4,213.83			4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,289.68	4,289.68			60,939.04	103,229.04	110,602.00	7,372.96
4575 AGY PROG RELATED SVCS & SUPP			3,466.50	2,517.25	2,854.25		3,429.00	2,504.00		3,270.50	2,464.25	3,394.80	2,457.75	(2,457.75)	4,743.75	4,220.28	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14		28,644.30	53,966.01	21,003.00	(32,963.01)
4650 OTHER SERVICES AND SUPPLIES		1,354.04	66,044.67	1,701.13	1,754.04	1,651.32	1,619.33	2,583.88	1,052.12	2,027.76	5,672.04	1,573.11	1,714.56	(348.75)	67,981.28	11,656.98	1,295.22	2,705.30	1,310.22	1,295.22	2,705.30	1,295.22	1,295.22	2,705.30	1,295.22	1,295.22		156,380.53	185,234.95	212,666.00	27,431.05
4700 EXPENDABLE PROPERTY							90.74									-	-	-	-	-	-	-	-	-	-	-		90.74	90.74	4,835.00	4,744.26
4715 IT EXPENDABLE PROPERTY		627.88				65.98	610.31	435.60			1,187.98	499.21			306.20	618.55	618.55	618.55	618.55	558.54	618.55	618.55	618.55	618.55	618.55	618.55		3,733.16	10,577.15	5,469.00	(5,108.15)
TOTAL SERVICES & SUPPLIES	16,039.70	21,038.97	128,836.04	24,023.12	19,239.02	18,246.60	41,280.93	26,211.80	12,911.39	46,259.25	20,333.32	32,743.98	9,804.57	2,635.35	120,557.54	55,008.05	26,544.95	33,689.01	27,385.95	28,801.94	32,262.01	25,999.95	25,824.95	32,337.86	26,074.80	21,611.12		528,403.43	876,302.19	947,114.00	70,811.81
CAPITAL OUTLAY																														
5150 OTHER CAPITAL OUTLAY												5,507.30																5,507.30		
Total Capital Outlay												5,507.30																5,507.30		
SPECIAL PAYMENTS																														
6055 DIST TO CONTRACT SVC PROVIDER																														-
TOTAL SPECIAL PAYMENTS																														
TOTAL EXPENDITURES	60,456.68	50,041.01	154,241.94	55,331.10	59,586.00	63,156.63	68,521.83	79,442.21	55,703.09	72,730.11	69,790.79	80,702.79	9,804.57	69,312.22	177,273.26	115,023.45	84,178.85	91,755.91	87,441.69	89,591.21	84,995.90	81,115.34	78,558.84	88,102.75	78,808.63	21,611.12	1,113,736.08	2,027,278.00	2,173,510.00	146,232.00
Ending Balance	601,112.36	628,512.60	540,971.91	560,322.31	564,323.56	555,668.18	967,144.61	945,419.15	969,764.56	959,552.95	963,921.66	957,782.57	814,370.58	954,341.31	859,908.30	819,805.86	810,548.03	793,713.14	781,192.46	780,922.26	785,247.38	793,453.06	804,215.23	799,633.50	810,145.83	788,534.71	877,773.75	794,042.01	228,781.00	
Unpaid Invoices Billed (89s Contro ler GL0501 F4150)							(381 244.12)	(359 333.28)	(358 531.28)	(227 062.55)	(207 729.28)	(215 104.57)	(219 837.85)	(171 310.24)	(168 123.53)												(171 310.24)	(171 310.24)		
Cash Available for Expenditure	601,112.36	628,512.60	540,971.91	560,322.31	564,323.56	555,668.18	585,900.49	586,085.87	611,233.28	732,490.40	756,192.38	742,678.00	594,532.73	783,031.07	691,784.77	819,805.86	810,548.03	793,713.14	781,192.46	780,922.26	785,247.38	793,453.06	804,215.23	799,633.50	810,145.83	788,534.71		622,731.77	228,781.00	

62s																													93,005.69	Average Monthly Revenue
APPN #: 30000																													84,469.92	Average Monthly Expend tures
Beginning Cash Balance	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	253,409.75	Working Capital (3 months)
Cash Revenue + Transfer In	61,321.50	138,762.75	205,464.00	280,145.50	343,732.75	415,421.50	514,165.70	576,615.73	657,466.23	876,050.73	950,210.23	1,030,281.23	1,030,281.23	1,101,223.48	1,184,063.73														7.37	Ending Cash Balance -
Accrued Revenue					-	382,812.50	364,066.56	359,333.28	358,531.28	207,729.28	207,729.28	207,729.28	212,462.56	212,462.56	212,462.56															# of Months of Expenditures to cover for AY:
Cash Expenditures (-) + Transfer Out	(53,062.13)	(100,012.02)	(264,205.53)	(320,070.73)	(378,727.83)	(428,891.29)	(527,936.60)	(590,160.67)	(640,652.60)	(743,375.87)	(801,513.79)	(887,303.41)	(887,303.41)	(961,839.49)	(1,112,204.21)															
Accrued Expenditures (-)	(7,394.55)	(10,485.67)	(534.10)		(928.90)	(13,922.07)	(576.15)	(616.73)	(5,827.89)	(432.00)	(1,028.57)	(547.36)	(749.33)	(5,128.07)	(28,849.90)															
Red of exp							17,177.56	-		19,333.27	8,276.97	7,375.29	7,375.29	7,375.29	4,188.58															
	601,112.36	628,512.60	540,971.91	560,322.31	564,323.56	955,668.18	967,144.61	945,419.15	969,764.56	959,552.95	963,921.66	957,782.57	962,313.88	954,341.31	859,908.30	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54			
Cash Flow Ending Cash Balance	601 112.36	628 512.60	540 971.91	560 322.31	564 323.56	955 668.18	967 144.61	945 419.15	969 764.56	959 552.95	963 921.66	957 782.57	814 370.58	954 341.31	859 908.30	819 805.86	810 548.03	793 713.14	781 192.46	780 922.26	785 247.38	793 453.06	804 215.23	799 633.50	810 145.83	788 534.71				
Difference													147,943.30			(219,558.32)	(210,300.49)	(193,465.60)	(180,944.92)	(180,674.72)	(184,999.84)	(193,205.52)	(203,967.69)	(199,385.36)	(209,858.29)	(188,287.17)				
		Q1			Q2			QTR 3			QTR 4				QTR 5			QTR 6			QTR 7			QTR 8						

811-010-0045
Chiropractic Students

(1) ~~Senior interns~~ Students in a CCE accredited chiropractic institution may obtain clinic instruction hours at a licensee's office while under the immediate on-site supervision of a licensed chiropractic physician, upon written notification by the institution's clinic administrator to the Board.

(2) ~~Interns~~ Students shall ~~wear name badges identifying them as senior interns and shall~~ not ~~use~~represent themselves, nor allow others to represent them, ~~the title~~as "Doctor~~.~~" in any written, verbal, or digital format.

(3) ~~A student who has completed a course in physiological therapeutics from an approved institution may apply for chiropractic assistant certification without the necessity of first having to complete the training program as outlined in OAR 811-010-0110(2)(a).~~ In lieu of chiropractic assistant initial training and the NBCE chiropractic assistant examination, official transcripts shall be sent to the OBCE showing a passing grade of physiological therapeutic coursework from an approved institution.

(a) Application procedure shall be pursuant to OAR 811-010-0110.

(b) Students working~~employed~~ as certified chiropractic assistants shall~~must~~ comply with OAR 811-010-0110.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.020 & 648.150

811-010-0093
Guide to Policy and Practice Questions

The Board's Guide to Policy and Practice Questions, originally dated January 14, 1998, and last revised ~~September~~ February 22~~17~~, 202~~1~~1, is hereby adopted.

[Publications: Publications referenced are available from the agency.]

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.150 & 684.155

811-010-0110
Chiropractic Assistants

(1) The certification period for chiropractic assistants in Oregon is a period equal to 12 months, expiring on the last day of the chiropractic assistant's birth month/renewal date.

(2) Chiropractic assistants may be certified upon compliance with the following:

(a) The chiropractic assistant applicant shall successfully complete a Board approved training course. The initial training course shall be at least twelve hours in length, of which eight hours shall be didactic training and four hours shall be practical training.

(A) The practical training must be in physiotherapy, electrotherapy and hydrotherapy administered by a health care provider licensed to independently provide those therapies.

(B) A chiropractic physician may perform the initial practical training provided this is direct contact time.

(C) The initial training must ~~have been~~be completed within 60 days preceding the application submission date.

(b) The applicant shall complete an application packet~~,~~ and an open book examination administered by the~~a n~~National Board of Chiropractic Examiners (NBCE)~~testing agency~~.

~~(c)~~(c) If an applicant has a certificate or license from another state and adequate documentation of training, the Board may waive the requirement for the initial training course.

(3) ~~Prior to initial certification, the training course verification form, completed application packet, passing examination results, and~~For approval of initial certification, the following fees shall be submitted ~~to the Board~~:

(a) A non-refundable examination fee to be paid to the NBCE; and

(b~~a~~) A non-refundable application fee and an initial certification fee to be paid to the OBCE.~~;~~

(A) A refund of the certification fee will only be allowed when requested within 60 days of the initial application review date.

(B) In circumstances beyond the applicant's control, the Board may determine to refund the fees or portion thereof.~~(b) A non-refundable examination fee; and~~

~~(c) An initial certification fee. A refund of the certification fee will only be allowed when requested within 60 days of the initial application.~~

~~(d) In circumstances beyond the applicant's control the Board may determine to refund the fees or portion thereof.~~

~~(e) In the event the Board requires the NBCE chiropractic assistant examination in lieu of the Board's examination, the fee in subsection (b) will be waived.~~

(4) Applications will not be fully processed until determined complete by the OBCE.

(a) The Board shall maintain an incomplete application ~~file~~ for six months from the date the application was ~~received~~reviewed; afterward, applicants will need to re-apply.

(b) Passing NBCE examination scores are valid for one year from the date the initial application was reviewed, not from the date the application was received.

(5) A certificate holder must be at least~~The applicant shall be at least~~ 18 years of age.

(6) ~~The~~ A chiropractic assistant shall not perform direct patient care ~~electrotherapy, hydrotherapy, or physiotherapy~~ until they are certified by ~~receive a certificate from~~ the Board.

(7) A chiropractic assistant shall be directly supervised by ~~the~~ a licensed chiropractic physician at all times. The supervising licensed chiropractic physician must be on the premises.

(8) ~~Only under the direct supervision of the licensed chiropractic physician~~ Supervised ~~the~~ chiropractic assistants may ~~;~~

~~(a) may~~ perform or provide physiotherapy, electrotherapy and hydrotherapy, the taking of vitals such as height, weight, blood pressure, temperature, pulse, respiration and/or body fat percentages, and other duties as described by the Board.~~;~~ ~~and~~

(9~~b~~) Chiropractic assistants may not perform or provide physical examinations, take~~ing~~ initial histories, ~~taking X-rays (unless properly licensed),~~ interpret~~ation of~~ postural screening, perform~~ing~~ manual muscle testing, or osseous adjustments or manipulations, or other tasks as prohibited by the Board.

(10) Chiropractic assistants must be licensed by the Oregon Board of Medical Imaging to perform x-rays.

(11~~9~~) Chiropractic assistants ~~shall~~ shall report to the Board using the online system, ~~in writing,~~ their mailing address and place of employment. Notification of a change of mailing address or place of employment must be made within 3~~1~~0 days of the change.

(12~~0~~) At least 30 days prior to the renewal date, the Board shall send the renewal notice to the chiropractic assistant at the last known mailing address~~,~~ and/or email address.

(13~~1~~) On or before the last day of the birth month, the chiropractic assistant shall submit to the Board the following:

(a) An attestation that the six hours of continuing education has been completed within the immediate 12 months prior to renewal date;

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

(c~~a~~) A completed renewal application and renewal fee.~~;~~

(A) The renewal application may include a request for fingerprinting and a criminal background check with fees to be paid ~~by the chiropractic assistant~~to the OBCE.

(B) Frequency of fingerprinting and criminal background checks will be determined by the Board.

~~(b) An attestation that the six hours of continuing education has been completed within the immediate 12 months prior to renewal date; and~~

~~(c) A completed OHA Healthcare Workforce Questionnaire; and~~

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

(142) Chiropractic assistants have a~~During the~~ 30-day grace period immediately following the renewal date, during which the chiropractic assistant may continue to perform assigned duties, but must submit a completed renewal application, proof of continuing education, and payment of the renewal fee plus a delinquent fee.

(153) After the 30-day grace period, the chiropractic assistant shall not perform assigned duties until the renewal application, proof of continuing education, payment to the Board of the renewal fee and a delinquent fee are all submitted to the Board and approved.

(164) A chiropractic assistant has up to one year following their renewal date to renew and reinstate their certificate upon meeting the provisions of (142) and (153) above. After 12 months, a person ~~must~~ shall reapply~~start the application process~~.

(175) Continuing education programs may be comprised of subjects that are pertinent to clinical practices of chiropractic. Continuing education must meet the criteria outlined in OAR 811-015-0025 ~~sections (8), (9) and (10)~~. No continuing education hours may be carried over into the next renewal year. Evidence of successful completion of six hours of continuing education during the 12 months preceding the renewal ~~must~~ shall be submitted upon request by the Board.

~~(16) The chiropractic assistant's certificate may be displayed in the chiropractic physician's office during the chiropractic assistant's employment, but is not required so long as the certificate is on file with the chiropractic physician's office.~~

(187) The Board may refuse to grant a certificate to any applicant, may suspend or revoke a certificate, or may impose upon an applicant for certification or chiropractic assistant a civil penalty not to exceed $10,000 ~~upon finding of any of the following.:~~

~~(a) Cause, which is defined as, but not limited to, failure to follow directions, unprofessional or dishonorable conduct, injuring a patient, or unlawful disclosure of patient information. The supervising chiropractic physician is required to notify the Board, in writing, of any dismissal of a chiropractic assistant for cause within ten days. The Board shall determine if there is cause for action and shall be governed by the rules of the Board adopted pursuant to ORS Chapter 183;~~

~~(b) Conviction of a misdemeanor involving moral turpitude or a felony;~~

~~(c) Non-disclosure of misdemeanor or felony convictions; or~~

~~(d) Failure to notify the Board of a change of location of employment as required by these rules.~~

(1918) Certified chiropractic assistants must not engage in ~~U~~unprofessional conduct as ~~or dishonorable conduct is~~ defined in OAR 811-035-0015 in its entirety. ~~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:~~

~~(a) Conduct that is prohibited as described in OAR 811-035-0019 Sexual Unprofessional or Dishonorable Conduct.~~

~~(b) Use of protected or privileged information obtained from the patient to the detriment of the patient.~~

~~(c) Violating section (8) of this rule;~~

~~(d) Charging a patient for services not rendered;~~

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

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

~~(g) Soliciting or borrowing money from patients;~~

~~(h) Receiving a conviction of a crime for 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;~~

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

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

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

~~(l) Using any controlled or illegal substance or intoxicating liquor to the extent that such use impacts the ability to safely conduct the assigned duties of a chiropractic assistant;~~

~~(m) Acting as a chiropractic assistant without a current Oregon certificate;~~

~~(n) Allowing another person to use one's chiropractic assistant certification for any purpose;~~

~~(o) Resorting to fraud, misrepresentation, or deceit in applying for or taking the certificate examination or obtaining a certificate or renewal thereof;~~

~~(p) Impersonating any applicant or acting as a proxy for the applicant in any chiropractic assistant certificate examination;~~

~~(q) Disclosing the contents of the certificate examination or soliciting, accepting, or compiling information regarding the contents of the examination before, during, or after its administration;~~

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

~~(s) 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;~~

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

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

~~(v) Disobeying a final order of the Board;~~

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

~~(x) Receiving a suspension or revocation of a certificate for a chiropractic assistant, or other license or certificate by any state based upon acts by the chiropractic assistant or applicant that describes acts similar to this section. A certified copy of the record of suspension or revocation of the state making that is conclusive evidence thereof.~~

~~(y) During a declared emergency, unprofessional conduct includes failing to comply with any applicable provision of a Governor's Executive Order or any provision of this rule.~~

~~(A) Failing to comply as described in subsection (y) includes, but is not limited to:~~

~~(i) Operating a chiropractic entity required to be closed by a current Executive Order;~~

~~(ii) Providing chiropractic services at a business required to be closed by a current Executive Order;~~

~~(iii) Failing to comply with applicable Oregon Health Authority (OHA) guidance implementing a current Executive Order; and~~

~~(iv) Failing to comply with any OBCE guidance or rule implementing an Executive Order.~~

~~(B) No disciplinary action or penalty action shall be taken under this rule if the Executive Order alleged to have been violated is not in effect at the time of the alleged violation.~~

(20~~19~~) Violations committed by a certified chiropractic assistant may be grounds for disciplinary action against the supervising chiropractic physician under ORS 684.100.~~(9)~~

Statutory/Other Authority: ORS 684.155
Statutes/Other Implemented: ORS 684.054 & 684.155(c)(A)

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 and certified chiropractic assistants:

(1) Conduct that is prohibited as described in OAR 811-035-0019 Sexual Unprofessional or Dishonorable Conduct;

(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) Receiving a conviction of a crime for 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 or performing the duties of a certified chiropractic assistant;

(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 or performing the duties of a certified chiropractic assistant;

(14) Practicing chiropractic or performing the duties of a certified chiropractic assistant without a current Oregon license or certificate;

(15) Allowing another person to use one's chiropractic license or certificate 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 keep complete, accurate, and minimally competent records on all patients;

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

(21) 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;

(22) Failing to answer truthfully and completely 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;

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

(24) Failing to provide and maintain a safe and sanitary treatment environment;

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

(26) Disobeying a final order of the Board;

(27) During a declared emergency, unprofessional conduct includes failing to comply with any applicable provision of a Governor's Executive Order or any provision of this rule.

(a) Failing to comply as described in subsection (27) includes, but is not limited to:

(A) Operating a chiropractic entity required to be closed by a current Executive Order;

(B) Providing chiropractic services at a business required to be closed by a current Executive Order;

(C) Failing to comply with applicable Oregon Health Authority (OHA) guidance implementing a current Executive Order; and

(D) Failing to comply with any OBCE guidance or rule implementing an Executive Order.

(b) No disciplinary action or penalty action shall be taken under this rule if the Executive Order alleged to have been violated is not in effect at the time of the alleged violation.

(28) Failing to comply with Oregon Health Authority's (OHA) applicable rules;

(29) Failing to comply with Oregon Occupational Safety and Health Administration's (OSHA) applicable rules;

(30) Fee splitting means compensation by or to a chiropractic physician or chiropractic clinic solely for referral of a patient.

(a) Chiropractic physicians may not refer patients based on whether the referring chiropractic physician has negotiated a discount for specialty services. Chiropractic physicians may not accept:

(A) Any compensation of any kind, from any source for referring a patient other than distributions of a health care organization's revenues as permitted by law.

(B) Compensation for services relating to the care of a patient from any health care facility/organization to which the physician has referred the patient.

(C) Compensation for referring a patient to a research study with the exception of remuneration for administrative costs.

(b) Compensation is defined as something given or received as payment including but not limited to: bartering, tips, money, donations, goods, or services.

(31) 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;

(32) 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

(33) 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

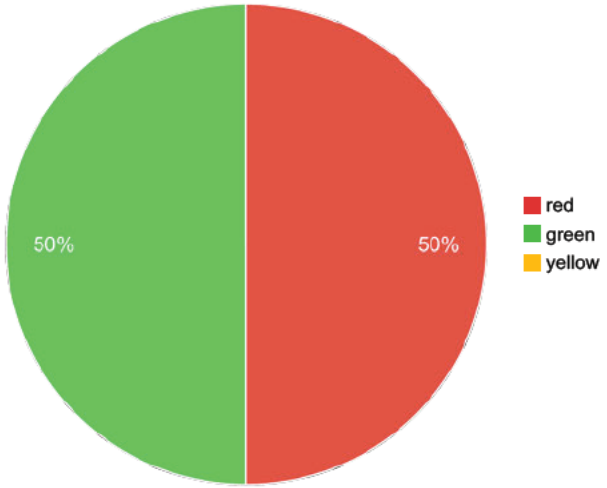
Chiropractic Examiners, Board of

Annual Performance Progress Repor

Repor ing Year 2022

Published 10/5/2022 9 51 14 AM

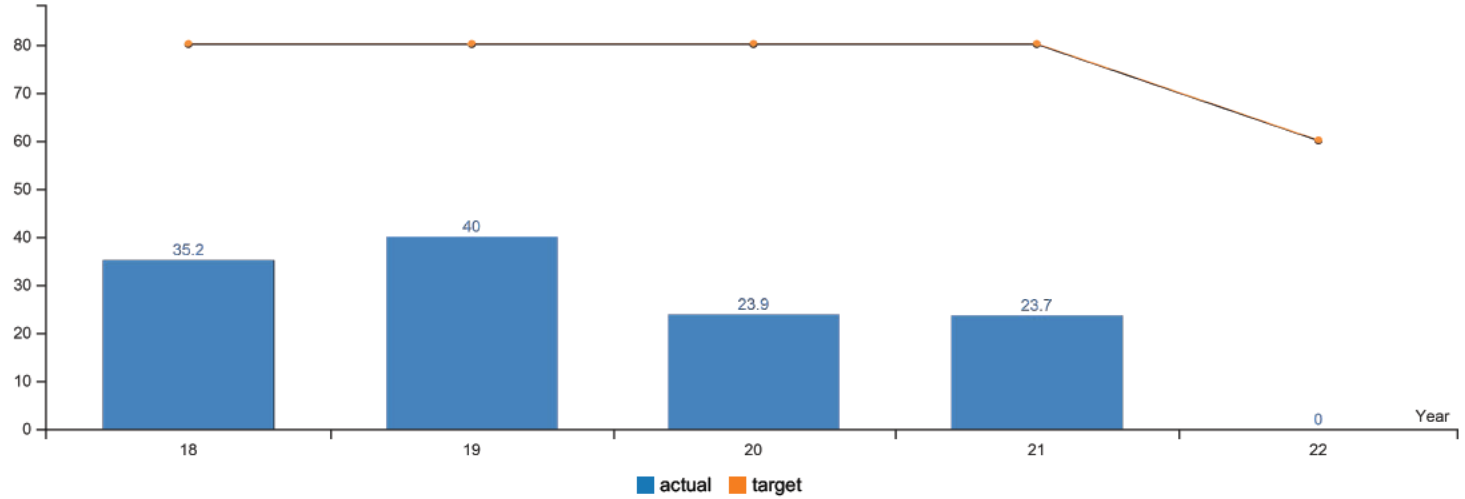
KPM #	Approved Key Performance Measures (KPMs)
1	Days be ween complain receip and inves iga ion repor finalized for Board (inves iga ive process s ep one) - Percen of cases having inves iga ive repor s wri en wi hin 120 days from when a complain is received o when he inves iga ion is prepared for Board review/ac ion
2	Days be ween inves iga ion repor finalized and presen a ion o he Board (inves iga ive process s ep wo) - Percen of cases wi h a prepared inves iga ion ha is ready for Board review/ac ion ha are presen ed o he Board wi hin 60 days of comple ion
3	Summary of inves iga ive s eps Percen age of new complain s ha are assessed inves iga ed and presen ed o he board for an ini ial decision wi hin 120 days -
4	Days be ween Board review/ini ial ac ion and case closure (inves iga ive process s ep hree) - Percen of cases closed wi hin 90 days of Board review/ini ial ac ion
5	Summary of inves iga ive s eps Average number of days o resolve a complain -
6	Percen of sexual misconduc /boundary complain s resolved in 180 days -
7	Percen age of chiroprac ic physicians mee ing he annual con inuing educa ion requiremen s -
8	Percen age of licenses issued wi hin 5 days once all applica ion componen s (ha are he responsibili y of he applican) have been received -
9	Cus omer Service - Percen of cus omers ra ing heir sa isfac ion wi h he agency's cus omer service as "good" or "excellen " overall cus omer service imeliness accuracy helpfulness exper ise and availabili y of informa ion
10	Board Bes Prac ices - Percen of o al bes prac ices me by he Board



Performance Summary	Green	Yellow	Red
	= Targe o -5%	= Targe -5% o -15%	= Targe > -15%
Summary Stats:	50%	0%	50%

KPM #1	Days between comp a nt rece pt and nvest gat on report f na zed for Board (nvest gat ve process step one) - Percent of cases hav ng nvest gat ve reports wr tten w th n 120 days from when a comp a nt s rece ved to when the nvest gat on s prepared for Board rev ew/act on.
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend positive result*



Report Year	2018	2019	2020	2021	2022
Complaint receipt to investigation preparation to Board.					
Actua	35.20%	40%	23.90%	23.70%	0%
Target	80%	80%	80%	80%	60%

How Are We Doing

In our ast report ng per od, of the 38 comp a nts rece ved, 29 of them (76.3%) nc uded nvest gator's reports that were subm tted n excess of 129 days from comp a nt rece ved. The average days from rece pt to nvest gator's report for hte 38 cases was 219.4 days/case. For the other cases (23.7%), the average days from rece pt to nvest gator's report was 89.9 days/case.

The OBCE d d not meet th s target for th s report ng per od. None of the 15 cases that nc uded an nvest gator's report for board rev ew were subm tted under the 120 days target t me ne. The average days from rece pt to nvest gator's report was 456 days.

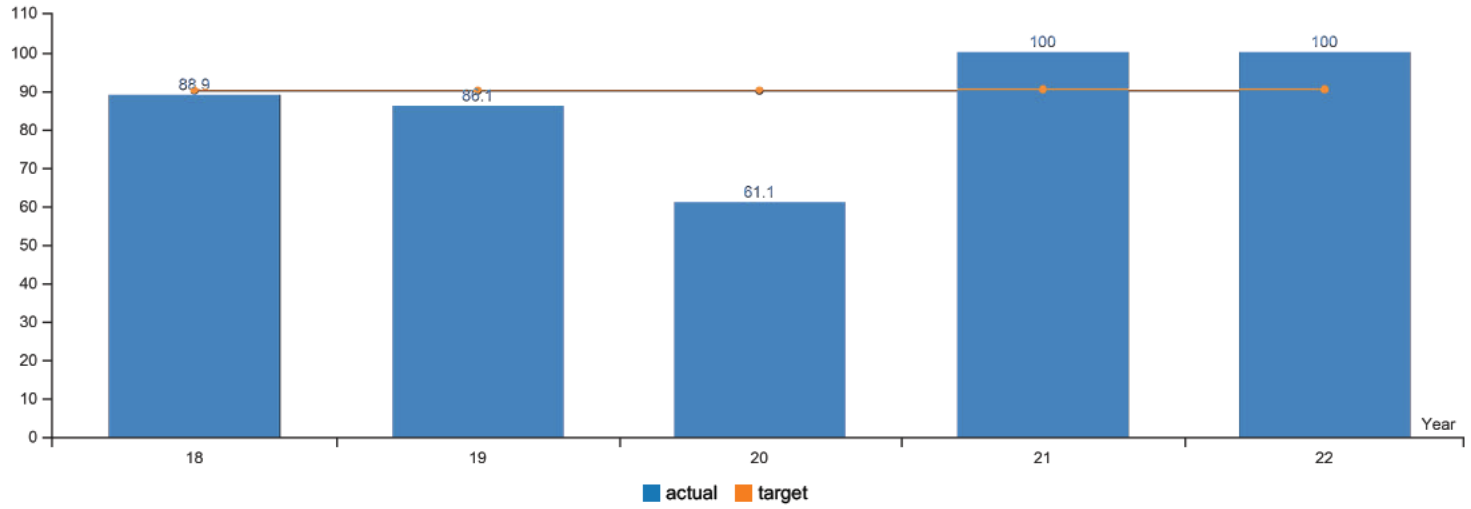
2 of these cases resu ted n cense revocat on and 2 other cases resu ted n den a of app cat ons.

Factors Affecting Results

The ower number of cases be ng fu y nvest gated and wr tten up, and n a onger t me span than prev ous years, s a comp ete y ant c pated outcome of hav ng no nvest gator on staff for over a year and the ret rement of our hea thcare nvest gator w th no rep acement be ng h red for approx mate y 9 months. We are now fu y staffed and ant c pate an appropr ate upt ck n nvest gat ons be ng comp eted and to the board n a gnment w th our KPM.

KPM #2	Days between nvest gat on report f na zed and presentat on to the Board (nvest gat ve process step two) - Percent of cases, w th a prepared nvest gat on that s ready for Board rev ew/act on, that are presented to the Board w th n 60 days of comp et on.
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend positive result*



Report Year	2018	2019	2020	2021	2022
Days between investigation preparation and presentation to the Board.					
Actua	88.90%	86.10%	61.10%	100%	100%
Target	90%	90%	90%	90%	90%

How Are We Doing

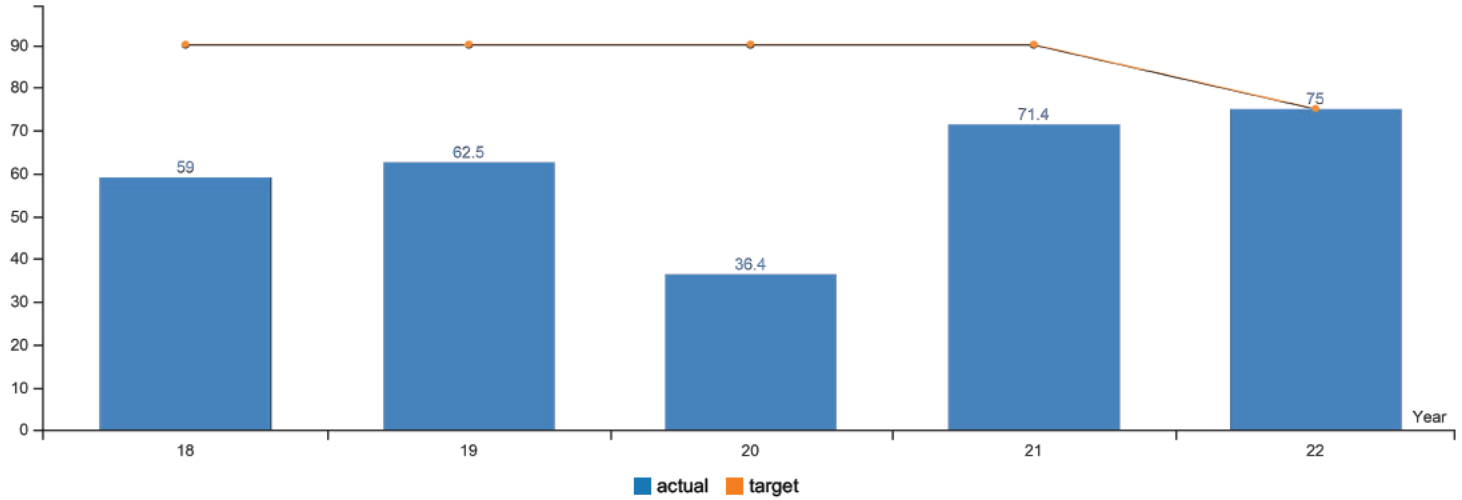
The 2021 Leg s at ve sess on brought a change to th s KPM, a ow ng 60 days nstead of the or g na 30 days, for prepared nvest gat ons to be presented to the Board due to our agency board meet ngs occur ng every other month.

W th that change, we have exceeded our target w th 100% of our cases (15/15) be ng presented w th n 60 days. Even at the or g na 30 day target, we wou d have exceeded that target at 93.3% of our cases (14/15) be ng presented w th n 30 days.

Factors Affecting Results

KPM #3	Summary of nvest gat ve steps: Percentage of new comp a nts that are assessed, nvest gated, and presented to the board for an n t a dec s on w th n 120 days. -
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend positive result*



Report Year	2018	2019	2020	2021	2022
Percentage of complaints/investigations presented to the Board within 120 days					
Actua	59%	62.50%	36.40%	71.40%	75%
Target	90%	90%	90%	90%	75%

How Are We Doing

We have met th s KPM th s report ng per od at 75%, w th 4 new cases, 3 of wh ch reported to the board at ess than 120 days. On y 1 case (25%) went before the board n over 120 days.

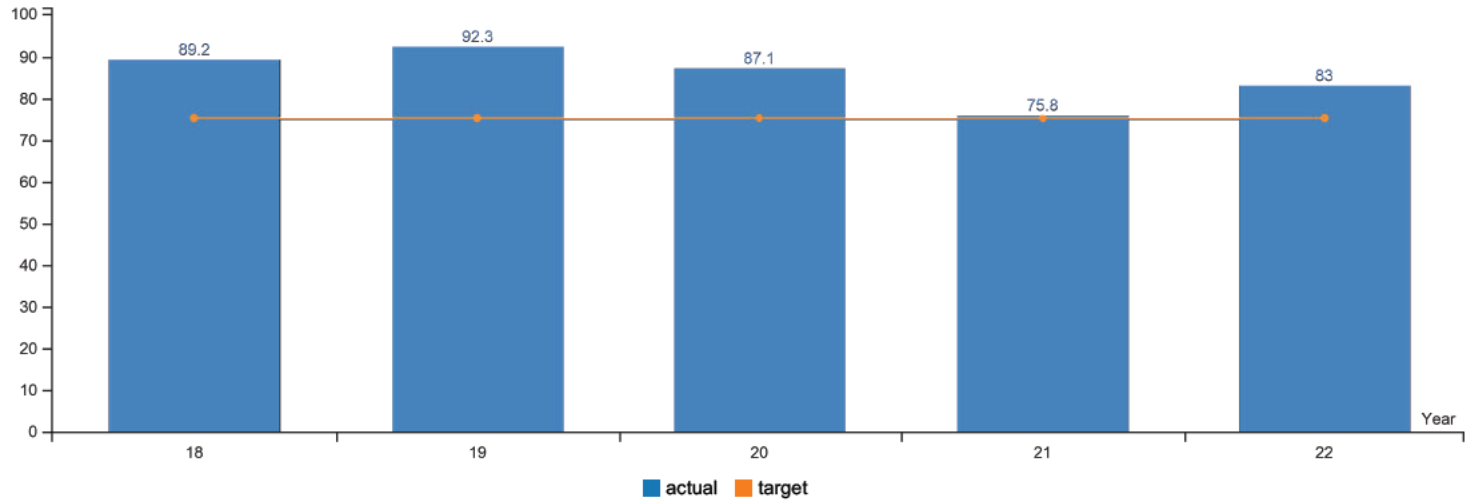
Factors Affecting Results

In 2021, we had a 68% decrease n new comp a nts be ng presented to the board dur ng that report ng per od over 2020. There was an even greater decrease n cases presented to the board th s year, however we were successfu n meet ng our KPM target.

These resu ts were abso ute y expected due to our ack of nvest gat on staff dur ng much of the ast two report ng per ods. We are now fu y staffed and ant c pate an appropr ate upt ck n nvest gat ons be ng comp eted and to the board n a gnment w th our KPMs.

KPM #4	Days between Board rev ew/ n t a act on and case c osure (nvest gat ve process step three). - Percent of cases c osed w th n 90 days of Board rev ew/ n t a act on.
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend positive result*



Report Year	2018	2019	2020	2021	2022
Days between Board review/initial action and case closure.					
Actua	89.20%	92.30%	87.10%	75.80%	83%
Target	75%	75%	75%	75%	75%

How Are We Doing

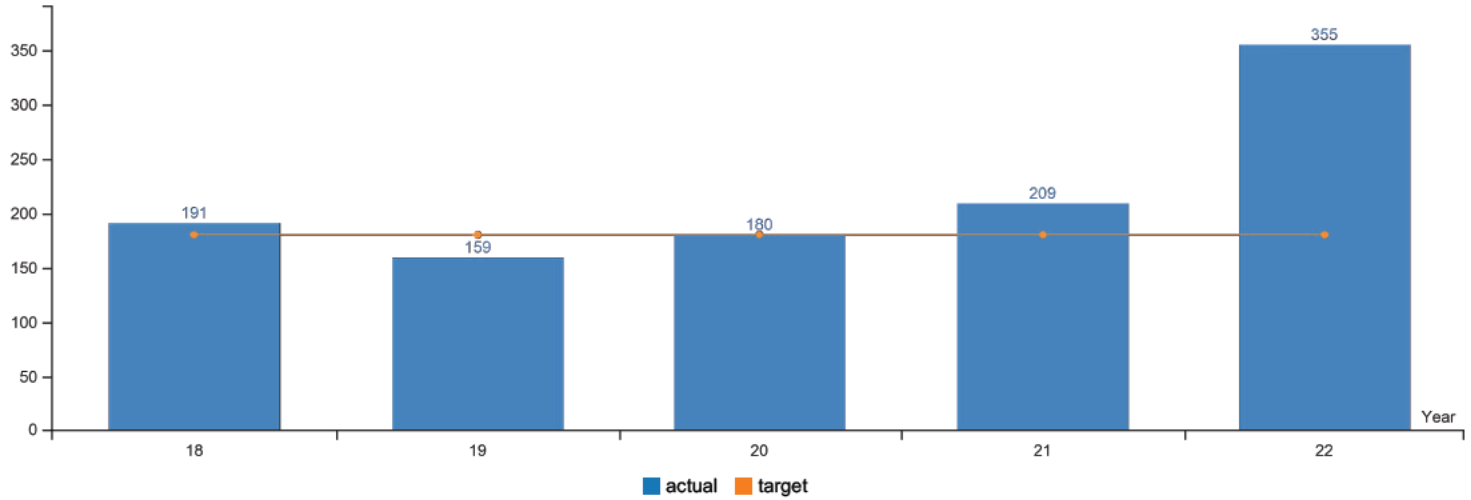
We have met the target of th s KPM (83%) for th s report ng per od. Of the 12 cases c osed, 10 of them c osed w th n 90 days after n t a board rev ew. 2 cases (17%) exceeded the 90 day target, a of wh ch resu ted n e ther d sc p nary act on or cense app cat on den a . These out y ng cases had an average of 106 days/case between n t a board rev ew and case c osure.

Factors Affecting Results

Wh e we have met th s KPM, we had been prev ous y understaffed for most, f not a , of the prev ous two report ng per ods. We are now fu y staffed and ant c pate a greater number of cases and nvest gat ons be ng comp eted and c osed w th n th s KPM's 90 day target.

KPM #5	Summary of nvest gat ve steps: Average number of days to reso ve a comp a nt. -
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend negative result*



Report Year	2018	2019	2020	2021	2022
Average number of days to resolve a complaint.					
Actua	191	159	180	209	355
Target	180	180	180	180	180

How Are We Doing

The average number of days to reso ve a comp a nt for our ast report ng per od (2021) was 209. 74 cases were c osed dur ng th s report ng per od w th 29 cases c os ng over the 180 day target. Of these 29 cases, 22 of our Oregon censed DCs were nvo ved (1.1% of tota 1924 censed DCs as of 9/1/2021). The 29 cases were open for an average of 437 days.

4 Oregon censed DCs (.2% of censee base) were respons b e for 11/298 cases (38%) that ran over hte 180 day target. These 11 cases were open for an average of 583 days. One DC was respons b e for the three ongest runn ng cases, wh ch had been appea ed to the Oregon Court of Appea s. The appe ate court uphe d the agency's F na Order. In contrast, the rema n ng 45 cases (60.8%) were open for an average of 62.6 days/case - an average we be ow our target of 180 days and be ow our average for th s category for the ast 3 report ng per ods.

For our current report ng per od, we have not met our target, w th the average number of days to reso ve a comp a nt be ng 355. 28 cases were c osed dur ng th s report ng per od w th 23 cases c os ng over the 180 day target. Of these 23 cases, 18 Oregon censed DCs were nvo ved (0.9% of tota 1981 censed DCs as of 9/1/2022). The 23 cases were open for an average of 413 days.

2 DCs (0.1% of censee base) were respons b e for 5 cases (17.8%), wh ch were open an average of 409 days and wh ch resu ted n cense revocat on and c v pena tes.

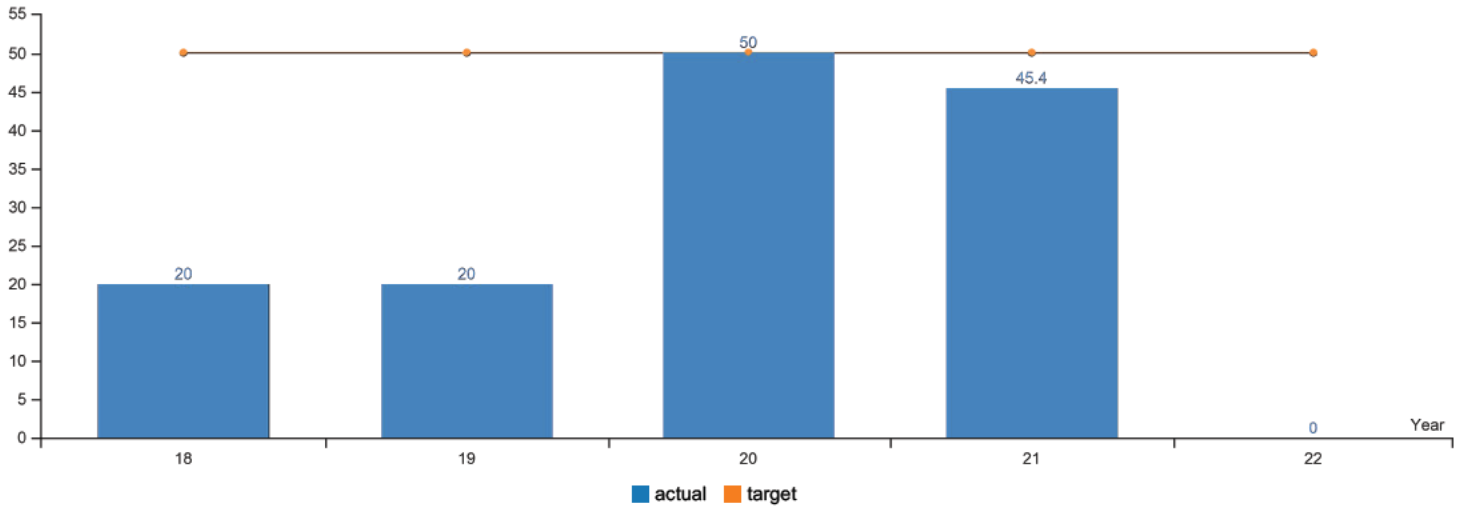
Of note for th s report ng per od s that we had a greater number of cert f ed CAs or CA app cants hav ng the r cert f cates or app cat ons den ed based on egreg ous behav ors.

Factors Affecting Results

In add t on to a of the unant c pated strugg es that have been COVID re ated dur ng these ast 2 report ng per ods, we were extreme y shortstaffed w th no nvest gators for most, f not a , of that t me. We are now fu y staffed and l ook forward to mprov ng these resu ts once they are fu y tra ned.

KPM #6	Percent of sexua m sconduct/boundary comp a nts reso ved n 180 days -
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend positive result*



Report Year	2018	2019	2020	2021	2022
Percent of sexual misconduct/boundary complaints resolved in 180 days					
Actua	20%	20%	50%	45.40%	0%
Target	50%	50%	50%	50%	50%

How Are We Doing

The OBCE has not met the target for th s report ng per od. There was a tota of 3 sexua m sconduct/boundary cases c osed dur ng th s t me, a of wh ch nc uded mu t p e v ct ms and resu ted n e ther cense revocat on or a st pu ated agreement w th f nes. 2 of the 3 cases nvo ved the same censee. These cases were open an average of 420 days.

Factors Affecting Results

The OBCE s the on y Hea th Profess ona Regu atory Board to track and report on sexua m sconduct/boundary comp a nts/cases. Th s s n arge part due to the very c ose and hands-on nature of ch ropract c med c ne and the poss b ty of profess ona boundar es be ng crossed w th n that rea m. Because boundary and sexua m sconduct cases are devastat ng to pat ents and other persons affected, we cont nue to nc ude th s KPM. It s w h n our pub c protect on m ss on to cont nue to mprove not on y our reso ut on t mes these cases, but mprove the types of reso ut ons that we come to, as we as educat ng our censee base about these dynam cs w th n the r pract ces n order to prevent v o at ons from occurr ng n the f rst p ace.

Genera y, these types of cases are much more comp ex and t me consum ng than non-sexua m sconduct cases (e.g. recordkeep ng, over treatment, etc.) often due to mu t p e and/or very traumat zed v ct ms (adu ts and m nors) and w tnesses, nvo vement of mu t p e cens ng and aw enforcement agenc es, cross jur sd ct ona (state and country) ssues, and engagement of expert rev ew for psycho- or psychosexua eva uat on of the perpetrat ng phys c an. Dur ng the cases that nvo ve mu t p e aw enforcement or state agenc es (sher ff departments, oca po ce, DHS, DOJ, county D str ct Attorneys, schoo d str cts, etc.), our cases and nvest gat ons are often opened when we rece ve a comp a nt or not ce of arrest and then often put on ho d unt the c osure of the cr m na proceed ngs, great y ncreas ng our reso ut on t me per od.

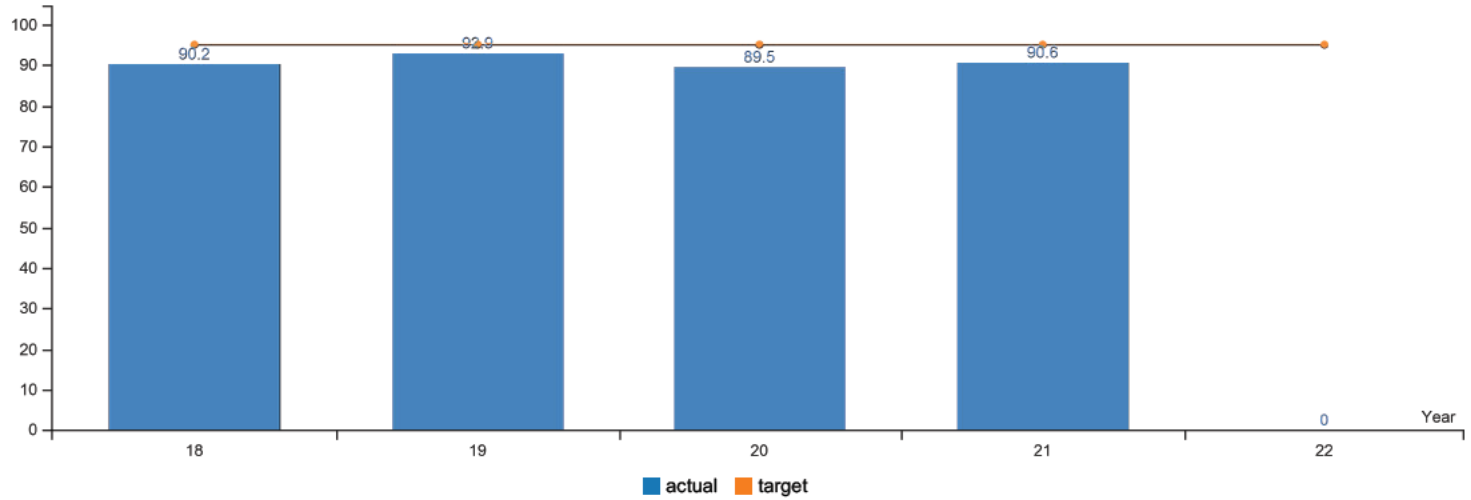
A so, because these cases nvo ve the poss b ty of strong d sc p ne - suspens on or revocat on of a DC's cense - DCs most often h re defense counse to represent them, wh ch s fu y w th n the r

due process r ghts. The fact that defense counse s nvo ved, however, s gn f c ant y ncreases the t me n wh ch these cases are reso ved. Counse often ut ze a too s ava ab e to them to a ow the r c ents to cont nue to work dur ng the pendency of the d sc p nary proceed ngs. In essence, pro ong ng the process before the r c ents are fu y he d accountab e. Th s may nc ude schedu ng conf cts, f ng an abundance of p ead ngs, cross-f ng cases n mu t p e jur sd ct ons/courts regard ng the same matter or part es, f ng mu t p e mot ons, request ng a hear ng, pro onged sett ement negot at ons, prepar ng for hear ng to sett e at the ast m nute, or go ng to hear ng and f ng for jud c a rev ew on appea once the F na Order s ssued, post-hear ng. More often than not, the major ty of these cases sett e mmed ate y before hear ng, after pro onged pre-hear ng engagement w th the agency.

Our goa s to protect our pub c and, by thorough y nvest gat ng a aspects of these cases, respect ng our comp a nants and w tnesses, fu y respect ng our censees' due process r ghts, and successfu y represent ng our agency and the pub c n negot at ons, at hear ng, and dur ng appea , we accomp sh that end. Reso v ng these cases sooner s what we str ve for, but not at the expense of pub c safety.

KPM #7	Percentage of ch ropract c phys c ans meet ng the annua cont nu ng educat on requ rements. -
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend positive result*



Report Year	2018	2019	2020	2021	2022
Percentage of chiropractic physicians meeting the annual continuing education requirements.					
Actua	90.20%	92.90%	89.50%	90.60%	0%
Target	95%	95%	95%	95%	95%

How Are We Doing

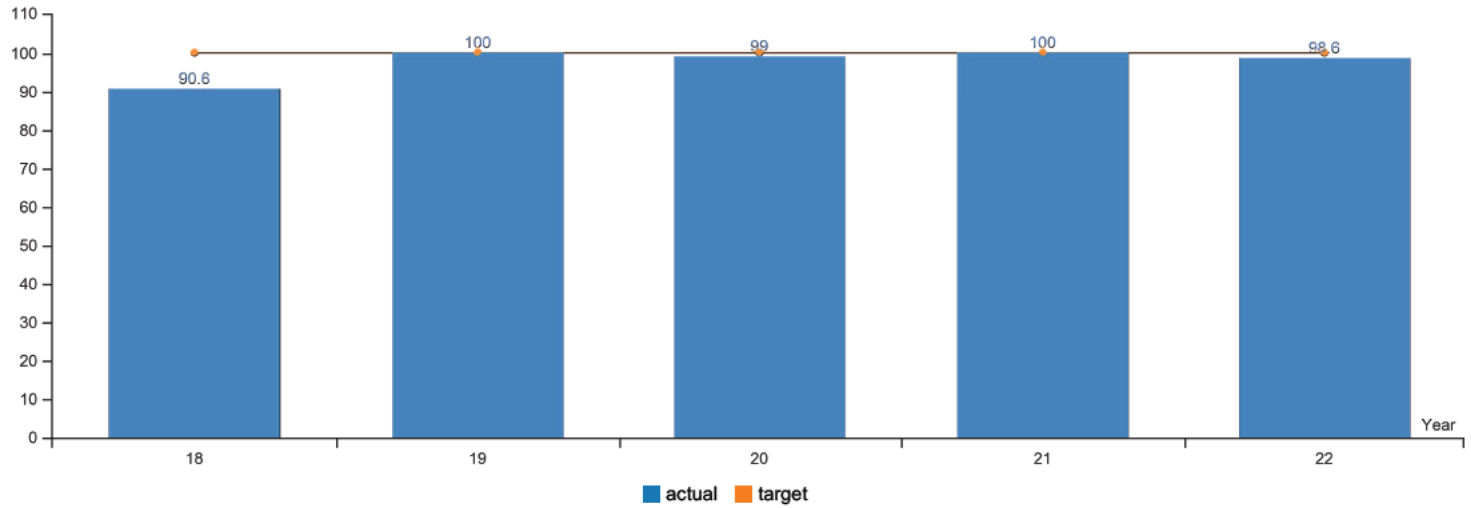
The OBCE d d not meet th s KPM dur ng th s report ng per od.

Factors Affecting Results

Due to our shortstaff ng, COVID effects on staff ng, and our mpend ng mp ementat on of a new cens ng database software, no aud ts on cont nu ng educat on were taken dur ng th s report ng per od. We ook forward to the software ro out and reestab sh ng our aud t procedures n the year to come.

KPM #8	Percentage of censes ssued w th n 5 days once a app cat on components (that are the respons b ty of the app cant) have been rece ved. -
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend positive result*



Report Year	2018	2019	2020	2021	2022
Time to process chiropractor applications					
Actua	90.60%	100%	99%	100%	98.60%
Target	100%	100%	100%	100%	100%

How Are We Doing

We a most h t th s target for th s report ng per od. 70 app cat ons were processed w th 98.6% be ng comp eted w th n 4 days.

The fo ow ng percentages comp eted n the fo ow ng t me frames:

Same day: 71.4% (50/70)

W th n 1 day: 91.4% (64/70)

W th n 2 days: 92.3% (65/70)

W th n 3 days: 95.7% (67/70)

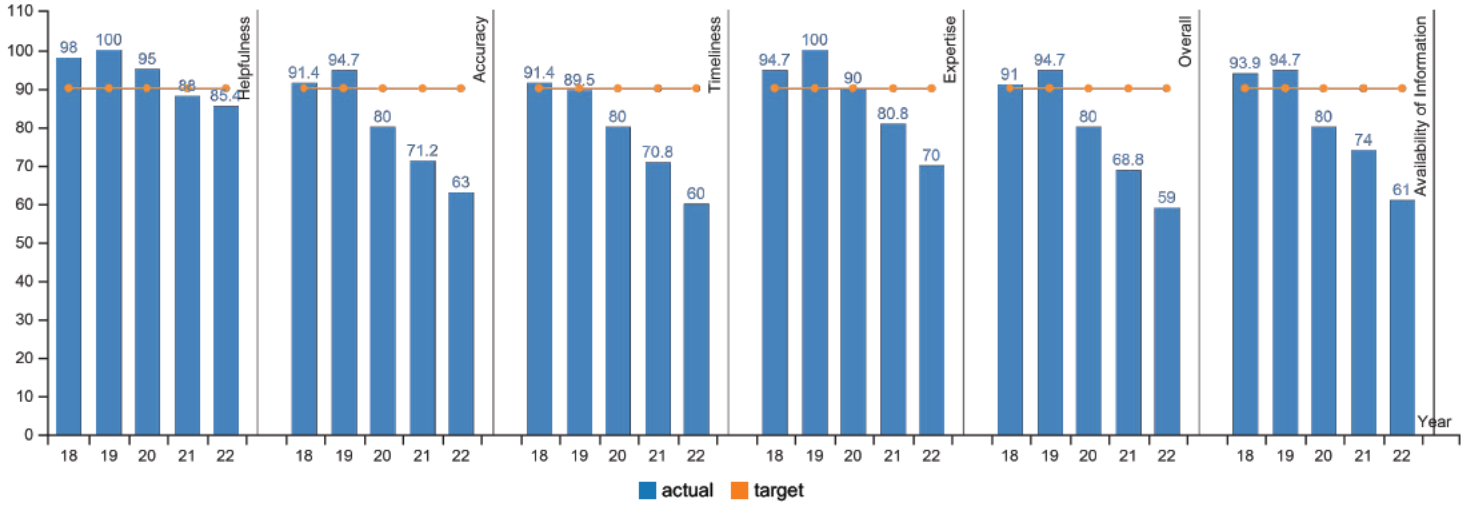
W th n 4 days: 98.6% (69/70)

W th n 6 days: 100% (70/70)

Factors Affecting Results

The onger app cat on process ng t mes corre ated w th the New Years Day state ho day and staff ness n m d-summer. W th the mp ementat on of our new on ne cens ng software, there w be tt e to no apse t me between the agency rece v ng a comp ete app cat on and the cense be ng ssued.

KPM #9	Customer Serv ce - Percent of customers rat ng the r sat sfact on w th the agency's customer serv ce as "good" or "exce ent": overa customer serv ce, t me ness, accuracy, he pfu ness, expert se, and ava ab ty of nformat on.
	Data Co ect on Per od: Sep 01 - Aug 31



Report Year	2018	2019	2020	2021	2022
Helpfulness					
Actua	98%	100%	95%	88%	85.40%
Target	90%	90%	90%	90%	90%
Accuracy					
Actua	91.40%	94.70%	80%	71.20%	63%
Target	90%	90%	90%	90%	90%
Timeliness					
Actua	91.40%	89.50%	80%	70.80%	60%
Target	90%	90%	90%	90%	90%
Expertise					
Actua	94.70%	100%	90%	80.80%	70%
Target	90%	90%	90%	90%	90%
Overall					
Actua	91%	94.70%	80%	68.80%	59%
Target	90%	90%	90%	90%	90%
Availability of Information					
Actua	93.90%	94.70%	80%	74%	61%
Target	90%	90%	90%	90%	90%

How Are We Doing

We d d not meet any of our targets for th s KPM dur ng th s report ng per od.

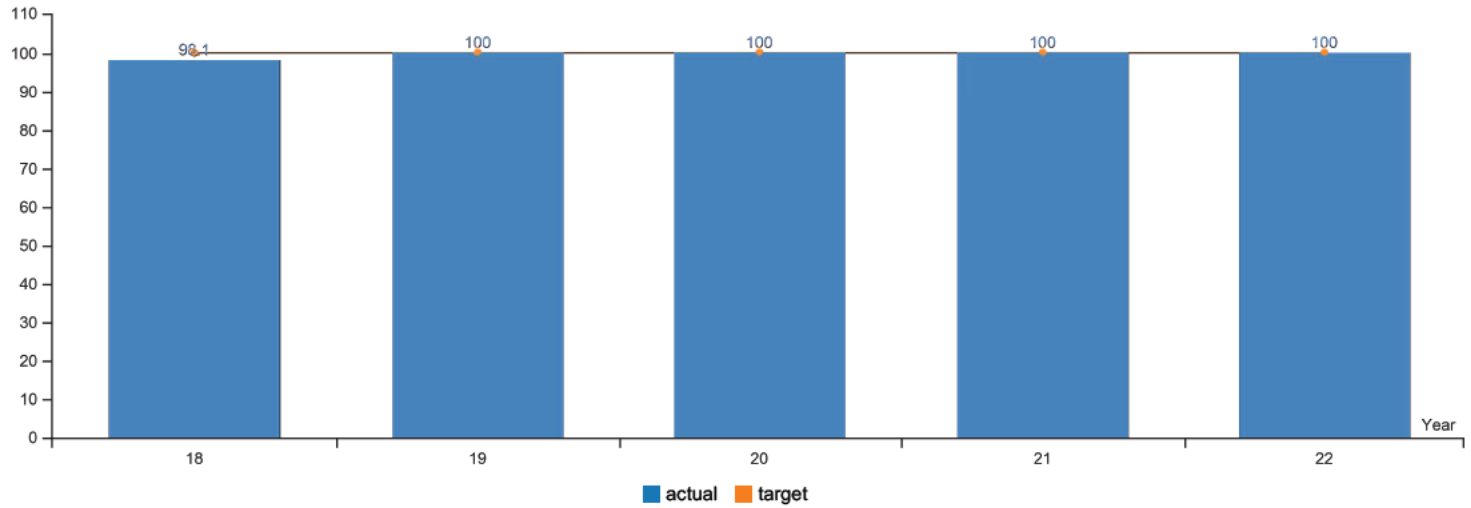
Factors Affecting Results

Imp ement ng the Governor's Execut ve Orders, OHA's vacc ne and mask ng requ rements, and the Board's own ru es regard ng appropr ate COVID protoco s and requ rements to protect the pub c from COVID has caused conf ct between the agency, the profess ona assoc at on, and many of our censees. The pushback from censees to our fac a cover ng ru e cont nues to be content ous and ref ected n these resu ts.

Add t ona y, we've been gr evous y shortstaffed for most of the ast two report ng per ods and are now just fu y staffed and gett ng everyone tra ned. Th s ag n expert se and know how was expected and ref ected n these resu ts. I ant c pate h gher scor ng n future years w th more tra n ng.

KPM #10	Board Best Pract ces - Percent of tota best pract ces met by the Board.
	Data Co ect on Per od: Sep 01 - Aug 31

** Upward Trend positive result*



Report Year	2018	2019	2020	2021	2022
Board Best Practices - Percent of total best practices met by the Board.					
Actua	98.10%	100%	100%	100%	100%
Target	100%	100%	100%	100%	100%

How Are We Doing

A 7 of our board members responded, w th an aggregate 100% assessment score, meet ng our target.

Factors Affecting Results

11. What changes, if any, can we make to improve our customer service?

76 Responses

ID ↑	Name	Responses
1	anonymous	There needs to be a way to speed up the timeline for a CA to get their license once the OBCE has received the application. I have lost 3 employees this year due to how long the process is taking.
2	anonymous	Be less expensive and actually help the chiropractors and not just the public. You charge too much for license and impose stupid CE requirements just to comply with some "identity" group.
3	anonymous	No phone calls are answered, all communication is done by email. Improve personal relationship skills. Create an environment of open and transparent communication.
4	anonymous	Reply to email inquires.
5	anonymous	Loaded survey, you should publish one on how the profession sees the board overall.
6	anonymous	None. You're perfect the way you are!
7	anonymous	Keep the phone lines please.
8	anonymous	The OBCE policy of not pre-approving continuing education performed by a DC needs further clarity. I have performed large and well thought out presentations to satisfy CA hours, with topics that I had emailed the board about ahead of time to best ensure the topics were approved and it would be OBCE criteria, to which the OBCE responded yes. Months later after one of our CAs was randomly audited, I received a voicemail stating that our "quote continuing education quote" just looked like review and wouldn't count. Over 40 hours and 40+ powerpoint slides were provided for this presentation, and some content was modeled after approved vendor's content (without flat out stealing it). There needs to be a more clear avenue for those of us that don't want to spend a thousand dollars for our staff to renew, without taking a shot in the dark and hoping our own content won't be declined. Furthermore, the way this particular incident was brought up to me was quite disrespectful, though every reasonable effort I could think of to prevent an incident like this was taken.
9	anonymous	Be more clear on your email blasts what the expectations are
10	anonymous	More timely on email responses. I emailed a question about the Cultural Competence requirements in December and didn't get a reply until February
11	anonymous	Clone McKenzie
12	anonymous	If someone asks if a specific CE is a allowed, give them a YES or NO! Don't just say, "we'll decide once you're audited." Unacceptable, unprofessional and this is what your job of the board is to do!
13	anonymous	Please proess CA appl8cations in a more timely manner
14	anonymous	Faster response time. Also, I would appreciate feeling like I matter rather than being an interruption to someone's busy day

15	anonymous	Considering the Board has made masking mandatory for the profession, it would follow that you would be able to provide some assistance in that regard. That was false, as you provided nothing. No resources to find them in bulk at the beginning of the pandemic, no resources to help figure out timing of when they are no longer needed. The Board has been VIRTUALLY USELESS during the pandemic, so I will not bother coming to it for assistance again.
16	anonymous	Return calls
17	anonymous	Timely Response to public information requests should be mandatory. 15 days is s suggestion. Also vaccine mandates and mask mandates should be left to the individual office with notification of the public at the door. Weak OBCE NOT RESECTING CHIROPRACTIC PRINCIPLES OR HISTORY
18	anonymous	Provide sources for all Continuing Education that you require, not general like this source may have it (they did not).
19	anonymous	Remember you work for us, your are a public servant. Remember you are also one of us and we aren't enemies.
20	anonymous	The info on the new CE requirements this year was confusing and the answers I Received were not clear.
21	anonymous	With the abundance of employees, phones and emails should be answered promptly. New requirements of DC's and CCA's should be more specific and follow a logical approach with recommendations from the board. Unfortunately a shoot from the hip approach is the status quo with picking up the pieces after errors are pointed out to the board.
22	anonymous	return phone calls, called twice, no return call back
23	anonymous	The website did not allow me to renew as a senior practitioner. I think that has been corrected but it should be confirmed.
24	anonymous	I am grateful for and appreciative of a competent and responsive staff and a caring and dedicated board of examiners. Thanks very much. Excellent work.
25	anonymous	Abide by your own by-laws in upholding response times within 14 business days, send requested documents in timely fashion, and be consistent in how you treat each request for response or document submittal
26	anonymous	The CE requirements are not clear. For example, on your website it does not even mention the BLS requirement. You need to probe and find a different link that makes mention of this.
27	anonymous	I received no reply from email.
28	anonymous	Actually care about the chiropractors who practice in the state and make decision that are not driven by identity politics and more for the general well being of the providers and consumer.
29	anonymous	None. Mackenzie is amazing!

30	anonymous	My only real gripe is about the new BLS requirement. The initial communication regarding this could have been better.
31	anonymous	None at this time
32	anonymous	My answers above refer to one episode in 2021. Simply put: I called twice and left 2 different phone messages asking to speak to Exec. Director. I never got a response (from anyone) to either call. At this point, it is irrelevant because so much time has passed and do not need a response. But I found the lack of any response (from anyone) unprofessional. Thank you.
33	anonymous	If you could lure Kelly Beringer back I'd pay half her salary.
34	anonymous	Faster response times.
35	anonymous	Attention to website updates and continuing education requirements & questions is way past due. Office staff does not answer the phone or follow-up on emails.
36	anonymous	none
37	anonymous	all good!
38	anonymous	Increase staff to handle requests in a timely manner
39	anonymous	Allow me to check several boxes under method I used to contact OBCE. I used a few. Option only allows 1 choice.
40	anonymous	no,, you do just fine.
41	anonymous	I won't bother, as its been years since the beginning of the pandemic, and the Board has been just as useless at providing insights or assistance now as it was then.
42	anonymous	None at this time.
43	anonymous	Make employees more responsive - waiting a week for a response to emails and phone calls is hardly acceptable . Get staff back in the office where they can be accountable
44	anonymous	Quicker response time
45	anonymous	doing great
46	anonymous	Have better detail on the requirements for our new CPR CCE. It sounded very vague.
47	anonymous	Stupid survey

48	anonymous	why not actually open your office instead of working remotely?
49	anonymous	Higher less bureaucrats.
50	anonymous	Higher less bureaucrats.
51	anonymous	Higher less bureaucrats.
52	anonymous	Higher less bureaucrats.
53	anonymous	Higher less bureaucrats.
54	anonymous	None
55	anonymous	Reply to your email.
56	anonymous	None
57	anonymous	Show up to work. Covid is no longer an excuse for poor customer service.
58	anonymous	You are asking all the wrong questions. Since Covid, the board has followed in lock-step with Gov. Kate Brown who is not following the science. The board needs new representation at every level, and needs those professionals willing to challenge "official narratives." The evidence coming out against mask, mandates and the vaccine from top journals and scientist, including Dr. Peter Doshi senior editor at The BMJ is staggering.
59	anonymous	It would be nice if I called OBCE I could talk to a human and not just be directed to a voicemail. When having urgent concerns, a voicemail does not help.
60	anonymous	provide actual customer service. you should not dismiss individuals attempting to gain information or point out inconsistencies in information given in order to serve only the administrative workers. people I have interacted with have been rude and dismissive as I attempted to navigate conflicting information given by different administrators.
61	anonymous	Follow up with any complaint ourcomes.
62	anonymous	have someone available to answer phones.. tried calling for weeks. never got an answer
63	anonymous	None at this time.
64	anonymous	Get the right hand to know what the left hand is doing.
65	anonymous	Be of service. Be approachable. Act like you care about other humans. Increase humility, decrease ambivalence.
66	anonymous	Take responsibility for your actions.

67	anonymous	Make it easier to remove an email address from the email list that go out.
68	anonymous	Quit trying to act like traditional medicine.
69	anonymous	Don't wait so long to certify Chiropractic Assistants
70	anonymous	I'm not licensed. Update your files.
71	anonymous	I emailed and left a message and never received a response. This has happened a few other times in the past years too.
72	anonymous	Stay the same
73	anonymous	for example, your first 2 questions offer options 'what method(s)', yet i can only pick one. stuff like this is annoying and to me suggestive of a canned response. I feel,as a profession we should have a board that is neutral & not affiliated (personally or in any way) with the chiropractic profession, especially the faction that is so extreme, loud and controversial regarding their personal beliefs on public health issues.
74	anonymous	In the past year I have struggled to get connected to whoever is in charge with CA renewals, whether it was email or by phone. We can't leave voice mails due to it being full or no answers.
75	anonymous	Can't think of any, very pleased overall
76	anonymous	A state agency such as the OBCE should be available to its stake holders during normal business hours Monday-Fridays. They were not on 2 occasions that I personally went to there office and no one was present. I left a phone message and asked for a return phone call after 3 days still no answer. This is very poor service for a service I pay money through my dues for re-licensing.

Centers for Disease Control and Prevention

COVID-19

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

Updated Sept. 23, 2022

For healthcare personnel, see Isolation and work restriction guidance. For strategies to mitigate healthcare personnel staffing shortages, see Contingency and crisis management. For healthcare professionals advising people in non-healthcare settings about isolation for laboratory-confirmed COVID-19, see Ending Isolation and Precautions for People with COVID-19.

Summary of Recent Changes

Updates as of September 23, 2022

- Updated to note that vaccination status is no longer used to inform source control, screening testing, or post-exposure recommendations
- Updated circumstances when use of source control is recommended
- Updated circumstances when universal use of personal protective equipment should be considered
- Updated recommendations for testing frequency to detect potential for variants with shorter incubation periods and to address the risk for false negative antigen tests in people without symptoms.
- Clarified that screening testing of asymptomatic healthcare personnel, including those in nursing homes, is at the discretion of the healthcare facility
- Updated to note that, in general, asymptomatic patients no longer require empiric use of Transmission-Based Precautions following close contact with someone with SARS-CoV-2 infection.
- Archived the Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes and special considerations for nursing homes not otherwise covered in Sections 1 and 2 were added to Section 3: Setting-specific considerations
  - Updated screening testing recommendations for nursing home admissions
- Clarified the types of long-term care settings for whom the healthcare infection prevention and control recommendations apply

Key Points

- This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health.

Introduction

Introduction

This interim guidance has been updated based on currently available information about COVID-19 and the current situation in the United States. Updates were made to reflect the high levels of vaccine-and infection-induced immunity and the availability of effective treatments and prevention tools. This guidance provides a framework for facilities to implement select infection prevention and control practices (e.g., universal source control) based on their individual circumstances (e.g., levels of community transmission).

This guidance is applicable to all U.S. settings where healthcare is delivered (including nursing homes and home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants) and not for persons outside of healthcare settings.** CDC's main landing page for COVID-19 content will help readers navigate to information regarding modes of transmission, clinical management, laboratory settings, COVID-19 vaccines and CDC guidance on other COVID-19-related topics.

Employers should be aware that other local, territorial, tribal, state, and federal requirements may apply, including those promulgated by the Occupational Safety and Health Administration (OSHA).

Defining Community Transmission of SARS-CoV-2

Select IPC measures (e.g., use of source control, screening testing of nursing home admissions) are influenced by levels of SARS-CoV-2 transmission in the community. Community Transmission is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention, before there is strain on the healthcare system and to better protect the individuals seeking care in these settings. The Community Transmission metric is different from the COVID-19 Community Level metric used for non-healthcare settings. Community Transmission refers to measures of the presence and spread of SARS-CoV-2. COVID-19 Community Levels place an emphasis on measures of the impact of COVID-19 in terms of hospitalizations and healthcare system strain, while accounting for transmission in the community.

1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic

Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses.

- HCP, patients, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine.

Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection

- Ensure everyone is aware of recommended IPC practices in the facility.
  - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can let help ensure people know that they reflect current recommendations.
- Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
  - 1) a positive viral test for SARS-CoV-2
  - 2) symptoms of COVID-19, or
  - 3) close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP)).
    - For example:
      - Instruct HCP to report any of the 3 above criteria to occupational health or another point of contact designated by the facility so these HCP can be properly managed.
        - The definition of higher-risk exposure and recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
      - Provide guidance (e.g., posted signs at entrances, instructions when scheduling appointments) about recommended actions for patients and visitors who have any of the above three criteria.
        - Patients should be managed as described in Section 2

- Visitors with confirmed SARS-CoV-2 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation (see Section 2); this time period is longer than what is recommended in the community. For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at higher risk for transmission, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet any of the criteria described in Section 2 (e.g., cannot wear source control).
  - Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at Policy & Memos to States and Regions | CMS .

Implement Source Control Measures

Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Further information about types of masks and respirators, including those that meet standards and the degree of protection offered to the wearer, is available at: Masks and Respirators (cdc.gov). People, particularly those at high risk for severe illness, should wear the most protective form of source control they can that fits well and that they will wear consistently.

Healthcare facilities may choose to offer well-fitting facemasks as a source control option for visitors but should allow the use of a mask or respirator with higher-level protection that is not visibly soiled by people who chose that option based on their individual preference. Additional information is available in the FAQ: What should visitors use for source control (masks or respirators) when visiting healthcare facilities?

Source control options for HCP include:

- A NIOSH-approved particulate respirator with N95 filters or higher;
- A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated);
- A barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks; OR
- A well-fitting facemask.

When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned. Additional information is available in the FAQ: Can employees choose to wear respirators when not required by their employer?

When SARS-CoV-2 Community Transmission levels are high, source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients.

- HCP could choose not to wear source control when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms) if they do not otherwise meet the criteria described below and Community Levels are not also high. When Community Levels are high, source control is recommended for everyone.

When SARS-CoV-2 Community Transmission levels are not high, healthcare facilities could choose not to require universal source control. However, even if source control is not universally required, it remains recommended for individuals in healthcare settings who:

- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10

days after their exposure; or

- Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or
- Have otherwise had source control recommended by public health authorities

Individuals might also choose to continue using source control based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease. For example, if an individual or someone in their household is at increased risk for severe disease, they should consider wearing masks or respirators that provide more protection because of better filtration and fit to reduce exposure and infection risk, even if source control is not otherwise required by the facility. HCP and healthcare facilities might also consider using or recommending source control when caring for patients who are moderately to severely immunocompromised.

Implement Universal Use of Personal Protective Equipment for HCP

If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).

As community transmission levels increase, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during patient care encounters. For example, facilities located in counties where Community Transmission is high should also consider having HCP use PPE as described below:

- NIOSH-approved particulate respirators with N95 filters or higher used for:
  - All aerosol-generating procedures (refer to Which procedures are considered aerosol generating procedures in healthcare settings?).
  - All surgical procedures that might pose higher risk for transmission if the patient has SARS-CoV-2 infection (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract).
  - NIOSH-approved particulate respirators with N95 filters or higher can also be used by HCP working in other situations where additional risk factors for transmission are present, such as the patient is unable to use source control and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place.
  - To simplify implementation, facilities in counties with high transmission may consider implementing universal use of NIOSH-approved particulate respirators with N95 filters or higher for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.
- Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters.

Optimize the Use of Engineering Controls and Indoor Air Quality

- Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (e.g., physical barriers at reception / triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas).
- Take measures to limit crowding in communal spaces, such as scheduling appointments to limit the number of patients in waiting rooms or treatment areas.
- Explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in patient rooms and all shared spaces.
  - Guidance on ensuring that ventilation systems are operating properly, and other options for improving indoor air quality, are available in the following resources:
    - Guidelines for Environmental Infection Control in Health-Care Facilities
    - American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities , which also provides COVID-19 technical resources for healthcare facilities
    - Ventilation in Buildings, which includes options for non-clinical spaces in healthcare facilities

Perform SARS-CoV-2 Viral Testing

- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.
- Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
  - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
  - Guidance for work restrictions, including recommended testing for HCP with higher-risk exposures, are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
  - Guidance for use of empiric Transmission-Based Precautions for patients with close contact with someone with SARS-CoV-2 infection are described in Section 2.
- Testing considerations for healthcare facilities with an outbreak of SARS-CoV-2 are described below.
- The yield of screening testing for identifying asymptomatic infection is likely lower when performed on those in counties with lower levels of SARS-CoV-2 community transmission. However, these results might continue to be useful in some situations (e.g., when performing higher-risk procedures or for HCP caring for patients who are moderately to severely immunocompromised) to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE used) and prevent unprotected exposures. If implementing a screening testing program, testing decisions should not be based on the vaccination status of the individual being screened. To provide the greatest assurance that someone does not have SARS-CoV-2 infection, if using an antigen test instead of a NAAT, facilities should use 3 tests, spaced 48 hours apart, in line with FDA recommendations .
  - In general, performance of pre-procedure or pre-admission testing is at the discretion of the facility. However, for residents admitted to nursing homes, admission testing is recommended as described in Section 3.
  - Performance of expanded screening testing of asymptomatic HCP without known exposures is at the discretion of the facility.

Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others

Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed.

If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. For example, in an outpatient dialysis facility with an open treatment area, testing should ideally include all patients and HCP. Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to HCP and patients on the affected units or departments, or a particular treatment schedule or shift, as opposed to the entire facility. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.

Guidance for outbreak response in nursing homes is described in setting-specific considerations below.

Healthcare facilities responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities.

2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection

The IPC recommendations described below (e.g., patient placement, recommended PPE) also apply to patients with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection. However, these

patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.

Duration of Empiric Transmission-Based Precautions for Symptomatic Patients being Evaluated for SARS-CoV-2 infection

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test.

- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Duration of Empiric Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection

In general, asymptomatic patients do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These patients should still wear source control and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section.

Examples of when empiric Transmission-Based Precautions following close contact may be considered include:

- Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
- Patient is moderately to severely immunocompromised
- Patient is residing on a unit with others who are moderately to severely immunocompromised
- Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

- Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
- If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

Patient Placement

- Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom.
  - If cohorting, only patients with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
- Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of patients with SARS-CoV-2 infection is high. Dedicated means that HCP are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of patients with SARS-CoV-2 infection.

- Limit transport and movement of the patient outside of the room to medically essential purposes.
- Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

Personal Protective Equipment

- HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher , gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
- Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134)
- Additional information about using PPE is available in Protecting Healthcare Personnel | HAI | CDC

Aerosol-Generating Procedures (AGPs)

- Procedures that could generate infectious aerosols should be performed cautiously and avoided if appropriate alternatives exist.
- AGPs should take place in an airborne infection isolation room (AIIR), if possible.
- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.

Visitation

- For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at Policy & Memos to States and Regions | CMS .
  - Counsel patients and their visitor(s) about the risks of an in-person visit.
  - Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
- Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- Visitors should be instructed to only visit the patient room. They should minimize their time spent in other locations in the facility.

Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection

The following are criteria to determine when Transmission-Based Precautions could be discontinued for patients with SARS-CoV-2 infection and are influenced by severity of symptoms and presence of immunocompromising conditions. Patients should self-monitor and seek re-evaluation if symptoms recur or worsen. If symptoms recur (e.g., rebound), these patients should be placed back into isolation until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.

In general, patients who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for patients with severe to critical illness.

In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for patients.

Patients with mild to moderate illness who are *not* moderately to severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* and
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications and

At least 24 hours have passed *since last fever* without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved

Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:

- At least 10 days have passed since the date of their first positive viral test.

Patients with severe to critical illness and who are *not* moderately to severely immunocompromised:

- At least 10 days and up to 20 days have passed *since symptoms first appeared* and
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved
- The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific patients. For a summary of the literature, refer to Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov)

Patients who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.

The criteria for the test-based strategy are:

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved, and
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Patients who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Environmental Infection Control

- Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
  - All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which AGPs are performed.
  - Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a *difficile* sporicidal agent is recommended to disinfect the rooms of patients with *C. difficile* infection).
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.

- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room without all recommended PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles [more information (to include important footnotes on its application) on clearance rates under differing ventilation conditions is available]. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

3. Setting-specific considerations

In addition to the recommendations described in the guidance above, here are additional considerations for the settings listed below.

Dialysis Facilities

Considerations for Patient Placement

- Patients on dialysis with suspected or confirmed SARS-CoV-2 infection or who have reported close contact should be dialyzed in a separate room with the door closed.
  - Hepatitis B isolation rooms can be used if: 1) the patient is hepatitis B surface antigen-positive or 2) the facility has no patients on the census with hepatitis B infection who would require treatment in the isolation room.
- If a separate room is not available, patients with confirmed SARS-CoV-2 infection should be cohorted to a specific well-ventilated unit or shift (e.g., consider the last shift of the day). Only patients with confirmed SARS-CoV-2 infection should be cohorted together:
  - In the context of an outbreak or an increase in the number of confirmed SARS-CoV-2 infections at the facility, if a separate shift or unit is not initially available, efforts should be made to create specific shifts or units for patients with confirmed SARS-CoV-2 infection to separate them from patients without SARS-CoV-2 infection.

Additional Guidance for Use of Isolation Gowns

- When caring for patients with suspected or confirmed SARS-CoV-2 infection, gowns should be worn over or instead of the cover gown (e.g., laboratory coat, gown, or apron with incorporate sleeves) that is normally worn by hemodialysis personnel.

Cleaning and Disinfecting Dialysis Stations

- Current procedures for routine cleaning and disinfection of dialysis stations are appropriate for patients with SARS-CoV-2 infection.
- Internal disinfection of dialysis machines is not required immediately after use unless otherwise indicated (e.g., post-blood leak). It should be done according to the dialysis machine manufacturer's instructions (e.g., at the end of the day).

Emergency Medical Services

Considerations for vehicle configuration when transporting a patient with suspected or confirmed SARS-CoV-2 infection

- Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.
- When possible, use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.
  - Before entering the isolated driver's compartment, the driver (if they were involved in direct patient care) should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.
  - Close the door/window between these compartments before bringing the patient on board.
  - During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.
  - If the vehicle has a rear exhaust fan, use it to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.
  - Some vehicles are equipped with a supplemental recirculating ventilation unit that passes air through high-efficiency particulate air (HEPA) filters before returning it to the vehicle. Such a unit can be used to increase the

number of air changes per hour (ACH) Health Hazard Evaluation Report 95–0031–2601 pdf .

- After patient unloading, allowing a few minutes with ambulance module doors open will rapidly dilute airborne viral particles.

- If a vehicle without an isolated driver compartment must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting to create a pressure gradient toward the patient area.
  - Before entering the driver's compartment, the driver (if they were involved in direct patient care) should remove their gown, gloves and eye protection and perform hand hygiene to avoid soiling the compartment. They should continue to wear their NIOSH-approved particulate respirator with N95 filters or higher.

Additional considerations when performing AGPs on patients with suspected or confirms SARS-CoV-2 infection:

- If possible, consult with medical control before performing AGPs for specific guidance.
- Bag valve masks (BVMs) and other ventilatory equipment should be equipped with HEPA filtration to filter expired air.
- EMS systems should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive-pressure ventilation.
- If possible, the rear doors of the stationary transport vehicle should be opened and the HVAC system should be activated during AGPs. This should be done away from pedestrian traffic.
- If possible, discontinue AGPs prior to entering the destination facility or communicate with receiving personnel that AGPs are being implemented.

Dental Facilities

- Dental healthcare personnel (DHCP) should regularly consult their state dental boards and state or local health departments for current information and recommendations and requirements specific to their jurisdictions, which might change based on SARS-CoV-2 transmission levels in the county where their healthcare facility is located.
- Patients with suspected or confirmed SARS-CoV-2 infection should postpone all non-urgent dental treatment until they meet criteria to discontinue Transmission-Based Precautions. Because dental patients cannot wear a mask, in general, those who have had close contact with someone with SARS-CoV-2 infection should also postpone all non-urgent dental treatment until they meet the healthcare criteria to end quarantine.
  - Dental care for these patients should only be provided if medically necessary. Follow all recommendations for care and placement for patients with suspected or confirmed SARS-CoV-2 infection. Extra attention may be required to ensure HVAC ventilation to the dental treatment area does not reduce or deactivate during occupancy based on temperature demands.
  - If a patient has a fever strongly associated with a dental diagnosis (e.g., pulpal and periapical dental pain and intraoral swelling are present) but no other symptoms consistent with COVID-19 are present, dental care can be provided following the practices recommended for routine health care during the pandemic.
- When performing aerosol-generating procedures on patients who are not suspected or confirmed to have SARS-CoV-2 infection, ensure that DHCP correctly wear the recommended PPE (including consideration of a NIOSH-approved particulate respirator with N95 filters or higher in counties with high levels of transmission) and use mitigation methods such as four-handed dentistry, high evacuation suction, and dental dams to minimize droplet spatter and aerosols.
  - Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.
- Dental treatment should be provided in individual patient rooms whenever possible with the HVAC in constant ventilation mode.
- For dental facilities with open floor plans, strategies to prevent the spread of pathogens include:
  - At least 6 feet of space between patient chairs.
  - Adjunct use of portable HEPA air filtration systems to enhance air cleaning
  - Physical barriers between patient chairs. Easy-to-clean floor-to-ceiling barriers will enhance effectiveness of portable HEPA air filtration systems (check to make sure that extending barriers to the ceiling will not interfere with fire sprinkler systems).
  - Operatories oriented parallel to the direction of airflow when possible.
  - Where feasible, consider patient orientation carefully, placing the patient's head near the return air vents, away from pedestrian corridors, and toward the rear wall when using vestibule-type office layouts.

- Ensure to account for the time required to clean and disinfect operatories between patients when calculating your daily patient volume.

Nursing Homes

- Assign one or more individuals with training in IPC to provide on-site management of the IPC program
  - This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the IPC risk assessment.
- Stay connected with the healthcare-associated infection program in your state health department, as well as your local health department, and their notification requirements. Report SARS-CoV-2 infection data to National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module. See Centers for Medicare & Medicaid Services (CMS) COVID-19 reporting requirements .
- Managing admissions and residents who leave the facility:
  - Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. In general, admissions in counties where Community Transmission levels are high should be tested upon admission; admission testing at lower levels of Community Transmission is at the discretion of the facility.
  - They should also be advised to wear source control for the 10 days following their admission. Residents who leave the facility for 24 hours or longer should generally be managed as an admission.
- Empiric use of Transmission-Based Precautions is generally not necessary for admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings) and do not meet criteria described in section 2.
- Placement of residents with suspected or confirmed SARS-CoV-2 infection
  - Ideally, residents should be placed in a single-person room as described in Section 2.
  - If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.
- Responding to a newly identified SARS-CoV-2-infected HCP or resident
  - When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority.
  - A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.
  - The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
  - Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
    - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
    - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
  - Empiric use of Transmission-Based Precautions for residents and work restriction for HCP are not generally necessary unless residents meet the criteria described in Section 2 or HCP meet criteria in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. However, source control should be worn by all individuals being tested.
    - In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.

- If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively.
- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.
  - If antigen testing is used, more frequent testing (every 3 days), should be considered.

– Indoor visitation during an outbreak response:
  - Facilities should follow guidance from CMS about visitation.
  - Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility.
  - If indoor visitation is occurring in areas of the facility experiencing transmission, it should ideally occur in the resident's room. The resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit.

Assisted Living, Group Homes and Other Residential Care Settings (excluding nursing homes)

In general, long-term care settings (excluding nursing homes) whose staff provide non-skilled personal care* similar to that provided by family members in the home (e.g., many assisted livings, group homes), should follow community prevention strategies based on COVID-19 Community Levels, similar to independent living, retirement communities or other non-healthcare congregate settings. Residents should also be counseled about strategies to protect themselves and others, including recommendations for source control if they are immunocompromised or at high risk for severe disease. CDC has information and resources for older adults and for people with disabilities.

Visiting or shared healthcare personnel who enter the setting to provide healthcare to one or more residents (e.g., physical therapy, wound care, intravenous injections, or catheter care provided by home health agency nurses) should follow the healthcare IPC recommendations in this guidance. In addition, if staff in a residential care setting are providing in-person services for a resident with SARS-CoV-2 infection, they should be familiar with recommended IPC practices to protect themselves and others from potential exposures including the hand hygiene, personal protective equipment and cleaning and disinfection practices outlined in this guidance.

*Non-skilled personal care consists of any non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing; it may also include the kind of health-related care that most people do themselves, like taking oral medications. In some cases where care is received at home or a residential setting, care can also include help with household duties such as cooking and laundry.

Definitions:

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Healthcare settings refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental offices, and others.

Source control: Use of respirators, well-fitting facemasks, or well-fitting cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control devices should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or

an underlying medical condition that precludes wearing one safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their source control device without assistance. Face shields alone are not recommended for source control. At a minimum, source control devices should be changed if they become visibly soiled, damaged, or hard to breathe through. Further information about source control options is available at: Masks and Respirators (cdc.gov)

Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. Guidance on design, use, and maintenance of cloth masks is available.

Facemask: OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as 'medical procedure masks'." Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

Airborne Infection Isolation Rooms (AIIRs):

- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 12 ACH (6 ACH are allowed for AIIRs last renovated or constructed prior to 1997).
- Air from these rooms should be exhausted directly to the outside or be filtered through a HEPA filter directly before recirculation.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- Facilities should monitor and document the proper negative-pressure function of these rooms.

Immunocompromised: For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the Interim Clinical Considerations for Use of COVID-19 Vaccines

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise. However, people in this category should still consider continuing to use of source control while in a healthcare facility.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Close contact: Being within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)

The studies used to inform this guidance did not clearly define "severe" or "critical" illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the National Institutes of Health (NIH) COVID-19 Treatment Guidelines are one option for defining severity of illness categories. The highest level of illness severity experienced by the patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions. Clinical judgement regarding the contribution of SARS-CoV-2 to clinical severity might also be necessary when applying these criteria to inform infection control decisions.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO_2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

More Information

- Interim Clinical Considerations for Use of COVID-19 Vaccines
- Management of Patients with Confirmed 2019-nCoV
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- Strategies to Mitigate Healthcare Personnel Staffing Shortages
- Clinical Questions about COVID-19: Questions and Answers
- Management of Patients with Confirmed 2019-nCoV

Previous Updates

Updates as of February 2, 2022

Due to concerns about increased transmissibility of the SARS-CoV-2 Omicron variant, this guidance is being updated to enhance protection for healthcare personnel, patients, and visitors and to address concerns about potential impacts on the healthcare system given a surge in SARS-CoV-2 infections. These updates will be refined as additional information becomes available to inform recommended actions.

- Empiric use of Transmission-Based Precautions (quarantine) is recommended for patients who have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses.
  - In general, quarantine is not needed for asymptomatic patients who are up to date with all recommended COVID-19 vaccine doses or who have recovered from SARS-CoV-2 infection in the prior 90 days; potential exceptions are described in the guidance. However, some of these patients should still be tested as described in the testing section of the guidance.
- A test-based strategy and (if available) consultation with infectious disease experts is now recommended for determining the duration of Transmission-Based Precautions for patients with SARS-CoV-2 infection who are moderately to severely immunocompromised.
- Included additional examples when universal respirator use could be considered
- Additional updates that will have implications for healthcare facilities were made in the following guidance documents:
  - Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
  - Strategies to Mitigate Healthcare Personnel Staffing Shortages
  - Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes

Updates as of September 10, 2021

- Updated source control recommendations to address limited situations for healthcare facilities in counties with low to moderate community transmission where select fully vaccinated individuals could choose not to wear source control. However, in general, the safest practice is for everyone in a healthcare setting to wear source control.
- Updated quarantine recommendations for fully vaccinated patients who have had close contact with someone with SARS-CoV-2 infection to more closely align with recommendations for the community.
- Clarified the recommended intervals for testing asymptomatic HCP with a higher-risk exposure and patients with close contact with someone with SARS-CoV-2 infection.
- Added content from previously posted CDC guidance addressing:
  - Recommendations for fully vaccinated HCP, patients, and visitors
  - SARS-CoV-2 testing
  - Duration of Transmission-Based Precautions for patients with SARS-CoV-2 infection
  - Specialized healthcare settings (e.g., dental, dialysis, EMS)

As of February 10, 2021

- Updated the Implement Universal Use of Personal Protective Equipment section to expand options for source control and patient care activities in areas of moderate to substantial transmission and describe strategies for improving fit of facemasks. Definitions of source control are included at the end of this document.
- Included a reference to Optimizing Personal Protective Equipment (PPE) Supplies that include a hierarchy of strategies to implement when PPE are in short supply or unavailable.

As of December 14, 2020

- Added links to Frequently Asked Questions addressing Environmental Cleaning and Disinfection and assessing risks to patients and others exposed to healthcare personnel who worked while infected with SARS-CoV-2
- Described recommended IPC practices when caring for patients who have met criteria for a 14-day quarantine based on prolonged close contact with someone with SARS-CoV-2 infection.
- Added reminders that:
  - Double gloving is not recommended when providing care to patients with suspected or confirmed SARS-CoV-2 infection
  - In general, HCP caring for patients with suspected or confirmed SARS-CoV-2 infection should not wear more than one isolation gown at a time.

As of November 4, 2020

- Provided different options for screening individuals (healthcare personnel, patients, visitors) prior to their entry into a healthcare facility
- Provided information on factors that could impact thermometer readings
- Provided resources for evaluating and managing ventilation systems in healthcare facilities
- Added link to Frequently Asked Questions about use of Personal Protective Equipment

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Last Updated Sept. 23, 2022

811-035-0007
Facial Covering Requirements

(1) Due to the COVID-19/Coronavirus pandemic and associated declared state of emergency in Oregon, effective immediately, all licensed chiropractic physicians, certified chiropractic assistants, and preceptor chiropractic interns are required to do the following:

(a) All chiropractic entities must have policies in place requiring all individuals to wear face coverings while in the building and treatment areas;

(b) All licensed chiropractic physicians, certified chiropractic assistants, and preceptor chiropractic interns are required to wear a face coverings (that cover the nose and mouth) at all times while providing patient care. Medical grade masks should be prioritized, as they offer both source control and protection from potentially infectious droplets, splashes, or sprays;

(c) Licensees and certificate holders shall utilize proper hand sanitization and appropriately disinfect treatment room surfaces and equipment that comes into contact with patients.; and

(d) Licensees and certificate holders may consider the addition of eye protection during patient care.

(2) Face coverings are defined as facemasks, facial shields, medical grade masks, and face coverings that are used in a medical setting.

(3) In regards to face covering requirements, the chiropractic entity should review state and federal disabilities laws, including the Americans Disabilities Act (ADA) which protects people with disabilities from discrimination in employment and requires employers to engage in the interactive process, for accommodations to be made. In addition, please refer to the Governor's Executive Orders and OHA public health guidance.

(4) Failure to abide by the requirements of this rule may result in disciplinary action by the Board.

(5) This rule shall remain in effect so long as an associated declared state of emergency is in effect. When the declared state of emergency is not in effect, this rule will not be effective.

Statutory/Other Authority: ORS 684.155
History:
BCE 3-2021, adopt filed 01/21/2021, effective 01/21/2021

Oregon Health Authority
PUBLIC HEALTH DIVISION

Health Care Setting Masking Requirements FAQ *(Updated 09-16-2022)*

Below are answers to frequently asked questions (FAQ) about the Oregon Administrative Rule (OAR) 333-019-1011, Masking Requirements to Control COVID-19 in Health Care Settings. These FAQ may be updated intermittently.

*New or updated question

Q: Was the mask requirement in health care settings lifted on March 11?

No. Masks are still required in health care settings under OAR 333-019-1011.

Q: What is considered a health care setting?

Under OHA's rule for masking requirements in health care settings (OAR 333-019-1011), a health care setting means any place where health care, including physical, dental, or behavioral health care is delivered and includes, but is not limited to any health care facility or agency licensed under ORS chapter 441 or 443, such as hospitals, ambulatory surgical centers, birthing centers, special inpatient care facilities, long-term acute care facilities, inpatient rehabilitation facilities, inpatient hospice facilities, nursing facilities, assisted living facilities, and residential facilities, behavioral health residential facilities, home health care, hospice, pharmacies, in-home care, vehicles or temporary sites where health care is delivered or is related to the provision of health care (for example, mobile clinics, ambulances, non-emergency medical transport vehicles (NEMT), secure transportation, and street based medicine),outpatient facilities, such as dialysis centers, health care provider offices, dental offices, behavioral health care offices, urgent care centers, counseling offices, school-based health centers, offices that provide complementary and alternative medicine such as acupuncture, homeopathy, naturopathy, chiropractic and osteopathic medicine, and other specialty centers.

Q: Who are considered health care personnel?

Under OHA's rule for masking requirements in health care settings (OAR 333-019-1011), health care personnel are individuals, paid and unpaid working, learning, studying, assisting, observing, or volunteering in a health care setting providing direct patient or resident care or who have the potential for direct or indirect exposure to patients, residents, or infectious materials, and includes but is not limited to any individual licensed by a health regulatory board as that is defined in ORS 676.160, unlicensed caregivers, and any clerical, dietary, environmental services, laundry,

security, engineering and facilities management, administrative, billing, student and volunteer personnel.

Q: If health care providers are providing health care in a setting that is not a health care setting under OHA's rule, such as a classroom or a gym, does that setting then become a health care setting?

No. The definition of health care setting is broad, but it was intended to apply to settings where health care is routinely provided, or temporary sites such as mobile clinics or ambulances. In addition, organizations may designate areas or rooms of their facilities as health care settings and those settings would be health care settings under OHA's rule.

Q: Under OHA's rule, does a health care setting include a part of a health care facility or medical office, or a building operated by a health care provider or health system where there are no patients and no health care being delivered?

If a health care provider or a health system has a stand-alone building where no health care is delivered and no patients are allowed to enter, it would not be considered a health care setting. If there is a part of a health care facility or medical office where no health care is delivered and no patients are allowed and it is physically separated from areas where patients are allowed or health care is delivered, with walls from floor to ceiling and a door that remains closed when not being used, that space would not be considered a health care setting. If individuals are permitted to be in these non-health care setting areas without a mask, face covering or face shield, they must still wear a mask, face covering or face shield within any area that is a health care setting. Oregon OSHA's rule for exceptional risk settings (437-001-0744) may differ from OHA's definition for health care, employers are encouraged to identify if Oregon OSHAs rule applies.

Q: Do health care personnel working for licensed in-home care agencies, licensed home-health agencies, and licensed hospice agencies have to wear a mask or face covering when providing care in an individual's private home?

Yes. Because in-home care, home health and hospice agencies are included in the definition of "health care setting" the individuals who work for licensed in-home care, home health, or hospice agencies must wear a mask or face covering when providing services to patients or clients in accordance with their agency's policies regardless of where they are providing care.

Q: If I am being provided care in my own private home, by an individual that works for an in-home care, home health or hospice agency, do I have to wear a face covering when they come to my home to provide care?

It is up to each patient/client to decide if they want to wear a mask in their own private home, even if they are receiving health care in their home. Patients/clients receiving care in the home should wear masks while receiving care if they or someone in their household is immunocompromised or at risk for severe disease, or if someone in the

household is not up to date with COVID-19 vaccines. Patients/clients should also wear a mask when asked to by their health care provider.

Q: Does a health care setting include senior centers or independent living facilities?

No. Senior centers that do not provide health care services and serve in a recreational capacity are not considered health care settings. Independent living facilities are not considered health care settings. Owners and operators of these settings may continue to apply and enforce mask, face covering and face shield guidance and physical distancing requirements at their discretion. When in-home care, home health care, or hospice services are being provided in independent living facilities, providers must still wear a mask or face covering in accordance with OAR 333-019-1011.

Q: Does a health care setting include settings like adult foster homes?

Some facilities licensed by the Oregon Department of Human Services (ODHS) are exempt from OHA's rule requiring masking in health care settings, such as adult foster homes, developmental disability foster homes, residential training homes and residential training facilities, but ODHS has established their own masking requirements for many of these settings.

For face covering requirements, visit https://www.oregon.gov/dhs/COVID-19/Pages/LTC-Facilities.aspx.

Q: Does a health care setting include a pharmacy department in a retail store?

The pharmacy "area" is a health care setting but not the entire retail store. If there is a pharmacy inside a retail store, the following areas related to the pharmacy are considered a health care setting:

- Any area where pharmacy staff are engaged in the pharmacy activities, including but not limited to preparing prescriptions, interacting with patients, and administering vaccines.
- Any area where patients are waiting to interact with pharmacy staff, including but not limited to waiting in a line or in a designated waiting area for the pharmacy.
- Any area where a patient is interacting with pharmacy staff, including but not limited to dropping off or picking up a prescription or consulting with the pharmacist.

For more information from the Oregon Board of Pharmacy about requirements in pharmacies, click here.

Q: Is a "closed door" pharmacy, such as a mail order pharmacy or a pharmacy in an office setting that does not directly serve or interact with the public or patients a health care setting?

If a pharmacy is in a stand-alone building or office setting/suite within a building where the public or patients are not directly served or interacted with, it would not be considered a health care setting.

If a pharmacy is in a part of a health care facility or medical office that is a health care setting where the public or patients are not directly served or interacted within the pharmacy "area" and it is physically separated from areas where patients are allowed or health care is delivered, with walls from floor to ceiling and a door that remains closed when not being used, that space would not be considered a health care setting.

Q: Is the optician counter in a retail setting a health care setting and therefore opticians and customers are required to wear masks in this setting?

No. Optician counters in retail settings are not health care settings. However, optometrist and ophthalmologist offices are health care settings and masks are required in these settings. If the optician counter is inside a doctor's office, masks are required at the counter as it is located within a health care setting.

Q: Are residential behavior rehabilitation services (BRS) facilities required to comply with the Oregon Health Authority's health care facility masking rule?

No. BRS residential facilities are exempt from complying with OHA's masking in health care settings rule, OAR 333-019-1011, because such facilities are licensed by the Oregon Department of Human Services (ODHS) and ODHS has its own masking requirements. BRS residential facilities are similar to the other ODHS licensed settings that are specifically exempt under the rule.

BRS residential facilities should implement **enhanced COVID-19 prevention strategies** when the **COVID-19 Community Level** **is medium or high,** or when **facility-level factors** **indicate increased risk.**

Note: Some ODHS licensed facilities are subject to OHA's masking in health care settings, rule, such as but not limited to long term care facilities and assisted living facilities.

Q: Are offices of licensed professional counselors in private practice considered health care settings and subject to the mask guidance for health care offices?

Yes. Settings where behavioral health services are offered are considered health care settings.

Q: Are recovery centers or settings where behavioral health services are offered, such as counseling services and therapy considered health care settings?

Yes, settings where behavioral health services are offered are considered health care settings.

Q: Why does the health care settings mask requirement apply to so many types of health care settings, including behavioral health settings?

Masks are an important part to reducing COVID-19 cases, hospitalizations and deaths. Health care workers are at increased risk of exposure to COVID-19 given close contact with multiple people throughout the day and the potential of asymptomatic transmission. In addition, health care settings are spaces that frequently have people with underlying conditions, including behavioral health conditions, that put them at risk for more severe illness from COVID-19. OHA's rule provides broad protection for patients, visitors and personnel in the many types of health care settings in the state.

Q: If I work in a long-term assisted living facility, do I have to wear a mask when at work?

Yes. Assisted living facilities, residential care facilities and nursing facilities licensed by Oregon Department of Human Services are considered health care settings and are subject to the masking rule.

Q*: Are clinics where WIC services are provided considered health care settings and subject to the mask requirement?

Yes. WIC clinics are health care settings and therefore are subject to the rule. This includes areas where clients are waiting to receive services or to interact with WIC staff.

Q: Is a massage therapy office considered a health care setting and subject to the mask requirement?

It depends. The definition of health care setting is broad, but it was intended to apply to settings where health care is routinely provided, or temporary sites such as mobile clinics or ambulances. Some settings where massage therapists are practicing are likely health care settings, but others not. For example, massage settings within in other health care settings like a doctor's office or acupuncture office are health care settings and subject to the mask requirement. Spas are not health care settings and massage areas in spas are not subject to the mask requirement. Massage practices that are not located in health care settings may require providers, visitors and clients to wear masks.

Q: Does the health care provider masking rule apply in veterinary clinics?

No. The rule applies in health care settings. A veterinary clinic is not a health care setting and therefore the rule does not apply to veterinarians who provide care to animals in a veterinary care setting.

Q: Why did OHA lift mask requirements in schools and in public indoor spaces and not in health care settings?

Universal masking as part of layered mitigation strategies is important in health care settings. Health care workers are at increased risk of exposure to COVID-19 due to the nature and setting of their work. Individuals with confirmed or suspected cases of COVID-19 often seek care in these settings. In addition, health care settings are spaces that frequently have people with underlying conditions that put them at risk for

more severe illness from COVID-19. Masking, along with other mitigation strategies protects all patients, providers and staff and support protection of the general community.

Q: Does OHA provide a sign with mask requirements for health care settings to post?

Yes. OHA provides signs at this link.

Q: If I am fully vaccinated and boosted, am I still required to wear a face covering in a health care setting?

Yes.

Q: If I work in a school-based health center, am I required to wear a mask under OHA's rule?

Yes. School-based health centers (as regulated in OAR 333-028-0200 through 333-028-0250) are health care settings and therefore masks are required for health care personnel, patients and visitors in these settings. In addition, masking may be required pursuant to OR-OSHA's rule on exceptional risk (OAR 437-001-0744) for those situations covered by the rule. OHA provides a sign here under "signage" that may be posted in health care settings

Q: If I am a school nurse, or a staff member providing services under direction of a school nurse, am I required to wear a mask when providing services in a school health care setting?

Yes. A school nurse, and school staff, students, and visitors are required to wear a mask in areas of the school that meet the definition of health care setting under OAR 333-019-1011(6)(d). This may include a school health room, isolation space, a mental or behavioral health care setting, and other areas that are designated for providing health care.

Q: If I am a school nurse, or a staff member providing services under direction of a school nurse, am I required to wear a mask when providing services in a classroom?

OHA's rule does not require masking in classrooms because classrooms are not health care settings. School areas including but not limited to classrooms, gymnasiums and playgrounds are not health care settings. Masking is only required by OHA's rule in parts of a school that have been specifically designated by the school as a health care setting. However, OHA recommends providers consider the nature of the health care task when determining whether they should wear a mask, even when they are not in health care settings. In addition, local government, districts, or school administrators may adopt masking requirements in areas not covered by OHA's rules and individuals in these areas must comply with local requirements. Masking also may be required pursuant to OR-OSHA's rule on exceptional risk (OAR 437-001-0744) for those situations covered by the rule.

School administrators should collaborate with school nurses and applicable school health staff to identify which areas of the school meet the definition of health care setting per OAR 333-019-1011(6)(d).

OHA provides a sign here under "signage" that may be posted in health care settings

Q: Are masks required for school mental health providers, such as a school-employed or community-based providers who deliver mental or behavioral health services in health care settings?

Yes. Providers, staff, visitors and patients are required to wear a mask in a health care setting. Academic counseling is not health care and academic counseling offices are not health care settings.

Q: If I am a person licensed by Teachers Standards and Practices Commission (TSPC), such as a TSPC-licensed school counselor, school social worker, or school psychologist, are the designated areas where I provide services considered health care settings under the OHA rule?

No, not unless the services offered falls under the OHA rule. The OHA rule does not apply to academic services. The OHA rule requires masks in settings "where health care (including behavioral health care) is delivered" and for "an individual working in a health care setting providing direct patient or resident care, or direct/indirect exposure to patients, residents, or infectious materials." OAR 333-19-1011(6).

Q: Are masks required for school health providers offering specialized services (e.g. physical therapy, occupational therapy, speech and language pathology) in health care settings?

Yes. Providers, staff, visitors and patients are required to wear a mask in health care settings.

Q: If aerosol-generating procedures (AGPs) are delivered in a classroom, is the classroom then considered a health care setting?

No. However, OHA strongly recommends that AGPs are performed in a separate room, away from other students and staff, and that providers wear masks when performing AGPs. Click here for more information about working with students with complex needs and populations needing close contact.

Q: Are masks required for juvenile correctional facility mental health providers who deliver mental or behavioral health services in health care settings?

Yes. Providers, staff, visitors, clients and patients are required to wear a mask in health care settings.

Q: If I am a juvenile correctional facility health provider, or a staff member providing services under the direction of a health provider, am I required to wear a mask when providing services in a housing unit or other area of campus other than health care setting?

Generally, no. OHA's rule does not require masking in housing units because housing units are not health care settings. Juvenile correctional facility areas including, but not limited to, housing units, classrooms, gymnasiums, administrative buildings, and outdoor areas are not health care settings unless the facility designates the area as a health care setting. Masking is only required by OHA's rule in parts of a campus that are health care settings such as clinical offices and in areas specifically designated health care settings. However, OHA recommends providers consider the nature of the health care task when determining whether they should wear a mask, even when they are not in health care settings when providing care. In addition, local government, districts, or facility administrators may adopt masking requirements in areas not covered by OHA's rules and individuals in these areas must comply with those requirements. Masking also may be required pursuant to OR-OSHA's rule for exceptional risk workplaces (OAR 437-001-0744).

Q: Are masks required in residential programs that are licensed by the Oregon Department of Human Services (ODHS)?

Some facilities licensed by the ODHS are exempt from OHA's rule requiring masking in health care settings, such as adult foster homes, behavior rehabilitation services facilities, developmental disability foster homes, residential training homes and residential training facilities, but ODHS has established their own masking requirements for many of these settings. If an ODHS licensed facility is not exempt under OAR 333-019-1011(4) and it otherwise meets the definition of a health care setting, then the masking requirements apply.

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the COVID-19 Communications Unit at 1-971-673-2411, 711 TTY or COVID19.LanguageAccess@dhsoha.state.or.us.

Rules Addressing the COVID-19 Public Health Emergency in All Oregon Workplaces

Adopted Rules
Oregon OSHA Administrative Order 5-2022
Filed September 9, 2022, Effective September 12, 2022

Text removed is in [~~brackets with line through~~].

Text added is in **bold and underline**.

437-001-0744 Rule Addressing COVID-19 Workplace Risks

Note: Oregon OSHA's temporary rule addressing COVID-19 in the workplace expired May 4, 2021, 180 days after its adoption. Under the Oregon Administrative Procedures Act, a temporary rule cannot be renewed or extended beyond 180 days. Therefore, in order to extend protections for workers against COVID-19, which remains a significant concern, Oregon OSHA **initially** adopted this rule following the normal process for permanent rulemaking. However, the purpose of this rule is to address the COVID-19 pandemic in Oregon workplaces. Oregon OSHA will repeal the rule when it is no longer necessary to address th[~~at~~]**e** pandemic. Because it is not possible to assign a specific time for that decision, Oregon OSHA will **continue to** consult with the Oregon OSHA Partnership Committee, the Oregon Health Authority, the two Infectious Disease Rulemaking Advisory Committees, and other stakeholders as circumstances change to determine when all or part of the rule can be appropriately repealed.[~~ The first of these discussions took place in June 2021, and they will continue every month until the rule has been repealed. In making determinations about when to repeal all or part of the rule]~~, Oregon OSHA and its stakeholders will consider indicators and other information such as (but not limited to) Executive Orders issued by the Governor, guidance issued by the Oregon Health Authority and the Centers for Disease Control, infection rates (including the rate of spread of COVID-19 variants), test positivity rates, and vaccination rates, as well as indicators of severity such as hospitalizations and fatalities.

In accordance with its commitment to repeal the rule when it is no longer necessary, on March 18, 2022, Oregon OSHA amended this rule to remove the indoor masking requirements and most of the other provisions no longer appropriate for that stage of the pandemic. The changes were in response to Governor Brown's announcement of updated health guidance on February 28, 2022, and direction from the Oregon Health Authority. In order for these changes to take immediate effect, they were effectuated via a temporary rule. As stated above, a temporary rule cannot be renewed or extended beyond 180 days. Therefore, in order to preserve the changes made on March 18, 2022, and to remove some additional requirements as advised by the Oregon Health Authority, Oregon OSHA is adopting this rule following the normal process for permanent rulemaking. Failure to adopt this rule would result in the rule reverting to its form as of December 21, 2021 (Administrative Order 14-2021).

(1) Scope and Application.

(a) This rule applies to all employees working in places of employment subject to Oregon OSHA's jurisdiction and exposed to one or more other individuals outside their household. For clarity and ease of reference, this rule refers to "COVID-19" when describing exposures or potential exposures to SARS-CoV-2, the virus that causes Coronavirus Disease 2019.

(b) The requirements of section**s** (3) [~~of this rule are applicable to all workplaces. In addition to the requirements of section (3), the requirements of section~~]**and** (4) of this rule are applicable to [~~all~~] exceptional risk workplaces. For purposes of this rule, "~~"~~workplaces at exceptional risk~~,"~~ include any setting (whether a healthcare setting or not) where an employee (including temporary and part-time employees) performs one or any combination of the following job duties:

(A) Direct patient care;

(B) Environmental decontamination services in a healthcare setting;

(C) Aerosol-generating healthcare or postmortem procedures;

(D) Direct client service in residential care or assisted living facilities;

(E) Emergency first responder activities;

(F) Personal care activities that involve very close contact with an individual, such as toileting or bathing; or

(G) Handling, packaging, cleaning, processing, or transporting human remains or human tissue specimens or laboratory cultures collected from an individual known or suspected to be infected with COVID-19.

¶

Note: "Contact tracing" requirements as described in subsections (3)(l) and (4)(i) of this rule are not applicable for law enforcement covered in the emergency first responder definition of subsection (2)(e), personal care activities in (1)(b)(F), and handling, packaging, cleaning, processing, or transporting human remains or human tissue specimens or laboratory cultures in (1)(b)(G).

Note: "Exceptional risk" does not include workers of other departments or job duties outside the scope and underlying definitions of **subsection** (1)([~~c~~]**b**) of this rule. For example, employees in the accounting department at a hospital would be covered by the requirements applicable to all workplaces, while other workers at the same hospital who actually perform any of those job operations listed under **subsection** (1)([~~c~~]**b**), such as direct patient care, would be subject to the supplementary requirements for workplaces at exceptional risk in addition to the requirements for all workplaces.

Note: It is important to recognize other regulatory bodies may have additional requirements relating to exceptional risk beyond Oregon OSHA requirements.

(c) The requirements of section (5) of this rule are applicable to all workplaces not otherwise covered under the exceptional risk workplace requirements of sections (3) and (4).

(2) Definitions.

(a) Aerosol-generating healthcare or postmortem procedure - means a medical, dental, or postmortem procedure on human patients or remains that is likely to result in exposure to small droplet nuclei in high concentration, presenting a risk for airborne transmission of COVID-19.

(b) Common areas - means building lobbies, reception areas, waiting rooms, restrooms, break rooms, eating areas, smoking areas, locker rooms, bathing areas, transit lounges, conference rooms, or other locations indoors or outdoors that multiple individuals may use or congregate that employers operate or control.

(c) Decontamination of filtering facepiece respirators (FFR) - means a process approved by the U.S. Food and Drug Administration (FDA) that reduces the number of pathogens, does not negatively affect the fit or filtration performance of the FFR, and presents no residual chemical hazard.

(d) Direct patient care - means any employee job duties that include direct physical contact with a patient during the delivery of healthcare services. A worker performs direct patient care under the authority granted by a license or certification issued by federal, state, or local entities to provide healthcare services within the scope of practice. Workers may be providing direct patient care under their own licensure or certification, or may be providing care under the supervision of a licensed or certified worker. Workers involved in direct patient care include, but are not limited to, physicians, physician assistants, nurses, nurse practitioners, certified nursing aides, medical technologists, phlebotomists, respiratory therapists, dentists, dental hygienists, physical or occupational therapists, chiropractors, and other workers who otherwise provide in-person healthcare services. Direct patient care does not include customer service activities provided in retail settings that have embedded healthcare offices, such as retail pharmacies.

(e) Emergency first responder activities - means those job duties that require an employee to be able to arrive first and provide assistance at the scene of an emergency, such as an accident, fire, or natural disaster. First responders include but are not limited to law enforcement officers, firefighters, emergency medical technicians, and paramedics. Emergency first responder activities under this rule

do not include tasks where only first aid is provided in accordance with OAR 437-002-0161.

(f) Employee - means any individual, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, financial or otherwise, subject to the direction and control of an employer; any salaried, elected and appointed official of the state, state agencies, counties, cities, school districts and other public corporations; and any individual who is provided with workers' compensation coverage as a subject worker pursuant to ORS chapter 656, whether by operation of law or election.

(g) Employer - means any person who has one or more employees, any sole proprietor or member of a partnership who elects workers' compensation coverage, or any corporation in relation to the exposure of its corporate officers except for corporations without workers' compensation coverage under ORS 656.128 and whose only employee is the sole owner of the corporation, or any successor or assignee of an employer as described in OAR 437-001-0015.

(h) Employment, Place of - has the meaning provided in OAR 437-001-0015 and excludes any place where the only employment involves workers not covered by workers' compensation and employed in or around a private home, as well as any corporate farm where the only employment involves the farm's family members

Note: The employment of home care and home healthcare workers by a resident of the home in which they work is not subject to workers' compensation (even though the employees receive such coverage through the Home Care Commission) and therefore their employment is not covered by Oregon OSHA. Such workers who are employed by private home health or in-home care agencies are subject to workers' compensation and therefore their employment is covered by Oregon OSHA. Private homes, such as adult foster care homes, where the only employment is for the care and comfort of the residents are also not required to obtain workers' compensation and are therefore not subject to Oregon OSHA unless the employer has opted to provide workers' compensation coverage under ORS 656.039.

(i) Environmental decontamination services - means the work performed by janitorial, custodial, maintenance, or similar employees who are responsible for cleaning equipment, surfaces, or other items in direct patient care healthcare settings. This includes routine and non-routine cleaning or disinfecting of high-touch surfaces as defined by this rule, equipment, or procedural tools that are used in patient care areas in healthcare settings, including those settings in which aerosol-generating procedures are performed.

(j) Face covering - means a cloth, polypropylene, paper or other covering that covers the nose and the mouth and that rests snugly above the nose, below the mouth, and on the sides of the face. Coverings that incorporate a valve that is designed to facilitate easy exhalation or mesh masks or other covers with openings, holes, visible gaps in the design or material, or vents are not

appropriate face coverings because they allow droplets to be released from the covering.

(k) Face shield - means a transparent plastic shield that covers the wearer's forehead, extends below the chin, and wraps around the sides of the face. Devices that place a shield in front of only the user's nose and mouth do not meet the definition of a mask, face covering, or face shield. Face shields are normally used as protection for the face and eyes and their use as a means of "source control" should be discouraged when more suitable alternatives are available, but they remain a compliant (although not preferred) means of "source control" in relation to COVID-19.

(l) Feasibility - refers to the ability of an employer to implement any requirement in a rule. Oregon OSHA rules never prohibit work. Whether feasibility is mentioned in a provision of the rule or not, if the employer can demonstrate that it is functionally impossible to comply or if doing so would prevent completion of the work, the employer need not comply, but must take any available reasonable alternative steps to protect the employees involved.

(m) Filtering facepiece respirator - means a tight-fitting, negative pressure, particulate respirator, where the particulate filter is the facepiece itself. Such respirators are often referred to as "dust masks," but dust masks that are not certified by the National Institute for Occupational Safety and Health are not respirators. The most common filtering facepiece respirators for general use are known as N95 respirators.

(n) Hand hygiene - means the cleaning, sanitizing, or disinfecting of one's hands by using standard handwashing methods with soap and running water, antiseptic hand wash, antiseptic hand rub (alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis.

(o) Healthcare setting - means any space at the workplace where a worker routinely provides direct patient care as defined by this rule or performs aerosol-generating healthcare or postmortem procedures. A healthcare setting does not include any establishment where only personal support services are provided or places where direct patient care is provided to a patient outside the healthcare setting itself.

(p) High-touch surface - means equipment or surfaces that are handled frequently throughout the day by multiple individuals. High-touch surfaces can include, but are not limited to, countertops, tabletops, credit card terminals, doorknobs, door handles, digital kiosks, touch-screen enabled devices, light switches, handrails, elevator control panels, and steering wheels in work vehicles

(q) Individual - means any person who is present in the place of employment, whether an employee or not.

(r) Mask - means a U.S. Food and Drug Administration (FDA) cleared surgical, medical procedure, dental, or isolation mask (commonly referred to as a "surgical mask"). Masks are medical grade masks that function as a physical barrier to protect workers from hazards such as splashes of large droplets of blood or bodily fluids; they do not provide reliable protection to the wearer against aerosols or airborne pathogens.

(s) Personal protective equipment (PPE) - means specialized clothing or equipment worn by a worker for protection against a hazard. General work clothing (for example, uniforms, pants, shirts or blouses) not intended to function as protection against a hazard for the user is not considered to be PPE.

(t) Personal support services - means the work performed by a caretaker or similar employee who is responsible for assisting individuals with day-to-day living issues that are not direct patient care activities. Personal support services include, but are not limited to housekeeping, assisting with medication, personal transportation (such as taking a client to an appointment), and other day-to-day living activities that may occur in an individual's private residence are not otherwise considered to be direct patient care under this rule.

(u) Respirator - means a type of personal protective equipment that protects against respiratory hazards by removing specific air contaminants from the ambient (surrounding) air or by supplying breathable air from a safe source. Respirators that remove contaminants from the ambient air are called air-purifying respirators. Respirators that supply air from a safe source other than the ambient air are called atmosphere-supplying respirators. Masks, face coverings, and face shields are not respirators.

(v) SARS-CoV-2 - refers to a specific betacoronavirus (MERS-CoV and SARS-CoV are other betacoronaviruses) that causes what has been designated as Coronavirus Disease 2019 (COVID-19)

(w) Shared equipment - means devices or tools that are used by multiple employees or other individuals including, but not limited to, elevators, computers, phones, gym or personal fitness devices, escalators, and work vehicles.

(x) Source control - means the use of protective equipment or other measures such as face coverings to prevent the spread of illness from a potentially infectious person to others. A typical example of source control for COVID19 is to use a mask or face covering to limit the spread of respiratory droplets and

aerosols from the wearer to others. Respirators can be used as source control in addition to providing protection for the wearer.

(y) Suspected to be infected with COVID-19 - means a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2 infection and no alternative diagnosis has been made consistent with Oregon Health Authority definitions.

(3) COVID-19 Requirements for [~~All~~]**Exceptional Risk** Workplaces. Except as otherwise provided by this rule, the following requirements [~~apply to all~~]**in section (3) apply to exceptional risk** workplaces.

(a) Physical distancing. Oregon OSHA [~~only~~]**no longer** requires employers to implement physical distancing[~~ in healthcare settings and transit settings in accordance with subsection (4)(k) and the appendix. Employers who wish to evaluate their workplaces to determine how they can keep their employees safe and healthy are encouraged to contact Oregon OSHA Consultation Services.~~]

(b) Masks, face coverings, or face shields. ~~[Employers with employees working in indoor workspaces must implement the requirements of OAR 333-019-1025: Masking Requirements for Indoor Spaces, adopted by the Oregon Health Authority.]~~¶ **The specific requirements for masks, face coverings, and face shields are covered under subsection (4)(l) of this rule**.

~~(A) [The employer must provide masks, face coverings, or face shields for employees at no cost to the worker. If an employee chooses to wear their own mask, face shield, or face covering instead of those provided by the employer, the employer may allow it but is not required to do so.~~

~~(B) When an employee chooses to wear a filtering facepiece respirator to protect against COVID-19, the employer must allow that use and follow the "voluntary use" provisions of the Respiratory Protection Standard (29 CFR 1910.134).~~

~~Note: An employer is not obligated to provide filtering facepiece respirators to employees under this section, nor are employers required to provide or allow any other type of respirator, unless required by another part of this rule.~~

~~(C) If an employee chooses to wear a mask, face shield, or face covering even when it is not required, the employer must allow them to do so. .]~~

(c) Cleaning and sanitation. Except for healthcare settings, which are covered under subsection (4)(d) of this rule, Oregon OSHA no longer requires employers to regularly clean or sanitize all common areas, shared equipment, and high-touch surfaces as defined by this rule that are under its control and that are used

by employees or the public. [~~All other sanitation requirements of OAR 437-001-0744(3)(c) remain in effect for all workplaces.~~]

(A) Employers must provide employees with the supplies (such as soap and water) and the reasonable time necessary to clean or sanitize more frequently than would otherwise be required if the worker chooses to do so.

(B) Employers must provide employees with the supplies (such as soap and water) and reasonable time necessary to perform hand hygiene before using shared equipment.

[~~(C) Except in healthcare settings where patients known or suspected to be infected with COVID-19 are being treated, employers must clean and disinfect any common areas, high-touch-surfaces, and any shared equipment under the employer's control that an individual known to be infected with COVID-19 used or had direct physical contact with. If the employer learns of the exposure between 24 and 72 hours after the individual was last present in the space, only cleaning is required, not sanitation. If the employer learns of the exposure more than 72 hours after the individual was last present in the space, no exceptional cleaning or sanitation is required.~~

~~Note: It is recommended that the area be closed off and a waiting period of at least several hours (or as long as is feasible) be followed prior to cleaning and disinfecting.~~]

Note: Additional sanitation requirements for exceptional risk workplaces are included in subsection (4)(d) of this rule.

(d) Posting requirements. [~~In addition to posting the "It's the Law" poster provided by Oregon OSHA in a conspicuous manner in a central location where workers can be expected to see it (for example, a location where employees report each day or at a location from which employees operate to carry out their activities), as required by OAR 437-001-0275(2)(a), employers must provide employees working remotely with a copy through electronic or equally effective means.~~] **Oregon OSHA no longer requires the COVID-19 poster to be posted in the workplace.**

(e) Building operators. [~~Those employers who operate or otherwise control buildings where the employees of other employers work must take the following steps in common areas to the extent that they have control over such areas:~~] **Oregon OSHA no longer requires building operators to take the additional steps related to sanitation and posting of signs**.

~~(A) [Ensure that the sanitation requirements under subsection (3)(c) of this rule are met; and~~

~~(B) Post signs in areas where masks, face coverings, or face shields are required To meet this provision, the building operator may post a copy of the "Masks Required," sign developed by the Oregon Health Authority]~~

(f) Routine ventilation maintenance and evaluation. [~~The e~~]**Employers covered by section (3) of this rule** must optimize the amount of outside air circulated through its existing heating, ventilation, and air conditioning (HVAC) system(s), to the extent the system(s) can do so when operating as designed and maintaining healthy indoor temperatures, whenever there are employees in the workplace and the outdoor air quality index remains at either "good" or "moderate" levels.

Note: This does not require installation of new ventilation equipment.

Note: While not required, ventilation systems that are installed and maintained in accordance with the provisions of the American National Standards (ANSI)/American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards 62.1 and 62.2 (ASHRAE 2019a, 2019b) meet this requirement.

(A) All employers **covered by section (3) of this rule** with more than ten employees statewide and an existing HVAC system must certify in writing that they are operating that system in accordance with the rule, to the best of their knowledge. Although not required, such certifications can be made using the sample format provided by Oregon OSHA.

(i) The certification must be dated and must include the name of the individual making the certification; and

(ii) Such certification records must be maintained as long as this rule is in effect.

(B) On a quarterly basis, all employers must ensure the following:

(i) All air filters are maintained and replaced as necessary to ensure the proper function of the ventilation system; and

(ii) All intake ports that provide outside air to the HVAC system are cleaned, maintained, and cleared of any debris that may affect the function and performance of the ventilation system.

(g) Exposure risk assessment. All employers **covered by section (3) of this rule** must conduct a COVID-19 exposure risk assessment, without regard to the use of

personal protective equipment, masks, face coverings, or face shields. A risk assessment conducted in compliance with the Oregon OSHA temporary COVID-19 rule adopted November 6, 2020, satisfies this requirement and need not be repeated. If an employer has multiple facilities that are substantially similar, the assessment may be developed by facility type rather than site-by-site so long as any site-specific information that affects employee exposure risk to COVID-19 is included in the assessment.

(A) The exposure risk assessment must involve participation and feedback from employees. This feedback may be achieved via a safety meeting, safety committee, supervisor, process negotiated with the exclusive bargaining agent (if any), or any other similarly interactive process.

(B) Each employer with more than ten employees statewide (including temporary and part-time workers) ~~or~~ that is covered by subsection (1)([~~c~~]**b**) of this rule (workplaces at exceptional risk) must record their COVID-19 exposure risk assessment in writing by documenting the following information

(i) The name(s), job title(s), and contact information of the person(s) who performed the exposure risk assessment;

(ii) The date the exposure risk assessment was completed;

(iii) The employee job classifications that were evaluated; and

(iv) A summary of the employer's answers to each of the applicable exposure risk assessment questions in this subsection.

(C) The risk assessment must address the following questions related to potential employee exposure to COVID19 in the workplace:

(i) Can employees telework or otherwise work remotely? How are employees encouraged or empowered to use those distance work options to reduce COVID-19 transmission at the workplace?

(ii) What are the anticipated working distances between employees? How might those physical working distances change during non-routine work activities?

(iii) What is the anticipated working distance between employees and other individuals? How might those working distances change during non-routine work activities?

(iv) How have the workplace or employee job duties, or both, been modified to provide at least six feet of physical distancing between all individuals?

(v) How are employees and other individuals at the workplace notified where and when masks, face coverings, or face shields are required? How is this policy enforced and clearly communicated to employees and other individuals?

(vi) How have employees been informed about the workplace policy and procedures related to reporting COVID19 symptoms? How might employees who are identified for quarantine or isolation as a result of medical removal under this rule be provided with an opportunity to work at home, if such work is available and they are well enough to do so?

(vii) How have engineering controls such as ventilation (whether portable air filtration units equipped with HEPA filters, airborne infection isolation rooms, local exhaust ventilation, or general building HVAC systems) and physical barriers been used to minimize employee exposure to COVID-19?

(viii) How have administrative controls (such as foot-traffic control) been used to minimize employee exposure to COVID-19?

(ix) What is the procedure or policy for employees to report workplace hazards related to COVID-19? How are these hazard reporting procedures or policies communicated to employees?

(x) How are sanitation measures related to COVID-19 implemented in the workplace? How have these sanitation practices been explained to employees and other individuals at the workplace?

(xi) How have the industry-specific or activity-specific COVID-19 requirements in Appendix A of this rule and applicable guidance from the Oregon Health Authority been implemented for workers? How will periodic updates to such Oregon Health Authority guidance documents incorporated into the workplace on an on-going basis?

(xii) In settings where the workers of multiple employers work in the same space or share equipment or common areas, how are the physical distancing, mask, face covering, or face shield requirements; and sanitation measures required under this rule communicated to and coordinated between all employers and their affected employees?

(xiii)How can the employer implement appropriate controls that provide layered protection from COVID-19 hazards and that minimize, to the degree possible, reliance on individual employee training and behavior for their efficacy?

Note: Oregon OSHA has made a Risk Assessment template and sample Risk Assessments available to assist employers in completing this task.

(h) Infection control plan. All employers **covered by section (3) of this rule** must establish and implement an infection control plan based on the risks identified in subsection (3)(g) of this rule that implements the controls identified in subparagraph (3)(g)(C)(xiii) including, but not limited to, ventilation, staggered shifts, redesigning the workplace to accommodate physical distancing, reducing use of shared surfaces and tools, limiting the number of employees and other individuals in work areas, personal protective equipment, etc. An infection control plan developed in compliance with the Oregon OSHA temporary COVID-19 rule adopted November 6, 2020, satisfies this requirement and need not be repeated. If an employer has multiple facilities that are substantially similar, its infection control plan may be developed by facility type rather than site-by-site so long as any site-specific information that affects employee exposure risk to COVID-19 is included in the plan. Employers may also rely upon materials developed by associations, licensing agencies, and franchisors to assist with compliance and provided that mechanisms for appropriate employee feedback and involvement are provided.

(A) Each employer with more than ten employees statewide (including temporary and part-time workers) and every employer, regardless of size, that is covered by subsection (1)([~~c~~]**b**) of this rule (workplaces at exceptional risk) must document their infection control plan in writing and must ensure that a copy is accessible to employees at their workplace.

Note: Additional requirements related to the infection control plan, which are applicable only to those employers covered by subsection (1)([~~c~~]**b**) of this rule (workplaces at exceptional risk), are contained in subsection (4)(c) of this rule.

(B) The infection control plan must contain, at a minimum, the following elements:

(i) A list of all job assignments or worker tasks requiring the use of personal protective equipment (including respirators) necessary to minimize employee exposure to COVID-19;

(ii) The procedures the employer will use to ensure that there is an adequate supply of masks, face coverings, or face shields and personal

protective equipment (including respirators) necessary to minimize employee exposure to COVID-19;

(iii) A list and description of the specific hazard control measures that the employer installed, implemented, or developed to minimize employee exposure to COVID-19;

(iv) A description of the employer's COVID-19 mask, face covering, and face shield requirements at the workplace, and the method of informing individuals entering the workplace where such source control is required;

(v) The procedures the employer will use to communicate with its employees and other employers in multiemployer worksites regarding an employee's exposure to an individual known or suspected to be infected with COVID-19 to whom other workers may have been exposed. This includes the communication to individuals identified through COVID-19 contact tracing and general communication to the workplace at large; and

(vi) The procedures the employer will use to provide its workers with the initial employee information and training required by this rule.

Note: Oregon OSHA has made sample Infection Control Plans available to assist employers in completing this task.

(i) Employee information and training. All employers **covered by section (3) of this rule** must provide workers with information and training regarding COVID-19. Infection control training conducted in compliance with the Oregon OSHA temporary COVID-19 rule adopted November 6, 2020, satisfies this requirement. This information and training can be provided remotely or using computer-based models but must be provided in a manner and language understood by the affected workers. Employers must ensure that the training provides an opportunity for feedback from employees about the topics covered in the training, which must include at least the following elements:

(A) Physical distancing requirements as they apply to the employee's workplace and job function(s);

(B) Mask, face covering, or face shield requirements as they apply to the employee's workplace and job function(s);

(C) COVID-19 sanitation requirements as they apply to the employee's workplace and job function(s);

(D) COVID-19 signs and symptom reporting procedures that apply to the employee's workplace;

(E) COVID-19 infection notification process as [~~required~~]**suggested** by this rule;

(F) Medical removal as required by this rule;

(G) The characteristics and methods of transmission of the SARS-CoV-2 virus;

Note: Oregon OSHA has provided training materials that can be used to complete this portion of the training.

(H) The symptoms of the COVID-19 disease;

Note: Oregon OSHA has provided training materials that can be used to complete this portion of the training.

(I) The ability of pre-symptomatic and asymptomatic COVID-19 persons to transmit the SARS-CoV-2 virus; and

Note: Oregon OSHA has provided training materials that can be used to complete this portion of the training.

(J) Safe and healthy work practices and control measures, including but not limited to, physical distancing, sanitation and disinfection practices.

Note: Oregon OSHA has provided training materials that can be used to complete this portion of the training.

(j) COVID-19 infection notification process. [~~The~~]**All** employer[~~must~~]**s covered by section (3) of this rule should** establish and implement a process to notify exposed employees (those who were within six feet of a confirmed COVID-19 individual for a cumulative total of 15 minutes or more, regardless of whether one or both of them were wearing source control) that they had a work-related contact with an individual who has tested positive for COVID-19, as well as to notify affected employees (those who worked in the same facility or in the same well-defined portion of the facility such as a particular floor) that an individual who was present in the facility has confirmed COVID-19. This notification process [~~must~~]**should** include the following elements:

(A) A mechanism for notifying both exposed and affected employees within 24 hours of the employer being made aware that an individual with COVID-

19 was present in the workplace while infectious or otherwise may have had work-related contact with its employee(s) while infectious; and

(B) This notification process [~~must~~]**should** be established and implemented in accordance with all applicable federal and Oregon laws and regulations.

Note: Employers can satisfy this requirement by adopting the model procedure published by Oregon OSHA.

Note: The reporting of COVID-19 cases [~~is~~]**may be** required under existing Oregon Health Authority rules regarding reporting of disease cases. OAR 333-018-0016 requires such cases to be reported by healthcare providers and laboratories within 24 hours of identification.

Note: Whenever an exposure notification as described by this rule is provided in writing, the notification may be subject to the existing requirements of Oregon OSHA's Access to Employee Exposure and Medical Records standard (29 CFR 1910.1020).

(k) COVID-19 testing for workers. The employer must cooperate by making its employees and appropriate space available at no cost to the workers whenever a local public health agency or Oregon Health Authority indicate that COVID-19 diagnostic testing within the workplace is necessary. If such testing is conducted at the employer's own direction, the employer is responsible for covering the costs of testing, including but not limited to the COVID-19 test itself, employee time, and employee travel. However, if the employer is not requesting the test, the employer is not expected to cover the direct cost of such testing or of any involved employee travel.

(l) Medical removal. Whenever the Oregon Health Authority, local public health agency, or medical provider recommends an employee be restricted from work due to quarantine or isolation for COVID-19, such as through identification during contact tracing activities, the affected worker(s) must be directed to isolate at home and away from other non-quarantined individuals.

Note**: There are additional medical removal provisions for healthcare settings in subsection (4)(j) of this rule.**

Note: Other than the obligation to provide such direction and to remove such employees from the workplace, the employer has no obligation to enforce the employee's quarantine or isolation.

Note: "Contact tracing" requirements as described in subsections (3)(l) and (4)(i) of this rule are not applicable for law enforcement covered in the emergency first responder definition of subsection (2)(e), personal care activities in (1)(c)(F), and handling, packaging, cleaning, processing, or transporting human remains or human tissue specimens or laboratory cultures in (1)(c)(G).

(A) Whenever an employee participates in quarantine or isolation for COVID-19, the employer must allow the affected employee(s) to work at home if suitable work is available and the employee's condition does not prevent it.

(B) Whenever an employee participates in quarantine or isolation, whether as a result of the requirements of this rule or because the employer chooses to take additional precautions, the affected worker(s) must be notified that they are entitled to return to their previous job duties if still available without any adverse action as a result of participation in COVID-19 quarantine or isolation activities. The employee must be advised in writing of the right to return as described and should be provided any relevant information about the employer's paid time off, sick leave, or any other available benefits in accordance with local, state, or federal law.

Note: The prohibition on "adverse action" does not require the employer to keep a job available that would not otherwise have been available had the employee not been quarantined or isolated, but it does mean that the employer cannot fill the job with another employee and thereby make it unavailable.

(C) Decisions regarding testing and return to work after an employee participates in COVID-19 quarantine or isolation activities must be made in accordance with applicable public health guidance and must be otherwise consistent with guidance from the employee's medical provider.

Note: This provision does not require a negative COVID-19 test or a separate contact with the medical provider.

Note: Employees are protected from discrimination or retaliation under ORS 654.062(5). This includes protections for actions against employees for opposing any practice forbidden under the Oregon Safe Employment Act and related statutes and rules (including this rule for COVID-19), making a complaint or causing any proceeding to be instituted under the Oregon Safe Employment Act, or exercising any rights under the law, including those conferred by this Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744).

Note: Notwithstanding the language of OAR 437-001-0700(10), employers do not need to record such "medical removal" cases on their OSHA 300 log(s) simply because the medical removal required by this rule occurred. Cases must be recorded only if the infection of a worker is determined to be "work-related" in accordance with OAR 437-001-0700.

(m) Mandatory appendi**x[**~~ces. Employers covered by one or more of the mandatory industry-specific and activityspecific appendices that make up Appendix A of this rule must comply with those appendices. To the degree an appendix provides specific guidance regarding an issue addressed by this rule, it supersedes the general~~ requirements of this rule. ~~To the degree a situation is not addressed by the specific language of an appendix, the~~ requirements of this rule ~~apply as written. Appendix A contains the following:¶]~~ **Employers covered by the mandatory industry-specific requirements for Emergency Medical**

Services: First Responders, Firefighters, Emergency Medical Services and Non-Emergency Medical Transport must comply with this appendix. To the degree the appendix provides specific guidance regarding an issue addressed by this rule, it supersedes the general requirements of this rule. To the degree a situation is not addressed by the specific language of the appendix, the requirements of this rule apply as written.¶

~~[A-1: No Longer Required - Restaurants, Bars, Brewpubs and Public Tasting Rooms at Breweries, Wineries and Distilleries]~~

~~[A-2: No Longer Required - Retail Stores]~~

~~[A-3: Personal Services Providers]~~

~~[A-4: No Longer Required – Construction Operations]~~

~~[A-5: Transit Agencies]~~

~~[A-6: No Longer Required - Professional, Division 1, Pac-12, West Coast Conference and Big Sky Conference Sports]~~

~~[A-7: No Longer Required - Employers Operating Fitness-Related Organizations]~~

~~[A-8: K-12 Educational Institutions (Public or Private)]~~

~~[A-9: Employers Operating Child Care and Early Education Programs]~~

~~[A-10: Veterinary Clinics]~~

~~[A-11: Emergency Medical Services: First Responders, Firefighters, Emergency Medical Services and NonEmergency Medical Transport]~~

~~[A-12: Law Enforcement Activities]~~

~~[A-13:Jails, Prisons, and Other Custodial Institutions]~~

(4) **Additional** COVID-19 Requirements for Workplaces at Exceptional Risk. Workplaces identified by subsection (1)([~~c~~**b**) of this rule must adhere to the following specific provisions and additional requirements.

(a) Infection control training. In addition to the employee information and training requirements for all workplaces under subsection (3)(i) of this rule, employers of

workplaces at exceptional risk must provide infection control training that includes the following provisions:

(A) The training is overseen or conducted by a person knowledgeable in the covered subject matter as it relates to the employee's job duties;

(B) The training material is appropriate in content and vocabulary to the education, literacy, and language of the affected workers; and

(C) The training provides an opportunity for interactive questions and answers (must be "live" in order to allow immediate response and further clarification but need not be in person) with a person knowledgeable in the training program's subject matter and basic epidemiology as it relates to the workplace and employee job duties.

(b) Infection control training for employees required under this subsection must include the following elements:

(A) An explanation of this rule and its applicable appendices and provisions;

(B) An explanation of contact, droplet, and airborne modes of transmission of COVID-19, including how workers can recognize hazardous work activities that may involve exposure to COVID-19 and how employees can take precautionary measures to minimize their exposure;

(C) An explanation of the basic risk factors associated with COVID-19 transmission including, but not limited to, behavioral risk factors (this may include non-work activities that are higher-risk activities such as attending large social gatherings); physiological risk factors; demographic risk factors; and environmental risk factors;

(D) An explanation of the employer's COVID-19 exposure risk assessment required by this rule and which employee job classifications, tasks, or job duties were considered as part of that risk assessment;

(E) An explanation of the employer's physical distancing; mask, face covering, and face shield requirements; and COVID-19 sanitation requirements at the workplace. Where applicable, this information must include any multiemployer worksite agreements related to the use of common areas and shared equipment that affect employees at the workplace;

(F) Information on the types, use, storage, removal, handling, and maintenance of masks, face coverings, face shields and personal protective

equipment (including respirators) provided to employees by the employer; and

(G) An explanation of the use and limitation of COVID-19 hazard control measures implemented or installed by the employer. Hazard control measures include engineering, administrative, or work practice controls that eliminate or otherwise minimize employee exposure to COVID-19.

(c) Additional infection control plan requirements. In addition to the infection control plan requirements for all workplaces, each employer covered by section (4) of this rule must provide the following in its infection control plan:

(A) The name(s) of the person responsible for administering the plan. This person must be knowledgeable in infection control principles and practices as they apply to the workplace and employee job operations; and

(B) The plan must be reevaluated as frequently as necessary to reflect changes in the facility, employee job duties, new technologies, or workplace policies established by the employer that affect worker exposure to COVID-19 or in response to updated guidance published by the Oregon Health Authority (including increases in COVID-19 community spread) that is applicable to the employer's workplace. This reevaluation and update of the infection plan must include feedback from non-managerial, front-line employees who perform activities that reflect the employer's exceptional risk under this rule. This feedback is not required from all employees and may be achieved via a safety meeting, safety committee, supervisor, process negotiated with the exclusive bargaining agent (if any), or any other similarly interactive process.

(C) Healthcare employers must develop and implement a written personal protective equipment (PPE) supply and crisis management plan in accordance with Oregon Health Authority and Oregon OSHA Interim Guidance: Use of **CDC's Optimizing Personal Protective Equipment by Healthcare Personnel in Resource Constrained Settings** [~~Personal Protective Equipment by Healthcare Personnel in Resource Constrained Settings~~].

(d) Additional sanitation requirements. Use appropriate sanitation measures in addition to the requirements of subsection (3)(c) of this rule to reduce the risk of COVID-19 transmission. Each employer must:

(A) Develop and implement procedures for routine cleaning and disinfection that are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed

(for example, using cleaners and EPA-registered, hospital-grade disinfectants for frequently touched surfaces or objects in accordance with manufacturer instructions and contact time specifications). Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2; and

(B) Follow standard practices for disinfection and sterilization of medical devices contaminated with COVID-19, as described in the CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008.

(e) Healthcare personal protective equipment. Depending on the requirements of the procedure (for example, aerosol generating procedures, **a.k.a. AGPs**) in question and the disease status of the involved patient(s), employers must use a combination of standard precautions, contact precautions, droplet precautions, airborne precautions, and eye protection (for example, goggles, face shields) to protect healthcare workers with exposure or potential exposure to COVID-19.

(A) When an employee performs an aerosol-generating healthcare or post-mortem procedure for a patient without evidence of COVID-19 infection, the employer must provide PPE in accordance with CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel. [~~During the Coronavirus Disease 2019 (COVID-19) Pandemic~~] Oregon OSHA recognizes that risk of infection in asymptomatic patients can vary based on clinical presentation, level of COVID-19 transmission in the community, recent COVID-19 testing results, and other factors. These factors must be considered in clinical judgment by healthcare personnel involved in direct patient care and medical examiners in making decisions about use of transmission-based precautions.

(B) Whenever an employee provides direct patient care for a patient known or suspected to be infected with COVID-19, the employer must provide the affected worker with gloves, a gown, eye protection (goggles or face shield), and either a NIOSH-approved respirator or a respirator with a current emergency use authorization by the United States Food and Drug Administration (FDA). If the employer can demonstrate that the availability of respirators is genuinely limited, the employer must ensure that a medical-grade mask is used in place of the respirator.

Note: If PPE availability is genuinely limited, a procedure cannot be deferred, and appropriate, good-faith efforts are made by the employer to ensure the safety and protection of the healthcare workers, Oregon OSHA will evaluate the situation based on PPE availability and the employer's adherence to **CDC's Optimizing Personal Protective Equipment (PPE) Supplies During the COVID-19 Pandemic[** ~~guidance outlined in the~~

~~Oregon Health Authority and Oregon OSHA Interim Guidance: Use of Personal Protective Equipment by Healthcare Personnel in Resource Constrained Settings~~].

(C) In lieu of (A) and (B) above, and if PPE availability is limited, such employers may follow **CDC's Optimizing Personal Protective Equipment (PPE) Supplies During the COVID-19 Pandemic** ~~[Oregon Health Authority Oregon OSHA Interim Guidance: Use of Personal Protective Equipment by Healthcare Personnel in Resource Constrained Settings~~].

Note: The CDC does not have a comprehensive list of AGPs in a healthcare setting. **Employers should refer to the AGP list maintained by Oregon Health Authority** ~~[Clinical Care, and Healthcare Infection Prevention and Control Guidance for COVID-19.]~~

(f) Heightened risk ventilation requirements. In addition to the ventilation provisions of subsection (3)(f) of this rule (including any applicable certification provisions), certain heightened risk facilities must meet the following requirements to the degree that they are under the employer's control:

(A) Existing ventilation systems in hospitals, ambulatory surgical centers, and long-term care facilities that provide skilled or intermediate level nursing care must be operated, when possible, in accordance with local building codes and applicable provisions of the American National Standards Institute (ANSI)/American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards 62.1 and 62.2 (ASHRAE 2019a, 2019b), which include requirements for outdoor air ventilation in most residential and nonresidential spaces, and ANSI/ASHRAE/ASHE Standard 170 (ASHRAE 2017a) covers both outdoor and total air ventilation in healthcare facilities.

Note: This does not require installation of new ventilation equipment.

(B) Existing ventilation systems in other healthcare facilities must be upgraded to a minimum MERV 13 rating, provided that such an upgrade will result in no significant performance reduction of the system.

Note: This does not require installation of new ventilation equipment.

(g) Barriers, partitions, and airborne infection isolation rooms in healthcare settings. The employer must employ the following measures to protect healthcare employees, support workers, patients, and visitors from individuals known or suspected to be infected with COVID-19:

(A) When available, use airborne infection isolation rooms (AIIRs) with proper ventilation to house patients known or suspected to be infected with COVID-19;

(B) Patients known or suspected of being infected with COVID-19 must don a face covering and be isolated in an examination room with the door closed. If an examination room is not immediately available, such patients must not be allowed to wait within six feet of other patients seeking care and should be encouraged to wait in a personal vehicle or outside the healthcare setting where they can be contacted by mobile device when it is their turn to be evaluated. During a medical emergency, all measures may not be feasible, but must be implemented in whole or in part as the patient's condition and necessary medical care allow. If a patient cannot tolerate any form of face covering due to a medical condition, strict physical distancing and appropriate PPE must be used to protect patients and workers, respectively;

(C) Use physical barriers or partitions in triage areas to guide patients when appropriate; and

(D) Use curtains to separate patients in semi-private areas.

(h) Screening in healthcare settings**. Oregon OSHA no longer requires employers to screen and triage all individuals entering its healthcare setting for symptoms of COVID-19.**[~~The employer must screen and triage all individuals entering its healthcare setting for symptoms of COVID-19. Although screening for symptoms may not identify asymptomatic or presymptomatic individuals with SARS-CoV-2 infection, symptom screening remains an important strategy to identify those who may have COVID-19 so appropriate precautions can be implemented. At a minimum, each employer must:~~]

~~(A)~~ [~~Limit and monitor points of entry to the healthcare setting where direct patient care, or aerosol-generating healthcare or postmortem procedures are performed by workers. Consideration must be given to establishing stations at the healthcare setting entrance to screen individuals before they enter;~~]

~~(B)~~ [~~Screen all individuals and employees (other than emergency responders entering with a patient) entering the healthcare setting for symptoms consistent with COVID-19. This can be achieved by asking the affected individual about symptoms of COVID-19 and asking if they have been advised to self-quarantine because of exposure to someone with COVID-19 or if they have been told to isolate after testing positive for COVID-19; and~~]

~~(C)~~ [~~Develop a triage and screening protocol that isolates patients known or suspected to be infected with COVID19 from other non-COVID-19 patients; procedures for transporting patients known or suspected to be infected~~

~~with COVID-19 within the facility and between facilities as applicable; implementation of temporary air infection isolation rooms (AIIRs) as available.]~~

(i) Exposure notification process in certain healthcare settings. **Oregon OSHA no longer requires exposure notification in healthcare settings.** ~~[The only exceptions to the notification requirements of subsection (3)(j) of this rule are in healthcare settings where patients are hospitalized on the basis that they are known or suspected to be infected with COVID-19 and in healthcare settings where contact tracing has become infeasible, based upon guidance from the Oregon Health Authority and the Centers for Disease Control regarding such scenarios and the implementation of universal PPE recommendations addressing both identified and unidentified risks.]~~

~~[Note: The term "settings where patients are hospitalized on the basis that they are known or suspected to be infected," is intended to be narrowly construed and applies only to those situations where patients are receiving health services primarily related to COVID-19 and where all workers are aware of that potential exposure. For example, patient care related to labor and delivery in a hospital that is also caring for COVID-19 patients is not subject to this exclusion.]~~

(j) Medical removal provisions in healthcare settings. The only exception to the quarantine and isolation provisions of subsection (3)(l) of this rule exists when a healthcare provider, emergency responder, or other worker who would otherwise be quarantined or isolated remains on the job under Oregon Health Authority guidelines.

(k) Physical distancing. Oregon OSHA no longer requires healthcare employers to implement physical distancing ~~[All healthcare employers must ensure that both work activities and workflow are designed to eliminate the need for any employee to be within six feet of another individual in order to fulfill their job duties unless the employer determines and can demonstrate that such physical distancing is not feasible for certain activities.]~~

(l) Mask, face covering, or face shield requirements.

(A) Healthcare employers must ensure that all individuals in the workplace wear a mask, face covering, or face shield **unless otherwise exempt under paragraph (4)(l)(B) of this rule.**

~~(i) [When working inside where six feet of distance between employees and other individuals cannot be consistently maintained, or]~~

~~(ii) [When an employee shares a room with one or more other individuals and the total enclosed area of the room does not provide at least 100 square feet per person.]~~

(B) Masks, face coverings, or face shields are not required if the individual:

(i) Is under 5 years of age (or is under 2 years of age and using public transportation or in transportation hubs),

(ii) Is eating or drinking,

(iii) Is engaged in an activity that makes wearing a mask, face covering or face shield not feasible, such as when taking a shower,

(iv) Is sleeping,

(v) Is in a room or vehicle shared only with members of the same household, or

(vi) Is required to briefly remove their mask, face covering, or face shield because their identity needs to be confirmed by visual comparison, such as at the bank or if interacting with law enforcement. During such instances, individuals should limit speaking while the mask, face covering, or face shield is removed or displaced.

Note: While reasonable accommodation for those unable to wear a mask, face covering, or face shield due to a disability must be provided under applicable state law (ORS 659A.103 to 659A.145) and federal law (42 U.S.C. Chapter 126), such an accommodation does not include simply exempting individuals from the requirement to wear masks, face coverings, or face shields in public spaces or places of employment.

(C) The employer must provide masks, face coverings, or face shields for employees at no cost to the worker. If an employee chooses to wear their own mask, face shield, or face covering instead of those provided by the employer, the employer may allow it but is not required to do so.

(D) When an employee chooses to wear a filtering facepiece respirator instead of a mask, face covering, or face shield, the employer must allow that use and follow the "voluntary use" provisions of the Respiratory Protection Standard (29 CFR 1910.134).

Note: An employer is not obligated to provide filtering facepiece respirators to employees under this section, nor are employers required to provide or allow any other type of respirator, unless required by another part of this rule.

(E) If an employee chooses to wear a mask, face shield, or face covering even when it is not required, the employer must allow them to do so.

(m) Medical removal protection benefits. Medical removal protection benefits as described by this subsection must be provided whenever employees covered by this subsection are unable to work due to the medical removal provisions outlined under subsections (3)(l) and (4)(j) of this rule.

(A) Except as otherwise provided by paragraph (4)(m)(B), medical removal protection benefits as outlined under paragraph (4)(m)(C) apply to all employees engaged in direct patient care or in direct support of such care, including patient intake or admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning or reprocessing services. This provision does not apply to office or administrative functions that do not involve contact with patients or patient care spaces, such as bookkeeping, payroll, or accounting services.

(B) The medical removal protection benefits of this subsection do not apply to the following:

(i) Employers with 10 or fewer employees,

(ii) Employees whose COVID-19 illness or quarantine cannot reasonably have resulted from a workplace exposure,

(iii) Individuals who are not in compliance with Oregon Health Authority COVID-19 vaccination requirements, without regard to the effective date of those requirements,

(iv) The provision of first aid by an employee who is not otherwise a healthcare provider,

(v) The dispensing of prescriptions by pharmacists in retail settings,

(vi) Non-hospital ambulatory care settings where all non-employees are screened prior to entry and individuals with suspected or confirmed COVID-19 are not permitted to enter those settings,

(vii) Well-defined ambulatory care settings within hospitals where all employees are fully vaccinated and all nonemployees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings,

(viii) Home healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present,

(ix)Healthcare support services not performed in a healthcare setting (for example, off-site laundry, off-site food preparation), or

(x) Telehealth services performed outside of a setting where direct patient care occurs.

(C) When an employee subject to this subsection is subject to medical removal as required by the rule and the required isolation or quarantine prevents the employee from working, the following medical removal protection benefits must be provided:

(i) The employer must continue to provide the benefits to which the employee would normally be entitled when working;

(ii) For employers with 500 or more employees, the employer must pay the employee the same regular (non-overtime) pay the employee would have received had the employee not been absent from work, up to a maximum of $1,400 per week, until the employee is able to return to work as described in subsection (3)(l) of this rule;

(iii) For employers with fewer than 500 employees, the employer must pay the employee benefit described in subparagraph (4)(m)(C)(ii) of this rule, but beginning in the third week of an employee's removal, the employer is permitted to reduce the amount to only two-thirds of the same regular pay the employee would have received had the employee not been absent from work, up to $200 per day ($1,000 per week in most cases).

(D) The employer's obligation under paragraph (4)(m)(C) of this rule is reduced by the amount of compensation for lost earnings that the employee receives from any other source, such as a publicly or employer-funded compensation program (for example, workers compensation, paid sick leave, administrative leave, or other employer-provided leave that does not carry a cash value). The employer cannot take such benefits into account until they have actually been received by the employee.

Note: It is important to recognize other regulatory bodies may have additional requirements relating to exceptional risk beyond Oregon OSHA requirements.

(5) COVID-19 Requirements for all workplaces not covered under exceptional risk workplaces sections (3) and (4), as defined in section (1)(b).

(a) Masks, face coverings, and face shields.

(A) The employer must provide masks, face coverings, or face shields for employees at no cost to the worker. If an employee chooses to wear their own mask, face covering, or face shield instead of those provided by the employer, the employer may allow it but is not required to do so.

(B) When an employee chooses to wear a filtering facepiece respirator to protect against COVID-19, the employer must allow that use and follow the "voluntary use" provisions of the Respiratory Protection Standard (29 CFR 1910.134).

Note: An employer is not obligated to provide filtering facepiece respirators to employees under this section, nor are employers required to provide or allow any other type of respirator, unless required by another part of this rule.

(C) When an employee chooses to wear a mask, face covering, or face shield even when it is not required, the employer must allow them to do so.

Note: Employees are protected from discrimination or retaliation under ORS 654.062(5). This includes protections for actions against employees for opposing any practice forbidden under the Oregon Safe Employment Act and related statutes and rules (including this rule for COVID-19), making a complaint or causing any proceeding to be instituted under the Oregon Safe Employment Act, or exercising any rights under the law, including those conferred by this Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744).

(b) COVID-19 testing for workers. If COVID-19 testing is conducted at the employer's own direction, the employer is responsible for covering the costs of testing including but not limited to the COVID-19 test itself, employee time, and employee travel. However, if the employer is not requesting the test, the employer is not expected to cover the direct cost of such testing or of any involved employee travel.

(c) Routine ventilation maintenance and evaluation. Employers covered by section (5) of this rule, should optimize the amount of outside air circulated through its existing heating, ventilation, and air conditioning (HVAC) system(s), in accordance of subsection (3)(f).

(d) COVID-19 infection notification process. The employers covered by this section (5) of this rule, should establish and implement a process to notify exposed employees (those who were within six feet of a confirmed COVID-19

individual for a cumulative total of 15 minutes or more, regardless of whether one or both of them were wearing source control) that they had a work-related contact with an individual who has tested positive for COVID-19, as well as to notify affected employees (those who worked in the same facility or in the same well-defined portion of the facility such as a particular floor) that an individual who was present in the facility has confirmed COVID-19. This notification process should include the following elements:

(A) A mechanism for notifying both exposed and affected employees within 24 hours of the employer being made aware that an individual with COVID-19 was present in the workplace while infectious or otherwise may have had work-related contact with its employee(s) while infectious; and

(B) This notification process should be established and implemented in accordance with all applicable federal and Oregon laws and regulations.

Note: Employers may use the model procedure published by Oregon OSHA.

Note: The reporting of COVID-19 cases may be required under existing Oregon Health Authority rules regarding reporting of disease cases. OAR 333-018-0016 requires such cases to be reported by healthcare providers and laboratories within 24 hours of identification.

Note: Whenever an exposure notification as described by this rule is provided in writing, the notification may be subject to the existing requirements of Oregon OSHA's Access to Employee Exposure and Medical Records standard (29 CFR 1910.1020).

(e) Medical removal. Employers covered by section (5) of this rule should follow Oregon Health Authority, public heath, or medical provider recommendations for isolation or quarantine of employees for COVID-19.

Statutory/Other Authority: ORS 654.025(2), ORS 654.035, ORS 656.726(4), ORS 654.025(3)(a)
Statutes/Other Implemented: ORS 654.001 through 654.295
Hist: OR OSHA Admin. Order 3-2020, f. 11/6/20, ef. 11/16/20
OR OSHA Admin. Order 4-2020, f. 12/11/20, ef. 12/11/20.
OR OSHA Admin. Order 2-2021, f. 5/4/21, ef. 5/4/21.
OR OSHA Admin. Order 5-2021, f. 6/30/21, ef. 6/30/21.
OR OSHA Admin. Order 10-2021, f. 8/13/21, ef. 8/13/21.
OR OSHA Admin. Order 12-2021, f. 9/14/21, ef. 9/16/21
OR-OSHA Admin. Order 14-2021, f. 12/21/21, ef. 12/21/21
OR-OSHA Admin Order 1-2022, f. 3/18/22, ef. 3/18/22
OR-OSHA Admin Order 5--2022, f. 09/09/2022, ef. 09/12/2022

OAR 437-001-0744
Rule Addressing COVID-19 Workplace Risks
[Appendix A – Mandatory Workplace Guidance For Industry Specific And Activity-Specific Situations

A-1: No Longer Required – Restaurants, Bars, Brewpubs, and Public Tasting Rooms at Breweries, Wineries, and Distilleries

This guidance is no longer required.

A-2: No Longer Required – Retail Stores

This guidance is no longer required.

A-3: Personal Services Providers

Application: This appendix applies to employers operating barber shops, hair salons, esthetician practices, medical spas, facial spas and day spas, non-medical massage therapy services, nail salons, tanning salons, and tattoo/piercing parlors. To the degree this appendix provides specific guidance, it supersedes the requirements of the Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744); to the degree a situation is not addressed by the specific language of this appendix, the requirements of the rule apply.

A. **Masks, Face Coverings, and Face Shields**. To reduce the risk of transmission from potentially infected individuals, employers of personal services providers must implement the requirements of OAR 437-001-0744 subsection (3)(b) of this rule, except as otherwise provided by this appendix.

1. Allow clients to remove the face covering when appropriate to or necessary for certain services; for example, a client does not need to wear a face covering when face-down on a massage table. And some services, such as mustache or beard trims, may require the cloth, paper or disposable face covering to be temporarily removed; and
2. Allow employees to wear medical grade masks if they choose to do so when providing services.

A-4: No Longer Required – Construction Operation

This guidance is no longer required.

A-5: Transit Agencies

Application: This appendix applies to public transit agencies and providers statewide. To the degree this appendix provides specific guidance, it supplements, but does not replace, the requirements of the Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744).

Note: This appendix is consistent with existing Oregon Health Authority statewide guidance as it relates to the protection of workers in such establishments. However, Oregon Health Authority guidance may also contain public health provisions that are not reflected by this document. Employers engaged in such activity need to be aware of and comply with those public health requirements as well as with this appendix.

A. **Physical Distancing Measures**. Transit agencies must take the following specific steps:

1. Require at least six feet of physical distance between the driver and passengers (except during boarding and when assisting those with mobility devices), cordoning off seats as necessary to reinforce this requirement;

2. Use physical partitions or visual cues (for example, floor decals, colored tape, or signs) to discourage passengers from standing or sitting within six feet of drivers and other transit employees on the bus or train;

3. Determine and post maximum occupancy for each bus; and

4. For rail systems, make verbal announcements about maximum occupancy before and after each stop.

B. Masks, Face Coverings, and Face Shields. To reduce the risk of transmission from potentially infected individuals, transit employers must ensure that any employees exposed to individuals without facial coverings are provided appropriate NIOSH approved respiratory protection (including N95 respirators or better) in accordance with the rule.

C. Signage. To reinforce the need to minimize COVID-19 risks, transit agencies must do the following:

1. Post clear signs listing COVID-19 symptoms, asking employees and visitors with symptoms to stay home and telling them whom to contact if they need assistance;

2. Use clear signs to encourage physical distancing; and

3. Post clear signs about the mask, face covering, or face shield requirements; and

4. For rail systems, post maximum occupancy for each train car using clear, prominently placed signs.

Note: Transit agencies are encouraged, but not required, to use signs at high traffic stops to encourage physical distancing while riders are waiting for a bus or train.

A-6: No Longer Required – Professional, Division 1, Pac-12, West Coast Conference and Big Sky Conference Sports

This guidance is no longer required.

A-7: No Longer Required – Employers Operating Fitness-Related Organizations

This guidance is no longer required.

A-8: K-12 Educational Institutions (Public or Private)

Application: This appendix applies to employers who operate schools or other educational institutions for children from kindergarten through the 12th grade (K-12 schools) or any portion thereof. To the degree this appendix provides specific guidance, it supersedes the requirements of the Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744); to the degree a situation is not addressed by the specific language of this appendix, the requirements of the rule apply.

A. **Masks, Face Coverings, and Face Shields.** Employers must ensure that the requirements of Oregon Health Authority's OAR 333-019-1015: Masking Requirements in Schools and other employee protections imposed by the Oregon Health Authority or the Oregon Department of Education are implemented and enforced in public and private K-12 schools.

A-9: Employers Operating Child Care and Early Education Programs

Application: This appendix applies to employers who operate any of the following types of child care and early education programs:

✓ All licensed programs, including Certified Center (CC), Certified Family (CF), and Registered Family (RF).

✓ All child care and preschool provided in public school settings.

✓ All Recorded Programs, including school age.

✓ Oregon Pre-Kindergarten (Prenatal to Kindergarten), Preschool Promise, and Baby Promise.

✓ Oregon Relief Nurseries.

✓ Early Intervention and Early Childhood Special Education (EI/ECSE) provided in a child care or early education setting.

A. Exception for Masks, Face Coverings, and Face Shields, and Personal Protective Equipment for Children and Adults.

1. All children who are in the child care facility or in the designated child care section of the child care provider's home must wear a face covering indoors unless:

   ✓ The child is under five years of age or not yet in kindergarten;

   ✓ They have a verified medical condition or disability that prevents them from safely wearing a face covering;

   ✓ They are unable to remove the face covering independently;

   ✓ They are sleeping, eating, or drinking.

A-10: Veterinary Clinics

Application: This appendix applies to veterinarians licensed under ORS 686, and to their assistants and other employees. To the degree this appendix provides specific guidance, it supplements, but does not replace, the requirements of the Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744).

A. **Personal Protective Equipment**. To reduce the risk of transmission, veterinary employers must provide and ensure the use of personal protective equipment in accordance with the following table:

"Interim Infection Prevention and Control Guidance for Veterinary Clinics Treating Companion Animals During the COVID-19 Response," published by the United States Centers for Disease Control and Prevention (last updated August 12, 2020)

Animal History	Mask	Eye Protection (face shield or goggles)	Gloves	Gown or Coveralls	N95 respirator or suitable alternative
Healthy companion animal without exposure to a person with COVID-19 compatible symptoms	No	No	No	No	No
Companion animal with an illness that is not suspicious of SARS-CoV-2 infection AND without exposure to a person with COVID-19 compatible symptoms	No	No	No	No	No
Companion animal that is not suspicious for SARS-CoV-2 infection BUT has exposure to a person with COVID-19 compatible symptoms	Yes	No	Yes	No	No
Companion animal with an illness that is suspicious for SARS-CoV-2 infection	Yes	Yes	Yes	Yes	No
Aerosol-generating procedure for any animal without an exposure to a person with COVID-19 compatible symptoms	Yes	Yes	Yes	Yes	No
Aerosol-generating procedure for any animal with an exposure to a person with COVID-19 compatible symptoms	No	Yes	Yes	Yes	Yes
Any procedure on an animal that is known to be currently infected with SARS-CoV-2 through detection by a validated RT-PCR assay	No	Yes	Yes	Yes	Yes
Any procedure where a person with known or suspected of being infected with COVID-19 will be present	No	Yes	Yes	Yes	Yes

~~A-11:~~]Appendix A – Emergency Medical Services: First Responders, Firefighters, Emergency Medical Services and Non-Emergency Medical Transport

Application: This appendix applies to first responders, firefighters, emergency medical services, and non-emergency medical transport employers. It also provides direction specific to Emergency Communication Centers. To the degree this appendix provides specific guidance, it supersedes the requirements of the Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744); to the degree a situation is not addressed by the specific language of this appendix, the requirements of the rule apply.

Note: Although this appendix is based upon the workplace health portions of Quarantine Guidance for Fire and EMS Responders and Information Bulletin 2020-02 on Personal Protective Equipment Advisory, published by the Office of the Oregon State Fire Marshal, it does not address many other issues included in that document. Employers of first responders, firefighters, EMS, and non-emergency medical transport should therefore be familiar with that guidance as well.

Definitions. For purposes of this appendix, the following definitions apply:

Emergency Communication Centers means 911 Public Safety Answering Points/Emergence Communication Centers (PSAP/ECCs).

Emergency Medical Services Provider (EMS Provider) means a person who has received formal training in prehospital and emergency care, and is licensed to attend to any person who is ill or injured or who has a disability. Police officers, fire fighters, funeral home employees and other persons serving in a dual capacity, one of which meets the definition of "emergency medical services provider" are "emergency medical services providers" within the meaning of ORS chapter 682.

Fire Department means public and private employers who engage in structural fire service activities, including emergency first response, who are covered under OAR 437-002-0182.

A. General Operations Screening, Isolation and Quarantine. In order to reduce the risks of outbreaks within the workplace and the broader community, EMS employers must take the following steps:

1. Instruct employees to self-monitor for symptoms consistent with COVID-19;
2. Screen employees for fever and symptoms prior to each shift, excluding them from the workplace as appropriate based on guidance from the Oregon Health Authority; and
3. Exclude any employees from the workplace if they test positive via a COVID-19 diagnostic test.

Note: Quarantine Guidance for Fire and EMS Responders provides detailed information on monitoring, quarantine, isolation, and subsequent return to work.

B. General Operations – Emergency Communication Centers. Emergency Communication Centers (ECC) must comply with the provisions of the rule, with the following specific provisions and exceptions:

~~[1. Whether shields or barriers have been installed, ECC communications personnel are not required to wear face coverings while handling emergency calls, but must be allowed to do so at their discretion;~~

~~2]~~**1**. ECC should implement an EIDS or screen for fever, cough, difficulty breathing, and diarrhea for all calls, when feasible, if local triggers determined by the PSAP director have been met. Additionally, PSAPs should ask:

- ✓ Is anyone in the call location a known or suspected COVID-positive individual undergoing either quarantine or isolation?
- ✓ Is the call location a long-term care facility known to have COVID-19 cases?

~~3.~~**2.** The query process should never supersede the provision of pre-arrival instructions to the caller when immediate lifesaving interventions (for example, CPR) are indicated.

~~4.~~**3.** If the patient meets the above criteria, then PSAPs should:

a. Provide medical care per protocol.

b. Alert responding agencies of the possibility of a respiratory pathogen as soon as possible.

c. Follow LPHA policies for reporting and follow up of healthcare workers with contact to suspected cases.

d. For ill travelers at US international airports or other ports of entry to the United States (maritime ports or border crossings) should be in contact with the CDC quarantine station of jurisdiction for the port of entry CDC Quarantine Station Contact List for planning guidance.

~~5~~**4.** If the patient does not meet criteria, discontinue questioning and follow appropriate case entry.

~~6.~~**5.** If call volumes increase to the point that screening is interfering with the timely processing of calls, consider suspending EIDS screening.

~~**C.[General Operations – Fire Departments and Ambulance Agencies.** Fire Departments and Ambulance Agencies must comply with the provisions of the rule, with the following specific provisions and exceptions:~~

~~1. Spacing requirements do not need to be followed on any Agency apparatus when responding to or returning from a call, although respiratory protection must be worn as necessary.~~

~~2. The personnel residing in common living areas in a fire station or ambulance agency facility are not required to wear masks, face coverings or face shields (this exception applies only to shared living areas; it does not apply to break rooms, shared toilet facilities, or other common areas used by other employees or individuals other than those residing in the living areas).~~

~~3. The driver of an emergency response vehicle may adjust or remove a mask or face covering that impedes their vision or distracts from the safe operation of the vehicle.~~

~~D.~~] **Personal Protective Equipment.** Masks or respirators must be worn by EMS providers while they are engaged in emergency medical services or other patient care. Face coverings must not be used as a substitute for a mask or respirator when respiratory protection (droplet precautions for a mask, airborne precautions for a respirator) is required. EMS providers must apply the following guidance:

1. During direct patient care in the EMS setting, use of respirators without exhalation valves is preferred but not required; and
2. When dealing with an individual known or suspected of being infected with COVID-19, EMS providers must wear a NIOSH-approved N95 or equivalent or a higher-level respirator, a gown, gloves, and eye protection (face shield or goggles).

Note: The use of respirators must comply with the Respiratory Protection standard (29 CFR 1910.134).

Note: The use of face coverings, masks, or respirators are not required when EMS employees are not involved in direct patient care, unless the conditions for the Special Provisions for the Transport of Patients of this appendix apply.

D. Special Provisions for the Transport of Patients (Emergency and Non-Emergency) with Suspected or Confirmed COVID-19.

For any patient meeting any of following criteria:

- Symptoms of lower respiratory infection, such as fever, cough, or shortness of breath;
- Recent contact with someone with known COVID-19; or
- Call location is a long-term care facility known to have COVID-19 cases.

EMS providers must apply the following procedures when engaging in transporting, whether emergency or non-emergency:

1. Involve the fewest EMS personnel required to minimize possible exposures; others riding in the ambulance must be limited to those essential for the patient's physical or emotional well-being or care (for example, care partner or parent);

2. Ensure that the patient is masked. The patient mask must not have an exhalation valve, as it would allow unfiltered, exhaled breath to escape;
3. Provide medical care per protocol;
4. Ensure that personnel use contact, droplet, and airborne precautions, as follows:
    a. Wear a single pair of disposable patient examination gloves.
    b. Wear disposable isolation gown. If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, and care activities where splashes and sprays are anticipated.
    c. Use respiratory protection (an N95 or higher-level respirator). If respirator supplies have been depleted, facemasks are an acceptable alternative. Respirators should be prioritized for procedures that are likely to generate respiratory aerosols.
    d. Wear eye protection (goggles or a disposable face shield that fully covers the front and sides of the face).
5. Use caution with aerosol-generating procedures and ventilate ambulance if possible;
6. Notify the receiving hospital (according to local protocols) of potential infection as soon as possible;
7. Disinfect using EPA registered Disinfectants for Use Against SARS-CoV-2; and
8. Drivers, if they provide direct patient care (for example, moving patients onto stretchers), must wear the PPE listed above.
    a. After completing patient care and before entering an isolated driver's compartment, the driver must remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.
    b. If the transport vehicle does not have an isolated driver's compartment, the driver must remove the face shield or goggles, gown, and gloves and perform hand hygiene, but continue to wear a respirator, mask, or face covering during transport.

Patients who do not meet the criteria listed above can be cared for using standard precautions, with use of transmission-based precautions determined by clinical presentation.

~~[A-12: Law Enforcement Activities~~

~~**Application**: This appendix applies to the activities of law enforcement officers in the performance of their duties. To the degree this appendix provides specific guidance, it supersedes the requirements of the Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744); to the degree a situation is not addressed by the specific language of this appendix, the requirements of the rule apply.~~

Definitions. For purposes of this appendix, the following definitions apply:

Law enforcement agency means the Oregon State Police, a county sheriff's office, a municipal police department, a police department established by a university under ORS 352.121 or 353.125, or an agency that employs one or more parole and probation officers as defined in ORS 181A.355.

Law enforcement officer means a member of the Oregon State Police, a sheriff or deputy sheriff, a municipal police officer, an authorized police officer of a police department established by a university under ORS 352.121 or 353.125, or a parole or probation officer as defined in ORS 181A.355.

A. **Masks, Face Coverings, and Face Shields**. To reduce the risk of transmission from potentially infected individuals, law enforcement agencies must require masks, face coverings, or face shields in spaces under their control and when employees interact with other individuals, as required by OAR 437-001-0744(3)(b). However, the following specific modifications apply to certain law enforcement activities:

1. Law enforcement agencies must ensure that all employees, visitors, and persons in custody wear a mask, face covering, or face shield as required in this rule unless enforcing this requirement would require the use of physical force or place an employee or member of the public at greater risk of COVID-19 exposure;
2. Law enforcement agencies must provide masks and face shield to law enforcement officers to wear in combination in situations when a person in custody refuses to wear a face covering;
3. Law enforcement officers are permitted adjust or remove the face mask, face covering, or face shield while interviewing a member of the public when necessary to establish sufficient rapport with the interviewee;
4. Law enforcement officers driving during an emergency response or pursuit may adjust or remove a mask, face covering, or face shield that impedes their vision or distracts from the safe operation of the vehicle;
5. Law enforcement officers are permitted to remove their mask, face covering, or face shield when the officer's ability to clearly communicate is impaired by the mask, face covering, or face shield; and
6. Law enforcement employees transporting a person in custody or a member of the public must ensure that that person wears a mask, face covering, or face shield unless compliance would require the use of force or place law enforcement employees or a member of the public at greater risk for COVID-19 exposure or physical jeopardy.

A-13: Jails, Prisons, and Other Custodial Institutions

Application: This appendix applies to jails, prisons, and other custodial institutions. To the degree this appendix provides specific guidance, it supersedes the requirements of the Rule Addressing COVID-19 Workplace Risks (OAR 437-001-0744); to the degree a situation is not addressed by the specific language of this appendix, the requirements of the rule apply.

A. **Masks, Face Coverings, and Face Shields**. To reduce the risk of transmission from potentially infected individuals, jails, prisons, and other custodial institutions must require masks, face coverings or face shields within the premises. However, the following specific modifications to the requirements to OAR 437-001-0744(3)(b) apply within the secure perimeter of the jail, prison, or other custodial institution:

1. Jails, prisons, and other custodial institutions must require all person entering the secure perimeter of the jail to wear a mask, face shield, or face covering when within six feet of other individuals, if there are no physical barriers between them, with the following exceptions:
   - ✓ During scheduled mealtimes when eating or drinking;
   - ✓ If a physical or mental condition or disability limits the ability to wear a mask, face covering, or face shield;
   - ✓ When an order from the Oregon Judicial Department, presiding judge, or local health authority provides an exception to the wearing of masks, face coverings or face shields;
   - ✓ In a housing unit where all adults in custody have been in quarantine for a minimum period of time established by the local health authority after considering CDC and OHA guidelines, provided that all staff members wear a mask or face covering at all times while in the unit;
   - ✓ In youth correctional facility common areas when all youth in custody have been in quarantine for a minimum period of time established by the Oregon Health Authority, provided that all non-youth-in-custody individuals wear a face covering and the Oregon Health Authority has authorized such practice; or
   - ✓ During an emergency, such as when responding to a spontaneous use of force event, a medical emergency, or a suicide attempt in a housing unit.
2. The jail, prison, or other custodial institution must not charge individuals in custody for masks, face coverings or face shields, except in the case of knowing damage or destruction to the mask, face covering, or face shield in violation of institution rules.
3. The jail, prison, or other custodial institution must not charge employees for masks, face coverings or face shields.

~~4. Custodial institution employees transporting a person in custody or a member of the public must ensure that that person wears a mask, face covering, or face shield unless compliance would require the use of force or place law enforcement employees or a member of the public at greater risk for COVID-19 exposure or physical jeopardy.]~~

OREGON
CHIROPRACTIC
ASSOCIATION

10580 SE Washington St.
Portland, OR 97216

T (503) 256-1601
F (503) 256-1602
E info@ocanow.com

October 5, 2022

Cassandra C. McLeod-Skinner, JD, Executive Director
Oregon Board of Chiropractic Examiners
Equitable Center Building
530 Center Street NE, Suite 620
Salem, Oregon 97301

RE: DCs administering Covid-19 Vaccinations

Dear Ms. McLeod-Skinner:

The Oregon Chiropractic Association requests OBCE's answer to the following question(s) relative to Oregon Doctors of Chiropractic administering Covid-19 vaccinations and booster shots:

1. Is the administration of Covid-19 vaccinations or booster shots within the current scope of license of Oregon chiropractic physicians to provide?
2. If so, is this a temporary or permanent part of the Oregon DCs scope of practice?

Ensuring the safety of our patients is of the highest priority of the Oregon Chiropractic Association. Keeping our membership informed is also our duty as their state professional association. The OCA respectfully asks that the OBCE respond timely to this question.

Sincerely,

Todd A. Turnbull, DC, CCSP, CBIS/T

President, Oregon Chiropractic Association

PURNELL Mackenzie G * BCE

From: PURNELL Mackenzie G * BCE
Sent: Tuesday, November 1, 2022 2:22 PM
To: PURNELL Mackenzie G * BCE
Subject: Obstetrics Question

From: MCLEOD-SKINNER Cass * BCE <Cass.MCLEOD-SKINNER@obce.oregon.gov>
Sent: Wednesday, August 31, 2022 3:52 PM
To: GILKER Heather * BCE <Heather.GILKER@obce.oregon.gov>; Franchesca Vermillion >
Cc: LARA Miriam * BCE <Miriam.LARA@obce.oregon.gov>; MCLEOD-SKINNER Cass * BCE <Cass.MCLEOD-SKINNER@obce.oregon.gov>
Subject: Re: Obstetrics Question

Heather and Miriam,

More specifically, the question is in the timing of the 200 hours requirement, right? Whether some or all of the hours can be taken prior to licensure or do all of them need to be taken post-licensure.

We have so few of these requests that nothing in the material Donna left for her position described her process in what these processes were.

Franchesca, I though you might know/remember the steps in this process or could provide a Board's perspective on timing.

Thanks,
Cass

Cassandra C. McLeod-Skinner, J.D.
Executive Director, OBCE
O: 503-373-1620
C: 503-779-9038

From: GILKER Heather * BCE <Heather.GILKER@obce.oregon.gov>
Sent: Wednesday, August 31, 2022 3:29:26 PM
To: Franchesca Vermillion
Cc: MCLEOD-SKINNER Cass * BCE <Cass.MCLEOD-SKINNER@obce.oregon.gov>; LARA Miriam * BCE <Miriam.LARA@obce.oregon.gov>
Subject: Obstetrics Question

Hello Franchesca,

I have a student wanting to practice chiropractic obstetrics in Oregon. Craig found the rule (Oregon Secretary of State Administrative Rules) that states:

(4) A chiropractic physician licensed in Oregon who wishes to practice obstetrics must apply to and receive from the Board a certification of special competency in obstetrics. To receive and maintain certification, the applicant must fulfill the following requirements:

(a) Successfully complete at least 200 hours of direct instruction hours at an approved chiropractic, naturopathic, medical, osteopathic college or hospital in obstetrics and furnish a signed log showing evidence that subsections (b) and (c) of this section have been completed under the direct supervision of a licensed practitioner with specialty training in obstetrics and/or natural childbirth;

(b) Take part in the care of 50 women in both the prenatal (including obstetrics intakes) and postnatal periods;

(c) Observe and assist in the intrapartum care and delivery of 50 natural childbirths in a hospital or alternative birth setting. These births must be under the supervision of a licensed practitioner with specialty training in obstetrics and/or natural childbirth. A labor and delivery that starts under the care of someone licensed to assist in childbirth and includes hospitalization shall count as a birth.

(d) Pass a certification exam in obstetrics and gynecology given by or approved by the Board.

Miriam found one DC in Oregon that is licensed to practice obstetrics. His file doesn't have any 'back-up' information/documentation on how he achieved that specialty. There's no mention of obstetrics in the P&P.

Do you recall any more information regarding the process or requirements for this?

Thank you,

Heather Gilker
Office Specialist
530 Center St. NE, Ste. 620
Salem, OR 97301
Ph: 503.983.4183 **Fax:** 503.362.1260
Work Hours: Mon.-Thurs. 8am – 3:30pm

OCTOBER 26TH 2022

DEAR EXECUTIVE DIRECTOR CASSANDRA C. MC(EOD)-SKINNER-TJ

530 CENTER ST. NE SUITE 620

SALEM, OREGON, 97301

I AM INTERESTED IN KNOWING IF YOUR BOARD HAS EVER CONSIDERED ALLOWING INCARCERATED INDIVIDUALS TO LEARN THE PROFESSION OF CHIROPRACTICS AND/OR IF THEY WOULD BE INTERESTED IN HELPING THOSE INCARCERATED INDIVIDUALS SEEKING TO LEARN SUCH A NOBLE PROFESSION. AS THE FOUNDER OF TRUE LAW FAITH THE BODY IS THE TEMPLE AND CHIROPRACTICS HELPS TO TUNE/BALANCE THAT TEMPLE THEREFORE I WISH FOR A CLASS THAT OUR SOON TO COME PELL GRANTS MAY APPLY TO. I AM CURRENTLY AT EASTERN OREGON CORRECTIONAL INSTITUTION THEREFORE THE PILOT PROGRAM WOULD STEM FROM HERE IF APPROVED BY YOU AND ODOC.

YOU CAN EMAIL THE AVENUE OF THE SISTERS OF THE ROSE OR CALL JODY WELCH TO WORK OUT THE DETAILS OR NEEDS OR TO DIRECT HOW INCARCERATED INDIVIDUALS COULD USE THEIR PELL GRANTS IN ANY WAY TO LEARN CHIROPRACTICS.

Sistersoftheroset1@gmail.com

THANK YOU FOR YOUR TIME, UNDERSTANDING, AND DIRECTION TO ENRICH PEOPLE'S LIVES WITH CHIROPRACTICS.

SINCERELY,

HOUSEMASTER

RECEIVED

OCT 31 2022

6825517 Haynes Mike

Oregon Department of Corrections - AIC Mail
Institution EOCI SID
Name Haynes, Mike
Address 2500 WESTGATE
City PENDLETON State OREGON Zip 97801

PORTLAND OR 972
27 OCT 2022 PM 6 L

CHIROPRATIC EXAMINERS BOARD
EXECUTIVE DIRECTOR
CASSANDRA C. McLEOD-SKINNER JD
530 CENTER STREET NE SUITE 620
SALEM, OREGON, 97301

97301-37917

THIS ENVELOPE IS RECYCLABLE AND MADE WITH 30% POST CONSUMER CONTENT

September 22'22

OBCE,

I am not interested in filling out any happy talk customer-satisfaction survey. So this is my what-I-am-not-satisfied-with-the-OBCE letter:

I hate the heavy-handedness of the OHA during this PLANdemic. It has been unscientific, un-medical B.S. from beginning to end.

I hate how the OBCE cow-towed to the OHA during this PLANdemic and did not challenge them on anything. Too, why was the OBCE not pro-active reminding DC's about vitamin D/C/ Zinc and more?

I hate how the OBCE has been taken over by the OHA. The OBCE is now middle management whereby we chiropractors have no defense against an autocratic, over-reaching agency.

This "Cultural Competency" is also B.S. from beginning to end. It's all "hate whitey" with actual quotes from the Black Panthers in one presentation. The feel-good pablum is nauseating in its inanity. Obviousism after obviousism.

Lastly I hate how we cannot have adult conversations about these issues without very legitimate concerns about bureaucratic censure/revenge. So I remain anon.

You say you are about protecting patients from wayward chiropractors. How about protecting chiropractors from wayward bureaucrats? I want to see more proactiveness for chiropractors coming out of the OBCE!!!

MEDFORD OR 975

21 SEP 2022 PM 1 L

OR. BD. CHIRO. EX.
530 CENTER ST. NE #620
SALEM, OR 97301

9730133791

PURNELL Mackenzie G * BCE

From: PURNELL Mackenzie G * BCE
Sent: Wednesday, October 19, 2022 6:36 AM
To: PURNELL Mackenzie G * BCE
Subject: Board Appointment

From: Allen Knecht <
Sent: Tuesday, October 18, 2022 1:23 PM
To: YERBY Jackie * GOV LINEBAUGH Kourtney * GOV ; MCLEOD-SKINNER Cass * BCE <Cass.MCLEOD-SKINNER@obce.oregon.gov>
Cc: Allen Knecht <dukeman12@mac.com>
Subject: Board Appointment

Hi Cass,

I just got off a zoom conference with Jackie and Kourtney regarding my recent board appointment. Unfortunately it appears that by Oregon Statute, I am required to be a resident of Oregon to serve on the OBCE.

This of course is disappointing to me as I have truly enjoyed the time spent with the OBCE and serving our profession here in the State of Oregon.

In my discussion with Jackie and Kourtney, i asked if there was a work around and of course the statue is prescriptive. However, if the opportunity presents itself, it might be beneficial to suggest a modification of the statute to read: Must be a resident and / or be in full time practice registered in the State of Oregon.

I am sure there are a number of physicians who reside in the Vancouver metro area and work full time in Oregon that would be good candidates for our board; and paying State income personal and business taxes :)

At any rate, as of now I must resign my position as the statue is prescriptive.

I will truly miss you all and only have fond memories of my time served with each and everyone of you.

Onwards and Upwards,

Allen Knecht DC

Allen Knecht, DC
Namaste Chiropractic
5901 S Macadam Ave
Suite 100
Portland, OR 97239
503-226-8010

<image001.png>

“If you change the way you look at things, the things you look at WILL Change!”

Anonymous

Oregon Board of Chiropractic Examiners

Chiropractic Assistant Initial Training

8 Hours Didactic and 4 Hours Hands-on

1. Licensing & Regulation **(30 minutes)**
   Scope of practice
   Board recommends add'l training for CAs who perform massage/soft tissue work
   Review Guide to Policy & Practice Questions (P&P)
   Duty to Report: To whom does this apply?
   Supervision required at all times (DC in office)

2. Principles of Chiropractic **(30 minutes)**

3. Basic Medical Terminology **(1 hour 15 minutes)**
   - 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)

4. Boundaries (**45 minutes)**
   - 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)**
    - 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)**
    - 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)**
    - Equipment (tables, physiotherapy, exercise)
    - Laundry (gowns/towels/shorts etc)
    - Personal
    - Other OSHA

8. Basic Anatomy **(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 **(1 hour 45 minutes)**

10. Understanding CPT Timed Codes & General Chart Noting **(45 minutes)**
    - *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)
    - Outcome based markers
    - Outcome assessments including Oswestry, NDI, VAS pain scale, etc.
    - Insurance and its requirements of functional outcome assessments
    - S.O.A.P. (explain parts)

The remaining 4 hours training shall be hands-on and must cover all of hydrotherapy, electrotherapy, and physiotherapy.

PREFACE

The main purpose of this manual is to act as a study guide for chiropractic assistants who are being examined and certified to assist with patient care in the chiropractor's office. This manual is intended to be a basic step-by-step guide, not a complete reference.

Original Printing March 1990

Revised August 2014

Revised September 20, 2022

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Training Syllabus

Required Info

LICENING AND REGULATION (60 MINUTES)

BASIC MEDICAL TERMINOLOGY (75 MINUTES)

BOUNDARIES (45 MINUTES)

PATIENT POSITIONING AND INFORMED CONSENT (30 MINUTES)

PATIENT CONFIDENTIALITY (30 MINUTES)

SANITATION AND SAFETY (30 MINUTES)

PHYSIOTHERAPY MODALITIES (1 HOUR 45 MINUTES

RECORD KEEPING AND X RAY (45 MINUTES)

I. INTRODUCTION

A. The Certified Chiropractic Assistant's Responsibility to the Public and the State of Oregon

As a Certified Chiropractic Assistant, you are regulated by the statutes and administrative rules of the State of Oregon that pertain to you. These statutes and rules are enforced by the Oregon Board of Chiropractic Examiners (OBCE) for the protection of the public. You are required to be aware of these regulations.

The rule outlining the conduct and expected behavior of Certified Chiropractic Assistants is Rule 811-010-0110. This rule is updated regularly and a link to the rule can be found here.

Chiropractic assistants (CAs) are able to help with many procedures in the office. They can help with obtaining parts of history such as taking the patient's subjective complaints.

In the state of Oregon, certified chiropractic assistants may not assist with manual muscle testing.

Commented [FV1]: This needs to line up with the PnP or a link to this to help address scope

Chiropractic assistants cannot help with anything that is considered any type of joint adjustment. This may be something gentle like a drop table or tool-assisted adjusting, or the standard high velocity, low amplitude adjustment.

Anatomy terms

CAs will need to be familiar with common anatomy and terms used by both the patient and the doctor

BONY ANATOMY

The spine is broken up into several regions. There are 26 Vertebra or bones in the spine, to include;

- Cervical Spine - known as the neck (7 vertebra)
- Thoracic Spine - known as the upper and mid-back (12 vertebrae)
- Lumbar Spine - known as the lower back(5 vertebrae)
- Sacrum - known as the tailbone

When the chiropractor adjusts the spine there are 5 regions listed. Some doctors may adjust a problem-focused area and adjust 1-2 regions while others may adjust the full spine every time.

- Cervical (neck)
- Thoracic (upper and mid-back)
- Lumbar (lower back)
- Sacrum (tailbone)
- Pelvis

Extraspinal adjustments occur to the following;

- Jaw
- Anterior ribs (chest)
- Shoulder
- Elbow
- Wrist
- Hand
- Fingers
- Anatomical hips
- Knees
- Ankles
- Feet
- Toes

There are 12 pairs of ribs off the thoracic spine. Ten of the ribs attach to cartilage and to the chest bone (sternum) in the front. The last two sets, ribs 11 and 12 are floating ribs and do not have a cartilage attachment.

There are seven main regions of the body

1) Head
2) Neck
3) Thorax (chest)
4) Abdomen
5) Pelvis
6) Upper Extremity
    a. Shoulder
    b. Arm
    c. Elbow
    d. Forearm
    e. Wrist
    f. Hand
    g. Fingers

7) Lower Extremity
    a. Hip
    b. Gluteal
    c. Thigh
    d. Knee
    e. Lower Leg
    f. Ankle
    g. Foot
    h. Toes

Movement Terminology

Joints of the spine will move the following ways

Movement	Description
Flexion	Bending forward
Extension	Bending backward
Right Lateral Flexion	Tilting towards the shoulder or knee to the right
Left Lateral Flexion	Tilting towards the shoulder or knee to the left
Right Rotation	Rotating or twisting around to the right
Left Rotation	Rotating or twisting around to the left

The Extraspinal Joints have additional movements

Movement	Description
Flexion	Decreasing the angle between two structures
Extension	Increasing the angle between two structures
Plantarflexion	Flexion of the plantar (underside) part of the foot
Dorsiflexion	Flexion of the dorsum (top) part of the foot
Abduction	Moving away from the midline
Adduction	Moving towards the midline – Think of ADDing the body part back to your trunk
Protrusion	Moving straight ahead or forward (tongue, mandible)
Retrusion	Moving backwards (tongue, mandible)
Protraction	Moving forward and laterally simultaneously
Retraction	Moving backward and medially simultaneously
Depression	Moving downward
Elevation	Moving upward
Medial (internal) rotation	Spiral movement towards the midline
Lateral (external) rotation	Spiral movement away from the midline
Pronation	Medial rotation of the radius, resulting in the palm of the hand facing posteriorly (if in anatomical position) or inferiorly (if elbow is flexed)
Supination	Lateral rotation of the radius, resulting in the palm of the hand facing anteriorly (if in anatomical position) or superiorly (if elbow is flexed) - Think of holding a bowl of soup in your hand for supination

Circumduction	Combined movement starting with flexion, then abduction, extension, and ending with adduction
Deviation	Movement of the wrist joint towards the radial or ulnar sides (radial deviation, ulnar deviation)
Opposition	Touching the pad of any one of your fingers with the thumb of the same hand
Reposition	Separating the pad of any of your fingers from the thumb of the same hand
Inversion	Plantar side of the foot is rotated towards the median plane
Eversion	Plantar side of the foot is rotated away from the median plane

Other Terms

Ipsilateral - Same side of the body. For example, the patient is having ipsilateral (same-sided) neck pain when laterally flexing to the right

Contralateral - Opposite side of the body– For example, the patient is having contralateral (opposite sided) neck pain when laterally flexing to the right

Posterior – Referring to the back side of something, the posterior region of the shoulder

Anterior – Referring to the front of an area. The chest is anterior on the body.

Medial – Towards midline or the center of the body

Lateral – Away from the midline of the body or on the outside of the body

Superior – Toward the head end of the body

Inferior - Away from the head

Proximal – Closer to the center of the body

Distal – Further from the center of the body

Patient Positions

Patients will lay on the table based on your doctors' instructions

Supine – Face up position

Prone - Face Down position

Hook Lying – Face up with knees bent

Side Lying - Laying on their side

Be sure to receive clear patient position and gowning instructions from your doctor.

Muscular Anatomy

There are three main muscle groups, smooth muscle - located in the stomach and along the GI tract and our blood vessels, cardiac muscle - located within the heart, and skeletal muscle, which makes up the majority of the muscle in the body.

Muscles are the main way anything in our body moves. Muscles are controlled by the brain and nerves which attach to those muscles. Some muscles are under voluntary control – such as skeletal muscle and some are under involuntary control such as cardiac muscle.

There are over 600 muscles in the human body. It is not required to know all of the muscles by name, but if you are going to do muscle work such as massage or other myofascial techniques, further training is required by your doctor's office. (site policy?)

Terminology

- Tendon - tough bands of connective tissue made of collagen - this collagen weaves itself into the bone at the attachment point
- Ligament - another form of tough connective tissue that connects bones to each other
- Joint - where two bones meet up and move around each other

Muscles have tendons at either end of them which help attach the muscle to the bone. Without our muscles we would not be able to move our joints.

All muscles have a normal tone to them. This often feels soft and supple to the touch.

Hypotonic - A lack of muscle tone. This could be due to impingement on the nerve which controls the contraction of the muscle or atrophy (wasting of the muscle) - Often times a limb coming out of a cast will have hypotonic and atrophied muscles from a lack of use. This muscle feels much softer than healthy muscle, it is easy to feel bone under this type of muscle if it is hypotonic or atrophied enough.

Hypertonic - More commonly muscles will be too tight. Each office will have a scale of tightness. It can vary from office to office. Some people use a tight and tender scale +1/4 to +4/4, a 0-5 scale, or even a 0-10 scale. Make sure to know your office's means of measurement for accurate records. These muscles feel much tighter than normal muscles and do not yield to touch or pressure as well when pushed on initially. These muscles can also be very painful when touched or massaged.

Spasm - This can be when the muscle stays tight for too long or it can be a rapid muscle contraction that does not release easily. Patients in muscle spasm will struggle to be able to move

Common Injuries

Contusion, commonly called a bruise, is caused by a direct blow to the body that can cause damage to the surface of the skin and to deeper tissues as well depending on the severity of the blow. It occurs when the small veins and capillaries under the skin break.

Hematoma - a hematoma is a more severe contusion or a collection (or pooling) of blood outside the blood vessel. This is usually a really bad bruise and not often a cause for concern.

Strain – When the muscle or tendon in the body is torn – There are 3 grades of tearing

Grade 1 - (mild) strains affect only a limited number of fibers in the muscle. There is no decrease in strength and there is a fully active and passive range of motion. Pain and tenderness are often delayed to the next day.

Grade 2 - (moderate) strains have nearly half of muscle fibers torn. Acute and significant pain is accompanied by swelling and a minor decrease in muscle strength.

Grade 3 - (severe) strains represent the complete rupture of the muscle. This means either the tendon is separated from the muscle belly or the muscle belly is actually torn in 2 parts. Severe swelling and pain and a complete loss of function are characteristic of this type of strain.

Sprain – When the ligament around a joint is torn

Grade 1 - Stretching or slight tearing of the ligament with mild tenderness, swelling and stiffness. The joint feels stable and it is usually possible to move with minimal pain.

Grade 2 - A more severe sprain, but incomplete tear with moderate pain, swelling and bruising. Although it feels somewhat stable, the damaged areas are tender to the touch and moving or weightbearing is painful.

Grade 3 - This is a complete tear of the affected ligament(s) with severe swelling and bruising. The joint is unstable and weight bearing is likely not possible because the joint gives out and there is intense pain.

With Grade 3 strains and sprains there is a possibility of a fracture of the bone nearby. A fracture is when the bone breaks or cracks. All of these terms are interchangeable. There are multiple different types of fractures. Your treating doctor will be the one to diagnose the types of fractures the patient has, but these are common fractures that may be associated with trauma and patients may bring them up as part of their history or care.

Avulsion Fracture - An avulsion fracture occurs when a fragment is pulled off the bone by a tendon or ligament. These types of bone fractures are more common in children than adults. Sometimes a child's ligaments can pull hard enough to cause a growth plate to fracture.

Compression Fracture - When bones are crushed it is called a compression fracture. The broken bone will be wider and flatter in appearance than it was before the injury. Compression fractures occur most often in the spine and can cause your vertebrae to collapse. A type of bone loss called osteoporosis is the most common cause of compression fractures.

Burst Fracture - **Burst fractures** are much more severe than compression fractures. The bones spread out in all directions and may damage the spinal cord.
Impacted Fracture - An impacted fracture occurs when the broken ends of the bone are driven together. The pieces are jammed together by the force of the injury that caused the fracture.

Comminuted Fracture - In this type of fracture, the bone shatters into three or more pieces.
Displaced Fracture - There is a gap between the broken ends of the bone. Repairing a displaced fracture may require surgery. There are also bone fragments present at the fracture site. These types of bone fractures occur when there is a high-impact trauma, such as an automobile accident.

Greenstick Fracture - This is a partial fracture that occurs mostly in children. The bone bends and breaks but does not separate into two separate pieces. Children are most likely to experience this type of fracture because their bones are softer and more flexible.

Open or compound Fracture – The skin may be pierced by the bone or by a blow that breaks the skin at the time of the fracture. The bone may or may not be visible in the wound.

Pathologic Fracture – this is a type of fracture that occurs without adequate trauma and is caused by a preexistent pathological bone lesion. Typical lesions are usually cancerous but there are many causes for this.

Segmental Fracture - The same bone is fractured in two places, leaving a "floating" segment of bone between the two breaks. These fractures usually occur in long bones such as those in the legs. This type of bone fracture may take longer to heal or cause complications.

Spiral Fracture - As the name suggests, this is a kind of fracture that spirals around the bone. Spiral fractures occur in long bones in the body, usually in the femur, tibia, or fibula in the legs. However, they can occur in the long bones of the arms. Spiral fractures are caused by twisting injuries sustained during sports, during a physical attack, or in an accident.

Stable or Closed Fracture – this may also be called a simple fracture. It is when the bones line up and the bone is barely out of place.

Stress Fractures - are also called hairline fractures. This type of fracture looks like a crack and can be difficult to diagnose with regular X-rays. Stress fractures are often caused by repetitive motions such as running. Often these types of fractures need follow-up x-rays or advanced imaging to diagnose.

Transverse Fracture - Transverse fractures are breaks that are in a straight line across the bone. This type of fracture may be caused by traumatic events like falls or automobile accidents.
Oblique fracture. An oblique fracture is when the break is diagonal across the bone. This kind of fracture occurs most often in long bones. Oblique fractures may be the result of a sharp blow that comes from an angle due to a fall or other trauma.

When it comes to evaluating fractures, some offices have in-house radiology to perform x-rays and some refer out. As a certified CA you cannot be trained to perform x-rays without additional certification through the Oregon Board of Medical Imaging. There is additional training and certification that needs to happen before you can legally perform x-ray imaging.

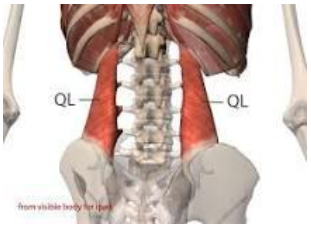
The CA's job may be to provide electro or physical therapies to specific muscle groups. More often these are superficial muscles. Doctors will often refer to groups for these types of therapies. It is important to spend time learning the anatomy your supervising physician and the patients refer to.

The commonly treated superficial muscles are:

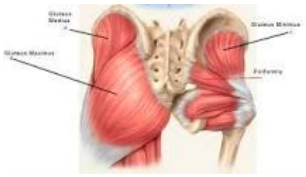
Trapezius muscles – these are divided into the upper, middle, and lower traps, and the upper traps are commonly hypertonic and tight on patients.

Spinal erector group/ Paraspinals - the muscles on either side of the spine from the cervical region down to the sacrum.

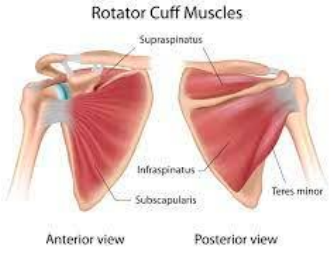
Quadratus Lumborum – Commonly aggravated lower back muscles



Gluteal muscles - the muscles that attach to the sacrum and hips. Patients will often point to this area complaining of back or hip pain.

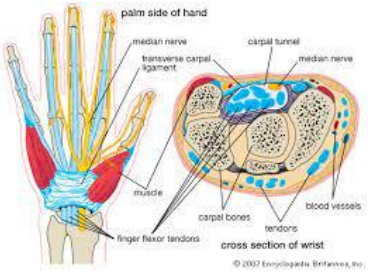


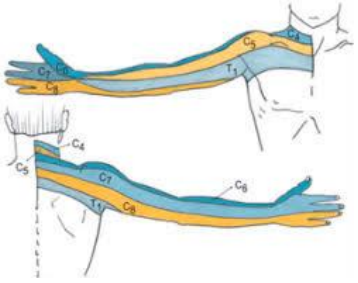
Rotator cuff – there are 4 muscles that make up the rotator cuff in the shoulder. Often times any injury to the shoulder, patients will refer to it as a rotator cuff injury. The supervising doctor is responsible for making the accurate diagnoses around this. Check the chart notes for accurate treatment plans and diagnoses.



Carpal Tunnel

Many patients will assume any hand pain, numbness, or tingling is due to issues within the carpal tunnel. Hand and wrist pain and symptoms may come from the radiating pain from the neck, the arm, or the wrist. This is up to the examining provider to examine and make an accurate diagnosis.





The chiropractor will do all of the joint adjusting for the patient. Joint dysfunction is also called a chiropractic subluxation. The chiropractic subluxation definition is different than the medical terminology of subluxation. Medical terminology definition of subluxation is a partial or complete dislocation of a bone within a joint. Many chiropractors see subluxation as **a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health**.

Some offices will heavily rely on the history of the subluxation and removing a chiropractic subluxation will lead to better overall health for the patient. There is a long history of the philosophy behind this. Other offices do not follow this type of philosophy and address patients from a musculoskeletal standpoint with evidence-based medicine practices. Each office you work for may be different.

Types of Pain

Local Pain – Patients will describe a pain that is located in the area of complaint. Local neck pain etc.

Radicular pain - This is pain that travels to a different area of the spine or into an extremity. They will have neck pain and pain that shoots down into the arm to the elbow. Radicular pain can feel like a muscle spasm, cramp, electric, burning, or even numb

Paresthesia - When patients describe feeling sensations in their limbs such as numbness or tingling but it is not numb when physically touched.

When documenting a patient's subjective complaint – it is important to note **where** the pain is, and if it travels anywhere along with a descriptor of the pain – numb, sharp, shooting, etc. Patients are encouraged to use their own words to describe these sensations vs putting words into their mouth. The more detailed the subjective complaint is, the better the treatment plan the treating doctor is able to write.

B.

The Certified Chiropractic Assistant's Responsibility to the Doctor and the Patient

Licensing Training and Scope of Practice

As a Certified Chiropractic Assistant, you are an agent of the chiropractor for whom you work. All rules, regulations, ethical, and moral considerations that apply to the chiropractor **also** apply to you. Therefore, it is important that you understand their instructions and that you follow those instructions carefully. Every action you take should be done with their knowledge and approval. Any act of wrongdoing is ultimately the responsibility of your doctor and can cause them problems.

When you apply physiotherapy modalities to a patient, you may spend considerable time with that patient. The patient may find it easy to confide in you. Anything that a patient tells you that might be significant to his chiropractic care should be reported to your doctor, **however, it should go no further.** The patient has the right to privacy which means that whatever they tell you will be kept in strict confidence and will not be told to anyone else. Your doctor will determine what information, if any, needs to be passed on to other sources.

You can be most helpful to your doctor and patient by reporting any changes in the patient's progress. A new injury, changes in activity at work or home, changes in intensity of pain or location of pain can all affect the patient's chiropractic care and should be reported to the doctor.

In order to become a CA you must:

1) Be 18 years or older

2) Complete a background check – and be able to explain anything that may show up on your background

3) 12 hours of study with 4 hours being didactic; and

4) Passing grade on the Chiropractic Assistant Test (open-book test)

The background check will look for any charges or convictions in the areas you have lived. It is important to note having any charges or convictions, depending on the nature of them does not mean you cannot obtain a chiropractic assistant certificate. If there is something on the background check that you know will come forward, be prepared to explain this and obtain related court paperwork. If you are not certain if a conviction has been expunged or would not be reported, then err on the side of caution and mention this in the application. Failure to do so will result in delays to the application and certification process.

The application and certification process may also be held up due to incomplete applications being submitted. It is important to fill out every question on the application to keep a seamless process.

Delays to application and certification come from

* Failure to completely fill out an application form

* Delays in background checks due to the system being backed up

* Failure to appropriately schedule the fingerprint appointment

* Failure to register and take the CA examination – hosted by an outside testing agency.

There is an outside testing agency called the National Board of Chiropractic Examiners (NBCE). They are not related to the Oregon Board of Chiropractic. Currently, NBCE hosts all of our state board examinations. When a CA has been cleared to take the test, the CA candidate will be notified and then must register on the external site for testing. It is an open-book test, so please have the pages for the Oregon Administrative Rules (OARs) available for searching. This process helps you know how to find answers to specific questions.

Places to find information. The main place to go is www.oregon.gov/OBCE. This site allows you to look up a licensee – CA or DC (doctor of chiropractic) and see if there are any public documents associated with the license. The OBCE website links to the OARs that regulate the profession. The website also hosts a Policy and Procedures manual which takes a deeper dive into scope questions. This manual is where you will find most of the FAQs to commonly asked questions.

CAs are to be under the supervision of a DC at all times. What this means, is the doctor must be in the building for you to be able to perform services. If the doctor leaves for lunch or early for the day, then billable services cannot be left to the CA to provide unless the CA is separately licensed. For example, if the CA also has a massage license and is performing massage and billing under massage, then the individual can perform massage under the LMT license. If the massage is being performed as a billable service under the CA scope, then the doctor must be in the building. It is important to say something to the supervising DC if they are not around.

CAs typically help with physiotherapies such as putting on hot and cold packs, putting on and taking off electrotherapies, performing ultrasound therapies, and running patients through stretches and exercises. Some offices even have CAs assist with massage and nutrition practices. It is importaor the CA to have appropriate training in all of the services they will provide. If you do not feel that you have had enough training to be able to appropriately answer patient questions or safely provide care, it is important to bring this information back to your supervising DC or even the office manager.

CAs also fall under the rule of “Duty to Report”. This can often be a hard situation to be in. The supervising DC may be engaging in unethical or immoral behaviors. Given that the supervising DC has a position of power over the CA, it may be hard to confront the doctor directly. The OBCE has handled anonymous phone calls to give the best advice to CAs or concerned patients, however the OBCE cannot investigate until a complaint has been filed. The OBCE is not able to investigate based on anonymous tips.

Other DUTY TO REPORT

All health professionals fall under other duty to report issues, in or out of the office.

This includes seeing any type of child abuse. In the office, it may be much easier to identify patterns of bruising or other marks. Out of the office it will not be as easy, but the duty to report still applies. When you must report: You must report **child abuse and neglect** 24 hours per day, seven days per week. The report must be made immediately. This requirement applies whether you observe the abuse or neglect during your work activities or on your personal time. Report child abuse to the Oregon Child Abuse Hotline by calling **1-855-503-7233**.

Elder abuse is another problem that requires mandatory reporting. Possible elder abuse should be reported through **Oregon's toll-free hotline: 1-855-503-SAFE (7233)** or on the DHS website.

Reporting to these departments is also anonymous but contact information does need to be left so they can interview you and ask further questions on this.

Complaint Process

The OBCE (Commonly referred to as the board in the chiropractic profession) is a reactionary board meaning no action is taken until a complaint is received. The complaint form is located on the OBCE website and can be submitted online or printed and mailed in. Once received, the OBCE office will review the complaint, and assign an investigator to look into the complaint. This means that witnesses will be interviewed as well as the person being investigated. The person being investigated will be informed of the nature of the complaint and asked to respond.

The process of the complaint is that all complainants are held anonymously, but if the nature of the complaint is specific, it may be clear to the licensee who complained about them. Many CAs are afraid to file a complaint against their supervising DC because they are afraid of losing their job. CAs and DCs alike agree to follow all rules and regulations of this state. If anyone is not complying, there is a possible risk of patient harm.

Many CAs may be included in a complaint for failing to come forward and file a complaint on their own.

Once the interviews have been complete, the information is presented to the board and the board will make a determination on what corrective or punitive action may be taken. The complainant is notified of the process when it is complete. There can be delays to this process if witnesses are hard to get a hold of or interviews lead to additional witnesses. Sometimes other state agencies have the information we are waiting on to complete our process. If the other agencies take their time in delivering this information to the OBCE, it can also delay our investigation and review times.

Duty to Report also applies to self-reporting. This means for example if a CA gets charged with Driving under the influence of intoxicants (DUII), it must be reported to the Board. This may also apply to unethical behavior in the office, CAs may be asked to charge for services not provided if they are involved in billing. The CA may initially go along with it during training but as they get a better sense of therapies and appropriate billing, they learn what is being done is wrong. This is an excellent time to self-report and provide detailed information to the OBCE. The duty to report does not apply to just inappropriate behavior of the DC, it applies to other CAs, other licensed individuals such as LMTs, Nurse Practitioners, as well as any inappropriate self-behavior.

Occasionally issues arise around being underpaid, lack of break time, or training on the job that is not related to the OBCE. The Oregon Bureau of Labor and Industries (BOLI) is the appropriate office to file a complaint with for those types of issues.

BOUNDARIES

Power dynamics exist in all relationships whether we acknowledge them or not. Employers have power over employees and healthcare providers have power over patients.

It is important to know these differentials exist as it does lead to people engaging in or tolerating behavior they might not otherwise engage in.

The profession of chiropractic involves a lot of hands-on application and treatment approaches. For us, it might be a day-to-day procedure but for someone who is new to chiropractic or had a different type of treatment they may see common touch as inappropriate. It is important to really spell out what you are going to do to patients, especially when they are face down on a table and cannot see what is happening.

A good rule of thumb when the patient is face down and new to the process is to let them know what will happen beforehand. For example, placing interferential current pads on a patient may go like this. If the patient is already face down. “Okay, I am going to raise your shirt to place these pads directly on your skin, since we are treating the lower back, I am going to place two on your lumbar region and two on the top of your glutes just below the belt line.” When taking any therapy off, especially if there is a lotion or massage gel on the patient, inform them you will be removing the remaining lotion or gel off of their skin. Once the patient is used to the therapies, they may not need the full explanation, but new patients are often shocked by procedures without a little extra communication.

Informed consent is really crucial at this time so patients are able to more fully participate in their care and agree or disagree with these treatment options. If a patient declines a therapy for a particular day for whatever reason, honor the patients request and then tell the treating doctor immediately. It will be up to the doctor to have a conversation with the patient about care and inform you of any changes to the treatment plan.

If you are a CA providing muscle work, it is very important to tell the patient to what level they must undress and what areas of skin need to be exposed. Patients may hear or understand something different than described so be slow and thorough with gowning instructions. When doing full body massage and the patient is mostly or fully disrobed on the table proper draping and covering of the body is especially important. This is something that needs to be practiced in the office if you have never done it before. Poor draping techniques often lead patients to not return for care and file complaints.

Conversations with patients are also important boundaries to maintain. Patients want to know their healthcare providers and will ask personal questions. It is okay to share information about day-to-day life

such as children and pets, but it is important to keep boundaries up around talking about finances or other such struggles in your life. We generally care about our patients and get to know them, but it is important to understand that we are their care providers and not their friends.

Each office will have its own policy about socializing with patients, whether it is via social media, engagement in person, or dating -know what the policy is in your office around these issues, particularly social media connections.

The OBCE maintains regulations around sexual misconduct and boundaries. The CA is not allowed to date or engage with a patient in a sexual manner. There are exceptions to this rule, such as the patient may be dating or married to you prior to being a patient in the office. If a patient does ask you out, the easiest answer is to say it is not allowed by law and you must decline. It is also important to decline not just on the basis of law but indicate disinterest so the patient does not think the law is the only eason you are not interested. It is important for the doctor to know if you have been asked out or hit on by a patient. Patients may also confide to you the crushes they have on their treating doctor. This is also a great time to acknowledge their feelings and let them know the law does not allow for dating. Many patients will take the hint and not broach the subject again. Other patients will be more persistent about trying to date you or talk about their attraction to the doctor. It is important for these issues to be communicated for the behavior may elevate and patient dismissal may be needed.

If a CA does find they are becoming attracted to a patient, it is important to talk with the treating or supervising chiropractor about this and see if there are other providers who can assist with care for this patient.

Many times, chiropractic students work as CAs while working on their DC degree. Nothing about any of these rules change given the CA will become a doctor even if they will not be staying in the office, they are working in.

The power dynamic is one neither the CA nor the DC has a full concept of because they are the ones with the advantage. Anything said as an aside or said as a joke may be interpreted differently by the patient because of this power exchange. It is important to be able to have fun in a safe way while still maintaining a professional distance.

Language Barriers

Patients who do not speak English as a first language may have additional barriers around treatment. If they are not fluent in English an interpreter, other than a family member, will be needed. Many cultures may not share personal details in front of family members or friends that they may otherwise share with their doctor. Interpreters are available over the phone as well as in person. It is important to have the office you are working in stay up to date on the rules as any offices that accept federal funds such as VA or Medicare contracts are required by law to provide interpretation services for anyone who requests them.

If there is any question that the patient is not fluent in English, especially with medical terminology, err on the side of caution and have an interpreter available. In the state of Oregon, healthcare interpreters (HCIs) have to be credentialed and registered through the Oregon Health Authority and cannot be simply native speakers.

Other Boundaries

There are patients who have different pronouns used from what they were assigned at birth. Make sure their charts reflect the accurate pronouns, preferred names, or nicknames. This simple act will help these patients feel acknowledged and welcome in the clinic.

The use of appropriate language will also help patients to feel accepted for who they are. Instead of assuming their sexuality, ask about partners vs husbands or girlfriends etc. Every patient simply wants to be seen and heard for who they are regardless of their sexuality, religion, or the color of their skin. We live in a society that does not automatically extend this respect to all types of people and we may have ingrained biases we are unaware of. Classes on cultural competency will help you to identify where those blind spots may be within you.

HIPPA

This is a federal regulation health information protection and portability act which means a patient is entitled to the privacy of their records at all times. When patients come into the office they will need to sign a privacy statement or be aware of their existence.

Patients do not need to give specific permission for their chart notes to be shared with their insurer, but permission is needed to send their charts to their attorney or another doctor's office.

If there are family members all being treated in the same office, it might be tempting to share information but unless a release is on file, it is important not to share. Information about minors may be given to the consenting adult, but once their child is 15 years old, the child has a right to have treatment without their parent's permission. It is important to check with anyone being treated who they will share their information with. This may cause a little irritation to the patient if they have to sign a form for us to be able to share information but it is looking out for the patient's best interest and providing them protection.

The times when HIPPA is overridden are usually in the case of records being subpoenaed for court or board investigations. Occasionally disability claims will subpoena charts. More often it is a request for records to which the patient must consent to. Offices are not allowed to release confidential information to employers even in the case of a workman's compensation claim. The employer is only allowed to know what the work restrictions are unless the patient wishes to share further information.

Patients do have the right with worker's compensation and motor vehicle crash claims to limit the information these companies can see about prior care. Work with the patient to send only the records they want to have sent, - as this may be limiting any prior care to a specific date range or specific problem area.

This applies to general protection in the office of chart notes as well. Anywhere a patient is, or can see, we must work to protect other patient names and forms.

All forms belonging to the patient by law must have: Patient's name, date, and the address of the office the patient is being treated out of on EVERY page. When sending charts to insurance companies, if these

WAYS TO PROTECT INFORMATION

Paper charts

- Forms or charts that are on desktops may need to be face down until they are being actively worked on or addressed.
- No other patient charts should be in the treatment room other than the active patient in the room.
- Physical charts will need to be secure and locked up when not in the office and during break times.

For electronic records

- Keep computers physically in a place where patients cannot oversee other patient information
- Purchase screen protectors which make it hard to see the screen from an angle, so only the person looking directly at the computer can see the information.

SANITATION AND SAFETY

All offices must follow a standard for keeping the office clean and safe for patients. Depending on the type of clinic, there will be different rules to follow set by the Occupational Safety and Health Administration (OSHA). There is an Oregon OSHA and there will be different rules depending on the number of employees, if there is a lab in-house or if there are other types of doctors other than chiropractors. Check in with the office manager on which OSHA rules apply to you.

An often-overlooked rule is the need to wear socks and shoes in the office. Many CAs who are also massage therapists do not wear shoes while massaging. Unless a specific type of massage, like Thai massage, is being offered, check in with office policies around this.

General safety in a chiropractic office involves cleaning the tables and equipment between each and every patient. The material on the tables will have a specific type of cleaning spray vs other equipment to keep the table from cracking. If there are reusable pads for electric therapy, they will need to be cleaned between each patient. If there are multi-use disposable pads patients buy for their use on them, keep them labeled and safe so they are not accidentally used on other patients.

Any reusable sheets, gowns, shorts, or towels used on a patient will need to be laundered before being put back in the rotation. Some offices have a laundry service or in-house laundry. Follow the rules for that specific office but make sure to bring all soiled items to the laundry. Other offices may have single-use gowns, shorts and table paper. Make sure these items are disposed of between patients.

Hand sanitizing – when working directly on patients, use soap and water or hand sanitizer before touching the next patient. If there are items that patients reuse such as pens, clipboards, ect. then make sure these items are briefly wiped down before the next use.

When patients are in the office feeling unwell, the office can make a policy to ask the patient to wear a mask or to reschedule. The provider may make that call and let the patient know what their options for treatment are. During State of Emergencies involving public health, the Oregon Health Authority may have additional requirements of health care offices. This will be in addition to other standard regulations and it is important to stay on top of the latest rules and regulations.

Scents

Many patients may have allergies or sensitivities to scents. To address this many offices, have a policy around the personal use of scented lotions, soap, or shampoos to help keep the environment smelling clean. Outside of the office, there are no issues with scents, but in the office, it is helpful to patients to minimize scents. This may include the smell of cigarette smoke if you are a smoker.

Patients may also be allergic to latex gloves, lotions, or even table cleaner and laundry detergent. Most electronic health records allow for alerts to flag yourself or the providers to these sensitivities and allergies. Work to make sure this information is in the patient chart and will pop up immediately when they are in the office.

OTHER SAFETY CONSIDERATIONS

For other safety purposes, it is also important to make sure any surgical conditions such as artificial joints, unstable joints, or spinal surgeries should be flagged in the patient chart for the provider to remember. Some patients may even need safety in terms of being in a specific room based on the treatment table in there or request not to see a specific provider. All of this information may be shared with you instead of the provider. Make sure to communicate these needs and put them in the patient chart for safety purposes. Providers may also flag a patient file if they do not want to treat specific patients as well. If you are a CA who helps with patient scheduling, make sure all of these types of notes are readily available to you.

DOCUMENTATION

Keeping accurate chart notes is an important piece of patient care.

Many offices will utilize a CA to help take the patient subjective complaints and provide all types of therapy.

Regarding subjective complaints – this goes into the chart note which follows a SOAP note format.

S – subjective – what and where the patient is complaining of. This includes the type of pain the patient is experiencing and the progression of their pain, better, worse, or no change. It is also very helpful to obtain activities of daily living or limitations to this, such as the ability to care for themselves, work, or engage in physical activities.

O – Objective What the physician finds relating to the patient's complaints

A – Assessment/ Action – The treating physician's assessment of how the patient is progressing and any care provided to the patient.

P – Plan – any changes to the treatment plan and current plan. Any additional concerns the provider has or additional referrals needed for the patient.

The CA will need to make detailed notes for the subjective. CAs are able to help with obtaining height, weight, temperature, pulse, and blood pressure as part of the examination findings. It is important to obtain this information when the patient presents as a new patient, for a new injury or condition, or for re-evaluations when indicated. If you are uncertain if these vitals are needed, err on the side of caution and obtain them.

When providing any type of physiotherapy be it electrotherapy, massage, or exercise it is important to document the following:

1) What therapy is being provided – physiotherapies often need to include the settings such as wattage or intensity.
2) The reason for the therapy being provided
3) The location of the therapy provided
4) The time - either exact time or time in the number of minutes; and
5) Who provided the therapy

For example – High intensity IFC was provided to the upper back and the middle back to help promote pre-adjustment relaxation for a total time of 15 minutes, therapy was provided by Sam Smith, CA

Pulsed ultrasound at 1.5 w/cm2 was delivered to the right anterior thigh to reduce pain and promote healing for 5 minutes from 3:45 pm to 3:50 pm provided by Sam Smith CA.

Exercise to the cervical region to help promote the range of motion and functionally improve the ability to look over shoulders was provided one on one to the patient for 10 minutes. The following exercises reviewed were, cervical towel rotation and extension exercises, cervical isometrics, and supine chin tucks.

Therapeutic myofascial work was provided to: The bilateral supraspinatus, infraspinatus, teres major and minor, and subscapularis from 11:00 AM- 11:25 AM to help decrease pain and improve the range of motion of the shoulder. Myofascial work was done with pin and stretch work along with instrument-assisted soft tissue therapy.

If the provider of record provided the therapy, no additional documentation for who provided the therapy is needed as the provider will be signing the chart note.

BILLING

When you provide therapy – note that some therapies are timed and some are not. It is still important to note the time of therapy provided. Some insurance companies are more specific and require the exact time to be notated and others just need the total time the therapy was provided.

As part of therapies provided the set up and tear down time is included in the billing. For example, if doing ultrasound preparing the area, placing gel on the area and cleaning the gel off the skin is all part of the timed code. Billing time frames run in 15-minute increments.

The minimum time to bill a 15-minute unit is to provide at least half of the time of the therapy, so 8 minutes minimum to be able to bill a 15-minute unit. To bill for the next 15-minute unit, half of the time of the next unit must also be provided, which means two units of care is 23 minutes (15 plus 8). Three units of care are 38 minutes minimum (30 plus 8), and 4 units of care are 53 minutes minimum (45 plus 8).

Timed codes also stack on each other so if massage and ultrasound are being provided at the same time, you may only bill for one unit of a timed code. Typically, the office will be allowed to bill for the code that reimburses at the highest rate.

Some insurance companies allow for billing for a reduced unit of care which is less than 8 minutes but typically not billable at 5 minutes or under.

In some offices, the CA will be asked to chart the therapy and bill for the service provided. It is important to know ethical billing procedures, what codes might stack on each other, and what codes do not. Also from a patient care standpoint, it is important to bill appropriately so they can receive the care they need without using up their insurance benefits.

Some therapies will not be covered by insurance. The insurance contract will also say if the patient can be billed for the non-covered services or not. There are new changes to federal rules that state the patient needs to be informed of all costs prior to engaging in care. Work with the office to ensure the patient has been appropriately informed of the billing and potential costs. Occasionally insurance coverage does not go as expected and the patient will need to be informed of this as soon as possible.

OUTCOME MARKERS

There are common patient questionnaires the patient can fill out to help track progress of the patient. Some offices automatically do this on intake and every re-evaluation. Many insurances require these forms for pre-authorization of care. The most common forms are;

Neck Disability Index (NDI) – this is a 10-question form with 6 choices for every question, it produces a disability score. The higher the score, the higher the disability

Oswestry Disability – This is the same form as the NDI but aimed at the lower back.

Disabilities of Arm, Shoulder, and Hand (DASH) - There is the full DASH form or the quick DASH form. This will also produce a disability score and help determine progress for the upper extremity

Lower Extremity Functional Scale – This program asks 20 questions about the lower extremity.

Bournemouth Back Form – This is a much simpler and straightforward form that helps track the progress of lower back pain and is easier to fill out than the Oswestry form. Many insurance companies will not accept this one, but it is better for office use.

STarT back screening tool – this form is required by certain insurance companies and has a more complex scoring but they are simple questions for the patient.

There are more forms that can be used such as the Activities of Daily Living Functional Scale. Become familiar with the office forms and when to use them. If a patient is complaining of a new injury or problem, these forms are useful to help create and manage treatment plans for the treating provider. There are on-line scoring tools for the more complex forms but many of the forms are relatively easy to score.

C What is Physiotherapy?

"Chiropractic physiologic therapeutics encompasses the diagnosis and treatment of disorders of the body, using the natural forces of healing such as air, cold, electricity, rest, exercise, traction, heat, light, massage, water, and other forces of nature."

Taber's Cyclopedic Medical Dictionary defines physical therapy as the application of specific modalities, including rehabilitative procedures, concerning the restoration of function and prevention of disability following disease, injury, or loss of a body part.2 The phrase is also to be considered synonymous with the term "adjunctive therapy".3

"Chiropractic physiotherapy" is probably the proper term for those modalities used in a chiropractor's office. However, the term has been shortened to "physiotherapy" for the sake of simplicity. "Physical therapy" is a term generally reserved for the field of medicine practiced by licensed physical therapists. In some countries, such as England, Canada, Australia, and New Zealand, the term "physiotherapy" is used instead of the term "physical therapy."

Commented [FV2]: Completely remove? We have physical therapy used in all of our state language.

For our purposes, "physiotherapy" will be used to refer to those modalities applied in the chiropractor's office or instructed to the chiropractic patient for home use.

The term "modality" should also be defined. According to the dictionary, a modality is "a method of application of, or the employment of, any therapeutic agent; especially a physical agent."4 So, a physiotherapy modality is the method of applying that physiotherapy.

1. **Jaskoviak, PA and RC Schafer, "Applied Physiotherapy" Arlington, Va.: The American Chiropractic Association, 1993,1-3.**
2. **Thomas, CL, ed. "Taber's Cyclopedic Medical Dictionary", 20th edition. Philadelphia: F.A. Davis, 2005**
3. **Physiotherapy and Rehabilitation Guidelines for the Chiropractic Profession, Journal of the American Chiropractic Association, July 1996.**
4. **Dorland's illustrated Medical Dictionary, 31st Edition, W.B. Saunders Co., Philadelphia, PA, 2004.**

D Why Do Physiotherapy?

Physiotherapy is used to increase the benefit of chiropractic adjustment and to help the healing process. In most cases, it allows the body to heal more quickly and more completely. For almost every condition that a chiropractor treats, there is at least one modality that can be used to improve the healing effect of chiropractic adjustment.

A good example of a condition that can be improved by physiotherapy is joint dysfunction. Joint dysfunction is a complex condition resulting from the improper function of es, joints, muscles, ligaments, or blood supply.

The chiropractic adjustment helps all these tissues to work more normally again. But the body takes time to heal and while it is healing there is a need to stabilize the condition and prevent re-injury. Different forms of physiotherapy may be used at different times to reduce pain, speed healing, reduce swelling, relax muscle spasm or strengthen weak muscles. The tissues are then given a better chance to recover.

In summary, the physiotherapy modalities help assist the chiropractic adjustment and the body's own ability to heal.

E Which Physiotherapy Modality Should Be Used?

Your doctor has chosen the physiotherapy modality or modalities that they are most comfortable with and feel will best meet the needs of the patient. A single modality can often be used to achieve several different effects. For example, a high voltage pulsed current can be used to relieve pain, relax the muscle or strengthen muscle, depending upon how it is applied. Different modalities may be used to achieve similar effects. For example, low voltage alternating current can also be used to relieve pain, relax muscles, or strengthen muscles. No single modality can be used to achieve every effect for every condition. That is why many chiropractors have several modalities in their office.

When your doctor instructs you to treat a patient with physiotherapy, the doctor will have chosen the modality or modalities that are most appropriate for that patient at that time. The doctor will also have chosen many of the particulars for the treatment, such as time, polarity, placement of pads, intensity level, etc. It is important that you follow the doctor's instructions carefully.

It might also be helpful for you to have additional information about the patient, such as the date of injury, the nature of the condition, and the effect that the doctor wants to achieve with the physiotherapy. It will make your job more interesting and you will be better able to help the patient.

With time and treatment, the patient's condition will change and different effects will be desired. For example, initially a patient may need treatment for reducing pain and swelling. Later, the pain and swelling will have decreased and the patient may need muscle strengthening. Whenever the patient's condition changes or the present modality is not achieving the desired effect, your doctor will inform you of the changes in the treatment program.

The most important thing to remember is: above all, do no harm. It is better to do nothing than to apply a modality that might worsen the patient's condition. If you have any doubts about the treatment you are instructed to give, ask your doctor about it.

F. **Stages of Tissue Repair**

After an injury, the tissues will go through several stages of repair. It is important that the physiotherapy modalities used at each stage be appropriate

Acute Stage (0-6 weeks)

An acute condition is usually a new injury that may be swollen, red,warm to the touch, and very painful. Even if the injury is not new it may be considered acute if the patient has not had adequate care or re-injury has occurred. Physiotherapy treatment for acute conditions must be gentle and must not aggravate the condition. The primary objective with the acute condition is to reduce swelling and pain. Some measures that can be used in the acute phase of a condition are: MOVE

1. Move the joint in a pain free range of motion as soon as possible
2. Options: offer options for pain relief and options for cross training
3. Vary rehabilitation with strength, balance, and agility
4. Early back to activity to avoid fear avoidance behavior and build mental health
5. Elevation

   Remembering the word MOVE (the first letter of each of those words) may help you to remember these measures.
6. Electrical Stimulation
7. Low Level Laser Therapy

A second "E" could be added to this list. Some forms of electrical stimulation are useful in reducing swelling and relieving pain. Electrical stimulation should be used for sensory stimulation only (that is, no muscle contraction) in the acute phase. **Do not use ice, NSIADs, or strong electrical stimulation in the acute phase of an injury.**

Healing Stage (7-12 weeks)

A sub-acute condition has progressed beyond the acute stage and has begun to repair.
The area may still be swollen, red, warm to the touch, and painful. Physiotherapy treatment should remain gentle but directed more toward starting normal movement of the injured part or area. Modalities might include, but not be limited to:

1. Contrast heat and cold
2. Electrical stimulation (mild)
3. Low Level Laser Therapy
4. Exercise (gentle)

Chronic Stage (over 12 weeks)

A chronic condition is an old injury or ongoing condition that is no longer swollen, red, or warm to the touch. The muscles may be tight and/or weak and scar tissue may have formed. Physiotherapy during this phase is aimed at loosening tight muscles, strengthening weak muscles, and reducing scar tissue. Some modalities that might be useful in the chronic phase of a condition are:

1. Traction
2. Heat, including hot packs, diathermy and ultrasound
3. Electrical stimulation
4. Massage
5. Exercise

   Think of the word THEME to help you remember these
6. Low Level Laser Therapy

Electrical stimulation in the chronic phase can often be gradually increased from sensory stimulation to muscle contraction level, to exercise the muscle.

G. Safety and Sanitation

Safety and sanitation in physiotherapy are mostly a matter of common sense; keep the patient safe and clean. Here are some basic suggestions to help achieve these objectives:

1 Stand close to the patient when he is getting off of a treatment table. You might even hold their arm. This is especially true for the elderly, getting off of a hi-lo table or if you have any reason to believe they might get dizzy. If a patient should collapse, do not try to hold them up; lower them gently to the table or floor and get the doctor immediately

Instruct the patients to use good body mechanics getting on and off the treatment table. If a patient is getting off the table from a back-lying (supine) position, have him roll to his side onto one hip, then bring his feet off the table and push up with his hands moving his body as a unit.

(Figure 1)

figure 1 - sidelying mounting table

The patient should not lift his head up first. If getting up from a stomach-lying position (prone), simply slide a leg off the table, bend the knees and push up with their hands.

(Figure 2)

figure 2 - prone mounting table

3. Safety precautions for electrical equipment:

   a. All electrical equipment should have a UL (Underwriters Laboratory) or CSA (Canadian Standards Association) sticker when it comes from the manufacturer. This indicates that the equipment was safe when it left the factory.

   b. All electrical equipment should have a 3-pronged plug and be plugged into a 3-pronged socket to be sure that the equipment is grounded. This will decrease the likelihood of an inadvertent shock.

   c. Any frayed or broken leads or wires should be replaced before that piece of equipment is used.

   d. Each piece of equipment should be safety checked once a year by a qualified individual.

4. Anything disposable (pads, probes, face paper, paper gowns, etc.) should be thrown away after use.

5. Anything non-disposable that touches the patient's skin should be thoroughly sanitized before it is used on another patient. For example, cloth gowns and towels should be laundered. Sponge pads should be soaked in a germicidal solution.

H. Positioning and Draping

It is important that the patient be comfortable, warm, and that the part being treated is positioned correctly. Your doctor will probably instruct you in the best position for the treatment. Here are some guidelines:

Place patients in a comfortable position.

Back-lying (supine): put a large pillow or bolster under the knees and a small pillow under the head and neck. Some treatment tables allow the headpiece to lift. Not all patients will need a pillow under their knees. Ask first. (Figure 3)

Figure 3 - Back Lying

Side-lying: put pillows between the knees and under the head. A pillow supporting the top arm might also help, especially if the patient has shoulder or arm problems. (Figure 4)

Figure 4 - Side Lying

c. Stomach-lying (prone): put a large pillow under the stomach and hips, unless the patient has a larger abdomen region. A cutout in the table is usually comfortable for the patient's face. A small roll under the ankles is helpful. (Figure 5) A patient with breasts might also like a pillow supporting their upper chest, especially if they are nursing.

Figure 3 - Stomach lying prone

2. Be sure that all body parts are supported in a resting and comfortable position, especially the part being treated.

3. Drape the patient with blankets or sheets, exposing only the area to be treated. After the treatment has begun, this area can often be covered as well.

4. When giving gowning or clothing instructions, be very specific on what the patient needs to take off, what to leave on, and how to put the gown on. For example, a patient who will have upper back work done may need to take off their shirt, leave on a bra, and have the gown with the ties facing the back.

5. Be sure that the patient is positioned in a way that is also best for your body mechanics. Ask the patient to slide closer to your side of the table, or raise the table to a higher position to decrease the stress on you. You may find that sitting on a stool or chair is helpful.

II. HEAT AND COLD

A. Heat Therapy

The therapeutic application of heat was probably the first physical modality man ever used. Whether it was in the form of hot rocks, hot mud, or hot water baths, heat was recognized early in history for its soothing and healing properties. Today heat is one of the most widely used modalities in a chiropractic office. The general therapeutic effects of heat are pain relief, reduction of muscle spasm, soft tissue stretching, and general relaxation.

The heat modalities can be divided into two major categories: superficial and deep heat. Superficial heat applications generally affect only those tissues close to the skin surface and do not penetrate to deeper structures. Deep heat applications go deeper than the skin and penetrate to the muscles and organs. The deep heat modalities are diathermy and ultrasound and will be discussed later in this manual. In this section we will address the application of superficial heat.

When applying superficial heat to a patient, there will be an increase in blood flow to that area and an increase in the local metabolism. This accounts for the pink skin that appears. One must be very careful not to burn the patient when using superficial heat. Heat that feels only mildly warm to your touch may to too much heat for the patient. This varies greatly from patient to patient. It varies as well from one area to another on individual patients. Both the patient's level of sensitivity and their condition must be taken into consideration. **Caution must be used when applying heat to patients who have a decreased awareness of sensory stimulation or touch.** This is common in elderly patients, patients with diabetes, or who have had a compromise of their sensory abilities from a surgical procedure. In these cases, heat may be used with caution exercised. Some patients do not tolerate heat very well; they may become dizzy, nauseous, or faint. It is even possible that some patients' pain levels will be increased with the application of heat. Therefore, until you know how a patient responds to heat, it is best to be cautious by monitoring the patient closely during the initial treatment. Particular attention should be paid to those patients who exhibit a history of high blood pressure, heart conditions, or diabetes. Elderly patients and children have thin skin and need additional protection when receiving heat treatments.

Because heat increases the flow of blood, patients with hemophilia or other bleeding conditions should not receive heat. Patients with cancer should not receive heat because it may increase the spread of the disease. Application of heat on the low back or abdomen of a pregnant woman can cause too much blood flow or metabolic activity in the unborn child and is not recommended. Heat should not be used when there is heart or kidney disease. Your doctor will determine when heat is to be used on a patient.

Indications

Condition	Effects
1. Chronic muscle spasm, nerve pain, injuries after 24-48 hours	Relieves pain, reduces muscle spasm
2. Chronic arthritis	Decreases joint stiffness
3. Chronic sprains and strains after 24 to 48 hours	Reduces pain, increases healing
4. Skin boils or superficial skin inflammation (cellulitis)	Hastens the healing process

Contraindications

1. Insensitivity to heat, e.g., diabetes, nerve damage
2. Increased sensitivity to heat, e.g., multiple sclerosis
3. Poor circulation, e.g., heart conditions, arteriosclerosis, high blood pressure, diabetes
4. Tendency to bleed, e.g., hemophilia
5. Cancer
6. Pregnant women
7. Severe swelling of arms, legs, or abdomen
8. Tuberculosis
9. Very weak patients.

Application of Superficial Heat Hot packs

(hydrocollator packs):

Hot packs are the single most common type of superficial heat used in a chiropractor's office. They are made of a sand-like silica gel housed in a canvas fabric. The hot packs are kept in a hot water bath at a temperature between 165-170°F. The silica gel will retain the heat for approximately 30 minutes. This is an excellent way to deliver moist heat to the patient. The hot packs come in several sizes and shapes making them easy to apply to most parts of the body.
(Figure 6)

Six to eight layers of toweling should be wrapped around a hot pack in order to avoid burning a patient. This is a general rule of thumb but special consideration must be made for all patients according to their needs. Commercial

hot pack covers are available for hydrocollator packs and are the equivalent of four layers of toweling. The hot packs should be completely wrapped so that no part of the pack is exposed and able to come in contact with the patient's skin.
(Figure 7)

Figure 7 - Hot Pack prone

Fresh towels should be used for each patient. The amount of heat can be controlled by increasing or decreasing the layers of toweling. More layers of toweling will be needed if the patient lies on top of the hot pack. The body's weight will compress the air space between the towels and more heat will be conducted. Additional toweling should be added if the patient exhibits sensitivity to heat. Additional toweling is required when placing hot packs over bony areas such as a shoulder or knee. Devise a system for rotating the packs so that each pack is allowed to heat fully before reuse. If hot packs are used frequently during the day, you may find that the packs will be cooler as the day progresses. You should make appropriate modifications by decreasing the towel layers to achieve a uniform treatment for all patients if the packs begin to cool. The patient should feel comfortably warm but not hot. It takes approximately 5-10 minutes before maximum heat transfer to the patient is achieved. The pack should be lifted from the patient and the patient's skin checked for the degree of redness every five or 10utes. Treatment time is typically 20-30 minutes. Once the treatment is complete, return the hot pack to the water bath and place the towel wraps with soiled laundry. The towels used on one patient should not be used on another; this will eliminate any cross-contamination or spread of germs.

A final word of caution: be sure that when you apply heat, the patient has a way of removing the heat or calling for assistance if he feels the heat is burning. Hot packs are the most frequent cause of burns of patients who are receiving physiotherapy. For this reason alone, you should be most careful when applying hot packs to patients.

Hot Wet Compresses

Hot wet compresses are another method of delivering moist heat to a patient. Wool or flannel towels are usually used for this purpose. They are placed in a hot water bath at a temperature of 165-170°F. When the towels are ready, they are removed, the excess water thoroughly wrung out and the towels placed in the desired area. The compresses cool quickly so they must be changed every few minutes or kept warm with a heating pad. The compresses can be left in place for 20-30 minutes when treating muscular conditions. They may be left up to an hour when treating inflammatory conditions.

Heating Pads

There are two basic types of heating pads: those that produce dry heat and those that produce moist heat. The moist heating pad utilizes a special cloth cover that pulls moisture from the patient's skin as well as the surrounding air. Heating pads are generally given to a patient for home use. A standard treatment time is 20 minutes out of every hour or 20-minute sessions three or four times a day. The patient should be instructed to place the temperature on a warm setting as opposed to a hot setting. This will decrease the risk of burns.

Home Heat Wraps

Heat wraps provide temporary relief of muscular aches and pains associated with overexertion, strains, sprains, muscle tension, arthritis, and menstrual cramps. Low-level heat wraps combine the benefits of heat with the ability to remain mobile and active. Heat wraps are made of a cloth-like material t comes in various sizes and conforms to the body's shape. They are fitted to wear on the lower back, neck/ shoulder or lower abdomen. Inside the wrap are air-activated heat discs made of natural heat-generating materials that heat up when exposed to oxygen. It takes up to 15-30 minutes for the wrap to reach its therapeutic temperature of 104-154°F.

Heat wraps stay warm for at least 8 hours and may provide up to 16-24 hours of pain relief, muscle relaxation, or relief from painful menstrual cramps. The wraps are generally single use packs and are disposed of after use. In addition to the general precautions with superficial heat special precautions for heat wraps include:

1. Do not wear wraps for more than 8 hours a day or more than 7 days in a row.
2. Do not use wraps with medicated lotions, creams, ointments, or on broken or damaged skin.
3. Do not use on patients who are unable to remove the wrap.
4. Do not use on infants or children under age 12.

Hot Water Bottles

Hot water bottles may be wrapped in moist or dry towels as per patient preference or the doctor's instructions. Hot water bottles retain their heat for only short periods of time and must, therefore, be changed frequently.

Water Baths and Whirlpools

Water baths and whirlpools are usually used to apply heat to arms and legs. Water is an excellent conductor of heat and water temperatures are easily controlled. Usually, hot water baths or whirlpool temperatures have a very narrow temperature range set at 100-105°F. This temperature setting is most desirable for the treatment of arm or leg complaints. If the whole body is covered, the temperature should be lowered slightly, not to exceed 104°F.

Whirlpools differ from water baths in that they have an electric motor that mixes air with water and forms a jet spray of water that can be directed to various body parts when submerged in the whirlpool tub. The jet stream of water mechanically massages sore muscles, increases circulation, removes dead skin, and cleans wounds and burns. To avoid spreading germs, attention must be given to proper maintenance and cleaning of the tub between each patient use. Disinfectants are recommended for cleaning a tub followed by a simple rinsing of the tub to remove any residual disinfectant. Additional cleaning is required for the whirlpool agitator (the motor). It is recommended that the disinfecting solution be mixed with an appropriate amount of water in a bucket and the agitator placed in the bucket. If the agitator is allowed to run for three or four minutes, the disinfectant will have sufficiently circulated through the internal mechanisms and cleaned them adequately. A whirlpool motor should never be turned on while it is out of the water. The water acts as a lubricant and without water being present, the motor will burn out rather quickly.

Towels should be readily available for the patient's use before treatment is terminated. This will decrease the likelihood of the patient chilling when being removed from the treatment tub. The patient should dry thoroughly and be kept warm. Treatment sessions vary from 10 to 25 minutes as prescribed by the doctor. On occasion, medications will be added to the baths to assist healing. This will be prescribed by the doctor as well.

Paraffin Baths

Paraffin baths are made by melting four to six parts common paraffin with one part mineral oil. This mixture is then heated to 125-130°F. Commercial paraffin baths are available but a 1 ½ quart double boiler can be used as well. This method of heat delivery is excellent for the treatment of hands, feet, or elbows. This method of treatment is particularly useful for arthritis pain in the extremities. Before treating the patient, remove all jewelry from the extremity to be immersed. Wash the extremity with hand soap and towel dry. Examine the skin for open wounds, unhealed scars, or skin infections. If these conditions are present, paraffin baths should not be used. To test the paraffin, check the temperature gauge (a candy thermometer works well for this purpose). You should be able to see a "skin" or film on the surface of the paraffin. If this is not present on the melted mixture, it may be too hot. Immerse the body part to be treated gently but quickly into and out of the melted wax.

Wait momentarily for the wax on the extremity to harden slightly and then immerse it again. Repeat this process ten to twelve times until a thick coat of wax forms on the extremity. Immediately after the last immersion, wrap the area in wax paper or plastic wrap and a dry towel. The patient can be left in this wrap for 20-30 minutes. Alternatively, the patient may leave the affected extremity immersed in the melted wax for the entire treatment time. However, it may be more difficult for the patient to maintain a comfortable position with this method.

The paraffin will surround the small joints of the hands and feet and leave the skin softened after treatment. When the treatment is completed, unwrap the extremity and peel off the paraffin and return it to the paraffin bath where it can be melted and reused. (Figure 9) Dirt and debris will collect in the paraffin with use. The paraffin should be replaced whenever impurities are noted. This is done by allowing the paraffin too cool down so it can be removed and replaced with a new paraffin/mineral oil mixture. When not in use, keep the paraffin bath covered and protected from contamination.

Infrared Heat

Infrared heat is a dry, even, steady, and comfortable source of superficial heat. Like hot packs and hot baths, it only penetrates the skin slightly. Although infrared is not as widely used in chiropractic offices as it once was, it continues to be a popular method of heat application in the home.

There are two types of infrared heat lamps: bulb and coil. The bulb type is a large "spotlight" bulb that may have either a clear or a red glass facing and a reflecting surface on the inside. This is what most people recognize as a "heat lamp." The second or coil type is a commercial lamp that is usually attached to a floor stand. This lamp has wires or filaments that are heated until they radiate heat. This is not unlike an electric range where the coiled stove top or element is heated. Infrared lamp coils usually have a reflector or mirrored surface to focus the heat. Some infrared heat lamps have movable reflectors that allow flexibility in directing the heat.
(Figure 10)

Figure 10 - Infrared heat lamp on leg

Infrared heat lamps have advantages over hot packs or hot baths in that the heat produced is steady and the patient doesn't cool down during the treatment period. Also, infrared heat is a dry heat and may be preferred by some patients. With infrared heat there is no contact with the patient's skin. The lamp is kept approximately 18-36" away from the patient. If applied cautiously, there is little risk of burning the patient with infrared heat lamps. Once the patient is positioned comfortably, they can be left unattended or undisturbed for the treatment period. After the treatment is finished, you might see a slight reddish skin or apparent sunburn. This is called erythema and may have a patchy appearance. Erythema will usually disappear quickly after treatment and is considered normal. Erythema lasting more than 24 hours should be reported to your doctor. Application procedures for that patient may need modification.

Some caution must be exercised when working with infrared heat. The heat source, be it bulb or coil type, will be hot to the touch, therefore one should avoid direct contact with the lamp. Infrared lamps are usually on floor stands and the bulb units will usually have a clamp to fix them to a stable support. Special attention

should be given to stabilizing the heat source before placing it over the patient to be sure that it will not fall onto the patient. As with any electrical device, check all the plugs and wires of the lamp for frayed or loose parts. Equipment in a state of disrepair should not be used and should be brought to the attention of the doctor.

Indications

Condition	Effects
1. Muscle spasm	Relaxes muscles
2. Chronic arthritis pain	Reduces pain
3. Swelling of non-acute injuries	Increases circulation and decreases and reduces swelling
4. Non-acute sprain/strain	Reduces pain, relaxes muscles, and reduces swelling

Contraindications

1. Cancer
2. Acute swelling
3. Bleeding
4. Inability of patient to perceive pain
5. Inability of patient to tolerate heat
6. Patients with heart conditions
7. Patients with poor circulation

Application

1. Preheat the infrared lamp for five minutes
2. Position and drape the patient as instructed in the Introduction (G. Positioning and Draping)
3. Remove all metal from the treatment area
4. Inspect the treatment area
5. If directing the heat to the face, place wet cotton cloths over the patient's eyes to prevent burning of this sensitive tissue
6. Place a towel over the treatment area
7. Place the lamp 18-36" from the area to be treated
   a. The heat is more effective if placed perpendicular to the treatment area
   b. If you lower the lamp to a closer position to the patient than the recommended 18-36", there will be a corresponding and marked increase in the amount of heat delivered to the patient. Be careful!
8. Inform the patient that he should feel a mild sense of warmth. If the patient feels too warm or you think his skin is too warm, move the lamp farther away from them.
9. Treat the patient for 20-30 minutes once or twice a day.

B. Cold Therapy

Cold baths and ice have been applied therapeutically in many different countries and cultures for many centuries. Methods of cold treatment have remained readily available and inexpensive. Today the application of cold therapies is widely used both in and out of the doctor's office for a variety of conditions. Although a debate continues over the appropriate time frame in which one should apply cold therapy or heat therapy, it is generally accepted that cold therapy should be used exclusively in the first 24-48 hours of an acute injury to decrease pain, swelling, spasm, and inflammation.

As one changes the treatment time of cold therapy, the treatment effects change also. If cold is applied for only a few minutes, you will get the opposite effect of applying heat. However, when one applies cold therapy for a greater time frame, cold can cause swelling like heat therapy. Most often, cold application is for 20-30 minutes.

Cold therapies can be applied safely in most circumstances, but occasionally patients may not tolerate cold either physically or psychologically. They may not tolerate the ache that accompanies cold application. They may exhibit a type of allergic reaction to the cold such as hives or itching. Should this occur, treatment should be discontinued immediately. Some patients find cold therapy irritating and will derive little benefit from it due to their resistance to its application. One should be cautious with all patients receiving cold therapy for extended periods of time; it is possible to cause frostbite or "cold burn" the patient.

Indications

Pain relief for non-acute injuries

Contraindications

1. Weak patients (elderly, children, etc.)
2. Hypersensitive patients: may produce hives, itching, or chills
3. Circulatory problems
4. Patients who are already chilled

General Application

1. Avoid generalized body cooling
2. Keep the treatment room at a warm, comfortable temperature
3. Keep the patient warm with a blanket or heating pad on non-treated areas
4. If the patient is chilled, either before or after treatment, a warm drink may be supplied
5. A warm-up *exercise* before or after treatment may be employed to reduce chilling
6. Monitor your patient for chills, "goose-bumps," bluish skin or hives during treatment. If found on the patient, discontinue treatment.

Types of Cold Therapies

The specific type of cold therapy you choose will be determined by the area of the body you are treating and the shape of the area you are treating. In turn, the specific modality will determine how much surface area can be treated as well as how intense the cold will be.

Cold Packs or Ice Packs

There are many different ways to make cold packs, all of which are effective. A quick and easy method of making a cold pack is to fill a plastic bag with crushed ice and add a bit of water. Commercial gel packs are effective but lose their cooling capacity more quickly than ice. Instant cold packs use a chemical reaction to produce cold, but these products do not effectively cool the tissues. For home use, patients may use a frozen bag of peas. This makes an excellent pack(s) for conforming to body contours and is very inexpensive.

Application

1. Inspect the treatment area
2. Place a warm, damp towel over the skin. Do not let the cold pack touch the skin (Figure 11)
3. Place the cold pack on the towel and stabilize it with a weight or strap

4. The treatment time is usually 15-20 minutes and can be repeated several times a day as instructed by the doctor.

Ice Massage

This is an excellent method for cooling small areas of acute injury. Patients may be instructed on how to do this at home if the doctor so prescribes. Ice massage is very effective for reducing pain and muscle spasm of chronic as well as acute injury.

Application

1. Fill a paper cup with water to freeze it. You may place a tongue depressor or Popsicle stick into the cup of water before freezing to use as a handle later.
2. Position and drape the patient as instructed in the Introduction.
3. Have at least one dry towel available.
4. Peel away an ample portion of the paper cup from the ice block to expose the frozen contents (Figure 12) or remove the ice block entirely if you have used a tongue depressor or Popsicle stick.
5. Rub your hand over the exposed ice surface to smooth out any sharp edges.
6. Rub the ice slowly with slight pressure over the desired area for several seconds. Use the dry towel to pat off any water accumulation on the skin. Do not rub the towel on the patient; the skin will be quite sensitive from the treatment.
7. Advise the patient that there may be some discomfort that progresses from a sensation of cold to burning to aching, think of the initials CBAN to remember the order. NOTE: on occasion the stages of burning and aching may reverse in some patients.
8. When the patient reports numbness, discontinue treating in that area.
9. Treatment usually takes 5-10 minutes. If the patient is not numb within 1 minute, the treatment should be discontinued anyway to avoid any possibility of frostbite. Bony areas lack fatty insulation and should be avoided. If an area blanches (turns white) for more than 30 seconds, discontinue treating in that area. Ice massage is not recommended for large area cold therapy; an alternative method should be employed.

Figure 12 - Ice Massage

Cold Compresses

Cold compresses are primarily used for treating large body areas but it is difficult to maintain a constant level of coldness. You can use a large towel or other appropriate material like wool or flannel.

Application

1. Immerse the towel in ice water for a couple of minutes and then wring it of excess water.
2. Lay the towel over the treatment area.
3. Cover the cold compress with a thin layer of plastic.
4. Place a dry towel over the plastic.
5. Treatment time is usually 20-30 minutes several times a day.

Cold Baths

Very cold temperatures can be applied with cold baths. Usually, cold baths are reserved for treating extremity injuries such as ankles, wrists, or elbows. The bath is made with cold water, and ice is added accordingly to reach ever decreasing temperatures. Treatment temperatures can be greatly varied from cool to very cold, depending on what your doctor has prescribed. Because the temperatures are usually quite cold and a relatively large area is being exposed, the patient should be closely monitored. In order to maintain a sanitized bath, the same cleaning instructions given for hot baths apply for maintaining the apparatus used for cold baths

C. Contrast Heat and Cold

Contrast heat and cold refers to the alternating use of a heat modality with a cold modality. Usually contrast applications are done with hot and cold baths or hot and cold packs, but they can be equally effective with a combination of any superficial heat and cold modality. This treatment approach is most commonly used after an injury has progressed from an acute stage to a subacute or chronic stage. Since heat causes an increase in circulation and cold causes a decrease in circulation, the contrast between the two is thought to cause an intense pumping action of the circulation to the injured area. This will improve the healing of the injured tissues, relieve muscle stiffness, reduce swelling and relieve pain.

Indications

Condition	Effects
1. Subacute sprain/strain	Decreases swelling, diminishes pain, Increases healing
2. Bruises	Improves circulation and healing
3. Muscle spasm	Relaxes spasms, increases circulation
4. Swelling	Reduces swelling
5. Arthritis	Reduces pain, promotes healing

Contraindications

1. Patients sensitive to heat or cold
2. Patients unable to feel heat or cold
3. Advanced blood vessel disease

Application

1. The temperatures range from 104°F-107°F for heat and 50°F-60°F for cold.
2. Contrast applications should begin and end with heat.
3. Apply heat for 4 minutes and immediately apply cold for 2 minutes.
4. Apply heat followed immediately by cold and repeat this process until a total of five applications have been given. Example:

   Heat 4 minutes Cold 2 minutes Heat 4 minutes Cold 2 minutes Heat 4 minutes

Total time — 16 minutes. Total applications = 5.

III. ELECTROTHERAPY

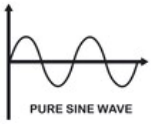
A. Introduction

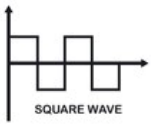
The biological effects of electrical currents have made them useful as an adjunct in treating many diseases. In general, electrotherapy modalities will decrease pain, relax muscles, decrease swelling, and help tissues to heal. All electrotherapy modalities have electrical currents that fall into one of two categories. The first of the two types of electrical currents are called direct current (DC or Monophasic), which is also called galvanic current or galvanism. The second of the two types are called alternating current (AC or Biphasic), which includes, sinewaves, square waves, and faradic currents.

A direct current (DC or Monophasic) is a steady flow of electricity from one point to the other, always flowing in the same direction. An example of a direct current is your car battery. Your battery has two posts (terminals); one is labeled negative and one is labeled positive. If you connect the two posts with a wire, the electricity made in the battery will flow from the negative post to the positive post as long as they are connected. You are creating a circuit along which the electricity will flow. When you apply a direct current to a patient it requires that you have one negative pad and one positive pad placed on the patient. In this situation the patient's body completes the circuit; that is, their body acts as a connecting wire between the two pads.

The second type of electrical current is the alternating current (AC or Biphasic). With this type of current you still start with a flow of electricity between two pads placed on the patient; however, there is a difference in that the electrotherapy machine causes the electricity to change the direction in which it flows. In an alternating current, the flow of electricity will go from the negative pad to the positive pad and then the machine will switch which pad is negative and which pad is positive so that the flow of electricity switches directions. That is why it is called an alternating current, because it alternates the direction in which it flows. An example of an alternating current is the electricity in your house.

Types of Alternating Currents (AC or Biphasic):

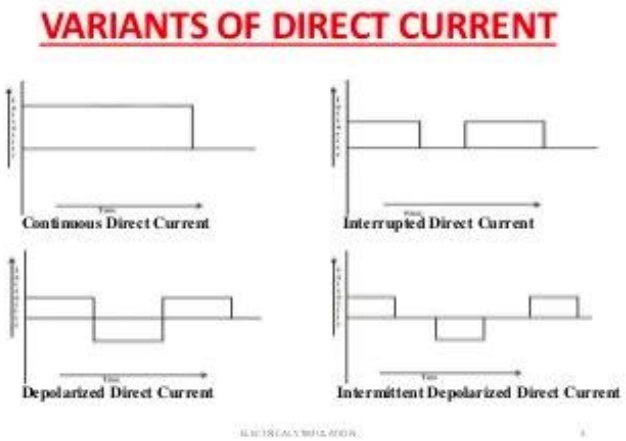




Faradic wave:

Faradic and Galvonic waveform

Types of Direct Currents (DC or Monophasic)Continuous direct current:



With any type of electrotherapy there are certain requirements that must be met before you can get the therapeutic effects. First, you must have a current or flow of electricity.

Second, you must have a complete circuit for the electricity to flow. If a current is interrupted or "broken" the electricity will stop flowing. In electrotherapy, we place electrode pads on the patient and the patient's body completes the circuit. Each machine will have wires called leads that carry the electricity from the machine's terminals to the electrode pads that are placed on the patient. The current must flow from the machine's terminals through the leads to the pads placed on the patient. If any one of these steps is interrupted, the current will not flow, and the patient will not feel anything.

Once the electrodes are properly placed on the patient, you have control over how the electricity is applied. You can control the intensity, or how strong the current is, and you can control the frequency, or how fast the current will be applied to the patient. The intensity is measured in microamps, milliamps (ma), microvolts, or volts (v). The frequency is measured in pulses per second (pps), cycles per second (cps), or hertz (hz). How it is measured depends on the type of machine you are using.

Intensity can be applied at two general levels. The first is called the sensory level. This occurs when you turn up the intensity dial and the patient feels a mild sensation of tingling, or needles and pins. The second level is called the motor or muscle stimulation level. This level is reached when you continue to increase the intensity beyond the sensory level of stimulation. At this level, you will cause muscle contraction or twitches. Which one of the two levels you use depends on what biological affects you want. Some electrotherapy machines have other controls that allow your doctor to prescribe different effects for the patient.

When applying any electrotherapy modality, it is important to keep your patient's comfort in mind. You do not want to cause pain or discomfort when applying the therapy. In order to prevent this, first check to make sure the machine is turned off and all controls are set to zero. Second, slowly turn up the intensity dial and ask the patient to tell you when he first feels something. The patient will report his first sensation to you (tingling). As you slowly turn up the intensity, ask the patient to tell you if it is uncomfortable. Continue to turn up the intensity until you get the desired effect or the patient reports that the therapy is uncomfortable, whichever comes first. If the patient reports discomfort, turn the intensity down to the patient's comfort zone.

Terms

- Direct current (DC or Monophasic): a steady flow of electricity in one direction between the negative and positive terminal of an electrotherapy machine.
- Alternating current (AC or Biphasic): a flow of electricity which changes its direction of flow in a rhythmic fashion between the negative and positive terminals. Current: a flow of electricity.
- Conductor: any substance that allows the flow of electricity.
- Insulator: any substance that prevents the flow of electricity.
- Intensity: the strength of the current.
- Frequency: how fast the current flows in pulses per second.
- Circuit: a complete flow of electricity from one terminal to the other with an electrical conductor in-between.
- Electrode pads: metal, sponge or rubber pads placed on the patient to apply the electricity for treatment.
- Leads: flexible wires that connect the terminals of the machine to the electrode pads.

Precautions of Application

As a safety consideration, always set all the controls on your machine to zero and make sure the machine is off before and after you apply a treatment. Some machines have an on/off switch on the back of the machine and automatically re-set the controls to zero when each treatment is finished. Other machines are turned on with mechanical timers. With these machines, if the intensity control is left turned up and you turn on the timer, the patient is likely to get a sudden jolt. As a consideration to the next person using the machine, make sure all controls are set to zero when you are finished with your treatments.

On occasion, you may find that as you turn up the intensity, the patient does not feel any sensation when you know he should. If this occurs, there may be an interruption to the circuit or your machine is malfunctioning. In either case, set the intensity control to zero before you move the electrode pads or test your connections. This is a safety rule that will prevent the patient from receiving a sudden stimulation that results from jiggling wires or moving electrode pads while the intensity is on.

Sponge electrode pads require that may be soaked in water to make sure there is a good connection with the skin of the patient. Some electrode pads require a gel for the same reason. In either case, unless water or gel is used, the electricity will not flow. When applying any electrotherapy modality, remove any metal or jewelry from the treatment area. The electrical current will have a tendency to be conducted along the metal or jewelry and may cause a bum to the skin.

All patients who have compromised mental faculties (senility, down syndrome, etc.) may not be able to accurately tell you if the electrotherapy is uncomfortable. In these situations great care must be taken in applying and monitoring the electrotherapy treatments.

The following sections will discuss the use and applications of specific electrotherapy modalities.

Contraindications

Certain disease states or areas of the body should not receive electrotherapy; these are said to be "contra-indicated" for treatment. For example, you should never use an electrotherapy on a patient with a pacemaker and never have an electrotherapy current pass through a patient's chest where his heart is located; it may cause his heart to beat abnormally. Other parts of the body that are sensitive to electrotherapy currents are the eyes and the brain. Electrotherapy is never applied so that the current passes from one pad through the brain to the other pad. Likewise, the front and sides of the neck are sensitive to electricity, therefore, your electrode pads should never be placed over the throat area or the sides of the neck. It is alright to place the electrode pads on the back of the neck.

Another condition in which you would not use electrotherapy is if the patient is pregnant. There is an increased risk to the unborn child if electrotherapy is used on the mid to lower back or the abdomen or pelvis of a pregnant woman. It is best to avoid electrotherapy altogether once the patient is pregnant. Your doctor may choose another type of therapeutic modality to help instead of electrotherapy.

Electrotherapy should not be applied over any known cancerous tissues or infections. The electro-therapy causes circulation to increase, and, thus, may cause the cancer or infection to worsen or spread to other parts of the body. If you notice an area of redness, swelling or pus on a patient, bring it to the attention of your doctor.

Some of the patients you treat may have areas of decreased sensitivity. The patients may not be able to feel pain or heat as well. Diabetes or paraplegia may also cause patients' sensitivity to be decreased. All areas of decreased sensitivity, regardless of the cause, pose a risk for patients because they are no longer able to accurately report back to you what they feel. It is possible to harm them without them knowing it. Great care must be taken when treating this kind of patient. If these patients are treated with electrotherapy they should be monitored closely and frequently.

All patients who have compromised mental faculties (senility, retardation, etc.) may not be able to accurately tell you if the electrotherapy is uncomfortable. In these situations great care must be taken in applying and monitoring the electrotherapy treatments.

The following sections will discuss the use and applications of specific electrotherapy modalities.

B. Low Volt Galvanism

Low volt galvanism (low volt direct current) occurs naturally in the form of lightening, electric eels and electric torpedo fish. For years low volt galvanism (LVG) has been used to treat many disorders including pain, weak muscles and healing fractures.

When using LVG you must be aware that it has the ability to burn the patient's skin or cause tissue damage. Therefore, LVG must be administered cautiously.

With LVG current the electricity flows from the negative pad to the positive pad. Each LVG machine will have a switch that allows you to decide which pad is positive and which pad is negative. This is important because there will be different biological effects under each pad. The term for being either positive or negative is polarity. You can have either a positive polarity or a negative polarity under a pad. The positive pad causes decreased blood flow, hardening of the tissues and is reasonably comfortable. The negative pad causes increased blood flow, softening of tissues and is relatively less comfortable. Your doctor will decide on the polarity of the pads.

When applying LVG, usually two electrode pads of different sizes are used. The smaller of the two electrode pads is called the active pad. This means that there is more concentration of current under this pad and the biological effects are greater. Place the smaller active pad, whether positive or negative, over the area that you want to treat to get the best biological effects. The second electrode pad is called the dispersive pad because it disperses or spreads out the current and therefore you get less biological effects under this pad. The dispersive pad must be at least twice the size of the active pad. It is the opposite polarity from the active pad and is placed away from the area of treatment.

(Figure 13)

Figure 13 - LVG

Terms

- Interrupted LVG: rather than flowing in a continuous stream, the current is stopped then started again. This is useful in stimulating muscles when the nerves to those muscles have been damaged.
- Continuous LVG: a steady stream of LVG current.
- Medical galvanism: using LVG to reduce pain or swelling in the patient. This approach may use either the positive or negative pad.
- Iontophoresis: using LVG to cause absorption of certain medicinal substances through the patient's skin for their therapeutic effects.
- Surgical galvanism: using LVG to treat hemorrhoids. Also known as "Keesey" treatment. Polarity: the ability to switch the machine to positive or negative and to determine which pad will have a positive or negative effect.
- Active pad: the smaller of the two electrode pads used. This concentrates more electricity at this pad and you will get more effects under this pad. The active pad is placed over the area of treatment. A probe may be used as a small active pad. (figure 14)
- Dispersive pad: the larger of the two pads. It is usually at least twice as large as the active pad.
- This spreads the electricity and you will get less effect under this pad. The dispersive pad is placed away from the area of treatment.

Figure 14 - LVG with **probe**

Indications

Condition	Effects
1. Stimulation of muscle that has lost its nerve supply (interrupted LVG)	Minimizes muscle weakness
2. Stimulation of weak muscles (interrupted LVG)	Maintains or improves muscle strength
3. When polarity effects are desired; strains, sprains, and scar tissue (continuous LVG)	Changes blood flow, reduces pain, softens or hardens tissues
4. When medicinals are topical (continuous LVG)	Will vary with the medicinals; can treat fungus, bacteria, or pain.
5. Hemorrhoid (surgical galvanism)	Reduces hemorrhoids

Contraindications

1. Cancer
2. Hemorrhage
3. Infection
4. Through the heart
5. Through the brain
6. Through the eyes
7. Front of neck
8. Pregnancy
9. Pacemaker
10. Over superficial metallic implants
11. Over recent scar tissue
12. Areas of increased or decreased sensitivity
13. Sensitive skin
14. Poor patient tolerance

Application

1 Position and drape and patient as instructed in the introduction.
2 Remove all metal from the treatment area.
3 Set all controls to zero.
4 Soak pads thoroughly or place gel on them. (If performing iontophoresis, soak the pad inthe desired solution.
5 Set the polarity of the machine so that you know which pad is positive and which pad isnegative.
6 Place the smaller active pad over the area to be treated. Place the larger dispersive padover a broad muscular area on the same side of the body close to the active pad. Keep the dispersive pad on the same side of the body. Remember to keep the current from crossing through the patient's chest. You may hold the pads to the patient's body with straps, weights, hot or cold packs, or the patient's own body weight.
7 Set the mode:
   a. continuous: for medical galvanism and iontophoresis
   b. interrupted: for stimulation of muscle.
8. Turn the intensity dial up slowly to patient tolerance (the maximum current is 1 milliamp on the meter for every square inch of active pad).
9 Treat for desired time:
   a. for muscle stimulation: stimulate the muscle until it begins to fatigue
   b. for medical galvanism and iontophoresis: the first treatment should be no longer than three to four minutes. The next treatments can gradually be increased to a maximum of 10 minutes.

10. Always check for signs of burning on the patient's skin. Slight redness is normal if it goes away in 24 hours.
11. Turn the intensity dial to zero before removing pads.

C. High Voltage Pulsed Current

High voltage pulsed current (HVPC) has been in use in clinics since the 1970's. Originally it was called "high volt galvanism" because it uses a type of direct current as does low volt galvanism (LVG). However, HVPC is very different from low volt galvanism in many respects. HVPC has a smoother, more comfortable feeling while LVG tends to be more intense and an almost "biting" feeling. Unlike low volt galvanism, HVPC does not produce strong polarity effects under each pad; therefore, it is incapable of burning the patient as easily. For these reasons, HVPC is more commonly used in the offices of chiropractors.

HVPC is used to reduce pain, relax muscles, and decrease swelling. It is often used in treating patients with recent (acute) injuries as well as those that have old (chronic) injuries. HVPC can also be used to build strength in muscles that are weak and to promote tissue healing in wounds. HVPC is typically used in a chiropractor's office for relieving pain, muscle spasm, and swelling from injuries, sprains, and strains of arms and legs.

Indications

Condition	**Effects**
1. Chiropractic Joint Dysfunction	Relieves pain and relaxes muscles
2. Soft tissue injuries (acute & chronic) such as strain and sprain	Relieves pain and relaxes muscles
3. Muscle spasm	Relaxes muscles
4. Muscle weakness	Strengthens muscles
5. Swelling	Reduces swelling
6. Arthritis	Relieves pain and swelling
7. Discogenic Pain	Relieves pain and increases healing
8. Trigger points	Stimulates trigger points and decreases pain

9. Muscle and nerve pain	Reduces pain

Contraindications

1. Cancer
2. Hemorrhage
3. Infection
4. Through the heart
5. Through the brain
6. Through the eyes
7. Front of neck
8. Pregnancy
9. Pacemaker
10. Over superficial metallic implants
11. Over recent scar tissue
12. Areas of increased and decreased sensitivity
13. Sensitive skin
14. Poor patient tolerance

Application

1. HVPC machines of older design use two or more electrode pads of unequal size. The smaller are the active pad(s) and the larger is the dispersive pad. The dispersive pad should be at least twice as large as the active pad, but it is best to use as large a pad as possible. Newer HVPC machines use two pads of equal size because any polarity effects are minimal.
2. Position and drape the patient as instructed in the Introduction.
3. Inspect the area and remove metal from the treatment area.
4. Set all controls to zero.
5. Set the polarity switch. This controls which pad is positive or negative.
6. Set the pulse rate as directed by your doctor. A low pulse rate (less than 40 pps) will cause individual muscle twitches, while a higher pulse rate (more than 40 pps) will cause a continuous, sustained muscle contraction or tetany. The higher pulse rate may be more comfortable for the patient.
7. Choose continuous or reciprocal mode:
    a. continuous: all pads operate in a constant manner -- best to reduce swelling or muscle spasm
    b. reciprocal: the current switches back and forth between two sets of active pads -- best to exercise muscle,

8. Soak the pads in water or place gel on them.

9. Apply the pads to the treatment area. (Figure 15) Use straps, weights, hot packs, cold packs, or the patient's body weight to hold the pads in place. Remember; do not cross the current through the chest. Sometimes instead of using electrode pads, you can substitute a very small pad on a handle called a "probe." (Figure 16) This will operate just like the flat pads but you can hold it in your hand. It is useful for stimulating small areas such as trigger points, acupuncture points, or small muscles.
10. Turn the timer to the desired time of treatment, usually 15-20 minutes.
11. Gradually turn up the intensity control until you achieve the desired effect within the patient's comfort zone. For acute painful conditions, the intensity is kept low so that the patient reports just a 191/77ing or tingling sensation and no muscle contraction occurs. If you want to reduce muscle spasm in a chronic condition, it will be necessary to turn up the intensity until you see or feel a muscle contraction, provided the patient can tolerate the intensity.
12. When the treatment is over, turn all the controls to zero and remove the pads.

D. Low Voltage Alternating Current (Biphasic or Sinewave)

Low voltage alternating current has been used to treat disease since the mid-I 800's. Low voltage alternating current (LVAC) is sometimes referred to as biphasic, sinewave or faradic current. Although there are some technical differences among the terms, it is proper to think of them as belonging to the larger category we call low voltage alternating currents.

LVAC is very effective in stimulating a muscle and causing it to contract strongly. This makes LVAC an ideal modality for reducing the swelling of an injured area, reducing muscle spasms, relieving pain and exercising muscles. LVAC does not require two different sized electrode pads although you may still choose to use different sized pads. On occasion it may be helpful to use a very small pad or a probe to treat small muscles or a specific treatment point. In these cases, the small pad will concentrate the current to the desired area for greater effectiveness.

LVAC machines will generally allow you to choose how the current is delivered to the patient. You may choose to use one of three forms of available treatment: PULSE, SURGE, or TETANIZE. With the machine set on pulse, the muscles will contract at a preset number of times or pulses per second. This mode is good for reducing swelling. In the surge mode, the low voltage alternating current gradually builds up and then gradually falls off. This effect can be controlled to occur from one to several times per minute. When this mode is being used, the patient's muscles can be seen to gradually contract and then relax. This is an effective treatment mode to either exercise or fatigue a muscle. The tetanize mode allows you to cause a smooth, continuous muscle contraction instead of muscle twitching as occurs with the pulse mode. The tetanize mode is good for releasing a chronic muscle spasm. Your doctor will determine the appropriate setting for each patient.

Terms

- Low Voltage Alternating Current (LVAC, biphasic, sinewave, faradic): a flow of electricity which changes directions in a rhythmic fashion between the positive and negative terminals or pads.
- Frequency: the number of times the LVAC changes directions each second. The frequency is measured in cycles or pulses per second.
- Pulse: a completed cycle of alternating current flowing from on terminal or pad to another and back again. One completed cycle is equal to one pulse.
- Surge: the gradual building up and dropping off of an alternating current so that a muscle under stimulation gradually tightens and then relaxes.
- Tetanize: that point which causes a smooth, continuous contraction. This contraction is referred to as tetany or tetanic contraction.

Indications

Condition	Effects
1. Chiropractic subluxations	Relieves pain, relaxes muscles
2. Soft tissue injuries (acute & chronic) such as muscle strain and ligament sprain	Relieves pain, relaxes muscles
3. Muscle spasms	Relaxes muscles
4. Muscle weakness	Strengthens muscles
5. Swelling	Reduces swelling
6. Arthritis	Relieves pain and swelling
7. Disc problems	Relieves pain and increases healing
8. Trigger points	Stimulates trigger points and decreases pain
9. Muscles and nerve pain	Reduces pain

Contraindications

1. Cancer
2. Hemorrhage
3. Infection
4. Through the heart
5. Through the brain
6. Through the eyes
7. Front of neck
8. Pregnancy
9. Pacemaker
10. Over superficial metallic implants
11. Over recent scar tissue
12. Areas of increased or decreased sensitivity
13. Sensitive skin
14. Poor patient tolerance

15. Over bony areas
16. Where muscle contraction is not desired; e.g., broken bones

Application

1. Position and drape the patient as previously instructed in the Introduction.
2. Remove all metal from the treatment area.
3. Set all controls to zero before turning machine on
4. Soak the pads in water or use gel and place them on the treatment area. Two or four pads may be used. Each two pads constitute a separate circuit. (Figure 17)

Figure 17 - Low Voltage Alternating Current

5. Set the mode as indicated by the doctor: PULSE, SURGE, or TETANIZE.
6. Turn the timer to the proper length of treatment (usually 15-20 minutes).
7. Increase the intensity gradually to the patient's tolerance or until the desired muscle contraction is achieved, whichever comes first.
8. After treatment, return all controls to zero and remove the pads.

E. Transcutaneous Electrical Nerve Stimulation

Transcutaneous electrical nerve stimulation (TENS) is a term that technically can be applied to any type of electrotherapy that electrically stimulates nerves by sending a current across the skin. However, TENS is usually used to describe the small portable electrical stimulators that can be carried in a patient's pocket or attached to a belt.

TENS is a relatively new form of electrotherapy. The basis for its use as a treatment modality comes from the 1960's work done on pain management and control. Since its development, it has proven to be useful in relieving acute and chronic pain. It is sometimes used to relieve the pain of those with terminal diseases such as cancer. Unlike other electrotherapies, TENS can be applied for several hours at a time. Aside from the obvious benefit of having an electrotherapy modality that is compact, portable, and easily applied for considerable lengths of time, the TENS units also have current delivery controls that can be operated by the patient. This allows the patient the flexibility of increasing or decreasing the intensity of the treatment as needed.

There are many different types of TENS units on the market today. Each may vary in its wave form (type of current) and amount of current available. The best type of current for pain reduction has not yet *been* established; therefore, TENS units of varying current types appear to be equally effective. The control switches of the TENS units modify the intensity of the current, the frequency of the pulses, and the width of the pulses. Your doctor will determine the initial treatment settings for each patient.

Achieving pain relief with a TENS unit can be difficult and may necessitate several trials of application to find the best settings and/or placement of the electrode pads. When using TENS it is important to remember that this unit relieves pain but does not cure the patient's condition. For this reason, it is important to caution all patients against increasing their activity level simply because they may be experiencing relief of their pain. The doctor will determine the appropriate time for the patients to normalize their work and social routines.

When TENS are sent home with patients, it is best to instruct them in the correct operation of the unit and have them verbally repeat as well as re-enact the instructions prior to leaving with the unit. Operation instructions should be limited to changing the intensity ONLY Other changes should be determined by the doctor. Be sure to replace or change the batteries for the units before sending them with the patients. Some units carry nine volt batteries while others use "AA" batteries.

Indications

Condition	Effects
1. Chronic pain, arthritis, and lower back pain	Relieve pain in 30-75% of cases
2. Acute pain, post-surgical pain, and post childbirth	Relieves pain in 30-80% of cases. May reduce need for pain medications. May return patient to normal activites sooner.
3. Intractable pain, i.e. cancer	Short-term relieve of pain in up to 65% of the cases.
4. Rehabilitation exercises	May reduce pain if used before and after exercise.

Contraindications

1. Pacemakers
2. Front of neck
3. Pregnancy
4. In the presence of skin irritations

Application

Control Settings:

The controls of intensity, frequency, pulse, and modulations will be prescribed by the doctor according to the needs of the patient.

Electrode Pad Attachment:

Since the TENS application may last several hours, it is necessary to firmly attach the pads to the patient and insure they remain moist and secure. Without this attention to placement, the conduction of stimulation may be considerably decreased.

To reduce the occurrence of skin irritation, suppliers have developed non-allergic conductive pads that are self-adherent and eliminate the need for either conducting gels or adhesive tapes. These pads have the additional benefit of being reusable. They are hypoallergenic and can be worn for long periods of time.

It is also possible to apply conducting gel to small rubber electrodes and use standard medical tape to secure the pads. Because of the length of time the pads may be in contact with the patient's skin, care must be taken to avoid skin irritation. It is recommended that non-allergic tape be used for prolonged applications

Electrode Pad Placement:

Another consideration when using the TENS is the proper placement of the electrode pads. This remains an important consideration in spite of the fact that there is a lack of specific guidelines for pad placement for best results in any given condition. Some general suggestions for pad placement are:

1. over the painful area
2. over acupuncture points
3. over trigger points
4. over a spinal nerve root
5. over the path of a nerve.

When applicable, it is best to use four electrode pads (two channels).
(Figure 18)

Figure 18 - TENS

Length of Treatment:

TENS units may be left in place on the patient for up to 24 hours in some cases. Your doctor will tell you how long the electrodes are to be left in place. Electrode pads should be removed daily to evaluate the condition of the skin and cleanse the area. Inspect the area carefully for signs of local skin irritation. If the skin shows signs of irritation, treatment at that particular site should be discontinued.

F Microcurrent Electrical Stimulation

Microcurrent electrical stimulation (MES) is another electric modality for use in chiropractic. It is popular for the treatment of sports injuries. Since the amounts of current used are so small, MES is probably safer to use than many of the other modalities.

Microcurrent electrical stimulation uses a very small microamperage current, in the range of 1/1000th the amperage of low volt galvanism, high voltage pulsed current, or low voltage alternating current. It operates on the theory that a sick or injured cell loses some of its energy and becomes weak. The microamperage current is similar to the natural currents of the body. When the current is applied to the sick cell, the cell is given a "quick charge," similar to charging a car battery when it is weak. After the cell has been charged, it is able to work normally again, allowing pain to diminish and healing to take place.

Indications

Condition	**Effect**
1. Pain	**Decreases Pain**
2. Unhealthy tissue	**Increases healing**
3. Swelling	**Decreases swelling**

Contraindications

1. Demand-type pacemakers
2. Front of neck
3. Over the eye
4. Pregnancy

Application

There are many ways of using microcurrent electrical stimulation. Some of them, such as electroacuuncture, should only be done by the doctor unless they have givenn you specific instructions. Applications discussed here will be limited to those which can safely be done by the ancillary personnel, chiropractic assistant. Your doctor will tell you which technique to use and how long to treat.

Before using microcurrent electrical stimulation, tell your patients that you are using a very small amount of current and they should feel no electricity. They may be surprised that they can get pain relief without feeling the current. Assure them that it is true!

Two or four pads:

The pads should be placed around or over the problem areas. (Figure 19) Follow the manufacturer's instructions for applying the pads. Treatment time is usually 10-60 minutes.

Figure 19 - MES

Gloves:

With the gloves, the current is attached to the gloves as the provider moves their hands. The patient will not feel any discomfort. Treatment time is 10-60 minutes.

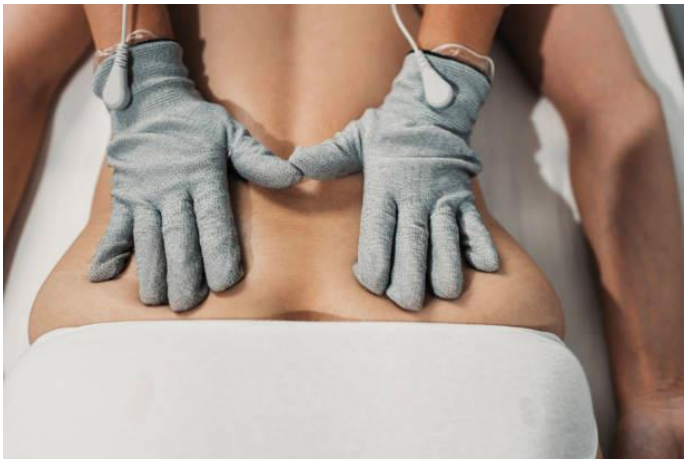


Figure 20 - MES with gloves

G. Interferential Therapy

Interferential therapy was first developed in Australia in the late 1940's. It has become a very popular modality in the United States because it is thought to treat deep tissues. In fact, it is one of a few modalities that can be placed to reach just about any place on the body, no matter how deep. Interferential therapy can be used on both acute and chronic conditions by changing the frequency and intensity used. Patients like it because it is comfortable and effective.

Interferential current needs four electrodes to work Two electrodes are needed to make one circuit and two more electrodes are needed to make a second circuit. The electrodes are put on the body so that the two circuits of current cross each other in an "X" pattern. In the middle of the "X" (where the two currents meet or "interfere") a different current is produced. This new current comes out in the shape of a cloverleaf with the middle of the cloverleaf being at the middle of the "X."
(Figure 21)

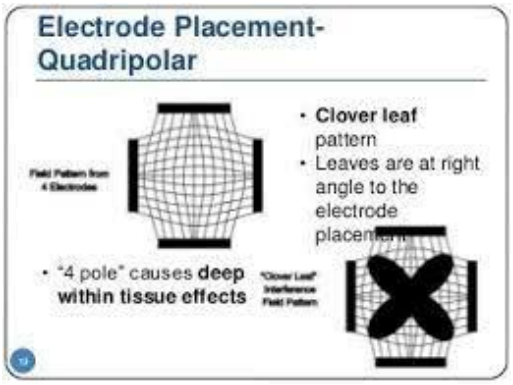


Figure 21 Interferential Clover-leaf pattern

This cloverleaf of current generates useful effects on the body. By moving the electrodes around, the cloverleaf is moved and different tissues are treated. For example, if all four electrodes are placed toward one side of the body, the currents will crisscross on that side of the body and the effects will take place at or near the skin on that side. (Figure 22) But if two electrodes are placed on one side of the body and two on

the other side (making sure to crisscross the two circuits), the cloverleaf will be in the middle of the body and the effects will take place in the deep tissues. (Figure 23)

Figure 22 - Interferential Therapy Example

The effects that occur will depend on the frequency of the current used. The following are guidelines:

90-100 Hz. for pain relief
40-50 Hz. for muscle contraction
10-150. Hz. for reducing bruising and swelling

It is important to remember that you do not want to cause a muscle contraction in an acute injury, so it is better to keep the frequency in the higher ranges (90-150 Hz.) and keep the intensity low, to where the patient just begins to feel the sensation.

Indications

Conditions	Effects
1. Soft tissue problems (acute & chronic) such as muscle strain, ligament sprain, nerve pain	Relieves pain and relaxes the muscles
2. Chiropractic subluxation	Relieves pain and relaxes muscles
3. Muscle spasm	Fatigues muscle causing it to relax
4. Weak muscles	Strengthens and teaches muscles to work correctly
5. Arthritis and other joint conditions	Relieves pain and swelling
6. Disc problems	Relieves pain and increases healing
7. Headache	Relieves pain and relaxes the muscles

Contraindications

1. Cancer
2. Hemorrhage
3. Infection
4. Through the heart
5. Through the brain
6. Through the eyes
7. Front of neck
8. Pregnancy
9. Pacemaker
10. Over superficial metallic implants
11. Over recent scar tissue
12. Areas of increased or decreased sensitivity
13. Sensitive skin
14. Poor patient tolerance

15. Within 20 feet of an operating diathermy (deep heat) machine.

Application

1. Position and drape the patient as previously instructed in the Introduction.
2. Place all four electrodes on the skin in a crisscross pattern, making sure that one circuit will cross the other. Each circuit should be about the same length. Thoroughly wet the sponges or put gel on the pads and place them on the skin in a crisscross pattern and secure them with straps, weights, hot packs, etc. Each circuit should be about the same length. (Figure 23)
3. Your doctor will tell you the frequency to use for the desired effect.
4. Push the vector/scan control if you want more generalized treatment. This causes the cloverleaf to rotate, reaching the tissues in between the cloverleaf area.
5. Tell the patient what you expect him to feel when the current is turned on. Turn the intensity up slowly and ask the patient to tell you if they feel uncomfortable. For a new patient or a patient with an acute injury, he should feel only a mild sensation of "buzzing or tingling." You should look at the muscle and feel it to be sure it is not contracting. Turn the intensity down if necessary. It should always be comfortable for the patient. Pay attention to your patients and believe them if they tell you the intensity is too high, even if you have not gone past zero on the gauge. When the injury is chronic, the patient can usually tolerate ever increasing levels of intensity until the muscles are contracting strongly. This is fine if it is comfortable for the patient and the last treatment did not cause any problems afterward. Too much stimulation too fast can cause uncomfortable muscle soreness after the treatment.
6. The electrodes can be rearranged if the current is not felt in the right place. Turn down the intensity and then reposition the electrodes.
7. Set the tinier for 15-20 minutes.
8. Make sure the patient is warm, comfortable, and has some way to call you. A bell or buzzer would suffice.
9. At the end of the treatment, set the intensity to zero and remove the electrodes.

H. Diathermy

Diathermy first came into clinical use in the early 1900's but did not take its present form until the 1930's. It was a popular form of deep heat for many years. Diathermy is no longer used as frequently as it once was. It can be awkward to use, has many contraindications and can cause burns deep within the tissues; it also interferes with many electrical devices that use radio waves. However, diathermy can still be a useful modality for many kinds of problems if used with care and caution. There are a number of conditions, such as lung congestion that can be effectively treated with diathermy. Other deep problems, such as spine and hip joint problems, also respond well to diathermy. In the chiropractic office, ultrasound is often used instead of diathermy for deep heat.

Diathermy is a very high frequency alternating electrical current, in the range of radio waves. Because it is such a high frequency, when it enters the body, it does not cause the same sensation or muscle contraction that low voltage alternating current or high voltage pulsed current cause. Instead, it causes molecules within the cells to vibrate back and forth. This vibration causes friction which causes heat. This is like the heat that you create when you rub your hands together very quickly; the friction creates heat. With diathermy the friction is deeper in the body and thus the heat is deeper in the layers of muscle.

The main effect of diathermy is heat, which can have other effects on the tissues.
These include:

1. decreased pain
2. decreased muscle spasm
3. decreased inflammation
4. decreased infection
5. increased healing.

These effects hold true for shortwave diathermy and microwave diathermy. There is a third type of diathermy, pulsed shortwave diathermy, which produces little or no heat. Pulsed shortwave diathermy can be used to help healing in conditions where heat is not desired.

Indications

1. Chronic muscle strains
2. Chronic ligament sprains
3. Chronic tendinitis
4. Chronic bursitis
5. Chronic arthritis and other joint conditions
6. Wound healing
7. Pneumonia and other lung infections

Note: conditions 1-5 above should be treated only with diathermy in the chronic phase because heat is not usually desired in the acute phase. If pulsed diathermy is used, however, these conditions may be treated in the acute phase. Follow the guidelines suggested by the manufacturer of the machine.


All wood table with
no metal components
Coil
Towels
Shortwave
diathermy device

Contraindications

1. In a room with a pacemaker patient
2. Over a pregnant uterus
3. Through the brain
4. Cancer
5. Poor circulation
6. Over any metal implant such as a total joint replacement, pins, staples, plates, screws, a diaphragm or an IUD with metal
7. Wet dressings or plaster cast
8. Over the pelvis of a woman during her period
9. Over any area where sensation is not normal
10. Severe osteoporosis
11. Moderate to severe swelling
12. Tuberculosis
13. Any patient who is unable to report what he is feeling (including the very old or very young)
14. Within 20 feet of an operating interferential machine

Precautions

1. Do not place the patient on a table or chair with metal parts.
2. Remove all jewelry in the area to be treated.
3. Inspect the skin carefully. If there is a surgical scar, inquire as to the reason for surgery to ensure that there was not a metallic implant inserted. Be sure that the patient has no metal inside of them. If in doubt, do not treat.
4. Diathermy can burn tissues under the skin without burning the skin. The patient should feel a comfortable, mild sense of warmth, not hot!
5. Diathermy can burn the skin if water is allowed to collect on the skin. The water will heat up and cause a burn. Drape areas of treatment with absorbent towels and place toweling in any folds of skin that touch each other, such as in the armpit.
6. The cables (going from the machine to the treatment heads) must not cross or touch anything metal.
7. Do not allow the patient to touch the machine or change the intensity.

Application

1. Preheat unit for five minutes.
2. Position and drape the patient as instructed in the Introduction.
3. Place a dry, absorbent towel over area to be treated.
4. Place the electrodes. Placement will depend on the type of diathermy being used Shortwave diathermy pads: (Figure 24)

5. Set the timer. The doctor will need to dictate the time. Guidelines are: 5-10 minutes for sub-acute conditions, 15-20 for chronic conditions

Figure 24 - Shortwave diathermy

Place the pads against the towel on the skin. The farther apart the pads, the deeper the treatment. (Figure 25) Both pads must be used.

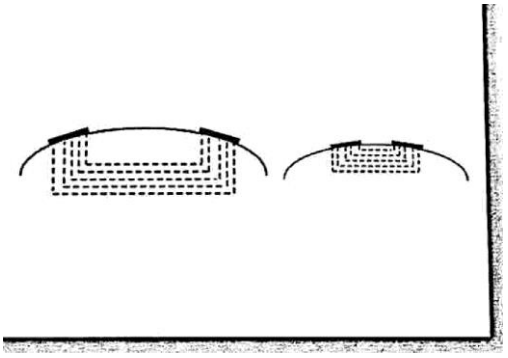


Figure 25 - Shortwave diathermy penetration

Shortwave diathermy air spaced electrodes: (Figure 26)

Figure 26 - Shortwave diathermy airspace electrodes

Place the electrodes 1-3" from the body, keeping the space between the skin and the electrodes as even as possible. Do not allow any part of the electrodes to touch the skin. Both electrodes must be used. Electrodes may be placed on opposite sides of the body for a deep treatment.

Shortwave diathermy drum electrode: (Figure 27)

Place the electrode up against a towel that has been placed adjacent on to the skin.

Shortwave diathermy induction coil electrodes:

Place the electrodes on a towel on the skin without touching it. One or both electrodes may be used. Placing the electrodes on opposite sides of the body will not make the treatment any deeper.

Microwave diathermy head:

Place the head approximately 1-8" from the skin with the flat part of the head parallel with the skin. The farther the head is from the skin, the larger will be the treatment area (Figure 28) and the more intensity needed.

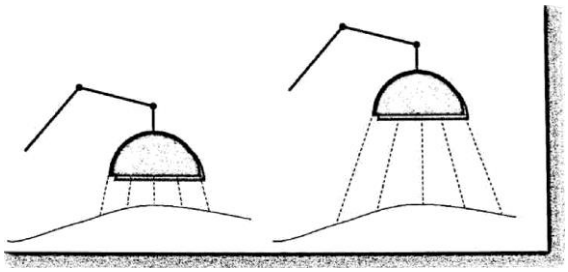


Figure 28 - Microwave diathermy distance

I Ultrasound

Ultrasound first came to the U.S. from Europe in the early 1950's. It became a popular modality and has remained quite popular because it is easy to use, relatively safe and can be used to treat a wide variety of conditions. It is used primarily for deep heat.

Ultrasound is actually a high frequency sound wave, so high that it cannot be heard by the human ear. Ultrasound is made when an electrical current is carried into the sound head of the machine (Figure 29) and causes the crystal inside to vibrate rapidly. This "sound" vibration then goes from the sound head into the patient's body and causes the tissues to vibrate. The vibration creates heat in the body where the sound head is applied.

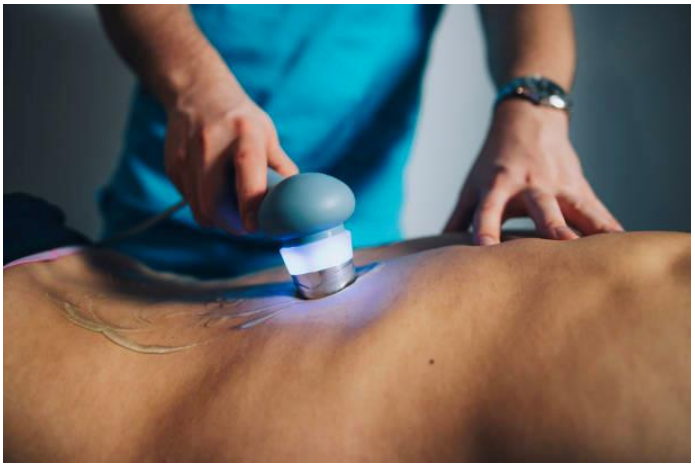


Figure 29 - Ultrasound head

Ultrasound is a sound wave and, as such, acts differently from electrical currents applied to the body. It has its greatest effect where two different types of tissues meet, such as where a tendon goes through its protective covering or sheath. That is why conditions such as tendonitis, bursitis, and carpal tunnel syndrome respond well to ultrasound.

The effects of ultrasound are:

1. Heat
2. Micro-massage, which can help to break up swelling and/or scar tissue
3. Cavitation, which can soften hard tissue and scar tissue.

Ultrasound can be pulsed so that heat does not have a chance to build up leaving only the micro-massage and cavitation effects. Pulsed ultrasound is useful for acute conditions or for small areas of treatment where heat is not desirable.

Because ultrasound is a sound wave, it does not travel well through air. For this reason, applying ultrasound requires the use of a special conducting gel, lotion, or water. If the ultrasound is turned on without the sound head being against gel, lotion, or water, the heat builds up inside the sound head and may burn out the crystal. It is important to keep the sound head against the patient's skin with gel or lotion or under water whenever the machine is turned on.

Indications

1. Muscle strain
2. Ligament sprain
3. Tendonitis
4. Bursitis
5. Arthritis
6. Adhesive capsulitis (for example, frozen shoulder)
7. Carpal tunnel syndrome (a wrist condition)
8. Scar tissue and adhesions
9. Swelling
10. Radiculitis or nerve irritation

Contraindications

1. Cancer
2. Hemorrhage
3. Infections
4. Through the heart
5. Through the brain
6. Over the eyes
7. Front of neck
8. Pregnancy
9. Pacemaker
10. Over the growth centers (the ends of the long bones) in a growing child
11. Over reproductive organs
12. Over deep vein blood clots
13. Over areas of poor blood supply
14. Over a fracture, until it is well healed
15. Directly over the spinal cord (do not move the sound head across the spine to get to the other side of the back, lift the sound head, then move it. It is safe to use ultrasound on the muscles of the spine)
16. Tuberculosis
17. Hemophilia

Precautions

1. Apply ultrasound cautiously over bony areas.
2. Always keep the sound head in contact with gel, lotion, or water.
3. Be careful with the sound head; it has some delicate and expensive parts.
4. It is a good idea to check your sound head weekly to be sure that it is working. Put the sound head under water, turn the intensity up and watch for turbulence. If you see no turbulence, ask your doctor to have the machine checked.
5. The sound head can easily carry germs from one patient to another. It is important to clean the sound head with soap and water or a germicidal solution after each use.

Application

With gel or lotion (good for treating large, fleshy areas):

1. Position and drape the patient as previously instructed in the Introduction.
2. Use a gel or lotion that is specifically designed for use with ultrasound (massage or hand lotion do not allow the ultrasound to penetrate as well and are not recommended). Apply the gel liberally to the patient's skin. Treat an area 2-3 times the size of your sound head.
3. Place the sound head in the gel on the patient's skin. Begin moving the sound head slowly in a circular or longitudinal motion, using moderately firm pressure. Keep the sound head flat on the patient's skin.
4. Set the machine to continuous or pulsed ultrasound, whichever your doctor has ordered.
5. Turn the intensity up slowly. Your doctor will tell you the maximum intensity desired. Guidelines are:
   acute conditions. -- 0.5 w/cm^2
   chronic conditions -- 1.0 w/cm^2
6. Explain to your patient that he may feel mild warmth, tingling, or may feel nothing at all. Ultrasound works deep within the tissues and many people feel nothing on the skin where we normally feel sensation. Ask them to let you know if it feels uncomfortable in any way. If it becomes uncomfortable, turn the intensity down.
7. For both continuous and pulsed ultrasound, move the sound head slowly in a circular or longitudinal motion, keeping contact with the skin.
8. Treat acute areas for 3-5 minutes and chronic areas for 8-10 minutes per your doctor's orders.
9. At the end of the treatment, turn the ultrasound off before removing the sound head from the skin.
10. Wipe the excess lotion off the patient. Clean the sound head with soap and warm water.

Under water (good for treating hands, elbows, feet):

1. Place the part to be treated in water (a plastic basin works best).
2. Place the sound head in the water.
3. Turn the ultrasound up to the desired intensity. Your doctor will tell you the maximum intensity. Guidelines are:
   acute conditions -- 1.0 w/cm^2
   chronic conditions -- 1.5 w/cm^2
4. Place the sound head about 1I2" away from the skin and move it in slow circular or longitudinal motions.
5. If the patient gets uncomfortable, turn the intensity down.
6. Treat acute areas for 3-5 minutes and chronic areas for 8-10 minutes, per your doctor's orders.
7. At the end of the treatment, turn the ultrasound off before removing the sound head from the water.
8. Dry the patient's skin and the sound head.

Ultrasound with electrical stimulation

Many machines are equipped with both ultrasound and either high voltage pulsed current or low voltage alternating current. They can be set so that both ultrasound and the electrical stimulation will come out of the sound head. Here are some things to remember:

1. Follow instructions for both ultrasound and the electrical stimulation being used (high voltage pulsed current or low voltage alternating current as outline in this manual).
2. Activate the control on the machine that allows for the two to be used together. It is usually called "combination" or "combo".
3. Remember to use one pad from the electrical stimulator.
4. Use continuous or pulsed ultrasound and keep the sound head moving.
5. Keep the intensity of the electrical stimulation low enough so that it is not too strong if it hits a painful area. The intensity can be turned up at each area but should be turned down again before moving on to a new area.
6. Never allow low volt galvanism to go through the sound head. It can pit and damage the sound head.

1 Ultraviolet

Ultraviolet (UV) was originally used in the early 1900's for the treatment of rickets; ultraviolet helped in the production of vitamin D in the body. When the cause of rickets was controlled by improved food preparation, ultraviolet treatments became unnecessary.

UV is seldom used in the chiropractor's office today but may occasionally be used for the treatment of psoriasis, wounds, or strep throat.

UV is a form of light that is given off by the sun at a higher frequency than our eyes can see. If you look at a rainbow you will see violet on one side, then blue, green, yellow, orange, and red on the side. Ultraviolet is just outside the rainbow on the violet side (and infrared is just outside it on the red side).

UV can burn tissue easily, especially the eyes. Fortunately, ultraviolet is very easy to block out. Even plain glass blocks out much ultraviolet light. Most sunglasses are made with special tints to block out ultraviolet light.

There are four different types of ultraviolet lamps that can be used for their beneficial effects. Each lamp has a specific use depending on the particular type of ultraviolet used and the size and shape of the lamp:

Hot quartz lamps (Figure 30) are good for producing erythema (sunburn) and for stimulating calcium and phosphorus use in the body. They are not as good for their germicidal (germ-killing) effects. They can treat large areas of the body. They are effective for treating psoriasis (a skin condition).

Figure 30 - Ultraviolet hot quartz lamp

Cold quartz lamps produce less erythema and they are not good for stimulating calcium and phosphorus. They are good for their germicidal effect on large areas of the body. Large wounds and areas of infected skin can be treated with a cold quartz lamp.

Cold quartz spot lamps are used for their germicidal effect on smaller wounds and ulcers. Cold quartz lamps are used for their germicidal effects inside openings of the body. They are effective for treating strep throat.

Indications

1. P s o r i a s i s
2. Wounds and ulcers that are infected or are not healing
3. R i c k e t s
4. Mild calcium and phosphorus deficiency in children
5. S t r e p t h r o a t
6. Osteomalacia (a condition causing softening or weakening of the bones) in pregnant or nursing women
7. A c n e
8. A n e m i a

Contraindications

1. Active and progressive tuberculosis (lung disease)
2. Advanced heart disease
3. Advanced arteriosclerosis (artery disease)
4. Renal or hepatic insufficiency
5. Hyperthyroidism
6. Diabetes mellitus
7. Generalized dermatitis such as chicken pox or measles
8. Porphyria (blood protein disease)
9. Pellagra (vitamin B3 deficiency)
10. Lupus erythematous (autoimmune disorder)
11. Sarcoidosis (disorder leading to inflammatory cells in the body)
12. Xeroderma pigmentosum (hereditary skin condition)
13. Skin cancers and precancerous areas

Precautions

1. Ultraviolet light is harmful to the eyes. Everyone in the area, the operator and the patient, must wear protective goggles while the LTV is on.

2. You should not stay in the area of the lamp any longer than is necessary.

3. In most cases a mild erythema is desirable after each treatment. Your doctor will know the approximate treatment times to start. Your doctor may perform, or teach you to perform, a sleeve or patch test on the patient to determine that patient's sensitivity. (This test will not be explained here). Be sure not to overexpose the patient or double expose any area of the body. Exact draping and exposure times are essential.

4. The lamp-to-patient distance is critical. Moving the lamp twice as makes the lamp four times stronger. Exact measurements are essential. Be consistent with each treatment.

Application

The application varies with the type of lamp being used:

Hot quartz lamp

1. Preheat the lamp for about 5 minutes.

2. Position and drape the patient as instructed in the Introduction.
3. Protect your eyes and the patient's eyes with goggles.

4. Place the lamp 18-30" from the area to be treated, keeping the lamp head as parallel to the body as possible.
5. Treat for the length of time that your doctor has instructed. The time is usually increased each treatment so that a mild erythema occurs each time.
6. Large areas of the body may require more than one exposure. Full body treatment is usually done in four exposures: front upper, front lower, back upper, and back lower.
7. Tell the patient to expect mild sunburn after the treatment. This is normal and desirable. Any reactions besides mild sunburn should be reported to the doctor.

Cold quartz lamp

1. Drape the area to be treated. For a wound, the normal skin around the wound should be covered.
2. Protect your eyes and the patient's eyes with goggles.
3. Turn the lamp on. (The lamp need not be pre-heated).
4. Position the lamp:
   a) Floor lamp: place 5-18" from area to be treated, keeping the lamp head as parallel to the body as possible.
   b) Spot lamp: place about /2" from the area to be treated.
   c) Orificial lamp: place the glass part in the opening (for example, the throat) as deep as possible about ½ "from the area to be treated without touching any of the membranes or skin.
5. Treat for the length of time your doctor has instructed. Usually, the first treatment is 15-30 seconds and each treatment is increased by 5-15 seconds

K. Low Level Laser Therapy (Cold Laser)

Light Therapy Low Level Laser Therapy (LLLT) is the use of light energy in the visible red and invisible infrared spectrum for tissue healing and pain reduction. It involves light energy produced by low power lasers and superluminous diodes (SLD's). Light is absorbed by the tissue where the light energy is transformed into biochemical energy that is available for cell activities.

Low power lasers used in rehabilitation are classified as group IIIb, which means they are relatively safe to use, but can cause damage to the eye if they shine directly into the eye. (Figure 32) There are several types of lasers with different characteristics that are used in rehabilitation, but they all require protective eye goggles.

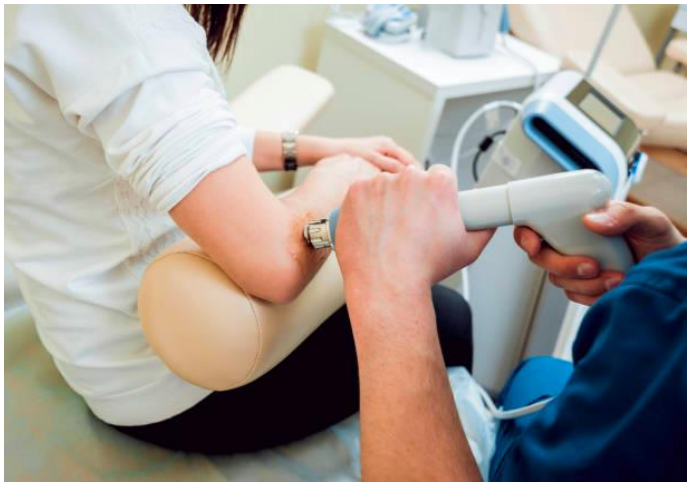


Figure 32 - Low level laser therapy

Laser light is very different from normal light in that laser light is all the same color (monochromatic), with all the light waves going in the same direction at the same time (coherent) and shines with a beam that is very narrow (collimated). As a result, laser light is very concentrated and delivers a lot of energy to the patient's tissues.

Another way of delivering light energy is with superluminous diodes (SLDs). These are small light diodes that give off bright red or invisible infrared light like a laser, but they are different than lasers. (Figure 33) SLDs are not as powerful or as concentrated as lasers, and in order for them to work as well as lasers more lights are needed and they must be applied for a longer period of time.

Figure 33 - Light therapy superluminous diodes

Lasers are used primarily for tissue healing and pain reduction although they can be useful in other areas.

Indications

1. Repetitive strain injuries
2. Strains and sprains
3. Skin ulcers and bums
4. Rheumatoid arthritis and osteoarthritis pain
5. Temporary increase in local blood circulation
6. Temporary relief of minor muscle and joint aches and pains
7. Stiffness and relaxation of muscles
8. Muscle spasms and minor pain and stiffness associated with arthritis
9. Adjunctive use for temporary relief of hand and pain associated with carpal tunnel syndrome

Contraindications

1. Direct exposure over the eye: Possible lesion of the retina. Use of protective goggles is mandatory for both patient and operator, regardless of the laser type, method, and technique used. The goggles should be designed to block the specific wavelength of the device being used.
2. Over the thyroid gland: Iodine in the thyroid may absorb high doses of laser energy.
3. Over suspicious lesions: May spread cancer
4. Over abdomen and pelvis area of pregnant women: May interfere with normal growth and development of the fetus
5. Patients receiving X-ray radiation for cancer
6. Over the areas of bleeding
7. Over skin areas that are sensitive to light
8. Over areas of recently injected steroids (72 hours)
9. When masking pain may be harmful

Not Contraindicated

1. Pacemakers
2. Implants: metal, plastic, joints
3. Over bony prominences
4. Peripheral vascular disease with decreased sensation
5. When heat is contraindicated (e.g. acute injury)

Safety Considerations

1. Avoid unnecessary exposure of surrounding staff and patients.
2. Keep the laser in a locked cabinet.
3. Keep the tip of the laser probe clean by swabbing with alcohol after each use.

Application

1. Instruct the patient regarding what you are going to do, what to expect from treatment, and what is expected of him.
2. Drape the area to be treated.
3. Protect your eyes and the patient's eyes with goggles.
4. Clean the surface of the skin with soap or rubbing alcohol.
5. May cover open wounds with plastic wrap.
6. Place the laser in direct contact with the patient and apply slight pressure if tolerated. If direct pressure is not tolerated place the laser 1/4 inch above the area.
7. Hold the laser at a 90° angle.
8. Treat for the length of time and at the location your doctor has instructed. Usually treatment is only a few minutes at each treatment spot.

Superluminous Diodes (SLDs)

SLDs are applied as "light pads" directly onto the skin. They are secured with elastic wraps. Since SLDs produce heat, be sure not to wrap them too tightly as this may cause more intense heat on the patient's skin and increase the possibility of burning the patient. (Figure 34)

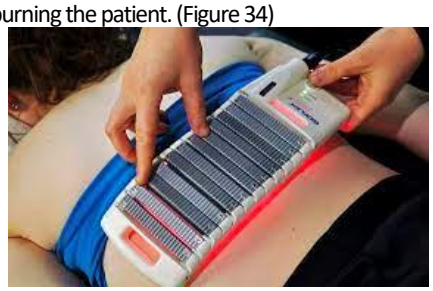


Figure 34 - Light therapy superluminous diodes

IV. OTHER PHYSIOTHERAPY MODALITIES

A. Spinal Traction

Traction has been used for several centuries in one form or another. It is still used in several forms in the chiropractor's office as an assist to the chiropractic adjustment.

Traction is a drawing or pulling force that is used to stretch muscles, ligaments and discs, and to separate joint surfaces. It is generally applied along the length of the spine, either in the cervical or the lumbar spine.

The effects of traction include:

1. Suction is created on the disc -- if you have ever put your fingers in a Chinese finger torture tube, you know the feeling of traction causing suction. As you pull your fingers away from each other, the pressure on the inside of the tube gets greater, keeping your fingers from pulling out. Spinal traction can have the same effect, especially on an injured spinal disc. The increased pressure pushes on the disc, drawing it back in toward its center.
2. Ligaments are stretched -- this adds to the suctioning effect above.
3. Joint spaces are separated.
4. Muscles relax.
5. The openings in the spinal column for the spinal nerves (the intervertebral foramen) are enlarged.
6. The spinal curves are straightened.
7. Circulation has increased in the area.

These effects will depend partly on whether static or intermittent traction is used. Static traction (where the traction stays on continuously) tends to put the tissues at rest causing discs to return toward a more normal position, joint spaces to separate, and muscles to relax. Intermittent traction (where the traction goes on and off at preset intervals) tends to improve circulation in the area, relieve swelling and increase the elasticity of the muscles.

Indication

1. Disc protrusion ("slipped" disc)
2. Joint dysfunction
3. Nerve root compression
4. Scoliosis
5. Muscle spasm

Contraindications

1. Tumor or infection that has affected bony structure
2. Circulatory problems
3. Acute sprains, strains or other acute soft tissue problems
4. Pregnancy
5. Osteoporosis or other bone weakening conditions
6. Any patients who cannot report what they feel (including the very young or very old)

Precautions

Traction can have a very strong effect on the tissues. It is important to start with light traction and increase gradually. Report any problems to your doctor.

Application

Application will vary depending upon the type of traction being used:

Supine cervical traction provides static or intermittent traction for office use.

Figure 35 - Supine cervical traction

1. Position the patient in a back-lying (supine) position. (Figure 35)
2. If using the Saunders attachment, have the patient place his head on the attachment with the two bumpers just under the skull. Tighten the forehead strap. If using a standard harness, place the neck harness over his head and tighten it so that it fits snugly around the chin and back of the skull. Tissues or paper should be placed between the harness and patient if the harness is not disposable and is not going to be washed between patient

Set the rope angle of pull according to your doctor's instructions. Usually 25-30 degrees from horizontal is comfortable and effective. You may need to support the head with a small pillow

3. Gently take the slack out of the rope.
4. Set the traction for static or intermittent type. If intermittent, set "on" time and "off" time.
5. Set the amount of traction according to your doctor's instructions. Usually 10% of the patient's weight is used for the first treatment and traction may be increased by 2-3 pounds per treatment until the maximum comfortable traction is achieved (maximum is usually 40-45 pounds). A patient with a small frame will generally not tolerate as much traction as a patient with a larger frame and more muscle mass.
6. Start the traction and make sure the patient is comfortable and that most of the pull is on the back of the skull and not on the chin or jaw. If there is too much pull on the chin or jaw, you may need to change the angle of the rope pull, readjust the harness straps or rearrange the pillow (Removing dentures can help, too!).
7. Set the timer according to your doctor's instructions. Usually 10-20 minutes is maximum. The first treatment may be only 2-3 minutes to see how the patient tolerates the traction.
8. Make sure that patients have a means of calling you. Give them the "off" switch if the machine is equipped with one.

Home supine cervical traction (Saunders device) provides static traction for home use. (Figure 36)

1. The patient positions himself in a back-lying (supine) position and lays his head over the soft rubber bumpers.

2. The patient should place his head on the Saunders device with the two bumpers just under the skull. The forehead strap should be tightened and secured.

3. The angle of pull is usually 25-30 degrees from horizontal and should be comfortable and effective.

4. The amount of traction is set using a pneumatic pump which slides the head piece along a rail applying distraction to the patient's neck. The amount of traction pull will be determined by your doctor. Usually 10% of the patient's weight is used for the first treatment and traction may be increased by 2-3 pounds per treatment until the maximum comfortable traction is achieved (maximum is usually 40-45 pounds). A patient with a small frame will generally not tolerate as much traction as a patient with a larger frame and more muscle mass.

5. Usually 10-20 minute treatments are used. The first treatment may be only 2-3 minutes to see how the patient tolerates the traction. Your doctor may prescribe treatment more than one time per day.

6. For safety reasons, a patient should be capable of getting himself out of the traction device at any time.

Over-the-door cervical traction provides static traction in a sitting position, for office or home use. (Figure 37)

1. Have the patient sit in a chair facing the door and the traction unit.
2. Fill the bag with sand or water, or use weights according to your doctor's instructions. Usually 10% of the patient's weight is used for the first treatment and traction may be increased by 2-3 pounds per treatment until the maximum comfortable traction is achieved (maximum is usually 40-45 pounds). Attach the weight to the rope and place it in the patient's lap.
3. Place the harness over the head and tighten it snugly.
4. Slowly lower the weight.
5. The angle of pull can be changed by sliding the chair closer to or farther away from the door. Sliding the chair farther from the door will cause the neck to bend forward more.
6. Treatment time should be instructed by the doctor. Usually 10-15 minutes is adequate. The treatment may be given twice a day when done at home.

Figure 37 - Over-the-door cervical traction

<u>Supine lumbar traction</u> provides static or intermittent traction for office use. (Figure 38)

Figure 38 - Supine lumbar traction

1. Position the patient in a back-lying (supine) position. The hips and knees should be bent with the lower legs resting on a stool or pillows.

2. Fasten the lumbar harness snugly over the hip bones (pelvis), making sure that the traction strap or straps are in the right position (a single strap should be centered in the back, two straps should be on either side of the hips, each in the same position as the other). Fasten the thoracic counter harness snugly under the rib cage, making sure the straps are even.

3. Attach the counter harness strap to its hook at the top of the table and attach the harness strap to the rope. The rope is generally not at an angle but is parallel to the table.

4. Gently take the slack out of the rope and the straps.

5. Set the traction for static or intermittent type, according to your doctor's instructions. If intermittent, set "on" time and "off' time.

6. Set the amount of traction according to your doctor's instructions. Generally, start out at about 25% of the patient's body weight for the first treatment and increase about 5 pounds per treatment until about 50% of the body weight is achieved or 120 pounds of traction, whichever comes first. For example, a 100-pound patient will start at 25 pounds for the first treatment and gradually increase to 50 pounds. A 200pound patient will start at 50 pounds and increase to 100 pounds. A patient with a small frame will generally not tolerate as much traction as a patient with a large frame and more muscle mass.

7. If the table is a split table, unlock the split so that the lower half of the table is free to move with the patient's hips. If there is not a split or rollers in the table, sprinkling baby powder on the table may help reduce friction.

8. Start the traction and make sure the patient is comfortable. Check to be sure that the harnesses are not slipping off the pelvis or rib cage.

9. Set the timer according to your doctor's instructions. Usually 10-20 minutes is maximum.

10. Make sure that patients have a means of calling you. Give them the "off' switch if the machine is equipped with one.

Home Supine Lumbar Traction (Saunders device) provides static lumbar traction for office or home use. (Figure 39)

Figure 39 - Home supine lumbar traction

1. The patient lies on their back.

2. The patient then attaches the lumbar harness snugly over his pelvis and the thoracic harness around his rib cage.

3. A pillow is place under the knees to bend them slightly.

4. The amount of traction is set using a pneumatic pump which slides the bottom one half of the device towards the feet. This applies distraction to the patient's low back. The amount of traction pull will be determined by your doctor. Generally about 25% of the patient's body weight is used for the first treatment and increased about 5 pounds per treatment until about 50% of the body weight is achieved with a maximum of 120 pounds of traction. For example, a 100-pound patient will start at 25 pounds for the first treatment and gradually

increase to 50 pounds. A 200-pound patient will start at 50 pounds and increase to 100 pounds. A patient with a small frame will generally not tolerate as much traction as a patient with a large frame and more muscle mass.

5. Treatment time will be instructed by the doctor. A patient with an acute condition mayfind it comfortable to be in fraction most of the day at a light tension level. A patient witha chronic condition may use it 2-3 times a day at a higher tension level.

6. For safety reasons, a patient should be capable of getting himself out of the traction device at any time.

Inversion table traction (backswing) provides static or intermittent traction to the entire spine, especially the lumbar spine, for office or home use. Inversion is difficult for some patients to tolerate, especially older patients. (Figure 40)

Figure 40 - Inversion Table

1. Set the footrest for the height of the patient.
2. Hold the table securely while the patient steps onto the footrest.
3. Fasten the patient's ankles onto the table securely.
4. Slowly raise the bottom of the table until the patient is horizontal. Have the patient stretch headward as far as possible. With the arms at the patient's side, the table should stay in a horizontal position without your help. If it does not, return the patient to standing and readjust the height of the footrest. If the patient is "bottom-heavy," raise the footrest. If the patient is "top heavy," lower the footrest. Return the table to a horizontal position.
5. Have the patient slowly slide his arms along the chest and over the head. Make sure to keep the arms close to the body. Hold on to the table and help the patient control the movement until you are sure he has good control. The patient can now hold steady in a comfortable position (static traction) or can swing back and forth for more of a pumping action (intermittent traction).
6. Stay with the patient the entire time. (If he is using the traction at home, instruct someone there to stay close). Treatment time is generally 3 minutes the first treatment, gradually increasing to a maximum of 10 minutes.
7. When the patient is ready to get up, have him bring his arms back to his sides and bend the knees. Do not allow him to lift the head to help him get up.

8. Hold the table securely while you undo the ankle holders and help the patient off.

Inversion frame traction provides static traction to the entire spine, especially the lumbar spine, usually for home use. Inversion is difficult for some patients to tolerate, especially older patients.

1. The patient steps up to the frame, placing the thighs against the pad.
2. He slowly leans forward, bending his hips and knees, lowering his hands along the frame until the head is down.
3. He relaxes in that position. Exercises, as instructed by the doctor, may be done in this position.
4. Treatment time is usually 3 minutes for the first treatment, gradually increasing to a maximum of 10 minutes.
5. At the end of the treatment, the patient returns to an upright position using the arms to push.

Flexion-distraction provides traction to a specific level of the spine, depending on the doctor's hand placement. Application of this type of traction will not be discussed here as it should always be done by the doctor.

B. Braces

Braces are generally used by a patient to allow a part of the body to rest. They allow relaxation of the muscles, joints, ligaments, and other tissues of the area being braced. For an acute condition, a brace will permit the tissues to rest and avoid further injury while the initial inflammation process is going on. For a chronic condition, a brace can give added support to the weak and injured tissues and can also act as a reminder to patients to keep them from doing things they should not be doing.

Braces come in a variety of materials and styles. Some offer very little support while others can be very restrictive and supportive. Your doctor will choose the brace that best meets the needs of the patient.

Ace bandages are sometimes used as temporary braces. They provide some rest and compression but they must be rewrapped often and do not provide a lot of support. Taping is also used as a temporary brace, especially in sports. Taping offers a lot of support but must be redone often.

Application

Your doctor may ask you to fit a brace or periodically check the fit of a brace. Some basic principles to remember when fitting a brace are:

1. The brace should hold the part in a neutral or resting position without any twisting or bending of the part.
2. The brace should fit as snugly as possible without pinching the skin or cutting off the circulation. If the skin turns white or the patient complains of numbness or tingling, the brace is too tight and should be loosened.

Your doctor will tell you and/or the patient how often and how long the brace is to be worn. Most often the brace is worn all the time during the acute phase of the condition, after which, wearing time is gradually reduced so that the patient's muscles will not get weak and dependent on the brace. Sport braces are usually worn whenever the patient is playing the sport.

The following is a list of some of the more common braces and their special fitting needs:

Soft cervical collar (Figure 41) should be tall enough to take some of the weight of the head off the neck but should not tip the chin up or down.

Figure 41 - Soft cervical collar

Back brace (Figure 42) should be tall enough to support the part of the back that needs to rest. The brace should not slip up or down. Narrow braces, such as sacroiliac belts, tend to slide up, especially on females with narrow waists.

Figure 42 Back brace

Clavicle brace (Figure 43) holds the shoulders back to keep the clavicles from moving.

Figure 43 - Clavicle Brace

Shoulder sling (Figure 44) should take the weight of the arm off the shoulder and hold the hand slightly higher than the elbow (for good blood circulation).

Elbow strap (Figure 45) is a strap that wraps around the wide part of the muscles in the forearm near the elbow. It is most often used for lateral epicondylitis or "tennis elbow" and helps to keep the muscles from pulling on the bone.

Figure 45 - Elbow strap

Wrist splint (Figure 46) usually holds the wrist in slight extension (knuckles up) and allows full use of the fingers and thumb. It is frequently used for carpal tunnel syndrome.

Figure 46 - Wrist Splint

Knee brace (Figure 47) gives support in the side-to-side direction but allows bending and straightening of the knee. The knee brace is often used in sports.

Figure 47 - Knee brace

Knee splint keeps the knee from bending in any direction.

Ankle brace (Figure 48) gives support in the side-to-side direction but still allows up-and-down bending of the foot. It is often used in sports.

Figure 48 - Ankle brace

C. Crutches, Walkers and Canes

Crutches are often needed when a patient is unable to support normal weight on one leg. The crutches can take all the weight bearing off the leg, or any part of it.

A walker would most likely be used by an elderly patient or a patient who cannot manage walking with crutches. A walker can provide added stability for the patient who is unable to walk safely. It can also be used to take weight bearing off one leg.

A cane should not be used to relieve weight bearing. It is used to increase stability in walking.

Your doctor will tell you which device the patient should use and how much weight the leg can bear.

Application

Crutches

1 Fit the crutches to the patient. Have them stand up straight with their shoulders relaxed.Place the crutch tips 6-9" to the front and to the sides of the feet. With the crutch pads under the armpits, you should be able to place 2 or 3 of your fingers between the crutch pads and the armpits. With the arms relaxed, the hand grips should be wrist high so that when the patient holds the hand grips there is a slight bend at the elbows. (Figure 49)

2. Teach the patient to use the crutches. To stand up, they place the crutches together, puts onehand on top of the hand grips, slides forward in the chair and pushes up from the chair with theother hand. Have them arrange the crutches under the arms. To walk, the patient moves the crutches forward, then the bad leg up to the crutches, then the good leg beyond the crutches. Continue in this same pattern. Remind your patient not to lean on the armpit pads. Have them push them into the ribs and put the weight on the hands only. To sit down, they back up to a chair, takes the crutches away from the armpits, places the crutches together, places one hand on top of the hand grips, reaches for the chair with the other hand and lower themselves into it.

Walker

1. Fit the walker to the patient. Have the patient stand with the shoulders relaxed and arms at their sides. The hand grips should come to the wrists. (Figure 50)

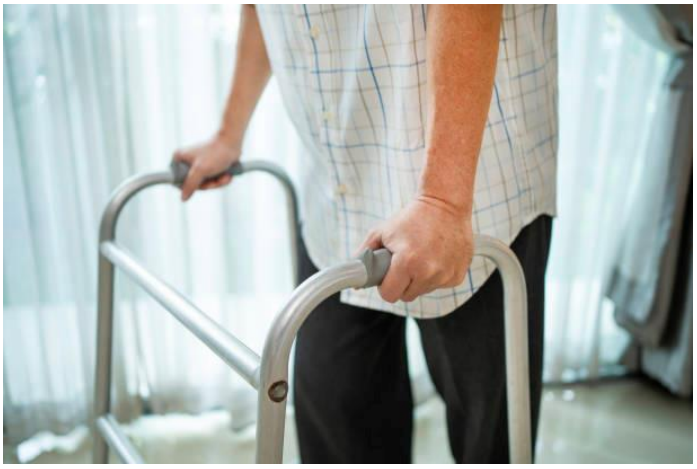


Figure 50 – Walker

2. Teach the patient to use the walker. The routine is the same as walking with crutches. The same pattern of "walker, bad leg, good leg" is followed.

Cane

1 Fit the cane to the patient. With the patient standing, having their shoulders, and arms relaxed, the top of the caneshould come to the patient's wrist.