Report to the General Assembly

The Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations:

Scope of Practice Review Committee Report on Athletic Trainers

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Department of Public Health

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Executive Summary

In accordance with Section 19a-16d of the Connecticut General Statutes, the Connecticut Athletic Trainers' Association (CATA) submitted a scope of practice request to the Department of Public Health to update the scope of practice to allow athletic trainers to practice to the full extent of their education and training. Within the scope request, the CATA has proposed the following changes:

- *Replace "athlete" with "physically active individual"*
  Athletic trainers are the only healthcare profession whose practice act does not use the term patient or individual. Any injury an athletic trainer will be dealing with is still athletic in nature or comparable to an athletic injury. An athletic trainer would only be working with individuals who have been determined "otherwise healthy by a health care provider".

- *Removal of a time requirement (3x/wk.) in participation of sports and activities, pertaining to those an athletic trainer can treat*
  The time constraint of three times per week may prohibit an athletic trainer from being on the sideline at youth sporting events. In addition, CT is the only state in the nation with a time constraint incorporated into the definition of the word athlete.

- *Stricter guidelines as it pertains to standing orders and the athletic trainer's direction from a licensed health care provider*
  Standing orders would pertain to only athletes (in the traditional sense). Under the proposed changes, standing orders would have to be reviewed annually and will have to reflect best practices. Outside of the traditional athletic setting, standing orders will not be present, and athletic trainers would be required to immediately refer "physically active individuals". The current practice act requires an athletic trainer to make a referral to a licensed healthcare provider for any athlete whose injury or illness have not improved within 4 days of onset and for those athletes who have physical or medical contraindications outside of an athletic trainer's education and training. The CATA keeps this requirement in their scope of practice request.

- *Inclusion of the ability of an athletic trainer to provide immediate and emergent care in an acute situation without standing orders (i.e. a road race)*
  There may be cases in which an athletic trainer is working at an event without standing orders. This proposed change will allow the athletic trainer to provide immediate and acute care to help individuals until emergency medical services and transport arrive.

The CATA made the request for a scope of practice update due to the profession evolving and changes within their education. The current scope of practice was written in the 1990's, passed by the General Assembly in 2000, and enacted by the Department of Public Health in 2006. At the time the practice act was passed, the educational requirements were being reviewed by the National Athletic Trainers Association Board of Certification (NATABOC) to ensure consistency of the educational process for athletic trainers. One major change by the NATABOC to the educational requirements was that all athletic trainers must graduate from an accredited program in order to sit for the Board of Certification examination. The accreditation requirement ensures athletic trainers have graduated from a program providing education that is meeting national standards established by a peer review board. According to the CATA, other states have updated their athletic training practice acts, or are in the process of updating their practice acts so an athletic trainer can practice to the full extent of their education and training. In Connecticut, athletic trainers practice under the direction of a healthcare provider who is licensed to practice medicine or surgery under chapter 370 of the general statutes, chiropractic under chapter 372 of the general statutes, podiatry under chapter 375 of the general statutes, or naturopathy under chapter 373 of the general statutes. It is the intent of the CATA's proposal to keep this requirement in place and implement stricter requirements pertaining to standing orders and the athletic trainer's direction from the healthcare provider mentioned above.

CATA asserts the requested scope of practice changes will improve healthcare for the residents of Connecticut, lower healthcare costs, and improve patient outcomes through collaboration of the athletic trainer with other health care practitioners. The CATA developed this scope of practice request, being mindful of concerns of other healthcare groups, and states it has put in place safeguards to protect the public and address those concerns. The CATA asserts the athletic trainer brings a unique skill set and collaborative nature to a comprehensive wellness team. The CATA is not intending to replace or restrict any other healthcare provider through this scope of practice request.

A scope of practice review committee was established to review and evaluate the request as well as subsequent written responses to the request and additional information that was gathered through the review process. The literature reviewed throughout the committee process focused on the educational changes and accreditation, standards of professional practice, and the potential to increase public access to healthcare while lowering costs.

All members of the review committee agreed athletic trainers provide a valuable service to the athletic population, and an aspect of this request would increase the athlete population's

access to health care, especially younger athletes who may be participating in sports that meet less than three times per week. However, members of the committee continued to express concerns about 1) replacing the term athlete with "physically active individual", 2) the education and training an athletic trainer receives, and 3) the broadness of the scope of practice request.

Background

Connecticut General Statutes Section 19a-16d through 19a-16f provides health care professionals a process to submit a request to the Department of Public Health to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this statute, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request;

2. Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and

3. The Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, non-voting member of the committee.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request my enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of

Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The CATA submitted a scope of practice request for athletic trainers licensed in Connecticut. As a result of an evolution of the profession, increased participation in sports and physical activity, and educational changes concerning competencies and accreditation of programs, the CATA believes the current scope of practice is outdated and does not allow an athletic trainer working in Connecticut to practice to the full extent of his or her education and training.

Since the writing and passage of the current scope of practice, the athletic training profession has matured, and the education and training an athletic trainer receives has changed. Prior to 2004, an individual could pursue board certification as an athletic trainer through either a curriculum or an internship. The NATABOC discontinued the internship route to certification in 2002, and required that by 2004 all athletic trainers graduate from a "curriculum program" to sit for the certification exam. Currently, in order to sit for the Board of Certification examination (BOC), an athletic trainer must graduate with a baccalaureate degree from an athletic training program accredited by the Commission on Accreditation of Athletic Training Education (CAATE), the national accrediting body recognized by the Council for Higher Education Accreditation (CHEA). Once certified by the BOC, athletic trainers are required to earn a minimum of 50 continuing education credits every two years in order to maintain certification. At least 10 of these credits must come from programs focusing on evidence-based practice.

In addition to athletic training education reform, the profession has expanded its populations of interest over the past 15-20 years. A profession that existed primarily to provide health care to professional, collegiate, and secondary school athletes has evolved beyond organized sports. According to the CATA, athletic trainers can be found working in fields such as the performing arts, U.S. military, NASA, police and fire departments, and industrial settings.

The CATA believes the current language in CT statute creates confusion among employers about who an athletic trainer can treat. As a result, athletic trainers who elect to practice in Connecticut are limited in their ability to practice to the full extent of their education and training. Most athletic trainers practicing in Connecticut are found in the traditional setting of high school or college athletics. The CATA states that in a recent 5 year period, three of Connecticut's five athletic training education programs reported an average of 54% of athletic training graduates leaving the state for employment or educational opportunities elsewhere.

The CATA asserts a change in the scope of practice may open up opportunities for athletic trainers to practice in non-traditional or emerging settings, leading to the creation of more jobs in the state, increased public access to a qualified healthcare provider, reduced health care costs for the public, and improvement of the overall economy.

The CATA believes the scope request and proposed language contains safeguards to protect the public and addresses concerns raised by other healthcare practitioners in the past. The CATA asserts an athletic trainer does not replace any other health care provider, and is not a primary health care provider. Rather, the athletic trainer is part of a comprehensive wellness team with a unique skill set and collaborative nature.

Impact Statements and Responses to Impact Statements

Written impact statements in response to the scope of practice request submitted by CATA were received from the following organizations:

- Connecticut Podiatric Medical Association
- Connecticut Society for Respiratory Care
- Connecticut State Medical Society
- Connecticut Academy of Physician Assistants
- Connecticut Advanced Practice Registered Nurse Society
- Connecticut Nurses Association
- Connecticut Physical Therapy Association
- Connecticut College of Emergency Physicians
- Connecticut Occupational Therapy Association
- Connecticut Chiropractic Association
- Connecticut Hospital Association
- Connecticut Orthopaedic Society

The items raised in the impact statements were discussed at the Scope of Practice Review Committee meetings, and the representatives from CATA responded.

Many of the impact statements submitted expressed concern that the scope of practice request could have ramifications for other healthcare professions. The Connecticut State Medical Society indicated support of the requested changes as it would allow athletic trainers to provide care and services for youth athletes and citizens seeking an active lifestyle.

Scope of Practice Review Committee Membership

In accordance with the provisions of Connecticut General Statutes Section 19a-16e, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by Connecticut Athletic Trainers' Association. Membership on the scope of practice review committee included up to two members from each of the following organizations:

1. Connecticut Athletic Trainers' Association
2. The Connecticut Advanced Practice Registered Nurse Society
3. Connecticut Occupational Therapy Association
4. Connecticut Orthopaedic Society
5. Connecticut State Medical Society
6. Connecticut College of Emergency Physicians
7. Connecticut Physical Therapy Association
8. Connecticut Nurses Association
9. Connecticut Hospital Association
10. Connecticut Chiropractic Association
11. Connecticut Podiatric Medical Association; and
12. The Commissioner's designee (chairperson and ex-officio, non-voting member).

Scope of Practice Review Committee Evaluation of Request

The CATA's scope of practice request included all of the required elements identified in Connecticut General Statutes 19a-16d. Relevant information is outlined below:

Health & Safety Benefits

The CATA outlined several ways in which their request supports the public health and safety of individuals who may receive care and services from an athletic trainer.

One of the main health and safety benefits highlighted in the scope of practice request is placing a stricter requirement on the review of standing orders. Athletic trainers work under the direction of a healthcare provider through standing orders in the traditional athletic setting. Current statutes do not require the athletic trainer and healthcare provider to review these standing orders. The suggested changes in the scope of practice request would mandate the athletic trainer and the healthcare provider meet at least annually to review the standing orders and ensure the orders reflect current best practices. Standing orders will only be used in the traditional athletic setting. In addition, to address concerns raised in the 2016 legislative session, the CATA has included the requirement of immediate referrals as a safeguard for the public. In the absence of standing orders, or when the athletic trainer encounters a physically active individual who has not been pre-screened by another licensed practitioner identified in statute, the proposed changes would require the athletic trainer to provide an immediate referral to a higher level healthcare provider for evaluation of the individual.

Another change raised in the scope of practice request is expanding athletic trainer care to other populations such as youth and recreational athletes. Youth athletes often practice less than three times per week, and the current practice act prohibits an athletic trainer from providing care on the sidelines to these individuals, simply because their practice schedule does not meet the legal requirement of the term “athlete” as defined in statute. As a result, many youth and recreational athletes receive sideline care by a parent volunteer, coach, teammate or other bystander who may lack the skills and experience to provide care and treatment beyond basic first aid. The CATA believes having an athletic trainer available to youth and recreational athletes will ensure that proper and timely care and treatment of more serious injuries, like concussions, is being received by athletes of all ages.

Lastly, the CATA believes replacing “athlete” with “physically active individual” in CT statute will benefit public health and safety by permitting athletic trainers to utilize their injury prevention skills and provide rehabilitative services in industrial and other emerging settings. The proposed language submitted by the CATA defines “physically active individual” as any person who is a member of any professional, amateur, school or other sports team, or is a regular participant in sports or other comparable activities associated with participating in exercise, employment or recreation that require strength, agility, flexibility, range of motion, speed or stamina. The CATA asserts the application of injury prevention skills by an athletic trainer in

the workplace setting may prevent musculoskeletal conditions from occurring in the first place, or assist employees in limiting disability due to acute and chronic conditions that may occur, such as low back pain. The CATA also believes a larger role in rehabilitative care would be beneficial to the public. The CATA asserts individuals released from therapy following the exhaustion of insurance coverage typically rely on personal trainers to continue their recovery and return to activity. Personal trainers are not licensed or regulated by CT, and often have minimal training, compared to athletic trainers, who the CATA believe, are well-educated in injury assessment and rehabilitation skills. The CATA believes an updated scope of practice permitting athletic trainers to care for "physically active individuals" and not just athletes may provide "physically active individuals" not yet fully recovered from injury the opportunity to receive continued quality health care as they return to participation.

During the committee meetings, many of the representatives agreed that having athletic trainers on the sidelines of youth and recreational sporting events would be of great benefit to public health and safety. However, many representatives expressed concern about changing the word "athlete" to "physically active individual", as they felt physically active individual could refer to anyone who can move and could open doors for care and treatment beyond the scope, education, and training of an athletic trainer. Several representatives suggested changing the definition of the word athlete so an athletic trainer can treat youth and recreational athletes, but not be so broad so anyone who does any sort of physical movement (i.e. gardening, walking) could receive treatment from an athletic trainer.

The CATA representatives clarified to the committee that if an athletic trainer is practicing within their defined scope of practice outside of the traditional athletic setting the athletic trainer would not be working under standing orders. The scope of practice request proposes that athletic trainers working without standing orders will be limited to providing immediate injury management and emergency care for acute injuries, and immediately refer any individual to a higher level healthcare provider, regardless of the injury or complaint. During discussions, the CATA recognized the proposed language in the scope of practice request did not clearly outline the requirement for an immediate referral, and submitted updated language clearly identifying this requirement for the committee's review (Appendix H).

Access to Healthcare

The CATA believes expanding their scope of practice to reflect current educational competencies and proficiencies will expand public access to healthcare in the state, but provided no data to support this claim. The CATA asserts an updated scope of practice will allow athletic trainers to be available to physically active individuals who are otherwise healthy

by becoming an integral part of a comprehensive wellness team. Athletic trainers receive training and education in the areas of prevention, wellness, and treatment of illnesses and injuries. The CATA states the profession has evolved from treating athletes to other physically active individuals. Statistics derived from the National Athletic Trainers' Association show almost 21% of athletic trainers nationwide are employed in emerging settings such as sales and marketing, occupational health, and the military. A news article provided by the CATA (Appendix I) demonstrated that several branches of the military have incorporated athletic trainers into their medical model.

Throughout discussions, committee representatives recognized the importance of increasing access to athletic trainers for youth and recreational athletes. However, some representatives questioned whether or not a need for athletic trainers outside of the traditional sports setting exists. Although no documentation or statistical evidence was available, the CATA asserted that some industrial companies in Connecticut hire athletic trainers and athletic trainers are being hired by physical therapy clinics to work in industrial settings as "injury prevention specialists." However, due to the language in the current statute, these athletic trainers are prevented from using most of their professional skills in the industrial setting, including providing emergency care to on-the-job injuries. The CATA believes other companies may also be interested in hiring athletic trainers if there is a change in the scope of practice providing clarification as to who the athletic trainer can treat, leading to job expansion and increasing public access to appropriate healthcare in a timely manner. However, it must be questioned whether this hiring is an attempt to avoid hiring more costly occupational health professionals.

Law Governing the Profession

Chapter 375a of the Connecticut General Statutes defines "athletic training" as the application or provision with the consent and under the direction of a health care provider, of (A) principles, methods and procedures of evaluation, prevention, treatment and rehabilitation of athletic injuries sustained by athletes, (B) appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, light massage, water, electric stimulation, sound, exercise and exercise equipment, (C) the organization and administration of athletic training programs, and (D) education and counseling to athletes, coaches, medical personnel and athletic communities in the area of the prevention and care of athletic injuries. For purposes of this subdivision, "health care provider" means a person licensed to practice medicine or surgery under chapter 370, chiropractic under chapter 372, podiatry under chapter 375 or naturopathy under chapter 373.

The terms "athletic injury", "athlete", and "standing orders" are defined in statute as:

(2) “Athletic injury” means any injury sustained by an athlete as a result of such athlete’s participation in exercises, sports, games or recreation requiring strength, agility, flexibility, range of motion, speed or stamina, or any comparable injury that prevents such athlete from participating in any such activities;

(3) “Athlete” means any person who is a member of any professional, amateur, school or other sports team, or is a regular participant in sports or recreational activities, including, but not limited to, training and practice activities, that require strength, agility, flexibility, range of motion, speed or stamina. For purposes of this subdivision, “regular” means not less than three times per week;

(4) “Standing orders” means written protocols, recommendations and guidelines for treatment and care, furnished and signed by a health care provider specified under subdivision (1) of this section, to be followed in the practice of athletic training that may include, but not be limited to, (A) appropriate treatments for specific athletic injuries, (B) athletic injuries or other conditions requiring immediate referral to a licensed health care provider, and (C) appropriate conditions for the immediate referral to a licensed health care provider of injured athletes of a specified age or age group;

Lastly, the current practice act requires the athletic trainer to refer an athlete to a licensed healthcare provider if injury symptoms have not improved within 4 days of the onset of injury, or if the athlete has a physical or medical condition that may require evaluation and treatment beyond the scope of athletic training.

(a) Each person who practices athletic training under standing orders shall make a written or oral referral to a licensed health care provider of any athlete who has an athletic injury whose symptoms have not improved for a period of four days from the day of onset, or who has any physical or medical condition that would constitute a medical contraindication for athletic training or that may require evaluation or treatment beyond the scope of athletic training. The injuries or conditions requiring a referral under this subsection shall include, but not be limited to, suspected medical emergencies or illnesses, physical or mental illness and significant tissue or neurological pathologies.

(b) Each person who practices athletic training, but not under standing orders, may perform initial evaluation and temporary splinting and bracing of any athlete with an athletic injury and shall, without delay, make a written or oral referral of such athlete to a licensed health care provider. The limitations on the practice of athletic training set forth in this subsection shall not apply in the case of any athlete that is referred to such person by a licensed health care provider, provided such practice shall be limited to the scope of such referral.

Current Requirements for Education and Training and Applicable Certification Requirements

The current education requirement is to complete a baccalaureate degree from a program accredited by the Commission on Accreditation of Athletic Training Education (CAATE). The CAATE is nationally recognized by the Council for Higher Education Accreditation. Although a baccalaureate degree is the entry point for the profession, the National Athletic Trainers' Association notes that almost 70 percent of athletic trainers hold either a master's or doctoral degree. In addition, the Athletic Training Strategic Alliance recently decided that a minimum professional degree level should be a master's degree. This educational change will be implemented over the next several years, and it is anticipated that baccalaureate programs will not be permitted to admit students after the start of the fall term 2022.

Upon completion of an accredited baccalaureate program, the graduate must pass a nationally recognized certification examination sponsored by the Board of Certification, Inc. (BOC). The BOC is accredited by the National Commission for Certifying Agencies. As a condition of obtaining and maintaining Connecticut state licensure, athletic trainers are required to pass the BOC exam and maintain certification through the BOC. To maintain certification, the BOC requires athletic trainers to complete a minimum of 50 continuing education credit units every two years. At least 10 of these education units must come from programs focusing on evidence based practice. The BOC requirement for continuing education exceeds that of most other rehabilitative health professions, with the exception of APRNs, who are also required to earn 50 continuing education units every two years to maintain licensure in Connecticut.

The CATA further added that changes to educational competencies established by the National Athletic Trainers' Association Executive Committee on Education (NATA-ECE) in 2011 added content areas designed to expand the education and training, clinical and didactic, an athletic trainer receives. These changes resulted in the implementation of clinical rotations encompassing general medicine and non-orthopedic injuries and illnesses. Committee members reviewed the education and training documentation provided, and some committee members expressed concern that athletic trainers do not receive enough training and education to treat "non-athletes". There may not be enough direct patient care within clinical rotations outside of the athletic setting, and the number of clinical hours completed in non-traditional and emerging settings is not equal to the number of clinical hours other health care provider education programs contain. Further concerns were raised concerning those athletic trainers who earned state licensure prior to 2011, as those individuals would not have undergone the added clinical and didactic education. While the CATA asserted those athletic trainers certified and licensed prior to 2011 should keep themselves up to date with new

competencies through continuing education units, committee members noted that CEUs cannot replace hands on training.

Summary of Known Scope of Practice Changes

Scope of Practice Requests submitted in August 2014 and August 2015 were not selected for review. A bill was raised by the Connecticut General Assembly's Public Health Committee (S.B. No. 356) in the 2016 legislative session. The bill was voted out of the public health committee and tabled for the calendar in the Senate, but was not voted upon before the conclusion of the legislative session.

Impact on Existing Relationships within the Health Care Delivery System

The CATA states athletic trainers already collaborate with other health care professionals to provide care and services. As the proposed changes in this scope of practice request impart stricter guidelines surrounding standing orders, the CATA believes collaborative relationships with other healthcare practitioners will be enhanced. In addition, the CATA believes the proposed requirement of immediate referrals when working in situations without standing orders may benefit other providers.

The CATA stresses that overlap among professions, particularly in healthcare is unavoidable. The CATA scope of practice request references a document concerning scope of practice produced by The National Council of State Board of Nursing. Page 9 of this documents states, "no one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within practice that makes any particular profession unique. Simply because a skill or activity is within one profession's skill set does not mean another profession cannot and should not include it in its own scope of practice."

Economic Impact

The CATA asserts if the requested changes to the scope of practice are implemented an increase in athletic training jobs will be seen, young athletic trainers will be more inclined to remain in Connecticut, healthcare costs will decrease, and the overall economy will benefit. However, no data was provided to support these broad claims about how this request will benefit healthcare costs and the overall economy.

Three of the 5 accredited athletic training education programs in the State of Connecticut collect retention data on graduates of their programs. Between 2008 and 2011 the University of Connecticut graduated 48 students from their athletic training program. Of those 48 students, only 1 remained in Connecticut. Of the 28 students who graduated from Southern

Connecticut State University in the past 3 years, 35% left the state to pursue other career or educational opportunities. Of the 24 students who have graduated from Sacred Heart University from 2009-2011, 30% were confirmed to have left the state to pursue other opportunities, and 58% pursued a graduate degree in another field of study.

Data reported from both the National Athletic Trainers' Association and the CATA suggests about 4% of athletic trainers in Connecticut are working in non-traditional or emerging settings, such as Physical Therapy/Sports Medicine clinics, Industrial and Corporate Settings, and physician's offices. Based on this data, the CATA believes the proposed changes may lead to more job opportunities in settings using athletic trainers

Based on an article referenced in the scope of practice request titled "Executive Summary: Athletic trainers provide return on investment and decreased injuries in occupational work settings", the CATA believes the State of Connecticut would see an impact on healthcare costs if athletic trainers were able to practice with a revised scope of practice. According to the article, of occupational and industrial settings using athletic trainers, 45% reported the athletic trainer made an impact on healthcare costs within 6 months, and 100% of companies that tracked healthcare costs reported an impact on healthcare costs within 1 year of utilizing an athletic trainer. Of occupational and industrial settings using athletic trainers that kept return on investment (ROI) data, 100% reported a positive ROI with more than 80% indicating a ROI of $3 or more for every $1 invested.

Regional and National Trends

Licensure laws governing athletic trainers across the nation are varied. Michigan allows athletic trainers to provide care to the non-athlete population provided the care is under the supervision of a physician. Arizona, Mississippi, Ohio, and Georgia allow athletic trainers to care for injures that occur outside of sports participation when the injuries occur as a result of activities requiring physical strength, agility, flexibility, speed, stamina, or range of motion, provided the care occurs under the supervision of a higher level health care provider. Washington and Virginia specifically allow for athletic trainers to practice in workplace settings under the direction of a physician.

Within the northeast, Maine, Massachusetts, New Hampshire, New Jersey, and Rhode Island limit the athletic trainer's scope of practice to athletes. Vermont and New York allow an athletic trainer to care for non-athletes with a referral and under the direction of a higher level health care provider. Pennsylvania allows athletic trainers to provide athletic training services to any physically active person who is under the care of a physician, dentist or podiatrist.

Additionally, athletic trainers in other states are attempting to update state practice acts to align with the current educational competencies. New York introduced legislation which would permit an athletic trainer to care for "active individuals", Massachusetts proposed a bill which would remove the limitation of athletic trainers only serving athletes, and New Hampshire has recently allowed for athletic trainers to perform joint mobilization techniques and dry needling.

The CATA notes that while some other states do limit the scope of practice for athletic trainers to only athletes, Connecticut is the only state in the nation which defines an athlete by the amount of time they participate in sport (i.e.: 3 times per week), resulting in Connecticut athletic trainers being unable to care for youth and recreational athletes who often practice less than the statute requires.

Other Health Care Professions that may be Impacted by the Scope of Practice Request as Identified by the Requestor

According to the CATA, athletic trainers currently collaborate with other healthcare providers and believe changes to their scope of practice would enhance collaborative relationships and improve patient care. During the course of preparing the scope of practice request the CATA made efforts to meet with and discuss the nature of the proposed changes with several other health care provider organizations, and provided a summary of those efforts in their scope of practice request. The organizations the CATA met with included the Orthopedic Society of CT, CT State Medical Society, CT APRN Society, CT Physical Therapy Association, Connecticut Nurses Association, CT Occupational Therapy Association, and the CT Chiropractic Association. The CATA asserts they continue to be open to continued discussions and collaboration in order to reach a consensus on appropriate scope of practice changes.

Description of How the Request Relates to the Profession's Ability to Practice to the Full Extent of the Profession's Education and Training

The professional domains of athletic training include injury/illness prevention and wellness, clinical evaluation and assessment, immediate and emergency care, treatment and rehabilitation, and organizational and professional health and well-being. The CATA believes the current practice act language limits their ability to practice to the full extent of their education and training.

The "three day" participation requirement in defining an "athlete" prevents an athletic trainer from serving the youth population and recreational athletes because these populations may not participate in a sport or physical activity three times per week. Although athletic trainers

and the CATA have worked closely with legislators on issues concerning automatic external defibrillators and concussion laws in youth sports, the current language and scope of practice in place restricts athletic trainers from being able to care for these individuals on the field.

Athletic trainers are also unable to provide immediate and rehabilitative care to individuals who may benefit from the care and services an athletic trainer can provide. Military personnel, firefighters, and industrial workers often engage in activities requiring strength, agility, flexibility, range of motion, and speed or stamina. However, due to the setting where the individuals participates in these activities and how many times per week the participation occurs, the athletic trainer is prohibited from treating these individuals despite the similarities of injuries that may occur.

According to the CATA the failure to recognize the role an athletic trainer can play in dealing with acute and chronic medical conditions is another limitation of the current practice act. Acute conditions that may arise that an athletic trainer is trained to address are diabetic emergencies, asthma, allergic reactions, seizures and sudden cardiac emergencies. While Connecticut statutes provide for the athletic trainer to assist with the administration of medications such as glucagon, epi-pens and asthma inhalers, this is limited only to athletic trainers working in the high school setting.

Other states have provided athletic trainers with expanded scopes of practice as the profession has evolved. States such as Georgia, Michigan, Ohio, Nebraska, Virginia, and Wisconsin allow the athletic trainer to care for individuals other than athletes under the direction of a higher level health care provider. For states such as Maine, Massachusetts, New Hampshire and Rhode Island that limit the scope of practice for athletic trainers only to athletes, none of these states define an athlete based on how many days per week the individual must participate in sport or physical activity.

Findings/Conclusions

The scope of practice review committee reviewed the information contained in the CATA scope of practice request and additional information provided as a result of discussions during committee meetings. The scope of practice committee focused on assessing the potential health and safety benefits associated with the request, if the request would enhance access to quality and affordable healthcare, and how the request may enhance the ability of the profession to practice to the full extent of the profession's education and training.

To demonstrate the health and safety benefits of the scope of practice request the CATA provided anecdotal news articles outlining instances across the nation in which an athletic trainer administered emergency care to athletes and non-athletes at sporting events. However, no peer reviewed literature was provided to support these claims.

Concerns raised during the 2016 legislative session led the CATA to propose language imposing stricter requirements on the review of standing orders, and to require athletic trainers to provide an immediate referral in situations when standing orders are not present.

While members of the group acknowledged athletic trainers provide an important service to the athletic population, and should be able to be present on the sidelines of youth and recreational sporting events, several committee members expressed concern about changing the word athlete to "physically active individual", believing it could open up the scope of practice for an athletic trainer to treat "anyone who moves". Committee members also expressed concern that an athletic trainer does not receive enough training and education on general medical conditions to be able to treat a non-athletic population or a population who may not be medically pre-screened. The CATA attempted to clarify for the group that in employment situations outside of the traditional athletic setting the athletic trainer would be required to immediately refer any individual who presented with an illness or injury because those non-traditional settings would not have standing orders. Representatives of the CATA also assert that in the industrial setting, much of the work the athletic trainer does centers around injury prevention. Although there may be occasions where first aid and/or emergent care is required, the CATA believes the athletic trainer has the training and education to provide injury management and acute care to help individuals until emergency medical services and transport arrives. No data was provided, however, to document a lack or need for such services in the industrial setting. It must be determined if this is merely a way to avoid hiring more highly trained, expensive health care workers.

Despite the safeguards the CATA feels have been put in place with this scope of practice request, several committee members continued to express concerns over changing the word "athlete" to "physically active individual" and the prospect of athletic trainers working outside of the traditional athletic setting. Concerns were raised that athletic trainers may be making assessments and not realizing they are out of scope, or that the proposed changes would allow an athletic trainer to open up their own business to treat anyone without language to restrict or prevent the athletic trainer from working in an area where they are not qualified. Additional concerns were that athletic trainers would be able to treat individuals with comorbidities in industrial and other emerging settings.

During committee discussions a few members did express some support for the athletic trainer in a non-traditional setting. Points were raised that athletic trainers are more qualified to provide acute emergency care than an individual in the workplace who is a first aid responder. Other members did not necessarily challenge the need for an athletic trainer to be in a non-traditional setting, but had concerns the training and education the athletic trainer receives does not sufficiently align to the expansions of scope being requested.

The CATA provided the committee with a peer reviewed journal article and a narrative with data from The Industrial Athlete, Inc. (Appendix F) demonstrating the positive effects non-traditional or emerging settings who hire athletic trainers have seen. These benefits included decreased workers compensation and emergency room costs, a decrease in workplace injuries, a decrease in the incidence of lost workdays, positive return on investment, and high-quality care resulting in better outcomes for employees. While the CATA was unable to address questions of whether or not there is an unmet need for athletic trainers in the non-traditional and emerging settings through official data and statistics, the representatives of the CATA claim there are jobs for athletic trainers outside of the traditional athletic setting. The Scope of Practice process however, is not focused on job opportunities for the profession. Additionally, legislative language from other states demonstrates that athletic trainers are practicing with a broader scope of practice in other parts of the country. States that limit an athletic trainer's scope of practice to only athletes do not define how many times per week an individual must engage in sport participating to be considered an athlete.

The scope of practice request submitted by the CATA contained a section of proposed language which was reviewed and discussed by the committee. In response to concerns raised during the committee meetings, the CATA provided revised language clarifying that any conditions encountered beyond the athletic trainer's scope of practice and education would require an immediate referral to a licensed healthcare provider. Despite the changes, concerns that the language was too broad continued to persist. Should the Public Health Committee decide to raise a bill regarding this scope of practice request, the Department of Public Health respectfully requests the opportunity to work with the Public Health Committee on statutory language.

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Appendix A

Scope of Practice Law

Sec. 19a-16d. Submission of scope of practice requests and written impact statements to Department of Public Health. Requests for exemption. Notification and publication of requests. (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, may submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

(C) The impact that the request will have on public access to health care;

(D) A brief summary of state or federal laws that govern the health care profession making the request;

(E) The state's current regulatory oversight of the health care profession making the request;

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

(I) The anticipated economic impact of the request on the health care delivery system;

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 19a-16e. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the

department a written statement identifying the nature of the impact not later than October first of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October fifteenth of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

Sec. 19a-16e. Scope of practice review committees. Membership. Duties. (a) On or before November first of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each timely scope of practice request submitted to the department pursuant to section 19a-16d. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 19a-16d to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

(b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an

assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.

(c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.

Sec. 19a-16f. Report to General Assembly on scope of practice review processes. On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections 19a-16d and 19a-16e and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on the effectiveness of such processes in addressing scope of practice requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

Appendix B

Committee Membership

Committee Membership

1. Connecticut Athletic Trainers' Association
2. The Connecticut Advanced Practice Registered Nurse Society
3. Connecticut Occupational Therapy Association
4. Connecticut Orthopaedic Society
5. Connecticut State Medical Society
6. Connecticut College of Emergency Physicians
7. Connecticut Physical Therapy Association
8. Connecticut Nurses Association
9. Connecticut Hospital Association
10. Connecticut Chiropractic Association
11. Connecticut Podiatric Medical Association; and
12. Department of Public Health (chairperson and ex-officio, non-voting member).

Appendix C

Scope of Practice Request

This document outlines the proposed changes and updates to the Athletic Trainer Scope of Practice in Connecticut based on the Education and Preparation of an Athletic Trainer.

Connecticut Athletic Trainers' Association

Scope of Practice Report

Submitted by: CATA Governmental Affairs

Introduction

The Connecticut Athletic Trainers' Association (CATA) greatly appreciates the opportunity to submit this scope report to the Connecticut Department of Public Health. This report will demonstrate the impact athletic trainers (ATs) can have on access to healthcare in Connecticut, the education and training of ATs, and proposed updates to the athletic training scope of practice. The proposed updates to the AT scope of practice will allow athletic trainers to practice to the full extent of their education and training. Additionally, it will improve healthcare for the residents of Connecticut, lower the rising costs of healthcare and improve patient outcomes through collaboration of the AT with other health care practitioners.

For many years the Connecticut Athletic Trainers' Association has been highly involved with various legislative issues impacting the health and safety of students, student-athletes, and other members of the public in Connecticut. The CATA has worked closely with the Public Health Committee, Education Committee, and Committee on Children and many individual legislators including but not limited to; Sen. Martin Looney, Sen. Betsy Ritter, Sen. Terry Gerratana, Rep. Joe Aersimowicz, Rep. Susan Johnson, Rep. Andrew Fleischmann, Rep. Janice Giegler, Rep. Themis Klarides, Rep. Diana Urban, among others. The CATA has been a leading advocate for legislation requiring AEDs in schools, concussion awareness and safety, improved access to emergency medications for students needing epi-pens, inhalers, and glucagon, and improved awareness of sudden cardiac arrest.

This scope report outlines the abilities, education and training of an AT, along with the efforts of the CATA to communicate, educate and remain transparent with all invested parties throughout the past 4 years. This is our third submission to the Department of Public Health and we look forward to working through this as a group. We look forward to continuing our work with various groups and health care professionals as well as the DPH. Please forward any questions to the CATA Governmental Affairs Committee:

- Eleni Diakogeorgiou, MBA, ATC, LAT – Co-Chair, CATA Governmental Affairs crfdiakoge@gmail.com 203-365-4475
- Perry Siegel, MS, ATC, LAT – Co-Chair, CATA Governmental Affairs perry.siegel@selectphysicaltherapy.com (860)794-3676
- Gary Morin, PhD, ATC, LAT-CATA Board of Directors moring1@southernct.edu 203-392-6089
- James Doran, MS, ATC, LAT – CATA Past President james.2.doran@uconn.edu 860-486-0481
- Jeffrey Shanley, MBA, ATC, LAT – CATA President CATApresident@gmail.com. 203-376-2987

Thank you for your time and consideration.

Connecticut Athletic Trainers' Association

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CH 1: Plain language description of the request

Introduction

The request for updating the Connecticut athletic training (AT) practice act (Connecticut General Statutes 375a) is primarily a result of the evolution of the profession and the increased participation of the population in sports and physical activity. With the addition of standardized educational competencies and the accreditation of educational programs, the current scope of practice and statutory language in Connecticut is outdated. A visual timeline of these events can be found in the Appendices. Additionally, Connecticut is the only state in the nation which defines an athlete by the amount of time they participate in sport (i/e: 3 times per week) this in turn restricts athletic trainers in covering various youth sporting events and giving care to youth athletes, in addition to those participating in recreational physical activities. The Connecticut Athletic Trainers' Association (CATA) would like to thank all the individuals involved in the initial licensing of ATs in the state including CATA members and leaders at the time, the Department of Public Health and the many legislators who support the AT profession.

Current Statutory Language

The current AT practice act was written in the 1990's, passed by the General Assembly in 2000, and enacted by the Department of Public Health in 2006. At the time the current practice act was written and subsequently passed, the profession was in the process of reform to ensure consistency of the educational process for ATs. The main result of this education reform was that all ATs must graduate from an accredited institution in order to sit for the Board of Certification Examination, a prerequisite for licensure in all states except Texas. More detailed information regarding the accreditation of athletic training education programs, educational competencies and the Board of Certification examination follow in Chapter 6: Education and Training. In addition to educational reform, many states have since updated their athletic training practice acts, and many more are now in the process, to ensure ATs can practice to the full extent of their education and training. Athletic trainers practice under the direction of a healthcare provider as defined in the CT state statute which reads as follows: "health care provider" means a person licensed to practice medicine or surgery under chapter 370 of the general statutes, chiropractic under chapter 372 of the general statutes, podiatry under chapter 375 of the general statutes or naturopathy under chapter 373 of the general statutes. ***In the remainder of the document health care provider refers to this definition***. More information regarding other states and the practice of athletic training is detailed in in Chapter 12.

Over the past 15-20 years, athletic training has evolved from a field that existed primarily to provide health care to professional, collegiate and secondary school athletes, to a profession providing prevention and care to a wide range of physically active individuals in various settings. Nationally, ATs commonly use their skills to provide services to individuals in fields as diverse as the performing arts, U.S. military, NASA, public safety (e.g., police and firefighters), and to those who work in industrial settings.[1] More information regarding the education and competencies of an AT can be found in Chapter 6 of this scope of practice report.

Although the current Connecticut AT practice act language was written in order to allow ATs to treat athletes, and individuals who have comparable injuries, this is often not the case because of confusion among employers about the statute. As a result, athletic trainers in Connecticut are limited in their ability to practice to the full extent of their education and training. All athletic trainers must graduate from a 4-year institution with a Bachelor's degree in athletic training and are required to pass a national board of certification exam. More information regarding education

can be found in Chapter 6. Furthermore, in a recent five-year period, three of Connecticut's five athletic training education programs reported an average of 54% of AT graduates leaving the state for employment or educational opportunities. For more information regarding statistics and the economic impact of the AT scope of practice, please refer to Chapter 9 of this scope of practice report.

Primary Areas of Concern

The primary areas the Connecticut Athletic Trainers' Association (CATA) would like to address with this scope of practice update are:

1) Remove the confusion about whom ATs may treat by substituting the word "physically active individual" for the word "athlete" in the statutory language.
    a. Outcome:
        i. This change will allow AT's to practice to the full extent of their education under the direction of a health care provider which includes: a person licensed to practice medicine or surgery under chapter 370 of the general statutes, chiropractic under chapter 372 of the general statutes, podiatry under chapter 375 of the general statutes or naturopathy under chapter 373 of the general statutes.
        ii. Codifies *existing* practice of AT's in non-athletic settings by permitting AT's to provide prevention and treatment skills on non-athletic populations with similar injuries
        iii. Affords greater access to injury prevention, treatment and rehabilitation services with referral to underserved populations such as youth and recreational individuals.
        iv. Removes the current restricting language that is *unique* to Connecticut regarding the definition of athlete which includes a 3 times per week criteria.

2) Clarify the ability of ATs to manage medical conditions other than injuries under the direction of a health care provider as defined above in section 1a-i. ATs regularly work with patients with chronic diseases and are some of the leading researchers in concussion and exertional heat illness. AT's are broadly trained to identify many other medical conditions such as but not limited to exertional sickling, rhabdomyolysis, asthma, diabetes, heat stroke, and other conditions that may be exacerbated by physical activity and carry out the orders of a health care provider in the management of these conditions. Furthermore, ATs are recognized in Connecticut statutes as health care providers for concussion, sudden cardiac care, and epi-pen, asthma inhaler, and glucagon administration in schools in the state. Ironically, the ability to provide care for these conditions is not necessarily permitted by the current AT licensure bill.
    a. Outcome:
        i. Allows a broader population access to health care professionals who can safeguard those patients before, during, and after physical exertion.
        ii. Helps provide direction into the care of non-orthopedic conditions by AT's and protects AT's from violating the state practice act when caring for non-orthopedic issues
        iii. Permits athletic trainers to care for all athletes, not just those who are involved in participation three or more days per week (as defined by the current AT practice act)

More detailed information regarding specific changes and limitations in the athletic training practice act please refer to Chapter 12.

References:

1. National Athletic Trainers' Association. Practice Settings for the Athletic Trainer. http://www.nata.org/athletic-training/job-settings

CH 2: Public Health & Safety

This chapter outlines the public health and safety benefits that the requestor believes will occur if the request is implemented and, if applicable, a description of any harm to public health and safety if it is not implemented

Public Health and Safety Benefits

ATs are health care professionals work under the direction of a healthcare provider as previously defined and collaborate with other allied health care professionals to provide health care particularly in the area of musculoskeletal injury. ATs provide services in the domains of prevention, emergency care, clinical assessment, therapeutic intervention and rehabilitation of injuries.[1] Athletic training is approved by the American Medical Association (AMA) for inclusion in the Health Professions Career and Education Directory. The Connecticut Athletic Trainers' Association (CATA) urges and fully supports updating the AT scope of practice to reflect ATs skills and full breadth of education and knowledge. Updating the scope of practice directly supports public health and safety in four critical ways:

- Strengthens supervision of AT's by placing stricter controls on standing orders
- Permits the extension of AT care to underserved populations such as *youth* and recreational athletes not covered by the current definition of athlete. This care includes injury prevention, assessment, emergency management and treatment.
- Allows otherwise healthy individuals to have greater access to rehabilitative care for injuries through access to AT practitioners with a *referral* from a health care provider.
- Permits AT's to apply their preventive skills in reducing work-place injury and job time loss thereby decreasing workmen's compensation claims as seen in other states
- Clarify the role of the AT in caring for illnesses related to an athlete's or individual's role in physical activity.

Overview

Athletic trainers work under the direction of a healthcare provider as previously defined through standing orders in an athletic setting. The suggested changes to the scope of practice would place a stricter requirement on ATs to review standing orders with their healthcare provider and maintain regular contact with them. Furthermore, any individual who is not pre- screened or in a situation where an athletic trainer is working without standing orders those individuals would be *referred to a physician* for further evaluation. Additionally, any individual or athlete who has sustained an injury and is not showing improvements within 4 days of injury also requires a referral. The current statute (CGS Chapter 375a, Sec. 20-65f) limits athletic trainers to the care of athletes who are regular participants in sports or recreational activities with regular defined as participating in activities "not less three times per week." This limitation is *unique* to Connecticut in that it is the only state that defines how many times someone must participate in order to be considered an athlete, and unfortunately can prevent ATs from providing necessary acute and/or emergency care to several groups of individuals.

Youth athletes, perhaps the most vulnerable to injury of all of the athletic populations, often practice less than the required minimum three days per week. Radelet et al. noted injury rates between 1 and 1.7 for every 100 athletes playing youth sports in youth across all sports.[1] Fourteen percent of the injuries in football were considered serious requiring immediate medical care.[1] Adirim and Chang noted that children are prone to sport injury due to a large surface area to mass ratio, and possess joint cartilage that is not fully mature. The authors also noted that with an earlier focus on specific sports, children are at greater risk for overuse injuries.[2] As a result the authors felt qualified medical personnel be available at all sporting events.[2] The current statute, as written, prevents an AT from providing care to these injured individuals as these youth athletes may not satisfy the legal requirements of being an "athlete" as

defined by the current AT practice act. Requested changes in the scope of practice will permit the AT to be available at those sports that do not meet the "three day a week" requirement, thereby providing qualified medical care for our children.

The current statute affects ATs employed in the workplace. ATs are employed in the workplace, normally under a different work title usually through a physical therapy clinic sponsoring work injury prevention programs. Athletic trainers in this work setting do not work in the capacity of an AT due to the requirement that ATs work only with "athletes" prevents them from providing care to the full extent of their education and training, or even officially as athletic trainers. The requested changes in the AT scope of practice would permit an AT to be employed as such in different workplace settings. Thereby allowing an AT to apply all of the knowledge and skills that are within her/his professional preparation and contribute to the comprehensive health care team. More detailed information regarding the return on investment of an AT in the workplace can be found in Chapter 9. Additionally, the update to the scope of practice which will reflect the ATs full knowledge and education will add supplementary employment opportunities for CT college graduates.

Rehabilitative Care

ATs are well-qualified to provide rehabilitative services to injured athletes and individuals, particularly in the area of musculoskeletal injury. Due to ATs extensive experience in athletics, ATs are highly experienced in functional and movement-specific exercise. With the proposed change in scope of practice, ATs would be able to extend this care to the physically active individuals and workers. A greater role in rehabilitation would be extremely beneficial in the care of Connecticut's citizens. The requested changes in the scope of practice would permit ATs to apply their expertise beyond the athlete for those patients who are referred by a health care provider. An expanded presence of ATs in the post-rehabilitation realm will allow individuals released from physical therapy practices and are not yet fully recovered opportunities for continued care. Individuals released from therapy following the exhaustion of insurance coverage typically rely on personal trainers to continue their recovery and return to participation. Unlike ATs, personal trainers often have minimal training, such as a home study or online course, and are not regulated by the state. The updated scope of practice would permit ATs, who are well-educated in injury assessment and rehabilitation skills to care for individuals who do not qualify as athletes under Connecticut law. As a result, the quality of care for all citizens can be improved with the increased access to quality rehabilitative care.

Prevention of Workplace Injuries

Injury and illness prevention have been reinforced in athletic training curriculums through the inclusion of courses such as exercise physiology, nutrition, strength / conditioning, and biomechanics throughout the history of athletic training education. The expansion of the ATs skills beyond the athletic setting could be extremely beneficial in preventing musculoskeletal conditions across the general population, particularly in the workplace setting.

Increased access to the workplace setting would allow ATs to apply their knowledge and professional skills in preventing workplace injury. Nationally, ATs have already demonstrated their ability to effectively reduce workplace related injury at such global corporations as Boeing, Delta Airlines, Kimberly-Clark and UPS. In Connecticut, a very limited number of athletic trainers are successfully employed in the industrial setting, albeit under a different title and in a restricted role. The requested changes in professional practice would allow an expansion of AT employment in the workplace setting across the multiple corporations housed in Connecticut. As a result, employer costs in workmen's compensation, and hiring replacement employees would be reduced assisting in the financial viability of the various companies. Application of prevention skills can assist the employee in limiting disability due to acute and chronic conditions such as low back pain.

Clarifying the Role of the AT in Caring for Illness

ATs routinely manage patients who have allergies, asthma, diabetes and other medical conditions. The AT is involved in these cases, often carrying out the recommended plan of the athlete's treating physician. Additionally,

ATs are responsible for providing care for acute manifestations of the athlete's conditions. The proposed changes to the practice act address current AT practice in managing and providing care for patients with medical conditions.

The proposed language which appropriately reflects the education and training of the AT, will enable ATs to effectively manage illnesses and other emergent conditions under the direction of a healthcare provider as previously defined. ATs will be permitted to administer the physician's orders in the care of an acute illness or condition. The intent is **NOT** to have athletic trainers diagnose and develop a plan of treatment for ill individuals, but to be able to follow through on the expectations of the patient's treating physician.

Potential Harm to Public Health and Safety without Implementation

The current statute prevents the AT from applying acute care to individuals who are not defined as an "athlete". As a result, vulnerable populations that could benefit from the professional skill and experience of an AT are not able to receive such care. Youth and recreational athletes, participating less than 3 days per week, are being "treated" by a parent volunteer on the sidelines, a teammate or a bystander when acutely injured, few of these individuals are qualified to do so. With so many recreational sports and youth athletics ensuring ATs are on the sidelines is of utmost importance to the protection of the CT public. For instance, concussion awareness in CT has drastically increased and having an AT on the sideline can ensure that athletes of all ages are being properly cared for and appropriately referred when warranted.

In terms of rehabilitation, the current restrictions affect the recovery of citizens across Connecticut. Not all individuals should be referred to ATs, licensed health care providers will decide who can best provide care to individuals. However, changes in the law would permit otherwise healthy people to receive qualified care from an AT for musculoskeletal injuries making the AT a viable piece of the rehabilitation team.

Failure to enact the requested changes will limit the ability of individuals to extensively employ ATs to prevent injuries at the workplace setting. Reducing the availability of Connecticut's corporations to hire personnel educated in preventing injury may harm business viability. The Health Care Cost Institute (www.healthcostinstitute.org) states that rising health care spending is injuring economic growth. The American Medical Association notes that the cost of healthcare is rising rapidly. Connecticut's premium rate in 2007 for workman's compensation was the 14th highest in the nation (www.cga.ct.gov/2007/rpt/2007-R-0173.htm). Clearly the escalating health care costs must be addressed with preventing injuries and illnesses representing the best option.

References:

1. Radelet, M., Lephart, s. Rubinstein, E., Myers, J. Survey of the injury rate for children in community sports, Pediatrics 110,3,2002
2. Adirim, T., Cheng, T. Overview of Injuries in the Young Athlete, Sports Medicine 33, 1, 75-81,2003

CH 3: Public Access to Healthcare

This chapter outlines the Impact this request will have on public access to healthcare in the state of Connecticut.

Impact on Public Access to Healthcare

Expanding the current athletic training scope of practice to appropriately reflect the current educational competencies as well as proficiencies set forth by the National Athletic Trainers Association Executive Committee on Education (NATA-ECE), will increase public access to healthcare in the state of Connecticut. These competencies and proficiencies are outlined in **Chapter 6: Education and Training of the scope of practice report.**

Updating the scope of practice will allow athletic trainers (ATs) to:

- Utilize all of their skills and expertise that reflect their educational training and certification
    - All ATs graduate from a 4 year institution and all have to pass a national board of certification exam. Please refer to **Chapter 6** for detailed information regarding education as well as information regarding updates to athletic training education.
- Expand job opportunities in health care settings within Connecticut that will permit ATs to serve a larger population, not just those defined as an athlete and becoming a viable part of the physical medicine and rehabilitation team.
- Be able to serve the general population of physically active individuals in areas where ATs have a professional area of expertise

We believe the preferred updates clarify the current athletic training scope of practice to reflect the training and examination requirements, and will lead to increased health care for the residents of Connecticut. The new statutory language will encompass all skill sets ATs can perform, including services not only to the "athletic" population, but also to other otherwise healthy individuals. According to Sam Gold, Service Line Strategy Advisor and Senior Analyst for the Advisory Board Company (www.advisoryboard.com)[1] in a presentation titled, *Expand Orthopedic Presence with Sports Medicine,* it was recommended that healthcare should expand the traditional roster of providers to enable a program of conservative care. Increasing a provider's scope of coverage will increase patient access to healthcare professionals. Healthypeople.gov[2] states the current US health care system saw an influx of patients in 2014 because many became insured for the first time. Healthypeople.gov outlines issues including. [2]

- Increasing and measuring access to appropriate, safe, and effective care, including clinical preventive services.
- Decreasing disparities and measuring access to care for diverse populations, including racial and ethnic minorities and older adults.
- Increasing and measuring access to safe long-term and palliative care services and access to quality emergency care.

The Athletic Trainer as a Qualified Healthcare Provider

ATs are educated in the areas of prevention, wellness, and treatment of injuries and illnesses. Throughout their education, ATs receive experiential learning to "provide efficient and effective health care and educational services."[3] The AT profession has evolved from caring only for the athletic population, to the care of a larger percentage of the population.[4,5] As demonstrated by National Athletic Trainers' Association (NATA) member statistics, ATs are employed in a variety of venues including: clinic, industry, and hospitals.[6] March 2016 statistics from the NATA show that 20.89% of NATA members work in emerging AT settings including but not limited to: business/sales/marketing, occupational health, fitness and performance, military and unemployed.[7] This information does not include students. Furthermore, clarification of the athletic training scope of practice will increase the access and timeliness to qualified and appropriate healthcare providers to the public.

References:

1. Gold, S. Expanding Orthopedic Presence with in Sports Medicine – Blog. www.advisoryboard.com **post available upon request**

2. Healthypeople.gov

3. Laurent TG, Bradney DA. Leadership behaviors of athletic training leaders compared with leader in other fields. *J Athl Train.*2007;42(1):120-125.

4. Delforge GD, Behneke RS. The history and evolution of athletic training education in the United States. *J Athl Train.*1999;34(1):53-61.

5. Lockard CB. Athletic trainers: Providing healthcare for athletes of all kinds. *Occupational Outlook Quarterly*.2005;38-41.

6. National Athletic Trainers' Association. Job settings. http://www.nata.org/athletic-training/job-settings. Retrieved June 11, 2014.

7. National Athletic Trainers' Association – https://www.nata.org/sites/default/files/ethnicity-demographics.pdf

CH 4: Summary of federal and state laws

This chapter outlines the federal and state laws that govern athletic trainers in the United States of America.

Licensure Laws for ATs in the U.S.

Licensure laws vary across the nation with the scope of practice, related to the date of the enactment of the practice act. Certain states acknowledge the need for athletic trainers to be able to assess and treat illnesses that are associated with athletic participation. Some of these states include Alaska, Arkansas, Michigan and Wisconsin.

Outside of our region, certain states permit athletic trainers to provide care for a non-athletic population. Michigan allows for care of individuals within the athletic trainer's scope of practice providing the care is under the supervision of a physician. Arizona, Mississippi, Ohio, and Georgia allow athletic trainers to care for athletic injuries that occur outside of sport participation when the injuries occur in an activity that requires physical strength, agility, flexibility, speed, stamina or range of motion. In these states the care must be under the supervision of a health care provider.

Certain states such as Washington and Virginia specifically permit athletic trainers to serve at the workplace. Athletic trainers are permitted to provide conditioning, assessment, treatment, rehabilitation and reconditioning activities for employees. In both cases, the care must be under the direction of a physician.

Northeastern States

In the northeast region, state licensure laws vary by the year the law was enacted. Maine, Massachusetts, New Hampshire, New Jersey and Rhode Island scopes of practice remain limited to athletes. Vermont permits athletic trainers to care for orthopedic injuries in non-athletes with a referral from a health care provider. The patients must be free from an underlying pathology that would affect treatment. Like Vermont, New York allows athletic trainers to care for athletic or orthopedic injuries in a health care organization to non-athletes when under the direction of a physician. Pennsylvania allows athletic trainers to provide 'athletic training services' to any **physically active person** who is under the care of a physician, dentist or podiatrist.

Additionally, states are similarly attempting to align their state practice acts with professional educational competencies. During the 2015-16 session, New York introduced a bill to permit the care of *'active' individuals*, such as athletes, performing artists and public safety officials. A proposed bill in Massachusetts removed the limitation of athletic trainers only serving athletes. The athletic training Board of New Hampshire recently confirmed the ability of athletic trainers licensed in that state to use joint mobilization techniques and dry needling.

Please see Chapter 10 for more detailed information.

References:

All information cited in this section was acquired from all the state practice acts and athletic training state association websites in addition to the following websites:

Board of Certification Inc. State Regulation Section. http://www.bocatc.org/state-regulation/map

National Athletic Trainers' Association. http://www.nata.org/state-practice-acts

CH 5: Current State Statute

This chapter outlines the current Athletic training practice act in the State of Connecticut

Current Statute

Connecticut General Statutes
Chapter 375a
Athletic training

Sec. 20-65f. Definitions. As used in this chapter:
(1) "Athletic training" means the application or provision, with the consent and under the direction of a health care provider, of (A) principles, methods and procedures of evaluation, prevention, treatment and rehabilitation of athletic injuries sustained by athletes, (B) appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, light massage, water, electric stimulation, sound, exercise and exercise equipment, (C) the organization and administration of athletic training programs, and (D) education and counseling to athletes, coaches, medical personnel and athletic communities in the area of the prevention and care of athletic injuries. For purposes of this subdivision, "health care provider" means a person licensed to practice medicine or surgery under chapter 370 of the general statutes, chiropractic under chapter 372 of the general statutes, podiatry under chapter 375 of the general statutes or naturopathy under chapter 373 of the general statutes;
(2) "Athletic injury" means any injury sustained by an athlete as a result of such athlete's participation in exercises, sports, games or recreation requiring strength, agility, flexibility, range of motion, speed or stamina, or any comparable injury that prevents such athlete from participating in any such activities;
(3) "Athlete" means any person who is a member of any professional, amateur, school or other sports team, or is a regular participant in sports or recreational activities, including, but not limited to, training and practice activities, that require strength, agility, flexibility, range of motion, speed or stamina. For purposes of this subdivision, "regular" means not less than three times per week;
(4) "Standing orders" means written protocols, recommendations and guidelines for treatment and care, furnished and signed by a health care provider specified under subdivision (1) of this section, to be followed in the practice of athletic training that may include, but not be limited to, (A) appropriate treatments for specific athletic injuries, (B) athletic injuries or other conditions requiring immediate referral to a licensed health care provider, and (C) appropriate conditions for the immediate referral to a licensed health care provider of injured athletes of a specified age or age group.
(5) "Commissioner" means the Commissioner of Public Health.

Sec. 20-65g. License required for practice and use of title. (a) Except as provided in section 20-65i, no person may practice athletic training unless such person is licensed pursuant to section 20-65j.
(b) No person may use the title "licensed Athletic Trainer" or make use of any title, words, letters or abbreviations indicating or implying that such person is licensed to practice athletic training unless such person is licensed pursuant to section 20-65k.

Sec. 20-65h. Referral to licensed health care provider. (a) Each person who practices athletic training under standing orders shall make a written or oral referral to a licensed health care provider of any athlete who has an

athletic injury whose symptoms have not improved for a period of four days from the day of onset, or who has any physical or medical condition that would constitute a medical contraindication for athletic training or that may require evaluation or treatment beyond the scope of athletic training. The injuries or conditions requiring a referral under this subsection shall include, but not be limited to, suspected medical emergencies or illnesses, physical or mental illness and significant tissue or neurological pathologies.
(b) Each person who practices athletic training, but not under standing orders, may perform initial evaluation and temporary splinting and bracing of any athlete with an athletic injury and shall, without delay, make a written or oral referral of such athlete to a licensed health care provider. The limitations on the practice of athletic training set forth in this subsection shall not apply in the case of any athlete that is referred to such person by a licensed health care provider, provided such practice shall be limited to the scope of such referral.

Sec. 20-65i. Exceptions to licensing requirement. A license to practice athletic training shall not be required of: (1) A practitioner who is licensed or certified by a state agency and is performing services within the scope of practice for which such person is licensed or certified; (2) a student intern or trainee pursuing a course of study in athletic training, provided the activities of such student intern or trainee are performed under the supervision of a person licensed to practice athletic training and the student intern or trainee is given the title of "Athletic Trainer intern", or similar designation; (3) a person employed or volunteering as a coach of amateur sports who provides first aid for athletic injuries to athletes being coached by such person; (4) a person who furnishes assistance in an emergency; or (5) a person who acts as an Athletic Trainer in this state for less than thirty days per calendar year and who is licensed as an Athletic Trainer by another state or is certified by the Board of Certification, Inc., or its successor organization.

Sec. 20-65j. Qualifications for licensure. Licensure by endorsement. a) Except as provided in subsections (b) and (c) of this section, an applicant for a license to practice athletic training shall have:
(1) A baccalaureate degree from a regionally accredited institution of higher education, or from an institution of higher learning located outside of the United States that is legally chartered to grant postsecondary degrees in the country in which such institution is located; and (2) current certification as an Athletic Trainer by the Board of Certification, Inc., or its successor organization.
(b) An applicant for licensure to practice athletic training by endorsement shall present evidence satisfactory to the commissioner (1) of licensure or certification as an Athletic Trainer, or as a person entitled to perform similar services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, and (2) that there is no disciplinary action or unresolved complaint pending against such applicant.
(c) Prior to April 30, 2007, the commissioner shall grant a license as an Athletic Trainer to any applicant who presents evidence satisfactory to the commissioner of (1) the continuous providing of services as an Athletic Trainer since October 1, 1979, or (2) certification as an Athletic Trainer by the Board of
Certification, Inc. or its successor organization.

Sec. 20-65k. License to practice athletic training. Fees. (a) The commissioner shall grant a license to practice athletic training to an applicant who presents evidence satisfactory to the commissioner of having met the requirements of section 20-65j. An application for such license shall be made on a form required by the commissioner. The fee for an initial license under this section shall be one hundred and ninety dollars.
(b) A license to practice athletic training may be renewed in accordance with the provisions of section 19a- 88, as amended, provided any licensee applying for license renewal shall maintain certification as an Athletic Trainer by the Board of Certification, Inc. , or its successor organization. The fee for such renewal shall be two hundred dollars.
(c) The department may, upon receipt of an application for athletic training licensure, accompanied by the licensure application fee of one hundred ninety dollars, issue a temporary permit to a person who has met the requirements of subsection (a) of section 20-65j, except that the applicant has not yet sat for or received the results of the athletic training certification examination administered by the Board of
Certification, Inc., or its successor organization. Such temporary permit shall authorize the permittee to practice athletic training under the supervision of a person licensed pursuant to subsection (a) of this section. Such practice

shall be limited to those settings where the licensed supervisor is physically present on the premises and is immediately available to render assistance and supervision, as needed, to the permittee. Such temporary permit shall be valid for a period not to exceed one hundred twenty calendar days after the date of completion of the required course of study in athletic training and shall not be renewable. Such permit shall become void and shall not be reissued in the event that the permittee fails to pass the athletic training certification examination. No permit shall be issued to any person who has previously failed the athletic training certification examination or who is the subject of an unresolved complaint or pending professional disciplinary action. Violation of the restrictions on practice set forth in this section may constitute a basis for denial of licensure as an Athletic Trainer.

Sec. 20-65l. Regulations. Administration within available appropriations. The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the provisions of this chapter. The commissioner shall administer the provisions of this chapter within available appropriations.

Sec. 20-65m. Disciplinary Action. Grounds. The Department of Public Health may take any action set forth in section 19a-17 of the general statutes if a person issued a license pursuant to section 20-65k of the general statutes, as amended by this act, fails to conform to the accepted standards of the Athletic Trainer profession, including, but not limited to, the following: Conviction of a felony; fraud or deceit in the practice of athletic training; illegal, negligent, incompetent or wrongful conduct in professional activities; emotional disorder or mental illness; physical illness including, but not limited to, deterioration through the aging process; abuse or excessive use of drugs, including alcohol, narcotics or chemicals; wilful falsification of entries into any patient record pertaining to athletic training; misrepresentation or concealment of a material fact in the obtaining or reinstatement of an Athletic Trainer license; or violation of any provisions of chapter 375a of the general statutes, or any regulation adopted under said chapter 375a. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if the license holder's physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17 of the general statutes. Notice of any contemplated action under said section 19a-17, the cause of the action and the date of a hearing on the action shall be given and an opportunity for hearing afforded in accordance with the provisions of chapter
54 of the general statutes.

Proposed Changes

Sec. 20-65f. Definitions. As used in this chapter:

(1)"Athletic training" means the application or provision, (A) with the consent and under the direction of a health care provider, of (A) principles, methods and procedures of ATHLETIC INJURY CARE TO INCLUDE (I) CLINICAL EVALUATION AND ASSESSMENT (II) MANAGEMENT AND EMERGENCY CARE, TREATMENT, DISPOSITION AND REHABILITATION (III) THE APPLICATION OF PHYSICAL AGENTS TO INCLUDE HEAT, COLD, LIGHT, ELECTRIC STIMULATION, MANUAL THERAPY TECHNIQUES, AQUATIC THERAPY, SOUND, THERAPEUTIC EXERCISE AND OTHER AGENTS AS PRESCRIBED BY A HEALTH CARE PROVIDER~~ prevention, treatment and rehabilitation of athletic injuries sustained by athletes, (B) appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, light massage, water, electric stimulation, sound, exercise and exercise equipment,~~ (B) ILLNESS RECOGNITION (I) THAT IS ACCOMPANIED BY REFERRAL TO AND (II) MANAGED AT THE DIRECTION OF A HEALTH CARE PROVIDER (C) THE APPLICATION OR PROVISION OF APPROPRIATE PREVENTATIVE AND SUPPORTIVE DEVICES (D) the organization and administration of athletic training programs, (E) education and counseling to athletes, coaches, medical personnel and THE COMMUNITY in the area of the prevention and care of athletic injuries. AND (F) INJURY PREVENTION AND WELLNESS CARE SERVICES THAT ARE DEVELOPED TO ASYMPTOMATIC INDIVIDUALS

For purposes of this subdivision,

"health care provider" means a person licensed to practice medicine or surgery under chapter 370 of the general statutes, chiropractic under chapter 372 of the general statutes, podiatry under chapter 375 of the general statutes or naturopathy under chapter 373 of the general statutes;

(2) "Athletic injury" means any MUSCULOSKELETAL injury sustained AS A result of participation in exercise, sports, games, RECREATIONAL ACTIVITIES OR DUE TO OTHER ACTIVITIES THAT REQUIRE COMPARABLE LEVELS OF STRENGTH, FLEXIBILITY AND AGILITY OCCURING TO A PHYSICALLY ACTIVE INDIVIDUAL;

~~(3) "Athlete"~~ "PHYSICALLY ACTIVE INDIVIDUAL" means any person who is a member of any professional, amateur, school or other sports team, or is a regular participant in sports OR OTHER COMPARABLE activities, ASSOCIATED WITH PARTICIPATION IN EXERCISE, EMPLOYMENT OR RECREATION that require strength, agility, flexibility, range of motion, speed or stamina~~. For purposes of this subdivision, "regular" means not less than three times per week;~~

(3) ILLNESS MEANS ANY DISEASE, DISORDER SICKNESS OF AFFLICTION (A) THAT ARISES FROM OR IS A MANIFESTATION OF AN ATHLETE'S PARTICIPATION IN, OR POST-RECOVERY IN EXERCISE, SPORTS GAMES OR RECREATIONAL ACTIVITIES, OR (B) OTHER CONDITIONS THAT MAY REQUIRE AN IMMEDIATE INTERVENTION BY THE ATHLETIC TRAINER DURING, PRIOR TO OR FOLLOWING AN ATHLETE'S PARTICIPATION IN SUCH ACTIVITIES, UNDER THE CONSENT AND DIRECTION OF A HEALTH CARE PROVIDER, SUCH CONDITIONS MAY INCLUDE, BUT ARE NOT LIMITED TO EMERGENT SITUATIONS RELATED TO CARDIORESPIRATORY, THERMOREGULATION, MUSCULOSKELETAL, NEUROVASCULAR, AND ENDOCRINE SYSTEMS, ILLNESS DOES NOT INCLUDE ANY CONDITION BEYOND THE SCOPE OF EDUCATION OF AN ATHLETIC TRAINER.

(4) "WELLNESS CARE" MEANS SERVICES RELATED TO RISK MANAGEMENT AND INJURY PREVENTION, INCLUDING BIOMECHANICS, CONDITIONING, FLEXIBILITY, NUTRITION, STRENGTH TRAINING AND FITNESS.

(5) "WITH THE CONSENT AND UNDER THE DIRECTION OF A HEALTH CARE PROVIDER" MEANS (A) A WRITTEN PRESCRIPTION FROM A HEALTH CARE PROVDIER SPECIFYING A PLAN OF CARE FOR A MUSCULOSKELETAL INJURY OR ILLNESS OF AN INDIVIDUAL (B) THE ISSUANCE OF WRITTEN STANDING ORDERS THAT ARE FOLLOWED IN THE PRACTICE OF ATHLETIC TRAINING IN THE CARE OF ATHLETES PARTICIPATING IN SPORTS AND GAMES WHILE UNDER THE OVERSIGHT AND DIRECTION OF A HEALTH CARE PROVIDER.

"ATHLETE" means any person who is a member of any professional, amateur, school or other sporting program, or is a regular participant in athletic activity

(4) "WRITTEN Standing Orders" means ~~written~~ protocols, recommendations OR guidelines for treatment and care OF AN ATHLETE"S PARTICIPATION IN PROFESSIONAL, AMATEUR, OR SCHOOL SPORTS OR RECREATIONAL ACTIVITIES THAT ARE (A) furnished and signed by a health care provider specified under subdivision (1) of this section, (B) followed BY AN ATHLETIC TRAINER WHILE UNDER THE CONSENT AND DIRECTION OF A HEALTH CARE PROVIDER, (C) ANNUALLY REVIEWED AND RENEWED BY THE HEALTH CARE PROVIDER AND ATHLETIC TRAINER TO ENSURE QUALITY PATIENT CARE AND (D) PROVIDE FOR AVAILIBILITY OF COMMUNICATION BETWEEN THE HEALTH CARE PROVIDER. WRITTEN STANDING ORDERS SHALL INCLUDE BUT ARE NOT LIMITED TO, (i) DELINEATION OR A PREDETERMINED PLAN FOR EMERGENCY SITUATIONS, (ii) APPROPRIATE TREATMENTS FOR SPECIFIC INJURIES OR OTHER MEDICAL CONDITIONS, (iii) TREATMENT AND MANAGEMENT OF CONCUSSIONS, AND (iv) CONDITIONS NECESSITATING THE IMMEDIATE REFERRAL TO A HEALTH

CARE PROVIDER OF AN ATHLETE OR (v) ANY CONDITION THAT IS BEYOND THE ATHLETIC TRAINER'S SCOPE OF PRACTICE~~. in the practice of athletic training that may include, but not be limited to, (A) appropriate treatments for specific athletic injuries, (B) athletic injuries or other conditions requiring immediate referral to a licensed health care provider, and (C) appropriate conditions for the immediate referral to a licensed health care provider of injured athletes of a specified age or age group.~~

(5) "Commissioner" means the Commissioner of Public Health.

Sec. 20-65g. License Required for practice and use of title. (a) Except as provided in section 20-65i, no person may practice athletic training unless such person is licensed pursuant to section 20-65j. (b) No person may use the title "licensed athletic trainer" or make use of any title, words, letters or abbreviations indicating or implying that such person is licensed to practice athletic training unless such person is licensed pursuant to section 20-65k.

Sec. 20-65h. Referral to licensed health care provider. (a) Each person who practices athletic training under standing orders shall make a written or oral referral to a licensed health care provider of any athlete who has an injury or illness whose symptoms have not improved for a period of four days from the day of onset, or who has any physical or medical condition that would constitute a medical contraindication for athletic training or that may require evaluation or treatment beyond the scope of athletic training. ~~The injuries or conditions requiring a referral under this subsection shall include, but not be limited to, suspected medical emergencies or illnesses, physical or mental illness and significant tissue or neurological pathologies~~.

(b) Each person who practices athletic training, but not under standing orders, SHALL BE LIMITED TO PROVIDING IMMEDIATE INJURY MANAGEMENT AND EMERGENCY CARE ~~may perform initial evaluation and temporary splinting and bracing~~ of any athlete SUFFERING AN ACUTE injury or illness ~~and shall, without delay, make a written or oral referral of such athlete to a licensed health care provider~~. The limitations on the practice of athletic training set forth in this subsection shall not apply in the case of any athlete that is referred to such person by a licensed health care provider, provided such practice shall be limited to the scope of such referral.

Sec. 20-65i. Exceptions to licensing requirement. A license to practice athletic training shall not be required of: (1) A practitioner who is licensed or certified by a state agency and is performing services within the scope of practice for which such person is licensed or certified; (2) a student intern or trainee pursuing a course of study in athletic training, provided the activities of such student intern or trainee are performed under the supervision of a person licensed to practice athletic training and the student intern or trainee is given the title of "athletic trainer intern", or similar designation; (3) a person employed or volunteering as a coach of amateur sports who provides first aid for athletic injuries to athletes being coached by such person; (4) a person who furnishes assistance in an emergency; or (5) a person who acts as an athletic trainer in this state for less than thirty days per calendar year and who is licensed as an athletic trainer by another state or is certified by the Board of Certification, Inc., or its successor organization.

Sec. 20-65j. Qualifications for licensure. Licensure by endorsement. a) Except as provided in subsections (b) and (c) of this section, an applicant for a license to practice athletic training shall have: (1) A baccalaureate OR A GRADUATE degree from a regionally accredited institution of higher education, or from an institution of higher learning located outside of the United States that is legally chartered to grant postsecondary degrees in the country in which such institution is located; and (2) current certification as an athletic trainer by the Board of Certification, Inc. , or its successor organization.

(b) An applicant for licensure to practice athletic training by endorsement shall present evidence satisfactory to the commissioner (1) of licensure or certification as an athletic trainer, or as a person entitled to perform similar services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, and (2) that there is no disciplinary action or unresolved complaint pending against such applicant.

(c) Prior to April 30, 2007, the commissioner shall grant a license as an athletic trainer to any applicant who presents evidence satisfactory to the commissioner of (1) the continuous providing of services as an athletic trainer since October 1, 1979, or (2) certification as an athletic trainer by the Board of Certification, Inc. , or its successor organization.

Sec. 20-65k. License to practice athletic training. Fees. (a) The commissioner shall grant a license to practice athletic training to an applicant who presents evidence satisfactory to the commissioner of having met the requirements of section 20-65j. An application for such license shall be made on a form required by the commissioner. The fee for an initial license under this section shall be one hundred and ninety dollars.

(b) A license to practice athletic training may be renewed in accordance with the provisions of section 19a-88, as amended, provided any licensee applying for license renewal shall maintain certification as an athletic trainer by the Board of Certification, Inc. , or its successor organization. The fee for such renewal shall be two hundred dollars.

(c) The department may, upon receipt of an application for athletic training licensure, accompanied by the licensure application fee of one hundred ninety dollars, issue a temporary permit to a person who has met the requirements of subsection (a) of section 20-65j, except that the applicant has not yet sat for or received the results of the athletic training certification examination administered by the Board of Certification, Inc., or its successor organization. Such temporary permit shall authorize the permittee to practice athletic training under the supervision of a person licensed pursuant to subsection (a) of this section. Such practice shall be limited to those settings where the licensed supervisor is physically present on the premises and is immediately available to render assistance and supervision, as needed, to the permittee. Such temporary permit shall be valid for a period not to exceed one hundred twenty calendar days after the date of completion of the required course of study in athletic training and shall not be renewable. Such permit shall become void and shall not be reissued in the event that the permittee fails to pass the athletic training certification examination. No permit shall be issued to any person who has previously failed the athletic training certification examination or who is the subject of an unresolved complaint or pending professional disciplinary action. Violation of the restrictions on practice set forth in this section may constitute a basis for denial of licensure as an athletic trainer.

Sec. 20-65l. Regulations. Administration within available appropriations. The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the provisions of this chapter. The commissioner shall administer the provisions of this chapter within available appropriations.

Sec. 20-65m. Disciplinary Action. Grounds. The Department of Public Health may take any action set forth in section 19a-17 of the general statutes if a person issued a license pursuant to section 20-65k of the general statutes, as amended by this act, fails to conform to the accepted standards of the athletic trainer profession, including, but not limited to, the following: Conviction of a felony; fraud or deceit in the practice of athletic training; illegal, negligent, incompetent or wrongful conduct in professional activities; emotional disorder or mental illness; physical illness including, but not limited to, deterioration through the aging process; abuse or excessive use of drugs, including alcohol, narcotics or chemicals; wilful falsification of entries into any patient record pertaining to athletic training; misrepresentation or concealment of a material fact in the obtaining or reinstatement of an athletic trainer license; or violation of any provisions of chapter 375a of the general statutes, or any regulation adopted under said chapter

375a. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if the license holder's physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17 of the general statutes. Notice of any contemplated action under said section 19a-17, the cause of the action and the date of a hearing on the action shall be given and an opportunity for hearing afforded in accordance with the provisions of chapter 54 of the general statutes.

Summary of Proposed Changes

Major Change 1: Removal of the term athlete and insertion of the word physically active individual

Section 2 defines an "athletic injury" and uses the term "physically active individual" instead of "athlete" - any injury an athletic trainer will be dealing with is still athletic in nature or comparable to an athletic injury.

Concern has been raised whether an AT can treat a patient that has underlying medical conditions. Based on the proposed language an AT would be working with individuals who have been determined "otherwise healthy by a health care provider."

Additional concern was raised in the 2016 legislative session regarding what a "physically active individual" is. We have therefore, proposed a definition of physically active individual to better determine who these people are and to help address concerns raised.

We have proposed physically active individual in lieu of athlete because:

1. We are the only healthcare profession that does not use the term patient or individual.

2. An athlete is interpreted as someone in a uniform that plays for a team - companies and municipalities in the state who have wanted to hire ATs did not because they were worried about liability

Major Change 2: Removal of a time requirement (3x/wk) in participation of sports and activities, pertaining to those an AT can treat

The time constraint of three times per week in participation of sport or exercise may preclude us from being on the sideline at some youth sporting events. Furthermore, the CT state statute makes CT the only state in the nation with a time constraint in the state statute

Major Change 3: Stricter guidelines as it pertains to standing orders and the ATs direction from a physician

Protecting the public is a #1 priority.

Section 5 clarifies the direction by a health care provider through written prescription or via standing orders. We are NOT primary care providers, nor are we trying to be. ATs work with the "oversight and direction" of a health care provider and thus we do not have and are not asking for direct access.

In order to address concerns raised in the 2016 legislative session standing orders pertains to only athletes (in the most traditional sense) and all other "physically active individuals" require a referral immediately.

Section 6 states that standing orders have to be reviewed at least annually and will have to reflect best practices - we have outlined what needs to be in the standing orders at minimum and we ensure that with in the standing orders it is clear what conditions need immediate referral.

Sec. 20-65h. Addresses major concerns by other professions and also ensures public safety. Anyone seen by an AT regardless of setting who has not improved in 4 days of injury requires immediate referral and those who have medical contraindications outside of an ATs education require a referral.

Major Change 4: Inclusion of the ability of an AT to provide immediate and emergent care in an acute situation without standing orders (i.e. a road race)

ATs deal with critical situations often and in the case where an AT may be working without standing orders an AT can provide immediate and acute care to help individuals until emergency medical services and transport arrive beyond that of the ATs scope.

We have safe guards in place to protect the public and that address concerns of some healthcare groups. ATs work under the direction of a physician and collaborate daily with all types of healthcare providers. ATs work in a variety of settings including: the military, physicians' offices, rehabilitation clinics, hospitals, municipalities, and within industry.

An AT does not replace any other health care provider, rather brings their unique skill set and collaborative nature encompassing a comprehensive wellness team.

CH 6: Education & Training

This chapter outlines all current education, training, examination requirements and relevant certification requirements applicable to the profession of Athletic training

Introduction

Athletic trainers must earn at least a Bachelor's degree from an athletic training program accredited by the Commission on Accreditation of Athletic Training Education (CAATE), the national accrediting body recognized by CHEA. The NATA recently reported that "Athletic training is an academic major or graduate equivalent major … The current minimum entry point into the profession of athletic training is the baccalaureate level, however it was recently decided by the AT Strategic Alliance that the minimum professional degree level will be a master's, a change to be implemented within the next several years." (www.nata.org) Furthermore, it is noted that more than 70 percent of athletic trainers hold at least a master's degree.

The **following programs in Connecticut are currently accredited by CAATE**: Central Connecticut State University, Sacred Heart University, Southern Connecticut State University, Quinnipiac University and the University of Connecticut. All five universities offer the athletic training program at the undergraduate level. All graduates must pass a nationally recognized certification examination sponsored by the Board of Certification Inc. The BOC examination is the primary requirement for state licensure across the United States, including Connecticut. The BOC is accredited by the National Commission for Certifying Agencies (NCCA). The Institute for Credentialing Excellence, which establishes the NCCA standards, also accredits certifying/licensure examinations for the American Academy of Nurse Practitioners Certification Program, American Board for Occupational Health Nurses, and the American Physical Therapy Association.

Once certified, athletic trainers are required to earn a minimum of 50 continuing education credit units every two years. At least 10 of the continuing education units must come from specifically designed programs that focus on evidenced-based practice. The continuing education requirement for athletic trainers exceeds all of the most extensive among the rehabilitative health professions. (See Table)

Profession	Reporting Agency	Required Continuing Education hours	Length of Reporting Period	Average Per Year
Athletic training	BOC	50	2 years	25
Massage Therapy	State	24	4 years	6
Occupational Therapy	State	24	2 years	12
Physical Therapy	State	20	1 year	20
Respiratory Care	State	6	1 year	6
APRN	State	50	2 years	25
RN	State	0	0	0

Prior to sitting for the BOC certification examination, all examinees must successfully complete an accredited entry-level Athletic Training Education Program at the masters or baccalaureate level. Entry-level accreditation is maintained by the Commission on Accreditation of Athletic Training Education (CAATE) which establishes necessary standards. CAATE is sponsored by The American Academy of Family Physicians (AAFP), The American Academy of Pediatrics (AAP), the American Orthopedic Society for Sports Medicine (AOSSM) and the National Athletic Trainers' Association (NATA).

Educationally, all accredited programs align their academic curriculum with the professional competencies established by the National Athletic Trainers' Association Executive Committee on Education (NATA-ECE). All CAATE accredited programs must ensure that they teach students and focus on **all of the competencies** set forth by the NATA-ECE. The appendix in this chapter outlines all of those competencies. A list of these competencies can be found in the Appendix.

The NATA-ECE establishes the minimum requirements or *professional competencies* for a student's professional education and is made of a panel of experts for each of eight clinical practice content areas. These clinical practice content areas include:

- Evidenced- Based Practice
- Prevention and Health Promotion
- Clinical Examination and Assessment
- Acute Care of Injury and Illness
- Therapeutic Interventions
- Psychosocial Strategies and Referral
- Healthcare Administration
- Professional Development and Responsibility

Evidenced-Based Practice

The content area of evidenced-based practice incorporates 14 distinct competencies. The use of evidenced-based practice is currently emphasized throughout the health care system and it is designed to improve patient outcomes. This emphasis is consistent with almost all allied health and medical programs, making athletic training consistent with all similar professions.

Prevention and Health Promotion

ATs have historically been educated to prevent the occurrence or reoccurrence of injury or illness in clients and patients. This piece of the profession makes the athletic trainer a valuable part in preventing workplace injury. Forty-nine (49) specific competencies in the athletic training curriculum are focused on preventing injury and illness, many of which are not included as part of any other allied health profession educational program.

No allied health professional can be considered well-prepared to be involved in wellness education or training without a sound understanding of nutrition. ATs are required to demonstrate proficiency in nutrition and its application in maintaining a healthy lifestyle (Professional Competencies [PC]: PHP-32-47). ATs are expected to educate clients and patients on healthy eating habits across the life spectrum and in different levels of health and recognize the need for referral when education and intervention by professions who are experts in nutrition is warranted. Additionally, ATs are educated on identifying and managing through referrals eating disorders (PC: PHP-46, 47) and issues related to the use/abuse of performance enhancing and recreational drugs (PC: PHP – 48, 49). Four of the five accredited institutions in Connecticut require at least one nutrition course with three of the institutions requiring at least 6 credits in nutrition, including applied nutrition.

In addition, institutions offering athletic training education must instruct their students in the promotion of fitness. The entry-level athletic trainer is expected to perform fitness testing in the areas of body composition, flexibility, muscular strength, power, speed, agility, endurance, posture and ergonomics (PC: PHP-19, 26). The entry-level athletic trainer is educated to assess an individual's readiness for physical activity and then design a fitness program that meets the individual needs of the client and/or patient (PC: PHP-27, PHP-28, PHP-29, PHP-30, PHP-31). The five institutions sponsoring athletic training meet these national requirements through the inclusion of several courses within each of their respective curriculums. All five universities require specific courses in exercise physiology, biomechanics *and* applied courses in strength and conditioning, more than any other allied health care profession.

Additionally, the entry-level athletic trainer receives professional instruction in areas of health and wellness across the lifespan. The entry-level athletic trainer is expected to know and implement techniques to prevent Occupational disease transmission (PC: PHP- 7), and environmental illnesses (PC: PHP-10-13, 18). The entry-level athletic trainer is capable of monitoring blood glucose levels and asthma symptoms to make decisions on participation status and referral (PC: PHP-15, 16). Moreover, the entry-level athletic trainer is expected to understand and observe for conditions that can lead to sudden death during physical activity such as cardiac issues, traumatic brain injury, hyponatremia, exertional sickling, and anaphylactic shock. (PC: PHP 17 a-l). All five Connecticut institutions require essential coursework in medical issues fulfilling this requirement.

As a result, the athletic trainer is well-educated in the area of injury and illness prevention and health promotion. With the need to prevent injury and illness in the workplace or in individuals, the ATs can be a vital component of an overall prevention program. ATs are well-suited to help reduce health care costs and time lost due to injury.

Clinical Examination and Assessment

ATs are educated in the assessment of injuries and chronic conditions. Current educational requirements necessitate the entry-level athletic trainer to identify risk factors that could affect physical activity across the lifespan (PC: CE-3-5). In addition, the athletic trainer is educated on identifying disabilities that may affect the patient/client's ability to perform activity in her/his life (PC: CE-7, 9). As a result the athletic trainer is instructed to identify if a co-morbid condition exists which can adversely affect participation in physical activity and properly refer to another health care professional trained in treating these types of conditions.

The athletic trainer learns the importance of a medical history and the importance of identifying underlying conditions that may necessitate referral (PC: CE-13). As part of athletic training practice, education in acute and emergency care is part of the normal education process. Unlike similar allied health professions, ATs are taught to handle specific emergencies that can occur daily. ATs are taught to provide emergency medical care and can react accordingly.

In learning to perform a clinical examination, entry-level ATs are expected to be educated to perform functional assessments and selective tissue testing techniques. Beyond the orthopedic assessment techniques, the athletic trainer is expected to be proficient in the assessment of basic neurological, respiratory, cardiovascular/circulatory and abdominal injury and pathology (PC: CE 20f-20m). ATs are expected to interpret their findings and determine the nature of the pathology, then manage the conditions as necessary to include referral (PC: CE-21, 22).

Acute Care of Injuries and Illnesses

Athletic training clinical practice involves providing immediate care to individuals with injuries, illnesses and/or potentially life threatening conditions. Therefore, ATs must be proficient in evaluating, identifying and managing these conditions. This athletic training knowledge skill set is unique among similar allied health professions.

Athletic training education includes instruction on dealing with acute life-threatening conditions. The athletic trainer is able to assess vital signs, evaluate the findings and differentiate between normal and abnormal conditions (PC: AC-

6, 7). Based on her/his findings, the entry-level athletic trainer has been educated to manage these conditions with airway adjuncts, CPR/AED, oxygen administration, cervical stabilization devices, spine boards, immobilization devices, asthma inhalers, and lesser therapeutic agents including epi-pens and glucagon injectors. (AC- 8-35). The appendix of this chapter includes position statements published by the NATA regarding Diabetic Emergencies, Disordered Eating, Sport Related Concussion, and Psychosocial Interventions.

ATs are able to identify the signs, intervention techniques and return to participation criteria for various physical conditions. Moreover, ATs are considered some of the foremost experts on concussion and environmental conditions such as hyperthermia. ATs are well-trained to deal with most acute medical conditions.

Therapeutic Interventions

ATs are taught a variety of methods to rehabilitate injuries and conditions. They are instructed on the pathophysiology of the healing process among different age groups and its application to employing treatment techniques (PC: TI-1-5, 7, 8). ATs are educated on treating pain (TI-2, 3). Through knowledge of surgical techniques, education in the pathophysiology of healing and exercise techniques, and considerable clinical experience, ATs are well-educated in the rehabilitation of orthopedic injury (TI-6).

As part of this educational process, the athletic training students are instructed to be able to assess patients in order to identify specific indications and contraindications while devising therapeutic interventions and develop plans for return to participation (TI-11, 12). In conducting therapeutic interventions ATs are expected to be able to employ therapeutic modalities such as ultrasound, electric stimulation, laser, short-wave diathermy and a variety of manual techniques, to facilitate healing, pain reduction and improved mobility. (TI- 13, 14, 15). For more detailed information please see the 5th Edition Education Competencies as outlined by the Professional Education Committee (now the NATA-ECE) n the Appendix of this chapter.

Psychosocial Interventions

ATs are educated in dealing with the emotional needs of their patients and clients. Entry-level ATs are expected to be able to identify patients in need of mental healthcare, including but not limited to disordered eating and other psychological concerns and refer them to the appropriate health professional (PS-12, 13). This is enabled through learning of the various mental health care providers such as psychiatrists, counselors, and social workers (PS-11). Please see Appendix for position statements on Mental Health and Disordered Eating published by the National Athletic Trainers' Association.

The NATA has collaborated with various and multiple health care professions in the creation of position statements and consensus statements outline the best practices in injury and illness care. Some of these position statements can be found in the Appendix of this report and are also available by request.

CH 7: Existing Relationships

This chapter outlines the impact this scope of practice change will have on existing relationships in the healthcare realm

Athletic trainers (ATs) are health care professionals who collaborate with physicians and other health care providers to provide preventative services, emergency care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions. Collaboration between healthcare providers should be the professional norm[1]. Nationally, athletic trainers provide their services to patients and clients, to include athletes, military personnel, performing artists, laborers and other individuals suffering from conditions ***similar to athletic injuries.*** Athletic trainers work under the direction of a healthcare provider as previously defined via standing orders primarily in the

athletic setting. In the case where an athletic trainer does not have standing orders those individuals would be referred to the proper medical provider by the athletic trainer after evaluation.

Athletic training education and preparation fall within these domains: Evidence Based Practice, Prevention and Health Promotion, Clinical Examination and Diagnosis, Acute Care of Injury and Illness, Therapeutic Interventions, Psychosocial Strategies and Referral, Healthcare Administration, and Professional Development and Responsibility.[2] Students wanting to become athletic trainers **must** earn a degree from an accredited athletic training curriculum. Accredited programs include formal instruction in areas such as injury/illness prevention, first aid and emergency care, assessment of injury/illness, human anatomy and physiology, therapeutic modalities, and nutrition. Classroom learning is enhanced through clinical education experiences. More than 70 percent of athletic trainers nationwide hold at least a master's degree.[2] Athletic trainers are required to pass a National Board of Certification[2] examination and obtain a license from the Department of Public Health to practice in the state of Connecticut. Athletic trainers are unique healthcare providers who collaborate with multiple health care professions in order to make up a comprehensive wellness team.

The Connecticut Athletic Trainers' Association has been meeting with and working with multiple groups in order to come to a consensus regarding the scope of practice update. The CATA has met with multiple organizations in an effort to educate those organizations on what athletic trainers do and how we can work together to benefit the citizens of Connecticut.

Finally, overlap among professions, especially in the healthcare arena is necessary and unavoidable. As healthcare evolves so do the healthcare professions. The National Council of State Board of Nursing developed a document concerning scope of practice and legislative considerations. On page 9 of this document it states: "no one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is within one profession's skill set does not mean another profession cannot and should not include it in its own scope of practice."[1]

Physicians

- **Athletic training relationship**: Athletic trainers currently work closely with physicians to provide medical care to their patients. Our current practice act requires that ATs work under standing orders ***or*** through a direct referral of a physician, which *will not change* with the scope of practice change. In fact, the suggested language reaffirms our commitment to the physician / athletic trainer relationship and strengthens standing order requirements. Physician direction, either through the standing orders process or through a direct referral, will provide guidance as to the care of athletes in need of athletic training care. *Patients from settings beyond the athletic realm will require a direct referral from a health provider, who has the expertise to rule out the co-morbidities that may require the individual to be referred to another rehabilitative practitioner.*

- In some cases, athletic trainers are expected to practice without physician direction as in the case of some sporting events for example: weekend jamborees, tournaments and/or road races. The suggested language permits athletic trainers to provide healthcare services including initial evaluation, often in emergent situations, providing acute injury/illness management, and **coordinate the necessary referrals** to ensure the primacy of the health care provider.

  The AT role in physician offices has expanded, as certain physicians have noted the value of having an AT on staff. Hajart, et al.[5] stated that athletic trainers provide value to a medical practice through their

skills in triage, taking patient histories, performing musculoskeletal evaluations, providing instructions on exercise prescription, rehabilitation, and general patient education. Research has indicated the positive impact ATs have in physician productivity by increasing the number of patients seen in orthopedic physician offices by 15-30%..[5,6] In addition to role of athletic trainers in assisting with patient preparation, athletic trainers have been involved with brace fitting and casting. Other athletic trainers have assisted patient care through instruction of home exercise programs and patient education.

- **Revised scope effects**: Changes to the current scope of practice will require athletic trainers to **work more closely with physicians** in terms of standing orders by mandating a more consistent review of physician guidelines and patient care.

Physical Therapists

- **Athletic training relationship**: ATs are employed in a variety of settings working often alongside physical therapists in rehabilitation facilities. The scope of practice for athletic training and physical therapy do overlap to some extent, mostly in the domain of treatment and rehabilitation of musculoskeletal injuries. Often, physical therapy practices provide AT outreach services to many high schools in the state of CT: Companies include but are not limited to, Select Physical Therapy, Eastern Rehabilitation Network, Preneta Physical Therapy and more. The clinic assumes the hiring, benefits, liability etc. of employing the AT, who then provides the service to the contracted secondary school. Often, due to the limited number of ATs at the schools and the extensive amount of athletes, ATs refer their athletes to the clinic for rehabilitative services where they communicate with the physical therapists about the care needed for the athlete in regards to rehabilitation. ATs often work collaboratively with physical therapists following a patients' surgical intervention, providing additional care, beyond what is covered by insurance. Similar to the physical therapists scope of practice, ATs also evaluate the function of and use of therapeutic exercise and rehabilitation of injuries, establish rehabilitation programs, treatment planning, and modality use for the purpose of preventing, correcting, or alleviating an injury. Furthermore, ATs are required to pass a National Board of Certification[2] examination for athletic training and obtain a license from the Department of Public Health to practice in the state of Connecticut. Additionally, athletic trainers must complete continuing education units in order to maintain their certification.
- **NATA and APTA Settlement**: In the past the NATA and American Physical Therapy Association (APTA) have had what is perceived as a "turf battle" due to the overlapping domains in the professions. In 2009 the NATA and APTA reached a settlement regarding the practice of AT and its similarities and differences with physical therapy. Appendix A in this chapter highlights the APTA and NATA settlement. [7]
- It is our intention *to help develop the relationship between the two professions* in the state of Connecticut. As previously mentioned we often work closely and can contribute to the same healthcare team providing excellent care to individuals. We have met with the Connecticut Physical Therapy Association on numerous occasions and voiced our intent to work together to develop a bill and relationship amendable to both professions.
- **Revised scope effects**: Changes to the current scope of practice will allow athletic trainers to practice within the full realm of their domains, both on the field and in the clinic. These changes will help athletic trainers care for patients as part of a comprehensive team of healthcare providers improving

access and enhancing healthcare for Connecticut's citizens. The changes to the scope of practice will in turn increase referrals and generated revenue to Connecticut physical therapy companies.

Nurses

- **Athletic training relationship**: Athletic trainers work with nurses in public and private secondary schools, medical offices, hospitals, and industrial settings. Nurses and athletic trainers collaborate to identify actual or potential health problems, provide supportive and restorative care, and collaborate and implement the total health care regimen. We have me with the Connecticut Nurses Association (CNA) on multiple occasions and understand their concerns and demonstrated that ATs are trained to do the activities outlined in the proposed scope of practice.
- **Revised scope effects**: Changes to the scope of practice should enhance an already existing collaborative relationship in our shared settings and not interfere, inhibit, or alter the current relationship with nurses in the Connecticut.

Workplace Settings

- **Athletic training relationship**: Athletic trainers are officially prevented from serving in this setting. However athletic trainers are being hired to perform in this role, often through physical therapy clinics or companies specializing in preventing workplace injury. These AT professionals assume this role as a 'injury prevention specialist' and do not use their actual title in this employment setting or act as an athletic trainer. They are prevented from using most of their professional skills including providing emergency care to on-the-job injuries.
- **Revised scope effects**: Changes in the scope of practice act may enhance the delivery of preventive medicine to the companies within Connecticut. By expanding the scope of practice to patients and clients beyond the athlete. Both professions can collaborate to provide improved preventive care to Connecticut's industrial workforce. The injury prevention skills of athletic trainers and their educational background in exercise physiology, biomechanics, fitness assessment and weightlifting techniques should complement the skills of Occupational Therapists to decrease injury / illness rates in workers. Consequently, there should be reduced work-time loss, decreased workman's compensation insurance costs, and improved viability of business in the state. Additionally, athletic trainers would be able to use all of their skills to include providing onsite acute injury care in case of emergency until emergency medical services personnel arrive.

Chiropractors

- **Athletic training relationship**: Athletic trainers may be supervised by a chiropractor through the execution of agreed standing orders as per the current scope of practice and Connecticut state law.
- **Revised scope effects**: Changes to the scope of practice should not interfere, inhibit, or alter the current healthcare delivery system. In fact, the suggested language should facilitate the employment of athletic trainers by chiropractors, similar to employment of athletic trainers as physician extenders. An enhanced role of athletic trainers with the chiropractic profession should assist patient outcomes by combining the strengths of both professions.

Dietitian-Nutritionists

- **Athletic training relationship**: Athletic trainers are educated in basic nutrition concepts under the Prevention and Health Promotion domain.[3] This provides the AT with a foundation to provide basic nutrition assessment, give recommendations regarding healthy eating habits, role in nutrition and healing, and identify potential pathologic behaviors/conditions. Athletic trainers often refer patients to nutritionists who are in need of more detailed nutritional assessment or counselling.
- **Revised scope effects**: Changes to the scope of practice should not interfere, inhibit, or alter the current healthcare delivery system.

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CH 8: Economic Impact of Athletic Trainers in the State of Connecticut

This chapter outlines the economic impact the change in the Athletic training scope of practice will have on the state of Connecticut. Outlined throughout is an introduction to Athletic training, Job Settings and Education of Athletic trainers, Connecticut Demographics based on Athletic trainers in the state and Return on Investment Data.

Introduction

The updates to the scope of practice can increase jobs and benefit the overall economy in the State of Connecticut.

The Athletic Trainer as a Healthcare Provider[1]

The American Medical Association (AMA) granted athletic training its official recognition as an allied health profession in 1990. This recognition allowed the accreditation of entry-level academic programs. Following AMA recognition, the American Hospital Association established Uniform Billing codes for athletic training that became effective in 2000. Subsequently, in 2000, the AMA granted Current Procedural Terminology (CPT) codes for athletic

training evaluation and re-evaluation. As with all other health care professionals, ATs may apply for a National Provider Identifier (NPI) number as assigned by the Centers for Medicare & Medicaid Services.

The designations allocated by these professional organizations/governmental agencies acknowledge that ATs fulfill the standards necessary to deliver health care within the accepted scope of practice and educational preparation of the practitioner.

6th edition BOC Role Delineation Study[1] and 5th Edition Competency Highlights[1, 2]

As outlined in previous chapters, candidates for certification as an entry-level athletic trainer must satisfy all the requirements of an Athletic Training Education Program (ATEP) that is accredited by the Commission on Accreditation of Athletic Training Education (CAATE) and hold an undergraduate degree or master's degree from a CAATE-accredited program. These candidates must then demonstrate their competency by passing a national certification examination that is administered by the Board of Certification (BOC).

Scope of Practice Change Request

The changes to the scope of practice will allow ATs to utilize all of their skills, allow ATs to practice in a variety of settings and ultimately increase jobs in Connecticut as well as benefit the overall economy.

ATs work in a multitude of settings nationally which include: [1,3]

- Public and private secondary schools
- Colleges and universities
- Professional sports teams
- Sports medicine clinics
- Health clubs
- Hospitals
- Emergency Departments
- Physicians' Offices
- Public Service Organizations such as the Military
- Corporate and Industrial health programs

Currently in the State of Connecticut

Athletic Training Education

There are 5 accredited Athletic Training Education Programs in the State of Connecticut and many of their students are pursuing their careers outside of the State in order to be able to utilize all of their skills. The 5 institutions include, Central Connecticut State University (CCSU), Quinnipiac University (QU), Sacred Heart University (SHU), Southern Connecticut State University (SCSU), and The University of Connecticut (UConn).

Statistics from CT Universities

UCONN:[4] The University of Connecticut reported graduating 48 students with a Bachelor of Science in athletic training from 2008-2011. Of those 48 students only 1 student remained in the state to pursue a job: thus 98% of their graduating classes are leaving CT to find jobs. All of the other students travel far distances in order to fulfill Graduate Assistantship positions, intern positions and various other positions.

SCSU:[5] Southern Connecticut State University reported graduating 28 students with a Bachelor of Science in athletic training in the past 3 years. Of those 28 students, 35% of them pursued other careers, graduate assistantships, full time jobs and other positions in athletic training outside of the state.

SHU:[6] Sacred Heart University graduated 24 students from 2009-2011 and have also retained some data on where these students have gone and what professional paths they have taken. Of the 24 students; 58% of students pursue a graduate degree in another major, 30% of students leave the state of CT and 12% is unknown.

Current Athletic Training Jobs in Connecticut[,8]

The data being reported below is borrowed from the National Athletic Trainers' Association (NATA) and the CATA. Numbers reported below are those ATs and AT students who are members of the NATA.

Most ATs working in the state of CT are in a traditional setting (for example, high school or college athletics). About 11% of CT's athletic training population is either unemployed or has not reported which setting they are employed. Approximately 4% of ATs are working in non-traditional or emerging settings which conclude that the change in the scope of practice can open more of these non-traditional settings; creating more jobs in the state, reducing health care costs and improving the overall economy.

Non Traditional Settings and the Return on Investment for CT Companies [1,3,8,9,10,11,12,13,14]

Currently the scope of practice for ATs is being interpreted in a manner where ATs cannot practice to their fullest education and training. These settings include: Physical Therapy/Sports Medicine Clinics, Industrial and Corporate Settings, and Physician's Offices. Although there are some ATs in CT working in these settings there are so many more that would employ ATs with the change in the statute.

Physician Office Settings: [9]

The ATs in this setting facilitate cost effective care and improve efficiency of the medical team.

• Decreased patient wait times and improved access to care
• ATs triage minor injuries allowing the physicians and nurses to attend to the more critical patients showing the ATs effectiveness as part of a comprehensive wellness team

Outpatient Rehabilitation [9,10]

According to the demographic data of CT ATs, almost 20% [8] of ATs work in a clinic setting and are not being utilized to their full capacity as they are restricted in the clinic. Connecticut ATs working in a clinic are often contracted out to local high schools and work in a traditional setting. When an AT is contracted for less than a 40-hour work week, the remainder of their time is spent in a clinic. In some situations, clinics utilize athletic trainers to work as aides and assistants to front desk personnel instead of utilizing their full education due to some current restrictions with in the clinical setting. It is well documented[7] that there is a shortage of therapy providers nationwide, resulting in longer wait times for access to care and more chronic illness/ailment as a result:

• ATs provide a cost effective, viable solution to fill that shortage that is straining our healthcare system

• ATs are a resource to provide consumers with the services they need to resume healthy, productive lives and reduce the risk of chronic injury and recurrence

• Demographic trends reflect that the population is living longer and are remaining more active in their later years

• A Bureau of Labor Statistics study showed that injuries related to athletic activities of middle aged adults were the result of 488 million days of restricted work in 2002. [15]

All of these measures aid in cost containment and overall stress on the healthcare system. ATs have demonstrated integral contributions to the healthcare market in this setting.

Athletic Trainers in the Workplace [8]

When working to the fullest extent of their education and training athletic trainers can benefit the workplace greatly as outlined below. The change in the athletic training scope of practice can bring some of the below listed information to fruition for Connecticut.

Benefits of the AT in a workplace setting [9,11,12,13,14]

According to the NATA's national manager for business development, in 2014 five states reported workers compensation carriers who recognize the AT as a healthcare provider. Ohio's workers compensation for instance recognizes athletic trainers as qualified health care providers and reimburses directly for their services.

Concentra's Athletic Health Specialist (WAHS) program employs ATs and Physical Therapists.[11] The company believes that by employing conditioning programs, injury screenings, and health and fitness improvement strategies, its incidence of lost workdays were reduced by more than half and associated workers' compensation costs decreased significantly. [11]

Within the first year of the program: [11]

- WAHS prevented 289 urgent care visits
    - Saving over $900,000 ($3,250 typical cost per case), according to the company's safety manager.

Ergonomics Plus[12] is a company that is focused on workplace injury prevention and hires ATs which they contract to warehouses and industrial corporate companies. Some of their clients include: [12]

- General Electric
- Amazon
- Schneider Electric
- DuPont
- Grainger

The Industrial Athlete, Inc.[13] also hires ATs and reported that their Sports Medicine Model had lower costs (approximately 1/3 that of traditional medicine) yet had higher quality care resulting in better outcomes. The Industrial Athlete provides ATs on site, supervised by corporate management and physician teams, to any industry that is in need of controlling medical costs. They provide companies with: [13]

- Injury Prevention
- On-site Rehabilitation
- On- site emergency care

The Return on Investment of an AT [1,3,9,11,12,13, 14]

- Of companies that kept return on investment (ROI) data, 100 percent reported a positive ROI with more than 80 percent indicating a ROI of $3 or more for every $1 invested.

- More than 85 percent of companies reported that both the number and costs of work-related injuries decreased by at least 25 percent.

- More than 90 percent of respondents indicated employee days away from work decreased by 25 percent or more at their company.

- Almost half of the companies had their emergency room costs reduced by 50 percent or more.
- More than 50 percent of surveyed companies reported a decrease in costs associated with workplace injuries.
- Of these companies, 35 percent reported a decrease in costs of more than 50 percent.

Of the companies that tracked their return on investment: [14]

- 2 (7.7%) reported a ROI of $1
- 3 (1.5%) reported a ROI of $2
- 3 (11.5%) reported a ROI of $3
- 6 (23.1%) reported a ROI of $3 - $5
- 6 (23.1%) reported a ROI of $5 - $7
- 6 (23.1%) reported a ROI of more than $7

Healthcare Costs [14]

Of respondents that followed their healthcare costs:

- 45 percent reported that the athletic trainer made an impact on healthcare costs within 6 months.
- 100 percent reported that the athletic trainer made an impact on healthcare costs within 1 year.

The US Bureau of Labor Statistics [15]

The Bureau of Labor Statistics (BLS) projects a 30 percent increase in athletic training jobs in the next 8 years. The BLS recognizes that ATs can work in multiple settings with multiple types of people, including young children, athletes and the older population. Additionally, the BLS reports that:

> "Insurance and workers' compensation costs have become a concern for many employers and insurance companies, especially in areas where employees are often injured on the job. For example, military bases hire ATs to help train military personnel in how to properly lift items or to create training programs aimed at keeping injury rates down. More insurance companies are recognizing ATs as healthcare providers and are reimbursing the cost of an athletic trainer's services." [15]

Connecticut Business and Industry Association[14]

In 2009 the Connecticut Business and Industry Association (CBIA) reported a survey on CT Companies. They reported the breakdown of companies in CT in 2009 with a projected growth in the next few years:

- 30% manufacturing
- 17% from the service sector
- 15% professional services
- 7% nonprofit associations
- 7% wholesale trade
- 6% construction
- 6% insurance and finance
- 5% retail
- 7% other industry sectors

Judging by the percentages of companies in CT there is a high potential of growth for ATs to help reduce healthcare costs, especially in work related industries such as manufacturing, construction and other industry sectors.

Highlights

- Increased job opportunities will allow graduates of CT's five Athletic training programs to stay in CT. CT has the high percentage of young people leaving the state and we need to keep these bright young adults in the state. State short term occupational projections for athletic training in the state alarmingly include a -.02 change.[17] The updates to the CT state practice act can help turn this number to a positive.
- Due to an ATs skill in biomechanical assessment, OSHA recognizes the athletic trainer as having the skills to function as an ergonomics consultant. [13]
- ATs cannot practice to their fullest potential in CT
- There are many potential jobs to create in CT by utilizing an AT
- Millions of dollars can be saved in companies by using an AT able to practice fully
- Millions of dollars can be saved in healthcare costs due to an ATs specialization in the area of Prevention [2,14]
- Return on Investment: [14]
    - Of companies that kept return on investment (ROI) data, 100 percent reported a positive ROI with more than 80 percent indicating a ROI of $3 or more for every $1 invested.

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CH 9: Healthcare Professions Directly Impacted

This chapter outlines the healthcare professions that will be directly impacted by this scope of practice change. The CATA has the utmost respect for all healthcare professions and hopes the scope of practice update will increase access and healthcare provided to CT residents. The efforts taken by the CATA to meet with and discuss the nature of this change with all the listed parties are outlined below. The CATA looks forward to continued collaboration and discussion with all groups in order to reach a consensus. We feel as though we have addressed many of these concerns with this scope of practice report submission.

Profession	Projected impact on profession	Nature of impact	CATA Efforts
Physicians	• Increased communication • Improved healthcare • Improved collaboration • Improved comprehensive care • Optimization of patient care	Positive	**Orthopedic Society of CT** **2014**: Requested via email with President of Orthopedic Association of CT (2014). GAC Chair spoke with president of association via phone (Sept 2014). A follow up call was made in **Fall of 2015**. **2016:** CATA President communicated with secretary of the association in 2016 regarding scope of practice submission to the Department of Public Health. The Orthopedic Association of CT submitted a neutral letter regarding suggested changes to the CT Athletic Training practice act during the 2016 legislative session.

			Individual Orthopedic Physicians **2014-2015**: CATA met with various orthopedic physicians in 2014 and 2015 regarding the scope summary and proposed language. **2016:** Numerous orthopedic physicians individually submitted letters of support in the 2016 legislative session. **CT State Medical Society** **2014**: Met with Chair of the CT State Medical Society's (CSMS) Committee on the Medical Aspect of Sport in August of 2014. A meeting with the entire CSMS Committee was held in September of 2014 and follow up meetings were held throughout the year and **spring of 2015**. **2016:** The CATA remains an active member of the Committee on the medical aspect of sport and CSMS submitted a letter of support during the 2015 legislative session.
Nurses	• Increased communication • Improved comprehensive care • Improved health care • Optimization of patient care	Positive	**CT APRN Society** **2015**: Met with members of the CT APRN society in June of 2015. The members we met with agreed to review our scope of practice report and provide us with feedback. **2015:** Before submission of the 2015 scope of practice report to the Department of Public Health the CATA sent the report and proposed language changes to the APRN society with no response. **2016:** During the 2016 legislative session the CT APRN society submitted a letter of opposition in regard to the CT athletic training scope of practice. The CATA wrote to the CT APRN Society asking to meet and discuss with littl reciprocation.

			CNA **2015**: The CATA met with the Connecticut Nurses Association multiple times during 2015-2016 and we have heard their concerns and understand them. We are looking forward to continuing to work with them and feel as though we have addressed some of their concerns.
Physical Therapists	• Collaboration of healthcare professionals for the optimization of patient care • Improved comprehensive care for physical medicine and rehabilitation mainly in the area of musculoskeletal injuries • Perceived that ATs would take jobs from PTs "turf battle", however each profession is uniquely trained in overlapping competencies and proficiencies of rehabilitation. • We have done our diligence in meeting with the CPTA and communicating changes and remaining transparent through the past 3 years.	Positive	**2014**: Met on 7/11/14 with Director of Doctor of Physical Therapy Program at the University of Connecticut Met on 7/28/14, with Regional Sports Medicine Director of Select Physical Therapy, the largest outpatient rehabilitation company in CT CATA President and CPTA president met in **Dec of 2014** and a follow up meeting with the new CPTA president followed in **2015**. In **June of 2015** the CATA governmental affairs committee chair and president along with the CATA lobbyist met with CPTA president and lobbyist. The CPTA gave us some suggestions on who they would like us to follow up with in regards to their membership. **2015:** We respected the request of the CPTA and met with 3 of the 4 physical therapy program directors in the state of CT. We highly regarded the suggestions of the program directors and the CPTA and thus in turn changed the term "individual" to "physically active individual" in the **2016** submission of the CT athletic training practice act submission to the Public Health Committee in the 2016 legislative session. We also sent the scope of practice report to the CPTA before submission to DPH in 2015. **2016**: We met with the CPTA in April of 2016 in order to discuss the proposed bill and received their feedback a couple of weeks after our meeting. We asked to discuss their comments and suggestions further with

			no response. We feel as though we have addressed their concerns with this current scope of practice report and proposed language and we look forward to further collaboration.
Occupational Therapists	• Change allows us to better address unhealthy lifestyle behaviors, and allows collaboration if necessary • The impact is seen as neutral (on the part of the CATA) due to the differences in the scope of an athletic trainer and an Occupational Therapist. Occupational Therapist deal with conditions outside of an ATs scope and we recognize this and would refer to the OT appropriately. • An athletic trainer would be seen providing prevention and wellness in the workplace as well as other services in their education and training	Neutral	**2014:** Met with ConnOTA president and governmental affairs chair in November of **2014**. We were able to discuss various aspects of the scope report and better understand each other's positions. A follow up email was sent and received a few weeks post meeting with a synopsis of what was discussed. A follow up email was sent in Aug of **2015** in order to meet and further discuss the scope of practice and specifics. The CATA also sent the scope of practice report to the ConnOTA while submitting to the DPH in **2015**. **2015**: In October the CATA GAC and the legislative chair of the ConnOTA discussed the scope of practice report and suggested changes and the CATA was under the impression the changes were understood. After reading the letter of opposition the CATA reached out again to the ConnOTA, a conference call was held and the CATA received feedback on the proposed bill. It was clear the ConnOTA felt as though ATs do not have the education to do what was proposed despite the conversations we had and the proof of educational competencies. We look forward to further collabortation.
Dietitians-Nutritionists	• We work well with dieticians & Nutritionists, we don't anticipate any changes and will continue to refer to the proper healthcare provider • ATs are educated on the recognition of disordered eating and work with and *refer athletes to nutritionists* when the issue is outside of the scope of an AT	Neutral	

Chiropractors	• Chiropractors will be able to hire ATs in their offices in order to provide care alongside them in turn improving healthcare, increasing communication and collaboration between healthcare providers and improving comprehensive care for CT residents	Positive	Met with the Chiropractic Association in April **2015.** The associations seemed to agree on many of the changes noted in the scope of practice report. **2016:** The CATA reached out to the Chiropractic Association through the groups lobbyists during the 2016 legislative session but no meeting was held.

CH 10: The Ability to Practice to the Full Extent of the Athletic Trainers' Education and Training

The professional domains of athletic training include: (1) injury/illness prevention and wellness, (2) clinical evaluation and assessment, (3) immediate and emergency care, (4) treatment and rehabilitation and (5) organizational and professional health and well-being.[1] As such athletic training stresses the importance of injury prevention. ATs have demonstrated their ability to provide the emergency care on thousands of athletic fields across the nation and have demonstrated success in rehabilitating various injuries and managing illnesses. ATs are recognized nationally for their role in the injury prevention and care of concussions and exertional heat illnesses, among other conditions.

The proposed scope of practice changes will reinforce the standing orders of the AT and the direction they receive from the physician signing those orders. The new language places new requirements on the use of standing orders mandating an annual review and better communication between the athletic trainer and physician. The proposed language better delineates the necessary guidelines that should be included in the standing orders to include concussion management, emergency management and referral. The proposed language requires that a licensed health care provider (e.g., the provider signing standing orders or a prescription for rehabilitative services) determine the patient is free of co-morbidities that would preclude an athletic trainer from providing care to a patient

ATs have traditionally been known for the care of athletic populations including *youth* and interscholastic players to elite professionals. Due to the restricting definition of athlete unique to Connecticut which includes a 3 times per week criteria – athletic trainers' often cannot serve the youth population and recreational athletes who would greatly benefit from their care because some of these individuals do not participate in sport or physical activity three times/week.

Furthermore, the skyrocketing costs of injuries across the United States, [2] have highlighted the value of ATs serving non-athletic populations, especially in workplace and Physical Medicine and Rehabilitation (PM & R) settings. ATs are employed nationally in various industries applying preventive wellness care, onsite injury assessment, treatment, and rehabilitation. ATs are also serving other physically active populations that include the U.S. military, performing arts, law enforcement and firefighters, and members of the general public.[3]

In turn, athletic training education has evolved in response to this growth in patient population. All athletic training students receive extensive education in domains listed in the first paragraph of this chapter and throughout the scope of practice report. ATs are taught to recognize illnesses, and often deal with medical conditions such as asthma, diabetes, concussions, allergic reactions and common illnesses like the flu which are often seen in the athletic population and traditional athletic settings athletic trainers are found in. The education and skill of the athletic trainer is well-adapted to provide care for most sectors of the population.

The requested changes in language will also recognize the existence of pre-professional (entry-level) Master's degree programs in athletic training. Current language recognizes the need for license applicants to have a baccalaureate degree. However, there has been a growth of Master's degree programs in athletic training at the entry-level and all programs will be required to transition to a Master's degree in the near future discussed in Chapter 6. Proposed language will acknowledge the graduates of these programs.

Finally, the proposed scope of practice changes will assist in correcting a typographical error that is present in current licensure law. Presently ATs are restricted to 'light massage'. The original proposed bill called for a comma after light, but was dropped inadvertently during the legislative process. The original intent was to recognize the use of modalities such as lasers (light) in the athletic training setting, as well as massage. Unfortunately, the missing comma allows for "light massage," limiting athletic training practice.

> 1.1. Employment limitations

ATs in Connecticut are significantly limited in the patient and client population that they can care for by the definition of athlete in the current athletic training scope of practice. As previously mentioned CT is the only state that has a definition of athlete with a specific amount of times an individual must participate in activity before they are considered an athlete. Connecticut's regulations are outdated in comparison to many of the more recent legislative acts enacted nationally. As such it is important to update the current scope of practice to reflect the latest trends and the enhanced value of the athletic trainer in serving youth, recreational, and 'non-athletic' but physically active populations. The proposed changes will permit ATs to take a more active role in caring for youth and recreational athletes on the sidelines, in addition to applying preventive techniques, assessment and treatment in work- place settings, effectively reducing health care costs and improving business viability.

The three-day requirement in defining an athlete has an effect on athletic training practice. Several youth sports do not meet three days per week thus, those athletes would be precluded from the care of an athletic trainer. This contrasts the recognition of ATs at the state level for their role in injury prevention and care. Athletic trainers and the Connecticut Athletic Trainers' Association have worked closely with many legislators and athlete safety advocates on issues concerning automatic external defibrillators (AEDs), helped pass one of the first concussion bills in the nation as well as heavily assisted with updating this bill recently, worked on and assisted with the recent passing of the sudden cardiac arrest bill and are constantly working to improve the safety of the Connecticut residents. ATs have been selected by the legislature to serve on a task force to identify best practices in concussion injuries occurring in youth sports, yet may not be allowed to offer their care on the field at the time of injury.

The current scope of practice prevents ATs from providing immediate and rehabilitative care to those individuals who can truly benefit from our expertise. Military, firefighters, industrial workers and even dance companies clearly demonstrate "the strength, agility, flexibility, range of motion, speed or stamina" characterized by the athlete definition in the current licensure laws. However, the requirement of where the individual participates ("regular participant in sports or recreational activities"), and how many times per week they participate, makes these individuals fall outside of the scope of care for ATs, despite a similarity of injury.

Another limitation of the current licensure law is its failure to recognize the role ATs have in dealing with acute and chronic medical conditions. Acute conditions frequently arise and require immediate assistance by the athletic

trainer; these include diabetic emergencies, respiratory issues such as asthma, allergic reactions, seizures and sudden cardiac emergencies. The existing law does not account for such emerging conditions, although the AT has significant education and training in these areas as addressed in Chapter 6, which places the athletic trainer in a potentially difficult situation – choosing to come to the rescue of a person in need versus the state-mandated restriction to care for injuries only. Connecticut statutes recognize a role for the athletic trainer in caring for these emerging conditions, providing for ATs to administer medications such as glucagon, epi-pens and asthma inhalers, but only for ATs employed at a high school.

> 1.2. Places ATs work around the country

Workplace Settings

ATs are employed in locations outside of the 'athletic setting.' One of the fastest areas of professional opportunities is the industrial setting. ATs are hired to develop preventive programs to reduce onsite work injuries and healthcare costs. Zimmerman[7] noted a 54% decrease in workman's compensation claims at a Michigan plant with the introduction of fitness program initiated by trained personnel. NASA and the Kennedy Space Center employ ATs and rehabilitative technicians to develop programs to prevent onsite workplace injury and exercise programs that will help overcome bone and muscle atrophy incurred during space flight. Boeing, Delta Airlines and Kimberly-Clark employ ATs in preventive and on-site injury management roles.[8] Robinette described a program at UPS, using a multidisciplinary team including ATs and ergonomic specialists that provided preventive education, injury intervention and post-rehabilitative expertise.[9] The program significantly reduced healthcare costs by 60%, with an 85% reduction in annual injury rates. AT positions have increased across the United States with companies like Workfit Inc., Welltrail and The Industrial Athlete developing injury prevention programs.

The performing arts have seen a dramatic rise in the employment of ATs. The Radio City Rockettes maintains several ATs on their staff providing acute and rehabilitative care. The Cirque du Soleil and similar acrobatic circuses have ATs serving with their shows. ATs are serving with ballet companies such as the Cincinnati Ballet and multiple dance organizations through the Harkness Center in New York City. ATs also provide care for cast members at Disneyland through an agreement with a local hospital. ATs are becoming commonplace working with our military. The Naval Base in San Diego, houses a sports medicine center which employs ATs. ATs serve in the naval base near Norfolk (VA), Fort Bragg (NC), with the U.S. Army and Marines, and with branches of U.S. Special Forces (e.g., Navy SEALS).

State Licensure Laws

Nationally, several states have given statutory recognition to a larger scope of practice for the athletic trainer, Georgia recognizes the athletic trainer's ability to provide care for an athletic injury that occurs to a person as a result of "any activities requiring physical strength, agility, flexibility, range of motion, speed or stamina without respect to where or how the injury occurs". It should be noted that unlike Connecticut, the patient population is not limited to 'athlete'. Furthermore, Indiana notes the presence of ATs in "a clinic accessible to the general public…" in identifying the need for referrals from a licensed health care professional.

In Michigan, athletic training means "…the clinical evaluation and assessment of an individual for an injury and illness…" not limiting the scope of practice to athletes. Ohio does not mention "athlete" in defining the scope of athletic training. Ohio law defines athletic training as the "practice of prevention, recognition, and assessment of an athletic injury…" Later in the law, athletic injuries are defined as an injury "that affects the individual's participation or performance in sports … or other activity that requires physical strength, agility, speed…" Once again the scope does not require ATs to care only for athletes. Pennsylvania permits an athletic trainer to provide services to a "physically active person under the care of a physician, dentist or podiatrist.

Nebraska recognizes the presence of ATs in an "outpatient medical facility' without identifying a specific patient population. Virginia and Wisconsin permit an athletic trainer to treat an individual incurring 'a substantially similar injury or condition resulting from occupational activity" to include the rehabilitation of these under the direction of a health care provider as previously defined.

Locally, Vermont defines athletic training as "the application of principles and methods of conditioning, the prevention, immediate care, and treatment of athletic or orthopedic injuries within the scope and training." Similar to wording in the proposed Connecticut scope of practice change request, Vermont permits ATs to provide care "to athletes or the physically active who have an athletic or orthopedic injury and have been determined by a physician's examination to be free of an underlying pathology that would affect treatment."

> 1.3. Athletic training Education Programs in the State

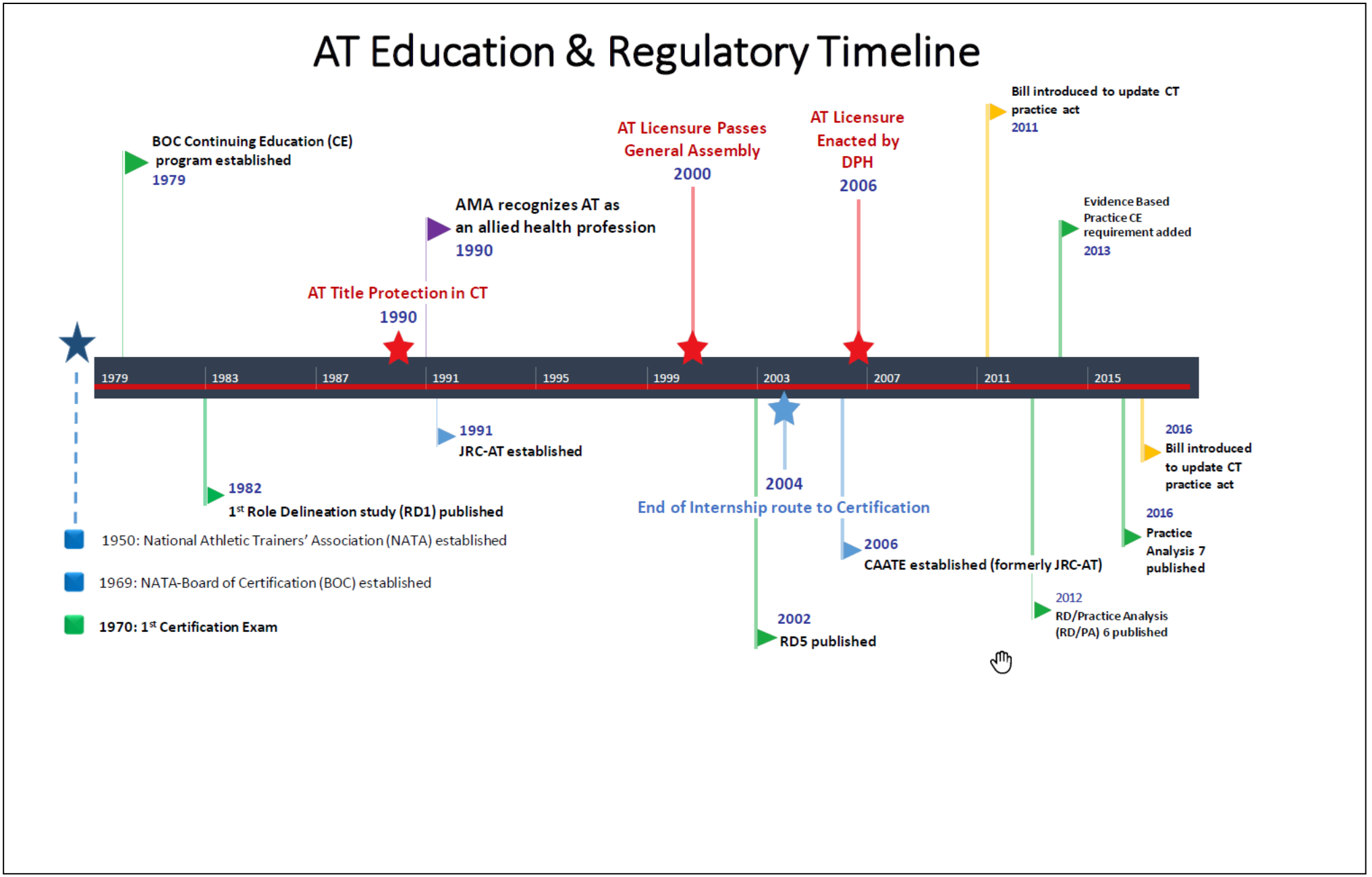
Currently, Connecticut has five undergraduate Athletic training Education Programs as outlined in earlier chapters. The schools include, 3 state schools: Central Connecticut State University, Southern Connecticut State University, and the University of Connecticut and 2 private institutions: Sacred Heart University and Quinnipiac University. Retention statistics can be found in Chapter 9 of this scope of practice report.

References

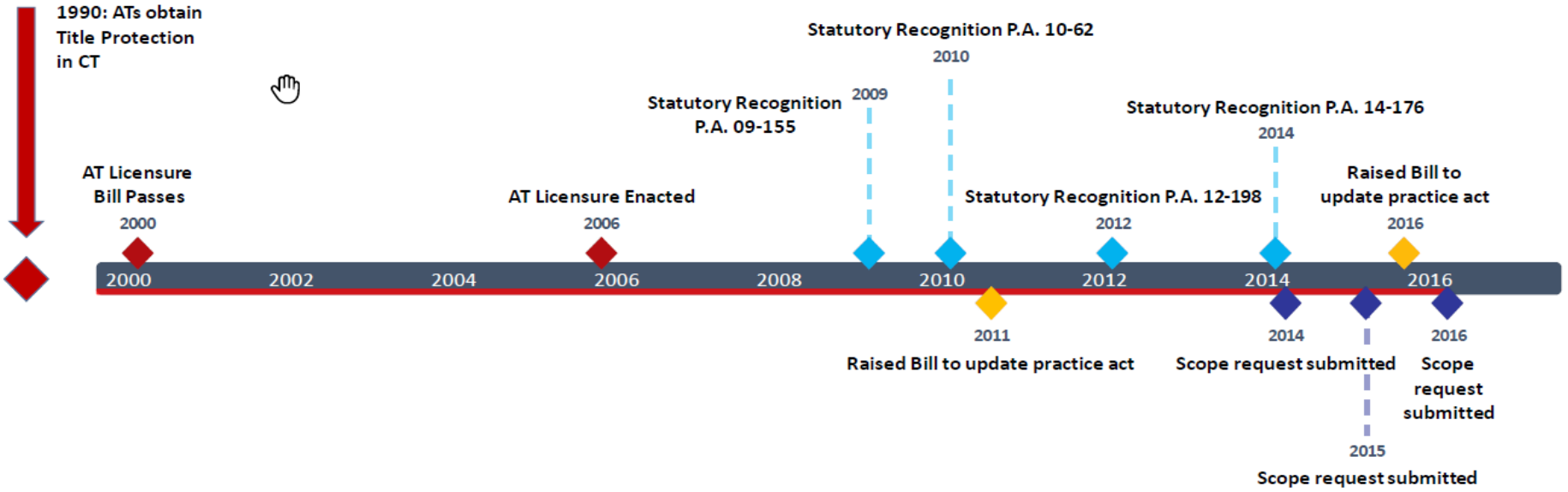
1. Board of Certification, Inc. www.bocatc.org
2. Health Care Cost Institute. www.heatlhcostinstitute.org/about
3. National Athletic Trainers' Association. http://www.nata.org/athletic-training/job-settings
4. CT Statutes: Chapter 169 Sec 10-212a. http://www.cga.ct.gov/2011/pub/chap169.htm#Sec10-212a.htm
5. CT Statutes Chapter 166 10-149c. http://www.cga.ct.gov/2011/pub/chap166.htm#Sec10-149c.htm
6. CT Public Act (2014) PA 14-93. http://www.cga.ct.gov/2014/act/pa/pdf/2014PA-00093-R00SB-00229-PA.pdf.
7. Zimmerman, GR. Industrial Medicine and the Athletic Trainer: Cost-Effectiveness in the Non-traditional Setting. *Journal of Athletic Training.* 1993; (28)3
8. Value Model of the Certified Athletic Trainer in the Workplace Setting. June 23, 2003. Document available upon request.*
9. Robinette, Z. Training the Industrial Athlete: Fitness Training at UPS. Journal of Workplace Health & Safety. 2007; 76: 34-38.

APPENDICIES:

Chapter 1: Timeline of the evolution of athletic training



AT Legislative & Regulatory Timeline



Chapter 6:

This appendix includes a list of position statements relevant to Chapter 6 of the document and highlights some of the education and expertise possessed by athletic trainers.

For a full list of position statements by the NATA please visit: http://www.nata.org/access-read/public/position-statements

1. *Management of Sport Concussion (March 2014)*
2. *Pre-participation Physical Examinations and Disqualifying Conditions (February 2014)*
3. *Conservative Management and Prevention of Ankle Sprains in Athletes (August 2013)*
4. *Lightning Safety for Athletics and Recreation (March 2013)*
5. *Evaluation of Dietary Supplements for Performance Nutrition (February 2013)*
6. *Anabolic-Androgenic Steroids (September 2012)*
7. *National Athletic Trainers' Association Position Statement: Sudden Death in Sport (February 2012)*
8. *National Athletic Trainers' Association Position Statement: Safe Weight Loss and Maintenance Practices in Sport and Exercise (June 2011)*
9. *Pediatric Overuse Injuries (April 2011)*
10. *Preventing, Detecting, and Managing Disordered Eating in Athletes (February 2008)*
11. *Management of the Athlete with Type 1 Diabetes Mellitus (December 2007)*
12. *Management of Asthma in Athletes (September 2005)*
13. *Endorsed by the American Academy of Pediatrics*
14. *Head down contact and spearing in tackle football (March 2004)*
15. *Fluid replacement for athletes (June 2000)*
16. *Exertional heat illnesses (September 2002)*
17. *Emergency planning in athletics (March 2002)*
18. *Environmental Cold Injuries*
19. *Acute Management of the Cervical Spine Injured Athlete*
20. *Skin Disease*

Introduction

This document is to be used as a guide by administrative, academic, and clinical program personnel when structuring all facets of the education experience for students. Educational program personnel should recognize that the Competencies are the ***minimum requirements*** for a student's professional education. Athletic training education programs are encouraged to exceed these minimums to provide their students with the highest quality education possible. In addition, programs should employ innovative, student-centered teaching and learning methodologies to connect the classroom, laboratory and clinical settings whenever possible to further enhance professional preparation.

The acquisition and clinical application of knowledge and skills in an education program must represent a defined yet flexible program of study. Defined in that knowledge and skills must be accounted for in the more formal classroom and laboratory educational experience. Flexible in that learning opportunities are everywhere. Behaviors are identified, discussed, and practiced throughout the educational program. Whatever the sequence of learning, patient safety is of prime importance; students must demonstrate competency in a particular task before using it on a patient. This begins a cycle of learning, feedback, refinement, and more advanced learning. Practice with concepts by gaining clinical experience with real life applications readies the student for opportunities to demonstrate decision-making and skill integration ability, Clinical Integrated Proficiencies (CIP). CIPs are designed to measure of real life application. Students should be assessed in their performance of CIPs on actual patients. If this is not possible, standardized/simulated patients or scenarios should be used to measure student proficiency.

Also, inherent in this document is the understanding that a comprehensive basic and applied science background is needed for students to develop appropriate levels of professional competence in the discipline-specific knowledge and skills described in this document.

All facets of the educational programs must incorporate current knowledge and skills that represent best practice. Programs must select such content following careful review of the research literature and consideration of the needs for today's entry-level practitioner. Because the knowledge within a profession is dynamic, information regarding current best practice is fluid and requires on-going examination and reflection.

Summary of Major Changes included in 5th Edition

- The 12 content areas of the previous edition have been reorganized into 8 to eliminate redundancies and better reflect current practice.
  - The pathology content area was eliminated, and these competencies are addressed throughout other content areas.
  - The risk management/prevention and nutritional considerations content areas were combined to form the new **Prevention and Health Promotion (PHP)** content area. This change was made to reflect the current emphasis on prevention and wellness across health care and the lifespan.
  - The orthopedic clinical exam/assessment and medical conditions/disabilities content areas were combined to form the **Clinical Examination and Assessment (CE)** content area. This change was made to emphasize that athletic trainers use one standard clinical examination model that changes based on the findings and needs of the patient.
  - The therapeutic modalities, conditioning and rehabilitative exercise and pharmacology content areas were combined to form one content area that incorporates all aspects of **Therapeutic Interventions (TI)**.
  - A new content area was added to provide students with the basic knowledge and skills related to **Evidence-Based Practice (EBP).** The importance of using EBP concepts and principles to improve

patient outcomes is being emphasized throughout the health care system and is reflected within this new content area.

- The **Acute Care (AC)** content area has been substantially revised to reflect contemporary practice.
  - The addition of skill in assessing rectal temperature, oxygen saturation, blood glucose levels, and use of a nebulizer and oropharyngeal and nasopharyngeal airways reflects recommendations of NATA position statements that are published or in development.
- The content areas now integrate knowledge and skills, instead of separate sections for cogni- tive and psychomotor competencies. The action verb used in each competency statement identifies the expected outcome. In some places, knowledge is the expectation and not skill acquisition. For example, acute care competency #9 (AC-9) requires that athletic training students be knowledgeable about the various types of airway adjuncts including oropharyn- geal airways (OPA), nasopharyngeal airways (NPO) and supraglottic airways. However, the accompanying skill competency AC-10 does not require skill acquisition in the use of the supraglottic airways.
- The **Clinical Integration Proficiencies (CIP)**, which are ideally assessed in the context of real patient care, have been removed from the individual content areas and reorganized into a separate section. This reorganization reflects clinical practice and demonstrates the global nature of the Proficiencies. For example, rather than just assessing students' ability to examine a real patient in a real clinical setting, the new CIPs require that students demonstrate the ability to examine and diagnose a patient, provide appropriate acute/emergent care, plan and implement appropriate therapeutic interventions, and make decisions pertaining to safe return to participation. This approach to student assessment better reflects the comprehensive nature of real patient care.

Comparison of the Role Delineation Study/Practice Analysis, 6th Ed and the Competencies

The Role Delineation Study/Practice Analysis, 6th ed (RDS/PA) of the Board of Certification serves as the blue print for the certification examination. As such, the Competencies must include all tasks (and related knowledge and skills) included in the RDS/PA. Working with the BOC, we compared the RDS/PA with this version of the Competencies and can confidently state that the content of the RDS /PA is incorporated in this version.

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Foundational Behaviors of Professional Practice

These basic behaviors permeate professional practice and should be incorporated into instruction and assessed throughout the educational program.

Primacy of the Patient

- Recognize sources of conflict of interest that can impact the client's/patient's health.
- Know and apply the commonly accepted standards for patient confidentiality.
- Provide the best healthcare available for the client/patient.
- Advocate for the needs of the client/patient.

Team Approach to Practice

- Recognize the unique skills and abilities of other healthcare professionals.
- Understand the scope of practice of other healthcare professionals.
- Execute duties within the identified scope of practice for athletic trainers.
- Include the patient (and family, where appropriate) in the decision-making process.
- Work with others in effecting positive patient outcomes.

Legal Practice

- Practice athletic training in a legally competent manner.
- Identify and conform to the laws that govern athletic training.
- Understand the consequences of violating the laws that govern athletic training.

Ethical Practice

- Comply with the NATA's *Code of Ethics* and the BOC's *Standards of Professional Practice*.
- Understand the consequences of violating the NATA's *Code of Ethics* and BOC's *Standards of Professional Practice*.
- Comply with other codes of ethics, as applicable.

Advancing Knowledge

- Critically examine the body of knowledge in athletic training and related fields.
- Use evidence-based practice as a foundation for the delivery of care.
- Appreciate the connection between continuing education and the improvement of athletic training practice.
- Promote the value of research and scholarship in athletic training.
- Disseminate new knowledge in athletic training to fellow athletic trainers, clients/patients, other healthcare professionals, and others as necessary.

Cultural Competence

- Demonstrate awareness of the impact that clients'/patients' cultural differences have on their attitudes and behaviors toward healthcare.
- Demonstrate knowledge, attitudes, behaviors, and skills necessary to achieve optimal health outcomes for diverse patient populations.
- Work respectfully and effectively with diverse populations and in a diverse work environment.

Professionalism

- Advocate for the profession.
- Demonstrate honesty and integrity.
- Exhibit compassion and empathy.
- Demonstrate effective interpersonal communication skills.

Evidence-Based Practice (EBP)

Evidence-based practitioners incorporate the best available evidence, their clinical skills, and the needs of the patient to maximize patient outcomes. An understanding of evidence-based practice concepts and their application is essential to sound clinical decision-making and the critical exam- ination of athletic training practice.

Practicing in an evidence-based manner should not be confused with conducting research. While conducting research is important to the profession of athletic training, developing the abil- ity to conduct a research project is not an expectation of professional education. This section fo- cuses on the knowledge and skills necessary for entry-level athletic trainers to use a systematic approach to ask and answer clinically relevant questions that affect patient care by using review and application of existing research evidence. One strategy, among others, is to use a five-step approach: 1) creating a clinically relevant question; 2) searching for the best evidence; 3) critically analyzing the

evidence; 4) integrating the appraisal with personal clinical expertise and patients' preferences; and 5) evaluating the performance or outcomes of the actions. Each competency listed below is related to such a systematic approach and provides the building blocks for em- ploying evidence-based practice. Other specific evidence-based practice competencies have also been included in appropriate content areas.

All items listed in parentheses (eg) are intended to serve as examples and are not all encompassing or the only way to satisfy the competency.

Knowledge and Skills

EBP-1. Define evidence-based practice as it relates to athletic training clinical practice.

EBP-2. Explain the role of evidence in the clinical decision making process.

EBP-3. Describe and differentiate the types of quantitative and qualitative research, research components, and levels of research evidence.

EBP-4. Describe a systematic approach (eg, five step approach) to create and answer a clinical question through review and application of existing research.

EBP-5. Develop a relevant clinical question using a pre-defined question format (eg, PICO= Patients, Intervention, Comparison, Outcomes; PIO = Patients, Intervention, Outcomes).

EBP-6. Describe and contrast research and literature resources including databases and online critical appraisal libraries that can be used for conducting clinically-relevant searches.

EBP-7. Conduct a literature search using a clinical question relevant to athletic training practice using search techniques (eg, Boolean search, Medical Subject Headings) and resources appropriate for a specific clinical question.

EBP-8. Describe the differences between narrative reviews, systematic reviews, and meta- analyses.

EBP-9. Use standard criteria or developed scales (eg, Physiotherapy Evidence Database Scale [PEDro], Oxford Centre for Evidence Based Medicine Scale) to critically appraise the structure, rigor, and overall quality of research studies.

EBP-10. Determine the effectiveness and efficacy of an athletic training intervention utilizing evidence-based practice concepts.

EBP-11. Explain the theoretical foundation of clinical outcomes assessment (eg, disablement, health-related quality of life) and describe common methods of outcomes assessment in athletic training clinical practice (generic, disease-specific, region-specific, and dimension-specific outcomes instruments).

EBP-12. Describe the types of outcomes measures for clinical practice (patient-based and clinician-based) as well as types of evidence that are gathered through outcomes assessment (patient-oriented evidence versus disease-oriented evidence).

EBP-13. Understand the methods of assessing patient status and progress (eg, global rating of change, minimal clinically important difference, minimal detectable difference) with clinical outcomes assessments.

EBP-14. Apply and interpret clinical outcomes to assess patient status, progress, and change using psychometrically sound outcome instruments.

Prevention and Health Promotion (PHP)

Athletic trainers develop and implement strategies and programs to prevent the incidence and/or severity of injuries and illnesses and optimize their clients'/patients' overall health and qual- ity of life. These strategies and programs also incorporate the importance of nutrition and physical activity in maintaining a healthy lifestyle and in preventing chronic disease (eg, diabetes, obesity, cardiovascular disease).

Knowledge and Skills

General Prevention Principles

PHP-1. Describe the concepts (eg, case definitions, incidence versus prevalence, exposure assessment, rates) and uses of injury and illness surveillance relevant to athletic training.
PHP-2. Identify and describe measures used to monitor injury prevention strategies (eg, injury rates and risks, relative risks, odds ratios, risk differences, numbers needed to treat/harm).
PHP-3. Identify modifiable/non-modifiable risk factors and mechanisms for injury and illness.

PHP-4. Explain how the effectiveness of a prevention strategy can be assessed using clinical outcomes, surveillance, or evaluation data.
PHP-5. Explain the precautions and risk factors associated with physical activity in persons with common congenital and acquired abnormalities, disabilities, and diseases.
PHP-6. Summarize the epidemiology data related to the risk of injury and illness associated with participation in physical activity.

Prevention Strategies and Procedures

PHP-7. Implement disinfectant procedures to prevent the spread of infectious diseases and to comply with Occupational Safety and Health Administration (OSHA) and other federal regulations.
PHP-8. Identify the necessary components to include in a preparticipation physical examination as recommended by contemporary guidelines (eg, American Heart Association, American Academy of Pediatrics Council on Sports Medicine & Fitness).
PHP-9. Explain the role of the preparticipation physical exam in identifying conditions that might predispose the athlete to injury or illness.
PHP-10. Explain the principles of the body's thermoregulatory mechanisms as they relate to heat gain and heat loss.
PHP-11. Explain the principles of environmental illness prevention programs to include acclimation and conditioning, fluid and electrolyte replacement requirements, proper practice and competition attire, hydration status, and environmental assessment (eg, sling psychrometer, wet bulb globe temperatures [WBGT], heat index guidelines).
PHP-12. Summarize current practice guidelines related to physical activity during extreme weather conditions (eg, heat, cold, lightning, wind).
PHP-13. Obtain and interpret environmental data (web bulb globe temperature [WBGT], sling psychrometer, lightning detection devices) to make clinical decisions regarding the scheduling, type, and duration of physical activity.
PHP-14. Assess weight loss and hydration status using weight charts, urine color charts, or specific gravity measurements to determine an individual's ability to participate in physical activity in a hot, humid environment.
PHP-15. Use a glucometer to monitor blood glucose levels, determine participation status, and make referral decisions.
PHP-16. Use a peak-flow meter to monitor a patient's asthma symptoms, determine participation status, and make referral decisions.
PHP-17. Explain the etiology and prevention guidelines associated with the leading causes of sudden death during physical activity, including but not limited to:
PHP-17a. Cardiac arrhythmia or arrest

PHP-17b. Asthma

PHP-17c. Traumatic brain injury

PHP-17d. Exertional heat stroke

PHP-17e. Hyponatremia

PHP-17f. Exertional sickling

PHP-17g. Anaphylactic shock

PHP-17h. Cervical spine injury

PHP-17i. Lightning strike

PHP-18. Explain strategies for communicating with coaches, athletes, parents, administrators, and other relevant personnel regarding potentially dangerous conditions related to the environment, field, or playing surfaces.

PHP-19. Instruct clients/patients in the basic principles of ergodynamics and their relationship to the prevention of illness and injury.

Protective Equipment and Prophylactic Procedures

PHP-20. Summarize the basic principles associated with the design, construction, fit, maintenance, and reconditioning of protective equipment, including the rules and regulations established by the associations that govern its use.

PHP-21. Summarize the principles and concepts related to the fabrication, modification, and appropriate application or use of orthotics and other dynamic and static splints.

PHP-22. Fit standard protective equipment following manufacturers' guidelines.

PHP-23. Apply preventive taping and wrapping procedures, splints, braces, and other special protective devices.

Fitness/Wellness

PHP-24. Summarize the general principles of health maintenance and personal hygiene, including skin care, dental hygiene, sanitation, immunizations, avoidance of infectious and contagious diseases, diet, rest, exercise, and weight control.

PHP-25. Describe the role of exercise in maintaining a healthy lifestyle and preventing chronic disease.

PHP-26. Identify and describe the standard tests, test equipment, and testing protocols that are used for measuring fitness, body composition, posture, flexibility, muscular strength, power, speed, agility, and endurance.

PHP-27. Compare and contrast the various types of flexibility, strength training, and cardiovas- cular conditioning programs to include expected outcomes, safety precautions, hazards, and contraindications.

PHP-28. Administer and interpret fitness tests to assess a client's/patient's physical status and readiness for physical activity.

PHP-29. Explain the basic concepts and practice of fitness and wellness screening.

PHP-30. Design a fitness program to meet the individual needs of a client/patient based on the results of standard fitness assessments and wellness screening.

PHP-31. Instruct a client/patient regarding fitness exercises and the use of muscle strengthening equipment to include correction or modification of inappropriate, unsafe, or danger- ous lifting techniques.

General Nutrition Concepts

PHP-32. Describe the role of nutrition in enhancing performance, preventing injury or illness, and maintaining a healthy lifestyle.

PHP-33. Educate clients/patients on the importance of healthy eating, regular exercise, and general preventative strategies for improving or maintaining health and quality of life.

PHP-34. Describe contemporary nutritional intake recommendations and explain how these recommendations can be used in performing a basic dietary analysis and providing appropriate general dietary recommendations.

PHP-35. Describe the proper intake, sources of, and effects of micro- and macronutrients on performance, health, and disease.
PHP-36. Describe current guidelines for proper hydration and explain the consequences of improper fluid/electrolyte replacement.
PHP-37. Identify, analyze, and utilize the essential components of food labels to determine the content, quality, and appropriateness of food products.
PHP-38. Describe nutritional principles that apply to tissue growth and repair.

PHP-39. Describe changes in dietary requirements that occur as a result of changes in an individual's health, age, and activity level.
PHP-40. Explain the physiologic principles and time factors associated with the design and planning of pre-activity and recovery meals/snacks and hydration practices.
PHP-41. Identify the foods and fluids that are most appropriate for pre-activity, activity, and recovery meals/snacks.

Weight Management and Body Composition

PHP-42. Explain how changes in the type and intensity of physical activity influence the energy and nutritional demands placed on the client/patient.
PHP-43. Describe the principles and methods of body composition assessment to assess a client's/patient's health status and to monitor changes related to weight management, strength training, injury, disordered eating, menstrual status, and/or bone density status.
PHP-44. Assess body composition by validated techniques.

PHP-45. Describe contemporary weight management methods and strategies needed to support activities of daily life and physical activity.

Disordered Eating and Eating Disorders

PHP-46. Identify and describe the signs, symptoms, physiological, and psychological responses of clients/patients with disordered eating or eating disorders.
PHP-47. Describe the method of appropriate management and referral for clients/patients with disordered eating or eating disorders in a manner consistent with current practice guidelines.

Performance Enhancing and Recreational Supplements and Drugs

PHP-48. Explain the known usage patterns, general effects, and short- and long-term adverse effects for the commonly used dietary supplements, performance enhancing drugs, and recreational drugs.
PHP-49. Identify which therapeutic drugs, supplements, and performance-enhancing substances are banned by sport and/or occupational organizations in order to properly advise clients/patients about possible disqualification and other consequences.

Clinical Examination and Assessment (CE)

Athletic trainers must possess strong clinical examination skills in order to accurately assessment and effectively treat their patients. The clinical examination is an on-going process, repeated to some extent each time the patient is treated. The development of these skills requires a thorough understanding of anatomy, physiology, and biomechanics. Athletic trainers must also apply clini- cal-reasoning skills throughout the physical examination process in order to assimilate data, select the appropriate assessment tests, and formulate a differential assessment.

The competencies identified in this section should be considered in the context of the compe- tencies identified in other domains. For example, the knowledge and skills associated with acute care and therapeutic interventions, while applicable for this domain, are not repeated here.

The clinical examination process is comprehensive and may include a review of the systems and regions identified below based on the patient's relevant history and examination findings. Con- sideration must also be given to the

patient's behavioral and cognitive status and history; competencies addressing this content area are included elsewhere.

Systems and Regions

a. Musculoskeletal
b. Integumentary
c. Neurological
d. Cardiovascular
e. Endocrine
f. Pulmonary
g. Gastrointestinal
h. Hepatobiliary
i. Immune
j. Renal and urogenital
k. The face, including maxillofacial region and mouth
l. Eye, ear, nose, and throat

Knowledge and Skills

CE-1. Describe the normal structures and interrelated functions of the body systems.

CE-2. Describe the normal anatomical, systemic, and physiological changes associated with the lifespan.

CE-3. Identify the common congenital and acquired risk factors and causes of musculoskeletal injuries and common illnesses that may influence physical activity in pediatric, adolescent, adult, and aging populations.

CE-4. Describe the principles and concepts of body movement, including normal osteokinematics and arthrokinematics.

CE-5. Describe the influence of pathomechanics on function.

CE-6. Describe the basic principles of diagnostic imaging and testing and their role in the diagnostic process.

CE-7. Identify the patient's participation restrictions (disabilities) and activity limitations (functional limitations) to determine the impact of the condition on the patient's life.

CE-8. Explain the role and importance of functional outcome measures in clinical practice and patient health-related quality of life.

CE-9. Identify functional and patient-centered quality of life outcome measures appropriate for use in athletic training practice.

CE-10. Explain diagnostic accuracy concepts including reliability, sensitivity, specificity, likelihood ratios, prediction values, and pre-test and post-test probabilities in the selection and interpretation of physical examination and diagnostic procedures.

CE-11. Explain the creation of clinical prediction rules in the assessment and prognosis of various clinical conditions.

CE-12. Apply clinical prediction rules (eg, Ottawa Ankle Rules) during clinical examination procedures.

CE-13. Obtain a thorough medical history that includes the pertinent past medical history, underlying systemic disease, use of medications, the patient's perceived pain, and the history and course of the present condition.

CE-14. Differentiate between an initial injury evaluation and follow-up/reassessment as a means to evaluate the efficacy of the patient's treatment/rehabilitation program, and make modifications to the patient's program as needed.

CE-15. Demonstrate the ability to modify the diagnostic examination process according to the demands of the situation and patient responses.

CE-16. Recognize the signs and symptoms of catastrophic and emergent conditions and demonstrate appropriate referral decisions.

CE-17. Use clinical reasoning skills to formulate an appropriate clinical assessment for common illness/disease and orthopedic injuries/conditions.

CE-18. Incorporate the concept of differential assessment into the examination process.

CE-19. Determine criteria and make decisions regarding return to activity and/or sports participation based on the patient's current status.

CE-20. Use standard techniques and procedures for the clinical examination of common injuries, conditions, illnesses, and diseases including, but not limited to:

CE-20a. history taking

CE-20b. inspection/observation

CE-20c. palpation

CE-20d. functional assessment

CE-20e. selective tissue testing techniques / special tests

CE-20f. neurological assessments (sensory, motor, reflexes, balance, cognitive function)

CE-20g. respiratory assessments (auscultation, percussion, respirations, peak-flow)

CE-20h. circulatory assessments (pulse, blood pressure, auscultation)

CE-20i. abdominal assessments (percussion, palpation, auscultation)

CE-20j. other clinical assessments (otoscope, urinalysis, glucometer, temperature, opthalmoscope)

CE-21. Assess and interpret findings from a physical examination that is based on the patient's clinical presentation. This exam can include:

CE-21a. Assessment of posture, gait, and movement patterns

CE-21b. Palpation

CE-21c. Muscle function assessment

CE-21d. Assessment of quantity and quality of osteokinematic joint motion

CE-21e. Capsular and ligamentous stress testing

CE-21f. Joint play (arthrokinematics)

CE-21g. Selective tissue examination techniques / special tests

CE-21h. Neurologic function (sensory, motor, reflexes, balance, cognition)

CE-21i. Cardiovascular function (including differentiation between normal and abnormal heart sounds, blood pressure, and heart rate)

CE-21j. Pulmonary function (including differentiation between normal breath sounds, percussion sounds, number and characteristics of respirations, peak expiratory flow)

CE-21k. Gastrointestinal function (including differentiation between normal and abnormal bowel sounds)

CE-21l. Genitourinary function (urinalysis)

CE-21m. Ocular function (vision, ophthalmoscope)

CE-21n. Function of the ear, nose, and throat (including otoscopic evaluation)

CE-21o. Dermatological assessment

CE-21p. Other assessments (glucometer, temperature)

CE-22. Determine when the findings of an examination warrant referral of the patient.

CE-23. Describe current setting-specific (eg, high school, college) and activity-specific rules and guidelines for managing injuries and illnesses.

Acute Care of Injuries and Illnesses (AC)

Athletic trainers are often present when injuries or other acute conditions occur or are the first healthcare professionals to evaluate a patient. For this reason, athletic trainers must be knowledgeable and skilled in the evaluation and immediate management of acute injuries and illnesses.

The competencies identified in this section should be considered in the context of the competencies identified in other domains. For example, the knowledge and skills associated with the process of examination and documentation, while applicable for this domain, are not repeated here. Likewise, the knowledge and skills associated with the administrative and risk management aspects of planning for an emergency injury/illness situation are not repeated here.

Knowledge and Skills

Planning

AC-1. Explain the legal, moral, and ethical parameters that define the athletic trainer's scope of acute and emergency care.

AC-2. Differentiate the roles and responsibilities of the athletic trainer from other pre-hospital care and hospital-based providers, including emergency medical technicians/ paramedics, nurses, physician assistants, and physicians.

AC-3. Describe the hospital trauma level system and its role in the transportation decision-making process.

Examination

AC-4. Demonstrate the ability to perform scene, primary, and secondary surveys.

AC-5. Obtain a medical history appropriate for the patient's ability to respond.

AC-6. When appropriate, obtain and monitor signs of basic body functions including pulse, blood pressure, respiration, pulse oximetry, pain, and core temperature. Relate changes in vital signs to the patient's status.

AC-7. Differentiate between normal and abnormal physical findings (eg, pulse, blood pressure, heart and lung sounds, oxygen saturation, pain, core temperature) and the associated pathophysiology.

Immediate Emergent Management

AC-8. Explain the indications, guidelines, proper techniques, and necessary supplies for removing equipment and clothing in order to access the airway, evaluate and/or stabilize an athlete's injured body part.

AC-9. Differentiate the types of airway adjuncts (oropharygneal airways [OPA], nasopharyngeal airways [NPA] and supraglottic airways [King LT-D or Combitube]) and their use in maintaining a patent airway in adult respiratory and/or cardiac arrest.

AC-10. Establish and maintain an airway, including the use of oro- and nasopharygneal airways, and neutral spine alignment in an athlete with a suspected spine injury who may be wearing shoulder pads, a helmet with and without a face guard, or other protective equipment.

AC-11. Determine when suction for airway maintenance is indicated and use according to accepted practice

protocols.

AC-12. Identify cases when rescue breathing, CPR, and/or AED use is indicated according to current accepted practice protocols.

AC-13. Utilize an automated external defibrillator (AED) according to current accepted practice protocols.

AC-14. Perform one- and two- person CPR on an infant, child and adult.

AC-15. Utilize a bag valve and pocket mask on a child and adult using supplemental oxygen.

AC-16. Explain the indications, application, and treatment parameters for supplemental oxygen administration for emergency situations.

AC-17. Administer supplemental oxygen with adjuncts (eg, non-rebreather mask, nasal cannula).

AC-18. Assess oxygen saturation using a pulse oximeter and interpret the results to guide decision making.

AC-19. Explain the proper procedures for managing external hemorrhage (eg, direct pressure, pressure points, tourniquets) and the rationale for use of each.

AC-20. Select and use the appropriate procedure for managing external hemorrhage.

AC-21. Explain aseptic or sterile techniques, approved sanitation methods, and universal precautions used in the cleaning, closure, and dressing of wounds.

AC-22. Select and use appropriate procedures for the cleaning, closure, and dressing of wounds, identifying when referral is necessary.

AC-23. Use cervical stabilization devices and techniques that are appropriate to the circumstances of an injury.

AC-24. Demonstrate proper positioning and immobilization of a patient with a suspected spinal cord injury.

AC-25. Perform patient transfer techniques for suspected head and spine injuries utilizing supine log roll, prone log roll with push, prone log roll with pull, and lift-and-slide techniques.

AC-26. Select the appropriate spine board, including long board or short board, and use appropriate immobilization techniques based on the circumstance of the patient's injury.

AC-27. Explain the role of core body temperature in differentiating between exertional heat stroke, hyponatremia, and head injury.

AC-28. Differentiate the different methods for assessing core body temperature.

AC-29. Assess core body temperature using a rectal probe.

AC-30. Explain the role of rapid full body cooling in the emergency management of exertional heat stroke.

AC-31. Assist the patient in the use of a nebulizer treatment for an asthmatic attack.

AC-32. Determine when use of a metered-dose inhaler is warranted based on a patient's condition.

AC-33. Instruct a patient in the use of a meter-dosed inhaler in the presence of asthma- related bronchospasm.

AC-34. Explain the importance of monitoring a patient following a head injury, including the role of obtaining clearance from a physician before further patient participation.

AC-35. Demonstrate the use of an auto-injectable epinephrine in the management of allergic anaphylaxis. Decide when auto-injectable epinephrine use is warranted based on a patient's condition.

AC-36. Identify the signs, symptoms, interventions and, when appropriate, the return-to-participation criteria for:

AC-36a. sudden cardiac arrest

AC-36b. brain injury including concussion, subdural and epidural hematomas, second impact syndrome and skull fracture

AC-36c. cervical, thoracic, and lumbar spine trauma
AC-36d. heat illness including heat cramps, heat exhaustion, exertional heat stroke, and hyponatremia
AC-36e. exertional sickling associated with sickle cell trait
AC-36f. rhabdomyolysis

AC-36g. internal hemorrhage

AC-36h. diabetic emergencies including hypoglycemia and ketoacidosis
AC-36i. asthma attacks

AC-36j. systemic allergic reaction, including anaphylactic shock
AC-36k. epileptic and non-epileptic seizures
AC-36l. shock

AC-36m. hypothermia, frostbite **AC-36n.** toxic drug overdoses **AC-36o.** local allergic reaction

Immediate Musculoskeletal Management

AC-37. Select and apply appropriate splinting material to stabilize an injured body area.

AC-38. Apply appropriate immediate treatment to protect the injured area and minimize the effects of hypoxic and enzymatic injury.
AC-39. Select and implement the appropriate ambulatory aid based on the patient's injury and activity and participation restrictions.

Transportation

AC-40. Determine the proper transportation technique based on the patient's condition and findings of the immediate examination.
AC-41. Identify the criteria used in the decision-making process to transport the injured patient for further medical examination.
AC-42. Select and use the appropriate short-distance transportation methods, such as the log roll or lift and slide, for an injured patient in different situations.

Education

AC-36. Instruct the patient in home care and self-treatment plans for acute conditions.

Therapeutic Interventions (TI)

Athletic trainers assess the patient's status using clinician- and patient-oriented outcome measures. Based on this assessment and with consideration of the stage of healing and goals, a therapeutic intervention is designed to maximize the patient's participation and health-related quality of life.

A broad range of interventions, methods, techniques, equipment, activities using body movement, and medications are incorporated into this domain. These interventions are designed to enhance function by identifying, remediating, and preventing impairments and activity restrictions (functional limitations) to maximize participation. Rehabilitation is conducted in a wide variety of settings (eg, aquatic, clinic) with basic and contemporary equipment/modalities and on a wide range of patients with respect to age, overall health, and desired level of activity. Therapeutic interventions also include the use of prescription and nonprescription medications. For this reason, the athletic trainer needs to be knowledgeable about common prescription and nonprescription drug indications, adverse reactions, and interactions.

The competencies identified in this section should be considered in the context of the competencies identified in other content areas. For example, the knowledge and skills associated with the process of examination and

documentation, while applicable for this content area, are not in- cluded here.

Therapeutic interventions include:

- Techniques to reduce pain
- Techniques to limit edema
- Techniques to restore joint mobility
- Techniques to restore muscle extensibility
- Techniques to restore neuromuscular function
- Exercises to improve strength, endurance, speed, and power
- Activities to improve balance, neuromuscular control, coordination, and agility
- Exercises to improve gait, posture, and body mechanics
- Exercises to improve cardiorespiratory fitness
- Functional exercises (eg, sports- or activity-specific)
- Exercises which comprise a home-based program
- Aquatic therapy
- Therapeutic modalities
  - superficial thermal agents (eg, hot pack, ice)
  - electrical stimulation
  - therapeutic ultrasound
  - diathermy
  - therapeutic low-level laser and light therapy
  - mechanical modalities
    - traction
    - intermittent compression
    - continuous passive motion
    - massage
    - biofeedback
- Therapeutic medications (as guided by applicable state and federal law)

Knowledge and Skills

Physical Rehabilitation and Therapeutic Modalities

TI-1. Describe and differentiate the physiological and pathophysiological responses to inflammatory and non-inflammatory conditions and the influence of these responses on the design, implementation, and progression of a therapeutic intervention.

TI-2. Compare and contrast contemporary theories of pain perception and pain modulation.

TI-3. Differentiate between palliative and primary pain-control interventions.

TI-4. Analyze the impact of immobilization, inactivity, and mobilization on the body systems (eg, cardiovascular, pulmonary, musculoskeletal) and injury response.

TI-5. Compare and contrast the variations in the physiological response to injury and healing across the lifespan.

TI-6. Describe common surgical techniques, including interpretation of operative reports, and any resulting precautions, contraindications, and comorbidities that impact the selection and progression of a therapeutic intervention program.

TI-7. Identify patient- and clinician-oriented outcomes measures commonly used to recommend activity level, make return to play decisions, and maximize patient outcomes and progress in the treatment plan.

TI-8. Explain the theory and principles relating to expected physiological response(s) during and following therapeutic interventions.

TI-9. Describe the laws of physics that (1) underlay the application of thermal, mechanical, electromagnetic, and acoustic energy to the body and (2) form the foundation for the development of therapeutic interventions (eg, stress-strain, leverage, thermodynamics, energy transmission and attenuation, electricity).

TI-10. Integrate self-treatment into the intervention when appropriate, including instructing the patient regarding self-treatment plans.

TI-11. Design therapeutic interventions to meet specified treatment goals.

TI-11a. Assess the patient to identify indications, contraindications, and precautions applicable to the intended intervention.

TI-11b. Position and prepare the patient for various therapeutic interventions.

TI-11c. Describe the expected effects and potential adverse reactions to the patient.

TI-11d. Instruct the patient how to correctly perform rehabilitative exercises.

TI-11e. Apply the intervention, using parameters appropriate to the intended outcome.

TI-11f. Reassess the patient to determine the immediate impact of the intervention.

TI-12. Use the results of on-going clinical examinations to determine when a therapeutic intervention should be progressed, regressed or discontinued.

TI-13. Describe the relationship between the application of therapeutic modalities and the incorporation of active and passive exercise and/or manual therapies, including therapeutic massage, myofascial techniques, and muscle energy techniques.

TI-14. Describe the use of joint mobilization in pain reduction and restoration of joint mobility.

TI-15. Perform joint mobilization techniques as indicated by examination findings.

TI-16. Fabricate and apply taping, wrapping, supportive, and protective devices to facilitate return to function.

TI-17. Analyze gait and select appropriate instruction and correction strategies to facilitate safe progression to functional gait pattern.

TI-18. Explain the relationship between posture, biomechanics, and ergodynamics and the need to address these components in a therapeutic intervention.

TI-19. Identify manufacturer, institutional, state, and/or federal standards that influence approval, operation, inspection, maintenance and safe application of therapeutic modalities and rehabilitation equipment.

TI-20. Inspect therapeutic equipment and the treatment environment for potential safety hazards.

Therapeutic Medications

TI-21. Explain the federal, state, and local laws, regulations and procedures for the proper storage, disposal, transportation, dispensing (administering where appropriate),
and documentation associated with commonly used prescription and nonprescription medications.

TI-22. Identify and use appropriate pharmaceutical terminology for management of medications, inventory control, and reporting of pharmacological agents commonly used in an athletic training facility.

TI-23. Use an electronic drug resource to locate and identify indications, contraindications, precautions, and adverse reactions for common prescription and nonprescription medications.

TI-24. Explain the major concepts of pharmacokinetics and the influence that exercise might have on these processes.

TI-25. Explain the concepts related to bioavailability, half-life, and bioequivalence (including the relationship between generic and brand name drugs) and their relevance to the patient, the choice of medication, and the dosing schedule.

TI-26. Explain the pharmacodynamic principles of receptor theory, dose-response relationship, placebo effect, potency, and drug interactions as they relate to the mechanism of drug action and therapeutic

effectiveness.

TI-27. Describe the common routes used to administer medications and their advantages and disadvantages.

TI-28. Properly assist and/or instruct the patient in the proper use, cleaning, and storage of drugs commonly delivered by metered dose inhalers, nebulizers, insulin pumps, or other parenteral routes as prescribed by the physician.

TI-29. Describe how common pharmacological agents influence pain and healing and their influence on various therapeutic interventions.

TI-30. Explain the general therapeutic strategy, including drug categories used for treatment, desired treatment outcomes, and typical duration of treatment, for the following common diseases and conditions: asthma, diabetes, hypertension, infections, depression, GERD, allergies, pain, inflammation, and the common cold.

TI-31. Optimize therapeutic outcomes by communicating with patients and/or appropriate healthcare professionals regarding compliance issues, drug interactions, adverse drug reactions, and sub-optimal therapy.

Psychosocial Strategies and Referral (PS)

Athletic trainers must be able to recognize clients/patients exhibiting abnormal social, emotional, and mental behaviors. Coupled with recognition is the ability to intervene and refer these individ- uals as necessary. Additionally, athletic trainers appreciate the role of mental health in injury and recovery and use interventions to optimize the connection between mental health and restoration of participation.

Knowledge and Skills

Theoretical Background

PS-1. Describe the basic principles of personality traits, trait anxiety, locus of control, intrinsic and extrinsic motivation, and patient and social environment interactions as they affect patient interactions.

PS-2. Explain the theoretical background of psychological and emotional responses to injury and forced inactivity (eg, cognitive appraisal model, stress response model).

PS-3. Describe how psychosocial considerations affect clinical decision-making related to return to activity or participation (eg, motivation, confidence).

PS-4. Summarize and demonstrate the basic processes of effective interpersonal and cross-cultural communication as it relates to interactions with patients and others involved in the healthcare of the patient.

PS-5. Summarize contemporary theory regarding educating patients of all ages and cultural backgrounds to effect behavioral change.

Psychosocial Strategies

PS-6. Explain the importance of educating patients, parents/guardians, and others regarding the condition in order to enhance the psychological and emotional well-being of the patient.

PS-7. Describe the psychological techniques (eg, goal setting, imagery, positive self-talk, relaxation/anxiety reduction) that the athletic trainer can use to motivate the patient during injury rehabilitation and return to activity processes.

PS-8. Describe psychological interventions (eg, goal setting, motivational techniques) that are used to facilitate a patient's physical, psychological, and return to activity needs.

PS-9. Describe the psychosocial factors that affect persistent pain sensation and perception (eg, emotional state, locus of control, psychodynamic issues, sociocultural factors, personal values and beliefs) and identify multidisciplinary approaches for assisting patients with persistent pain.

PS-10. Explain the impact of sociocultural issues that influence the nature and quality of healthcare received

(eg, cultural competence, access to appropriate healthcare providers, uninsured/underinsured patients, insurance) and formulate and implement strategies to maximize client/patient outcomes.

Mental Health and Referral

PS-11. Describe the role of various mental healthcare providers (eg, psychiatrists, psychologists, counselors, social workers) that may comprise a mental health referral network.

PS-12. Identify and refer clients/patients in need of mental healthcare.

PS-13. Identify and describe the basic signs and symptoms of mental health disorders (eg, psychosis, neurosis; sub-clinical mood disturbances (eg, depression, anxiety); and personal/social conflict (eg, adjustment to injury, family problems, academic or emotional stress, personal assault or abuse, sexual assault or harassment) that may indicate the need for referral to a mental healthcare professional.

PS-14. Describe the psychological and sociocultural factors associated with common eating disorders.

PS-15. Identify the symptoms and clinical signs of substance misuse/abuse, the psycho- logical and sociocultural factors associated with such misuse/abuse, its impact on an individual's health and physical performance, and the need for proper referral to a healthcare professional.

PS-16. Formulate a referral for an individual with a suspected mental health or substance abuse problem.

PS-17. Describe the psychological and emotional responses to a catastrophic event, the potential need for a psychological intervention and a referral plan for all parties affected by the event.

PS-18. Provide appropriate education regarding the condition and plan of care to the patient and appropriately discuss with others as needed and as appropriate to protect patient privacy.

Healthcare Administration (HA)

Athletic trainers function within the context of a complex healthcare system. Integral to this func- tion is an understanding of risk management, healthcare delivery mechanisms, insurance, reim- bursement, documentation, patient privacy, and facility management.

Knowledge and Skills

HA-1. Describe the role of the athletic trainer and the delivery of athletic training services within the context of the broader healthcare system.

HA-2. Describe the impact of organizational structure on the daily operations of a healthcare facility.

HA-3. Describe the role of strategic planning as a means to assess and promote organizational improvement.

HA-4. Describe the conceptual components of developing and implementing a basic business plan.

HA-5. Describe basic healthcare facility design for a safe and efficient clinical practice setting.

HA-6. Explain components of the budgeting process including: purchasing, requisition, bidding, request for proposal, inventory, profit and loss ratios, budget balancing, and return on investments.

HA-7. Assess the value of the services provided by an athletic trainer (eg, return on investment).

HA-8. Develop operational and capital budgets based on a supply inventory and needs assessment; including capital equipment, salaries and benefits, trending analysis, facility cost, and common expenses.

HA-9. Identify the components that comprise a comprehensive medical record.

HA-10. Identify and explain the statutes that regulate the privacy and security of medical records.

HA-11. Use contemporary documentation strategies to effectively communicate with patients, physicians, insurers, colleagues, administrators, and parents or family members.

HA-12. Use a comprehensive patient-file management system for appropriate chart documentation, risk

management, outcomes, and billing.

HA-13. Define state and federal statutes that regulate employment practices.

HA-14. Describe principles of recruiting, selecting, hiring, and evaluating employees.

HA-15. Identify principles of recruiting, selecting, employing, and contracting with physicians and other medical and healthcare personnel in the deployment of healthcare services.

HA-16. Describe federal and state infection control regulations and guidelines, including universal precautions as mandated by the Workplace Safety and Health Adminis- tration (OSHA), for the prevention, exposure, and control of infectious diseases, and discuss how they apply to the practicing of athletic training.

HA-17. Identify key regulatory agencies that impact healthcare facilities, and describe their function in the regulation and overall delivery of healthcare.

HA-18. Describe the basic legal principles that apply to an athletic trainer's responsibilities.

HA-19. Identify components of a risk management plan to include security, fire, electrical and equipment safety, emergency preparedness, and hazardous chemicals.

HA-20. Create a risk management plan and develop associated policies and procedures to guide the operation of athletic training services within a healthcare facility to include issues related to security, fire, electrical and equipment safety, emergency preparedness, and hazardous chemicals.

HA-21. Develop comprehensive, venue-specific emergency action plans for the care of acutely injured or ill individuals.

HA-22. Develop specific plans of care for common potential emergent conditions (eg, asthma attack, diabetic emergency).

HA-23. Identify and explain the recommended or required components of a pre-participa- tion examination based on appropriate authorities' rules, guidelines, and/or recommendations.

HA-24. Describe a plan to access appropriate medical assistance on disease control, notify medical authorities, and prevent disease epidemics.

HA-25. Describe common health insurance models, insurance contract negotiation, and the common benefits and exclusions identified within these models.

HA-26. Describe the criteria for selection, common features, specifications, and required documentation needed for secondary, excess accident, and catastrophic health insurance.

HA-27. Describe the concepts and procedures for revenue generation and reimbursement.

HA-28. Understand the role of and use diagnostic and procedural codes when documenting patient care.

HA-29. Explain typical administrative policies and procedures that govern first aid and emergency care.

HA-30. Describe the role and functions of various healthcare providers and protocols that govern the referral of patients to these professionals.

Professional Development and Responsibility (PD)

The provision of high quality patient care requires that the athletic trainer maintain current com- petence in the constantly changing world of healthcare. Athletic trainers must also embrace the need to practice within the limits of state and national regulation using moral and ethical judgment. As members of a broader healthcare community, athletic trainers work collaboratively with other healthcare providers and refer clients/patients when such referral is warranted.

Knowledge and Skills

PD-1. Summarize the athletic training profession's history and development and how current athletic training practice has been influenced by its past.

PD-2. Describe the role and function of the National Athletic trainers' Association and its influence on

the profession.

PD-3. Describe the role and function of the Board of Certification, the Commission on Accreditation of Athletic training Education, and state regulatory boards.

PD-4. Explain the role and function of state athletic training practice acts and registration, licensure, and certification agencies including (1) basic legislative processes for the implementation of practice acts, (2) rationale for state regulations that govern
the practice of athletic training, and (3) consequences of violating federal and state regulatory acts.

PD-5. Access, analyze, and differentiate between the essential documents of the national governing, credentialing and regulatory bodies, including, but not limited to, the NATA *Athletic training Educational Competencies*, the BOC *Standards of Professional Practice*, the NATA *Code of Ethics*, and the BOC *Role Delineation Study/Practice Analysis*.

PD-6. Explain the process of obtaining and maintaining necessary local, state, and national credentials for the practice of athletic training.

PD-7. Perform a self-assessment of professional competence and create a professional development plan to maintain necessary credentials and promote life-long learning strategies.

PD-8. Differentiate among the preparation, scopes of practice, and roles and responsibilities of healthcare providers and other professionals with whom athletic trainers interact.

PD-9. Specify when referral of a client/patient to another healthcare provider is warranted and formulate and implement strategies to facilitate that referral.

PD-10. Develop healthcare educational programming specific to the target audience (eg, clients/patients, healthcare personnel, administrators, parents, general public).

PD-11. Identify strategies to educate colleagues, students, patients, the public, and other healthcare professionals about the roles, responsibilities, academic preparation, and scope of practice of athletic trainers.

PD-12. Identify mechanisms by which athletic trainers influence state and federal healthcare regulation.

Clinical Integration Proficiencies (CIP)

The clinical integration proficiencies (CIPs) represent the synthesis and integration of knowledge, skills, and clinical decision-making into actual client/patient care. The CIPs have been reorgan- ized into this section (rather than at the end of each content area) to reflect their global nature. For example, therapeutic interventions do not occur in isolation from physical assessment.

In most cases, assessment of the CIPs should occur when the student is engaged in real client/pa- tient care and may be necessarily assessed over multiple interactions with the same client/patient. In a few instances, assessment may require simulated scenarios, as certain circumstances may occur rarely but are nevertheless important to the well-prepared practitioner.

The incorporation of evidence-based practice principles into care provided by athletic trainers is central to optimizing outcomes. Assessment of student competence in the CIPs should reflect the extent to which these principles are integrated. Assessment of students in the use of Founda- tional Behaviors in the context of real patient care should also occur.

Prevention & Health Promotion

CIP-1. Administer testing procedures to obtain baseline data regarding a client's/patient's level of

general health (including nutritional habits, physical activity status, and body composition). Use this data to design, implement, evaluate, and modify a program specific to the performance and health goals of the patient. This will include instruct- ing the patient in the proper performance of the activities, recognizing the warning signs and symptoms of potential injuries and illnesses that may occur, and explaining the role of exercise in maintaining overall health and the prevention of diseases. Incor- porate contemporary behavioral change theory when educating clients/patients and associated individuals to effect health-related change. Refer to other medical and health professionals when appropriate.

CIP-2. Select, apply, evaluate, and modify appropriate standard protective equipment, taping, wrapping, bracing, padding, and other custom devices for the client/patient in order to prevent and/or minimize the risk of injury to the head, torso, spine, and extremities for safe participation in sport or other physical activity.

CIP-3. Develop, implement, and monitor prevention strategies for at-risk individuals (eg, persons with asthma or diabetes, persons with a previous history of heat illness, persons with sickle cell trait) and large groups to allow safe physical activity in a variety of conditions. This includes obtaining and interpreting data related to potentially hazardous environmental conditions, monitoring body functions (eg, blood glucose, peak expiratory flow, hydration status), and making the appropriate recommendations for individual safety and activity status.

Clinical Assessment & Assessment/Acute Care/Therapeutic Intervention

CIP-4. Perform a comprehensive clinical examination of a patient with an upper extremity, lower extremity, head, neck, thorax, and/or spine injury or condition. This exam should incorporate clinical reasoning in the selection of assessment procedures and interpre- tation of findings in order to formulate a differential assessment and/or assessment, determine underlying impairments, and identify activity limitations and participation restrictions. Based on the assessment data and consideration of the patient's goals, provide the appropriate initial care and establish overall treatment goals. Create and implement a therapeutic intervention that targets these treatment goals to include, as appropriate, therapeutic modalities, medications (with physician involvement
as necessary), and rehabilitative techniques and procedures. Integrate and interpret various forms of standardized documentation including both patient-oriented and clinician-oriented outcomes measures to recommend activity level, make return to play decisions, and maximize patient outcomes and progress in the treatment plan.

CIP-5. Perform a comprehensive clinical examination of a patient with a common illness/condition that includes appropriate clinical reasoning in the selection of assessment procedures and interpretation of history and physical examination findings in order to formulate a differential assessment and/or assessment. Based on the history, physical examination, and patient goals, implement the appropriate treatment strategy to include medications (with physician involvement as necessary). Determine whether patient referral is needed, and identify potential restrictions in activities and participa-tion. Formulate and communicate the appropriate return to activity protocol.

CIP-6. Clinically evaluate and manage a patient with an emergency injury or condition to include the assessment of vital signs and level of consciousness, activation of emergency action plan, secondary assessment, assessment, and provision of the appropriate emergency care (eg, CPR, AED, supplemental oxygen, airway adjunct, splinting, spinal stabilization, control of bleeding).

Psychosocial Strategies and Referral

CIP-7. Select and integrate appropriate psychosocial techniques into a patient's treatment or rehabilitation program to enhance rehabilitation adherence, return to play, and overall outcomes. This includes, but is not limited to, verbal motivation, goal setting, imagery, pain management, self-talk, and/or relaxation.

CIP-8. Demonstrate the ability to recognize and refer at-risk individuals and individuals with psychosocial disorders and/or mental health emergencies. As a member of the manage- ment team, develop an appropriate management plan (including recom- mendations for patient safety and activity status) that establishes a professional helping relationship with the patient, ensures interactive support and education, and encourages the athletic trainer's role of informed patient advocate in a manner consistent with current practice guidelines.

Healthcare Administration

CIP-9. Utilize documentation strategies to effectively communicate with patients, physicians, insur- ers, colleagues, administrators, and parents or family members while using appropriate ter- minology and complying with statues that regulate privacy of medical records. This includes using a comprehensive patient-file management system (including diagnostic and proce- dural codes) for appropriate chart documentation, risk management, outcomes, and billing.

Chapter 7 Appendix_NATA & APTA Settlement

The National Athletic trainers' Association, Inc.
And

The American Physical Therapy Association

JOINT STATEMENT ON COOPERATION

The National Athletic trainers' Association, Inc. ("NATA") and the American Physical Therapy Association ("APTA") have agreed to settle their legal dispute pending in the United States District Court for the Northern District of Texas, Dallas Division.

This Joint Statement on Cooperation arises from an effort by both Associations to work together to resolve differences through dialogue and mutual cooperation

The Associations

The NATA is the international professional membership association for athletic trainers ("ATs"). The NATA has more than 30,000 members. The NATA's mission is to enhance the quality of health care provided by certified athletic trainers and to advance the athletic training profession. Information about athletic training and the education, licensure, and certification of ATs is available on the NATA website, www.nata.org.

The APTA is the national association for licensed physical therapists ("PTs") and physical therapy assistants ("PTAs"). It has over 70,000 members. The mission of the APTA is to further the role of the physical therapy profession in the prevention, diagnosis, and treatment of movement dysfunction and the

enhancement of the physical health and functional abilities of members of the public. Information about physical therapy and the education, licensure, and specialist certification of PTs is available on the APTA website, www.apta.org.

The Litigation

The members of the NATA and the APTA share a dedication to improving the health, functioning, and well-being of their patients and clients. Over the years, these two organizations have cooperated at times on certain public policy issues, but they have also disagreed on other issues.

In early 2008, the NATA sued the APTA, alleging it had violated the antitrust laws and seeking injunctive and other relief. The APTA denies any factual basis for these allegations and contends NATA's claims lack any merit. The federal district court in Dallas denied APTA's request to dismiss the case, finding that NATA could maintain claims for declaratory and injunctive relief. The Court also stated, however, that NATA could not seek damages from APTA. Instead of continuing the legal dispute, the two sides have decided to enter into a settlement agreement and to issue this Joint Statement.

Qualifications of Physical Therapists and Athletic trainers

The APTA and the NATA acknowledge that physical therapists and athletic trainers are health care professionals authorized to provide interventions within their scope of practice as defined by applicable state law and, within that scope, to the extent of their individual educational/training competencies. The scopes of practice of the two professions overlap to some extent. The education, qualifications and training of the two professions are different. The patients and conditions treated and interventions performed by PTs and ATs are often different. The professional education of both physical therapists and athletic trainers calls for competence in some forms of manual therapy, on which physical therapists and athletic trainers are tested by their certification/licensure examinations.

Non-Exclusive Procedures

The APTA's longstanding position is that the term "physical therapy" should be used to characterize health care services only when those services are provided by a licensed PT or by a PTA acting under the direction and supervision of a licensed PT. The NATA recognizes that CPT codes 97001 and 97002 (physical therapy evaluation and physical therapy re-evaluation) are used to denote services provided by a licensed PT.

The NATA's position is that the term "athletic training" should be used to characterize health care services only when those services are provided by a licensed and/or certified athletic trainer. The APTA recognizes that CPT codes 97005 and 97006 (athletic training evaluation and athletic training re-evaluation) are used to denote services provided by a licensed and/or certified AT.

The NATA and the APTA both believe that the current Physical Medicine and Rehabilitation codes other than 97001, 97002, 97005 and 97006 are not exclusive to any one particular health care profession.

PTs are not the "exclusive" providers of manual therapy. Further, depending on individual qualifications and certification and state regulations, ATs are qualified to perform certain forms of manual therapy.

Legal Scope of Practice

The APTA and the NATA agree their members should practice within their respective licensed or regulated scopes of practice. The NATA and the APTA agree that the appropriate legal scope of practice for their respective members, as for any profession, is determined by legislatures and regulatory bodies. Both NATA and APTA agree it is a priority to protect the public from harm, and to compete ethically in the marketplace.

Access to Continuing Education

With respect to continuing education programs offered by PTs or PTAs, the APTA has agreed to clarify its existing policy on continuing clinical education for non-- PTs. The policy adopted by the APTA House of Delegates applies only to PTs and PTAs and says that they should identify the target audiences for continuing education programs and that course materials should indicate course content is not intended for use by participants outside the scope of their license or regulation. The policy also says that, in order to protect the public, physical therapists should not teach elements of physical therapy patient/client management to "individuals who are not licensed or otherwise regulated."

Because athletic trainers in the vast majority of states are licensed or otherwise regulated, this part of the policy does not apply to teaching ATs in those states where they are licensed or otherwise regulated. The House of Delegates policy does not require PTs to make determinations concerning the scope of practice of individuals who practice other professions.

The APTA and several APTA Chapters are continuing education providers approved by the National Athletic trainers' Association Board of Certification, Inc. ("BOC"). The Associations agree that PTs and ATs are free to refrain from teaching certain content to any audience if they determine that the content is not appropriate for the audience, including, but not limited to, because someone lacks the requisite education and training.

The Professions

NATA states: ATs gain professional qualifications after: 1) graduation from a bachelor's or master's academic program accredited by the Commission on Accreditation of Athletic training Education ("CAATE"); and 2) passing a national exam administered by the BOC, the independent credentialing body for the athletic training profession. The BOC certification program is accredited by the National Commission for Certifying Agencies ("NCCA"). Certified athletic trainers are required to obtain 75 hours of continuing education every three years. Athletic trainers are licensed, registered, and/or exempt from licensure in the statutes of 47 states. Athletic trainers serve patients through injury and illness prevention, clinical evaluation and diagnosis, appropriate interventions, management, and treatment of emergency, acute and chronic medical conditions, and rehabilitation.

- APTA states: PTs gain professional qualifications by: 1) graduating from a master's or doctoral academic program accredited by the Commission on Accreditation in Physical

Therapy Education, which is recognized by the U.S. Department of Education; and 2) passing the national physical therapy licensure examination administered by the Federation of State Boards of Physical Therapy ("FSBPT") for all fifty states. PTs provide clinical examination and evaluation, diagnoses, appropriate interventions and rehabilitation to individuals of all ages who have impairments, limitations in activities or participation, or changes in physical function or health status resulting from injury, disease, or other causes, and they provide prevention and health promotion and wellness services.

Truth in Advocacy

The NATA and the APTA agree that decisions about which professionals should be deemed qualified to provide particular services and which services provided by such professionals should be reimbursed by insurers and public programs are issues to be decided in the marketplace by consumers, insurers, federal and state legislatures, policy makers, and, in the case of athletic trainers (as dictated by state law), physicians. Thus, each Association and its individual members are free, like other citizens, to make truthful statements and to express their opinions about their professions or about others within the health care marketplace. That being said, statements made by the APTA and the NATA about PTs and ATs should not mislead consumers, insurers, physicians, or the public, and neither organization will make false or deceptive statements, including false or deceptive statements about qualifications of PTs or ATs. Specifically, neither organization will make false or misleading statements referring to PTs or ATs as "non-qualified," "unqualified," "not qualified," or any variation of these terms. Nothing in this Joint Statement shall be construed to impede the rights of either the APTA or the NATA to conduct all lawful activities, and make all lawful statements. Members and representatives of the APTA and the NATA should respect the rights, knowledge and skills of the other profession and compete honestly and ethically in the heal!h care.. marketplace.

Mutual Cooperation

The APTA and the NATA acknowledge many PTs and ATs have established productive, mutually respectful and collaborative relationships. Such cooperation should be fostered. The APTA and the :KATA will commit, at the level of the two national associations, to confer periodically on issues of common interest and discuss inter- professional disputes.

Inter-Association Communication

The NATA and the APTA agree to candidly discuss areas of friction between the organizations and identify issues on which the organizations can lawfully and appropriately work together to improve the health, functioning, and well-being of the communities they serve, including their patients and clients.

This Joint Statement is hereby signed on this 22ND day of September, 2009

R. Scott Ward

President of APTA

Signature did not copy over to this document. Please view in original via link below.

http://www.apta.org/uploadedFiles/APTAorg/Media/Releases/APTA/2009/NATAJointStatement.pdf

By NATA:

Marjorie J. Albohm, MS, ATC
President
National Athletic Trainers' Association, Inc.

Appendix D

Impact Statements

CPMA
Connecticut Podiatric Medical Association | 342 North Main Street, West Hartford, CT 06117-2507 | 860.586.7512 | Fax 860.586.7550 | www.CPMA.org

September 24, 2016

TO: Ms. Karen G. Wilson, HPA
Practitioner Licensing & Investigations Section
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

FR: Peter Blume, DPM
President
Connecticut Podiatric Medical Association

Our organization, the Connecticut Podiatric Medical Association, would like to submit this impact statement in regard to the Scope of Practice request offered by the Conn. Athletic Trainers' Association (CATA). We have reviewed the proposal and believe it could have significant ramifications for the Podiatric profession. This proposal, as submitted, could intersect with the Podiatric practice act. As such, we request two appointments to a Scope of Practice Review Committee in the event the Commissioner accepts this proposal for further consideration.

Sincerely,

Marc A. Lederman, DPM
Executive Director
Phone: 860.586.7512
marclederman@comcast.net

October 23, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson:

The Connecticut Society for Respiratory Care has reviewed a scope of practice proposal submitted by the Connecticut Athletic Trainers' Association.

CTSRC is concerned over the aspects of the proposal that permits Athletic Trainers to use pulse oximetry, and deliver nebulized medications, as well as what items might be included in their delivery of "emergency care." These items typically are within our practice act and our practitioners are competency validated annually for compliance with The State and The Joint Commission regulations. We also provide competency based education to our patients on a continual basis. In the event this proposal is selected for a full Scope of Practice Review Committee, CTSRC would like to request that we be included in the process and have two members of the panel. Thank you.

Sincerely,

Connie Dills, MBA, RRT, RPFT
President

Connecticut State Medical Society
FOUNDED IN 1792

127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473
Phone (203) 865-0587 Fax (203) 865-4997 www.csms.org

September 29, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
40 Capitol Avenue MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear. Ms. Wilson:

On behalf of the membership of the Connecticut State Medical Society (CSMS) we submit these comments, as consistent with the requirements of Public Act 11-209, regarding the recent submission for an expansion in scope of practice by the Connecticut Athletic Trainers Association (CATA).

You currently have before you a Request for Consideration of Scope of Practice Change submitted by CATA. CATA has communicated with CSMS regarding the intent of its proposal and we are pleased CATA chose to use the process established by Public Act 11-209 to allow the collegial and appropriate approach to establishing appropriate policy for scopes of practice.

Members and leadership of CATA have been partners with CSMS on critical issues regarding the health and well-being of our athletes in Connecticut. By statute, Athletic Trainers provide vital services to our athletes in Connecticut, especially those who participate in organized sports. However, together, our organizations (among many others) have grappled with the issue of protecting and caring for all student and youth athletes as well as all citizens seeking an active lifestyle. This submission is an effort by CATA to discuss the potential of athletic trainers to expand what is currently in statute by allowing trainers to replace the term “athlete” with “physically active individual” allowing trainers to provide services in settings other than those limited to athletics. It further would expand the settings and spectrum in which athletic trainers may provide service.

CATA has submitted comprehensive documentation regarding training, education and state and federal law regarding athletic trainers. We do not dispute any of the submitted information and know that CATA members meet the highest standards for athletic trainers. We do offer that the proposed change in statute holds the potential for a significant alteration in the settings and situations in which athletic trainers may provide services. We assume that this submission by CATA might also be considered by other currently licensed

health care professionals to encroach on their current scope of practices. Therefore, we fully request that prior to any proposed policy or legislation that a scope of practice review committee be established and that CSMS be provided representation on the committee.

Sincerely,

Ken Ferrucci
Senior Vice President of Government Affairs

cc: CATA Government Affairs

Connecticut Academy of Physician Assistants

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Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340408
Hartford, CT 06134

September 27, 2016

Dear Ms. Wilson

The Connecticut Academy of PAs (ConnAPA), would like to submit this impact statement in regard to the Connecticut Athletic Trainers Association (CATA) scope of practice request. We feel that the request could have ramifications on the physician assistant profession. We kindly seek appointment to the Scope of Practice Committee should this particular request be chosen for review.

Thank you for your time and consideration.

Respectfully,

Jason P. Prevelige, MHS, PA-C
President

Impact Statement for the Connecticut Advanced Practice Registered Nurse Society (CTAPRN Society) in opposition to the Connecticut Athletic Trainers Association Scope of Practice Change Request

1. Plain Language Description of the Request:

The Connecticut Athletic Trainers' Association (CATA) requests a scope of practice change for Athletic Trainers (ATs) to reflect significant expansion of their patient population and a significant expansion in the clinical care that ATs provide. This request seeks to change the population treated from "athlete' to "physically active individual." The request would change the current definition of the patient that an AT can treat from some who participates in physical activity three times weekly or more to anyone who participates in regular physical activities for recreation or employment. The new definition would also include "asymptomatic physically active individuals," which would greatly increase the target population of the AT. This definition could be broadly applied to nearly any individual.

CATA also requests to be able to implement standing orders for treatment of athletic conditions but also for administration of drugs. They would do this through the "identification" of acute and chronic illnesses. The standing orders would include the administration of pharmacological agents, such as epinephrine, albuterol, or glucagon. The administration of drugs is an activity historically limited to specifically trained and licensed health care providers.

The CTAPRN Society agrees with the expansion of the definition of the target population treated by ATs to "physically active individuals," and the focus on injury prevention during athletic or workplace activities. This should not include comparable activities or asymptomatic individuals as this is too broad. The scope of practice should include a prerequisite that these individuals have been cleared by a healthcare provider to participate in such activities. The Society also agrees that ATs should be able to provide immediate assistance with musculoskeletal injuries incurred in a clearly defined setting and under individualized orders. CTAPRN Society does not agree with the proposed wording of treating individuals with standing orders, which may be too broad, and outside of the realm of musculoskeletal injuries, especially including pharmacological agents.

2. Public Health and Safety Benefits and Risks

The requested change regarding administration of standing orders and medications to a broad population poses a serious public health risk. While changing the target population to "physically active individual", CATA would like to have standing orders and medication orders

for “athletes”. However, athlete is not defined in the SOP request. This would enable ATs to administer medications and standing orders to anyone that they deem to be an athlete, a potentially very broad population.

Additionally, the SOP requests the ability to “identify” and “treat” acute and chronic illnesses. CATA states that this is not “diagnosing” but the request does not include any specification or safeguards to ensure that ATs will not be diagnosing illness. The broad terminology used by CATA poses a serious public safety risk as ATs do not have the training to diagnose disease.

The scope of practice request proposes to change not only the target populations, but also settings where ATs may be employed. This demonstrates broad situations, instead of the narrow focus of athletic training, which is in the care of the athlete. This change is not appropriate for an AT who is trained and educated to care for athletes in the domains of prevention, emergency care, clinical assessment, therapeutic intervention and rehabilitation of injuries sustained during sports participation.

3. Impact on Public Access to Health Care:

CATA notes that the expansion of their scope of practice will increase public access to healthcare in the state of Connecticut. Notably, the public access will increase, but the population that is specific to the education and training of the AT will significantly change. Public access will be broad and confusing to patients who need health care from qualified providers. The requested scope change would increase the practice areas to include the workplace and informal settings, where it is postulated that the ATs care would limit disability, lower health care costs and workmen’s compensation and assist the financial viability of various companies. There is limited data to support this claim.

4. Brief Summary of State or Federal Laws Governing the Profession:

CATA reviews CT state law and national guidelines for ATs. The CT APRN Society concurs.

5. Current State Regulatory Oversight of the Profession:

CATA reviews CT statute for ATs. The CT APRN Society concurs. Specifically noting that “Athletic training” means the application or provision, with the consent and under direction of a health care provider of principles, methods and procedures of evaluation, prevention, treatment and rehabilitation of athletic injuries sustained by athletes. The proposed changes to the scope of practice would change the population from athlete to all populations, including “asymptomatic individuals”, and broadens scope to clinical evaluation and assessment, management and care, treatment and disposition and rehabilitation.

6. All Current Education, Training, and Examination Requirements and Any Relevant Certification Requirements Applicable to the Profession:

CATA provides voluminous descriptions to educational components in an AT program. The CT APRN Society concurs. However, it must be noted that CATA states that the current scope of

practice and statutory language in Connecticut is outdated, citing the causes of this antiquated scope are due to "the addition of standardized educational competencies and the accreditation of educational programs". There are no specific documented changes in the education programs that specifically identified additional competencies during the time since the original scope of practice was imposed.

7. Summary of Known Scope of Practice Changes Requested or Enacted Concerning the Profession in the Five Years Preceding the Request:

Licensure was requested and enacted in 2010. The CT APRN Society concurs. A scope of practice change request was submitted not reviewed in 2014 and 2015 .

8. Extent to Which the Request Directly Affects Existing Relationships within the Health Care Delivery System:

Physicians – Current practice act requires that ATs work under standing orders or through a direct referral of a physician or health care provider. This would not change.

Physical Therapists- Current practice scopes of practice define the patient population. The scope change requests ATs to enlarge their patient pool, and does not reflect the need for more extensive educational needs, such as the training PTs receive, for cardiovascular rehabilitation, neurological rehabilitation, and care for patients who are not athletes.

Nurses – The current scope of practice and the scope change will not change. The scope change request does note that, "APRNs are now permitted to function independently of physicians, it is probably that they will be able to refer patients to athletic trainers, similar to health care providers." The statement does not reflect an understanding of APRN practice, which has been independent since 1999, with a collaborative agreement, and as of 2014 the collaborative agreement is no longer required.

Chiropractors – The scope request allows ATs to work directly with chiropractors.

Podiatrists – The scope of practice request allows ATs to work directly with podiatrists.

9. Anticipated Economic Impact of the Request on the Health Care Delivery System:

The request notes proposed limits in disability, lower health care costs, and lower workmen's compensation claims, and improvement to the financial viability of various companies. There is limited evidence to support this.

CATA states the professional domains of athletic training include (1) injury/illness prevention and wellness, (2) clinical evaluation and assessment, (3) immediate and emergency care, (4) treatment and rehabilitation and (5) organizational and professional well-being. The request notes that the "skyrocketing costs of injuries across the US have highlighted the value of ATs serving non-athletic populations". The cost of such injuries will not change by inappropriately broadening the scope of practice for ATs.

10. Regional and National Trends in Licensing of the Health Profession Making the Request and a Summary of Relevant Scope of Practice Provisions Enacted in Other States

The trends in state licensure laws documented in the scope request are not consistent with the language requested by the CATA. The request for broad administration of medications and standing orders are not consistent with other states per the CTAPRN review. However, the change to the limited definition of "athlete" is consistent with other states.

11. Identification of Any Health Care Professions that can be Reasonably Anticipated to be Directly Affected by the Request, the Nature of the Impact, and Efforts Made by the Requestor to Discuss It with Such Health Care Professions

CATA states that the change would not affect other health care professions in any negative manner. The gains in the professions that are stated are unrealistically obtainable, as they require less time of the qualified professional with their patient, and would require the AT to provide services they are not currently educated and trained specifically for, such as triage. The CTAPRN Society feel that this SOP request is not in the best interest of public safety.

12. Description of How the Request Relates to the Health Care Profession's Ability to Practice to the Full Extent of the Profession's Education and Training:

This SOP request would allow ATs to function outside of their training. ATs are not trained to "identify" acute and chronic illness outside of a very narrow setting. Likewise, they are not trained to administer medications to the general population, which is what they are requesting. CTAPRNS would welcome an opportunity to discuss this application further should it be selected

Respectfully submitted by
Monte Wagner, DNP, MPH, APRN, FNP-BC
Health Policy Committee
CT APRN Society

phone: 860-690-1146
email: ctorthoexec@gmail.com
www.ctortho.org

Connecticut ORTHOPAEDIC Society

September 30, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue – MS 12APP
P.O. Box 340308
Hartford, CT 06134

Dear. Ms. Wilson,

On behalf of the more than 240 orthopaedic surgeon members of the Connecticut Orthopaedic Society (COS), we are writing regarding the Scope of Practice Request for the 2017 Legislative Session submitted by the Connecticut Athletic Trainers' Association.

As orthopaedic surgeons, we have strong professional relationships and work closely with athletic trainers in our State. The care they provide under the direction of a physician, oftentimes an orthopaedic surgeon, is an important component to the "team approach" of caring for athletes.

The scope change they are requesting directly impacts orthopaedic surgeons and patients. Orthopaedic surgeons have a comprehensive understanding of the role of athletic trainers and the injured athlete and the COS respectfully requests participation and representation if the Department of Public Health grants the review and convenes a committee.

The COS seeks to ensure that patient safety be given the highest priority when considering expanding and adding to any professions scope of practice. Thank you for your review and consideration of our request and we look forward to hearing from you.

Sincerely,

F. Scott Gray, MD
President, Connecticut Orthopaedic Society

CONNECTICUT NURSES' ASSOCIATION

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

September 30, 2016

Dear Ms. Wilson:

The Connecticut Nurses' Association, a professional association for Registered Nurses, respectfully submits this impact statement for the Connecticut Athletic Trainers Association Scope of Practice Determination.

There are over 60,000 licensed Registered Nurses in CT. Nurses are a member of the health care team and may work with or refer to practices with Athletic Trainers especially in schools and outpatient settings.

While we strongly believe in working to the full extent of your training and education, it is important to consider the impact on public health and others in the health care team. In addition, considering the impact of the change on evolving practice settings and how the practice change may change their interaction with the clients. While the AT practice is currently in the care of athletes, who have seen a health care provider and cleared for athletics, a change in their scope may allow them to see patients without medical clearance. It may then rest on the AT to identify concerns that may impact the athletic regimen of the athlete, it is unclear if their education and training supports diagnosing. The Connecticut Nurses' Association has submitted testimony on the proposed bills over the years as well as had several meetings with the CATA leadership.

We request to be part of a discussion to advocate for and ensure there are no barriers to collaboration within nursing's scope of practice and to ensure the protection of the public health.

Thank you and we look forward to the discussion.

Sincerely,

Mary Jane Williams Kimberly A. Sandor

Mary Jane Williams Kimberly A. Sandor

1224 Mill St. Bldg B
East Berlin, CT 06023

(203) 238-1207
WWW.CTNURSES.ORG

Chair, Government Relations
Executive Director, CT Nurses' Association

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CONNECTICUT PHYSICAL THERAPY ASSOCIATION
A COMPONENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION
15 NORTH RIVER ROAD, TOLLAND, CT 06084
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September 20, 2016

Karen G. Wilson, HPA
Practitioner Licensing & Investigation Section
Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134
e-mail: Karen.Wilson@ct.gov

RE: Connecticut Athletic Trainers Association's 2016 Scope of Practice Request

Dear Ms. Wilson:

In accordance with Public Act 11-209, the Connecticut Physical Therapy Association (CPTA) is submitting this impact statement in response to the Connecticut Athletic Trainers Association's (CATA) submission for a scope of practice review request to the Department of Public Health.

If the Department of Public Health moves forward with CATA's request for a scope of practice review, CPTA respectfully requests participation in the scope of practice review committee. CPTA would like to participate in the scope of practice review committee to ensure that the public's health and safety are given every consideration during the process and that changes to the athletic trainer statutory scope of practice reflects their education and training.

Should you have questions or require further information, please contact me at your convenience.

Sincerely,

James Leahy, CAE
Executive Director

cc: Michael Dugan, Capitol Consulting – CPTA Lobbyist

American Physical Therapy Association

Connecticut College of Emergency Physicians
60 Kings Highway, North Haven, CT 06473
www.ctacep.org - 203-464-3793

September 28, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Ave., MS #12APP
PO. Box 340308
Hartford, CT 06134

RE: Connecticut Athletic Trainers Association 2016 Scope of Practice Request

Dear Ms. Wilson:

In accordance with Public Act 11-209, the Connecticut College of Emergency Physicians (CCEP) is submitting this impact statement in response to the Connecticut Athletic Trainers Association (CATA) submission for a scope of practice review request to the Department of Public Health.

If the Department of Public Health moves forward with CATA's request for a scope of practice review, CCEP respectfully requests participation in the scope of practice review committee.

It is imperative that CCEP and emergency physicians understand how this scope of practice change will impact emergency care and the treatment of patients presenting to the emergency department.

Should you have questions or require further information, please contact me at your convenience.

Sincerely,

Thomas A. Brunell, M.D., F.A.C.E.P.

President
Connecticut College of Emergency Physicians

cc: Michael Dugan, Capitol Consulting – CCEP Lobbyist

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Pubic Health
410 Capitol Ave, MS #12APP
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Hartford, CT 06134
Email: Karen.Wilson@ct.gov

10/03/16

Dear Ms. Wilson,

ConnOTA would like to take this opportunity to respond to the proposed scope of practice revisions being proposed by the Connecticut Athletic Trainers' Association for 2016.

A review of the Occupational Therapy profession: As of September 30, 2016 , there were 2450 licensed Occupational Therapists and 948 licensed Certified Occupational Therapy Assistants in the state of CT. Occupational Therapists currently enter the field at the Master's level and must pass a national certification examination in order to obtain licensure in each state.

Occupational Therapy is a science-driven, evidence based profession that enables people of all ages to live life to its fullest by helping them promote health and prevent – or live better with their illness, injury or disability. Patients (clients) who receive our services range in age from the pre-mature infant to the geriatric patient and all ages in-between. When we evaluate a patient (client) we take into account the complete person including his or her psychological, physical, emotional and social makeup so they can function at the highest possible level.

As outlined on the AOTA website, "Common occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, helping people recovering from injury to regain skills, and providing supports for older adults experiencing physical and cognitive changes. Occupational therapy services typically include:

- an individualized evaluation, during which the client/family and occupational therapist determine the person's goals,

- customized intervention to improve the person's ability to perform daily activities and reach the goals, and
- an outcomes evaluation to ensure that the goals are being met and/or make changes to the intervention plan.

Occupational therapy services may include comprehensive evaluations of the client's home and other environments (e.g., workplace, school), recommendations for adaptive equipment and training in its use, and guidance and education for family members and caregivers. Occupational therapy practitioners have a holistic perspective, in which the focus is on adapting the environment to fit the person, and the person is an integral part of the therapy team.

Upon review of the proposed changes to the Connecticut Athletic Trainers' scope of practice, we continue to express concern regarding:

1. The removal of the word "Athlete" from their scope of practice. It would seem that adding "physically active individual" would be less objectionable than substituting the term, as their profession exists to serve this population but we are asking for:

- A clear definition and qualification of the term "physically active individual" as we compare it to the previous CATA scope of practice that defined an "athlete."
- Recognize that the term "physically active individual" can impact the role and scope of other health care professionals in regards to whom they provide treatment to and how therefore even this term has the potentiality of scope infringement.

2. In reviewing who the Athletic Trainers' are proposing to expand services to in the health care field we object to the use of the word "therapeutic exercise" as there are currently many other disciplines who are already experts in their fields to perform therapeutic exercise and rehabilitate complex injuries; attempting to serve those populations without the necessary skills, education and training is not sound science -driven, evidenced -based or clinically appropriate. The general health care field is not the intended population of the Athletic Trainer and these services should be performed by established disciplines.

- Certainly we support the athletic trainers' performing wellness and preventative services for the physically active individuals pursuing physical activity to maximize physical condition and fitness and have no objection to them assisting individuals who are active less than three times per week. We want to ensure that the scope of practice clearly defines who the recipients of services are and the context within in which the services are provided to avoid infringement upon other health care scope of practices such as Occupational Therapy.

3. Employment Settings: Occupational Therapists are the proven discipline to address workplace injuries and ergonomics and to promote AT's working in these settings for the purpose of adding supplementary employment opportunities for CT College graduates is inappropriate given their intended scope of practice.

4. Page 9, paragraph 2, bullet 3 regarding long term care, palliative care and emergency services:

- ConnOTA is asking for clarification of the educational curriculum to support ATs providing services within the proposed context, especially as it relates to emergency services when the term "physically active individual" is utilized as the recipient in the AT scope of practice language. What is the population and services provided within the context of "emergency services?"
- ConnOTA is asking for clarification of intent to provide services and the content of proposed AT services to the long term care and palliative care populations in an effort to ensure that the Occupational Therapy scope of practice is not infringed upon given the current provision of Occupational Therapy medically necessary services are currently provided to these specific populations.

We look forward to continued dialogue with the Connecticut Athletic Trainers' Association regarding their proposed changes.

Sincerely,

Judith Sheehan, OTR/L

ConnOTA President

Morgan Villano, MPA/MSPS, OTR/L

ConnOTA Member for Government Affairs

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406

September 29, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134
karen.wilson@ct.gov

RE: Athletic Trainer Scope of Practice Proposal

Dear Ms. Wilson:

The Connecticut Chiropractic Association (CCA) submits this impact statement with regard to a Scope of Practice proposal submitted by the Connecticut Athletic Trainer's Association. The proposal in question would place in statute the expansion of population to which an Athletic Trainer may treat.

In general we believe the current health care system (UCONN Health Center, hospitals, clinics, state university system, etc.) should fully integrate the services of chiropractic physicians before expanding the scope of other professions. Patient access to quality and effective care, especially at the physician level of training, is best assured when all healing arts practitioners, as defined in Section 20-1, are fully integrated and available in the health care system and institutions.

Specifically we note that the proposal is a major realignment of the AT profession—from one that treats individuals who have sports or activity-related pain or conditions to treating essentially any patient. With more individuals, especially our youth getting more involved in organized athletics and especially the concerns with concussion related conditions, the demand for a specific well trained athletic health care provider increases. The necessity to expand the athletic trainer profession beyond their traditional and stated population of care is of questionable need with all due respect. This could have a negative ramification for the chiropractic profession, the athletic population and general population. In the event that the Department selects this proposal for a full Scope of Practice Committee review, we would request to have two appointments to it.

Sincerely,

Richard Duenas, D.C.
President

Copy: File
Eleni Diakogeorgiou: crfdiakoge@gmail.com
Perry Siegel: perry.siegel@selectphysicaltherapy.com

CONNECTICUT HOSPITAL ASSOCIATION

MEMORANDUM

TO: Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Connecticut Department of Public Health

FROM: Karen Buckley
Vice President, Advocacy

DATE: October 1, 2016

SUBJECT: Impact Statement – Scope of Practice Request – Athletic Trainers

The Connecticut Hospital Association (CHA), a trade association representing 27 acute care hospitals in Connecticut, submits this impact statement, in accordance with Chapter 368a of the Connecticut General Statutes, in response to the scope of practice change requested by the Connecticut Athletic Trainers' Association. The Connecticut Athletic Trainers' Association is seeking to revise and expand the scope of practice for Athletic Trainers.

Connecticut hospitals employ or utilize athletic trainers. CHA wishes to ensure that any revisions or expansions to the scope of practice be crafted in such a way as to avoid unintended consequences that would have a negative impact on the delivery of services in hospitals and other settings.

If the Department appoints a Scope of Practice Review Committee, CHA respectfully requests an appointment to the Committee.

KMB:mb
By E-Mail

Appendix E

State Law Governing Athletic Training

Connecticut General Statutes
Chapter 375a
Athletic Training

Sec. 20-65f. Definitions. As used in this chapter:

(1) "Athletic training" means the application or provision, with the consent and under the direction of a health care provider, of (A) principles, methods and procedures of evaluation, prevention, treatment and rehabilitation of athletic injuries sustained by athletes, (B) appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, light massage, water, electric stimulation, sound, exercise and exercise equipment, (C) the organization and administration of athletic training programs, and (D) education and counseling to athletes, coaches, medical personnel and athletic communities in the area of the prevention and care of athletic injuries. For purposes of this subdivision, "health care provider" means a person licensed to practice medicine or surgery under chapter 370 of the general statutes, chiropractic under chapter 372 of the general statutes, podiatry under chapter 375 of the general statutes or naturopathy under chapter 373 of the general statutes;

(2) "Athletic injury" means any injury sustained by an athlete as a result of such athlete's participation in exercises, sports, games or recreation requiring strength, agility, flexibility, range of motion, speed or stamina, or any comparable injury that prevents such athlete from participating in any such activities;

(3) "Athlete" means any person who is a member of any professional, amateur, school or other sports team, or is a regular participant in sports or recreational activities, including, but not limited to, training and practice activities, that require strength, agility, flexibility, range of motion, speed or stamina. For purposes of this subdivision, "regular" means not less than three times per week;

(4) "Standing orders" means written protocols, recommendations and guidelines for treatment and care, furnished and signed by a health care provider specified under subdivision (1) of this section, to be followed in the practice of athletic training that may include, but not be limited to, (A) appropriate treatments for specific athletic injuries, (B) athletic injuries or other conditions requiring immediate referral to a licensed health care provider, and (C) appropriate conditions for the immediate referral to a licensed health care provider of injured athletes of a specified age or age group.

(5) "Commissioner" means the Commissioner of Public Health.

Sec. 20-65g. License Required for practice and use of title. (a) Except as provided in section 20-65i, no person may practice athletic training unless such person is licensed pursuant to section 20-65j.
(b) No person may use the title "licensed athletic trainer" or make use of any title, words, letters or abbreviations indicating or implying that such person is licensed to practice athletic training unless such person is licensed pursuant to section 20-65k.

Sec. 20-65h. Referral to licensed health care provider. (a) Each person who practices athletic training under standing orders shall make a written or oral referral to a licensed health care provider of any athlete who has an athletic injury whose symptoms have not improved for a period of four days from the day of onset, or who has any physical or medical condition that would constitute a medical contraindication for athletic training or that may require evaluation or treatment beyond the scope of athletic training. The injuries or conditions requiring a referral under this subsection shall include, but not be limited to, suspected medical emergencies or illnesses, physical or mental illness and significant tissue or neurological pathologies.
(b) Each person who practices athletic training, but not under standing orders, may perform initial evaluation and temporary splinting and bracing of any athlete with an athletic injury and shall, without delay, make a written or oral referral of such athlete to a licensed health care provider. The limitations on the practice of athletic training set forth in this subsection shall not apply in the case of any athlete that is referred to such person by a licensed health care provider, provided such practice shall be limited to the scope of such referral.

Sec. 20-65i. Exceptions to licensing requirement. A license to practice athletic training shall not be required of: (1) A practitioner who is licensed or certified by a state agency and is performing services within the scope of practice for which such person is licensed or certified; (2) a student intern or trainee pursuing a course of study in athletic training, provided the activities of such student intern or trainee are performed under the supervision of a person licensed to practice athletic training and the student intern or trainee is given the title of "athletic trainer intern", or similar designation; (3) a person employed or

volunteering as a coach of amateur sports who provides first aid for athletic injuries to athletes being coached by such person; (4) a person who furnishes assistance in an emergency; or (5) a person who acts as an athletic trainer in this state for less than thirty days per calendar year and who is licensed as an athletic trainer by another state or is certified by the Board of Certification, Inc., or its successor organization.

Sec. 20-65j. Qualifications for licensure. Licensure by endorsement. a) Except as provided in subsections (b) and (c) of this section, an applicant for a license to practice athletic training shall have: (1) A baccalaureate degree from a regionally accredited institution of higher education, or from an institution of higher learning located outside of the United States that is legally chartered to grant postsecondary degrees in the country in which such institution is located; and (2) current certification as an athletic trainer by the Board of Certification, Inc. , or its successor organization.

(b) An applicant for licensure to practice athletic training by endorsement shall present evidence satisfactory to the commissioner (1) of licensure or certification as an athletic trainer, or as a person entitled to perform similar services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, and (2) that there is no disciplinary action or unresolved complaint pending against such applicant. (c) Prior to April 30, 2007, the commissioner shall grant a license as an athletic trainer to any applicant who presents evidence satisfactory to the commissioner of (1) the continuous providing of services as an athletic trainer since October 1, 1979, or (2) certification as an athletic trainer by the Board of Certification, Inc. , or its successor organization.

Sec. 20-65k. License to practice athletic training. Fees. (a) The commissioner shall grant a license to practice athletic training to an applicant who presents evidence satisfactory to the commissioner of having met the requirements of section 20-65j. An application for such license shall be made on a form required by the commissioner. The fee for an initial license under this section shall be one hundred and ninety dollars.

(b) A license to practice athletic training may be renewed in accordance with the provisions of section 19a-88, as amended, provided any licensee applying for license renewal shall maintain certification as an athletic trainer by the Board of Certification, Inc. , or its successor organization. The fee for such renewal shall be two hundred dollars.

(c) The department may, upon receipt of an application for athletic training licensure, accompanied by the licensure application fee of one hundred ninety dollars, issue a temporary permit to a person who has met the requirements of subsection (a) of section 20-65j, except that the applicant has not yet sat for or received the results of the athletic training certification examination administered by the Board of Certification, Inc., or its successor organization. Such temporary permit shall authorize the permittee to practice athletic training under the supervision of a person licensed pursuant to subsection (a) of this section. Such practice shall be limited to those settings where the licensed supervisor is physically present on the premises and is immediately available to render assistance and supervision, as needed, to the permittee. Such temporary permit shall be valid for a period not to exceed one hundred twenty calendar days after the date of completion of the required course of study in athletic training and shall not be renewable. Such permit shall become void and shall not be reissued in the event that the permittee fails to pass the athletic training certification examination. No permit shall be issued to any person who has previously failed the athletic training certification examination or who is the subject of an unresolved complaint or pending professional disciplinary action. Violation of the restrictions on practice set forth in this section may constitute a basis for denial of licensure as an athletic trainer.

Sec. 20-65l. Regulations. Administration within available appropriations. The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the provisions of this chapter. The commissioner shall administer the provisions of this chapter within available appropriations.

Sec. 20-65m. Disciplinary Action. Grounds. The Department of Public Health may take any action set forth in section 19a-17 of the general statutes if a person issued a license pursuant to section 20-65k of the general statutes, as amended by this act, fails to conform to the accepted standards of the athletic trainer profession, including, but not limited to, the following: Conviction of a felony; fraud or deceit in the practice of athletic training; illegal, negligent, incompetent or wrongful conduct in professional activities; emotional disorder or mental illness; physical illness including, but not limited to, deterioration through the aging process; abuse or excessive use of drugs, including alcohol, narcotics or chemicals; wilful falsification of entries into any patient record pertaining to athletic training; misrepresentation or

concealment of a material fact in the obtaining or reinstatement of an athletic trainer license; or violation of any provisions of chapter 375a of the general statutes, or any regulation adopted under said chapter 375a. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if the license holder's physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17 of the general statutes. Notice of any contemplated action under said section 19a-17, the cause of the action and the date of a hearing on the action shall be given and an opportunity for hearing afforded in accordance with the provisions of chapter 54 of the general statutes.

Appendix F

Journal Articles and Documents on Athletic Trainers in the Industrial Setting

Abstract: *Helping disabled workers to return to work is the goal of many corporate rehabilitation efforts. Increasingly, employers are providing rehabilitation services either as part of their overall disability management approach, or as a special program aimed at facilitating return to work. Finding a program that offers cost management, as well as facilitating appropriate return to work is the objective of most employers in effective disability management. Disability management involves two types of costs: wage-related benefit costs and costs for rehabilitation services or treatment. Whether the injuries occur at work or leisure, the costs will be borne by the company in some fashion. There are clear benefits from using an in-house program. Increasingly, corporate managers are employing athletic trainers to provide this rehabilitation service on-site.*

Industrial Medicine and Athletic Training: Cost-Effectiveness in the Non-traditional Setting

Gregory R. Zimmerman, MSA, ATC

Around the country, companies of all sizes are realizing what collegiate sports and professional teams have known for a long time; in-house rehabilitation is cost-effective. This is revealed most dramatically by the number of rehabilitation/fitness centers springing up around corporate America. Recognizing that employee productivity is the determining factor dictating red or black ink on the company ledger, and that morale and goodwill greatly influence that productivity, modern industry has embarked upon a program designed to complement both. The prompt return to work of injured and/or sick employees is the goal, with the corporation and employees the beneficiaries.

Increasingly, athletic trainers are finding employment with midsize to large companies. However, the role that athletic trainers play is still puzzling, especially to corporate managers.

Gregory Zimmerman is Coordinator of Rehabilitation at General Motors—Saginaw Division in Saginaw, MI 48601.

Industrial Health Care Costs

Industrial medicine traditionally has concentrated on prevention of acute and chronic disease and injury. Research indicates, however, that a comprehensive team approach for rehabilitation of an injured or disabled worker is necessary.[2-5,7,11,13,15,19] This enables him/her to remain a productive member of the work force and society.

Failure to attend to the needs of disabled workers creates a cost to society in at least three ways:

1. severe financial implications for industry in terms of labor turnover and the recruitment and training of new workers;
2. secondary effects on the workforce participation of persons who must care for a disabled person; and
3. diminutive number of workers in the active workforce whose financial contributions sustain systems of social insurance and benefits.[4]

Business and industry have come to realize that healthy employees can help reduce costs. Many industrial firms have reevaluated the practice of simply "pensioning off" chronically injured or disabled employees. Experienced employees represent an investment, an appreciating asset, and a resource to their firms. Goldfarb[5] suggests that America's competitiveness in the world market depends, to an extent, on industry's ability to keep workers healthy, fit, and on the job.

Not only does the employer have an investment in the employee in training costs, experience, and goodwill, but a healthy employee is more productive, has fewer accidents, takes fewer sick days, and uses fewer health insurance benefits. After assuming the presidency of Chrysler Corporation, Lee Iacocca discovered that Blue Cross/Blue Shield was the company's biggest supplier. Chrysler was spending more money on health care than for steel and rubber.[9]

Cost containment of workers' compensation medical expenses has become the focus of heightened levels of interest. Standard industry practice has been to send an injured employee either back to work, home, or to an outside doctor or hospital for treatment and rehabilitation. The extent of treatment and rehabilitation has never really been controlled effectively by the company.[7]

The Wyatt Company reported in 1989 that 80% of hospital bills are incorrect.[2] One third of the bills reviewed in the study were too low, and two thirds of the bills were too high. It is estimated that hospital bill reviews result in as much as 15% savings in overall costs. According to Lynn Jones, manager of worksite health services in the American Hospital Association's Division of Ambulatory Care and Health Promotion, "From the employer's perspective, the goal is to get the employee back on the job. For the employee, the goal is to prevent the injury from recurring; for the hospital, it is to make a profit."[3]

Industrial Rehabilitation Programs

The aim of early rehabilitation is to prevent an employee's passing from

productive activity to social security rolls by maintaining his or her working capacity and adjusting work to his or her capabilities. If proven successful, this activity might prevent the disability process and thus limit the growth of the cost of social and medical services. Increasingly, employers are providing rehabilitation services either as part of their overall disability management approach, or as a special program aimed at facilitating return to work.[13]

Some employers, resenting the high cost of workers' compensation, tend to feel the injury payment system is abused by workers who see even the most minor ache as a ticket to getting money for nothing. Indeed, such abuses might exist. Factory workers tell of rehabilitation programs in their plants where workers' compensation recipients are brought in to perform simple tasks while collecting full pay. Some participants, they report, come in on crutches, but drop the act when the work day is done.[11]

There always will be those who take advantage of a situation, but coordinators of rehabilitation programs supervised by athletic trainers remark that most injured workers just want to get better.[19] They maintain, and employers are beginning to agree, that getting injured workers into programs immediately and working with them to prevent further injuries are steps that help ease the pain of workers' compensation bills.

Physical rehabilitation programs, expanding in part because the US Department of Labor requires employers to make some kind of rehabilitation effort for injured employees, use a variety of techniques to achieve their goals. The distinction between industry-based rehabilitation programs and disability management programs is a bit artificial. Certainly, there are many common objectives, policies, and service elements. Disability management is essentially a secondary and tertiary prevention strategy closely allied to occupational health care, while industry-based rehabilitation programs more commonly reflect restorative rehabilitation practices, usually following a substantial injury.[4,11]

The benefits of early return from injury and/or sickness for both the employees and the companies are readily apparent. Proper and prompt rehabilitation, in terms of alleviating pain and stress, is invaluable. Monetarily, companies have realized savings of hundreds of thousands of dollars, and employees gain by returning sooner to full paychecks.

Industry-based rehabilitation efforts might include a comprehensive array of medical treatment, retraining, counseling, work adjustment, sheltered work, and job accommodations. Employer-based, "in-house" rehabilitation schemes have been demonstrated in Australia, Sweden, and the United States.[4] These programs all make an effort to avoid the injured employee's withdrawal from the labor market through a conscious and proactive policy of in-house physical rehabilitation/fitness.

Perhaps the most common remark made by employees who have used their respective employers' rehabilitation/fitness facilities is one of gratitude towards their company.[19] Workers who have suffered the trauma of injury recognize not only the physical benefits of these programs, but also the psychological effects. Active participation in their own wellness, not merely waiting for nature to take its own time and course, is a positive and beneficial ingredient in the healing process and one that is nurtured by these rehabilitation/fitness programs.

Companies with these programs are somewhat unique in their approach to the fitness movement that has swept the country. There is a presumption that these programs have proven their value in increasing productivity and reducing the spiraling costs of health care. They might also give a company the competitive edge in obtaining and keeping good workers. Many corporate rehabilitation/fitness programs are viewed as an "elitist" perk, reserved for top managers and executives only. However, on any given day in these rehabilitation/fitness centers, one can witness high-level brass working side-by-side with the unionized blue-collar workers.

Industrial Injury Surveys

Companies started offering health programs after surveys nationwide and throughout the automobile industry revealed that 80% of workers do not get enough exercise, 42% smoke, and at least 50% have high cholesterol levels.[12] The number of on-the-job injuries and illnesses in America surged in 1991 to 6.8 million, the highest level on record. This marked an increase of approximately 200,000 from the previous year, according to a study by the Bureau of Labor Statistics. It was the highest number of work-related injuries and illnesses since the US Department of Labor began tracking such figures in 1972. Of all the reported cases of injury and illness in 1990, nearly half were serious enough to require workers to lose time on the job or have their work activity restricted.[1]

Eight industries reported at least 100,000 injury cases each in 1991.[16] Those reporting were eating and drinking places, hospitals, retail grocery stores, trucking and over-the-road couriers, nursing and personal care facilities, department stores, motor vehicle manufacturing, and hotels and motels.[18]

Although manufacturing injuries had decreased slightly, factory injuries and illnesses accounted for approximately one third of the total reported injuries. The service industry accounted for 20%. As in other recent years, disorders associated with repeated trauma, for example, carpal tunnel syndrome, continued to increase. These disorders, which now make up nearly 60% of all illnesses, often are suffered by typists or assembly line workers who repeat the same action throughout the day.[1]

Program Models

The rehabilitation/fitness facility at Saginaw Division-General Motors Corporation is within the boundaries of the 1 square-mile manufacturing complex of approximately 10,000 employees. GM's 13-year-old, in-house rehabilita-

tion program was implemented after a local orthopedic surgeon, Dr. Ben Mayne, challenged upper GM management to enlist the services of athletic trainers in rehabilitating injured and postoperative employees. The initial capital outlay for equipment and facilities, in addition to the benefits and salaries of the athletic trainers, were recovered within 6 months of operation through cost savings.

Currently, the rehabilitation/fitness center at Saginaw Division GM employs two certified athletic trainers, is open Monday through Friday from 6 AM to 8 PM and averages 312 patients annually. In 1991, we administered 9162 treatments during 3791 patient visits. Strains, sprains, contusions, dislocations, fractures, and inflammatory disorders make up 81% of the caseload. More than 280 employees regularly use the center for some form of fitness/maintenance following recovery from injuries. Over a 3-year period, beginning in 1988, Saginaw Division has saved $3,531,335 by conducting rehabilitation in-house versus outsource care rehabilitation.[19] Like many of the in-house models, Saginaw Division GM also rehabilitates nonoccupational injuries suffered by their employees. There are no charges or billing for services rendered. This is seen as a benefit for both the company and the employees and helps to improve relations between management and labor.

At Walbro Corporation in Cass City and Caro, Michigan, officials have recorded a 54% decrease in workers' compensation claims since the company initiated fitness programs in 1985. Walbro, which employs more than 300 people, builds small engine carburetors and fuel pumps. Nearly all injured Walbro workers make use of the 21 pieces of Nautilus and aerobic exercise equipment that are located at the facility for rehabilitation. In 1985, Walbro management calculated that dollars saved from reduced insurance claims would cover the facility cost within 4 years. They were surprised and pleased when the books balanced within 10 months. During the first quarter, there was a 36% reduction in absenteeism, and the company realized a savings of 7.6 cents an hour per employee on all medical costs, including workers' compensation. In addition, Walbro has realized a 79% reduction in occupational time off because of injury and illness.[14]

In-house rehabilitation/fitness programs are represented not only in the manufacturing industry, but also in such diverse settings as the educational arena. The Central Health Improvement Program at Central Michigan University (CMU) invested $450,000 into a healthletics program designed to reduce work-related injuries and, in turn, decrease the amount of money the university was spending for workers' compensation payments. Central Michigan University employs 2364 people. For the first 6 months of operation, CMU savings because of their employees' ability to return to work sooner were estimated at $213,244. The Central Health Improvement Program facility also saved approximately 2423 days of lost time.[10] Unfortunately, recent state educational budget cuts have placed the Central Health Improvement Program facility in a precarious position. Too often, athletic trainers face an uncertain future because these types of programs are the first to be sacrificed during depressed economic times.

One industry realizing a high incidence of overuse and repetitive motion disorders is the meatpacking industry. Wilson Brands Corporation, with 1200 employees, has reduced dramatically two significant cost-related areas through its rehabilitation program. Comparing a 6-month period in 1988 with the same period in 1990, days lost were cut in half, and workers' compensation cases requiring surgical care were reduced by 95%.[8]

While these programs' figures are impressive, without direct correlation, one must consider that other extraneous factors also might have had an impact. Financial incentives, benefits restructuring, improved medical technology, and creative bookkeeping are some possible influences.

Corporate/Industrial Survey

In the Fall of 1991, I conducted an informal survey of 10 corporate/industrial sites that employ certified athletic trainers. The sites included the following variety of company settings: meatpacking and beverage, service industry, builder's hardware, chemical production, petroleum, automobile manufacturing, university, rubber, and small engine components.

Six of the corporate/industrial athletic trainers worked a 40-hour week, with nonworking weekends and holidays. The remaining four occasionally worked upwards of 60 hours per week. Half of the sites did not have assistant staff. In those that did, the average annual starting salary of assistant staff members was $22,000 to $24,000. The supervisory ATCs had an average annual salary of $40,000 to $42,000. The ATCs in industry spent, on an average, 54% of their work day conducting physical rehabilitation. The remaining time was shared among administrative, wellness, and safety programs.

The ratio of number of patients to each ATC in the industrial setting average 10:1. Approximately 60% of the injuries were sustained at work (occupational), and nonoccupational injuries accounted for the remaining 40%. Six of the surveyed sites routinely have annual caseloads of more than 250 patients.

Nine of the 10 corporate industrial sites surveyed reported that they did not bill for services. These employed only certified athletic trainers. The one site that did bill for services was coordinated by a physical therapist.

Results of the survey indicated that the title of certified athletic trainer was an inaccurate description of the profession, based on the type of work performed at the corporate/industrial sites. In addition, the majority of the athletic trainers working within this unique setting felt that the NATA was not adequately addressing the needs of corporate/industrial athletic trainers.

Conclusions/ Recommendations

Certified athletic trainers are beginning to have a substantial impact in an area outside of the standard athletic arena. Extraneous costs associated with

the treatment and rehabilitation of injuries sustained by employees of corporate/industrial America have been reduced substantially with the employment of an athletic trainer. There currently are 15 to 20 industrial athletic trainers in the United States market.[17] The primary objective of these trainers is the prompt treatment and rehabilitation of injuries sustained by the company's most valuable assets, its employees.

Whether the injuries occur at work or leisure, the company bears the cost in some fashion. For many companies, it is an assumed debit or liability. The majority of corporate managers and administrators are unaware of the options available in reducing these costs.

An in-house model in a corporate setting is clearly beneficial. Advantages include: 1) firsthand knowledge of the company's culture, objectives, and workforce characteristics; 2) a tendency by internal employees to be more diligent in efficiently and economically using the services provided; and 3) the greater potential to ensure coordination, continuity, and availability of services.

The opportunities available for the certified athletic trainer in this setting are relatively unlimited. However, industry currently is not searching out and attracting athletic trainers. Until top level executives of industry learn of the advantages of in-house rehabilitation, it will be necessary for the National Athletic Trainers' Association to become proactive. An extensive plan needs to be designed to include curriculum development and continuing education of specialized athletic trainers. Also, a marketing strategy targeted at the managers of midsize to large corporations and industrial firms needs to be implemented.

For the student or athletic trainer contemplating a career in the corporate/industrial setting, a working knowledge of specific subject matter is recommended. This coursework would include ergonomics, occupational health and safety, labor relations, workers' compensation, environmental disease and industrial hygiene, worksite wellness, work simulation/hardening, functional capacity testing, cost jus-

tification and budgeting, and human resource management.

Sports medicine is the study of the physiological, biomechanical, psychosocial, and pathological phenomena associated with exercise and athletics. It includes the clinical application of the knowledge gained from this study to the improvement and maintenance of functional capacities for physical labor, exercise, and athletics. It also encompasses the prevention and treatment of disease and injuries related to exercise and athletics.[6,16]

The field of sports medicine is established and respected. However, ignorance exists in the general public regarding the practice of sports medicine and athletic training, and the continued expansion of athletic trainers working in industry on nonathletic injuries. Traditional terminology that is presented in both NATA public relations efforts and printed materials needs to be modified and expanded to include this growing segment of our profession.*

We must not close our minds to potential employment opportunities. Currently, there is dialogue concerning name change and state licensure. Many state licensure efforts have limited severely the practice and scope of athletic trainers to athletes and athletic injury. Much of the talk regarding name change centers around titles which are already self-limiting. As discussion continues and progresses to the point of action, the corporate/industrial athletic trainer needs to be considered. A title encompassing all specialties of our profession is a necessity and should not exclude future employment opportunities.

Industrial medicine is not new, but the concept of athletic trainers in industry is just beginning to grow. The single greatest threat to potential jobs for athletic trainers in the industrial and corporate setting continues to be restrictive state legislation. Employment, in this so-called nontraditional arena, depends on the foresight of our leaders and general membership. They must become proactive on state- and national-level policy and defeat protectionism.

*Editor's note: The NATA has begun using "physically active" to describe those who receive our services.

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The Industrial Athlete, Inc. (TIA)

Data from a Supermarket Distribution Center serving 130 Stores

Period: 10/1/11 – 5/31/15

Narrative

Introduction

This narrative is intended to assist the reader in navigating through the accompanying tables, graphs and data. The information documents the impact that The Industrial Athlete, Inc. (TIA) Program has on employee injuries and their related costs. The data will show the efficiency, cost effectiveness and Return-On-Investment (ROI) that is the result of TIA's SMART℠ (Sports Medicine, Athletic Rehabilitation and Training) model of injury management. The Sports Medicine Model outcomes fare quite favorably when compared with the Traditional Healthcare Model. Please keep in mind the fact that although this data was taken from a different industry, the mechanisms of injury and the ways in which injuries are treated and prevented are the same.

The narrative explains the following:

- OCR (Observe, Coach, Reinforce)
- Injury Prevention and Treatment
- "All-in" Injury Data
- "DART" and DART rates (DART = Lost time injuries resulting in Days Away, Restricted duty, Transfer to another department)
- Initial Evaluation Data

The Table and Graphs are displayed in "Periods" (e.g., Period 1, Period 2, etc.). A Period represents a four week time span within the client's fiscal year. Period 1 begins May 1 , the first four week period of the client's fiscal year. Currently (6/17/15), we would be into Period 2 of Fiscal Year 2016.

Table (1) is for FY15, Period 13 (May 2015). The last tab in the left, lower corner of the Table, "Sheet 3," displays the graphs referenced in this document. Tabs to the left open Tables from previous Periods.

TABLE 1 (attachment FYE15.Period13)

Nearly all of the data are derived from two major departments within the Distribution Complex, which historically sustain the highest job-related injury rates. The two departments are "Grocery" and "Perishables."

OCRs

OCR means **Observe, Coach and Reinforce.** It is the process by which TIA trains and reinforces the proper biomechanics for the respective jobs performed within the Distribution Complex. The OCR process is implemented as follows:

1. The TIA Athletic Trainer who is a Certified Ergonomic Evaluation Specialist conducts ergonomic assessments of the various jobs within the client site.
2. Key behaviors necessary to achieve proper biomechanics are identified and listed on an **"OCR Form"** with weighted values assigned to each for purposes of scoring each OCR conducted. The behaviors range from:
    - "rarely ever" performs the behavior properly, to
    - "almost always" performs if properly
3. TIA conducts **"Coaches Clinics"** to train supervisors on how to properly conduct OCR's, what behaviors to look for and how to assess proper biomechanics. Supervisors are given a break-in period to gain competency and confidence.
4. Supervisors are assigned a quota of OCR's to conduct in their department each week. Athletic Trainers also conduct an assigned number of random OCR's across all departments.
5. Scores on each behavior are collected; group data analyzed and behaviors most often violated are identified and recorded as **"Unsafe Acts."** These behaviors become the focus of the client's ongoing Safety Awareness campaign.
6. The frequency of OCR's is increased in those areas or departments with higher rates of **"Unsafe Acts"** with various measures taken. These are referred to as **"Target OCR's"** and the remedies include:
    - job coaching
    - training in the "lifting lab"
    - positive and/or negative incentives
    - team member accountability

Across the top of the Table is the heading, "Behavior", with proper behaviors listed. The next two columns list the average scores for each behavior by department (Grocery, Perishables) from OCR's conducted.

Injury Prevention & Treatment

This section shows the count for that Period of each category of Prevention & Treatment procedures that TIA provides. The data show the cost had the Treatment been performed at an outside clinic and at the regional workers compensation fee schedule rate. The total outside cost by procedure category and the total cost avoidance per month is also shown. The following needs to be considered when interpreting the data.

TIA's numbers are a "conservative estimate" of direct workers comp cost avoidance because we only perform those treatments and procedures that are necessary to promote

healing. Historically, traditional healthcare providers often engage in less than completely ethical business practices. The following are fairly common:

1. While they may bill in 15-minute treatment units, they may order a 20 minute treatment, which enables them to bill your workers comp insurance for two units rather than one. This is regretfully a fairly common practice.
2. Add unnecessary treatments or procedures in order to increase their billing. This is also a fairly common practice, although some abuse it more than others. They can afford to risk an audit from one or more of the major carriers because typically this is only detected if there is a large upsurge in their billings. This business practice usually goes undetected.
3. Require frequent and unnecessary follow-up visits with the physician for the sake of increasing their billings.
4. This example client does not even have standard modality resources, i.e., ultrasound, electronic muscle stimulation or iontophoresis equipment for use by TIA Athletic Trainers. These are the most commonly administered treatment modalities in either a clinical or athletic training room setting and are within the Athletic Trainer's "Scope of Practice" capabilities.
5. If the treatment is performed at an outside clinic, the actual "direct cost" billed against workers compensation insurance would typically be 2 to 3 times higher. The cost of transporting to and from work or home, possible lost work time during the treatment, etc. must be added on. This only represents "direct cost."
6. The **"Total Comp Cost"** is equal to "direct cost" + "indirect cost." Most companies don't have a good grasp of what their "indirect costs" actually amount to. The National Safety Council estimates that "indirect cost" is equal to approximately 3 times "direct cost." The **"Total Comp Cost"** is determined by the following formula:

Direct cost (X) + Indirect Cost (3X) = Total Comp Cost (4X)

Total Workers Compensation Cost is equal to approximately four times Direct Cost. In this example using the TIA SMART℠ Program and TIA's conservative estimated formula, the Return On Investment **(ROI)** for this client is **6:1.**

<u>Grand Totals</u>

This section illustrates:

- Total Treatments
- Total Treatment Visits
- Average Visits per Injury
- Average Cost Avoidance per Injury by shift/department and totals.
- Average Cost Avoidance per Visit by shift/department and totals.

All In OR All Injuries

This section represents all injuries reported, including those that required first aid, evaluation, or any attention by the athletic trainers or outside medical staff. It does not include near misses, which did not result in any harm to the employee. Rates and counts are displayed by shift/department.

DART

This section represents those injuries, which resulted in **D**ays **A**way, **R**estricted duty and/or **T**ransfer to another department. Rates and counts are displayed by shift/department.

YTD Initial Evaluation Breakdown

This section lists the number of initial evaluations from the Injury Prevention/Treatment section above, separated into those which pertained to job-related injuries: [Worker's Comp] (WC) and non-job-related injuries (Non-WC). The data show the majority of injuries being treated are not work related, but still affect productivity on the job. When determining ROI, the allowable rates for third-party billing and reimbursement for general health insurance claims is even greater than that allowable for worker's comp claims. TIA's conservative ROI figures need to be considered.

Summary

In addition to the ROI realized by the TIA SMART℠ model of care, additional ROI benefits result from:

1. Fewer claims billed against workers comp insurance.
2. Fewer claims billed result in a reduction in workers comp third-party administrator's expense.
3. Fewer claims billed against health insurance.
4. Fewer claims billed result in a reduction in health insurance third-party administrator's expense.
5. Reduction in workers compensation reserves over time.
6. More productive workforce.
7. More effective delivery and reinforcement of the employee health and wellness message through a team of preventive healthcare professional facilitators.

GRAPHS ("A – D" in attachment "FYE 15 Period 13, SHEET 3"; "E" in attachment "Correlation FYE 15 P3"; "F" in attachment "OCR AND CORRELATION GRAPH"

A. DART Rates – FY 2012 - FY2015

Displays DART rates by Period for FY 2012 – 2015 for Grocery and Perishable departments. Raw data appears in Table to left of Graph. DART rates for the last period and Year-to-Date for all departments within Distribution appears in Table below that.

A single lost time injury can cause a major change on the graph, as shown in the jump from P9 to P10, 2013 in Grocery. The sharp decline appearing from June to July (P3 – P4, 2013) coincided with the cancellation of the client's contracted on-site physician and medical clinic. At an annual cost of over $500,000 the client determined they were not getting much for their investment, as almost every employee who visited was referred out to orthopedic or other medical specialists or physical therapy. The Medical Director refused to allow our athletic trainer's to triage injuries before being referred outside. If we were not allowed to triage, we would have little lasting impact on DART rates, since the client is at the mercy of the third-party billing/reimbursement system. The contracted on-site physician profited by ordering procedures, which resulted in DART's and an increased DART Rate. We added the second athletic trainer on October 1, 2013. Our client officially changed their policy in November 2012 directing supervisors to send injured employees to our athletic trainer's for triage. The graph shows both departments were injury free in December with only one injury occurring in January in Grocery.

B. YTD Initial Evaluation Breakdown – FY 2015

This Graph illustrates the number of initial injury evaluations performed in Grocery, Perishables and all other departments, broken down by "Workers Comp" and "Non-Workers Comp" in nature. The numbers might prompt the reader to assume that the injury rates are unusually high. Keep in mind the following:

- At any given time there are numerous "walking wounded" who show up to work, but due to muscle/joint discomfort, are hindered in their job performance (presenteeism); though not considered an actual injury at this time by traditional healthcare standards, they are clearly an injury or chronic condition waiting to happen
- Due to the preventive nature of the sports medicine model of care, employees know to come to the athletic trainer before the condition becomes totally debilitating
- Figures include Non-work related injuries which can be just as costly on an employer's bottom line, representing conditions which never resulted in health insurance claims

This is an excellent example of the emphasis that is placed on prevention in the SMART℠ model of care.

C. Cost Avoidance – FY 2013 – FY 2015

This graph tracks Total Cost Avoidance during this time period. Estimated ROI on a month-to-month basis can be calculated using the formula "Injury Prevention/Treatment," Section 1.f. This graph also illustrates how understaffing the program, shifting the athletic trainer's priorities from one area of service to another, can detract temporarily from the cost effectiveness. One athletic trainer was on maternity leave from FY 14, P10 – FY 15, P1. From FY 13, P11 –FY 14, P3, most of the athletic trainers' time was focused on conducting one-on-one lifting labs for every employee (1,110) within Distribution, resulting in much less time spent in the treatment room.

D. Total Treatments – FY 2014, FY 2015

The horizontal axis shows each period of FY 2015; the vertical axis displays the number of treatments. Raw data for FY 2014 and 2015 appear to the left of the Graph. Utilization increased gradually, peaking twice during the last half. Peaks coincided with two waves of new hires, most of whom were unaccustomed to working within a distribution center setting. Utilization has increased significantly over the nearly four year period since TIA started there, as the employees became more familiar with the services available, skills of the athletic trainer and word spread about the results employees experienced. The athletic trainers spend much of their time out on the floor building relationships and a bond of trust with the employees. As is typically the case, once familiar with the services available, employees who have had aches and pains flock to the athletic trainer early on. Over time, these issues are addressed and the "early injury recognition/early intervention" efforts reduce the demand somewhat.

E. Ergo Related Injuries by Period, FY 2012 – FY 2015, P3; Correlation Graph

Graph illustrates the number of ergonomic-related injuries that occurred over the period from the start of FY 2012 through FY 2015 Period 3, correlated with benchmark events in the development of the SMART System program. The horizontal axis shows the period through each fiscal year, while the vertical axis represents the number of ergonomic-related injuries which occurred during each Period.

The Industrial Athlete's SMART℠ program was not in place until Period 7 of FY 2012 (October 2011). After approximately 6 weeks start up time, the athletic trainer was treating employees by mid-to-late November 2011, or Period 8 FY 2012. Our athletic trainer had little to no control over DART Rates until late in FY 2013 Period 8 (November 2012). By that time, the second athletic trainer had been added providing coverage over most shifts, Monday through Friday. Additionally, the company policy

requiring that a physician evaluate all injuries had been revised to require that supervisors direct all injuries through the athletic trainer's for triage. Without this crucial step, potential injuries would have been directed to the third-party billing/reimbursement system. The likelihood of becoming a DART would be almost inevitable.

F. Ergo Related Injuries by Quarter, FY 2012 – FY 2015 P3; Correlation Graph

The same information illustrated in "E", above, but represented by quarter, rather than each period. Makes it slightly easier for the reader to see trends as related to various stages of program development and implementation.

Appendix G

Standards of Professional Practice and Documents Concerning Education and Accreditation

Board of Certification, Inc.

BOC STANDARDS OF PROFESSIONAL PRACTICE

Published May 2016
Implemented September 2016

INTRODUCTION

The *BOC Standards of Professional Practice* is reviewed by the Board of Certification, Inc. (BOC) Standards Committee and recommendations are provided to the BOC Board of Directors. The BOC Standards Committee is comprised of five Athletic Trainer members and one Public member. The BOC Board of Directors approves the final document. The BOC Board of Directors includes six Athletic Trainer Directors, one Physician Director, one Public Director and one Corporate/Educational Director.

The BOC certifies Athletic Trainers (ATs) and provides exceptional credentialing programs that support the protection of the public. An AT is a healthcare professional who renders service or treatment, under the direction of or in collaboration with a physician, in accordance with their education and training and the states' statutes, rules and regulations. As a part of the healthcare team, services provided by ATs comprise, but are not limited to, prevention and education, emergent care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions.

The BOC is the only accredited certification program for ATs in the United States. Every five years, the BOC must undergo review and re-accreditation by the National Commission for Certifying Agencies (NCCA). The NCCA is the accreditation body of the Institute of Credentialing Excellence.

The *BOC Standards of Professional Practice* consists of two sections:

I. Practice Standards
II. Code of Professional Responsibility

Council for
Higher Education
Accreditation

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October 21, 2014

Dr. Micki Cuppett
President
Commission on Accreditation of Athletic Training Education
6836 Austin Center Boulevard, Suite 250
Austin, TX 78731

Dear Micki:

At its meeting on September 29-30, 2014, the Council for Higher Education Accreditation (CHEA) Board of Directors reviewed the recommendation of the CHEA Committee on Recognition regarding the recognition application submitted by the Commission on Accreditation of Athletic Training Education (CAATE).

I am pleased to inform you that the board of directors accepted the committee's recommendation and granted recognition to CAATE.

The CHEA-recognized scope for CAATE is the following:

> *The Commission on Accreditation of Athletic Training Education (CAATE) accredits professional and post-professional programs in athletic training at the baccalaureate and master's degree levels and non-degree residency programs in specialty areas of athletic training within the United States.*

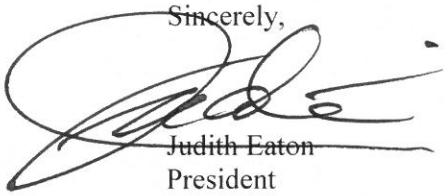
The *2010 CHEA Recognition Policy and Procedures (#17, p. 8*) provides that, at a minimum, the accrediting organization will undergo a recognition review every 10 years. Recognized accrediting organizations will provide interim reports, normally at the end of the third and sixth years. The first Interim Report for CAATE is due July 1, 2017.

CHEA may elect to review a recognized accrediting organization out of sequence when (1) the accrediting organization proposes to change the scope of its activities or other fundamental aspects of its organization or accreditation activities; (2) there has been a pattern of documented concerns related to CHEA eligibility or recognition standards from institutions or programs following accreditation reviews by the accrediting organization over time, and received by CHEA, and the institutions have utilized the accrediting organization's procedures for addressing complaints; or (3) there have been documented concerns that, in its judgment, the Committee believes indicate that the organization may not be meeting one or more of the CHEA eligibility or recognition standards *(2010 CHEA Recognition Policy and Procedures (#17, p. 9).*

Under the *2010 CHEA Recognition Policy and Procedures*, CHEA will provide notice through its publications that CAATE is a CHEA-recognized accrediting organization and will provide CAATE with a copy of CHEA's *Public Notice: Recognition Decision Summary* that will appear on the CHEA Website.

Thank you.

Sincerely,



Judith Eaton
President

cc: Judith Watkins, Interim Vice President for Recognition Services

BOC BOARD OF CERTIFICATION
FOR THE ATHLETIC TRAINER
Be Certain.™

caATe

Crosswalk Analysis:

Role Delineation Study/Practice Analysis, Sixth Edition
vs.
Athletic Training Education Competencies, Fifth Edition

The crosswalk analysis serves to illustrate that the content for the BOC Exam is incorporated into accredited athletic training programs.

- The *Role Delineation Study/Practice Analysis, Sixth Edition* (RD/PA) serves as the validated basis of knowledge and skills for an entry-level Athletic Trainer (AT) and is the blueprint for the exam.
- The *Athletic Training Education Competencies, Fifth Edition (Competencies)* define the educational content that is expected of students within an accredited athletic training program.
- Although these are two distinct documents, both hold a major role in the preparation and evaluation of entry-level ATs.

The RD/PA task, knowledge and skill statements are listed below with the corresponding athletic training education competency numbers. Please visit the CAATE website, www.caate.net, to obtain a copy of the *Competencies*.

- For tasks to become entry-level, they must first be incorporated into athletic training programs – which stimulate the concepts to permeate into entry-level practice.
- It is not uncommon for there to be athletic training education competencies not included in the RD/PA. This illustrates that those competencies have not permeated entry-level practice as of yet.

BOC Domains

I. Injury/Illness Prevention and Wellness Protection
II. Clinical Evaluation and Diagnosis
III. Immediate and Emergency Care
IV. Treatment and Rehabilitation
V. Organizational and Professional Health and Well-being

Education Competencies

EBP = Evidence Based Practice
PHP = Prevention and Health Promotion
CE = Clinical Examination and Diagnosis
AC = Acute Care of Injuries and Illnesses
TI = Therapeutic Interventions
PS = Psychosocial Strategies and Referral
HA = Healthcare Administration
PD = Professional Development and Responsibility
CIP = Clinical Integration Proficiencies

BOC *Role Delineation Study/Practice Analysis, Sixth Edition* Domain/Task/Knowledge/Skill Statements	Education Competencies
DOMAIN I: Injury/illness prevention and wellness protection	---
A. Minimize risk of injury and illness of individuals and groups impacted by or involved in a specific activity through awareness, education and intervention.	**PHP,CE,AC, PS,HA,CIP**
Knowledge of:	---
1. Roles of appropriate individuals (e.g., administrators, management, parents/guardians/family members, coaches, participants and members of the health care team) in risk and illness prevention	PHP 18 AC 2 HA 24
2. Behavioral risks (e.g., nutritional, sexual, substance abuse, blood-borne pathogens, sedentary lifestyle and overtraining)	PHP 5,24,25
3. Catastrophic risks (e.g., cardiorespiratory, neurological, thermoregulatory, endocrinological and immunological)	PHP 10,11 PS 16
4. Common risks (e.g., musculoskeletal, integumentary, neurological, respiratory and medical)	PHP 6 CE 3
5. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts and oral communication)	PHP 18
6. Environmental risks (e.g., heat, cold, altitude, sunburn, insects, visibility/lighting and lightning)	PHP 10,11
7. Mechanisms of common and catastrophic injury	PHP 3
8. Preventive measures (e.g., safety rules, accepted biomechanical techniques, ergonomics and nutritional guidelines)	PHP 4
Skill in:	---
9. Communicating effectively	CIP 9
10. Identifying appropriate resources	CIP 3
11. Identifying risks	PHP 1,5,17 CIP 3

B. Interpret individual and group pre-participation and other relevant screening information (e.g., verbal, observed, written) in accordance with accepted and applicable guidelines to minimize the risk of injury and illness.	**PHP,AC,HA,PD,CIP**
Knowledge of:	---
1. Established laws, regulations and policies (e.g., institutional, state and national)	PD 3-5 AC 1
2. Established guidelines for recommended participation	PD 5,8,9
3. Pre-participation evaluation process and procedures	HA 23
4. Privacy laws	PD 3
Skill in:	---
5. Applying appropriate pre-participation screening information	HA 23 CIP 1
6. Applying established guidelines and regulations	PD 3-5
7. Collecting appropriate pre-participation screening information	AC 5
8. Identifying appropriate resources	CIP 1,3
9. Identifying health-related conditions that may limit or compromise participation	PHP 5
10. Identifying established guidelines and regulations	PD 4,5 PHP 12
C. Identify and educate individual(s) and groups through appropriate communication methods (e.g., verbal, written) about the appropriate use of personal protective equipment (e.g., clothing, shoes, protective gear and braces) by following accepted procedures and guidelines.	**PHP,PD,CIP**
Knowledge of:	---
1. Commercially available protective products	PHP 20-22
2. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts and oral communication)	PHP 18
3. Effective use of prophylactic/protective measures	PHP 2,23
4. Established standards pertaining to protective equipment (e.g., NOCSAE and ASTM)	PHP 20 PD 5
5. Intended purpose, limitations and capabilities of protective equipment	PHP 20,21
6. Legal risks and ramifications of making equipment modifications	PHP 20,21 PD 3-5
7. Legal and safety risks involved in the construction and use of custom and commercial protective devices	PHP 20,21 PD 3-5
8. Manufacturer's guidelines regarding selection, fit, inspection and maintenance of equipment	PHP 20,21,22
9. Materials and methods for fabricating custom-made protective devices	PHP 21

10. Physical properties of the protective equipment materials (e.g., absorption, dissipation and transmission of energy)	PHP 20-22
Skill in:	---
11. Educating individuals on the selection of standard protective equipment	CIP 1,2
12. Fabricating and fitting custom-made devices	PHP 21
13. Fitting standard protective equipment	PHP 22
14. Interpreting rules regarding protective equipment	PHP 20 PD 5
15. Identifying injuries, illnesses and health-related conditions that warrant the application of custom-made or commercially available devices	CIP 1,2
16. Selecting and applying commercial devices	CIP 1,2
D. Maintain physical activity, clinical treatment and rehabilitation areas by complying with regulatory standards to minimize the risk of injury and illness.	**PHP,TI,PD**
Knowledge of:	---
1. Laws, regulations and policies (e.g., institutional, state and national) regarding safety and sanitation	PHP 7,20 TI 19 PD 3-5
2. Manufacturer's guidelines for maintaining equipment and devices	PHP 22 TI 19
3. Health-related conditions that pose risk	PHP 5
Skill in:	
4. Complying with manufacturer's recommendations for maintenance of equipment	PHP 20
5. Maintaining a safe and sanitary environment in compliance with established standards (e.g., OSHA, universal precautions, local health department and institutional policy)	PHP 22 TI 19,20 PD 4,5,7
6. Recognizing noncompliance with safety and sanitation standards	PHP 7
7. Recognizing malfunction or disrepair of therapeutic modalities, rehabilitation equipment or furnishings in clinical and treatment areas	TI 20
E. Monitor environmental conditions (e.g., weather, surfaces, client work-setting) using appropriate methods and guidelines to facilitate individual and group safety.	**PHP,HA,PD,CIP**
Knowledge of:	---
1. Health-related conditions of participants that predispose them to environmentally caused illness (e.g., prior heat illness, sickle cell trait, asthma, recent viral infection, use of medication, ergogenic aids, obesity and dehydration)	PHP 29
2. Emergency communication systems	HA 24

3. Environmental conditions that create risk (e.g., heat, humidity, cold, altitude, pollution, weather extremes, insect swarms, infectious pathogens and ergonomic conditions)	PHP 10
4. Ergonomic and epidemiological risk factors as they relate to participation	PHP 19
5. Established standards regarding environmental risks (e.g., governing body rules/regulations, NATA, NCAA, ACSM, etc.)	PHP 12 HA 15,16 PD 3-5
6. Hazards common in activity areas (e.g., surface irregularities, obstructions, inadequate offsets, moisture and other foreign objectives, inadequate lighting, inadequate ingress and egress)	PHP 18
7. Hazards common to equipment (e.g., shoulder pads, goal posts, computer keyboards, desk chairs, hand trucks)	PHP 18,19
8. Methods for reducing risk from environmental conditions (e.g., activity scheduling, clothing selection and fluid replacement)	PHP 10-12
9. Policies and procedures for removing participants from environmental risk situations (e.g., heat index, lightning and activity scheduling)	PHP 11
10. Policy statements and guidelines pertaining to safety hazards (e.g., NATA and NCAA)	PD 4
11. Rules governing play and established standards and practices	PD 4
Skill in:	---
12. Conducting inspections and recognizing hazards	PHP 18
13. Monitoring techniques (e.g., weight charts, fluid intake and body composition)	PHP 14
14. Recognizing environmental and ergonomic risks	PHP 13
15. Recognizing characteristics in participants that would predispose them to environmental and ergonomic risks	PHP 18,19
16. Recommending and implementing appropriate methods for addressing hazards	CIP 3
17. Using available resources to gather/interpret information regarding environmental data	PHP 13
F. Maintain or improve physical conditioning for the individual or group by designing and implementing programs (e.g., strength, flexibility, CV fitness) to minimize the risk of injury and illness.	**PHP**
Knowledge of:	---
1. Components of a physical conditioning program	PHP 25,29,30
2. Current strength and conditioning techniques	PHP 26,29,31
3. Ergonomics	PHP 19
4. Human physiology	PHP 25
5. Physiological adaptation to exercise (e.g., space and altitude)	PHP 28,30
6. Various conditioning stages and program intervals	PHP 28,30
Skill in:	---
7. Addressing the components of a comprehensive conditioning program (e.g., strength, flexibility, endurance, sport requirements and individual needs)	PHP 27,29,30,44

8. Assessing appropriateness of individual or group participation in conditioning programs	PHP 27,29,30
9. Correcting or modifying inappropriate, unsafe or dangerous activities undertaken in conjunction with physical conditioning programs	PHP 26,28,31
10. Educating appropriate individuals in the effective application of conditioning programs (e.g., guardians, coaches, participants and administration)	PHP 29
11. Instructing in the use of appropriate conditioning equipment (e.g., bikes, weight machines and treadmills)	PHP 29-31
G. Promote healthy lifestyle behaviors using appropriate education and communication strategies to enhance wellness and minimize the risk of injury and illness.	**PHP,CE,PS,PD**
Knowledge of:	---
1. Accepted guidelines for exercise prescription	PHP 27,29
2. Accepted nutritional practices	PHP 32-35,38,39,45
3. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts and oral communication)	PHP 33
4. Predisposing factors for nutritional and stress-related disorders	PHP 32,45 PS 13
5. Professional resources for addictions (e.g., tobacco, alcohol and narcotics)	PS 13
6. Professional resources for stress management and behavior modification (e.g., anger management, HIV/STD prevention and operational stress control)	CE 22 PS 11
7. Related nutritional disorders, inactivity-related diseases, overtraining issues and stress-related disorders	PHP 24,32,33,35,45 PS 12,13
Skill in:	---
8. Accessing information concerning accepted guidelines for nutritional practices	PHP 35-37,39,40 PS 13
9. Addressing the issue of special nutritional needs in regard to competition or activity (e.g., pre- and post-game meals and nutritional supplements)	PHP 33,40-42
10. Communicating with appropriate professionals regarding referral and treatment for individuals	PHP 43,47 PS 11,14 PD 10
11. Educating appropriate individuals on nutritional disorders, maladaptation, substance abuse and overtraining	PHP 32 PS 18
12. Recognizing signs and symptoms of nutritional, addiction and stress-related disorders	PHP 43,46 PS 14
DOMAIN II: Clinical Evaluation and Diagnosis	---
A. Obtain an individual's history through observation, interview and/or review of relevant records to assess injury, illness or health-related condition.	**CE,PS,CIP**
Knowledge of:	---

1. Biomechanical factors associated with specific activities	CE 4,21
2. Communication techniques in order to elicit information	PS 17
3. Injuries, illnesses and health-related conditions associated with specific activities	CE 7,20,21
4. Medical records as a source of information	CE 21
5. Pathomechanics of injury	CE 5,20,21
6. Pathophysiology of illnesses and health-related conditions	CE 5,20,21
7. Relationships between injuries, illnesses and health-related conditions and outside factors (e.g., predisposing, nutritional, ergogenic aids, infectious agents and medications)	CE 20,21 PS 14
8. Signs and symptoms of injuries, illnesses and health-related conditions	CE 13,20,21 PS 12
9. Standard medical nomenclature and terminology	CE 1,2
10. The body's immediate and delayed physiological response to injuries, illnesses and health-related conditions	CE 2,20
Skill in:	---
11. Obtaining and recording information related to injuries, illnesses and health related conditions	CE 13,20,21 PS 12
12. Identifying anatomical structures involved in injuries, illnesses and health-related conditions	CE 1,2,20,21
13. Identifying nutritional factors related to injuries, illnesses and health-related conditions	CIP 1
14. Identifying psychosocial factors associated with injuries, illnesses and health-related conditions	CE 21
15. Identifying the extent and severity of injuries, illnesses and health-related conditions	CE 13
16. Identifying the impact of supplements and prescription and nonprescription medications associated with injuries, illnesses and health-related conditions	CIP 1,5
17. Interpreting medical records and related reports	CIP 9
18. Recognizing predisposing factors to specific injuries, illnesses and health-related conditions	CE 21
19. Relating signs and symptoms to specific injuries, illnesses and health-related conditions	CE 13,21
B. Utilize appropriate visual and palpation techniques to determine the type and extent of the injury, illness or health-related condition.	**CE,PS**
Knowledge of:	---
1. Human anatomy with emphasis on bony landmarks and soft tissue structures	CE 2,21
2. Immediate and delayed physiological response to injuries, illnesses and health-related conditions	CE 20
3. Normal and abnormal structural relationships to the pathomechanics of injuries and health-related conditions	CE 20
4. Principles of palpation techniques and visual inspection	CE 20
5. Response to injuries, illnesses and health-related conditions	CE 20
6. Signs of injuries, illnesses and health-related conditions	CE 20 PS 12

7. Standard medical nomenclature and terminology	CE 20
Skill in:	---
8. Assessing immediate and delayed physiological responses to injuries, illnesses and health-related conditions	CE 20
9. Assessing pre-existing structural abnormalities and relating them to pathomechanics of injuries, illnesses and health-related conditions	CE 20
10. Identifying bony surface landmarks and soft tissue abnormalities of specific injuries, illnesses and health-related conditions	CE 1,20 PS 12
11. Identifying the relationship and severity of pathological signs of injuries, illnesses and health-related conditions	CE 20
12. Locating and palpating bony landmarks, articulations, ligamentous structures, musculotendinous units and other soft tissues	CE 1,20,21
13. Palpating appropriate structures in order to assess the integrity of human anatomical/physiological systems	CE 1,20,21
14. Recognizing severity of pathological signs and symptoms of injuries, illnesses and health-related conditions	CE 20,21
C. Utilize appropriate tests (e.g., ROM, special tests, neurological tests) to determine the type and extent of the injury, illness or health-related condition.	**PHP,CE**
Knowledge of:	---
1. Mechanics, principles and techniques of specific/special tests (ligamentous, neurological, manual, fracture and functional tests)	CE 20,21
2. Signs and symptoms of systemic failure during exercise	CE 20,21
3. Signs, symptoms and interpretations of specific/special tests	CE 20,21
4. Standard/individual special tests for range of motion, muscular strength, structural integrity and functional capacity	PHP 26 CE 20,21
Skill in:	---
5. Assessing muscular strength through the use of manual or non-manual muscle tests	PHP 26 CE 20,21
6. Assessing neurological function	CE 20,21
7. Assessing joint range of motion using test and measurement techniques	CE 20,21
8. Identifying appropriate specific/special tests	PHP 26 CE 20,21
9. Identifying location, type, function and action of each joint	CE 20,21
10. Identifying structural and functional integrity of anatomical structures	PHP 26 CE 20,21
11. Interpreting the information gained from specific/special tests	CE 21

12. Performing specific/special tests	PHP 26 CE 20,21
13. Using equipment associated with specific/special tests	PHP 26 CE 20
D. Formulate a clinical diagnosis by interpreting the signs, symptoms and predisposing factors of the injury, illness or health-related condition to determine the appropriate course of action.	**CE,TI,PS,PD,CIP**
Knowledge of:	---
1. Basic pharmacology associated with diagnosis and courses of action	TI 24-31
2. Signs, symptoms and predisposing factors related to injuries, illnesses and health-related conditions	CE 21
3. Guidelines for return to participation	CE 7
4. Indications for referral	CE 16 PD 10
5. Standard medical terminology and nomenclature	CE 1
6. Pathomechanics of injuries and/or health-related conditions	CE 21
7. Psychosocial dysfunction and implications associated with injuries, illnesses and health-related conditions	PS 7,9
Skill in:	---
8. Identifying appropriate courses of action (e.g., treatment plan, referral)	CE 12,16 PD 10
9. Interpreting the pertinent information from the evaluation	CE 17,18,21
10. Synthesizing applicable information from an evaluation	CE 17,18,21 CIP 2,10,11
E. Educate the appropriate individual(s) about the clinical evaluation by communicating information about the injury, illness or health-related condition to encourage compliance with recommended care.	**CE,AC,PS,PD,CIP**
Knowledge of:	---
1. Commonly accepted practices regarding the care and treatment of injuries, illnesses and health-related conditions	PS 4,6
2. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts and oral communication)	PS 4,6
3. Patient confidentiality rules and regulations	PS 18 PD 3-5
4. Potential health-related complications and expected outcomes	CE 8
5. Role and scope of practice of various health care professionals	AC 2 PS 10 PD 1,2,8,9
6. Standard medical terminology and nomenclature	CE 1

Skill in:	---
7. Communicating with appropriate professionals regarding referral and treatment for individuals	PS 11,14
8. Directing a referral to the appropriate professionals	CE 16 PD 10
9. Interpreting standard medical terminology and nomenclature and describing the nature of injuries, illnesses and health-related conditions in basic terms	CE 1
10. Utilizing appropriate counseling techniques	CIP 7
11. Using standard medical terminology and nomenclature	CIP 9
DOMAIN III: Immediate and Emergency Care	---
A. Coordinate care of individual(s) through appropriate communication (e.g., verbal, written, demonstrative) of assessment findings to pertinent individual(s).	**AC,PS,HA,PD,CIP**
Knowledge of:	---
1. Components of the emergency action plan(s)	AC 2-4,8 HA 21
2. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts and oral communication)	PS 4
3. Roles of individual members of the medical management team	AC 2 PD 8,10
Skill in:	---
4. Communicating effectively with appropriate individuals (e.g., medical providers, patients, parents, administrators)	AC 2 PD 14 CIP 20
5. Educating individuals regarding standard emergency care procedures	AC 2,3 PD 14
6. Implementing the emergency action plan(s)	CIP 15
B. Apply appropriate immediate and emergency care procedures to prevent the exacerbation of health-related conditions to reduce the risk factors for morbidity and mortality.	**PHP,CE,AC,TI, HA,PD,CIP**
Knowledge of:	---
1. Appropriate management techniques for life-threatening health-related conditions (e.g., respiratory, cardiac and central nervous)	AC 5-7,19,20,22, 27,28,30,33,34,38
2. Appropriate use of emergency equipment and techniques (e.g., AED, CPR masks and BP cuff)	PHP 15,16 CE 23 AC 6-10,29,31,32,35 TI 28
3. Mechanisms (biomechanics/kinesiology) of catastrophic conditions	AC 23,24
4. Common life-threatening medical situations (e.g., respiratory, central nervous and cardiovascular)	AC 7,27,36

5. Emergency action plan(s)	HA 20
6. Federal and state occupational, safety and health guidelines	AC 21 PD 4,5
7. Human physiology: normal and compromised functions	AC 7
8. Physiologic reactions to life-threatening conditions	AC 36
9. Pharmacological and therapeutic modality usage for acute health-related conditions	AC 27,31,32,35 TI 30
10. Signs and symptoms of common medical conditions	AC 27,36
11. Standard protective equipment and removal devices and procedures	AC 10
Skill in:	---
12. Applying pharmacological agents	CIP 4,6
13. Applying therapeutic modalities	CIP 4
14. Performing cardio-pulmonary resuscitation techniques and procedures	AC 12-18
15. Implementing emergency action plan(s)	AC 4 CIP 6
16. Implementing federal and state occupational, safety and health guidelines	PD 4,5
17. Implementing immobilization and transfer techniques	AC 23-26
18. Managing common non-life-threatening and life-threatening emergency situations/health-related conditions (e.g., evaluation, monitoring and provision of care)	AC 1,2,7,11-18
19. Measuring, monitoring and interpreting vital signs	AC 6,7,28,29,32
20. Removing protective equipment using appropriate removal devices and/or manual techniques	CIP 6
21. Transferring care to appropriate medical and/or allied health professionals and/or facilities	PD 10
22. Using standard medical equipment	AC 31,32 TI 28
23. Utilizing emergency equipment	CIP 6
C. Implement appropriate referral strategies, while stabilizing and/or preventing exacerbation of the condition(s), to facilitate the timely transfer of care for health-related conditions beyond the scope of practice of the Athletic Trainer.	**AC,PS,HA,CIP**
Knowledge of:	---
1. Common management strategies for life- and non-life-threatening health-related conditions	AC 36-39
2. Emergency action plan(s)	AC 1,2
3. Health-related conditions beyond the scope of the Athletic Trainer	PS 11
4. Indications for referral to other health care providers	PS 11,14,15
5. Roles of medical and allied health care providers	AC 2 HA 31
Skill in:	---

6. Communicating with appropriate professionals regarding referral and treatment for individuals	PS 18
7. Directing a referral to the appropriate professionals	PS 11
8. Immobilization, splinting and transfer techniques	AC 37
9. Implementing the emergency action plan(s)	CIP 6
10. Managing common non-life-threatening and life-threatening emergency situations/health-related conditions until transfer to appropriate medical providers and facilities	AC 37
11. Recognizing acute health-related conditions beyond the scope of the Athletic Trainer	CIP 5,6
D. Demonstrate how to implement and direct immediate care strategies (e.g., first aid, emergency action plan) using established communication and administrative practices to provide effective care.	**EBP,AC,PS,HA,CIP**
Knowledge of:	---
1. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts and oral communication)	PS 4
2. Emergency action plan(s)	HA 20
3. Evidence based practice	EBP 1-14
4. Pertinent administrative practices	HA 29
5. Roles of medical and allied health care providers	HA 31
Skill in:	---
6. Implementing the emergency action plan(s)	HA 20
7. Implementing relevant administrative practices (e.g., injury reports, documentation, case reports)	CIP 9
8. Instruction of emergency care techniques	AC 43
DOMAIN IV: Treatment and Rehabilitation	---
A. Administer therapeutic and conditioning exercise(s) using appropriate techniques and procedures to aid recovery and restoration of function.	**CE,TI,PS**
Knowledge of:	---
1. Adaptation of the cardiovascular and muscular systems related to treatment, rehabilitation and reconditioning	TI 4,8
2. Age-specific considerations related to treatment, rehabilitation and reconditioning	TI 5,8
3. Available equipment and tools related to treatment, rehabilitation and reconditioning	CE 6 TI 10
4. Functional criteria for return to activity	CE 19 TI 7
5. Indications and contraindications related to treatment, rehabilitation and reconditioning	CE 7
6. Inflammatory process related to treatment, rehabilitation and reconditioning	TI 1
7. Neurology related to treatment, rehabilitation and reconditioning	TI 1,4,5
8. Pharmacology related to treatment, rehabilitation and reconditioning	TI 29,30
9. Principles of adaptation and overload of tissues	TI 4,5,8

10. Principles of adaptation of systems	TI 4,5,8
11. Principles of strength and conditioning exercises (e.g., plyometrics, core stabilization, speed, agility and power)	TI 8
12. Principles of therapeutic exercise (e.g., isometric, isotonic, isokinetic, work, power and endurance)	TI 8,13,17
13. Proprioception and kinesthesis related to treatment, rehabilitation and reconditioning	TI 8,17,24
14. Psychology related to treatment, rehabilitation and reconditioning	PS 7-10
15. Structure, growth, development and regeneration of tissue	TI 1,4,5
16. Surgical procedures and implications for treatment, rehabilitation and reconditioning	TI 6
Skill in:	---
17. Applying exercise prescription in the development and implementation of treatment, rehabilitation and reconditioning (e.g., aquatics, isokinetics and closed-chain)	TI 11,17
18. Evaluating criteria for return to activity	CE 19,20,22 TI 11 PS 3
B. Administer therapeutic modalities (e.g., electromagnetic, manual, mechanical) using appropriate techniques and procedures based on the individual's phase of recovery to restore functioning.	**CE,TI,CIP**
Knowledge of:	---
1. Available therapeutic modalities related to treatment, rehabilitation and reconditioning	TI 10,14
2. Indications and contraindications for therapeutic modalities	TI 11
3. Inflammatory process related to therapeutic modalities	TI 1
4. Pharmacology related to therapeutic modalities	TI 21-23
5. Physiological response to therapeutic modalities	TI 3,5,8
6. Principles of mechanical, electromagnetic and acoustical energy	TI 8,9
7. Principles of therapeutic exercise (e.g., isometric, isotonic, isokinetic, work, power and endurance)	TI 8
8. Structure, growth, development and regeneration of tissue	TI 8
9. Theories of pain	TI 2,3
Skill in:	---
10. Applying manual therapy techniques	TI 13-15
11. Applying thermal, electrical, mechanical and acoustical modalities	TI 9
12. Communicating with appropriate professionals regarding referral and treatment for individuals	CE 22 TI 11
13. Recognizing the status of systemic illnesses	TI 11 CIP 5
14. Recognizing the status of bacterial, viral, fungal and parasitic infections	CIP 5
C. Apply braces, splints or other assistive devices according to appropriate practices in order to facilitate injury protection to achieve optimal functioning for the individual.	**PHP,CE,TI**

Knowledge of:	---
1. Commercially available soft goods	TI 16
2. Functions of bracing	TI 16
3. Legal risks and ramifications for bracing	PHP 20
4. Pathomechanics of common and catastrophic injury	CE 3,4
5. Materials and methods for fabricating custom-made devices	TI 16
6. Pathomechanics of the injury or condition	CE 3-5
Skill in:	---
7. Applying braces, splints or assistive devices	TI 16
8. Fabricating braces, splints or assistive devices	TI 16
D. Administer treatment for injury, illness and/or health-related conditions using appropriate methods to facilitate injury protection, recovery and/or optimal functioning for individual(s).	**EBP,PHP,CE,TI, PS,HA,CIP**
Knowledge of:	---
1. Available reference sources related to injuries, illnesses and health-related conditions	EBP 6
2. Medical and allied health care professionals involved in the treatment of injuries, illnesses and health-related conditions	CE 22
3. Pathophysiology associated with systemic illness, communicable diseases and infections (e.g., bacterial, viral, fungal and parasitic)	PHP 5,6 HA 15
4. Pharmacology related to the treatment of injuries, illnesses and health-related conditions	TI 25-30 PHP 48
5. Psychological reaction to injuries, illnesses and health-related conditions	TI 8 PS 1,2
6. Structure, growth, development and regeneration of tissue	TI 8
Skill in:	---
7. Applying topical wound or skin care products	CIP 4,5
8. Applying thermal, electrical, mechanical and acoustical modalities	TI 9
9. Communicating with appropriate professionals regarding referral and treatment for individuals	CE 22 TI 10,31 PS 6
10. Directing a referral to the appropriate professionals	CE 22 PS 11
11. Indications for referral	CE 22 PS 14
12. Recognizing the status of systemic illnesses	CIP 5
13. Recognizing the status of bacterial, viral, fungal and parasitic infections	CIP 5

E. Reassess the status of injuries, illnesses and/or health-related conditions using appropriate techniques and documentation strategies to determine appropriate treatment, rehabilitation and/or reconditioning and to evaluate readiness to return to a desired level of activity.	**CE,TI,PS,HA**
Knowledge of:	---
1. Adaptation of the cardiovascular and muscular systems related to rehabilitation, recovery and performance	TI 5,18
2. Age-specific considerations related to rehabilitation, recovery and performance	CE 7 TI 5
3. Appropriate documentation protocols	HA 11,12
4. Functional criteria for return to activity	CE 19 TI 7
5. Indications and contraindications related to rehabilitation, recovery and performance	TI 5,8
6. Inflammatory process related to rehabilitation, recovery and performance	TI 1
7. Neurology related to rehabilitation, recovery and performance	TI 5
8. Principles of adaptation and overload of tissues	TI 4
9. Principles of strength and conditioning exercises (e.g., plyometrics, core stabilization, speed, agility and power)	TI 8
10. Principles of therapeutic exercise (e.g., isometric, isotonic, isokinetic, work, power and endurance)	TI 8
11. Proprioception and kinesthesis related to rehabilitation, recovery and performance	TI 8
12. Psychology effects related to rehabilitation, recovery and performance	PS 7
13. Structure, growth, development and regeneration of tissue	TI 5,8
14. Surgical procedures and implications for rehabilitation, recovery and performance	TI 6
Skill in:	---
15. Evaluating criteria for return to activity	CE 9,19 TI 7
16. Interpreting assessment information necessary to modify, continue or discontinue treatment plans	CE 14,15 TI 4,7,10,12
F. Provide guidance and/or referral to specialist for individual(s) and groups through appropriate communication strategies (e.g., oral and education materials) to restore an individual(s) optimal functioning.	**CE,TI,PS,HA,PD,CIP**
Knowledge of:	---
1. Applicable methods and materials for education	PS 4,5
2. Appropriate documentation protocols	HA 11
3. Available support systems (e.g., psychosocial, community, family and health care) related to rehabilitation, recovery and performance	PS 11 HA 30

4. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts and oral communication)	PS 4,5
5. Learning process across the lifespan	PD 7 PS 5
6. Psychology effects related to rehabilitation, recovery and performance	PS 3,7-9
7. Referral resources	CE 22 PD 10
Skill in:	---
8. Communicating with appropriate professionals regarding referral and treatment for individuals	CIP 9
9. Directing a referral to the appropriate professionals	CE 22 PS 11 PD 10
10. Identifying appropriate individuals to educate	TI 10 PS 18
11. Indications for referral	CE 22 PS 14 PD 10
12. Providing guidance/counseling for the individual during the treatment, rehabilitation and reconditioning process	PS 4,7,8,10
DOMAIN V: Organizational and Professional Health and Well-being	---
A. Apply basic internal business functions (e.g., business planning, financial operations, staffing) to support individual and organizational growth and development.	**HA,PD**
Knowledge of:	---
1. Appropriate computer software applications	HA 12
2. Credentialing systems and general requirements for pertinent professions	PD 2,6
3. Facility design and operation	HA 5,29
4. Human resource management	HA 12-14
5. Institutional budgeting and procurement process	HA 6,8
6. Institutional and federal employment regulations (e.g., EEOC, ADA and Title IX)	HA 15-17 PD 3
7. Management techniques	HA 2,3
8. Leadership styles	HA 2,3
9. Revenue generation strategies	HA 7,25-28
10. Staff scheduling, patient flow and allocation of resources	HA 2,6,8
11. Storage and inventory procedures	HA 6
12. Strategic planning and goal setting	HA 3,4

Skill in:	---
13. Facility design, operation and management (e.g., planning, organizing, designing, scheduling, coordinating, budgeting)	HA 5
14. Managing financial resources (e.g., planning, budgeting, resource allocation, revenue generation)	HA 6,8
15. Managing human resources (e.g., delegating, planning, staffing, hiring, firing and conducting performance evaluations)	HA 12-14
16. Using computer software applications (e.g., word processing, data base spreadsheet and Internet applications)	HA 6,8
B. Apply basic external business functions (e.g., marketing and public relations) to support organizational sustainability, growth and development.	**HA,PD**
Knowledge of:	---
1. Appropriate computer software applications	HA 12
2. Credentialing systems and general requirements for pertinent professions	PD 3
3. Facility design and operation	HA 5,29
4. Human resource management	HA 12-14
5. Institutional budgeting and procurement process	HA 6,8
6. Institutional and federal employment regulations (e.g., EEOC, ADA and Title IX)	HA 15,16,17 PD 3
7. Management techniques	HA 2,3
8. Leadership styles	HA 2,3
9. Revenue generation strategies	HA 7,25-28
10. Staff scheduling, patient flow and allocation of resources	HA 2
11. Storage and inventory procedures	HA 6
12. Strategic planning and goal setting	HA 3,4
Skill in:	---
13. Facility design, operation and management (e.g., planning, organizing, designing, scheduling, coordinating, budgeting)	HA 5
14. Managing financial resources (e.g., planning, budgeting, resource allocation, revenue generation)	HA 6,8
15. Managing human resources (e.g., delegating, planning, staffing, hiring, firing and conducting performance evaluations	HA 12-14
16. Using computer software applications (e.g., word processing, data base spreadsheet and Internet applications)	HA 6,8
C. Maintain records and documentation that comply with organizational, association and regulatory standards to provide quality of care and to enable internal surveillance for program validation and evidence-based interventions.	**EBP,PHP,CE,AC, TI,HA,PD,CIP**
Knowledge of:	---

1. Appropriate computer software applications	HA 11
2. Credentialing systems and general requirements for pertinent professions	PD 3
3. Criteria for determining the legal standard of care in athletic training (e.g., state statutes and regulations, professional standards and guidelines, publications, customs, practices and societal expectations)	AC 1 TI 21
4. Evidence based practice, epidemiology studies and clinical outcomes assessment	CE 10,11 TI 7
5. Federal and state statutes, regulations, and adjudication that apply to the practice and/or organization and administration of athletic training (e.g., OSHA, DEA, Title IX, Civil Rights Act, HIPAA, Buckley Amendment, labor practices, patient confidentiality, insurance and record keeping)	PD 3 HA 10
6. Guidelines and regulations for decreasing exposure to environmental hazards	PD 3,5
7. Guidelines for development of risk management policies and procedures	PD 3,5
8. Institutional drug testing and substance abuse policies	PHP 17,18
9. Institutional, governmental and appropriate organizational guidelines for safety, health care delivery and legal compliance	PD 3-5
10. Institutional review boards, policies and procedures regarding informed consent guidelines	PD 8
11. Institutional risk management policies and procedures	PHP 18 HA 18
12. Prescreening participation guidelines	HA 23
13. Relevant policy and position statements of appropriate organizations (e.g., ACSM, AOASM, AOSSM, AMSSM, NCAA, NATA, NFHSA, NAIA, USOC)	PD 5
14. Standard medical terminology and nomenclature	CE 1 TI 22
15. State statutes, regulations and adjudication that directly govern the practice of athletic training (e.g, state practice and title acts, state professional conduct and misconduct acts, liability and negligence)	PD 3-5
16. State statutes, regulations and adjudication governing other professions which impact the practice of athletic training (e.g., medicine, physical therapy, nursing, pharmacology)	PD 8
Skill in:	---
17. Creating and completing the documentation process	HA 9,11
18. Obtaining, interpreting, evaluating and applying relevant research data, literature and/or other forms of information	TI 7
19. Obtaining, interpreting, evaluating and applying relevant policy and position statements	PD 3,5
20. Interacting with appropriate administration leadership	CIP 9
21. Researching practice methods and procedures	EBP 1-14
22. Researching professional standards and guidelines (e.g., BOC, NATA, state organizations)	HA 10 PD 3-6

23. Using computer software applications (e.g., word processing, data base spreadsheet and Internet applications)	CIP 9
D. Demonstrate appropriate planning for coordination of resources (e.g., personnel, equipment, liability, scope of service) in event medical management and emergency action plans.	**EBP,PHP,AC,TI, PS,HA,PD,CIP**
Knowledge of:	---
1. Appropriate medical equipment and supplies	AC 8-10,13,15,16,18 HA 19,20
2. Criteria for determining the legal standard of care in athletic training (e.g., state statutes and regulations, professional standards and guidelines, publications, customs, practices and societal expectations)	PD 3-6
3. Federal and state statutes, regulations and adjudication that apply to the practice and/or organization and administration of athletic training (e.g., OSHA, DEA, Title IX, Civil Rights Act, HIPAA, Buckley Amendment, labor practices, patient confidentiality, insurance and record keeping)	TI 21 HA 15-17
4. Institutional drug testing and substance abuse policies	PHP 49 PS 14,15
5. Institutional, governmental and appropriate organizational guidelines for safety, health care delivery and legal compliance	HA 29 PD 3-6
6. Institutional review boards, policies and procedures regarding informed consent guidelines	PD 8
7. Institutional risk management policies and procedures	HA 18,19
8. Prescreening participation guidelines	HA 23
9. Reimbursement issues	HA 25-28
10. Staff preparedness	HA 20-22
11. State statutes, regulations and adjudication that directly govern the practice of athletic training (e.g., state practice and title acts, state professional conduct and misconducts acts, liability and negligence)	HA 15-17 PD 3-6
12. State statutes, regulations and adjudication governing other professions that impact the practice of athletic training (e.g., medicine, physical therapy, nursing, pharmacology)	HA 15-17 PD 8
13. Site-specific access issues	HA 20
Skill in:	---
14. Creating and completing the documentation process	CIP 9
15. Interacting with appropriate administration leadership	CIP 9
16. Obtaining, interpreting, evaluating and applying relevant policy and position statements	PD 8
17. Researching practice methods and procedures	EBP 1-14
18. Researching professional standards and guidelines (e.g., BOC, NATA, state organizations)	PD 3-5
19. Using computer software applications (e.g., word processing, data base spreadsheet and Internet applications)	CIP 9

E. Demonstrate an understanding of statutory and regulatory provisions and professional standards of the practice of athletic training in order to provide for the safety and welfare of individual(s) and groups.	**PHP,TI,PS,PD**
Knowledge of:	---
1. Appropriate equipment and facility inspection procedures and documentation	PHP 18 TI 19,20
2. Criteria for determining the legal standard of care in athletic training (e.g., state statutes and regulations, professional standards and guidelines, publications, customs, practices and societal expectations)	PD 3-5
3. Federal and state statutes, regulations and adjudication which apply to the practice and/or organization and administration of athletic training (e.g., OSHA, DEA, Title IX, Civil Rights Act, HIPAA, Buckley Amendment, labor practices, patient confidentiality, insurance, record keeping)	TI 21 PS 18 PD 4,6
4. Institutional, professional and governmental guidelines for maintenance of facilities and equipment	PD 4
5. Manufacturer's operational guidelines	PHP 20 TI 19
6. Safe playing and treatment environments	PHP 12,18
7. State statutes, regulations and adjudication that directly govern the practice of athletic training (e.g, state practice and title acts, state professional conduct and misconducts acts, liability and negligence)	PD 4,6
8. State statutes, regulations and adjudication governing other professions which impact the practice of athletic training (e.g., medicine, physical therapy, nursing, pharmacology)	PD 4
Skill in:	---
9. Researching and applying state and federal statutes, regulations and adjudications	PD 4,6
10. Researching professional standards and guidelines (e.g., BOC, NATA, state organizations)	PD 4,6
11. Researching practice methods and procedures	PD 4-6
F. Develop a support/referral process for interventions to address unhealthy lifestyle behaviors.	**AC,PS,HA,PD,CIP**
Knowledge of:	---
1. Appropriate professional behaviors	PD 5,6
2. Credentialing systems and general requirements for health care professions	PD 5,6
3. Community resources	PD 8,10 AC 2
4. Confidentiality policies	PS 18
5. Effective communication techniques (e.g., multimedia videos, pamphlets, posters, models, handouts and oral communication)	PS 4
6. Effective meeting planning	PD 10
7. Federal and state statutes, regulations and adjudication which apply to the practice and/or organization and administration of athletic training (e.g., OSHA, DEA, Title IX, Civil Rights Act, HIPAA, Buckley Amendment, labor practices, patient confidentiality, insurance, record keeping)	HA 31 PD 4,6

8. Institutional and governmental regulations regarding drug use, substance abuse and mental illness	PD 3-5
9. Institutional chain of command	
10. Role and scope of practice of various health care professionals	HA 1 PD 4-6
Skill in:	---
11. Communicating with appropriate professionals regarding referral and treatment for individuals	PD 10
12. Directing a referral to the appropriate professionals	PD 10 CIP 8
13. Identifying appropriate individuals to educate	CIP 3,9
14. Indications for referral	PD 10
15. Interpreting standard medical terminology and nomenclature for appropriate individuals	CIP 9
16. Mitigating conflict	HA 2
17. Networking and recruiting qualified medical team members	PS 11
18. Nurturing professional relationships	PS 11
19. Providing guidance/counseling for the individual during the treatment, rehabilitation and reconditioning process	CIP 7
20. Respecting diversity of opinions and positions	PS 5

BOC STANDARDS OF PROFESSIONAL PRACTICE

I. PRACTICE STANDARDS

Preamble

The primary purpose of the Practice Standards is to establish essential duties and obligations imposed by virtue of holding the ATC® credential. Compliance with the Practice Standards is mandatory.

The BOC does not express an opinion on the competence or warrant job performance of credential holders; however, every Athletic Trainer and applicant must agree to comply with the Practice Standards at all times.

Standard 1: Direction

The Athletic Trainer renders service or treatment under the direction of, or in collaboration with a physician, in accordance with their training and the state's statutes, rules and regulations.

Standard 2: Prevention

The Athletic Trainer implements measures to prevent and/or mitigate injury, illness and long term disability.

Standard 3: Immediate Care

The Athletic Trainer provides care procedures used in acute and/or emergency situations, independent of setting.

Standard 4: Examination, Assessment and Diagnosis

The Athletic Trainer utilizes patient history and appropriate physical examination procedures to determine the patient's impairments, diagnosis, level of function and disposition.

Standard 5: Therapeutic Intervention

The Athletic Trainer determines appropriate treatment, rehabilitation and/or reconditioning strategies. Intervention program objectives include long and short-term goals and an appraisal of those which the patient can realistically be expected to achieve from the program. Appropriate patient-centered outcomes assessments are utilized to document efficacy of interventions.

Standard 6: Program Discontinuation

The Athletic Trainer may recommend discontinuation of the intervention program at such time the patient has received optimal benefit of the program. A final assessment of the patients' status is included in the discharge note.

Standard 7: Organization and Administration

The Athletic Trainer documents all procedures and services in accordance with local, state and federal laws, rules and guidelines.

II. CODE OF PROFESSIONAL RESPONSIBILITY

Preamble

The Code of Professional Responsibility (Code) mandates that BOC credential holders and applicants act in a professionally responsible manner in all athletic training services and activities. The BOC requires all Athletic Trainers and applicants to comply with the Code. The BOC may discipline, revoke or take other action with regard to the application or certification of an individual that does not adhere to the Code. The Professional Practice and Discipline Guidelines and Procedures may be accessed via the BOC website, www.bocatc.org.

Code 1: Patient Care Responsibilities

The Athletic Trainer or applicant:

1.1 Renders quality patient care regardless of the patient's age, gender, race, religion, disability, sexual orientation, or any other characteristic protected by law

1.2 Protects the patient from undue harm and acts always in the patient's best interests and is an advocate for the patient's welfare, including taking appropriate action to protect patients from healthcare providers or athletic training students who are, impaired or engaged in illegal or unethical practice

1.3 Demonstrates sound clinical judgment that is based upon current knowledge, evidence-based guidelines, and the thoughtful and safe application of resources, treatments and therapies

1.4 Communicates effectively and truthfully with patients and other persons involved in the patient's program, while maintaining privacy and confidentiality of patient information in accordance with applicable law

- 1.4.1 Demonstrates respect for cultural diversity and understanding of the impact of cultural and religious values

1.5 Develops and maintains a relationship of trust and confidence with the patient and/or the parent/guardian of a minor patient and does not exploit the relationship for personal or financial gain

1.6 Does not engage in intimate or sexual activity with a patient and/or the parent/guardian of a minor patient

1.7 Informs the patient and/or the parent/guardian of a minor patient of any risks involved in the treatment plan

- 1.7.1 Does not make unsupported claims about the safety or efficacy of treatment

BOC STANDARDS OF PROFESSIONAL PRACTICE

Code 2: Competency

The Athletic Trainer or applicant:

2.1 Engages in lifelong, professional and continuing educational activities to promote continued competence

2.2 Complies with the most current BOC recertification policies and requirements

Code 3: Professional Responsibility

The Athletic Trainer or applicant:

3.1 Practices in accordance with the most current BOC Practice Standards

3.2 Practices in accordance with applicable local, state and/or federal rules, requirements, regulations and/or laws related to the practice of athletic training

3.3 Practices in collaboration and cooperation with others involved in a patient's care when warranted; respecting the expertise and medico-legal responsibility of all parties

3.4 Provides athletic training services only when there is a reasonable expectation that an individual will benefit from such services

3.5 Does not misrepresent in any manner, either directly or indirectly, their skills, training, professional credentials, identity, or services or the skills, training, credentials, identity, or services of athletic training

3.5.1 Provides only those services for which they are prepared and permitted to perform by applicable local, state and/or federal rules, requirements, regulations and/or laws related to the practice of athletic training

3.6 Does not guarantee the results of any athletic training service

3.7 Complies with all BOC exam eligibility requirements and ensures that any information provided to the BOC in connection with any certification application is accurate and truthful

3.8 Does not possess, use, copy, access, distribute or discuss certification exams, score reports, answer sheets, certificates, certificant or applicant files, documents or other materials without proper authorization

3.9 Takes no action that leads, or may lead, to the conviction, plea of guilty or plea of nolo contendere (no contest) to any felony or to a misdemeanor related to public health, patient care, athletics or education; this includes, but is not limited to: rape; sexual abuse or misconduct; actual or threatened use of violence; the prohibited sale or distribution of controlled substances, or the possession with intent to distribute controlled substances; or improper influence of the outcome or score of an athletic contest or event

3.10 Reports any suspected or known violation of applicable local, state and/or federal rules, requirements, regulations and/or laws by him/herself and/or by another Athletic Trainer that is related to the practice of athletic training

3.11 Reports any criminal convictions (with the exception of misdemeanor traffic offenses or traffic ordinance violations that do not involve the use of alcohol or drugs) and/or professional suspension, discipline, or sanction received by him/herself or by another Athletic Trainer that is related to athletic training

3.12 Cooperates with BOC investigations into alleged illegal or unethical activities. Cooperation includes, but is not limited to, providing candid, honest, and timely responses to requests for information

3.13 Complies with all confidentiality and disclosure requirements of the BOC and existing law

3.14 Does not endorse or advertise products or services with the use of, or by reference to, the BOC name without proper authorization

Code 4: Research

The Athletic Trainer or applicant who engages in research:

4.1 Conducts research according to accepted ethical research and reporting standards established by public law, institutional procedures and/or the health professions

4.2 Protects the human rights and well-being of research participants

4.3 Conducts research activities intended to improve knowledge, practice, education, outcomes, and/or public policy relative to the organization and administration of health systems and/or healthcare delivery

Code 5: Social Responsibility

The Athletic Trainer or applicant:

5.1 Strives to serve the profession and the community in a manner that benefits society at large

5.2 Advocates for appropriate health care to address societal health needs and goals

Code 6: Business Practices

The Athletic Trainer or applicant:

6.1 Does not participate in deceptive or fraudulent business practices

6.2 Maintains adequate and customary professional liability insurance

6.3 Acknowledges and mitigates conflicts of interest

Who is CAATE recognized by?

- The CHEA (Council for Higher Education Accreditation)
  - Largest institutional higher education membership organization in the United States, with approximately 3,000 degree-granting colleges and universities.
  - Sixty recognized institutional and programmatic accrediting organizations.
  - Governed by a 20-person board of college and university presidents, institutional representatives and public members.
- CHEA Purposes - Advocacy
  - A primary national voice for accreditation and quality assurance to the U.S. Congress and U.S. Department of Education.
  - www.chea.org
  - See attached letter from CHEA on CAATE website:

CHEA RECOGNITION

At the September 29-30, 2014 meeting, the Board of Directors of the Council for Higher Education Accreditation (CHEA) granted Recognition to the Commission on Accreditation of Athletic Training Education (CAATE).

The Council for Higher Education Accreditation is a national advocate and institutional voice for self-regulation of academic quality through accreditation. CHEA is an association of 3,000 degree-granting colleges and universities, and recognizes 60 institutional and programmatic accrediting organizations.

The recognition process included a self-study, an on-site observation visit from a member of the Committee on Recognition, a public comment period, and a public hearing. The CAATE will undergo a full recognition review every ten years.

We are extremely excited about this accomplishment for athletic training education and for the profession of athletic training. The recognition status is an affirmation of CAATE's commitment to upholding quality assurance standards, and a testament to the high quality of education in CAATE accredited programs! Read the CHEA letter here.

Literature/evidence on the need for ATs in the industrial setting

Information provided by The Industrial Athlete, Inc out of Michigan for contract with a Supermarket Distribution Center for period of 3.5 years. (See attached report)

1. Programs focusing on proper biomechanics and injury prevention and treatment resulted in at total Return of Investment of 6:1 compared to traditional Total Compensation Cost. (Third party Billing/Reimbursement System)
2. An Athletic Trainers ability to triage injuries resulted in substantial decrease in DART Rates (Days away, Restrict Duty, and/or Transfer to another Department)
3. SMART Program (Sports Medicine, Athletic Rehabilitation and Treatment) resulted in increase in Total Cost Avoidance through an athletic trainer's ability to perform the initial evaluation.

Similar programs have shown similar results:

1. Over a 3-year period, beginning in 1988, Saginaw Division has saved $3,531,335 by conducting rehabilitation in-house versus outsource care rehabilitation.

2. Wilson Brands Corporation, with 1200 employees, has reduced dramatically two significant cost-related areas through its rehabilitation program. Comparing a 6-month period in 1988 with the same period in 1990, days lost were cut in half, and workers' compensation cases requiring surgical care were reduced by 95%.

Pre 2011 ATs and new competencies

Board of Certification Practice Analysis

- See attached "Crosswalk Analysis" which outlines and cross references a practice analysis, with skills and aligns the skill with the associated CAATE Competency.

BOC Standards of Practice

Ensuring up to date ATs

- It is the ATs responsibility to ensure they can perform a skill before doing the skill
- The skills they can perform are outlined in the standing orders for that AT
- All ATs must comply with the BOC standards of practice
    - Standards may be viewed here: http://www.bocatc.org/images/stories/resources/sopp-2016vf.pdf

General Medical and Non-Orthopedic Clinical Rotations

All Athletic Training Institutions must comply with CAATE standards. The standards related to general medical and non-orthopedic knowledge and education is below.

CAATE Standards which support general medicine and non-orthopedic education:

44. Program Delivery - Healthcare Provider

Description

Students must interact with other medical and health care personnel.

Instructions

- Provide Medical and Other Health Care Personnel Table.
- Describe student interactions with other medical and health care personnel and demonstrate how all students meet this standard.

48. Program Delivery - Clinical Education- Patient Populations

Description

The variety of patient populations, care providers, and health care settings used for clinical education must be consistent with the program's goals and objectives.

Instructions

- Describe how the program allows students opportunities to practice with a variety of patient populations, care providers, and in various allied health care settings.
- Provide a narrative that explains how your outcomes demonstrate achievement of this standard.

50. Program Delivery - Clinical Education Continuum of Care.

Description

Students must gain clinical education experiences that address the continuum of care that would prepare a student to function in a variety of settings with patients engaged in a range of activities with conditions described in athletic training knowledge, skills and clinical abilities, role delineation study and standards of practice delineated for a certified athletic trainer in the profession. Examples of clinical experiences must include, but should not be limited to: Individual and team sports; Sports requiring protective equipment (e.g., helmet and shoulder pads); Patients of different sexes; Non-sport patient populations (e.g., outpatient clinic, emergency room, primary care office, industrial, performing arts, military); A variety of conditions other than orthopedics (e.g., primary care, internal medicine, dermatology).

Clinical rotations from each of our CT institutions outlining general medical and non-orthopedic based rotations. It is important to note that all clinical rotations have an element of general medicine and non-orthopedic related injuries and illnesses.

School	Type of Rotation	Hours Required	Areas of Content
Sacred Heart University	2 General Medical Rotations PT Clinical Rotation Concussion Clinics	12 hours 25 hours 10 hours	Performing vitals, patient history, documenting patient interaction Concussion Testing, Vitals, Pt Intake and History
University of Connecticut	PT Rotation UConn Health & Health Services	25-50 hours per rotation	Performing vitals, patient intake & history, facilitation of rehabilitation protocols
Central Connecticut State University	Emergency Medical Technician Course Medical Clinical Rotations (Hospital of Central CT and/or New Britain EMS General Med Rotation with Primary Care MD	 10-20 hours per rotation 30 hours	 Assist with airway management, AED application, ECG application, CPR and other BLS skills. Performing vitals, patient intake & history
Southern Connecticut State University	Waiting on info		
Quinnipiac	Waiting on info		

Standing orders and how other healthcare practitioners handle meeting with their directing physician.

- Emergency Medical Technicians (EMTs) operate under written protocols and standing orders for administration of injectable medicine. (ie. epinephrine).

- EMTs are the only other profession that has statutory standing orders. In the statute it does not require meeting with the physician. The AT proposed changes require a higher level of communication with a physician – meeting *at least* once annually.

Appendix H

Athletic Training Licensure Laws in Other States and Updated Proposed Language by the CATA

CONNECTICUT ATHLETIC TRAINERS' ASSOCIATION

Contemporary Athletic Training Laws – Submission to DPH

The following states recognize athletic trainers in serving with individuals beyond athletes. Any relevant language in the various licensure acts have been highlighted in yellow and italicized.

State	Patient Population	Scope of Practice (what is permissible)	Injury Definitions
Arizona	See Injury definition (bold in yellow), no limitation in age of patient	Includes the following performed under the direction of a licensed physician AND FOR WHICH THE ATHLETIC TRAINER HAS RECEIVED APPROPRIATE EDUCATION AND TRAINING AS PRESCRIBED BY THE BOARD: (a) THE PREVENTION, RECOGNITION, EXAMINATION, EVALUATION, REHABILITATION AND MANAGEMENT OF ATHLETIC INJURIES. (b) THE PREVENTION, EVALUATION, IMMEDIATE CARE AND MONITORING OF ATHLETIC ILLNESSES. (c) THE REFERRAL OF A PERSON RECEIVING ATHLETIC TRAINING SERVICES TO APPROPRIATE HEALTH CARE PROFESSIONALS, AS NECESSARY. (d) THE USE OF heat, cold, water, light, sound, electricity, passive or active exercise, massage, mechanical devices OR ANY OTHER THERAPEUTIC MODALITY to PREVENT, treat, rehabilitate or recondition athletic injuries. (e) THE PLANNING, ADMINISTRATION, EVALUATION, AND MODIFICATION OF METHODS FOR PREVENTION AND RISK MANAGEMENT OF ATHLETIC INJURIES AND ATHLETIC ILLNESSES. (f) Education and counseling related to all aspects of the practice of athletic training. (g) THE USE OF TOPICAL PHARMACOLOGICAL AGENTS IN CONJUNCTION WITH THE ADMINISTRATION OF THERAPEUTIC MODALITIES AND PURSUANT TO A PRESCRIPTION ISSUED PURSUANT TO THE LAWS OF THIS STATE AND FOR	"Athletic injury" means an injury sustained by a person as a result of that person's participation in or preparation for GAMES OR SPORTS OR PARTICIPATION IN RECREATIONAL ACTIVITIES OR PHYSICAL FITNESS ACTIVITIES, *OR ANY INJURY SUSTAINED BY A PERSON THAT IS OF THE TYPE THAT OCCURS DURING PARTICIPATION IN OR PREPARATION FOR GAMES OR SPORTS OR PARTICIPATION IN RECREATIONAL ACTIVITIES OR PHYSICAL FITNESS ACTIVITIES, REGARDLESS OF THE CIRCUMSTANCES UNDER WHICH THE INJURY WAS SUSTAINED*

		WHICH AN ATHLETIC TRAINER HAS RECEIVED APPROPRIATE EDUCATION AND TRAINING.	
Florida		"Athletic trainer" means a person licensed under this part who has met the requirements under this part, including education requirements as set forth by the Commission on Accreditation of Athletic Training Education or its successor and necessary credentials from the Board of Certification. An individual who is licensed as an athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing. (2) "Athletic training" means service and care provided by an athletic trainer under the direction of a physician as specified in s. 468.713. Such service and care must relate to the prevention, recognition, evaluation, management, disposition, treatment, *or rehabilitation of* ***a physically active person*** *who sustained an injury, illness, or other condition involving exercise, sport, recreation, or related physical activity.* For the provision of such care and services, an athletic trainer may use physical modalities, including, but not limited to, heat, light, sound, cold, electricity, and mechanical devices. (3) "Board" means the Board of Athletic Training. (4) "Board of Certification" means the nationally accredited certifying body for athletic trainers or its successor agency. (5) "Department" means the Department of Health.	
Georgia	See Injury Definition (italics, highlighted in yellow)	'Athletic trainer' means a person with specific qualifications, as set forth in Code Sections 43-5-7 and 43-5-8 who, upon the advice and consent of a	'Athletic injury' means any injury sustained by a person as a result of such person´s participation in exercises, sports, games, or recreational activities,

		physician, carries out the practice of prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of athletic injuries; and, in carrying out these functions, the athletic trainer is authorized to use physical modalities, such as heat, light, sound, cold, electricity, or mechanical devices related to prevention, recognition, evaluation, management, disposition, rehabilitation, and treatment	*or **any activities requiring physical strength, agility, flexibility, range of motion, speed, or stamina without respect to where or how the injury occurs.** Nothing in this paragraph shall be construed to expand the scope of practice of an athletic trainer beyond the determination of the advising and consenting physician as provided for in paragraph (2) of this Code section*
Michigan	Patient population defined as individual	Practice of athletic training" means the treatment of ***an individual*** *for risk management and injury prevention, the clinical evaluation and assessment of an individual for an injury or illness, or both, the immediate care and treatment of an individual for an injury or illness, or both, and the rehabilitation and reconditioning of an individual's injury or illness*, or both, as long as those activities are within the rules promulgated under section 17904 and performed under the direction and supervision of an individual licensed under part 170 or 175. The practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine and surgery, the practice of chiropractic, or medical diagnosis or treatment.	
New York		As used in this article "athletic trainer" means any person who is duly certified in accordance with this article to perform athletic training under the supervision of a physician and limits his or her practice to secondary schools, institutions of postsecondary education, professional athletic organizations, *or a person who, under the supervision of a physician, carries out comparable functions on orthopedic athletic injuries, excluding spinal cord injuries, in a health care organization.* Supervision of an athletic trainer by a physician shall be continuous but shall not be construed as requiring the physical presence of the supervising	

		physician at the time and place where such services are performed. The scope of work described herein shall not be construed as authorizing the reconditioning of neurologic injuries, conditions or disease.	
Ohio		"Athletic training" means the practice of prevention, recognition, and assessment of an athletic injury and the complete management, treatment, disposition, and reconditioning of acute athletic injuries upon the referral of an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry, a dentist licensed under Chapter 4715. of the Revised Code, a physical therapist licensed under this chapter, or a chiropractor licensed under Chapter 4734. of the Revised Code. Athletic training includes the administration of topical drugs that have been prescribed by a licensed health professional authorized to prescribe drugs, as defined in section 4729.01 of the Revised Code. Athletic training also includes the organization and administration of educational programs and athletic facilities, and the education of and consulting with the public as it pertains to athletic training.	Athletic injury" means any injury sustained by an individual that affects *the individual's participation* or performance in sports, games, recreation, exercise, *or other activity that requires physical strength, agility, flexibility, speed, stamina, or range of motion*
Pennsylvania	General rule.--An athletic trainer certified by the board may, under the direction of a physician, podiatrist or dentist, *provide athletic training services to a* ***physically active person*** under the care of a physician, dentist or podiatrist. An athletic trainer certified under this section shall refer a		

	physically active person with conditions outside the scope of athletic training services to a physician, dentist or podiatrist		
Vermont	Athlete" means any individual participating in fitness training and conditioning, sports or other athletic competition, practices or events requiring physical strength, agility, flexibility, range of motion, speed or stamina.	Athletic training" means the application of principles and methods of conditioning, the prevention, immediate care, recognition, evaluation, assessment, and treatment of athletic and orthopedic injuries within the scope of education and training, the organization and administration of an athletic training program and the education and counseling of athletes, coaches, family members, medical personnel, and communities in the area of care and prevention of athletic and orthopedic injuries. Athletic training may only be applied in the "traditional setting" and the "clinical setting": (A) Without further referral, to athletes participating in organized sports or athletic teams at an interscholastic, intramural, instructional, intercollegiate, amateur, or professional level. (B) *With a referral from a physician, osteopathic physician, dentist, or chiropractor, to athletes or* ***the physically active*** *who have an athletic or orthopedic injury and have been determined, by a physician's examination, to be free of an underlying pathology that would affect treatment*	
Virginia		Practice of athletic training means the prevention, recognition, evaluation and treatment of injuries or conditions related to athletic or recreational activity that requires physical skill and utilizes strength, power, endurance, speed, flexibility, range of *motion, or agility or a substantially similar injury or condition* ***resulting from occupational activity*** *immediately upon the onset of such injury or condition, and subsequent treatment and rehabilitation of such injuries or conditions under the direction of the patient's*	

		physician, or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry, while using heat light, sound cold, electricity, exercise or mechanical of other devices	
Washington		The definitions in this section apply throughout this chapter unless the context clearly requires otherwise. (1) "Athlete" means a person who participates in exercise, recreation, sport, or games requiring physical strength, range-of-motion, flexibility, body awareness and control, speed, stamina, or agility, and the exercise, recreation, sports, or games are of a type conducted in association with an educational institution or professional, amateur, or recreational sports club or organization. (2) "Athletic injury" means an injury or condition sustained by an athlete that affects the person's participation or performance in exercise, recreation, sport, or games and the injury or condition is within the professional preparation and education of an athletic trainer. (3) "Athletic trainer" means a person who is licensed under this chapter. An athletic trainer can practice athletic training through the consultation, referral, or guidelines of a licensed health care provider working within their scope of practice. (4)(a) "Athletic training" means the application of the following principles and methods as provided by a licensed athletic trainer: (i) Risk management and prevention of	

		athletic injuries through preactivity screening and evaluation, educational programs, physical conditioning and reconditioning programs, application of commercial products, use of protective equipment, promotion of healthy behaviors, and reduction of environmental risks; (ii) Recognition, evaluation, and assessment of athletic injuries by obtaining a history of the athletic injury, inspection and palpation of the injured part and associated structures, and performance of specific testing techniques related to stability and function to determine the extent of an injury; (iii) Immediate care of athletic injuries, including emergency medical situations through the application of first-aid and emergency procedures and techniques for nonlife-threatening or life-threatening athletic injuries; (iv) Treatment, rehabilitation, and reconditioning of athletic injuries through the application of physical agents and modalities, therapeutic activities and exercise, standard reassessment techniques and procedures, commercial products, and educational programs, in accordance with guidelines established with a licensed health care provider as provided in RCW 18.250.070; (v*) Treatment, rehabilitation, and reconditioning* ***of work-related injuries*** *through the application of physical agents and modalities, therapeutic activities and exercise, standard reassessment techniques*	

		and procedures, commercial products, and educational programs, under the direct supervision of and in accordance with a plan of care ***for an individual worker*** *established by a provider authorized to provide physical medicine and rehabilitation services for injured workers; and* (vi) Referral of an athlete to an appropriately licensed health care provider if the athletic injury requires further definitive care or the injury or condition is outside an athletic trainer's scope of practice	
Wisconsin		"Affiliated credentialing board" means the athletic trainers affiliated credentialing board. (4) "Athletic trainer" means an individual who engages in athletic training. (5) "Athletic training" means doing any of the following: (a) Preventing, recognizing and evaluating injuries or illnesses sustained while participating in physical activity. (b) Managing and administering the initial treatment of injuries or illnesses sustained while participating in ***physical activity*****.** (c) Giving emergency care or first aid for an injury or illness sustained while participating in physical activity. (d) Rehabilitating and physically reconditioning injuries or illnesses sustained while participating in physical activity. (e) Rehabilitating and physically reconditioning injuries or illnesses that impede or prevent an individual from returning to participation in physical activity, if the individual recently participated in, and intends to return to participation in, physical activity.	

		(f) Establishing or administering risk management, conditioning, and injury prevention programs. (5m) "Consulting physician" means a person licensed as a physician under subch. II who consults with an athletic trainer while the athletic trainer is engaging in athletic training. (6) "Licensee" means a person who is licensed as an athletic trainer under this subchapter. 448.95(7)(7) "*Physical activity" means vigorous participation in exercise, sports, games, recreation, wellness, fitness, or* ***employment activities***	

CURRENT PROPOSED SOP BILL

Sec. 20-65f. Definitions. As used in this chapter:

(1) "Athletic training" means the application or provision, (A) with the consent and under the direction of a health care provider, of(I)CLINICAL EVALUATION AND ASSESSMENT (ii) MANAGEMENT AND EMERGENCY CARE, TREATMENT, DISPOSITION, AND REHABILITATION OF ACUTE AND CHRONICATHLETIC INJURIES (III) THE APPLICATION OF PHYSICAL AGENTS OF HEAT, COLD, LIGHT, ELECTRIC STIMULATION, MANUAL THERAPY TECHNIQUES, AQUATIC THERAPY, SOUND, THERAPEUTIC EXERCISE OR OTHER AGENTS AS PRESCRIBED BY A HEALTH CARE PROVIDER ~~prevention, treatment and rehabilitation of athletic injuries sustained by athletes, (B) appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, light massage, water, electric stimulation, sound, exercise and exercise equipment,~~(B)ILLNESS RECOGNITION (i) THAT IS ACCOMPANIED BY REFERRAL TO AND (ii) MANAGED AT THE DIRECTION OF A HEALTH CARE PROVIDER (C) THE APPLICATION OR PROVISION OF APPROPRIATE PREVENTATIVE AND SUPPORTIVE DEVICES, TEMPORARY SPLINTING, BRACING AND CASTING (D) the organization and administration of athletic training programs, (E) education and counseling to athletes, coaches, medical personnel and THE community in the area of the prevention and care of athletic injuries. AND (F) INJURY PREVENTION AND WELLNESS CARE SERVICES THAT ARE DEVELOPED AND APPLIED TO ASYMPTOMATIC INDIVIDUALS.

For purposes of this subdivision, "health care provider" means a person licensed to practice medicine or surgery under chapter 370 of the general statutes, chiropractic under chapter 372 of the general statutes, podiatry under chapter 375 of the general statutes or naturopathy under chapter 373 of the general statutes;

(2) "Athletic injury" means any MUSCULOSKELETAL injury sustained AS A result of participation in exercise, sports, games, RECREATIONAL ACTIVITIES, OR DUE TO OTHER ACTIVITIES THAT REQUIRE COMPARABLE LEVELS OF STRENGTH , FLEXIBILITY, AND AGILITY OCCURRING TO A PHYSICALLY ACTIVE INDIVIDUAL

PHYSICALLY ACTIVE INDIVIDUAL-means any person who is a member of any professional, amateur, school or other sports team, or is a regular participant in sports OR OTHER COMPARABLE-activities-ASSOCIATED WITH PARTICIPATION IN EXERCISE, EMPLOYMENT OR RECREATION that require strength, agility, flexibility, range of motion, speed or stamina. ~~For the purposes of this subdivision, "regular" means not less than three times per week;~~

(3) "ILLNESS MEANS ANY DISEASE, DISORDER, SICKNESS OR AFFLICTION (A) THAT ARISES FROM OR IS A MANIFESTATION OF AN INDIVIDUAL'S PREPARATION FOR, PARTICIPATION IN, OR POST-RECOVERY IN EXERCISE, SPORTS GAMES OR RECREATIONAL ACTIVITIES, OR (B) OTHER CONDITIONS THAT MAY REQUIRE IMMEDIATE INTERVENTION BY THE ATHLETIC TRAINER DURING, PRIOR TO OR FOLLOWING AN INDIVIDUAL'S PARTICIPATION IN SUCH ACTIVITIES, UNDER THE CONSENT AND DIRECTION OF A HEALTH CARE PROVIDER. SUCH CONDITIONS MAY INCLUDE, BUT ARE NOT LIMITED TO EMERGENT SITUATIONS RELATED TO CARDIORESPIRATORY, THERMOREGULATION, MUSCULOSKELETAL,

NEUROVASCULAR, AND ENDOCRINE SYSTEMS. ILLNESS DOES NOT INCLUDE ANY CONDITION THAT IS BEYOND THE SCOPE OF EDUCATION AND TRAINING OF AN ATHLETIC TRAINER.

(4) “WELLNESS CARE’ MEANS SERVICES RELATED TO RISK MANAGEMENT AND INJURY PREVENTION, INCLUDING BIOMECHANICS, CONDITIONING, FLEXIBILITY, NUTRITION, STRENGTH TRAINING AND FITNESS.

(5) "WITH THE CONSENT AND UNDER THE DIRECTION OF A HEALTH CARE PROVIDER” MEANS (A) A WRITTEN PRESCRIPTION FROM A HEALTH PROVIDER SPECIFYING A PLAN OF CARE FOR A MUSCULOSKELETAL INJURY OR ILLNESS OF AN INDIVIDUAL OR (B) THE ISSUANCE OF WRITTEN STANDING ORDERS THAT ARE FOLLOWED IN THE PRACTICE OF ATHLETIC TRAINING IN THE CARE OF ATHLETES PARTICIPATING IN SPORTS AND GAMES WHILE UNDER THE OVERSIGHT AND DIRECTION OF A HEALTH CARE PROVIDER.

“ATHLETE” means any person who is a member of any professional, amateur, school, or other sporting program or is a regular participant in athletic activity

(6) "WRITTEN Standing orders" means ~~written~~ protocols, recommendations ~~and~~ OR guidelines for treatment and care OF AN ATHLETE’S PARTICIPATION IN PROFESSIONAL, AMATEUR, OR SCHOOL SPORTS OR RECREATIONAL ACTIVITIES THAT ARE (A) furnished and signed by a health care provider specified under subdivision (1) of this section, ~~to be~~ (B) followed ~~in the practice of athletic training~~ BY AN ATHLETIC TRAINER WHILE UNDER THE CONSENT AND DIRECTION OF A HEALTH CARE PROVIDER, (C) ANNUALLY REVIEWED AND RENEWED BY THE HEALTH CARE PROVIDER AND ATHLETIC TRAINER TO ENSURE QUALITY PATIENT CARE, AND (D) PROVIDE FOR AVAILABILITY OF COMMUNICATION BETWEEN THE HEALTH CARE PROVIDER AND THE ATHLETIC TRAINER. WRITTEN STANDING ORDERS SHALL INCLUDE BUT ARE ~~NOT~~ LIMITED TO, (i) DELINEATION OR A PREDETERMINED PLAN FOR EMERGENCY SITUATIONS, (ii) APPROPRIATE TREATMENTS FOR SPECIFIC INJURIES OR OTHER MEDICAL CONDITIONS, (iii) TREATMENT AND MANAGEMENT OF CONCUSSIONS, AND (iv) CONDITIONS NECESSITATING THE IMMEDIATE REFERRAL TO A HEALTH CARE PROVIDER OF INDIVIDUALS AND (v) CONDITIONS NECESSITATION THE IMMEDIATE REFERRAL TO A HEALTH CARE PROVIDER OF AN ATHLETE OR (v) ANY CONDITION THAT IS BEYOND THE ATHLETIC TRAINER’S SCOPE OF PRACTICE AND EDUCATION ~~in the practice of athletic training that may include, but not be limited to, (A) appropriate treatments for specific athletic injuries, (B) athletic injuries or other conditions requiring immediate referral to a licensed health care provider, and (C) appropriate conditions for the immediate referral to a licensed health care provider of injured athletes of a specified age or age group.~~

(5) "Commissioner" means the Commissioner of Public Health.

Sec. 20-65g. License required for practice and use of title. (a) Except as provided in section 20-65i, no person may practice athletic training unless such person is licensed pursuant to section 20-65j. (b) No person may use the title "licensed athletic trainer" or make use of any title, words, letters or abbreviations indicating or implying that such person is licensed to practice athletic training unless such person is licensed pursuant to section 20-65k.

Sec. 20-65h. Referral to licensed health care provider. (a) Each person who practices athletic training under standing orders shall make a written or oral referral to a licensed health care provider of any athlete who has an athletic injury whose symptoms have not improved for a period of four days from the day of onset, or who has any physical or medical condition that would constitute a medical contraindication for athletic training or that may require evaluation or treatment beyond the scope of athletic training. ~~The injuries or conditions requiring a referral under this subsection shall include, but not be limited to, suspected medical emergencies or illnesses, physical or mental illness and significant tissue or neurological pathologies.~~

(b) Each person who practices athletic training, but not under standing orders~~,~~ SHALL BE LIMITED TO PROVIDING IMMEDIATE INJURY MANAGEMENT AND EMERGENCY CARE ~~may perform initial evaluation and temporary splinting and bracing~~ of any athlete SUFFERING AN ACUTE injury or illness ~~and~~ and shall, without delay, make a written or oral referral of such athlete to a licensed health care provider~~.~~ The limitations on the practice of athletic training set forth in this subsection shall not apply in the case of any athlete that is referred to such person by a licensed health care provider, provided such practice shall be limited to the scope of such referral.

Sec. 20-65i. Exceptions to licensing requirement. A license to practice athletic training shall not be required of: (1) A practitioner who is licensed or certified by a state agency and is performing services within the scope of practice for which such person is licensed or certified; (2) a student intern or trainee pursuing a course of study in athletic training, provided the activities of such student intern or trainee are performed under the supervision of a person licensed to practice athletic training and the student intern or trainee is given the title of "athletic trainer intern", or similar designation; (3) a person employed or volunteering as a coach of amateur sports who provides first aid for athletic injuries to athletes being coached by such person; (4) a person who furnishes assistance in an emergency; or (5) a person who acts as an athletic trainer in this state for less than thirty days per calendar year and who is licensed as an athletic trainer by another state or is certified by the Board of Certification, Inc., or its successor organization.

Sec. 20-65j. Qualifications for licensure. Licensure by endorsement. a) Except as provided in subsections (b) and (c) of this section, an applicant for a license to practice athletic training shall have: (1) A baccalaureate OR A GRADUATE degree from a regionally accredited institution of higher education, or from an institution of higher learning located outside of the United States that is legally chartered to grant postsecondary degrees in the country in which such institution is located; and (2) current certification as an athletic trainer by the Board of Certification, Inc. , or its successor organization. (b) An applicant for licensure to practice athletic training by endorsement shall present evidence satisfactory to the commissioner (1) of licensure or certification as an athletic trainer, or as a person entitled to perform similar services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, and (2) that there is no disciplinary action or unresolved complaint pending against such applicant.
(c) Prior to April 30, 2007, the commissioner shall grant a license as an athletic trainer to any applicant who presents evidence satisfactory to the commissioner of (1) the continuous providing of services as an athletic trainer since October 1, 1979, or (2) certification as an athletic trainer by the Board of Certification, Inc. , or its successor organization.

Sec. 20-65k. License to practice athletic training. Fees. (a) The commissioner shall grant a license to practice athletic training to an applicant who presents evidence satisfactory to the commissioner of having met the requirements of section 20-65j. An application for such license shall be made on a

form required by the commissioner. The fee for an initial license under this section shall be one hundred and ninety dollars.

(b) A license to practice athletic training may be renewed in accordance with the provisions of section 19a-88, as amended, provided any licensee applying for license renewal shall maintain certification as an athletic trainer by the Board of Certification, Inc., or its successor organization. The fee for such renewal shall be two hundred dollars.

(c) The department may, upon receipt of an application for athletic training licensure, accompanied by the licensure application fee of one hundred ninety dollars, issue a temporary permit to a person who has met the requirements of subsection (a) of section 20-65j, except that the applicant has not yet sat for or received the results of the athletic training certification examination administered by the Board of Certification, Inc., or its successor organization. Such temporary permit shall authorize the permittee to practice athletic training under the supervision of a person licensed pursuant to subsection (a) of this section. Such practice shall be limited to those settings where the licensed supervisor is physically present on the premises and is immediately available to render assistance and supervision, as needed, to the permittee. Such temporary permit shall be valid for a period not to exceed one hundred twenty calendar days after the date of completion of the required course of study in athletic training and shall not be renewable. Such permit shall become void and shall not be reissued in the event that the permittee fails to pass the athletic training certification examination. No permit shall be issued to any person who has previously failed the athletic training certification examination or who is the subject of an unresolved complaint or pending professional disciplinary action. Violation of the restrictions on practice set forth in this section may constitute a basis for denial of licensure as an athletic trainer.

Sec. 20-65l. Regulations. Administration within available appropriations. The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the provisions of this chapter. The commissioner shall administer the provisions of this chapter within available appropriations.

Sec. 20-65m. Disciplinary Action. Grounds. The Department of Public Health may take any action set forth in section 19a-17 of the general statutes if a person issued a license pursuant to section 20-65k of the general statutes, as amended by this act, fails to conform to the accepted standards of the athletic trainer profession, including, but not limited to, the following: Conviction of a felony; fraud or deceit in the practice of athletic training; illegal, negligent, incompetent or wrongful conduct in professional activities; emotional disorder or mental illness; physical illness including, but not limited to, deterioration through the aging process; abuse or excessive use of drugs, including alcohol, narcotics or chemicals; wilful falsification of entries into any patient record pertaining to athletic training; misrepresentation or concealment of a material fact in the obtaining or

reinstatement of an athletic trainer license; or violation of any provisions of chapter 375a of the general statutes, or any regulation adopted under said chapter
375a. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if the license holder's physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17 of the general statutes. Notice of any contemplated action under said section 19a-17, the cause of the action and the date of a hearing on the action shall be given and an opportunity for hearing afforded in accordance with the provisions of chapter 54 of the general statutes.

Appendix I

NATA News Articles, Typical Workday of Athletic Trainer in Industrial Setting

NATA News — April 2016

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Opportunities Continue to Grow for ATs in the Military

JoeEllen Sefton

Musckuloskeletal (MSK) injuries are the single largest impediment to operational readiness in the military setting. More than 600,000 service members sustain an MSK injury each year, resulting in more than 2.2 million medical encounters.1-3 Along with the impact on readiness, MSK injuries are the largest contributor to time lost and account for more than $550 million in direct-care patient costs per year.

Athletic trainers have been utilized in the armed services for more than 50 years. Originally, military ATs worked at the U.S. Military, Naval, Air Force and Coast Guard academies in the traditional roles with sports teams. The physical, physiological and psychological demands of more than 14 years of sustained combat has forced the military to take a new look at the human dimension aspect of caring for warfighters. Repeated deployments with short dwell times have taken a hard toll on warriors. Forward thinking units have been employing the sports medicine team model to help improve fitness and performance while decreasing MSK injuries. Use of this integrated, multidisciplinary approach to care has now spread across all branches of the military, producing positive changes in health, wellness, fitness and performance. ATs have been shown to be a vital part of these sports medicine teams.

ATs in the military setting are now providing care in all types of units in all of the different military branches. The largest use of ATs currently is in Initial Entry Training (IET), initiated at Fort Jackson, South Carolina, about 10 years ago. ATs have been embedded in the five brigades at Fort Benning, Georgia, (Auburn University Warrior Athletic Training Program) for more than seven years, and the decision was just made to install embedded AT programs at four major Army IET training commands this year.

The Air Force has just started an AT program, based on the Army IET/BTC model, at Lackland Air Force Base, Texas, with the 323rd Training Squadron (Basic Military Training), 342nd Training Squadron (Technical Training - Special Ops/Battlefield Airmen) and 343rd Training Squadron (Technical Training - Security Forces).

These programs incorporate the sports medicine team model to provide rapid evaluation, treatment, rehabilitation and return to duty, as well as education, injury prevention and fitness/wellness improvement. These programs not only expose new warfighters to the benefits of working with ATs, they are also demonstrating the importance of having subject matter experts in prevention, evaluation, treatment, rehabilitation and fitness immediately accessible within the unit. These programs have proven their value to the commands through actionable data on cost and time-lost savings and injury mechanisms information that direct prevention initiatives. The commands have become the force behind the expansion of the sports medicine team concept.

The Navy and Marine Corps (USMC) have incorporated ATs into the medical model for the past 15 years. The Navy and USMC sports medicine and rehabilitation team (SMART) model was designed to provide early diagnosis, intervention and treatment of injuries and to manage rehabilitation and minimize the effects of injuries on training. The SMART clinic allows health care leaders, clinicians and training staff to implement strategies to mitigate MSK injuries within their population. The co-location of the health care staff to an area proximal to the training sites allows for superior communication among providers, as well as other workplace synergies that can improve the delivery of MSK care. USMC quickly recognized the cost and significance of MSK injuries to readiness and incorporated the Sports Medicine Injury Prevention (SMIP) initiative to mitigate these potential losses. The primary focus of the SMIP program is reduction of injury risk, rapid injury detection and assurance that initial evaluation and treatment assets are readily available.

The Navy has incorporated a similar model in the special operations community (U.S. Navy SEALS) and eventually branched out to the Naval Special Warfare Command Basic Underwater Demolition School and several other training commands. Army ranger and other special operations units were some of the first Army units to incorporate the sports medicine team concept. These programs are an integral part of the daily sustainment of the “Tip of the Spear” combat units, keeping them ready to deploy with a few hours’ notice.

Through this multidisciplinary sports medicine team model, ATs are influencing every aspect of the military human dimensions initiatives. ATs are a part of the team developing injury prevention and education programs, providing

evaluation and assessment, treatment, rehabilitation and restoration of function post injury as well as influencing the human performance initiatives throughout the military by improving fitness and functional performance of tactical athletes.

AT researchers are currently looking at the data collected in all of these settings to develop the most effective measures to train tactical athletes, predict and prevent injury, screen for movement dysfunction, and develop better ergonomic designs for military equipment to decrease MSK injury. New methods of treatment and rehabilitation are being developed as ATs work to speed return to duty and decrease training time lost as a part of the overall effort to improve the health and wellness of warfighters while improving military readiness.

The NATA Committee on Practice Advancement Military Workgroup was developed to increase the opportunities for the athletic training professionals who currently serve military service members and those who may be interested in working in the military setting. The missions of the military workgroup are to 1) provide military medical professionals educational materials about the athletic training profession: scope of care, lines of supervision and certification requirements; 2) improve utilization of ATs; and 3) improve dissemination of information to the AT community regarding employment (location of postings, requirements, knowledge, skills and abilities). The military workgroup has made great progress on this mission over the past few years and will continue to work to improve access to ATs for military service personnel.

JoeEllen, PhD, ATC, Auburn University associate professor and Warrior Research Center director, and Michael Hooper, MA, ATC, LAT, CSCS, Naval Special Warfare Sports Medicine Program manager, are members of the NATA Committee on Practice Advancement Military Workgroup. For more information on the military setting, contact Hooper at mhooper3@cox.net.

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NATA News — February 2016

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Quigley Saves the Life of Manheim Township Assistant Basketball Coach

In November 2015, Dan Quigley, MSED, LAT, ATC, the longtime Manheim Township athletic trainer, was called to the high school gymnasium for an emergency when the assistant girls' basketball coach collapsed on the gym floor and was not breathing. When Quigley couldn't find a pulse, he administered CPR and directed others to retrieve the automated external defibrillator. Quigley performed several cycles of CPR followed by electrical shocks before the coach started to breathe on his own. Quigley continued to provide the necessary care until emergency medical services arrived on the scene. The coach was transported to the emergency room and continues to recover.

Roger Czerwinski, director of athletics for Manheim Township High School, said this was the first time in his 14 years as an athletic administrator that he experienced a situation similar to this one.

"Our licensed athletic trainer took complete control of the situation and was able to save our coach's life with his quick thinking and acting," he said. "In our opinion, [as the] first responders, his heroic actions may go unnoticed by some, but here at Manheim Township, we are truly grateful for the efforts of Mr. Quigley not only last Friday, but each day."

ATs Win Research Award to Fund Air Force Project

Two University of the Incarnate Word athletic trainers, Shandra Esparza, EdD, ATC, LAT, and Reid Fisher, EdD, ATC, were awarded a Clinical Research Initiative Intramural Research Award to fund a project titled "Athletic Trainer Integration in U.S. Air Force Basic Training: Reducing Injury and Related Costs." This 30-month, $970,000 project will embed two athletic trainers within an Air Force squadron of 1,200 Trainee Airmen at Lackland Air Force Base in San Antonio, Texas. The project hopes to prove efficacy for a larger Air Force initiative planned to eventually employ more certified athletic trainers. The award will also establish a research agenda and a freestanding athletic training facility within the squadron as well as educate independent duty medical technicians to provide better care within their scope. Activities such as gait analysis and modification will be the focus in order to reduce stress-related injuries that commonly affect Air Force trainees, adding significant time and cost to training. Outcomes hope to show decreased rate of injury and time out of training.

Sacred Heart ATP to Study Lacrosse/Brain Injury Relationship

The athletic training education program at Sacred Heart University received a $15,000 grant from U.S. Lacrosse to study the possible connection between lacrosse and brain injuries. The grant will fund research into the effects of on-field head impacts received by players on the university's men's lacrosse team during the course of the season. Athletic training students will work with the program's professors and the athletic training staff to collect data for the 2016 season. The data will be provided through helmet-mounted impact sensors worn for practices and games. In addition to the helmet sensors, the grant money will be used to provide a system for testing the athletes before and after suffering a head injury. The title of the study is "The Effect of Cumulative Impacts on Vestibular Ocular Reflex in Division I Men's Lacrosse Players," and it will be managed by Athletic Training Program Director Theresa Miyashita, PhD, ATC.

Sigman Helps Save Quarterback in Distress

Brian Sigman, ATC, was watching the Hurricane High School boys' basketball practice when he received a phone call telling him a football player passed out in the weight room. After rushing to the facility, Sigman found Andrew Parks, a 14-year-old freshman quarterback, on the floor. Parks was unconscious and Sigman could not detect a pulse. Sigman began to perform CPR until EMS arrived. Parks received six shocks from a defibrillator and was transferred to Cincinnati Children's Hospital where he was kept on a ventilator for two days. He was diagnosed with Long QT syndrome, a rare inherited heart condition that can cause rapid and chaotic heartbeats. Parks was expected to return to school in early 2016.

Brewers Staff Received Martin-Monahan Award

The medical staff of the Milwaukee Brewers became the first repeat recipient of the Martin-Monahan Award when it was honored for the 2015 season. The staff previously won the award in 2005. The Martin-Monahan Award was named after athletic trainers Dick Martin, ATC, of the Minnesota Twins and Gene Monahan, ATC, of the New York Yankees, and is based on statistical measures such as days lost to injury and costs in lost salaries. The Brewers staff is headed by Roger Caplinger, ATC, the director of medical operations, and Dan Wright, MS, ATC, CSCS, the head athletic trainer.

VIEW ALL ARTICLES

NATA News — January 2016

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THE HUB

AT Collaborates to Save Life of Cross Country Meet Volunteer

Bellin Health Sports Medicine's Chad Carter, LAT, ATC, CES, helped to save a life at the Green Bay City Cross Country meet. A volunteer who was working the event had fallen to the ground and was nonresponsive. The individual had suffered a sudden cardiac issue that resulted in staff and coaches at the prerace meeting performing CPR until Carter arrived and was able to use his AED and continue CPR. With the effort of all those involved, the patient made it to the hospital and through surgery that afternoon, and he recovered in a local hospital with his family.

ATs Recognized By Soccer Player's Family

In a letter on the WestportNow website, members of the athletic training staff at Staples High School were lauded by the family of a soccer player for helping to save his life. Head Athletic Trainer Gaetana Deiso, ATC, Assistant Athletic Trainer Corey Iomonico, ATC, and Tiffany Kinahan, an athletic training intern from Southern Connecticut State University, were instrumental in saving the life of Andrew Ingber when he collapsed during halftime of a game. After Ingber fell, Deiso performed CPR with the assistance of Kinahan while Iomonico brought an AED to the scene. This episode also served as a catalyst to improve safety for other area schools. Seeing the critical role the AED played in saving his son's life, Ingber's father, David Ingber, began to work with the Adam Greenlee Foundation to provide AEDs for other schools. After they appeared together at a meeting before the Board of Education, the superintendent of schools requested to purchase approximately 50 AEDs, including portable units for field trips and travel games.

IADMS Honors Two Athletic Trainers as Fellows

Two ATs were inducted as Fellows of the International Association for Dance Medicine & Science (IADMS) in October 2015. Jatin Ambegaonkar, PhD, ATC, OT, CSCS, of George Mason University, and Dr. Jeff Russell, PhD, ATC, of Ohio University, were among six fellows honored at the IADMS conference in Pittsburgh. Both also began new terms on the IADMS Board of Directors.

Athletic Training Summer Camp Scholarship Available

In 2016, the New Hampshire Musculoskeletal Institute will again offer the Letendre Student Athletic Training Summer School Scholarship. This scholarship provides funds for students interested in careers in the sports medicine field or athletic training to attend a summer camp. The scholarship recipient may select which camp to attend. The award will have a $750 cap. The deadline to apply for the scholarship is April 1. The 2015 Scholarship winner was Kaitlyn Maguire from Arlington Catholic High School in Massachusetts, and she attended a camp at Springfield College. Current-year high school sophomores and juniors are eligible to apply. Complete information about the scholarship, including past recipients and application, is available at www.nhmi.net/scholarship.html.

AT Honored by Troy University

After 29 years at Troy University, with 25 of them as the university's head athletic trainer, Chuck Ash, MS, ATC, decided that the time was right to retire. On the occasion of his final home football game, former students and players converged on the campus to pay tribute to the man who played such an influential role in their lives. The guests returned to campus from cities as far away as Boston and Indianapolis to attend a reception that was held after the game. In addition to his long working relationship with the university, Ash graduated from the school, which was then known as Troy State, in 1978 and earned a master's in education in 1979. He would return to the school in 1987 as the school's assistant athletic trainer. Earlier this season, the team marked Ash's 300th game by presenting him with the game ball. Although he will be retired from his day-to-day responsibilities with the university, Ash still plans to work there on a part-time basis.

Emergency Action Plan Helps Save Softball Player

The quick actions of Rachel Hall, ATC, and Terry Adair, ATC, helped save a softball player during a tournament in Lincoln, Nebraska. The two ATs were working at the first aid tent when 15-year-old Madison Schrader was brought in for

evaluation after exhibiting confusion and impaired vision. Hall said Schrader was lethargic, had trouble staying awake and demonstrated other neurologic symptoms. She decided they needed to transport Schrader to the hospital as soon as possible. It was at this point Adair activated their emergency action plan. They kept Schrader comfortable and stable until the ambulance arrived. She was taken to the Bryan Trauma Center, where she was in a coma for 36 hours because of a brain injury. Schrader was later transferred to Children's Hospital in Omaha where she was able to begin therapy.

VIEW ALL ARTICLES

NATA News — March 2016

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Spectator Saved By Aukamp and Tucker

During the Delaware State Boys' Soccer Tournament, two secondary school athletic trainers worked with a spectator and school administrator to save a life. Jim Tucker, ATC, and Craig Aukamp, ATC, sprinted across the field, reacting quickly to screams for help from the stands. They were able to use an AED to save the life of a spectator who had suffered a heart attack.

University of Louisiana at Lafayette Study on Concussions in Hockey

The director of the University of Louisiana at Lafayette's athletic training program is leading a study to compile data on concussions and ice hockey. Randy Aldret, EdD, ATC, LAT, and UL Lafayette have partnered with the Southern Professional Hockey League's Louisiana IceGators. Twenty players on the team have agreed to participate in the study, which will examine physiology and neurocognitive function. The players will be evaluated over the course of the season, in addition to the pre- and post-season periods. The IceGators season runs October through April. Specific areas the study will focus on are cognition, balance and sleep patterns. These will be observed through a battery of established tests, including MRIs. The players will also have their blood analyzed to monitor certain protein levels, which are elevated with a brain injury.

Hockey Association to Award Carrier

Michigan State University associate head athletic trainer and NATA Hall of Fame member Dave Carrier, MA, ATC, will receive the 2016 Jim Fullerton Award from the American Hockey Coaches Association (AHCA) at the ACHA convention in April. The Jim Fullerton Award was established to honor individuals who exhibit a passion for the sport and exemplify the award's namesake, who was the longtime hockey coach at Brown University. Carrier has worked with the hockey team at Michigan State for 32 years. He also worked with the hockey team at Ferris State University for five years before coming to East Lansing. Carrier worked with the U.S. hockey team at the 1988 Olympics and 1990 World Championships, and worked with ski jumpers and Nordictrack athletes during the 1992 Olympics. In addition to his Hall of Fame election, Carrier has received the Most Distinguished Athletic Trainer Award from NATA, the Outstanding Educator Award from the Great Lakes Athletic Trainers' Association and is a past president of the Michigan Athletic Trainers' Society.

Hodges and Snoddy Recognized at TATS Meeting

Chelsea Hodges, LAT, ATC, and Chris Snoddy, ATC, LAT, received a Lifesaver Certificate of Recognition from the Tennessee Athletic Trainers' Society at the group's annual meeting. Hodges and Snoddy performed CPR and used an AED to save the life of a middle school parent watching a basketball practice at Goodpasture Christian School. After taking a few jump shots, the parent began to feel ill so he went to sit down on the bleachers. His condition worsened and the athletic trainers were called. The man had suffered a heart attack and when Hodges and Snoddy arrived, they performed a quick assessment, immediately began CPR and provided timely defibrillations. The parent was transported to a local hospital, where the emergency room physician said Hodges and Snoddy saved the 45-year-old's life. Hodges and Snoddy were nominated for the honor by by Jill Krantz, a parent, teacher and school administrator at Goodpasture Christain School.

Ransone Director of Nebraska Athletic Performance Lab

Jack Ransone, PhD, ATC, took on a new challenge when he was appointed director of the Nebraska Athletic Performance Lab (NAPL). To take the position, Ransone left Texas State University, where he had been the director of athletic training as well as a professor in the program. The NAPL facility was created in 2013 and is a state-of-the-art laboratory for enhancing athlete performance. NAPL occupies 23,000 square feet on the second and third floors of East Memorial Stadium. It has weight machines, a 50-foot Kenzo mat for running, a half basketball court and a runway for sprinters. About 20 three dimensional cameras hang throughout NAPL. They pick up reflective markers placed all over the athlete's body, part of a motion-analysis system that quantifies joint and whole-body movement patterns. Also, force

plates are under the mat, court and turf to measure weight distribution force output, vertical jump and improve horizontal plyometrics, respectively. Another feature of NAPL is a saliva lab, used to identify and help alleviate stresses by assessing the physiological and pathological status of an individual.

WATA Honors Life Saver Carter

The Wisconsin Athletic Trainers' Association recognized Chad Carter, LAT, ATC, CES, from Bellin Health Sports Medicine for helping save a volunteer's life at a cross country event. Carter was working the Green Bay City Cross Country meet when he was notified there was an issue on the other side of the park. A volunteer who was also working the event had fallen to the ground and was nonresponsive. The individual had suffered a sudden cardiac issue that resulted in staff and coaches performing CPR until Carter arrived and was able to use his AED and perform CPR while waiting for EMS to arrive. With the effort of all those involved, the patient made it to the hospital and through surgery that afternoon. He recovered in a local hospital with his family.

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The Hub

Burke and Bennett Save Sports Writer

In March, reporter Marty Myers drove to Freedom High School in Bethlehem, Pennsylvania, to cover a basketball game for the Scranton Times-Tribune. Before he made it into the gym, though, he collapsed due to sudden cardiac arrest. Athletic trainers Maureen Burke, ATC, and Dana Bennett, MS, LAT, ATC, were on site and able to quickly provide care. Burke is the AT for Dunmore High School and Bennett is the AT for Freedom High School. After assessing his condition, Bennett began CPR and Burke employed an AED the Dunmore AT staff brings to all the events they cover. The use of the AED recovered Myers's heartbeat and he was transported to St. Luke's Hospital for further treatment.

Oregon State Basketball Player Saved by Fregoso

A student basketball player was doing drill work with an assistant coach when he collapsed. Tom Fregoso, MS, ATC, was summoned and immediately assessed the situation. EMS was called and the AED was applied. Shocks were delivered and the student athlete stabilized. He was transported to a local hospital. Follow-up analysis showed that the timeliness of Fregoso's action saved the student's life.

Leonard Aids Wrestler With Wolff-Parkinson- White Syndrome

Greater Regional Medical Center AT Chris Leonard, ATC, LAT, CSCS, was covering the Iowa high school state wrestling tournament when he had to employ his lifesaving skills during a semifinal duals match. Tayler Pettit was competing for Creston/Orient-Macksburg High School when, after his second match of the day, he told Leonard he was experiencing shortness of breath. Shortly after, Pettit collapsed, began seizing and went into cardiac arrest. Leonard was soon joined by other members of the Iowa High School Athletic Association medical staff at the tournament. They started CPR and used an AED and were able to shock Pettit's heart back into rhythm. Pettit was taken to Mercy Children's Hospital where a respirator was used to help him breathe while doctors monitored his heart. Testing revealed he suffered from Wolff-Parkinson-White Syndrome, a disorder of the heart's electrical system. According to the doctors, Pettit should be able to return to sports during the spring. When he was discharged, a statement from Pettis's parents was included in the announcement from the hospital in which they specifically acknowledged Leonard for his role in saving their son's life.

Blood Test Shows Promise for Detecting Concussions

A study featured in the journal JAMA Neurology provides evidence that a simple blood test could be used to detect concussions in the future. Although the results are preliminary, the study involving patients at a Florida hospital indicated that a protein associated with head trauma was still detectable in the blood up to a week after the injury. This fact could assist in diagnosing patients who don't immediately seek treatment. Regular use of the test is most likely several years away, but the study findings are a major advancement in the development process.

Ivy League Football Teams to Remove Tackling from Practices

In an effort to reduce the risk of brain trauma and other injuries during the college football season, the coaches of the Ivy League schools voted to eliminate all full-contact hitting from practices. The eight head coaches voted unanimously to adopt the new measure. This will be in addition to the current conference standards governing contact for spring and preseason practices, which are some of the strictest in college football. The inspiration for the new standards came from conference member Dartmouth, which had eliminated full-contact practices in 2010. In addition to football, the league is investigating the rules of several other sports, including men's and women's hockey, lacrosse, soccer, rugby and wrestling to see if there are ways to reduce brain trauma.

NCAA-DOD Concussion Study Expands to 30 Schools

The NCAA-Department of Defense Concussion Assessment, Research and Education (CARE) Consortium study recently added nine institutions to the roster of participants. The new members of the study are Bloomsburg University of Pennsylvania, University of Chicago, University of Miami (Florida), University of North Georgia, University of

Pennsylvania, Temple University, Wake Forest University, Wilmington College (Ohio) and Winston-Salem State University. The new schools will begin the process of baseline screening for all student athletes this summer. In addition to a comprehensive preseason evaluation for concussion, all student athletes will be monitored in case an injury occurs. To date, more than 25 million data points from 16,000 student athletes at the 21 institutions have been collected. With the nine additional testing sites, it is expected that more than 25,000 student athletes will participate in the study over the three-year course run.

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CONNECTICUT ATHLETIC TRAINERS ASSOCIATION

TYPICAL DAY – ATHLETIC TRAINER AT CLINICAL SITE

Athletic Trainer is assigned to company 15 hours per week

* First Aid according to OSHA for employees: Massage, brief assessments, taping, ice/heat

* Job Analysis: Break down of the physical demands required to complete a task

* Risk Analysis: Estimation of potential injuries that could occur when completing a task

* Job Coaching: Instructing employees on better body mechanics

* Preventative Stretching

* Health and wellness presentations

* Functional movement Screen

We could also do Pre employment Screens while on site depending on contract.

As for training, the athletic trainers complete a 16 hour training course about ergonomics, OSHA, & safety.