CHIROPRACTIC ASSESSMENTS

Guideline G-013
Quality Assurance Committee
Approved by Council: April 24, 2018

Note to readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

INTENT

The purpose of this document is to clarify the role and importance of assessments that are an essential part of any chiropractic care/plan of care of a patient. Evidence of these assessments in the patient health record helps to demonstrate the chiropractor's critical clinical thought processes.

OBJECTIVES

- To outline the various assessments a member should be conducting on initial and subsequent visits as well as on a periodic basis during the care of patients. Acknowledging previous precedent-setting decisions of discipline panels, it is prudent to keep in mind that, at the bare minimum, a comprehensive re-evaluation must be conducted on or before each 24th visit.

- To emphasize that assessments are ~~a~~ critical components of patient care.

- To ensure members understand their responsibilities to both communicate the importance of assessments, as well as the various fees associated with those assessments, and to conduct and record evidence of these assessments in the patient health record at the appropriate times in the care/plan of care of the patient.

DESCRIPTION OF GUIDELINE

Patient assessments are a mandatory component of patient care and performed for reasons including but not limited to the following:

- To determine the appropriate course of care/plan of care based on current consultation and examination findings;
- To set appropriate goals and expectations for patient care/plan of care;
- To outline, as much as possible, potential costs of the expected care/plan of care;
- To periodically plan, during the course of care/plan of care, and evaluate the patient's current condition in relation to any previous assessments;
- To assess the effectiveness of the member's chiropractic care/plan of care;
- To discuss the patient's goals and expectations for his/her ongoing care/plan of care;
- To affirm and/or revise the member's recommendations for the patient's care/plan of care; and

- To provide necessary clinical referral information when appropriate.

Patient assessments should be dedicated to furthering the clinical decision-making processes and formed in conjunction with the best available evidence, patient values and needs and always in accordance with CCO regulations, standards of practice, policies and guidelines.

Types of assessments, conducted by the member, in the typical course of patient care:

1. Initial Assessment

- Done on the first patient visit;
- Before any care/plan of care has been provided; and
- Including appropriate consultation and examinations.

2. Subsequent Visits

- Frequency and goals of these visits are based on previous assessments, either initial, comparative or updated;
- Involves the implementation of the most recent care plan recommendation;
- Done on a visit-to-visit basis, prior to the delivery of care, an evaluation is conducted to determine the next step for that visit (e.g. subjective patient comments, spinal motion or static palpation); and
- Entries are made in the patient health record in a SOAP note or similar format sufficient to document legible, accurate, individualized and personalized notes capturing the unique aspects of that particular patient encounter.

3. Comparative assessment

- Assessment related to progress of ***initial, new or updated conditions/goal assessment***;
- Be sufficiently comprehensive for the member to:
  - evaluate the patient's current condition in relation to any previous assessments;
  - assess the effectiveness of the member's chiropractic care/plan of care;
  - discuss with the patient, the patient's goals and expectations for his/her ongoing care/plan of care;
  - affirm or revise the member's care/plan of care for the patient; and
  - include documented evidence on the performance of three or more of the clinically indicated analytical/assessment procedures listed in section 4(4)(b) (not an exhaustive list) of Standard of Practice S-002: Record Keeping in order to demonstrate the need for ongoing care. Members may use additional procedures not listed.

4. New Conditions/Goal Assessment

- Assessment of any new condition/goal unrelated to any previous ***initial, new or updated conditions/goal assessment***;
- Conducted before any care has been provided to address this condition/goal; and
- Including appropriate consultation and examinations.

5. Updated Condition/Goal Assessment

- Updating status after an interruption in the expected care/plan of care of the most recently evaluated ***initial, new or updated conditions/goal assessment***;
- Be sufficiently comprehensive for the member to:
  - evaluate the patient's current condition in relation to any previous assessments;
  - assess the effectiveness of the member's chiropractic care/plan of care;
  - discuss with the patient, the patient's goals and expectations for his/her ongoing care/plan of care; and
  - affirm or revise the member's care/plan of care for the patient.

6. Discharge assessment (where applicable)

- Would be appropriate to conduct at termination of care/plan of care for a particular ***initial, new or updated conditions/goal assessment*** or meeting a particular goal of care/plan of care even if other aspects of care are ongoing;
- Be sufficiently comprehensive for the member to:
  - evaluate the patient's current condition in relation to any previous assessments;
  - assess the effectiveness of the member's chiropractic care/plan of care; and
  - provide referral reports where applicable.

It is acknowledged that a patient may discharge themselves or terminate care without completing the recommended care/plan of care. This should be noted in the patient health record, in lieu of any record of a discharge assessment.

Please note: There may be different fees associated with each type of assessment outlined. This must be clearly communicated to the patient prior to conducting the assessment. Fees and billing practices must comply with all relevant CCO regulations, standards, policies and guidelines such as Guideline G-008: Business Practices.

Periodic and regular assessments are a mandatory component of any care/plan of care and are based on the same clinical judgement components used in all phases of patient care. Implementation of any evaluation, assessment or treatment is always a clinical judgement call made by the member ~~doctor~~ and based on clinical necessity, best evidence, best practices, experience, patient presentation and many other factors.

Additionally, assessments are valuable opportunities to revisit informed consent with the patient. It is typical that informed consent is obtained and dealt with at the time of the initial examination and then again after the initial diagnosis and plan of care has been delivered to the patient. It is important to remember that informed consent is not a one-time event and it may be necessary to update informed consent on a periodic basis. Some reasons for updating consent include but are not limited to the following:

- Assessing for a new complaint or goal;
- Changes to material risk; and

- Absence from care or an interruption to a plan of care for a period of time.

Therefore, revisiting informed consent is an important component of some assessments.

The timing and reason for each comparative assessment depends on a number of factors including but not limited to:

- patient progress;
- expectations of progress;
- presentation of new conditions; and
- requests from third-party payors such as WSIB, etc.

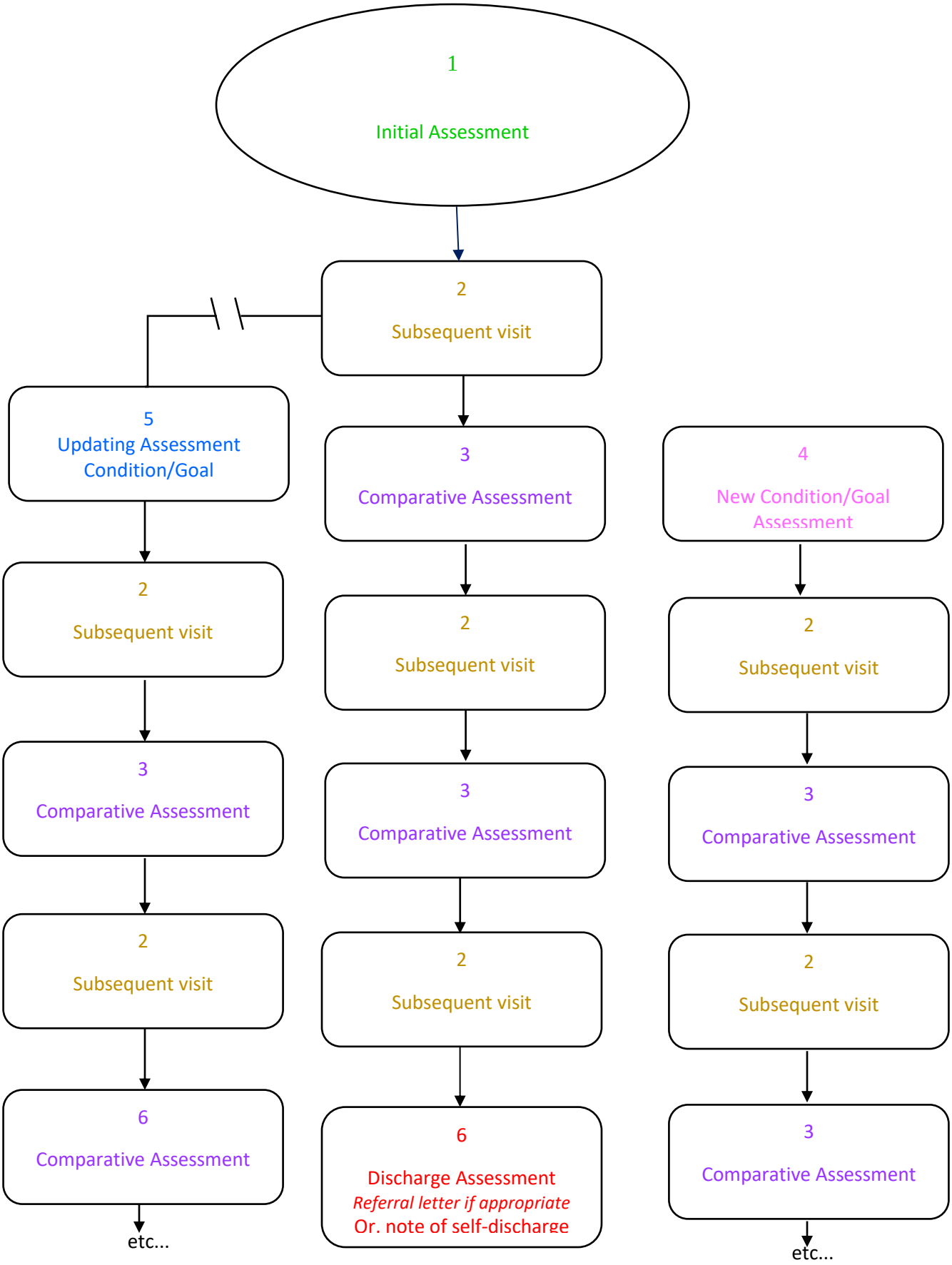
LEGISLATIVE CONTEXT AND REFERENCE DOCUMENTS

Regulation pursuant to the *Chiropractic Act, 1991*. Further, it is an act of professional misconduct under Ontario Regulation 852/93 (Professional Misconduct) to contravene or fail to comply with a standard of practice.

This guideline should be read in conjunction with the following:

- R-852/93: Professional Misconduct
- S-001: Scope of Practice
- S-002: Record Keeping
- S-006: Ordering, Taking and Interpreting Radiographs
- S-008: Communicating a Diagnosis
- S-013 Informed Consent
- S-022: Ownership, Storage, Security and Destruction of Records of Personal Information
- G-008: Business Practices
- Relevant privacy legislation such as the *Personal Health Information Protection Act, 2004*
- *Partnership of Care* Document
- Core Competencies for CCO Members

The following chart is designed to outline the most typical scenarios encountered in a typical chiropractic practice and to demonstrate when the common assessments might fall in the typical course of patient care. It is considered a crucial component of quality patient care to clearly explain, at various stages and prior to the assessment during a patient's care, the reasons for these assessments, when they will occur and the fees associated with each type of evaluation. The importance of communicating this information with the patient cannot be understated.


1
Initial Assessment
2
Subsequent visit
5
Updating Assessment
Condition/Goal
2
Subsequent visit
3
Comparative Assessment
2
Subsequent visit
6
Comparative Assessment
etc...
3
Comparative Assessment
2
Subsequent visit
3
Comparative Assessment
2
Subsequent visit
6
Discharge Assessment
Referral letter if appropriate
Or. note of self-discharge
4
New Condition/Goal
Assessment
2
Subsequent visit
3
Comparative Assessment
2
Subsequent visit
3
Comparative Assessment
etc...